AGENDA

Executive Quality Improvement Health Equity Committee (EQIHEC) Meeting

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

Tuesday, March 17, 2026

7:15 A.M.

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

COMMITTEE MEMBERS: Cassandra Mulder; Satya Arya, MD; Danielle Colayco, PharmD; Todd Jeffries; Allen Kennedy; Chan Park, MD; Rukiyah Polk, Tammy Torres.

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 December 16, 2025 – APPROVE

CA-4) Pharmacy Drug Utilization Review (DUR) Minutes from November 24, 2025 – APPROVE

CA-5) Physician Advisory Committee (PAC) Redacted Minutes from October 1, 2025 – APPROVE

CA-6) Physician Advisory Committee (PAC) Redacted Minutes from November 5, 2025 – APPROVE

CA-7) Physician Advisory Committee (PAC) Redacted Minutes from December 3, 2025 – APPROVE

CA-8) Utilization Management (UM) Minutes from December 4, 2025 – APPROVE

CA-9) Population Health Management (PHM) Minutes from December 3, 2025 – APPROVE

CA-10) Quality Improvement Workgroup (QIW) Minutes from December 8, 2025 – APPROVE

CA-11) Network Adequacy Committee (NAC) Q4 2025 Report – APPROVE

CA-12) Behavioral Health Advisory Committee (BHAC) Q4 2025 Report – APPROVE

CA-13) Wellness & Prevention (W&P) Q4 2025 Report – APPROVE

CA-14) Grievance Q4 2025 Report – APPROVE

15) Utilization Management (UM)

a. Q4 2025 UM Report – APPROVE

b. 2026 Program Description – APPROVE

c. 2025 Annual Evaluation – APPROVE

16) Population Health Management (PHM)

a. 2025 & 2026 Strategy – APPROVE

b. 2025 Annual Evaluation – APPROVE

17) Member Engagement (ME)

a. 2025 Member Satisfaction Survey – RECEIVE AND FILE

18) Network Advisory Committee (NAC)

a. 2025 Provider Satisfaction Survey – RECEIVE AND FILE

19) Quality Improvement Workgroup (QIW)

a. 2025 QIHEP Annual Evaluation – APPROVE

b. 2026 QIHEP Program Description – APPROVE

c. 2026 QIHEP Work Plan – APPROVE

20) Quality Performance (QP)

a. Q4 2025 QP Report – APPROVE

21) Health Equity Transformation Steering Committee (HETSC)

a. 2026 HEO Work Plan – APPROVE

b. Birth Bridge Program Description – RECEIVE AND FILE

c. 2025 Annual Evaluation – RECEIVE AND FILE

d. Q4 2025 RAC Report – RECEIVE AND FILE

ADJOURN MEETING TO TUESDAY, JUNE 16, 2026 @ 7:15 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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

COMMITTEE: ***EXECUTIVE QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (EQIHEC)***
DATE OF MEETING: ***December 16, 2025***
CALL TO ORDER: ***7:17 AM BY TRACO MATTHEWS, CHAIR***

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

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Quorum	7 of 11 committee members present; Allen Kennedy, Philipp Melendez, Debra Cox, and Martha Tasinga were absent.	Committee quorum requirements met.	N/A
Call to Order	Traco Matthews, Chair, called meeting to order at 7:17 am.	N/A	N/A
Public Presentation	There were no public presentations.	N/A	N/A

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Committee Announcements	Traco Matthews gave the opportunity for member updates. • Danielle C. thanked Pawan G. for her support for the Komoto vaccine coloring books and added that there	• N/A	• N/A

KHS PROPRIETARY PROPERTY – CONFIDENTIAL

	are 9 languages available. • Magdee H. announced that the EQIHEC needs to fill two positions for 2026 and asked for recommendations for a Federally Qualified Health Provider (FQHC) and a Participating Primary Care Physician (PCP).	• N/A	• N/A
Committee Minutes	**Approval of Minutes** • CA-3) The Committee's Chairperson, Traco Matthews, presented the EQIHEC Minutes from September 23, 2025, for approval.	**Action:** • James M., Todd J. second. All aye's. Motion carried.	12/16/25
Old Business	There was no old business to present.	N/A	N/A
New Business	**Consent Agenda Items** • CA-4) Health Equity Transformation Steering Committee (HETSC) Minutes from August 12, 2025. • CA-5) Behavioral Health Advisory Committee (BHAC) Minutes from July 16, 2025. • CA-6) Pharmacy Drug Utilization Review (DUR) Minutes from August 25, 2025. • CA-7) Physician Advisory Committee (PAC) Redacted Minutes from August 6, 2025. • CA-8) Physician Advisory Committee (PAC) Redacted Minutes from September 10, 2025. • CA-9) Population Health Management Committee (PHMC) Minutes from September 3, 2025. • CA-10) Utilization Management Committee (UMC) Minutes from August 13, 2025. • CA-11) Quality Improvement Workgroup (QIW) Minutes from September 11, 2025. • CA-12) Network Adequacy Committee (NAC) Minutes from July 25, 2025. • CA-13a) Wellness & Prevention (W&P) Q3 2025 Activities Report. • CA-13b) Cultural & Linguistics (C&L) Q3 2025 Activities Report. • A motion to approve Consent Agenda Items was requested.	**Action:** • Satya A. first, Todd J. second. All aye's. Motion carried.	12/16/25

KHS PROPRIETARY PROPERTY – CONFIDENTIAL

	14) Health Equity Transformation Steering Committee (HETSC) • Pawan G. provided an update of the following previously added work plan programs: the 2026 EPT (Equity and Practice Transformation) Payment Program, the Intimate Partner Violence Program, the Cervical Cancer Screening Program (for the Asian and Pacific Islander community), and the Chlamydia Screening Measure Interventions (for Hispanic and rural communities). She advised that no additional programs were added for 2025 and the 2026 work plan will be presented at the first meeting of next quarter. EPT Payment Program highlights include data exchange enhancements with the 12 practices. The practices are improving the capture and sharing of clinical data such as blood pressure, BMI, and visit scheduling; workflow improvements include pre-visit screenings, preventive care prompts, vitals capture, and behavioral health screening integration. The KHS Health Equity department continues to receive positive engagement from the 12 practices. Pawan G. also provided an update on the Q3 Regional Access Committee (RAC) on which the topic was transportation access. The key findings were low awareness of available transportation benefits, confusion about eligibility and how to schedule rides, access challenges in low-mobility or rural areas, and underutilization even among those aware of the benefit. Cassandra M. commented that Uber drivers may deny rides without car seats and that public health offers them for free. A motion to approve was requested. **15) Quality Improvement Workgroup (QIW)** • Magdee H. reintroduced the QIW for the new members of the EQIHEC. He outlined the department's core responsibilities; including maintaining the Quality Program Description, Annual Workplan, and Annual Evaluation; overseeing member safety through review of Quality of Care concerns, Potential Quality Issues,	Action: • Satya A. first, Chan P. second. All aye's. Motion carried. • Chan P. first, Satya A. second. All aye's. Motion carried.	12/16/25 12/16/25

KHS PROPRIETARY PROPERTY – CONFIDENTIAL

	and Provider Preventable Conditions; conducting clinical reviews for member and provider appeals; supporting NCQA accreditation and continuous compliance; and performing clinical network and delegate audits to ensure compliance with DHCS requirements, evidence-based standards, and KHS policies. The QIW is currently focusing on sampling IHA's, lead screening, and telehealth services. A motion to approve was requested. **16) Quality Performance (QP)** • Aurora D. presented the Q3 QP report including trending performance for MY2025 vs MY2024. Some key highlights included: •Purchased multiple lead screening machines for providers in rural regions. • 5 mobile unit providers deployed across Kern County. • Partnerships with more than 15 school districts. • Weekend and evening clinics with two local pediatricians. • Streamline member rewards for behavioral health and children's services. • Dedicated outreach team focused on children's health, specifically driven by need for annual well-care visits. Aurora D. also presented the QP site review updates. For 2025 YTD, 100% of the initial and periodic site reviews passed. Highlights included: • YTD there were 40 site reviews completed by early September 2025. • All site reviews completed timely and thoroughly for Q3 2025. • There are no open CAPs pending follow-up actions. • CMT participates in multiple statewide workgroups focused on updating CDPH training to supplement provider education of children's screenings. • Collaborating with PNM and Learning & Development to share with PCPs. • Traco M. asked for projections on expected performance and which measures may be difficult to meet. Aurora D. anticipates meeting approximately 12-	• Rukiyah P. first, Chan P. second. All aye's. Motion carried.	12/16/25

KHS PROPRIETARY PROPERTY – CONFIDENTIAL

	13 measures at minimum. She added that her personal goal is to meet 14 measures. The measures she identified as challenging are FUA, FUM, and WCV due to large denominators and have historical difficultly improving performance in these areas. Cassandra M. expressed appreciation to Aurora D. for her ongoing support and collaboration with the Childhood Lead Poisoning Prevention Program and highlighted the favorable outcomes of the partnership such as improved communication and engagement with providers, access to data and statistics to better target outreach efforts, and increased provider contacts and inquiries regarding affected children. The partnership is highly effective and valuable, with strong communication and coordination supporting improved care and outreach. A motion to approve was requested. **<u>17) Behavioral Health Advisory Committee (BHAC)</u>** • Melinda S. provided a quick overview of the BHAC and shared Q3 updates. The subcommittee focuses on quality monitoring and performance, clinical guidelines and innovation, care coordination and integration, member experience and engagement, and governance and compliance. Q3 accomplishments and initiatives include the completion of audit tool development, enhanced reporting and tracking processes, expansion of Behavioral Health Treatment services, and finalization of policies and procedures. Melinda S. also shared that there are ongoing efforts to expand and strengthen the provider network. The department is actively working to clean and validate network data, confirm active providers, and address service gaps. A data exchange highlight includes their partnership with KBHRS (Kern Behavioral Health & Recovery Services) that is nearing go-live after a three-year development effort. Final testing is underway and the key benefits would include real-time enrollment visibility, improved coordination between medical and behavioral health providers, and enhanced whole-person car planning. This current shift in focus is to	• Todd J. first, Maggie V. second. All aye's. Motion carried.	12/16/25

KHS PROPRIETARY PROPERTY – CONFIDENTIAL

	support ABA (Applied Behavioral Analysis) program needs which allow CHWs (Community Health Workers) to reallocate efforts to higher-need areas and hard-to-reach populations. The departments are seeing a continued growth in non-specialty behavioral health enrollment. Melinda S. shared the new behavioral health features of the provider portal which include behavioral health conditions, utilization patterns, gaps in care, assigned providers/teams, and records and coordination tools which align with NCQA care integration standards. A motion to approve was requested. **18) Population Health Management (PHM)** • Michelle C. shared that PHM submitted three initiatives that demonstrate a holistic, integrated approach to address complex needs of underserved and vulnerable members. The initiatives are the PCCP (Palliative Care Coordination Program), the High Resource Utilizer Initiative, and the Birthing Care Pathway. The PCCP was presented as a best practice at the Coalition for Compassionate Care of California (CCCC) Annual Summit. The PCCP consists of trained social workers that initiate conversations about palliative care, educate members, and support symptom management and quality of life. A one-year program evaluation showed a 15% reduction in emergency department visits. The next evaluation phase will assess inpatient admissions, urgent care, and outpatient utilization. The High Resource Utilizer Initiative consists of weekly interdisciplinary care team meetings that include physicians, nurses, pharmacy, social workers, behavioral health, and other specialists. The meeting reviews consist of medical complexity, family supports, housing stability, and care readiness and connects members to ECM (Enhanced Care Management), CCM (Complex Care Management), BH, Palliative Care, and Community Services. The third, and final, initiative is the Birthing Care Pathway which is a DHCS requirement for health plans that	• Todd J. first, Satya A. second. All aye's. Motion carried.	12/16/25

KHS PROPRIETARY PROPERTY – CONFIDENTIAL

	aims to address high maternal and infant morbidity/mortality rates statewide. Todd J. shared the positive and effective collaboration between palliative care and hospice services. He stressed the importance of the program and thanked Michelle C. and her team for doing a great job. Michelle C. added that she would like to strengthen her collaboration with public health to leverage their maternal, child, and adolescent health programs to avoid duplication of services. A motion to approve was requested. • Satya A. left the meeting at 8:20am. **19) Utilization Management (UM)** • Dr. Khalsa presented the Q3 UM report and emphasized the departments focus on directing care to the most appropriate provider or setting to improve outcomes and reduce unnecessary cost. Timeliness remains strong with performance near 99% compliance. There is a slight increase in referrals due to expanded review of community supports applications and medically tailored meals requests. The UM audit and compliance review showed improvements in mailing notifications within two days of a decision and referral processing accuracy. The ongoing focus is reducing missing criteria documentation. A policy update was provided and showed that 29 new DSNP policies were approved to support the new Medicare-Medi-Cal (DSNP) line of business. Policies will be available upon request and posted online. Traco M. acknowledged the team' strong performance and significant policy work this quarter and praised UM presentations that clearly state key objectives and clearly track progress and outcomes. A motion to approve was requested. **20) Network Adequacy Committee (NAC)** • Greg P. shared Q3 provider network management activities and network adequacy performance whose	• Chan P. first, Cassandra M. second. All aye's. Motion carried. • Danielle C. first, Rukiyah P. second. All aye's. Motion carried.	12/16/25 12/16/25

KHS PROPRIETARY PROPERTY – CONFIDENTIAL

	responsibilities include establishing network standards, monitoring network compliance, promoting health equity, and steering continuous improvement initiatives. His review included the after-hours survey results, provider accessibility monitoring survey, access grievance review, geographic accessibility and DHCS network certification, network adequacy and provider counts, and recent network provider reporting.
	• After-Hours Survey:
	  ○ 149 PCP Offices Contacted
	  ○ 145 Compliant with Emergency Access Standards
	  ○ 143 Compliant with Urgent Care Access Standards
	  ○ 3% Non-Compliant for Emergency Access Standards
	  ○ 4% Non-Compliant for Urgent Access Standards
	  ○ All non-compliant providers received outreach letters and direct plan follow-up to correct messaging/answering services
	  ○ Outreach has been successful
	• Provider Accessibility Monitoring Survey:
	  ○ Random sample of PCPs, Non-Physician Mental Health, Ancillary, OB/GYN providers addressed for appointment availability
	  ○ Plan-wide compliance achieved for all urgent and non-urgent regulatory standards
	• Provider Accessibility Monitoring Survey by Region:
	  ○ Southern region below 80% non-urgent compliance
	  ○ Eastern and Central regions improved to above 80% compliance this quarter
	  ○ Identified challenges with rural provider availability and repeat sampling
	  ○ Plan will update sampling methodology to better represent the network
	• Access Grievance Review:
	  ○ Overall grievances declined from previous quarter
	  ○ Grievances per 1,000 members decreased		

KHS PROPRIETARY PROPERTY – CONFIDENTIAL

	○ Slight decline grievances resolved in favor of members ○ Most common grievance types: timely access, technology issues, provider availability ○ Continued travel challenges for desert-area members noted, though overall grievances decreased • Geographic Accessibility & DHCS Network Certification: ○ Under review ○ Approved in Q3 ○ Further discussion scheduled for next quarter • Network Adequacy & Provider Counts: ○ PCP count, including both mid-level and physicians, continues to grow ○ Total Specialists Count: 3,612 ○ Increased mental health providers which consist of LCSWs, MFTs, and psychologists • Maggie V. asked where doulas are counted in the provider counts. Greg P. responded that doulas are not counted but can be. He added that they are a new provider benefit and it would be beneficial to see; they will be in the next report. A motion to approve was requested. **21) Member Services** **a) Operation Board Update- Grievance Report** • Amy S. presented the grievance trends that were identified in the 3rd quarter when compared to the previous four quarters. The overall volume of grievance and appeals increased 13.6% in the second quarter and there was also an increase in appeals of 43% from the previous quarter which can be attributed to changes in the criteria for several Community Support Services (CSS) benefits and Applied Behavioral Analysis (ABA) therapy services. After a comprehensive evaluation of CSS, the analysis identified a less-than-favorable return on investment. In response,	• Danielle C. first, Chan P. second. All aye's. Motion carried.	12/16/25

KHS PROPRIETARY PROPERTY – CONFIDENTIAL

	KHS implemented additional oversight for the Medically Tailored Meals (MTM) program to better align the service with DHCS eligibility requirements. The refinements ensure that only members with medically sensitive conditions are approved for the benefit. KHS anticipated an increase in grievances from members who are no longer qualified under the updated criteria and additional oversight. After a comprehensive evaluation of ABA, the analysis identified possible overuse of the services. Most of the records in the sample analysis did not meet medical necessity. To prevent overuse and establish a process, KHS partnered with AllMed, an organization with trained providers who review ABA services for other health plans in California. Amy S. also shared that the volume of exempt grievances increased as well, up 9.5% from the previous quarter, which can be attributed to the changes in scheduling criteria for transportation. It is taking time for members to get used to the new criteria and scheduling time. A motion to approve was requested. **21) Member Services** **b) Grievance Summary Report** • Amy S. presented the Grievance Summary Report which gives a more in-depth look at data than the Operational Board Report. Amy S. shared that 4,024 were received during Q3 with Access to Care Grievances at 22.3%, Quality of Service Grievances at 19.5%, and Quality of Care Grievances at 14.6%. Standard Grievances were at 73% (resolved within 30 days) and Exempt Grievances were at 27% (resolved within one business day). Resolution Outcomes closed in favor of the enrollee were at 44.26%, closed in	• Cassandra M. first, Danielle C. second, All aye's. Motion carried.	12/16/25

KHS PROPRIETARY PROPERTY – CONFIDENTIAL

	favor of the plan or provider at 55.02%, and remained open at time of reporting at .72%. A motion to approve was requested. **22) Wellness & Prevention** • Isabel S. provided a Q3 update on activities and outcomes supporting the W&P department roadmap goals, with emphasis on member engagement, preventative care, and community health initiatives. The key highlights and updates for member communications and outreach included their member newsletter, text message campaigns, and digital campaigns. • Member Newsletter: o 66,000 newsletters distributed o 3,500 large-font newsletters (English and Spanish) to support visually impaired members o First-ever newsletter digital distribution for members opted into SMS o 17,000 members received the newsletter digitally, reducing paper mailings o Fall issues, mailed mid-September, focused on pediatric preventative care, sick visits, member portal access, and Kern Regional Center resources • Test Message Campaigns: o Topics included immunizations, obesity, and health literacy o 46,000 texts sent o 10% click rate which is consistent with the national benchmark • Digital Campaigns (Facebook): o Pediatric immunization post at 5.6% engagement o Well-child visit post at 5.4% engagement o Pain management/fibromyalgia post at 1.5% engagement (intended for a targeted audience) o Engagement rate exceeds the 1% benchmark which indicates a strong community interest	• Chan P. first, Danielle C. second. All aye's. Motion carried.	12/16/25

KHS PROPRIETARY PROPERTY – CONFIDENTIAL

	• Isabel S. also shared updates of their partnerships with Kick It California for nicotine replacement therapy and the Motherhood Project for a postpartum support group.
	• Kick It California:
	  ○ 1,000 members referred
	  ○ 1,000 outreach attempts
	  ○ 14 members enrolled
	  ○ Challenges with cessation engagement were acknowledged
	• Postpartum Support Group:
	  ○ 12 members participated
	  ○ Weekly sessions for 6 weeks
	  ○ Topics included mindfulness and relaxation, maternal mental health, infant nutrition, wellness exams, and care seat safety
	  ○ Participants received diaper bags, resources, and educational materials
	• Isabel S. also shared updates for the following community health and wellness initiatives: the Comprehensive Obesity Management Program, the Live Better Program, Read Your Beats Kern, and a 2 Year School Wellness Grant.
	• Comprehensive Obesity Management Program:
	  ○ 20,000 referrals, 1,000 active participants
	  ○ Provider led obesity medicine training and medication management
	  ○ 250 members lost 5% body weight
	  ○ 200 members lost 10% body weight
	• Live Better Program:
	  ○ 4th site launched in Shafter
	  ○ 69 pilot participants
	  ○ Average of 11 visits per month
	• Read Your Beats Kern:
	  ○ Blood pressure (BP) self-monitoring stations located at Library & Learning Center and Beale library
	  ○ Utilization and BP data being tracked
	• School Wellness Grant:
	  ○ Serving 10 schools countywide
	  ○ Wasco Union High School and Clemens		

KHS PROPRIETARY PROPERTY – CONFIDENTIAL

	Elementary opened "Wellness Corners/Caring Closets" ○ Basic hygiene products include food, clothing, diapers, menstrual products and laundry services ○ Addresses students' and families' basic needs to support overall wellness • Rukiyah P. suggested that the department collaborate with her non-profit, Period Poverty. • Cassandra M. shared her involvement with a drinking and driving program that focuses on the importance of seat belt use. She asked if one of the department posts could be about seat belt use and drinking and driving causing a strain on the medical system. Isabel S. will investigate and advise. • A motion to approve was requested.		

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Next Meeting	The next meeting will be held on Tuesday, March 17, 2026, at 7:15am.	Informational only.	N/A
Adjournment	The Committee adjourned at 9:25am. ***Respectfully Submitted:*** ***Vanessa Nevarez, Health Equity Project Coordinator***	N/A	N/A

For Signature Only – EQIHEC Minutes 12/16/25

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

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

KHS PROPRIETARY PROPERTY – CONFIDENTIAL

KERN HEALTH SYSTEMS

COMMITTEE: **DRUG UTILIZATION REVIEW (DUR) COMMITTEE**
DATE OF MEETING: **NOVEMBER 24, 2025**
CALL TO ORDER: **6:43 P.M. BY BRUCE WEARDA – ALTERNATE CHAIR**

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call – The meeting was called to order at 6:43 pm by Bruce Wearda, RPh, Director of Pharmacy.	Committee quorum requirement met.	*11/24/25*
APPROVAL OF MINUTES	The Committee's Alternate Chairperson, Bruce Wearda, presented the meeting minutes for approval.	☑ **ACTION**: Dr. Srinivas moved to approve minutes of May 19, 2025, seconded by Pat Person. 5 approved, 0 nays.	*11/24/25*
OLD BUSINESS	None		*N/A*
NEW BUSINESS	• **Report on Plan Utilization Metrics** Bruce Wearda shared the metrics with the committee. There were no discussion items.	N/A	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• **Educational Articles** Bruce Wearda shared the articles in the packet with the committee. 1. Xylazine in Illicit Drugs Increases Dangers Associated with Overdose 2. Medi-Cal Coverage of Vaccines • **DUR General Topics** 1. Vaccine Coverage 2. D-SNP Update - Bruce shared that open enrollment is underway and we have members signing up. Bruce then explained that Health Plans must follow CMS guidelines regarding Medicare Part B coverage criteria. Plans must adhere to National Coverage Determination (NCD) and Local Coverage Determination (LCD). If no NCD or LCD exists, plans then may make their own criteria. • **Intravitreal Eye Injection Criteria** 1. Bruce presented the criteria, there was no discussion. • **DHCS/Executive Order N 01-19** 1. Changes 01/01/2026	Dr. Srinivas asked if these articles will go to members. Bruce answered no, these articles were designed for providers and KFHC forwards what DHCS sends to us. • Recommended action – Bruce called for a vote to adopt KHS' Intravitreal Eye Injection Criteria. Dr. Srinivas moved to approve, and Dr. Farrer seconded. 5 approved, 0 nays. Bruce explained the changes to the committee that will be effective 01/01/2026. They primarily include no coverage for GLP-1 for weight loss and some OTC products, primarily vitamins and minerals. Dr. Sarabjeet Singh stated Zepbound is covered for sleep apnea, will KHS also cover this? Zepbound is also used for fatty-liver disease. Bruce stated they are carved out of KFHC and Medi-Cal would cover, but requires a prior-auth.	*11/24/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	2. Prior Authorization Enhancements Bruce shared Medi-Cal's bulletin on how they are improving or enhancing the prior-authorization process. There was no discussion. 3. Updates to Physician Administered Drugs Bruce shared that there were updated and modifications on how they will cover physician administered drugs.	Dr. Srinivas expressed concern about administering the medicine and not getting paid. Bruce stated this would only apply to those facilities and providers that are able to bill as a NCPDP-type claim. Which is your typical pharmacy claim.	
OPEN FORUM	There were no topics presented during open forum.	☑ **ACTION**: N/A	*11/24/25*
NEXT MEETING	Next meeting will be held **Monday,** **February 23, 2026 at 6:30 pm**	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned 7:20 pm.	☑ **ACTION**: Dr. Srinivas moved to adjourn the meeting. Dr. Farrer seconded it. 5 Ayes, 0 Nays.	*11/24/25*

Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator

For Signature Only – Drug Utilization Review Committee Minutes 11/24/25

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____

Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***October 1, 2025***
CALL TO ORDER: ***7:05 AM BY MARTHA TASINGA, MD – KHS CHIEF MEDICAL DIRECTOR***

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga MD, KHS Chief Medical Officer, called the meeting to order at 7:05 AM.		N/A
Public Presentation	There were no requests for public or committee member presentations.		
Committee Minutes	**Approval of Minutes** Dr. Tasinga presented the meeting minutes of September 10, 2025 for review and approval.	☑ **ACTION**: Dr. Amin moved to approve minutes of September 10, 2025, seconded by Dr. Parmar. Motion carried.	10/1/25
Committee	There were no committee announcements	☑ **CLOSED** – Informational Only	N/A

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Announcements			
PEER REVIEW REPORTS ACTIVITIES	**Peer Review Reports** **CREDENTIALING REPORT** **Mental Health Pre-Approvals from Reports dated 10/29/2025:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on 10/29/2025 Credentialing Reports, all files met clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers pre-approved by Dr. Tasinga were accepted as presented with no additional questions or alternative actions. Comprehensive Reviews regarding mental health & behavioral health providers were reviewed under the Initial Credentialing Report below. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **10/01/2025.** The clean files were accepted as presented with no additional discussion. The following initial applications were presented for comprehensive review: • [redacted] **RECREDENTIALING REPORT** Recredentialing Providers Lists Dated **10/01/2025** were presented**:** • Recredentialing files meeting clean file review, report dated	☑ **ACTION**: Dr. Lascano moved to approve the Behavioral/Mental Health Credentialing Report dated 10/29/2025, seconded by Dr. Amin. Motion carried. ☑ **ACTION**: Dr. Amin moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated 10/01/2025, seconded by Dr. Lascano. Motion carried. ☑ **ACTION**: Dr. Amin moved to approve Comprehensive Reviews as listed with approval recommendations for [redacted] (3-yr appointment), seconded by Dr. Lascano. Motion carried.	*10/29/25* *10/01/25*

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	10/01/2025, were accepted as presented with no additional questions or alternative actions. **Member Grievances**: Magdee Hugais presented the Member & Quality Grievances of .99 or higher; there was 3 providers listed over .99, however, it was reported there were no QOC concerns identified. The following recredentialing applications were presented for comprehensive review: • [redacted] • [redacted] • [redacted] **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated **October 1, 2025**, were accepted as presented with no additional questions or comments by the committee members.	**ACTION**: Dr. Amin moved to approve Comprehensive Reviews as listed with approval recommendations for [redacted] and [redacted] (3-yr appointments), seconded by Dr. Parmar. Motion carried.	*10/01/25*

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS: Yolanda Herrera, KHS Credentialing Manager reported on the September 2025 Monthly Monitoring of Disciplinary Actions and/or Adverse Events. **No new events to report.** Monthly monitoring includes state and federal websites including OIG, SAM, NPDB Continuous Query, DHCS Restricted Providers, DHCS Suspended & Ineligible resulted in no new findings or updates. **No new events to report.**	☑ **ACTION**: Dr. Amin moved to approve the monthly monitoring report as presented with no new findings or updates, seconded by Dr. Lascano. Motion carried.	*10/1/25*
OLD BUSINESS	**Level 2 Potential Quality Issues (PQIs)** Magdee Hugais, Director of Quality Improvement presented the August Level 2 PQI Report. [redacted]	☑ **CLOSED**: Dr. Amin moved to approve closure of PQI Case and Track and Trend Level 2, seconded by Dr. Lascano. Motion carried.	*10/1/25*

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEW BUSINESS	**Level 2 Potential Quality Issues (PQIs)** There were no new cases to present.	☑ **CLOSED** – Informational Only	*N/A*
	Quality Improvement Revised Policy and Procedures Magdee Hugais, QI Director presented the following QI P&P 2.70-I Potential Quality Issues revisions as follows: • *Revised to be bring compliant with current practice.* • *Update PQI Levels and definitions* • *Revisions to Processing PQI Referrals* • *Revisions to Corrective Action Plans* • *Revisions to Tracking and Trending process* • *Revisions to AttachmentsA-E: Medical Request Form, Medical Director Referral Form, Dispositions for Grievances, Corrective Action Plan Form and PQI Tracking Categories*	☑ **ACTION**: Dr. Amin moved to approve the revisions to QI P&P #2.70-I Potential Quality Issues as presented, seconded by Dr. Parmar. Motion carried	*10/01/25*
	Credentialing Revised Policy and Procedures Yolanda Herrera, Credentialing Manager presented the following P&P revisions: • **23.09-P_Urgent Care Center Revised** *Minor revisions to bring up-to-date with current practice and credentialing requirements.* • **23.14-P_CLIA Certification Requirements Revised** *Minor revision to include Medicare approved laboratory accreditation sources. Added verification source website to be used during primary source validation of CLIA Certificates.* • **23.22-I_Ongoing Monitoring and Interventions Revised** *Added new NCQA Standards CR5 related to Medicare and Medi-Cal Sanctions and Exclusions. Changed monitoring from every 6-months to monthly. Added new Licensing monitoring of expirations dates monthly. Added appropriate interventions and evidence of review in PAC Meeting minutes.*	☑ **ACTION**: Dr. Amin moved to approve the revisions to QP-Credentialing P&Ps #23.09-P, 23.14-P and 23.22-I and New Policy Monitoring Provider Exclusions as presented, seconded by Dr. Parmar. Motion carried	*10/01/25*

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• **NEW P&P Monitoring Provider Exclusions** *New Medicare Policy to ensure all providers who submit a contract to the plan as well as all providers to whom a claims payment is made will be monitored against federal and state exclusion lists and describes if any contracted provider is found to be subsequently included on any of the identified lists that provider will be promptly terminated from the applicable network*		
OPEN FORUM	There was no open discussion.	☑ **CLOSED** – Informational Only	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, November 5, 2025	Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 7:45 AM. **Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator**	**N/A**	*N/A*

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

For Signature Only – Physician Advisory Committee Minutes 10/01/2025:

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
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

KERN HEALTH SYSTEMS

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***November 15, 2025***
CALL TO ORDER: ***7:04 AM BY MARTHA TASINGA, MD – KHS CHIEF MEDICAL DIRECTOR***

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga MD, KHS Chief Medical Officer, called the meeting to order at 7:04 AM.		N/A
Public Presentation	There were no requests for public or committee member presentations.		
Committee Minutes	**Approval of Minutes** Dr. Tasinga presented the meeting minutes of October 1, 2025, for review and approval.	☑ **ACTION**: Dr. Patel moved to approve minutes of October 1, 2025, seconded by Dr. Parmar. Motion carried.	11/5/25

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Committee Announcements	There were no committee announcements	☑ **CLOSED** – Informational Only	N/A
PEER REVIEW REPORTS ACTIVITIES	**Peer Review Reports** **CREDENTIALING REPORT** **Mental Health Pre-Approvals from Reports dated 11/03/2025:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on **11/03/2025** Credentialing Reports, all files met clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers pre-approved by Dr. Tasinga were accepted as presented with no additional questions or alternative actions. Comprehensive Reviews, if any, regarding mental health & behavioral health providers were reviewed under the Initial Credentialing Report below. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **11/05/2025.** The clean files were accepted as presented with no additional discussion. The following initial applications were presented for comprehensive review: • [redacted] **RECREDENTIALING REPORT** Recredentialing Providers Lists Dated **11/05/2025** were presented**:** • Recredentialing files meeting clean file review, report dated **11/05/2025**, were accepted as presented with no additional questions or alternative actions. **Member Grievances**: Magdee Hugais presented the Member &	☑ **ACTION**: Dr. Patel moved to approve the Behavioral/Mental Health Credentialing Report dated 11/03/2025, seconded by Dr. Parmar. Motion carried. ☑ **ACTION**: Dr. Patel moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated 11/05/2025, seconded by Dr. Parmar. Motion carried. ☑ **ACTION**: Dr. Patel moved to approve Comprehensive Reviews as listed with approval recommendations for [redacted]**0** (3-yr appointment), seconded by Dr. Parmar. Motion carried.	11/5/25 11/5/25

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Quality Grievances of .99 or higher; there was 3 providers listed over .99, however, it was reported there were no QOC concerns identified. The following recredentialing applications were presented for comprehensive review: • [redacted] • [redacted] • [redacted] • [redacted] **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated **November 5, 2025**, were accepted as presented with no additional questions or comments by the committee members.	**ACTION**: Dr. Patel moved to approve Comprehensive Reviews as listed with approval recommendations for [redacted] (3-yr appointments), seconded by Dr. Parmar. Motion carried.	11/5/25

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS: Yolanda Herrera, KHS Credentialing Manager, reported on the October 2025 Monthly Monitoring of Disciplinary Actions and/or Adverse Events. The following new event was reported: [redacted] Monthly monitoring includes state and federal websites including OIG, SAM, NPDB Continuous Query, DHCS Restricted Providers, DHCS Suspended & Ineligible resulted in no new findings or updates. **License Expirations included 1-Provider who stated license renewal was paid and pending renewal by MBC. Credentialing Staff will continue to monitor.**	☑ **ACTION**: Dr. Patel moved to approve the monthly monitoring report as presented with no new findings or updates, seconded by Dr. Parmar. Motion carried.	11/5/25
NEW BUSINESS	**Level 2 Potential Quality Issues (PQIs)** John Miller, MD, Medical Director QI presented the Level 2 PQI Report for November 2025: [redacted]	☑ **CLOSED**: Dr. Patel moved to approve closure of PQI Case and Track and Trend Level 2, seconded by Dr. Parmar. Motion carried.	11/5/25

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted]		

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted]		

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted]		
NEW BUSINESS	**QI Track and Trend September & October Report 2025** Magdee Hugais, Director of Quality Improvement, presented the Potential Quality Issues (PQI) Track and Trend Report data for 9/1/2025-9/30/2025 and 10/1/2025-10/31/2025. The report was accepted as presented with no further action requested or taken by the committee.	☑ **CLOSED** – Informational Only	*N/A*

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Quality Improvement Revised Policy and Procedures No QI Policy and Procedures presented for review	**N/A**	*N/A*
	Credentialing Revised Policy and Procedures No Credentialing Policy and Procedures presented for review	**N/A**	*N/A*
	Pharmacy IV-Iron Criteria Bruce Weada, Director of Pharmacy, presented the revisions to Pharmacy IV Iron Criteria. Criteria were revised to align with the American College of Oncology Guidelines.	☑ **APPROVED**: Dr. Patel moved to approve the modifications to the Pharmacy IV Iron Criteria as presented, seconded by Dr. Parmar. Motion carried.	11/5/25
	Musculoskeletal Epidural Injections – UM MCP-001 Dr. Tasinga and Dr. Sidhu presented the Musculoskeletal Epidural Injections criteria for Prior Authorization Process. The MCG Criteria has been used in the past; however, it was vague, and KHS wants to include more specific guidance and detail for the covered indications for epidural steroid injections.	☑ **APPROVED**: Dr. Patel moved to approve the modifications to the Pharmacy IV Iron Criteria as presented, seconded by Dr. Parmar. Motion carried.	11/5/25
OPEN FORUM	Mental Health Providers: Committee Member posed the questions regarding MH Providers prescribing medications under Psychotherapy and then the wait time to get member to psychiatrist is a very long time, leaving the PCP to manage the patient which usually involves getting the police to take members to the crisis mental health units. What is the process for PCPs when they can no longer manage the patient? Dr. Tasinga informed the members that a referral can be placed to Kern Behavioral Health and Recovery Services and the KHS Behavioral Health Department may be able to assist and are handling those referrals to ensure the members get the appropriate treatment and care necessary.	☑ **CLOSED** – Informational Only	*N/A*

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEXT MEETING	Next meeting will be held Wednesday, December 3, 2025 @ 7:00 am.	Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 8:30 AM. **Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator**	**N/A**	*N/A*

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

For Signature Only – Physician Advisory Committee Minutes 11/05/2025:

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
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

KERN HEALTH SYSTEMS

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***December 3, 2025***
CALL TO ORDER: ***7:02 AM BY MARTHA TASINGA, MD – KHS CHIEF MEDICAL DIRECTOR***

Members Present On-Site:	Atul Aggarwal, MD – Network Provider, Cardiology 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	
Members Virtual Remote:	David Hair, MD - Network Provider, Ophthalmology Ashok Parmar, MD– Network Provider, Pain Medicine		
Members Excused=E Absent=A	Martha Tasinga, MD – KHS Chief Medical Officer (E)		
Staff Present:	Alan Avery, Chief Operating Officer Michelle Curioso, Director of PHM Amy Daniel, Executive Health Services Coordinator	Jake Hall, Deputy Director of Contracting Yolanda Herrera, Credentialing Manager Magdee Hugais, Director of Quality Improvement	John Paul Miller MD, QI Medical Director Yesenia Sanchez, Credentialing Coordinator Sukhpreet Sidhu MD, PHM Medical Director Bruce Wearda, Director of Pharmacy

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga MD, KHS Chief Medical Officer, called the meeting to order at 7:02 AM.		N/A
Public Presentation	There were no requests for public or committee member presentations.		
Committee Minutes	**Approval of Minutes** Dr. Tasinga presented the meeting minutes of November 5, 2025 for review and approval.	☑ **ACTION**: Dr. Amin moved to approve minutes of November 5, 2025, seconded by Dr. Lascano. Motion carried.	12/3/25

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Committee Announcements	There were no committee announcements	☑ **CLOSED** – Informational Only	N/A
PEER REVIEW REPORTS ACTIVITIES	**Peer Review Reports** **CREDENTIALING REPORT** **Mental Health Pre-Approvals from Reports dated 12/03/2025:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on **12/03/2025** Credentialing Reports, all files met clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers pre-approved by Dr. Tasinga were accepted as presented with no additional questions or alternative actions. Comprehensive Reviews, if any, regarding mental health & behavioral health providers were reviewed under the Initial Credentialing Report below. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **12/03/2025.** The clean files were accepted as presented with no additional discussion. The following initial applications were presented for comprehensive review: • [redacted] **RECREDENTIALING REPORT** Recredentialing Providers Lists Dated **12/03/2025** were presented**:** • Recredentialing files meeting clean file review, report dated **12/03/2025**, were accepted as presented with no additional questions or alternative actions.	☑ **ACTION**: Dr. Patel moved to approve the Behavioral/Mental Health Credentialing Report dated 12/03/2025, seconded by Dr. Parmar. Motion carried. ☑ **ACTION**: Dr. Amin moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated 12/03/2025, seconded by Dr. Patel. Motion carried. ☑ **ACTION**: Dr. Amin moved to approve Comprehensive Reviews as listed with approval recommendations for [redacted] (3-yr appointment), seconded by Dr. Patel. Motion carried.	12/3/25 12/3/25

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Member Grievances: Magdee Hugais presented the Member & Quality Grievances of .99 or higher; there were 3 providers listed over .99, however, it was reported there were no QOC concerns identified. The following recredentialing applications were presented for comprehensive review: • [redacted] • [redacted] • [redacted] • [redacted] **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated **December 3, 2025**, were accepted as presented with no additional questions or comments by the	**ACTION**: Dr. Amin moved to approve Comprehensive Reviews as listed with approval recommendations for [redacted] (3-yr appointments), seconded by Dr. Patel. Motion carried.	12/3/25

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	committee members. **MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS:** Yolanda Herrera, KHS Credentialing Manager, reported on the November 2025 Monthly Monitoring of Disciplinary Actions and/or Adverse Events. The following new events were reported: [redacted] [redacted] [redacted]

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• Reason/Allegation: Health Plan Termination with Anthem BC • PAC 12/3/2025. [redacted] Monthly monitoring includes state and federal websites including OIG, SAM, NPDB Continuous Query, DHCS Restricted Providers, DHCS Suspended & Ineligible resulted in no new findings or updates. • **License Expirations included 5-Providers with expired licenses: 1-KHS Term letter for non-renewal of license and 4-providers termed by the group. Credentialing Staff will continue to monitor.** • **DEA Expirations included: 1-expired DEA who was terminated by the group practice.**	[redacted] No additional actions on license or DEA expirations.	
OLD BUSINESS	**Level 2 Potential Quality Issues (PQIs)** Level 2 PQI Report for November 2025 PENDING: [redacted]	☐ **PENDING**: Case #3 pending response from CSS oversight and Case #4 Pending AMR Independent review report.	Pending

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted]		

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted]		
NEW BUSINESS	**Delegated Credentialing – 3rd Quarter 2025 HICE Reports** Yolanda Herrera KHS Credentialing Manager informed the committee that the delegates have submitted their 3rd Quarter HICE Credentialing Updates and Rosters indicating initial appointments, recredentialing and terminations during the reporting period. There were no significant changes in the provider network or to the delegates credentialing programs.	☑ **ACTION**: Dr. Amin moved to approve the 3rd Quarter Delegation HICE Reports, seconded by Dr. Lascano. Motion carried	*12/3/25*
	QI Track and Trend November Report 2025 Magdee Hugais, Director of Quality Improvement, presented the Potential Quality Issues (PQI) Track and Trend Report data for 11/1/2025-11/30/2025. The report was accepted as presented with no quality of care issues to present for further action or discussion by the committee.	☑ **CLOSED** – Informational Only	*N/A*

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Quality Improvement Revised Policy and Procedures No QI Policy and Procedures presented for review	**N/A**	*N/A*
	Credentialing Revised Policy and Procedures No Credentialing Policy and Procedures presented for review	**N/A**	*N/A*
	Pharmacy Clinical Criteria – Annual Review Bruce Weada, Director of Pharmacy, presented the Pharmacy Clinical Criteria for annual review and approval of all criteria it uses for making medical determinations. Pharmacy Criteria references Medicaid criteria, Milliman Care Guidelines as well as meeting the California Code of Regulations. The following Criteria have had no changes since last year, or its creation: • Abatacept (Orencia) Criteria • Alpha-1 Proteinase Inhibitor (Aralast NP, Glassia, Prolastin-C, and Zemaira) Criteria • Amphotericin B Criteria - Fungizone, Abelcet, Ambisome • Botulinum Toxin Criteria – Anal Fissure Management • Botulinum Toxin Criteria - Cervical Dystonia and Spasticity • Botulinum Toxin Criteria - Chronic Migraine Management • Botulinum Toxin Criteria – Overactive Bladder (OAB) and Neurogenic Bladder Dysfunction • Burosumab-twza (Crysvita) Criteria • C1 Inhibitor (Berinert, Cinryze, Haegarda) Criteria • Calcitonin Gene-Related Peptide (CGRP) Criteria – erenumab (Aimovig), fremanezumab (Ajovy), galcanezumab (Emgality), eptinezumab (Vyepti) • Cantharidin (Ycanth) Criteria • Certolizumab (Cimzia) Criteria • Colony Stimulating Factors Criteria – filgrastim (Neupogen), filgrastim-aafi (Nivestym), filgrastim-ayow (Releuko), tbo-filgrastim (Granix), filgrastim-sndz (Zarxio), pegfilgrastim	☑ **APPROVED**: Dr. Amin moved to approve the annual review and approval of all Pharmacy Criteria as presented, seconded by Dr. Lascano. Motion carried.	12/3/25

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	(Neulasta), sargramostim (Leukine) • Erythropoiesis Stimulating Agents (ESAs) – Retacrit, Procrit, Epo, Epogen, NeoRecormon, Aranesp, (Epoetin and Darbepoetin) • Exagamglogene Autotemcel (Casgevy) Criteria – Sickle Cell Disease • Exagamglogene Autotemcel (Casgevy) Criteria – β-Thalassemia • Fabry Disease Criteria – Agalsidase Beta (Fabrazyme), Pegunigalsidase Alfa-iwx (Elfabrio) • Gaucher Disease Criteria – Cerezyme (Imiglucerase), Elelyso (Taliglucerase Alfa), Vpriv (Velaglucerase Alfa) • Givosiran (Givlaari) Criteria • Golimumab (Simponi Aria) Criteria • Gonadotropin Releasing Hormones (GnRH) Analogs Criteria for Non-Oncology Uses • Guselkumab (Tremfya) Criteria for Intravenous (IV) Use • Hyaluronic Acid Derivatives Criteria – Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz, SynoJoynt, Synvisc, Synvisc One, Triluron, TriVisc, and Visco-3 • Icatibant (Firazyr, Sajazir) Criteria • Immune Globulin Criteria – IVIG and SCIG • Inebilizumab-cdon (Uplizna) Criteria • Infliximab Criteria – Avsola, Inflectra, Remicade, Renflexis, and Zymfentra • IV Iron Criteria • IV Magnesium Criteria • Lanadelumab-flyo (Takhzyro) Criteria • Lecanemab-irmb (Leqembi) Criteria • Lovotibeglogene Autotemcel (Lyfgenia) Criteria • Luspatercept-aamt (Reblozyl) Criteria • Medical Injection Drug Criteria for Hyaluronan or Derivative Injections • Medical Supplies and Devices Criteria		

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• Mirikizumab (Omvoh) Criteria • Multiple Sclerosis (MS) Treatment Criteria • Myasthenia Gravis (MG) Treatment Criteria • Neuromyelitis Optica Spectrum Disorder (NMOSD) Treatment Criteria • Nusinersen (Spinraza) Criteria – Spinal Muscular Atrophy • Omalizumab (Xolair) Criteria – Idiopathic Urticaria • Oncology Criteria • Osteoporosis Criteria – Zoledronic acid (Zometa, Reclast) and Denosumab (Prolia) • PCSK9 Inhibitor Criteria – alirocumab (Praluent), evolocumab (Repatha) • Pegloticase (Krystexxa) Criteria • Primary Hyperoxaluria Type 1 Criteria – Lumasiran (Oxlumo) and Nedosiran (Rivfluza) • Pulmonary Arterial Hypertension (PAH) Prostanoids Criteria – nebulized iloprost (Ventavis), epoprostenol (Flolan, Veletri), treprostinil SQ (Remodulin), inhaled treprostinil (Tyvaso, Tyvaso DPI) • Recombinant Human Parathyroid Hormone Criteria – teriparatide (Forteo), abaloparatide (Tymlos) • Risankizumab (Skyrizi) Criteria for Intravenous (IV) Use • Rituximab Criteria for Non-Oncology Uses • Somatostatin Analogs Criteria for Non-Oncology Uses – Octreotide (Sandostatin LAR), Lanreotide (Somatuline) • Step Therapy Criteria • Tardive Dyskinesia VMAT2 Inhibitor Criteria – Deutetrabenazine (Austedo), Tetrabenazine (Xenazine), and Valbenazine (Ingrezza) • Teprotumumab-trbw (Tepezza) Criteria • Thrombopoietin-Receptor (TPO) Agonists – Eltrombopag (Promacta), Romiplostim (Nplate) • Tildrakizumab-asmn (Ilumya) Criteria • Tocilizumab Criteria – Actemra, Tyenne, and Tofidence • Ustekinumab Criteria for Intravenous (IV) Use – Stelara,		

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Steqeyma, Wezlana, and Yesintek • Vedolizumab (Entyvio) Criteria		
OPEN FORUM	Dr. Tasinga informed the members that effective 1/1/2026 GL-1 weight loss medications, some over-the-counter medications such cough and cold meds will not be covered by Medi-Cal. Members informed the Executives that the new DSNP pre-authorization process is not being thoroughly communicated to the providers by Universal MSO nor KHS PR Representatives.	Informational only. This feedback will be taken back and review with the DSNP Team.	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, February 4, 2026 @ 7:00 am.	Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 7:30 AM. **Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator**	**N/A**	*N/A*

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

For Signature Only – Physician Advisory Committee Minutes 12/03/2025:

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
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
KHS PROPRIETARY PROPERTY – CONFIDENTIAL

KERN HEALTH SYSTEMS

COMMITTEE: ***UTILIZATION MANAGEMENT COMMITTEE***
DATE OF MEETING: ***DECEMBER 4, 2025***
CALL TO ORDER: ***12:37 PM BY MANINDER KHALSA, MD, UM MEDICAL DIRECTOR - CHAIR***

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements were met as the composition described in the committee charter.	N/A
Call to Order	Dr. Maninder Khalsa, KHS UM Medical Director called the meeting to order at 12:03 PM.		N/A
Committee Minutes	**Approval of Minutes** The minutes of August 13, 2025 were presented for review and approval.	☑ **ACTION**: Dr. Sharma moved to approve minutes of August 13, 2025, seconded by Dr. Parmar. Motion carried.	12/04/25
OLD BUSINESS	There was no old business to present.	N/A	N/A
NEW BUSINESS	**Welcome & Introduction** **Introductions:** Dr. Khalsa welcomed the members of UM Committee.	☑ **CLOSED**: Informational only.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	UM Report 3rd Quarter 2025 Dr. Khalsa presented the 3rd Quarter 2025 UM Report. The following highlights were noted: • UM Timeliness of Decisions – KHS remains consistent with Urgent compliance at 99.4% and Routine compliance timelines at 99%. • UM Referral Notification is compliance remains at 100% for member notification and 100% provider notification and MD Signature. • Outpatient Referrals – slightly decreased in numbers to 100776 from last quarter which was 103228. • Adult & Pediatric Referrals – remain consistent in comparison to past quarters. • Denial Percentage – 3rd Quarter denied referrals are 6.3% for Sept, 6.6% for August and 3.7% July. • Quarterly Clinical Audits were also completed with no significant issue to report.	☑ **CLOSED**: Report accepted as presented with no further discussion or questions from the committee members.	*12/4/25*
	D-SNP Policies Christine Pence reported the D-SNP Policy and Procedures were previously sent electronically for review: • Separate policies from Medi-cal • 002 Separation of Financial Decision Making • 003 Application of Medical Necessity and Clinical Criteria • 005 Referral Processing Turn Around Times • 006 Adverse Determinations • 007 Specialty Referrals and Use of Board Certified Practitioners • 008 Standing Referrals • 013 Reopening Service Determinations • 016 Emergency and Post Stabilization Requirements • 017 Inter-Rater Reliability Audits • 018 Downgrading UM Referral Requests • 019 Canceling, Withdrawing, or Dismissing a UM Service Request • 020 Request for Medical Policies • 022 Medicare Certified Facilities • 023 Reconstructive Procedures	☑ **ACTION**: Dr. Sharma moved to approve the D-SNP Policy and Procedures as listed, seconded by Dr. Parmar. Motion carried.	*12/4/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• 027 Second and Third Opinions • 030 Retrospective Review • 032 Direct Access to Women's Services • 5 Discharge Planning • 11 Onsite Facility Review • 13 Interdisciplinary Care Rounds • 16 UM Monthly Audits • Concurrent Review • Medical Director Referral • Medical Director Peer –to Peer • Requests for Experimental Treatment • Lack of Clinical Information • Organization Determination Mail • Termination of Medicare Services • Continuity of Care Dr. Srivastava requested additional information regarding what services are being overutilized. Dr. Khalsa explained KHS's processes for identifying potential overutilization. Additional discussion ensued regarding the DSNP Line of Business and how membership is fluctuating for both Medi-Cal and DSNP. Christine informed the members that DSNP enrollment is steadily increasing to about 300+ members to date. Medi-Cal enrollment is seeing some changes primarily due to the State removing the auto-renewal process that was in place during the pandemic. DHCS is expected to provide guidance regarding DHCS's plans to comply with H.R. 1. Christine described the efforts KHS is undertaking to ensure members maintain their insurance coverage. Nate also provided an update that KHS is looking to get a scanner for our building to be able to upload documents from our office to the County Office as a way to renew member's state benefits without having to go to the county office.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED

	UM/Internal Auditing Activities
	Christine Pence reported on the UM Auditing Activities that included the following items:
	• 3rd Quarterly audits of the NOA Team are done to monitor for accuracy and 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
	  • July - 1 NOA Finding with formatting error and grammatical error.
	  • August there were no errors
	  • September there were 2-NOA formatting and verbiage errors and 1-timeframe error
	  • Errors will be discussed during staff 1:1 meetings.
		☑ **CLOSED**: Report accepted as presented with no further discussion or questions from the committee members.	*12/4/25*

	Epidural Steroid Injection Authorization Protocol Christine Pence reported the Epidural Steroid Injection Authorization Protocol was submitted to the Physician Advisory Committee and approved as presented.	☑ **CLOSED**: Protocol accepted as presented with no further discussion or questions from the committee members.	*12/4/25*
OPEN FORUM	**Open Forum**	☑ **CLOSED**: Informational discussion only.	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, February 25, 2026 at 12:00 PM	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 1:24 PM ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Utilization Management Committee Minutes 12/04/2025

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____

Date Name

KERN HEALTH SYSTEMS

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

Members Present On-Site:	Lito Morillo, Executive Director at KC Human Services	Sukhpreet Sidhu, MD PHM Medical Director Curt Williams, Director Homeless/Foster at KCSOS	
Members Virtual Remote:	Lourdes Bucher, Administrator at KCSOS Paula De La Riva-Barrera, Manager at First 5 Kern Alissa Lopez, Administrator at KCBHRS	Colleen Philley, Program Director at KC Aging & Adult Maggie Vasquez, Kern County Public Health	
Members Excused=E Absent=A	Maria Bermudez, Asst. Director at Dept. of Human Services (E) Brynn Carrigan, Director at KC Public Health (E) Cristina Castro, Recovery Specialist at KCBHRS (E) Dr. Babita Datta, MD OB/GYN Wasco Medical Plaza (E) Dixie Denmark-Speer, Social Services Director Height Street (E)	Minty Dillon, Administrator at Premier Valley Medical Grp (E) Desiree Escobedo, Admissions at Height Street SNF Laura Hasting, NP at Priority Urgent Care (E) Kristine Khuu, Assistant Director at Kern Regional Ctr. (E) Gina Lascon, DON at Delano SNF (E) Lito Morillo, Executive Director at KC Human Services (E)	Jasmine Ochoa, Manager at KC Public Health (E) Ashok Parmar MD, Pain Mgmt. (E) Dr. Vivek Radhakrishan, Primary Care ECM Provider (E) Cody Rasmussen, Administrator at Height Street SNF (E) Martin Reynoso, Supervisor at KC Aging & Adult Jennie Sill, Administrator at KCBHRS (E) Alejandra Vargas, BOM at Height Street SNF (E)
Staff Present:	Desiree Buena, PHM Manager of Special Programs RN Michelle Curioso, Director of PHM Amy Daniel, Executive Health Services Coordinator Pawan Gill, Health Equity Manager Russell Hasting, PHM Manager of CM	Magdee Hugais, Director of QI Loni Hill-Pirtle, Director of ECM Runa Lemminn, PHM Senior Support Clerk John Miller, MD QI Medical Director	Melinda Santiago, Director of Behavioral Health Nate Scott, Senior Director of Member Services Isabel Silva, Senior Director of Wellness & Prevention

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Sukhpreet Sidhu, MD, KHS PHM Medical Director called the meeting to order at 11:03 AM.		N/A
Committee Minutes	**Approval of Minutes** The minutes of September 3, 2025 were presented for review and approval.	☑ **ACTION**: Paula De La Riva-Barrera moved to approve minutes of September 3, 2025, seconded by Lourdes Bucher. Motion carried.	*12/3/2025*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• Welcome & Introduction • PHM Announcements: Michelle Curioso presented the following: • DHCS Audit (Michelle) – DHCS will be conducting an audit next year. The plan is in preparation for this routine annual audit, ensuring the plan is in compliance. • DHCS – Medi-Cal Connect (Russ) – There is continuing effort to be data driven, transferring member info into a database, that is being rolled out to just the Medi-Cal plans. The overall goal is to enhance member experience and be rolled out to additional partners by end of 2026. Most recent information reflects data from 6-8 months ago, so it will be improved over time. Dr. Sidhu identified "stale data" as the primary challenge with Medi-Cal Direct, explaining that data lags occur because reporting is driven by claims received rather than real-time activity. Melinda Santiago added that claims are submitted on an ongoing daily basis, reinforcing that there is no access to real-time data. Dr. Sidhu further noted that data collection is inconsistent, as some hospitals submit data while others do not, resulting in a lack of uniformity. In response, Russ is collaborating with the Business Intelligence team to conduct risk stratification using data collected from DHCS. • Cervical Cancer Screening (Desiree Buena) – Cervical cancer screening initiative is underway to support our compliance with MCAS measures, we've had great success so far, we've sent over 4,000 members to Dr. Parmar over last 2 months, contacted over 2,000 of our members with approximately 200 of our members scheduled with a specialist.	☑ **CLOSED**: Informational discussion only.	*12/3/2025*
REVIEW AND APPROVAL	**<u>Review and Approval of Policy</u>** Review and Approval of the following Policy revisions: (*Approval by Committee Members)* • The Risk Stratification and Risk Assessment Process for California Children's Services (California Children's Services) is a new PHM policy that describes the tools and processes used to assess and stratify CCS members by risk level. The policy ensures members are accurately classified and that data-driven care management strategies are applied. Its purpose is to meet members' needs, address gaps in care,	☑ **ACTION**: Curt Williams moved to approve the listed Policy and Procedures, seconded by Lito Morillo. Motion carried.	*12/3/2025*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	and connect members to the appropriate programs and services. Long Term Support Services (LTSS) Liaison: **Desiree disc**ussed a new policy required by the Department of Health Care Services (DHCS). LTSS includes services such as Community-Based Adult Services, long-term care, and In-Home Supportive Services. Dr. Sidhu expressed concerns about who would be responsible for implementing the policy, noting that the PHM Department has limited experience with payment claims and provider billing disputes. The policy states that the LTSS Liaison serves as the main point of contact for providers and is familiar with internal plan resources needed to address provider concerns. Additionally, Melinda Santiago asked whether the process could be streamlined in the future and questioned whether the next person overseeing the role would follow the same approach. The policy is acceptable as written; however, the committee members would like to know who is the key stakeholder that will be responsible for the oversight and will this person want to make additional changes. • **Discharge Planning Documents:** This policy was reviewed and explains the requirement to complete discharge risk assessments before a member is discharged, as well as to provide discharge packets that support continuity of care. The policy ensures that all discharge planning documents are completed correctly, meet the requirements of the Department of Health Care Services (DHCS) 2024 Operational Readiness Contract, and are given to members, parents, guardians, or authorized representatives when a member is discharged from a hospital, institution, or facility. These requirements are also part of Transitional Care Services.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OLD BUSINESS	No old business.	**N/A**	*12/3/2025*
NEW BUSINESS	• <u>Palliative Care Coordination:</u> (Pg. 31 of agenda packet) • Michelle was invited to share at Coalition of Care for Children conference, working together to enhance the care of our children. The Bridging Gaps presentation is what they learned about from Michelle at the conference. o Palliative care lowers the ER visits of these members – helps our members understand their services, provide them information including it's not an end-of-life care. Meet monthly, as needed with these members to ensure no one falls through the cracks. Gap is made worse with limited providers, no transportation. Goal of report was to evaluate how effective the program is, 900 + members were evaluated, office visits dropped 13%, ed visits dropped 15%, and urgent care went up 8%. o Michelle – next steps involve looking at inpatient, enrolled vs non-enrolled. Melinda Santiago brought up tracking engagement. Dr Sidhu replied monthly touchpoint with provider will aid in feedback regarding "Who is engaged?" Curt brought up an exit poll as a tool. Michelle then stated: basic needs need to be met, or they will ignore you. Dr Sidhu commented that general overwhelm is a problem too. Nate suggested re-engaging members…Michelle stated that if they decline now, we call again in 6 mos. • <u>High Resource Utilization: (Michelle) p.44</u> o Michelle: CCM+ turned into ICT weekly meetings. We want to ensure our members get the proper care and major things get stopped ahead of time. If	☑ **ACTION**: Lito Morillo moved to approve, seconded by Curt Williams. Motion carried.	*12/3/2025*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	unable to contact, CHWs are sent out with a 63% successful home visit. Dr. Sidhu stated there appears to be a big disconnect within Kern County with regards to Behavioral Health. Michelle stated that if members decline services, we contact them again. KHS CEO is updated weekly on these. Alyssa Lopez from Kern Behavioral Health said they are getting the lists daily but asked for someone to reach out if needed.		
OPEN FORUM	**Open Forum** Michelle Curioso, Director of PHM invited the members to stay and network while enjoying lunch.	**N/A**	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, March 4, 2026 at 11:00 am	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 11:48 AM. ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Quality Improvement Committee Minutes 12/03/2025

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____

Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***QUALITY IMPROVEMENT WORKGROUP***
DATE OF MEETING: ***DECEMBER 8, 2025***
CALL TO ORDER: ***12:07 PM BY JOHN P. MILLER, MD, QI MEDICAL DIRECTOR - CHAIR***

Members Present On-Site:	Dr. John Paul Miller, KHS QI Medical Director, Chair		
Members Virtual Remote:	Archana Reddy Bongurala, MD, Omni Family Health Danielle Colayco, PharmD, Executive Director Komoto	Carmelita Magno, Kern Medical Process Improvement Dir.	
Members Excused=E Absent=A	Dr. Mansukh Ghadiya, Family Practice (E)	Dr. Irving Ayala-Rodriguez, CSV (E)	
Staff Present:	Monique Barrios, QP Clinical Supervisor Amy Daniel, Executive Health Services Coordinator Dan Diaz, RN, ECM Clinical Manager Alma Garcia, NCQA Accreditation Specialist	Kalpna Patel, QI Supervisor Loni Hill-Pirtle, Director of Enhanced Case Management Magdee Hugais, Director of QI	Steven Kinnison, NCQA Manager Melinda Santiago, Director of Behavioral Health Sukhpreet Sidhu, KHS PHM Medical Director

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements were met.	12/8/25
Call to Order	Dr. John Paul Miller, KHS QI Medical Director called the meeting to order at 12:03 PM.		N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, Dr. John Miller, presented the September 11, 2025 meeting minutes for approval.	☑ **ACTION**: Danielle Colayco made a motion to approve minutes of September 11, 2025, seconded by Carmi Magno. Motion carried.	12/08/25
OLD BUSINESS	**No Old Business presented.**		N/A
NEW BUSINESS	**Quality Performance 3rd Quarter 2025 Update:** Monique Barrios, QP Clinical Supervisor, presented the Quality Performance 3rd Quarter 2025 updates with key highlights as follows: **Managed Care Accountability Set (MCAS)** • QP Team continues to support all measures for current year	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	12/8/25

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION / CONCLUSIONS</th><th>RECOMMENDATIONS/ ACTION</th><th>DATE RESOLVED</th></tr>
<tr><td></td><td>with heavy focus on Children's domain of care.
• 18 measures have improved compared to last year.

<u>Performance Improvement Projects (PIPs)</u>
• PIPs began in August 2023 and run through 2026
• First PIP is focused on the W30 MCAS measure, specific to Health Equity of the 0-15 months African American
• QP will be partnering with KHS' Behavioral Health Department to ensure success of this PIP

<u>Facility Site Reviews (FSRs)</u>

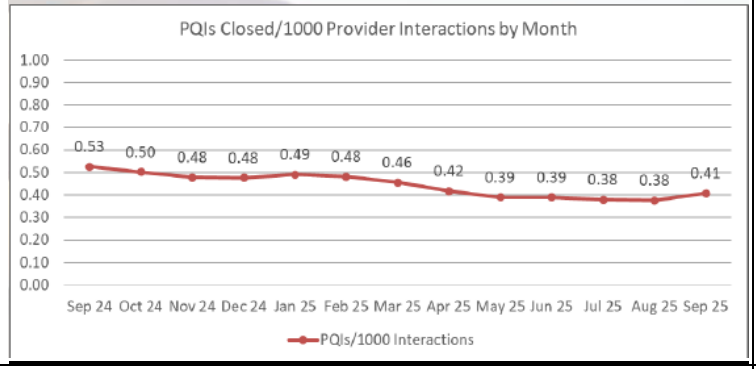
• 5 Initial Facility Site Reviews and 4 Initial Medical Record Reviews were completed in Q3 2025. 8 Periodic FSRs and 8 periodic MRRs were also completed
• 100% of Facility Site Reviews passed and 96% YTD of Medical Record Reviews passed
• 2 of 54 sites failed the first review, however Corrective Action Plans were completed and closed.
• QP department also conducts Physical Accessibility Review Surveys (PARS) and 6 were completed in Q3 2025</td><td></td><td></td></tr>
<tr><td></td><td><u>QOC Grievances & PQIs</u>

Magdee Hugais, QI Director presented the Quality-of-Care Grievances and Potential Quality of Care issues for 3rd Quarter 2025. Magdee reported there were no QOC concern identified to warrant further investigation or additional action.

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

<table>
<tr><th>Severity Level</th><th>Q1 2024</th><th>Q2 2024</th><th>Q3 2024</th><th>Q4 2024</th><th>Q1 2025</th><th>Q2 2025</th><th>Q3 2025</th></tr>
<tr><td>Level 0 - No Quality Concern</td><td>129</td><td>85</td><td>18</td><td>74</td><td>73</td><td>67</td><td>66</td></tr>
<tr><td>Level 1 - Potential for Harm</td><td>108</td><td>75</td><td>95</td><td>94</td><td>71</td><td>48</td><td>93</td></tr>
<tr><td>Level 2 - Actual Harm</td><td>0</td><td>2</td><td>0</td><td>2</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>Level 3 - Actual Morbidity</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Total</td><td>237</td><td>162</td><td>113</td><td>170</td><td>144</td><td>115</td><td>115</td></tr>
</table>
</td><td>☑ CLOSED: Report received and accepted as informational with no additional discussion.

Dr. Miller provided an explanation to the committee members describing the exact process of an overturned authorization for clarity.</td><td>12/8/25</td></tr>
</table>

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Appeals and Clinical Network: Kalpna Patel, QI Supervisor presented the Appeals for 3rd Quarter. PQIs Closed per 1000 Provider Interactions by Month continue at a stable trend and turn-around-time in 30-days is continue to trend downwards.  		
	<u>Cultural and Linguistics Monitoring 3rd Quarter 2025</u> Isabel Silva, Director of Wellness and Prevention, presented the C&L Monitoring for 3rd Quarter Report**.** • Bilingual staff call audits 30-Calls Audited with 98% compliance with no difficulty communicating. • 93% of members were satisfied with the linguistic performance (10,680 Spanish Post Call Surveys) • 100% of audited calls for OPI Interpreter Service met expectations with no difficulty communicating with members. • Overall members continue to be very satisfied with KFHC Services.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	12/8/25
	<u>Member Wellness and Prevention</u> Isabel Silva, Director XX presented the Wellness and Prevention Report 3rd Quarter 2025. Service Audit was conducted and revealed 100% audit score with no areas of improvements or concerns noted. Report accepted as presented.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	12/8/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	CHW/APS Audits Tiffany Chatman, Manager of Wellness and Prevention Partnerships, presented an overview of the proposed CHW/APS Audit Process as follows: The presentation, *Community Health Worker (CHW) and Asthma Preventive Services (APS) Audits*, provided participants with a clear overview of the KFHC's internal audit processes for both Medi-Cal benefits. It outlined the distinct responsibilities of in-network Providers and the Wellness and Prevention Partnerships team, emphasizing how each group contributes to accurate documentation and service delivery. The presentation highlighted how audits function as a key safeguard against fraud, waste, and abuse while ensuring compliance with APL 24-006 requirements. Participants were guided through the workflow used to review CHW and APS encounters, including verification steps and quality checks. The presentation concluded with a review of evaluation points that help measure program integrity, identify improvement opportunities, and strengthen overall accountability.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	12/8/25
	Enhanced Care Management 3rd Quarter 2025 Dan Diaz, ECM Clinical Manager, RN, presented the 3rd Quarter 2025 ECM Report. The following highlights were noted: • As of November 11, 2025, ECM had a total of 14,683 members currently enrolled in Enhanced Care Management services • ECM continually improves 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 • Revamped our ECM incentive package to garner a more metric, outcome-based approach in looking at three domains of utilization (avoidable urgent care, inpatient and emergency department visits)	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	12/8/25
	QI Workplan Scorecard – 3rd Quarter 2025 Magdee presented the KHS Quality Improvement Workplan scorecard for 3rd Quarter 2025. QI Workplan Score Card for Q3-2025 was included in the meeting packet. Due to time constraints, the QIW did not have a formal discussion around this agenda item.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	12/8/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OPEN FORUM	**Open Forum** No additional questions or issues were presented for open forums.	☑ **CLOSED**: Informational only.	N/A
NEXT MEETING	Next meeting will be held Wednesday, March 5, 2026 at 12:00 noon.	☑ **CLOSED**: Informational only.	N/A
ADJOURNMENT	The Committee adjourned at 1:03 pm. ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	N/A

For Signature Only – Quality Improvement Committee Minutes 12/08/25

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

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

KERN HEALTH SYSTEMS

To: Executive Quality Improvement Health Equity Committee (EQIHEC)

From: James Winfrey, Deputy Director of Provider Network Management

Date: March 17, 2026

Re: Network Adequacy Committee (NAC) Report Q4 2025

Background:
The Network Adequacy Committee (NAC) shall advance the mission of Kern Health Systems (KHS) to improve the health status of our members through an integrated managed health care delivery system. The NAC will report to the KHS Executive Quality Improvement Health Equity Committee (EQIHEC) on KHS' monitoring activities, corrective actions, and regulatory requirements related to network access, availability, and adequacy.

The functions of the NAC are as follows:

1. **Establish Network Standards**: Ensuring network accessibility standards (capacity/adequacy, appointment availability, geographic accessibility, etc) align with Department Health Care Services (DHCS), Department of Managed Health Care (DMHC), and National Committee for Quality Assurance (NCQA) standards.
2. **Monitor Network Compliance:** Review monitoring activities conducted by the Plan to measure network compliance with established standards.
3. **Promote Health Equity**: Implement review processes that monitor network adequacy amongst diverse populations, focusing on equitable access to care across different demographic and geographic groups**.**
4. **Steer Continuous Improvement:** Provide feedback on proposed corrective actions and ensure they are appropriate to address identified issues. Track progress of active corrective action plans.

Discussion:
Enclosed is an overview of the Plan's network adequacy standards, monitoring activities, findings, and process improvements discussed during the 4th Quarter Network Adequacy Committee meeting, including minutes.

Fiscal Impact:
None.

Requested Action:
Review for approval.

Provider Network Management – Network Review Q4, 2025

Executive Quality Improvement Health Equity Committee

March 17, 2026

Network Adequacy Committee

The Network Adequacy Committee (NAC) is delegated by the Executive Quality Improvement Health Equity Committee (EQIHEC) to monitor and report on network adequacy.

Establish Network Standards	• Ensuring network accessibility standards align with regulatory and quality assurance standards
Monitor Network Compliance	• Review monitoring activities conducted by the Plan to measure network compliance with established standards
Promote Health Equity	• Implement review processes that monitor network adequacy amongst diverse populations, focusing on equitable access to care across different demographic and geographic groups.
Steer Continuous Improvement	• Provide feedback on proposed corrective actions and ensure they are appropriate to address identified issues

Q4 Committee Meeting

Quarter 4, 2025 Meeting – 11/14/2025

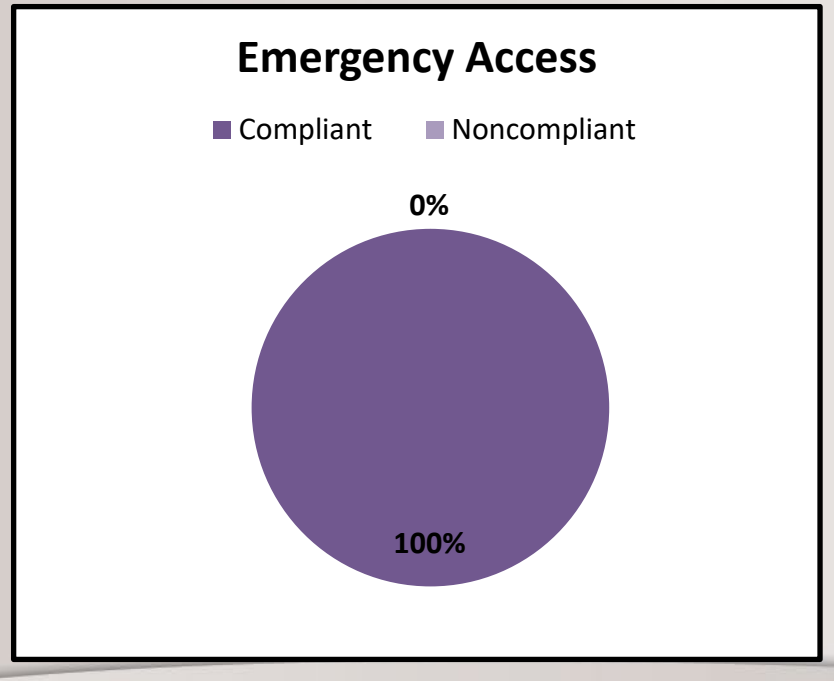
- Reviewed Quarter 3, 2025 Provider Network Management, Quarterly Network Review:
  - After Hours Survey Results
  - Provider Accessibility Monitoring Survey
  - Access Grievance Review
  - Geographic Accessibility & DHCS Network Certification
  - Network Adequacy & Provider Counts
  - Recent Provider Network Reporting

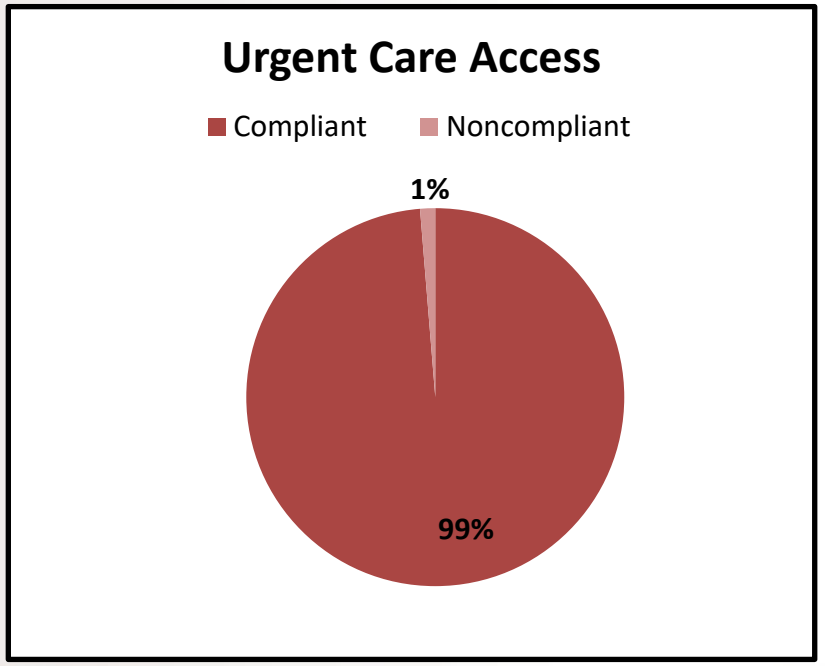


After-Hours Survey Report

Results

During Q4 2025 **155** primary care provider offices were contacted. Of those offices, **155** were compliant with the Emergency Access Standard and **153** were compliant with the Urgent Care Access Standard.





After-Hours Survey Report

Action Taken

Two provider offices were identified as non-compliant with the urgent access standard. The provider offices were educated via letter and Plan outreach.

Recommendation

Plan's ongoing outreach and education continues to be successful when instances of noncompliance are identified. Plan will continue to monitor quarterly, and no other action is needed at this time.

Provider Accessibility Monitoring Survey

- The Plan selected a random sample of 25 PCP and 25 Specialty providers.
  - The Plan's methodology is to randomly select providers from the entire network. Providers will be sampled by region at least once annually or as necessary.
- Additionally, a random sample of 5 non-physician mental health providers, 5 ancillary providers, and 5 OBGYN providers were contacted to assess network compliance with accessibility standards.
- All providers who were noncompliant in Q3 2025 were resurveyed and found to be compliant in Q4 2025.

Average urgent wait time in hours	Standard	Q4 2025
Primary Care	48 Hours	**13.2 Hours**
Specialist	96 Hours	**34.5 Hours**

Average wait time in days	Standard	Q4 2025
Primary Care	10 Business	**1.9 Days**
Specialist	15 Business	**10.6 Days**
Non-Physician Mental Health	10 Business	**2.4 Days**
Ancillary	15 Business	**1.8 Days**
First Prenatal OB/GYN*	10 Business*	**5.2 Days**

*The lesser of 10 business days or within 2 weeks

Provider Accessibility Monitoring Survey

Analysis

- While instances of non-compliance were identified, at a county/network level the Plan was compliant with accessibility standards across all provider types.

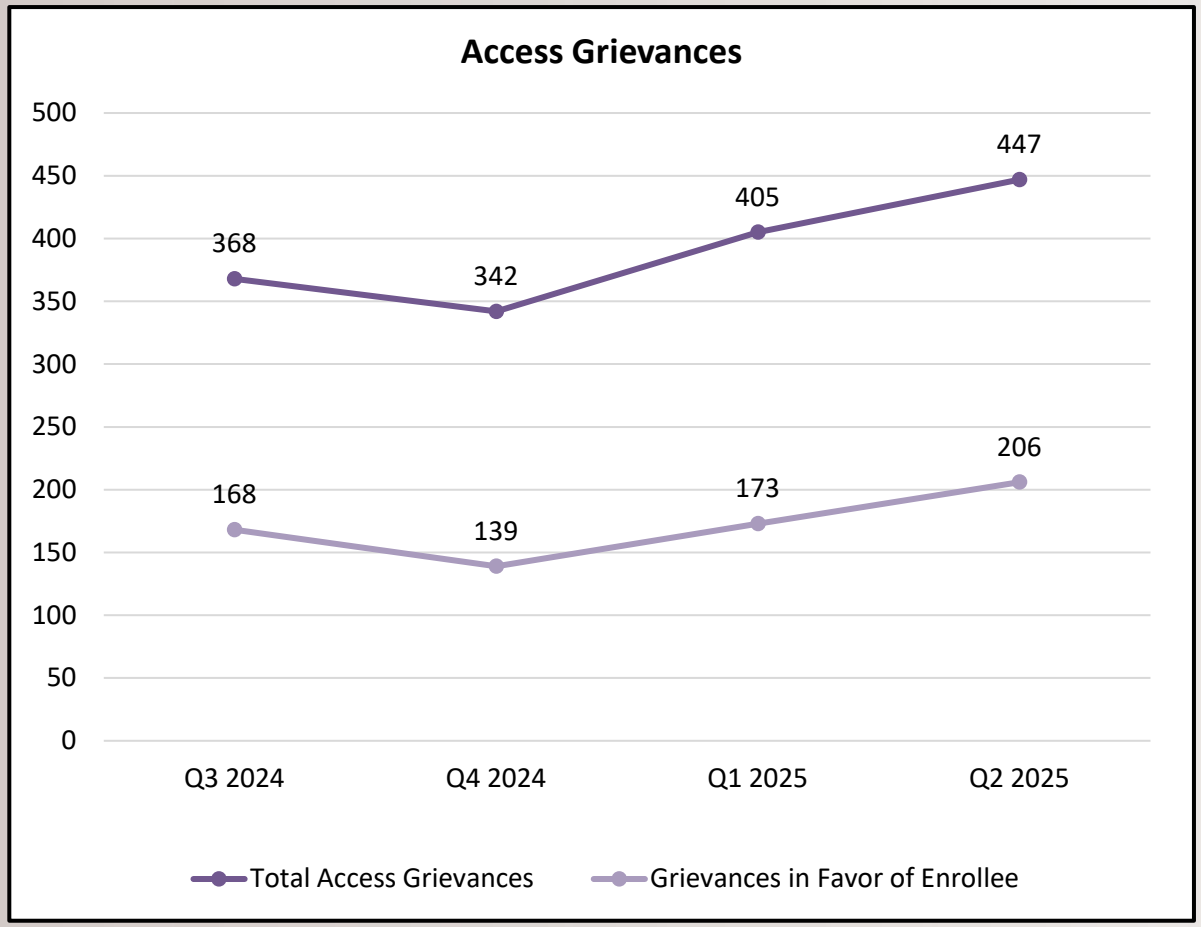
Action Taken

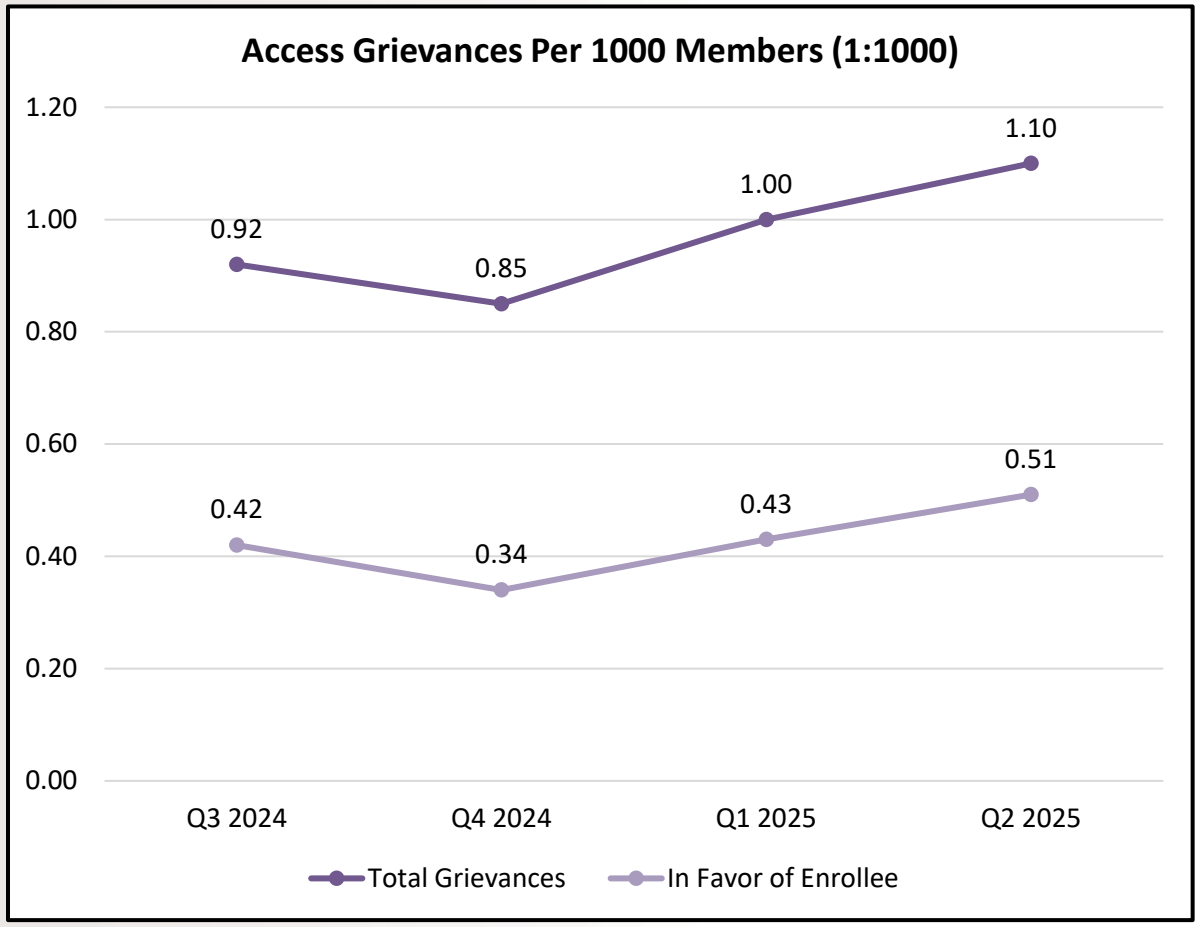
For all providers identified as noncompliant during Q4 2025, the Plan sent letters notifying the providers of the survey results and Plan policy.

Recommendation

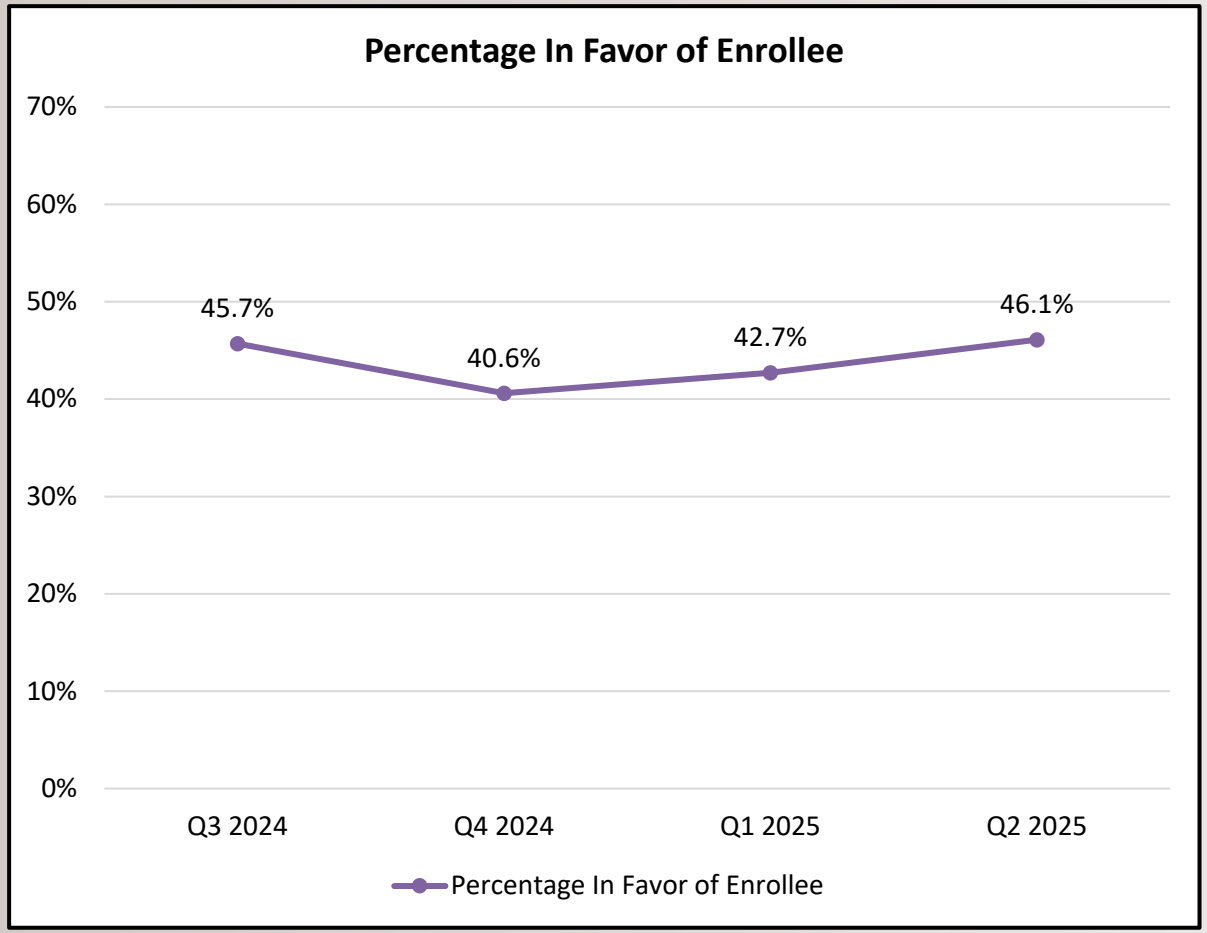
The Plan will resurvey all noncompliant providers in Q1 2026. The Plan will continue to monitor quarterly, and no other action is needed at this time.

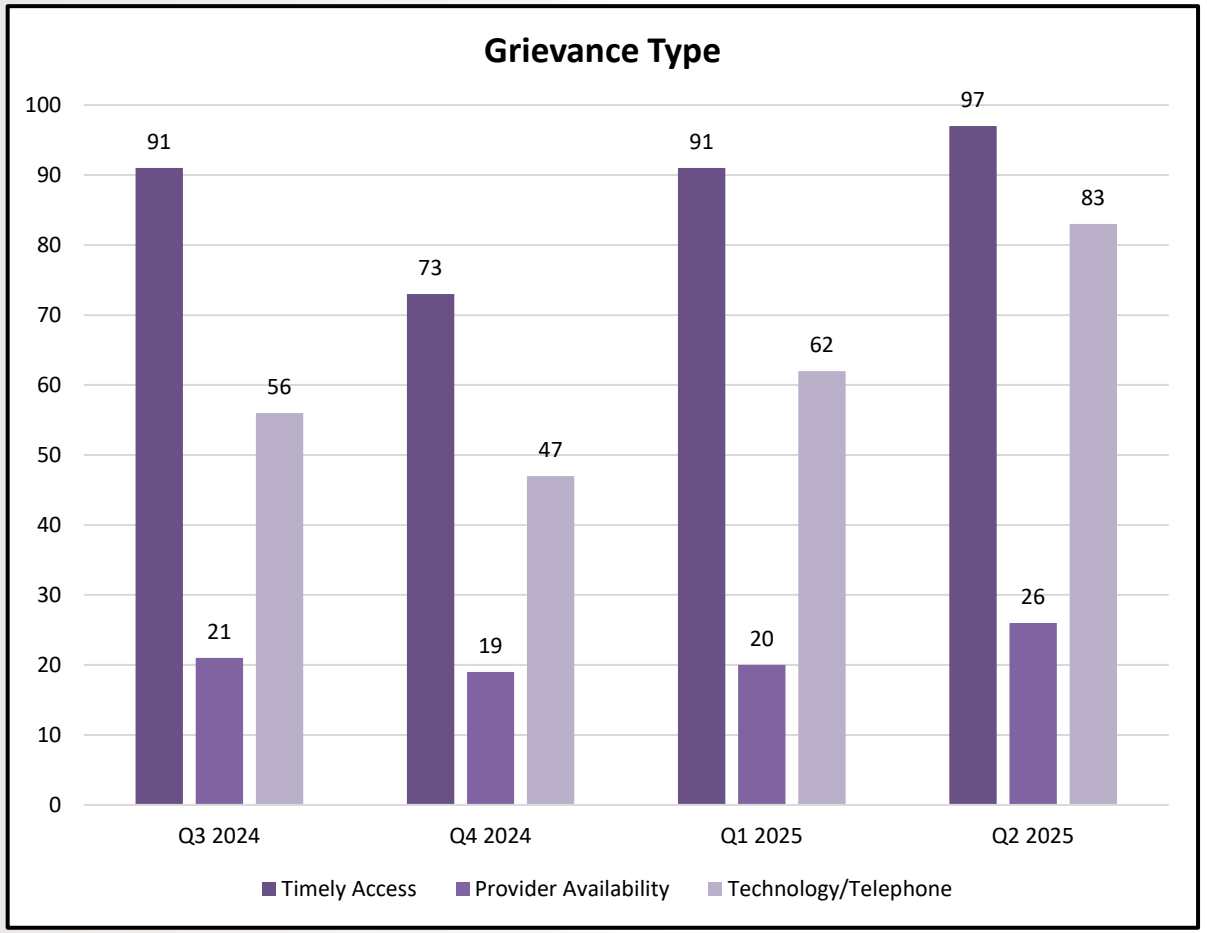
Access Grievance Review





Access Grievance Review





Access Grievance Review

Analysis

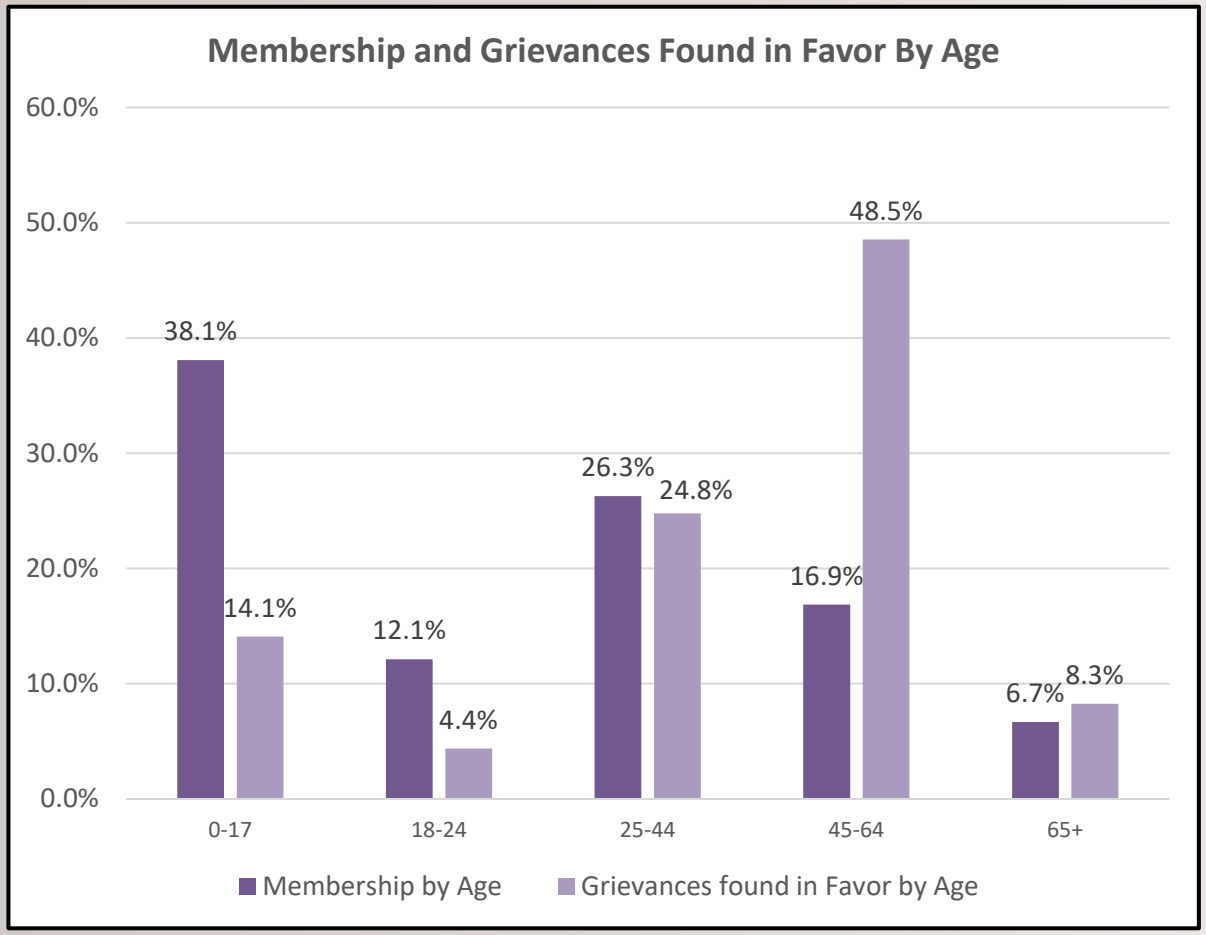
- The Plan experienced an increase in both total access grievances and those resolved in favor of the enrollee.
- Provider Availability and Technology/Telephone grievances increased in Q2 2025, while Timely Access remained consistent.
- Central Pain Management had 17 Technology/Telephone grievances
- Timely Access remains the predominant type of grievance.

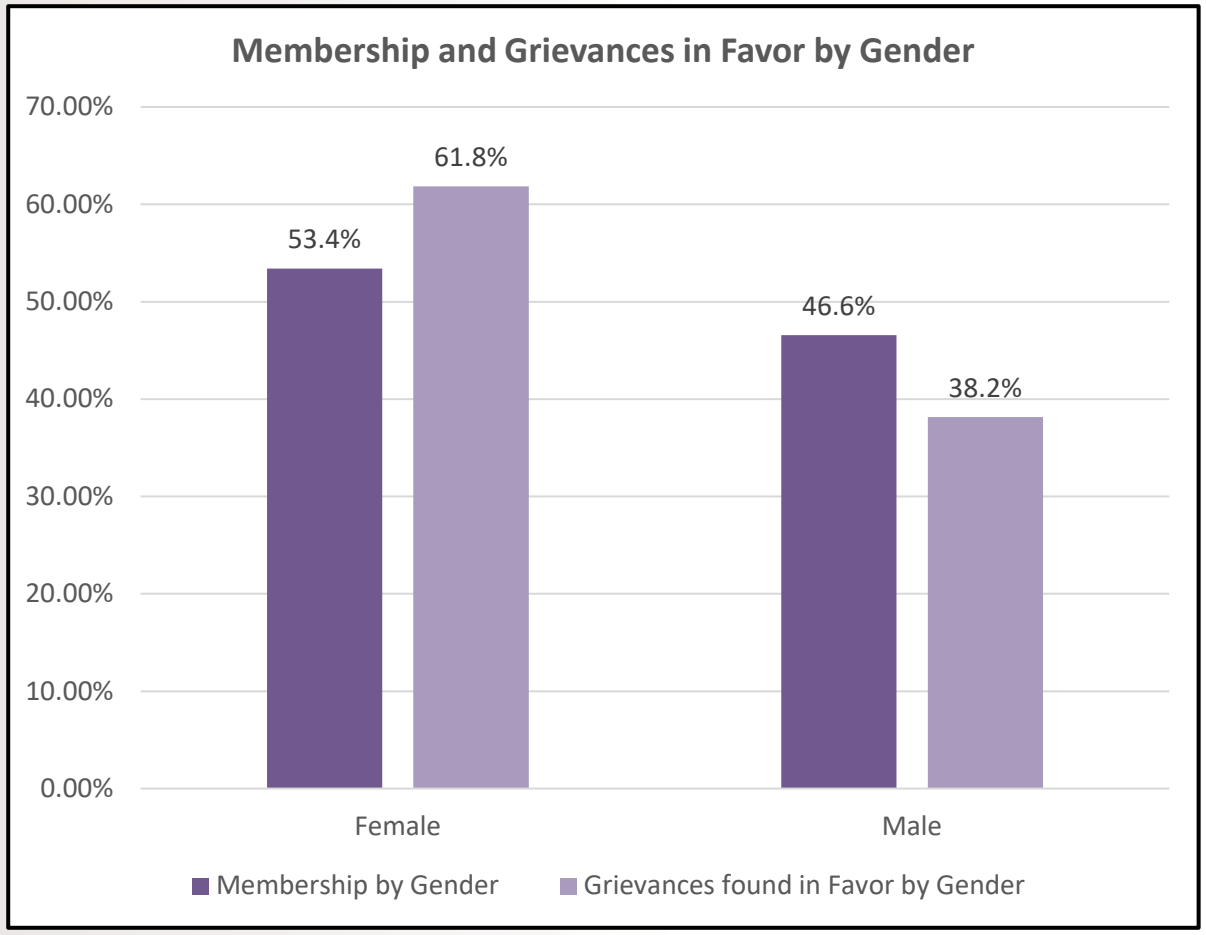
Timely Access	Grievance related to timely access to a state plan approved provider within the timeframe requirements based on type of appointment and condition of member's health.

Recommendation

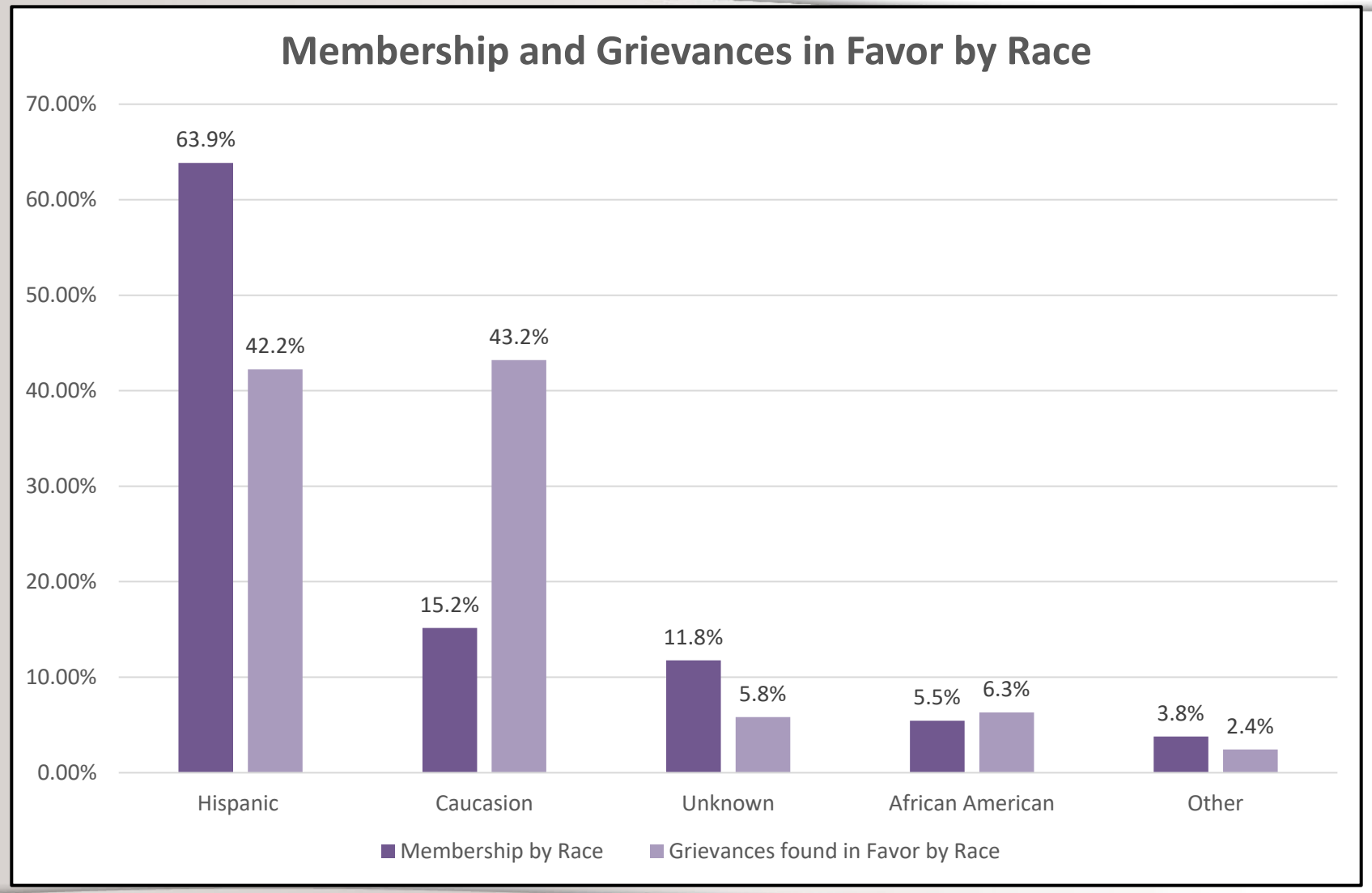
The Provider Network Management Department will continue to monitor access grievances to identify trends.

Access Grievance Review

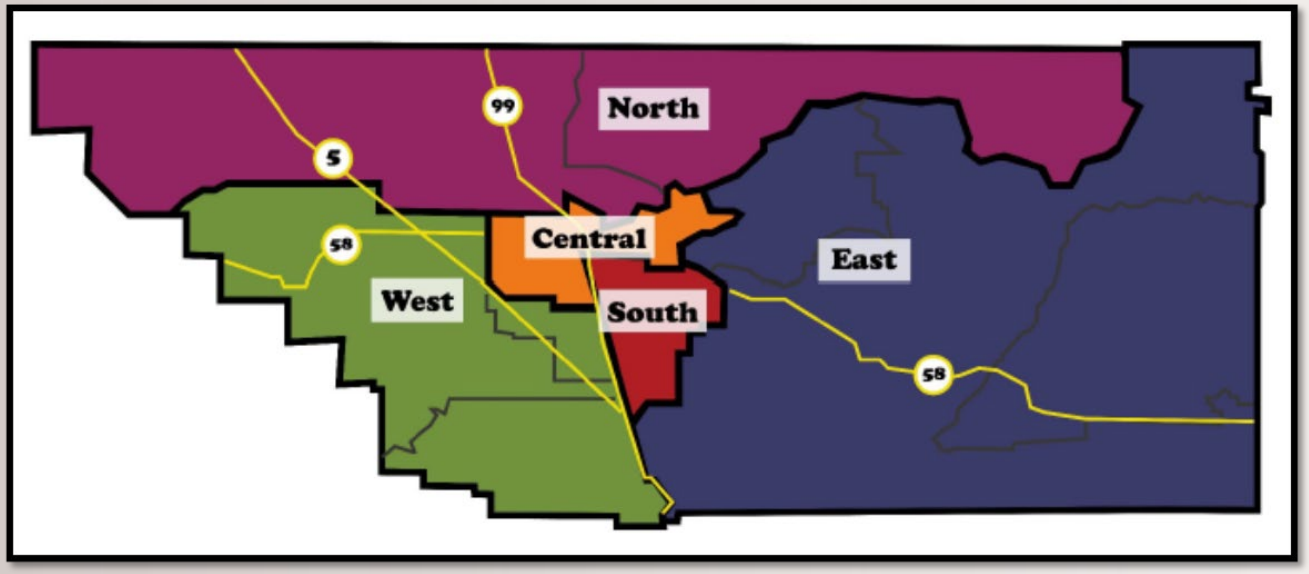




Access Grievance Review



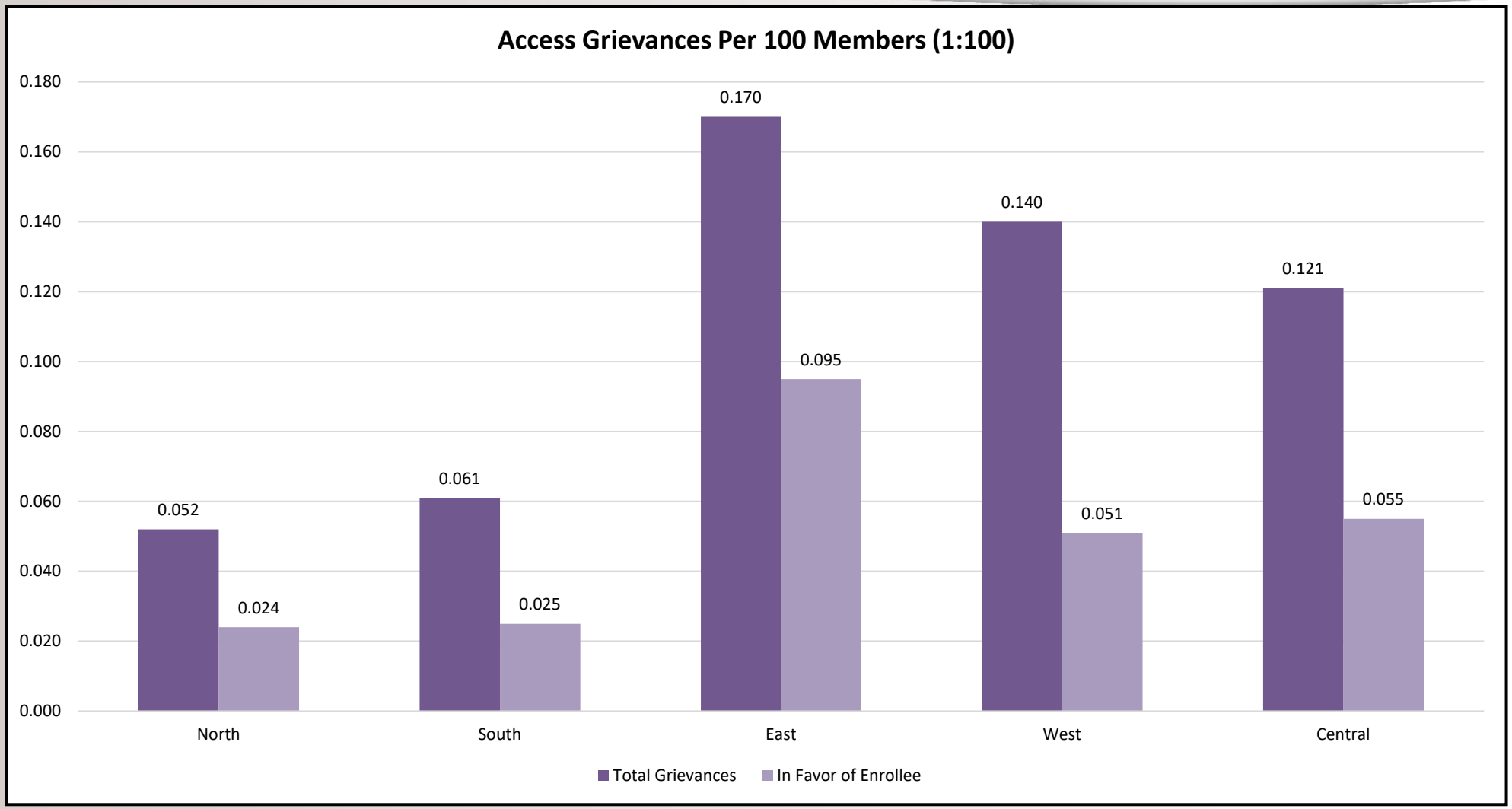
Access Grievance Review



Region	Total Members
North	61,056
South	27,886
East	29,737
West	15,550
Central	268,445

	North	South	East	West	Central	Out-of-Area
Provider	3	1	16	0	158	12
Member	15	7	28	8	148	N/A

Access Grievance Review



Access Grievance Review

Analysis

- The Plan identified higher grievance rates within the East, West, and Central regions in Q2. This trend is due to East and West Kern's largely rural setting, which requires members to travel to Central Kern for medical services. Historically, this trend has been seen for East and Central Kern.

Recommendation

The Provider Network Analyst team recommends discussion and feedback regarding additional demographic analysis provided above.

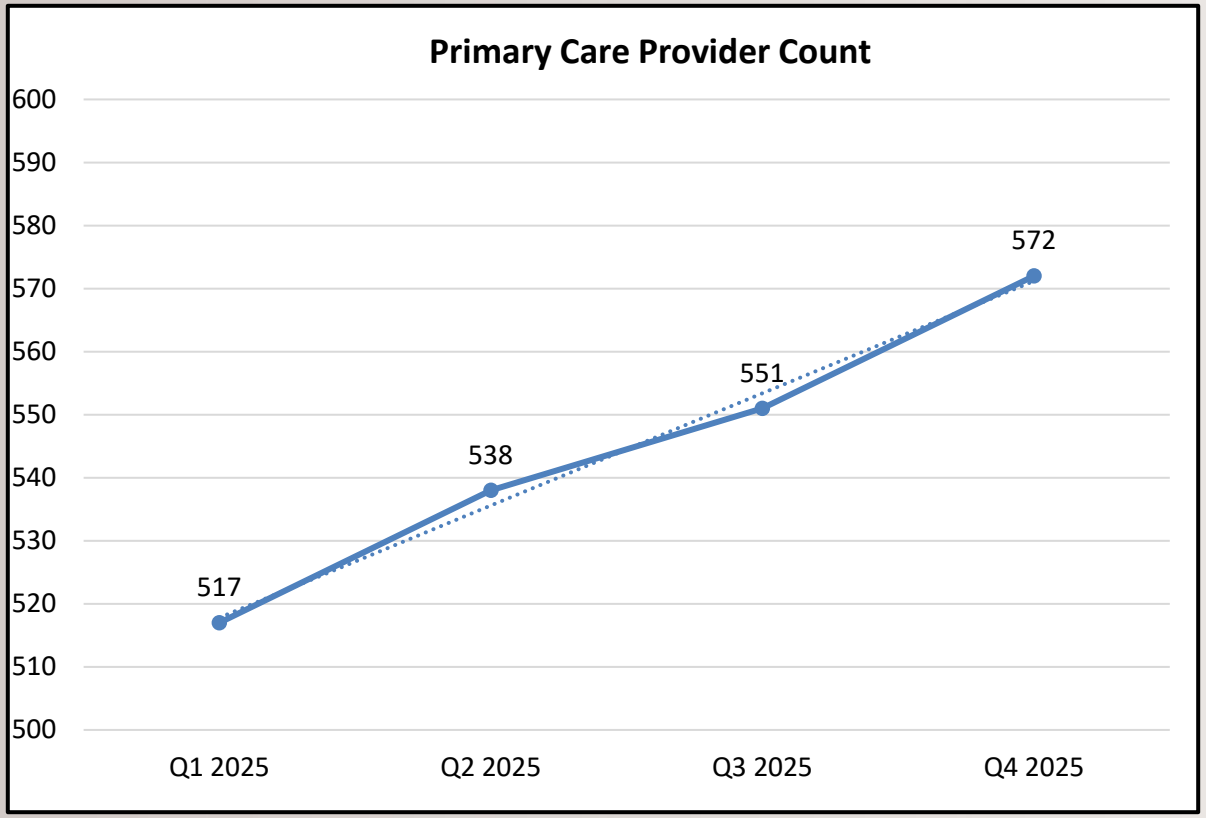
Geographic Accessibility & DHCS Network Certification

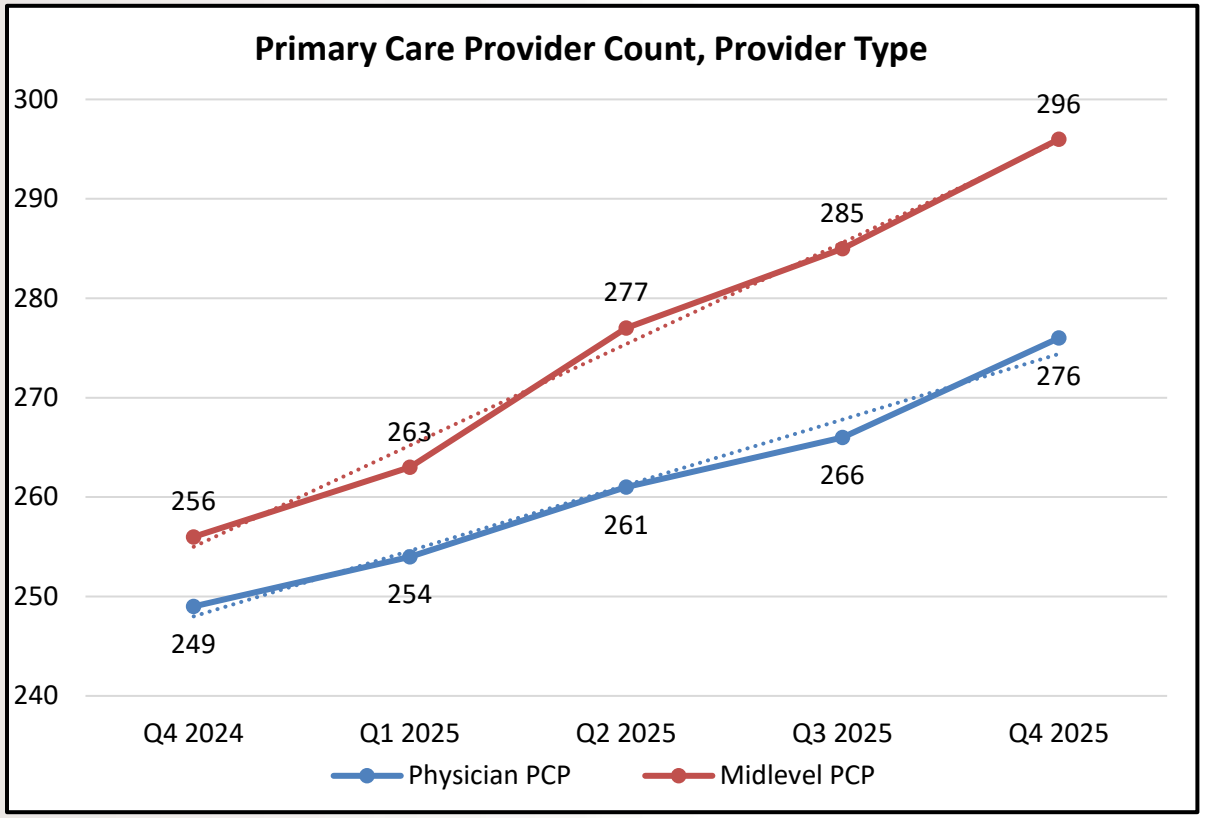
DHCS Annual Network Certification – 2023/2024

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

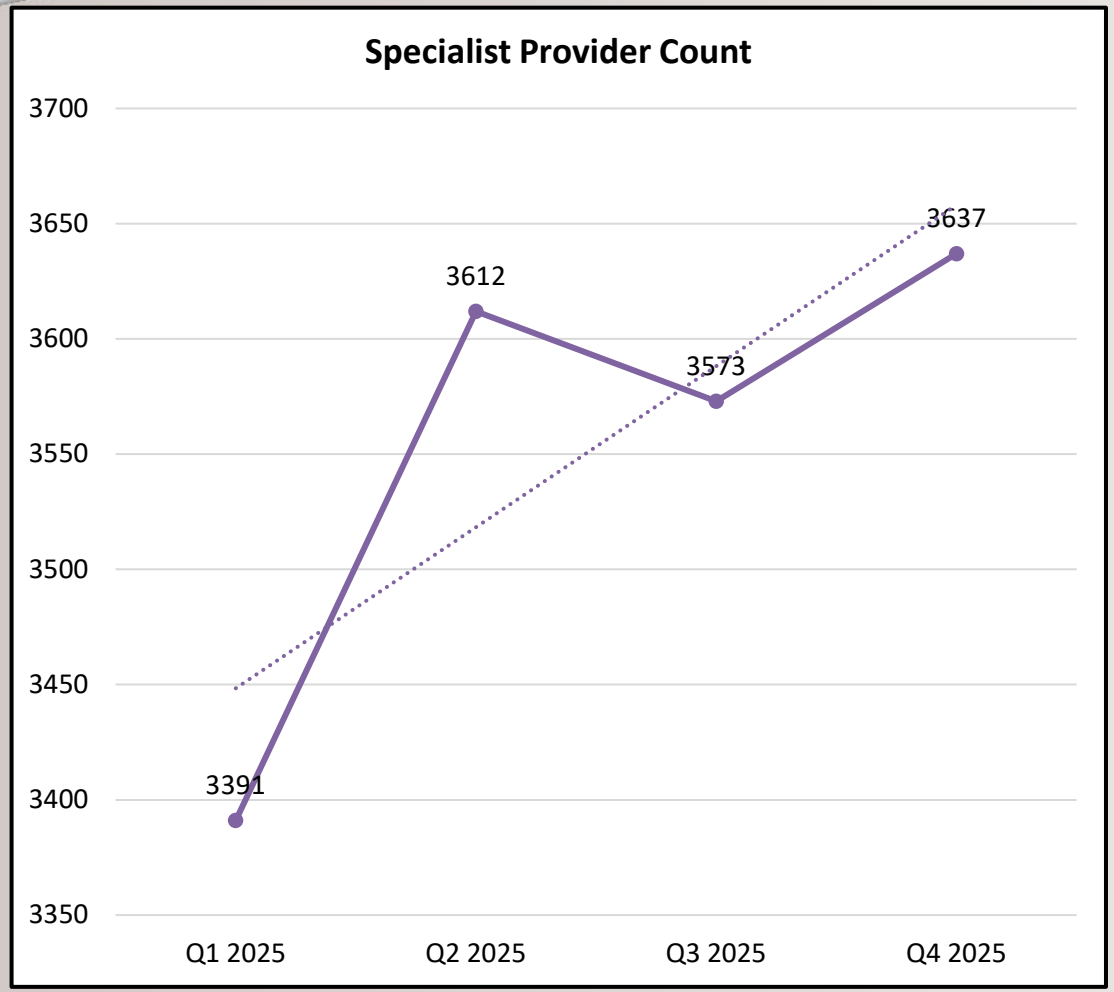
- The Plan submitted 232 AAS requests to the DHCS in Q1 2025. Of these 232 “population points”, 77 “population points” were newly identified for the 2024 ANC and 155 “population points” remained the same from the 2023 ANC.
- The Plan reviews all network deletions and as of the end of Q3 2025, the Plan did not identify terminations any that impacted the Plan’s geographic accessibility.
- **Analysis**: In Q4 2025, the DHCS completed review of the ANC and found no deficiencies. On December 18th, the Plan passed the 2024 Annual Network Certification.
- **Recommendation**: The Plan will continue to monitor geographic access both ongoing and through the DHCS Network Certification process.

Network Adequacy & Provider Counts





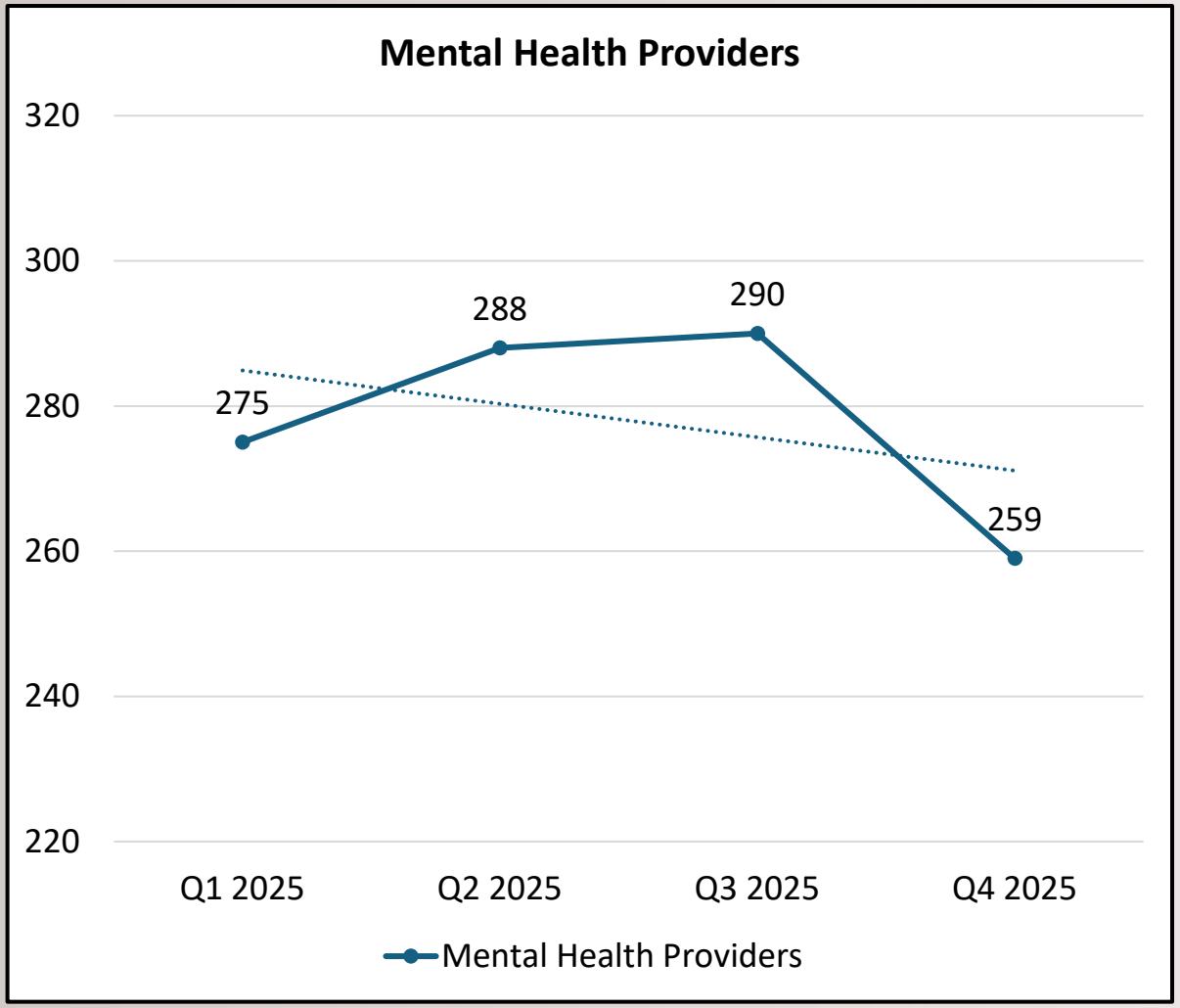
Network Adequacy & Provider Counts

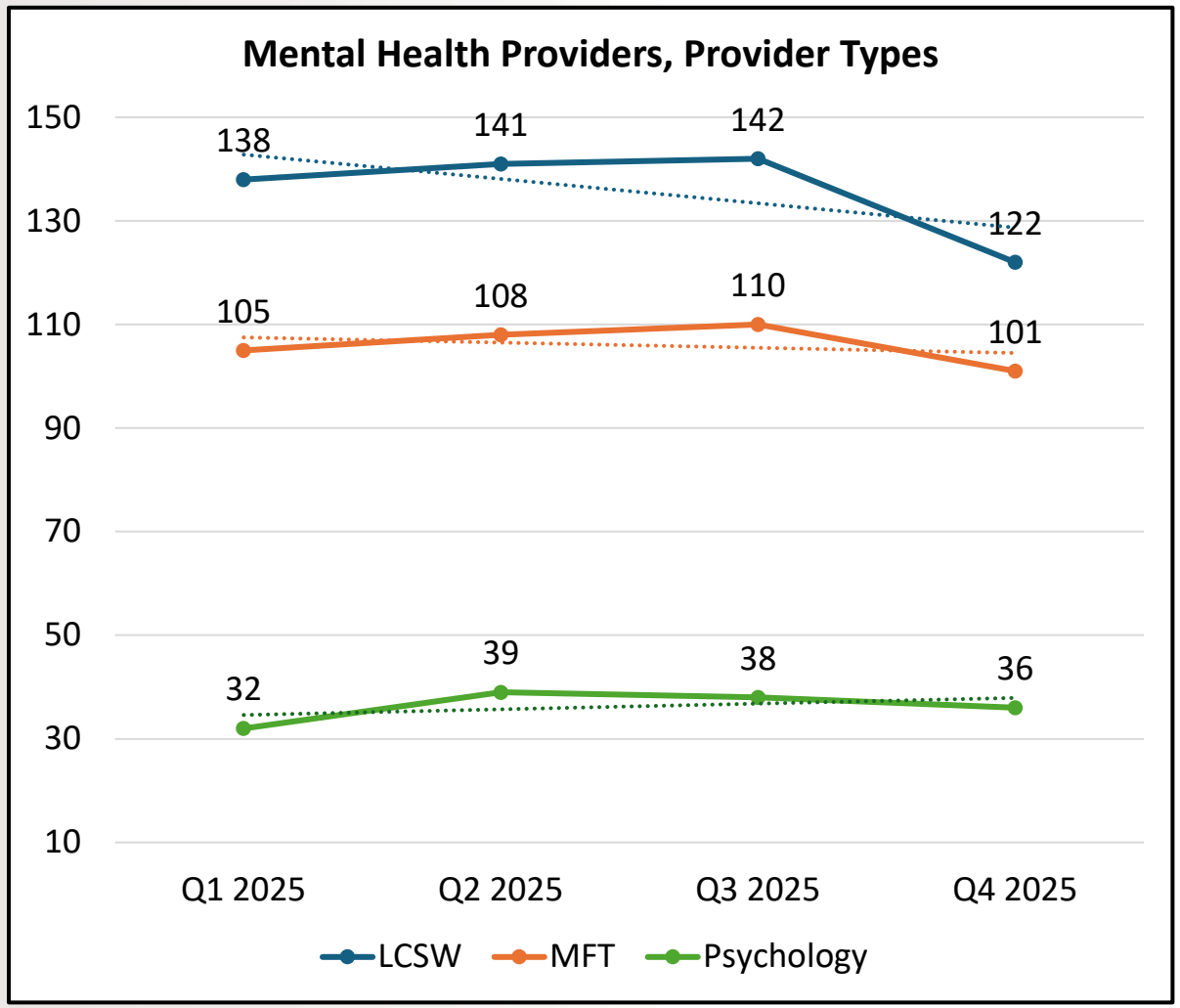


DHCS Core Specialty	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Cardiology	45	46	48	46
Dermatology	51	54	60	60
Doula*	9	10	13	18
Endocrinology	32	33	35	37
Gastroenterology	38	42	42	40
General Surgery	68	71	72	74
Hematology	29	29	30	25
Infectious Disease	13	13	13	12
Nephrology	24	32	32	32
Neurology	33	33	33	32
Oncology	30	32	34	28
Ophthalmology	32	38	37	37
Orthopedic Surgery	28	29	28	29
Otolaryngology	15	16	16	16
Physical Med & Rehab	8	8	11	11
Podiatry*	25	24	23	24
Psychiatry	105	200	221	214
Pulmonary Disease	23	23	27	25
Rheumatology*	21	19	25	22
	> 5% Increase		> 5% Decrease	
	≤ 5% Increase		≤ 5% Decrease	

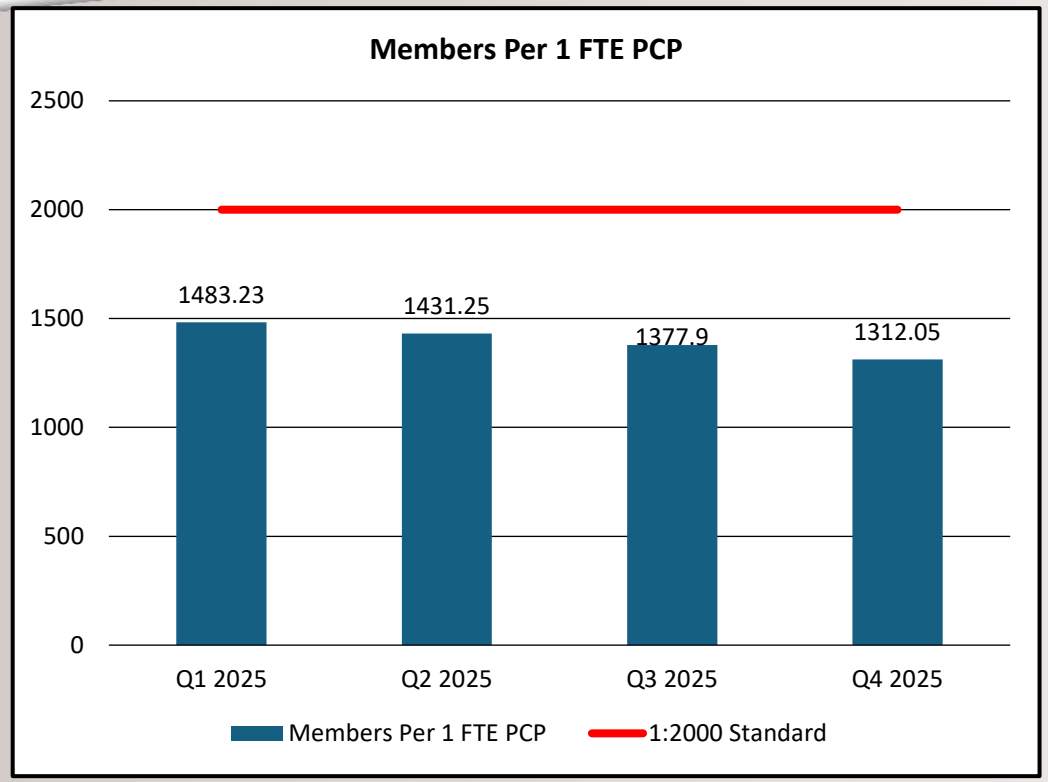
* Internally monitored – not a DHCS Core Specialty

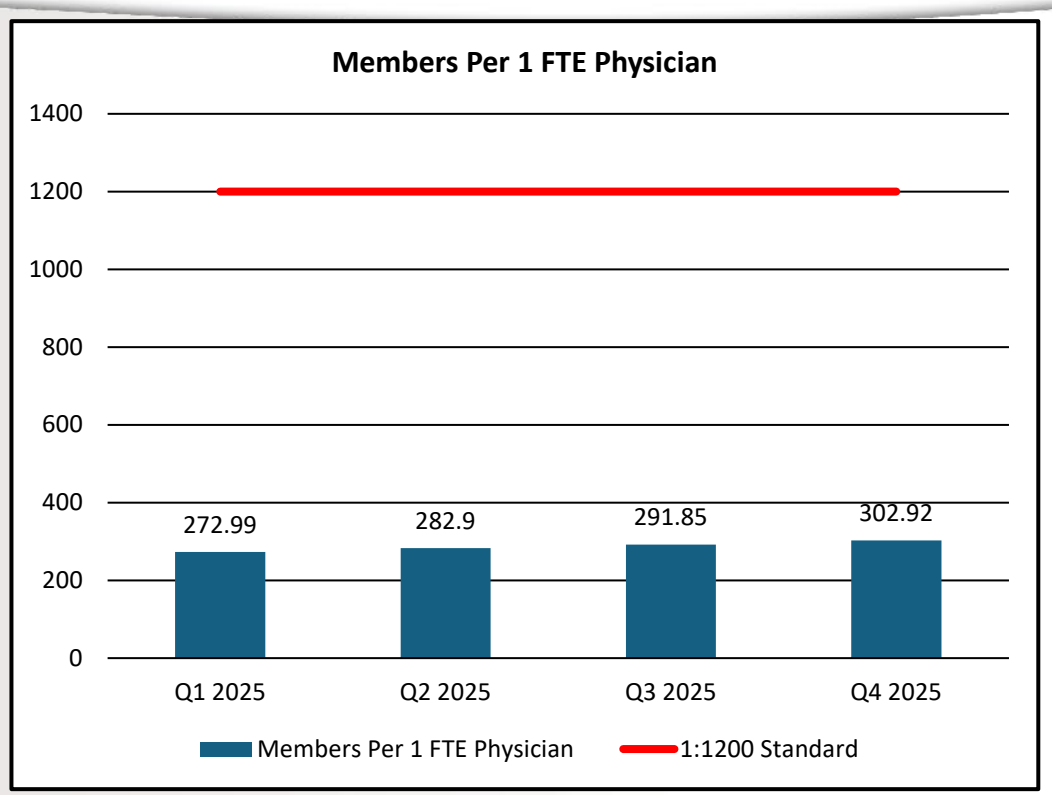
Network Adequacy & Provider Counts





Network Adequacy & Provider Counts





Analysis: Network growth illustrated in the slides above, has resulted in a positive impact on the Plan's network adequacy goals.

Recommendation: The Provider Network Analytics team will continue to monitor network adequacy and growth.

KERN HEALTH SYSTEMS

Network Adequacy Committee (NAC)
Agenda – November 14th, 2025

AGENDA ITEM	AGENDA TOPIC	PRESENTER	TIME	ACTION
CALL TO ORDER	Call meeting order / Attendance-Quorum	***James Winfrey, KHS, Deputy Director of Provider Network Management***	*3 min*	*N/A*
APPROVAL OF MINUTES	Review, Discussion, Motion to Approve	***James Winfrey, KHS, Deputy Director of Provider Network Management***	*1 min*	*Approve*
OLD BUSINESS	N/A – There is no old business from prior committee meeting to discuss.	***James Winfrey, KHS, Deputy Director of Provider Network Management***	*1 min*	*N/A*
NEW BUSINESS	1. Provider Network Management, Q3 2025 Quarterly Network Review	***Greg Panero, KHS, Provider Network Analyst Program Manager***	*20 min*	*Approve*
	2. NCQA Reporting – Provider Network Demographic Availability	***James Winfrey, KHS, Deputy Director of Provider Network Management***	*10 min*	*N/A - Discussion*
	3. ABA Services	***Greg Panero, KHS, Provider Network Analyst Program Manager***	*1 min*	*N/A - Discussion*
	4. Department of Health Care Services (DHCS) 2025 Medical Audit	***James Winfrey, KHS, Deputy Director of Provider Network Management***	*1 min*	*N/A - Discussion*
OPEN FORUM	Open Forum / Committee Members Announcements / Discussion	***Open to all Members***	*10 min*	*Discussion*
NEXT MEETING	Next meeting will be held Friday, January 23rd, at 2:00 PM.	***Informational only***	*N/A*	*N/A*
ADJOURNMENT	Meeting Adjournment	***James Winfrey, KHS, Deputy Director of Provider Network Management***	*N/A*	*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

KERN HEALTH SYSTEMS

COMMITTEE: **Network Adequacy Committee**
DATE OF MEETING: **November 14, 2025**
CALL TO ORDER: **3:32 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:	Alan Avery, KHS - Chief Executive Officer (Virtual)
Members Excused (E), Absent (A)	Amisha Pannu, KHS - Senior Director of Provider Network Management (E)
Staff Present:	Greg Panero, KHS - Provider Network Analytics Program Manager (Virtual) Clarice Garcia, KHS - Provider Network Analyst I (Virtual) Stephanie Lopez, KHS – Provider Relations Coordinator I (Virtual)

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
CALL TO ORDER	- James Winfrey called the meeting to order at 3:32 PM - Quorum/Attendance	- Committee quorum requirements met.	N/A
APPROVAL OF MINUTES	- James Winfrey presented the Q3 2025 Network Adequacy Committee meeting minutes for approval.	☑ **CLOSED**: The committee members in attendance approved Q3 2025 Network Adequacy Minutes.	*11/14/25*
OLD BUSINESS	- No items.	☑ **CLOSED**: Informational only.	*11/14/25*
NEW BUSINESS	Provider Network Management, Q3 2025 Quarterly Network Review - Greg Panero presented the Provider Network Management Q3 2025 Quarterly Network Review. o After-Hours Survey Results: Emergency Access at 99% compliant, Urgent Care Access at 99% compliant. Discussed Plan follow up action with provider who has been non-compliant for two consecutive quarters. KHS is working with this provider to ensure they are compliant in Q4 2025. Provider seems to be having issues with turning on	☑ **CLOSED**: The committee members in attendance approved Provider Network Management, Q2 2025 Quarterly Network Review.	*11/14/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	their after-hours system. ▪ During discussion of after-hours survey Deb Murr stated her question was already answered regarding the phone issues. Greg further clarified, historically this provider did not have these issues prior to Q1 2025. o Provider Accessibility Monitoring Survey: In Q3 2025 the Plan revised the methodology to randomly select 25 PCP and 25 Specialty providers to survey. Providers will be sampled by region at least once a year or as necessary. o Plan compliant with all standards (appointment availability, hours of operation, phone answering timeliness, in-office wait times) based on results of Q3 2025 Survey. ▪ During discussion of Provider Accessibility Monitoring Survey James explained we were surveying the same providers in the rural region and in the Central Bakersfield area not many providers were being surveyed. ▪ Greg Panero also brought up discussion of when the best time would be for the regional survey accessibility and suggested Q1 or Q2. James Winfrey indicated Q1 may be best as it would have been 6 months since last review. ▪ Traco Matthews agreed with Q1 for the regional survey since that would give an opportunity to resurvey in other quarters in case of any non-compliance. ▪ Melissa stated it may be better to switch to a different quarter to avoid survey fatigue, but James added in Q2 providers are completing the provider satisfaction survey. o Access Grievance Review: The Plan had 405 access grievances in Q1 2025, 173 of which were found in favor of the member, for a total of 0.43 grievances for every 1,000 members.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	▪ During discussion of access Grievance Review Deb Murr asked what is meant by Provider Availability? Greg responded Provider Availability indicates that it's normal practice, hours, days. For example, if the provider is only in office every third Wednesday for limited hours making it hard to get an appointment, this could be considered Provider availability. James added if the Network is lacking a certain type of provider this may also be Provider Availability. ▪ Traco Matthews asked Alan Avery if the increases in access grievances could be due to policy changes related to transportation. James pointed out since these are Q1 2025 access grievances the timeline may not match the transportation policy change. Adding PNM was surprised about the increase and is working with Member Services to identify the root cause. ▪ Melissa asked for more clarification on the bar chart of the increase in Technology /Telephone grievance type and what could be the cause. Greg indicated this can be further researched. In the past there has been large provider groups having phone issues and this could be a cause. ▪ Greg presented new analysis of membership and grievances by age and gender. James pointed out that the 0-17 age group is 37.92% the Plan's membership and 18.02 % of the grievances found in favor of the Member were in this age group. The 45-64 age group was 16.75% of the Plans membership and 39.53% of the grievances found in favor of the Member were in this age group. ▪ Traco inquired if this could be because the parents are advocating on the child's behalf when filing a grievance. James		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	explained that is not the case as this data is based on data for the Member that the grievance was filed for. Traco would like to continue monitoring this as data could indicate parents may not be advocating for children. ○ Geographic Accessibility & DHCS Network Certification: The Plan is in compliance with DHCS Network Standards or maintains a DHCS-approved access standard when non-compliance identified. ▪ In Q1 2025, the Plan submitted 232 AAS requests to DHCS. Of these 232, 77 were newly identified for the 2024 ANC and 155 remained the same from the 2023 ANC. As of Q3 2025, the Plan received one resubmission request for 93285 Zip code, Wofford Heights CA. The Plan resubmitted the request on August 14th, 2025. ○ Network Adequacy & Provider Counts: ▪ FTE PCP ratio at 1:1378 ▪ FTE Physician ratio 1:292 ▪ PCP Accepting new members: 90% ▪ NPMH accepting new members: 98% ▪ NPMH locations accepting new members: 94% ▪ PCP Count: 551 ▪ Specialist Provider Count: 3573 ▪ Mental Health Provider Count: 290 ○ Traco asked who manages the team that recruits new providers. James explained PNM has a recruitment specialist whose job is to identify providers and get them into the network. James also mentioned the recruitment and retention grant is wrapping up and they were in charge of getting providers to Kern County. ○ James added that the FTE ratios look good, adding to the concern about why Access grievances are increasing.	☑ **CLOSED:** Informational only. Continue monitoring age and grievances.	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	○ Significant Network Change: In Q3 2024, the Plan submitted a new significant network change filing on September 20, 2024. ▪ On June 9th, 2025, the Plan received a Comment Letter from the DMHC. The Plan submitted the response to the comment letter on July 2nd, 2025. ▪ On July 29, 2025, the Plan's Significant Network Change was approved by the DMHC. NCQA Reporting – Provider Network Demographic Availability - James presented demographic availability analysis. ○ For Rating of Personal Doctor, Black/African American members satisfaction was 5.7% less than that of the Plan's overall results for that category. ○ As of the most recent data available, 24.6% of Primary Care providers and 14.3% of Specialty providers have provided race/ethnicity data to the Plan. ▪ The Plan reviewed the race/ethnicity of its provider network against Plan membership race/ethnicity data. The Plan has identified that while 63.4% of the Plan's enrollees identify as Hispanic, only 31.1% of the Plan's Primary Care provider network, and 24.8% of the Plan's Specialty network are Hispanic. ▪ 6.6% of the Plan's Primary Care provider network and 7% of the Plan's Specialty provider network identified as Black/African American, of providers who responded to the race/ethnicity question, inline with the 5.8% of the Plan's membership who identified as Black/African American. ○ In reviewing data segmentation by language, the Plan found that scores from Spanish language survey responses were between 5-9% higher than the Plan's overall totals for 4 of the 5 survey questions/summary areas.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	○ The Plan has identified that while Spanish is the preferred language for 31.8% of Plan membership, only 26.2% of the Plan's Primary Care network and 20.3% of the Plan's Specialty network speak Spanish. - James asked if there were any other measures this committee would like to look at. No other measures were requested. ABA Services - Greg reviewed with BH department. It seems the issue KHS is having is visibility. The authorization will go out to a specific provider, and the provider will have a waitlist. Greg advised another provider may not have a waitlist and the authorization may need to be redirected but the ABA provider will not do that. Greg advised there needs to be better communication within the ABA providers and with KHS as well. ○ James advised PNM has rep that works with ABA providers and working with BH team to get issues resolved. James advised there are other issues with ABA providers as well. ○ Deb advised issues are also with getting original assessment done. Deb asked how we can manage the network better to ensure the members are getting the services they need and to ensure they are medically necessary. ○ James advised he will continue to monitor ABA from an access Point of view. Department of Health Care Services (DHCS) 2025 Medical Audit - James advised there are no deliverables at this time related to Access and this is the second year in a row they have not asked for it. ○ Traco stated he is aware there is a community of practice and asked if there is ever any sort of benchmarking in that community of practice with		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	other local Plans. James advised benchmarks are regulatory and there are some annual benchmarks. James advised they focus on issues that are currently happening with members.		
OPEN FORUM	**Open Forum** - Melissa has an item, suggests to extend the quarterly meetings since DSNP is launched and will most likely want to dive deeper into discussion. - Alan asked when will they know the results of the pilots. Melissa stated there are no results, but guesses they are aiming for late 2026 or 2027.	☑ **CLOSED**: Report to Melissa of reporting requirements and extending Q1 2026 meeting.	*11/14/25*
NEXT MEETING	Next meeting will be held Friday, January 23, 2025 at 2:00 PM.	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 4:24 PM. ***Respectfully submitted: James Winfrey; Deputy Director of Provider Network Management***	**N/A**	*N/A*

For Signature Only – NAC Minutes 11/14/25

The foregoing minutes were APPROVED AS PRESENTED on: 3/3/2026 (Date) James Winfrey (Name)

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

To: Executive Quality Improvement Health Equity Committee (EQIHEC)

From: Melinda Santiago, Director of Behavioral Health

Date: March 17, 2026

Re: Behavioral Health Advisory Committee (BHAC)

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

Meetings Held:
January 21, 2026

Discussion Items:
1. Q4 2025 Updates
2. O&E Plan
3. NCQA QI 7E
4. ABA Audit Tool and Results
5. Provider Training Efforts

Fiscal Impact:
None

Requested Action:
Review for approval.

KERN HEALTH SYSTEMS

BEHAVIORAL HEALTH ADVISORY COMMITTEE (BHAC) MEETING

Wednesday, January 21, 2026 at

12:00 pm

2900 Buck Owens Blvd. Bakersfield, CA 93308

4th Floor – Kern River Room

For more information, call (661) 664-5000

KHS PROPRIETARY PROPERTY – NOT FOR PUBLIC DISCLOSURE

KERN HEALTH SYSTEMS

Behavioral Health Advisory Committee (BHAC) AGENDA

Wednesday, January 21, 2026

12:00 pm

AGENDA ITEM	AGENDA TOPIC	PRESENTER	ACTION
CALL TO ORDER	Call meeting order / Attendance-Quorum	Dr. Martha Tasinga, CMO and Melinda Santiago, BH Dir	*N/A*
APPROVAL OF MINUTES	October 15, 2025, Minutes Review, Discussion, Motion to Approve	***All Voting Members***	*Approve*
OLD BUSINESS			
NEW BUSINESS	1. Q4 2025 Updates 2. O&E Plan 3. NCQA QI 7E 4. ABA Audit Tool and Results 5. Provider Training Efforts	Melinda Santiago, BH Dir	*Approve*
OPEN FORUM	Open Forum / Committee Members Announcements / Discussion	***Open to all Members***	*Discussion*
NEXT MEETING	Next meeting will be held Wednesday, **April 15, 2026, at 12:00-1:30**	Informational only	*N/A*
ADJOURNMENT	Meeting Adjournment	Dr. Martha Tasinga, CMO and Melinda Santiago, BH Dir	*N/A*

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

KERN HEALTH SYSTEMS

COMMITTEE: **BEHAVIORAL HEALTH ADVISORY COMMITTEE**
DATE OF MEETING: **October 15, 2025**

Members Present On-Site:	Marisa Garcia-Trebizo, LMFT - Director at CSV Alison Burrowes, LCSW – Dir. KBHRS Cherilyn Haworth, PsyD, LCSW – CSUB Mesha Muwanga, LMFT – Rhema Albert Ma, M.D. – Arise	Melinda Santiago, KHS Director of Behavioral Health	Dr. Sukhpreet Sidhu, M.D – Medical Director (Proxy for CMO)
Members Virtual Remote:	Anuradha Rao, MD - Omni		
Members Excused=E Absent=A	Matthew Beare, MD – Clinica Sierra Vista (E) Tara Gray, Tribal Liaison – BAIHP (A)		Martha Tasinga MD, KHS Chief Medical Officer
Staff Present:	Amy Daniels, Executive Health Services Coordinator Yolanda Herrera, KHS Credentialing Manager	Courtney Morris, KHS Behavioral Health Supervisor Vanessa Hernandez, KHS Senior Support Clerk	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Melinda Santiago, KHS Director of Behavioral Health called the meeting to order at 12:08 PM.		N/A
Committee Minutes	**Approval of Minutes** Approval of Minutes from July 16, 2025 meeting.	☑ **APPROVED**: A motion was made by M.Garcia-Trebizo LMFT and seconded by Alison Burrowes, to approve the minutes of July 16, 2025. Motion carried.	10/15/25
OLD BUSINESS	**Announcements:** The following announcements were shared with the committee: • Dr. Sidhu, KHS Medical Director will be joining committee	☑ **CLOSED**: Informational discussion only	10/15/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	meeting. • Dr. Albert Ma, Network Provider, is also new and joining this committee. • Melinda reminded the committee members that this is a 2-year commitment as outlined in the Committee charter.		
NEW BUSINESS	**Behavioral Health 3rd Quarter 2025 Updates** **Presenter:** Melinda Santiago, Director of Behavioral Health Services Melinda Santiago provided an update on Behavioral Health Department activities and progress for the 3rd Quarter of 2025. Key developments included: • As noted on page 9 of the update packet, the Behavioral Health Advisory Committee (BAHC) reports to the EQIHEC, and the program overview outlines the committee's activities, accomplishments, and ongoing challenges. • Three-year Strategic Goals were reviewed. KHS will begin developing new strategic goals at the end of the year, informed by prior efforts and aligned with the quality improvement framework. • The NSMHS Audit Tool has been completed and is available for review. • Transition of Care (TOC) training and related provider communications have been completed. • A provider bulletin was developed and distributed to network providers outlining correct billing submission processes for associate providers working under licensed providers. • The Applied Behavior Analysis (ABA) Audit for 3rd Quarter 2025 has been completed; outcomes will be shared at a future meeting. • ABA network recruitment for in-person providers continues, with an emphasis on identifying providers committed to	☑ **CLOSED**: BH Report for 3rd Quarter 2025 was accepted as presented - Informational discussion only.	10/15/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	serving KHS members. • The KHS Behavioral Health Department is in the final stages of data exchange efforts. • 3rd Quarter metrics for inbound and outbound calls, activities, and Care Management (CM) episodes remain consistent. The department continues refining data methodology to better reflect successful member engagement. • NSMHS utilization has increased. While some outreach attempts remain unsuccessful, staff continue to make a minimum of three contact attempts per member.		

	Provider Portal Enhancements
	Presenter: Courtney Morris, KHS Behavioral Health Supervisor
	
	Courtney Morris presented the proposed Provider Portal Enhancements and provided the following highlights:
	• Addition of a Behavioral Health Overview page within the Member Overview section of the Provider Portal.
	• Providers will be able to view:
	  ○ Behavioral health data points reflected in reports
	  ○ Approved behavioral health authorizations
	  ○ Behavioral health medications
	  ○ Follow-Up After Hospitalization (FUA) / Follow-Up After Mental Health Visit (FUM) Reports, which have been sent to select provider groups
	  ▪ Report enhancements include additional member information such as:
	  ▪ Member contact information
	  ▪ Member's Primary Care Provider (PCP)
	  ▪ Affiliated behavioral health providers
	  ▪ These reports will be available once the new Provider Portal is operational
	• The overall goal of the enhancements is to improve cross-coordination between PCPs and behavioral health providers.
		☑ **CLOSED**: Informational discussion only	10/15/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• Mockups were not available at this meeting but are expected to be shared at the January meeting. **Committee Discussion** Committee members expressed concern regarding the volume of outreach attempts members may receive from both the health plan (KHS) and provider groups, which can sometimes increase member anxiety and frustration. Courtney Morris clarified that when a member is assigned, the KHS Behavioral Health Department will contact the provider directly rather than the member, reducing the likelihood of members feeling overwhelmed. Dr. Ma raised concerns regarding patients discharged from the Emergency Department with instructions to follow up with Behavioral Health within one week. This places the burden on the members and does not align with the intent of state regulations. Dr. Ma emphasized that members should be discharged with a scheduled behavioral health appointment. Dr. Rao discussed challenges related to Applied Behavior Analysis (ABA) follow-up, noting that while providers may receive authorization approval or denial notifications, they often do not receive a closed-loop referral confirming when a member completes their first visit. Dr. Rao asked how health plans and providers can partner more effectively to close these gaps. Melinda expressed appreciation for the feedback and stated she will research these concerns and report back to the committee.		
	<u>Reporting: EPSDT, FUM/FUA Reports & Inpatient Reports</u> **Presenter: Courtney Morris** **EPSDT Reporting** Courtney Morris reported that when a member has a positive depression screening through EPSDT, the member is offered mental health services and/or follow-up care to ensure timely access to appropriate treatment. **FUM/FUA Reports & Reconciliation**	☑ **CLOSED**: Informational discussion only.	7/16/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED

	Courtney Morris reviewed the Follow-Up After Mental Health Visit (FUM) and Follow-Up After Hospitalization for Mental Illness (FUA) reports and explained the distinctions between them. She discussed how these reports are used to demonstrate the impact of staff outreach efforts on successful linkage to care.
	Key discussion points included:
	• Outreach barriers, including:
	  ○ No contact attempts
	  ○ Age-outs
	  ○ Audit eligibility based on MCAS tracking
	• Analysis of percentages reflecting successful contact versus no contact
	• Use of reconciliation data to support member management improvements and quality monitoring
	Inpatient Reports
	Courtney Morris displayed the Inpatient Report, explained the data elements being captured, and reviewed how the information is shared. The purpose of the report is to support outreach and coordination for members hospitalized with primary behavioral health–related concerns, ensuring appropriate follow-up and continuity of care.		

	<u>Member Experience Surveys</u> **Requirement:** Annual behavioral health–specific member experience survey **Methodology** • Two surveys administered: Adult and Child populations. • Follow-up phone calls were not conducted this year; surveys were distributed via email only. • Survey sample included members with five or more behavioral health services in the year.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Response Rates • Adult Survey: 202 responses • Child Survey: 35 responses (noted as a limitation) **Adult Survey Results (Improvements Noted)** • Access to care improved from 64% to 74% • Clinician communication improved • Office wait times improved • Medication information and patient rights awareness improved • Counseling treatment ratings improved • Compared favorably in several areas against national Book of Business (BOB) benchmarks **Child Survey Results** • Slight improvement in access to care (52% to 58%) • Communication remained stable • Office wait times declined • Medication side effect education scored well • Overall results remain below national benchmarks • Access issues align with grievance trends **Discussion** • Access challenges noted, particularly for pediatric mental health services. • Sample size limitations acknowledged. • Plans to notify providers in advance next year to encourage member participation. • Survey results (provider "grade book") will be shared with providers.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	ABA Audit Tool Tabled to next meeting.		
	Regional Access Committee – Quarter 1 2025 Update Melinda provided the Regional Access Committee for the 1st Quarter 2025 for members to review at their leisure.	☑ **CLOSED**: Informational discussion only.	10/15/25

OPEN FORUM	**Open Forum**
	Mesha Muwanga, LMFT, raised concerns during the Open Forum regarding the increasing number of behavioral health providers transitioning to telehealth or tele-remote services. She noted that members are requesting more in-person services and emphasized the need for additional in-person providers within the network.
	In response, KHS shared that it is actively addressing this issue by closing the panel to telehealth-only providers in order to strengthen access to in-person behavioral health services.
	Following Ms. Muwanga's comments, committee members discussed ongoing challenges and trends related to the behavioral health provider network, including:
	• Ongoing shortages in child psychiatry, contributing to access challenges for pediatric members.
	• A notable increase in telehealth-only providers, particularly among private practices.
	• Network policy requiring providers offering telehealth services to also offer in-person services.
	• Enhancements to the credentialing process, including provider questionnaires reviewed by leadership to prioritize:
	  ○ In-person service availability
	  ○ Providers located within Kern County
	• Emphasis on improving quality of care, access, health equity,
		☑ **CLOSED**: Informational discussion only.	10/15/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	and the safe management of high-risk cases. • Concerns regarding the impact of large telehealth platforms on local provider sustainability and health equity. **Committee Administration** • 2026 meeting date placeholders will be distributed to committee members. • Members will receive an invitation to continue participation on the committee for 2026.		
NEXT MEETING	Next meeting will be held January 21, 2026.	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 1:32 pm. ***Respectfully submitted: Amy Daniel, Executive Health Services Coordinator***	**N/A**	*N/A*

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

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

KERN HEALTH SYSTEMS

Melinda Santiago

Director of Behavioral Health

1/21/2026

Behavioral Health Advisory Committee

The **Behavioral Health Advisory Committee (BHAC)**, delegated by the Executive Quality Improvement Health Equity Committee (EQIHEC), serves as a collaborative forum to align Kern Health Systems (KHS) with the County Behavioral Health Plan (BHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). The committee supports, reviews, and evaluates behavioral health interventions with the goal of ensuring continuity of care, reducing barriers to access, strengthening linkages to appropriate services, integrating behavioral and medical care, and providing resources for members living with mental illness and/or substance use disorders.

Quality Monitoring & Performance	• Review quality monitoring activities (compliance, corrective actions, delegation oversight) • Evaluate network accessibility and provider compliance • Monitor Medi-Cal Managed Care Accountability Set (MCAS) targets for BH • Track member complaints, appeals, and experience (quantitative & qualitative analysis) • Review quality performance and improvement initiatives
Clinical Guidelines & Innovation	• Provide feedback on BH clinical guidelines and UM criteria • Assess new BH technologies and treatment innovations • Review monitoring tools, site/chart reviews, and access to care standards • Ensure culturally appropriate service and program design
Coordination & Integration of Care	• Review processes for continuity and coordination of medical and behavioral health services • Oversee methods of information exchange across systems • Address carved-out services to improve coordination and reduce fragmentation
Member Experience & Engagement	• Provide feedback based on direct interactions with BH members • Review and integrate member satisfaction survey results • Support priorities for behavioral health education and outreach programs • Advance health equity and improve accessibility of services
Governance & Compliance	• Review and approve the BH Program Description annually • Monitor compliance with Memorandum of Understanding (MOU) with KBHRS • Provide structured support to KHS management on BH service delivery

BH Updates Q4 2025

Strategy 1: Internal Behavioral Health Department Development

•Highlight **Key Accomplishments**:

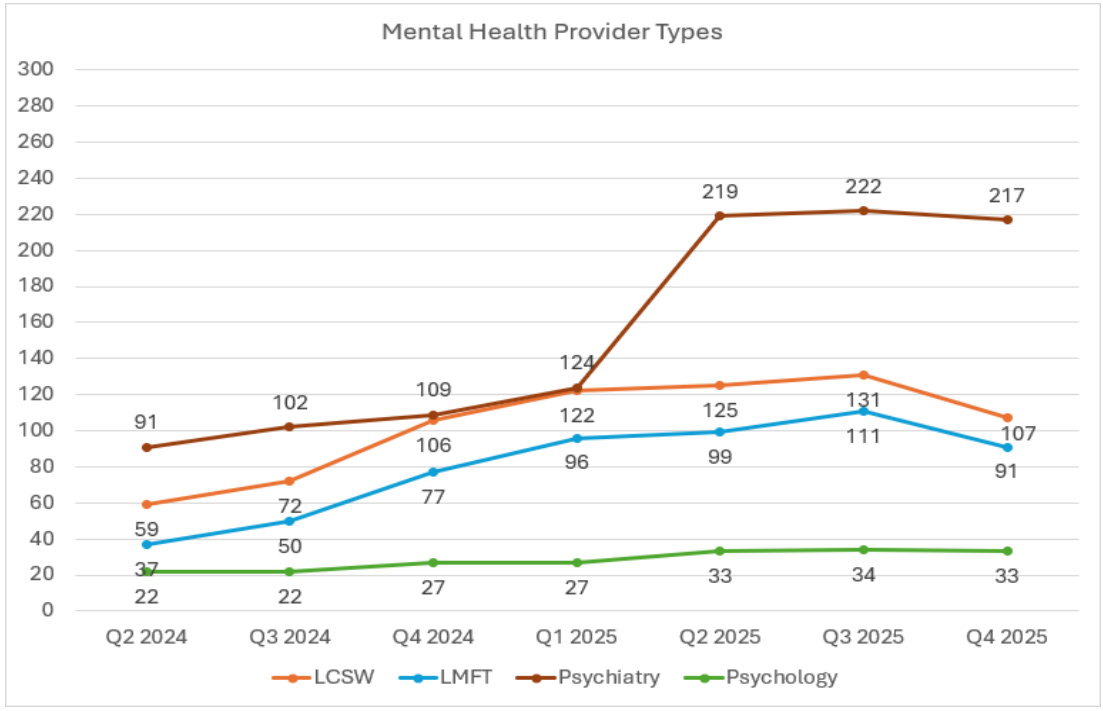
- **•BH Program Quality Improvement Framework**
  - Strengthened QI infrastructure through improved data reporting, performance monitoring, and outcome tracking
  - Finalized key governance policies, including DSNP BH Integration Oversight and ABA Medical Necessity Review
  - Continued provider training and technical assistance, reinforcing TOC compliance and documentation standards
  - Completed Q3 ABA chart audits and submitted NCQA ME-7E (Grievances & Appeals)
- **Expansion of the BHT Program:**
  - Enhanced UM–BH–PNM collaboration and transitioned Peer-to-Peer ownership to BH
  - Expanded BCBA clinical oversight, including P2P participation and provider outreach
  - Implemented structured AMR Independent Medical Review workflows
  - Conducted targeted provider support and denial trend analysis to improve authorization outcomes

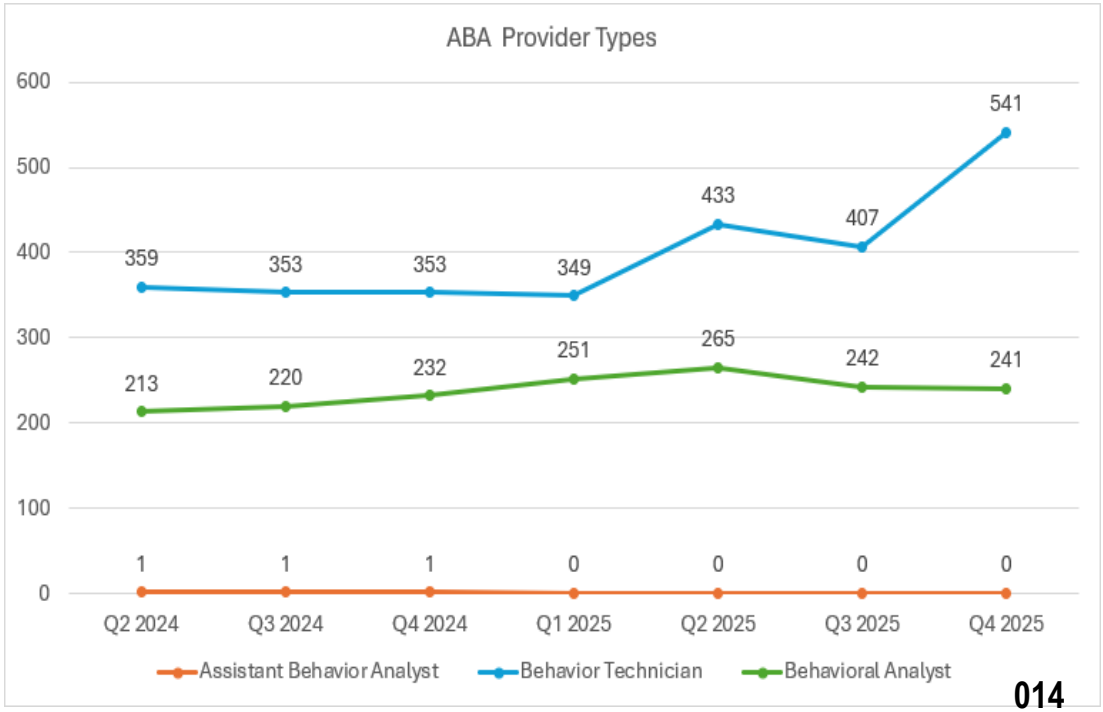
BH Updates Q4 2025

Strategy 2: Mental Health Provider Network Evaluation

•Key Accomplishments:

- Ongoing recruitment and support to expand provider network.
- Ongoing efforts to address provider gaps, particularly in ABA services and in-person care.
- There was a slight decrease in providers in both areas from Q3 to Q4





014

BH Q4 Updates

Q4 2025 Highlights

14974 inbound/outbound calls

- 3082 total episodes per quarter
  - MH: 1959
  - SUD: 143
  - BHT: 980
- 2100 Referrals
  - Difference of Referrals and Episodes
    - 982
    - Barriers in Data

BH Total Calls	Oct	Nov	Dec	Q4 Totals
Inbound	1986	1520	1362	4868
Outbound	4355	2985	2766	10106
Total	6341	4505	4128	14974

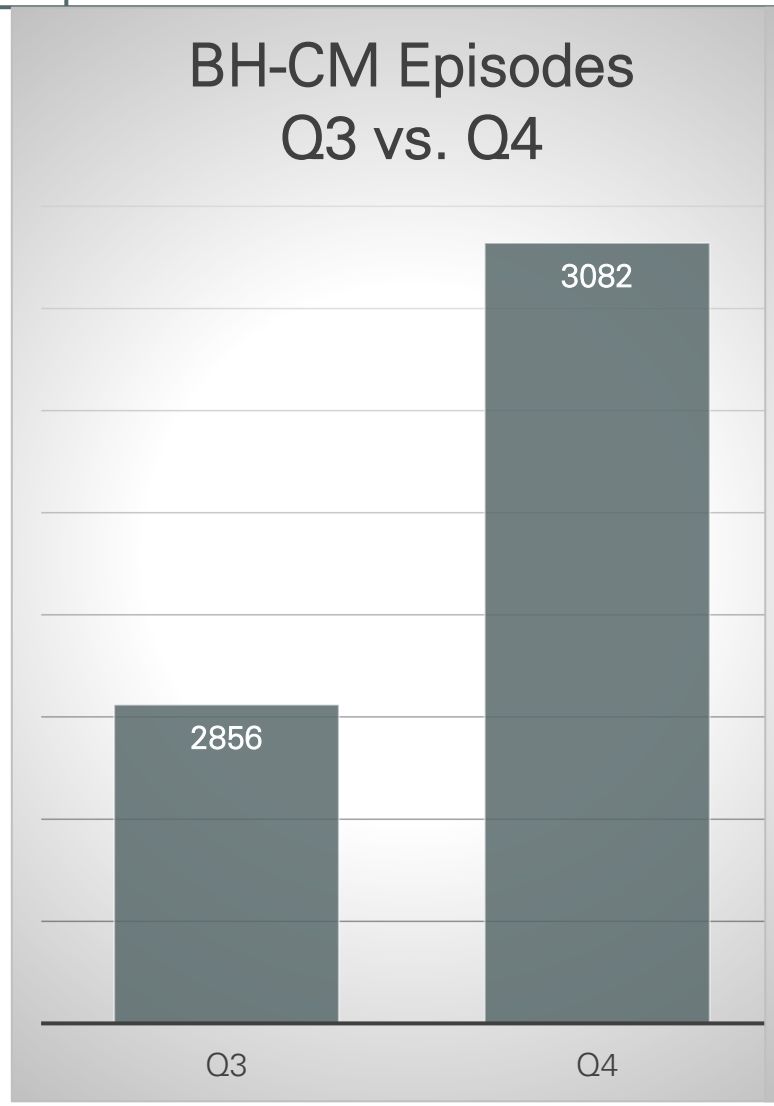
Referrals Received	Oct	Nov	Dec	Q4 Totals
Nurses Portal	173	111	83	367
Provider Portal	321	289	203	813
BH Grievances	2	3	1	6
TOC	113	88	85	286
Other Referral	252	127	249	628
Total	861	618	621	2100

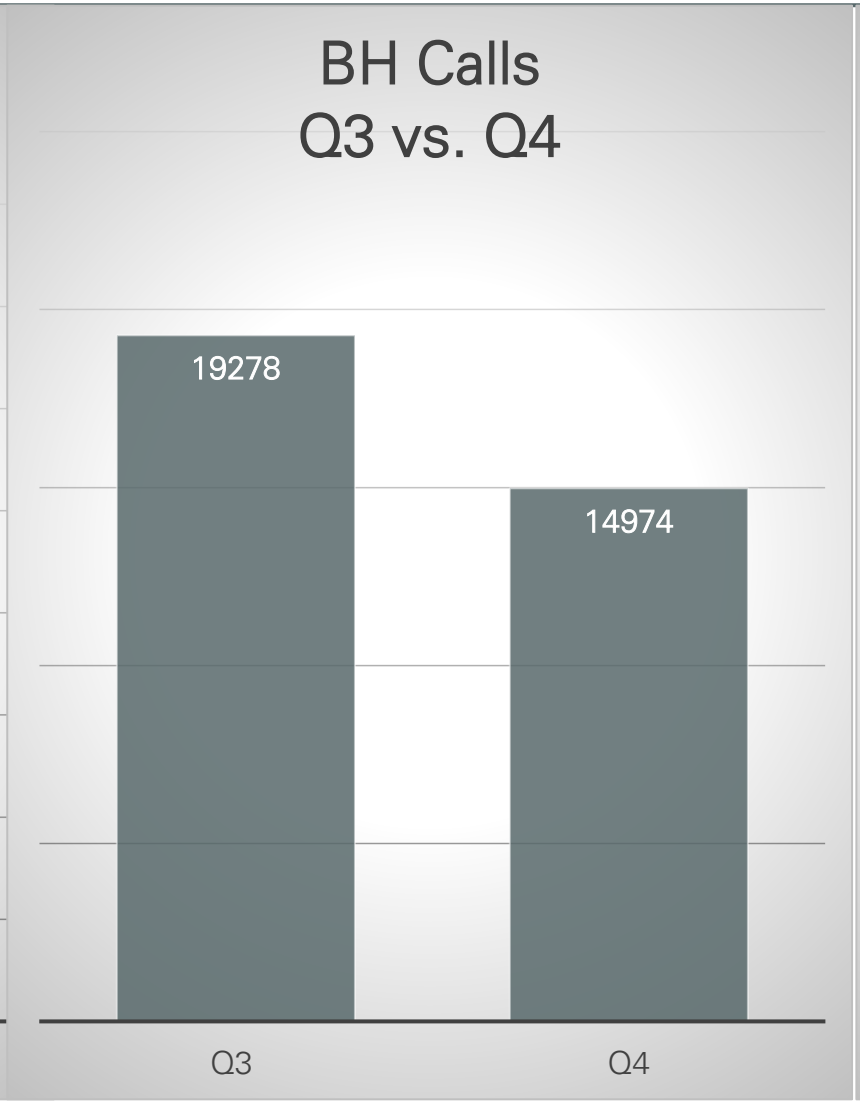
BH Episode Created per month	Oct	Nov	Dec	Q4 Totals
MH	799	568	592	1959
SUD	63	50	30	143
BHT	410	299	271	980
Total	1272	917	893	3082

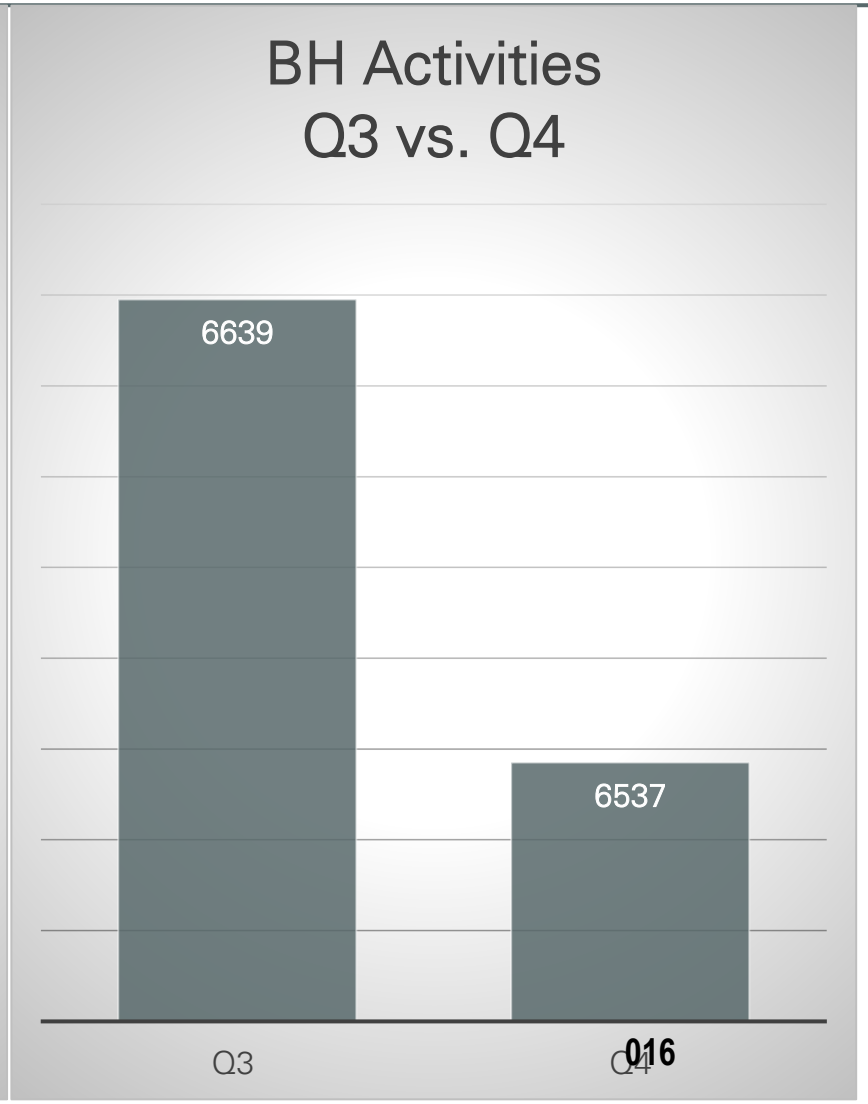
Closed Activities	Oct	Nov	Dec	Q4 Totals
NSMHS/SUD	2535	1877	1632	6044
BHT/ABA	104	71	116	291
CHW	117	66	19	202
Total	2756	2014	1767	6537

015

BH Updates: 2025 YTD Highlights







BH CHW Updates

- **BH CHW efforts pivoted from FUM/FUA outreach to supporting BHT/ABA efforts**
  - **Scheduling P2Ps**
  - **Monitoring & Tracking ABA auths through determination process**
  - **Assisting with Uploads for AMR review**

- **What BH CHW data is most important to share with the committee?**

Q4 Scheduled ABA P2P Call

Date Range:10/1/2025 – 12/31/2025

*Distinct count

Oct: 32
Nov: 70
Dec: 148
Total Scheduled: 250

Q4 Submitted ABA authorizations

Date Range:10/1/2025 – 12/31/2025

*Distinct count

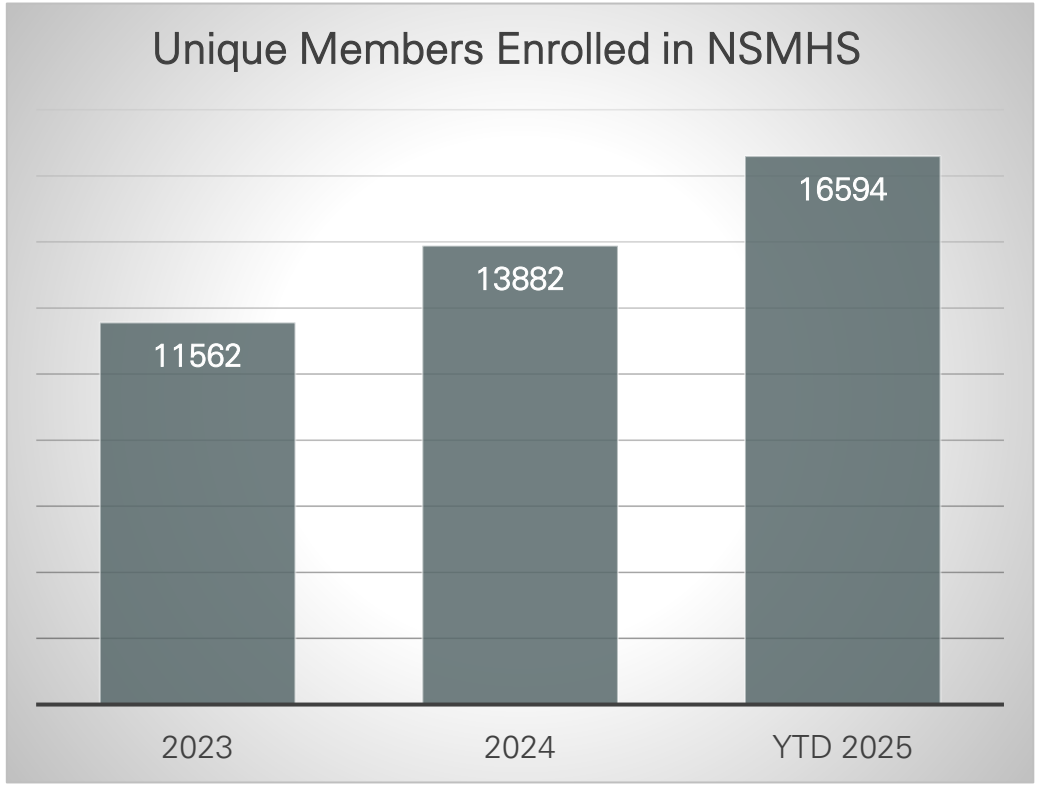
Approved: 631
Denied: 452
Total: 1083

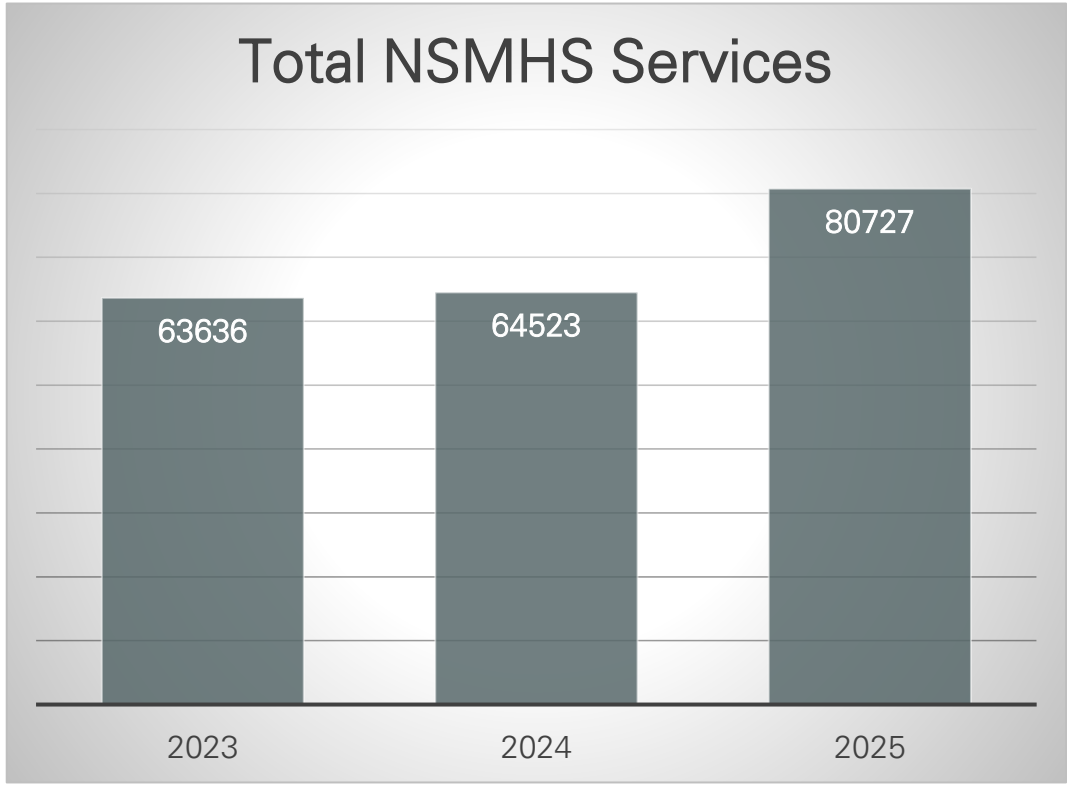
BH Grievance

- Future data will show number of Grievances with NCQA categories
    - What would the BHAC like to see presented?

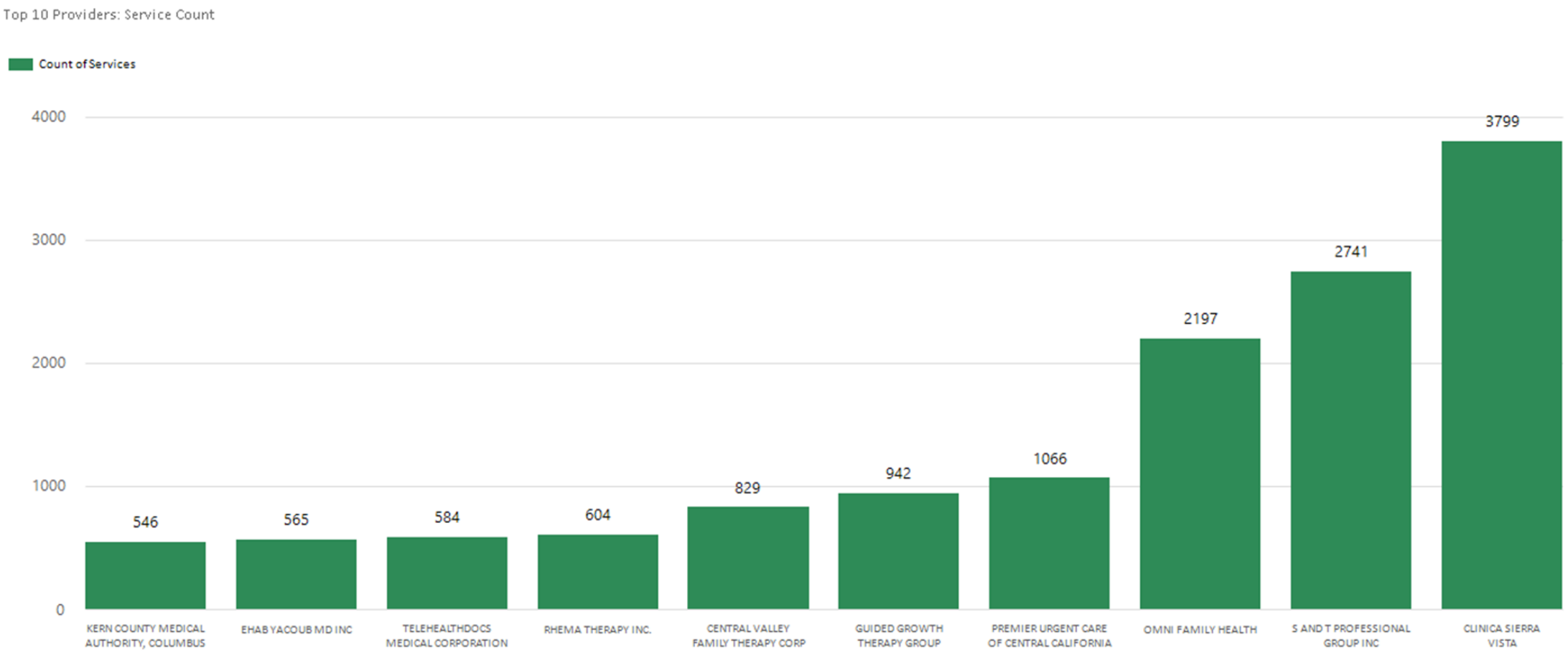
BH Q4 Updates

Utilization for Non-Specialty Mental Health Services





BH Provider Utilization Updates for Q4 2025



020

Behavioral Health Department Initiatives

CYBHI Statewide Multi-Payer Fee Schedule for School-Linked Behavioral Health Services

Objective:

- Align healthcare and education systems to provide sustainable, reimbursable behavioral health services in school settings.
- Ensure equitable access to school-linked behavioral health care for all students, regardless of insurance or payer status.
- Streamline reimbursement and administration by standardizing rates and simplifying provider participation across Medi-Cal and commercial plans.

Minor Consent to Outpatient Mental Health Treatment or Counseling (APL 24-019) - AB 665

- New Provision:
- Minors Aged 12+ may consent to non-specialty outpatient Medi-Cal mental health treatment or counseling without parental or guardian consent.
- Professional Judgment: The attending professional must determine, based on their clinical expertise, whether the minor is mature enough to make an informed decision about participating in treatment.

Non-Specialty Mental Health Services (NSMHS) Outreach and Education Plan

- Purpose of SB 1019: Address low utilization of Medi-Cal NSMHS.
- Mandates: Annual outreach plans by MCPs targeting members and PCPs.
- Goals: Improve awareness and access, with a focus on culturally and linguistically appropriate outreach.
- Plan Submission: Submitted to DHCS on Dec 31, 2024

D-SNP for Behavioral Health Coverage

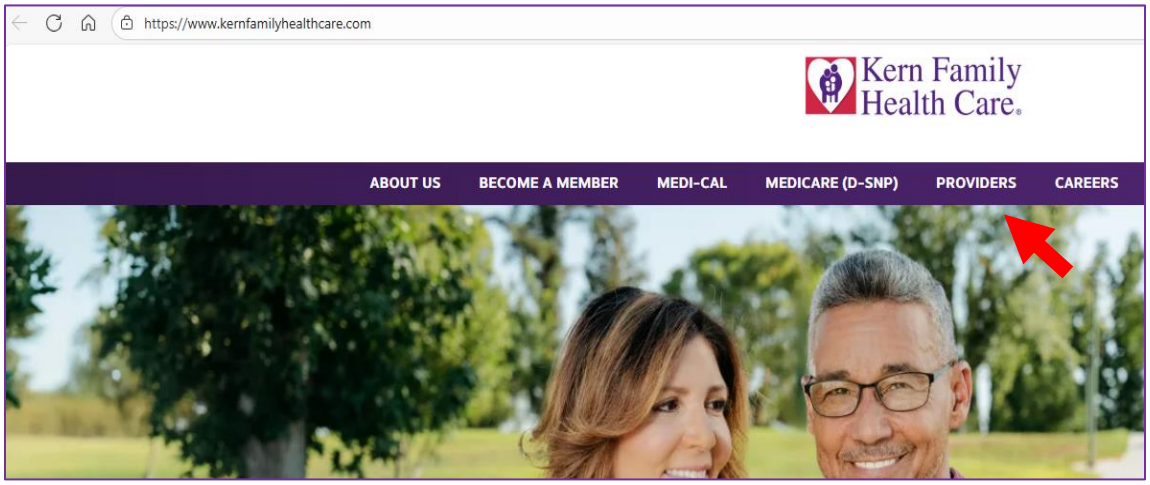
- Objective:
- Create oversight for scope of work related to Behavioral Health Coverage.
- Develop future state requirements for D-SNP line of business, focusing on behavioral health services across the continuum of care (Outpatient & Inpatient).

KERN HEALTH SYSTEMS

How to Access Outreach & Education Plan

Kern Family Health Care (KFHC) Training Materials

Step 1: Access the Kern Family Health Care website at https://www.kernfamilyhealthcare.com/

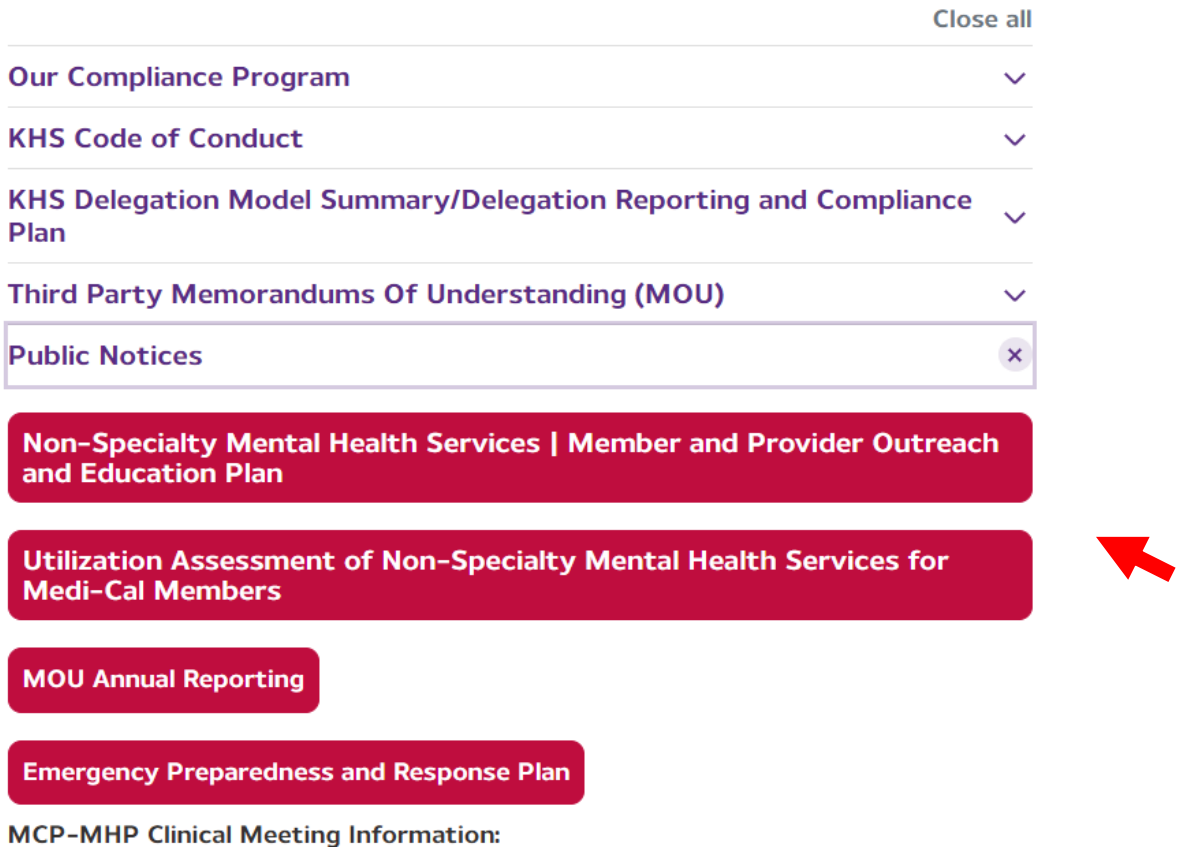


Step 2: Navigate to the About tab located in the top dark purple menu running across the top the Kern Family Health Care webpage, then click to access the Compliance page.



KERN HEALTH SYSTEMS

Step 3: From the Compliance Page, click on the  for Public Notices, and click on the Non-Specialty Mental Health Services | Member and Provider Outreach and Education Plan and the Utilization Assessment of Non-Specialty Mental Health Services for Medi-Cal Members



NCQA Qualitative Data Analysis Report

Date Written: December 1, 2025

Behavioral Health Complaints and Appeals

Introduction

This analysis supports NCQA ME 7E requirements and contributes to the ongoing monitoring of behavioral health service quality and member experience. This report summarizes the behavioral health complaints and appeals received during the 2024 calendar year. Data covering January 1, 2024, through December 31, 2024, was gathered and evaluated by the Grievance Department and Behavioral Health leadership to identify trends, areas for improvement, and opportunities for quality enhancement. The analysis incorporates both quantitative and qualitative components to provide a comprehensive understanding of complaint and appeal patterns and to guide continuous quality improvement efforts.

Methodology

Data was reviewed monthly and validated through the Grievance and Appeals reporting system. The analysis was conducted in two parts:

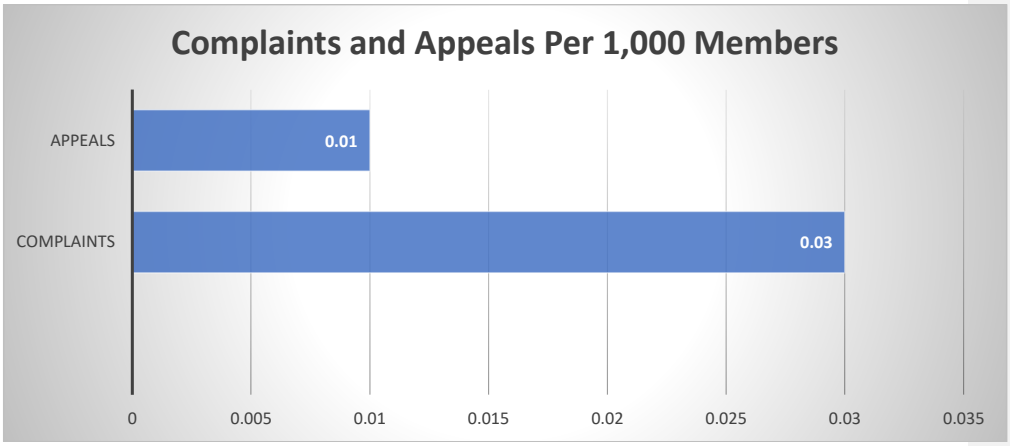
- **Quantitative Analysis:** Involves the numerical tracking of complaints categorized by issue type, frequency, and resolution status.
- **Qualitative Analysis:** A detailed review of the nature and context of complaints and appeals, identifying underlying themes and patterns. This analysis was performed by Behavioral Health leadership to gain insights into the experiences of members and to understand the root causes of the complaints.

Complaint Categories

The Grievance Department tracks complaints within the following five categories:

1. Access to Care: Complaints related to difficulties in obtaining timely appointments, finding appropriate providers, or issues with care accessibility (e.g., geographic barriers, availability of services).
2. Attitude and Services: Complaints regarding the interpersonal aspects of care, including issues with the attitudes, behaviors, or professionalism of behavioral health staff, or dissatisfaction with the quality of customer service.
3. Billing and Financial Issues: Complaints related to problems with billing, insurance coverage, out-of-pocket costs, or financial assistance for behavioral health services.
4. Quality of Care: Complaints concerning the perceived quality, effectiveness, or appropriateness of the behavioral health services provided, including concerns about treatment plans, therapy, and outcomes.
5. Quality of Practitioner Office Site: Complaints regarding the physical environment of the practitioner's office, including cleanliness, comfort, accessibility, or safety concerns.

Year 2024



Behavioral Healthcare Complaints

The following tables provides data on behavioral healthcare complaints filed in 2024. Kern Health Systems (KHS) has an overall behavioral health grievance goal of 10 per 1000 members per year and 2 per 1000 members per year for each grievance category.

Table 1: Complaint Volume Report – Behavioral Healthcare

Category	2024			
	Complaints Total	**Complaints per 1,000 members**	**Performance Goals**	**Performance Goals Met?**
Access	51	0.01	<2	Yes
Attitude and Service	51	0.01	<2	Yes
Billing and Financial Issues	1	0	<2	Yes
Quality of Care	32	0.01	<2	Yes

Quality of Practitioner Office Site	0	0	<2	Yes
Total	**135**	**0.03**	**<10**	**Yes**

Quantitative Analysis: In 2024, a total of 135 behavioral healthcare complaints were filed, totaling 0.03 complaints per 1000 members. KHS met our goals of <10 grievances per 1000 members per year and <2 grievances per 1000 members per grievance category for the year. Due to the small number of complaints relative to total membership, year-to-year variation cannot be interpreted as a statistically meaningful trend. Overall, Kern Health Systems maintained the overall category and per category performance goal.

Commented [AK1]: ME-7E.1 Complaints

Behavioral Healthcare Appeals

The following tables provides data on non-behavioral healthcare appeals filed in 2024. Kern Health Systems has overall category goal of 10 per 1000 members per year and 2 per 1000 members per year for each grievance category.

Table 1: Appeal Volume Report – Behavioral Healthcare

Category	2024			
	Appeals Total	**Appeals per 1,000 members**	**Performance Goals**	**Performance Goals Met?**
Access	0	0	<2	Yes
Attitude and Service	0	0	<2	Yes
Billing and Financial Issues	0	0	<2	Yes
Quality of Care	4	<.01	<2	Yes
Quality of Practitioner Office Site	0	0	<2	Yes
Total	**4**	**.01**	**<10**	**Yes**

Quantitative Analysis: In 2024, there were 4 behavioral healthcare appeals filed, totaling less than .01 appeals per 1000 members per year, with <1 grievance per 1000 members per grievance category per year. Overall, Kern Health Systems maintained the overall grievance and per category performance goal.

Commented [AK2]: ME-7E.1 Appeals

Qualitative Analysis: In 2024, the top three categories for grievances and appeals were Access, Attitude and Service and Quality of Care. Overall complaint volume between 2023 and 2024 remained stable and continued to meet performance goals. The complaint volume in both 2023 and 2024 was very low and changes between the years were not significant, the data does not suggest underlying systemic issues. However, the fact that the same complaint categories—Access, Attitude & Services, and Quality of Care—continue to appear indicates ongoing opportunities for improvement. Although the trends are not statistically meaningful, they still highlight areas where targeted enhancements may further strengthen member experience.

The qualitative analysis revealed the following key themes:

- **Access to Care:** Many complaints centered around long wait times for appointments, particularly for specialized behavioral health services. Issues with limited provider availability and difficulties in scheduling were also commonly cited.
- **Attitude and Services:** Complaints in this category typically focused on negative experiences with staff behavior, including perceived unprofessionalism, lack of empathy, or communication challenges with providers.
- **Quality of Care:** Complaints in this area frequently involved concerns about the adequacy of treatment, including dissatisfaction with the effectiveness of therapy or the alignment of treatment plans with individual needs.

KHS continues its efforts to increase provider capacity in collaboration with Provider Network Management (PNM); however, several barriers persist that may affect the success of these initiatives. Although telehealth options have expanded access for many members, a subset of patients—particularly seniors, individuals who experience challenges with digital technology, and those without reliable internet access—prefer or require in-person care. In some cases, especially in rural areas or for certain populations, the availability of in-person appointments does not fully meet demand, limiting access and contributing to ongoing disparities.

Recommendations

Commented [AK3]: ME-7E.1 Opportunities

Based on the findings of the quantitative and qualitative analysis, the following recommendations are proposed:

1. **Improve Access to Care:**

   a. Appointment Availability Monitoring
   - Implement dashboards to track wait times, telehealth vs. in-person availability, and provider capacity gaps.
   - Require quarterly access reporting from high-volume provider groups.

   b. Scheduling Optimization
   - Review provider scheduling practices to ensure urgent, routine, and follow-up appointments are appropriately allocated.
   - Support adoption of standardized scheduling templates to reduce delays.

   c. Telehealth Utilization Strategy
   - Identify populations preferring in-person care and tailor outreach accordingly.

- Expand hybrid care models in rural or underserved regions where telehealth alone does not improve access.

d. Improve Navigation & Communication (Access-focused)

- Develop clear member-facing navigation guides explaining how to schedule timely appointments and use telehealth effectively.

2. **Attitude and Services:**

a. Customer Service, Communication, & DEI Training

- Require annual refresher training for BH providers and staff on empathy, professionalism, cultural responsiveness, and active listening.

b. Member Feedback Loop

- Implement short post-appointment SMS/email surveys to capture real-time experience feedback.
- Create rapid-response workflows when negative feedback is received.

c. Strengthen RAC (Regional Advisory Committee) Engagement

- Increase frequency of RAC meetings and/or add virtual town halls to capture member experiences and improve transparency.

d. Provider Coaching

- Offer targeted coaching to providers or staff with repeated complaints related to interpersonal skills or communication.

3. **Improve the Quality of Care:**

a. Case Review & Clinical Audits

- Conduct periodic treatment plan audits to ensure alignment with evidence-based practices.
- Use audit findings to provide targeted provider education.

b. Improve Care Coordination

- Strengthen communication pathways between primary care and BH providers to reduce fragmented care concerns.

c. Member Education (Quality-Focused)

- Provide materials that explain care pathways, treatment expectations, and what constitutes high-quality behavioral health care.

d. Predictive Monitoring (Quality-specific)

- Identify early signals of potential quality issues by tracking repeat complaints related to clinical care from specific providers or provider groups.

Conclusion

Kern Health Systems met the goals for both complaint and appeal categories in 2024. Complaint volume remained very low, and the year-to-year differences between 2023 and 2024 were not statistically significant. As a result, the data does not indicate underlying systemic issues or

meaningful shifts in member experience. However, the recurrence of complaints in the areas of Access to Care, Attitude & Services, and Quality of Care highlights ongoing opportunities to enhance the member experience and strengthen service delivery.

Although the trends are not significant, targeted improvements in access management, provider communication, clinical oversight, and care coordination are recommended to support continuous quality improvement and further reduce avoidable complaints in 2025. KHS will continue monitoring complaint trends quarterly throughout 2025 and collaborate with Provider Network Management, Utilization Management, and provider partners to ensure that access, member experience, and quality of care remain aligned with organizational expectations and NCQA standards.

Report prepared and reviewed by
Melinda Santiago, Director of Behavioral Health

KERN HEALTH SYSTEMS

Behavioral Health Audit

Audit Score: Pass = 90%+ Fail = Less than 90%

Scoring:
1 = Compliant
.5 = Partial
0 = Non-Compliant
NA = Not Applicable and does not count in the total score

Audit Date:					
CIN #					
Member Name					
Member DOB					
MR #					
Provider Name					
Clinic Affiliation (e.g. CSV; KM; Omni; etc.)					
Age Group (Adult or Peds)					
Birth Gender (Male or Female)					
Section 1 (Authorization & Service Delivery)	**Total Possible Points**				
1. Initial recommendation by Licensed physician, surgeon, or psychologist	1				
2. Current authorization letter on file	1				
3. Intake/diagnostic documentation: proof of ASD diagnosis by qualified provider. (If CDE was completed)	1				
4. Informed consent for ABA services documented	1				
Section 2 (Treatment Plan)					
1. Treatment plan current (within 6 months).	1				
2. Goals are measurable, individualized, and tied to ASD core deficits.	1				
3. Objectives updated based on progress data.	1				
4. Caregiver goals/training included.	1				
Section 3 (Assessment)					
1. Initial clinical assessment (Functional Behavior Assessment [FBA]) completed?	1				
2. Assessment includes demographics, reason for referral, background, interview, review of assessments, procedures, results.	1				
3. Frequency of baseline behaviors documented and linked to treatment	1				
4. Goals/objectives measurable, behaviorally defined, developmentally appropriate, socially significant, observation-based	1				
5. Outcome measurement criteria identified for each objective	1				
6. Member's current level of need documented (baseline, mastery criteria, dates, generalization plan, status)	1				
7. Evidence-based BHT services tailored to member	1				
8. Service type, hours, supervision, caregiver training, measurement frequency, transition/crisis plan, responsible providers	1				
9. For 2:1, does the Behavioral Intervention Plan include clinical justification for a second staff, and clear, instructions for how the second staff will be used	1				
10. Care coordination with caregivers, school, state programs, other entities documented	1				
11. Hours of service consider age, school, activities (without reducing medically necessary hours)	1				

12. Services delivered in home/community settings; school services clinically indicated and proportioned	1				
13. Exit criteria/plan documented (EPSDT standard for service termination)	1				
Section 4 (Session Notes)					
1. Date of service documented	1				
2. Start/end times & duration documented	1				
3. HCPCS/CPT code billed matches documentation	1				
4. Interventions delivered (ABA-specific terminology)	1				
5. Goals targeted during session identified	1				
6. Member response to intervention documented	1				
7. Caregiver involvement documented (if applicable)	1				
8. Signature of staff providing service present	1				
9. Justification and use for 2 to 1 staffing if billing reflects use.	1				
10. Supervision notes include frequency, content, staff training, caregiver guidance	1				
Section 5 (Progress Monitoring)					
1. Progress reports (quarterly or at re-auth) showing member's response to treatment.	1				
2. Graphs or data sheets supporting progress on goals.	1				
3. Documentation of any treatment plan updates/revisions included	1				
Section 6 (Coordination of Care)					
1. Evidence of coordination with PCP, behavioral health, school, and/or regional center	1				
2. Documentation of communication with caregivers about progress and planning	1				
Section 7 (Language Preferred)					
1. Interpreter services offered or services delivered in preferred language	1				
2. Forms provided in Spanish if Spanish is preferred language (HIPAA, ROI, Consent forms, Medical consents)	1				
Section 8 (Compliance)					
1. Incident reports, grievance logs, or family complaints documented (if applicable)	1				
2. Evidence of discharge/transition planning documented (if applicable)	1				
Total NA items			0	0	0
Total Compliant Items			0	0	0
Total Non-Compliant Items			0	0	0
Total POSSIBLE POINTS minus total N/A for this medical record	**40**	40	40	40	40
SCORE: TOTAL divided by TOTAL POSSIBLE POINTS (%)		0%	0%	0%	0%

KERN HEALTH SYSTEMS

Consolidated Q3 Audit Findings – ABA Service Records Review

1. Purpose

The purpose of this audit was to review a sample of ABA service records from five providers to assess compliance with documentation standards, clinical best practices, and regulatory requirements.

---

2. Methodology

- **Sample size:**
  - **Five (5) records reviewed per provider**
  - **Five (5) providers reviewed**
  - **Total records reviewed: 25**
- **Audit approach:**
  - **Records were evaluated against documentation standards, clinical best practices, and regulatory requirements applicable to ABA services.**
  - **Each provider received an overall compliance score based on aggregate performance across reviewed domains (e.g., informed consent, treatment planning, session documentation, care coordination, supervision, and discharge planning).**
- **Provider Compliance Scores:**
  - **Provider A: 90%**
  - **Provider B: 89%**
  - **Provider C: 84%**
  - **Provider D: 80%**
  - **Provider E: 72%**

Key Patterns / Observations

1. **Universal Issues**
   - **Lack of informed consent documentation**
   - **FBA/progress reports missing core goals and measurable baselines**
   - **Care coordination documentation insufficient**
   - **Session notes inadequately reflect member response and billed services**
   - **Supervision notes incomplete**
   - **Discharge and transition planning missing or generalized**
2. **Frequent Issues (≥60% of records)**
   - **Caregiver participation not documented in session notes**
   - **Educational/academic goals not tied to core deficits**
   - **Insufficient documentation of member routines and daily schedules**
   - **Active care coordination not demonstrated**
3. **Moderate Issues (40–50% of records)**
   - **Treatment goals misaligned with baseline data**

- **Incomplete session documentation for billed service hours**
- **Limited or incomplete discharge planning**
- **2:1 staffing justification missing**

Consolidated Audit Findings Across 5 Providers

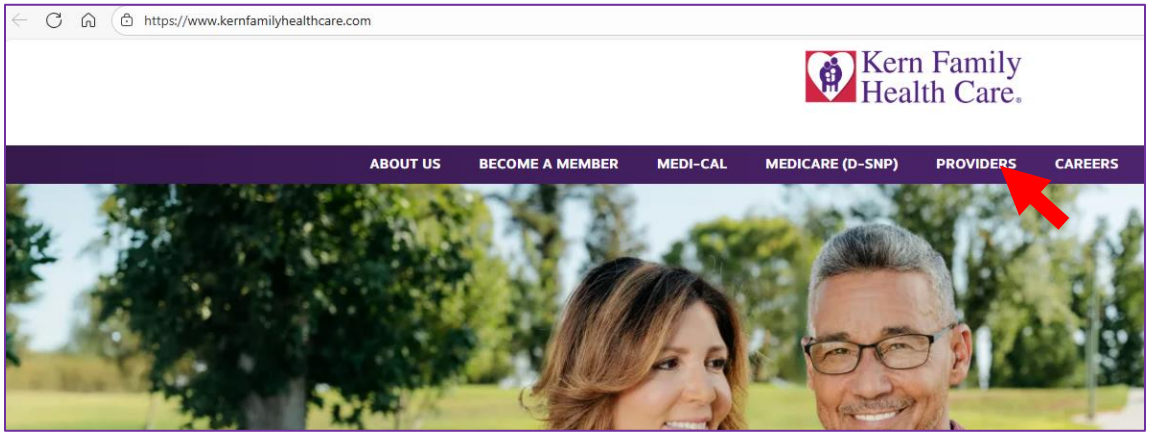
Area	Key Findings
Informed Consent	Missing documentation for ABA services, including confidentiality
Treatment Goals	- Misaligned mastery criteria (baseline vs method) - Educational/academic goals not tied to core deficits - Caregiver goals without progress data
FBA / Progress Reports	Missing measurable goals, baseline behaviors, and response tracking; inadequate care coordination
Care Coordination	Active coordination with schools/PCPs incomplete; communication often “as needed” or “will occur”
Caregiver Participation	Not consistently documented in session notes; only in separate parent training notes
Session Documentation & Billing	Limited detail to support billed hours; missing ABA-specific data (frequency, duration, percentages); incomplete signatures
Discharge / Transition / Fade Planning	Missing individualized plans and hour fade plans; generalized exit criteria
Staffing (2:1 Ratios)	Clinical justification and staff roles not documented
Supervision / Indirect Documentation	Missing frequency/data monitoring, staff training, and caregiver guidance
School / Daily Routine Documentation	Missing schedules, daily activities, routines

KERN HEALTH SYSTEMS

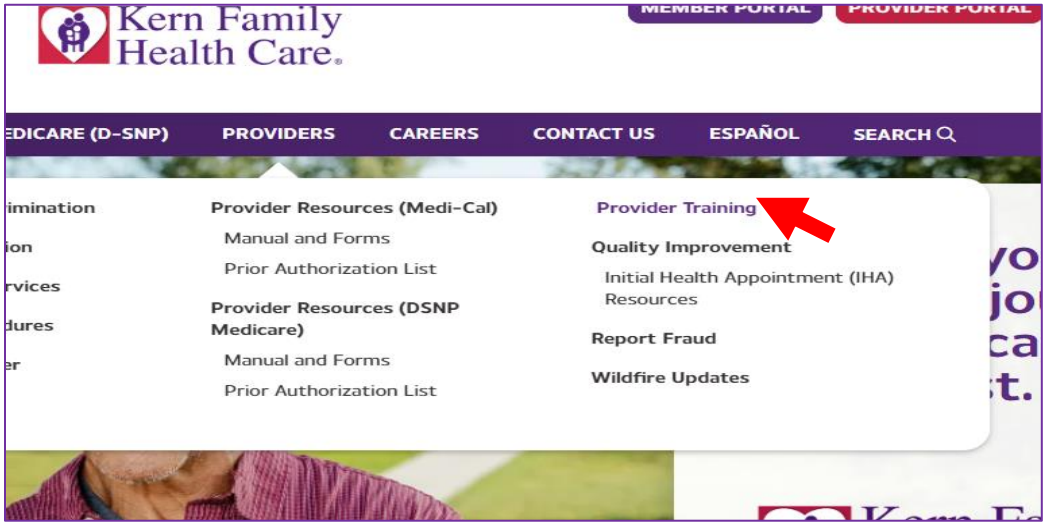
How to Access Training Materials

Kern Family Health Care (KFHC) Training Materials

Step 1: Access the Kern Family Health Care website at https://www.kernfamilyhealthcare.com/

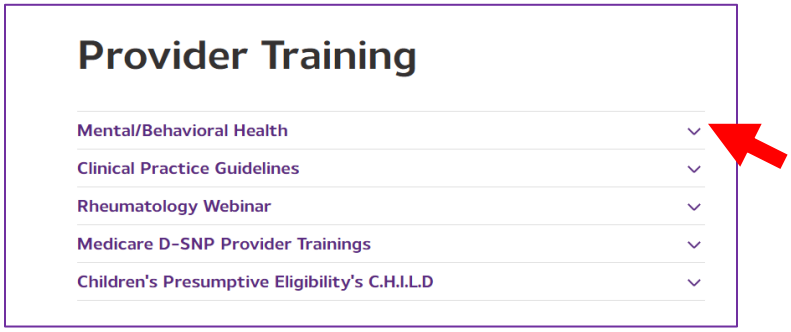


Step 2: Navigate to the Providers tab located in the top dark purple menu running across the top the Kern Family Health Care webpage, then click to access the Provider Training page.



KERN HEALTH SYSTEMS

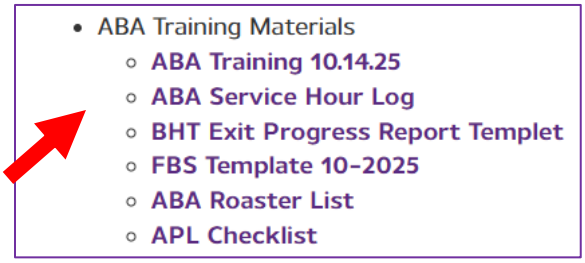
Step 3: From the Provider Training Page, click on the ⌄ for Mental/Behavioral Health



Step 4: Scroll Down to the ABA Training Materials.



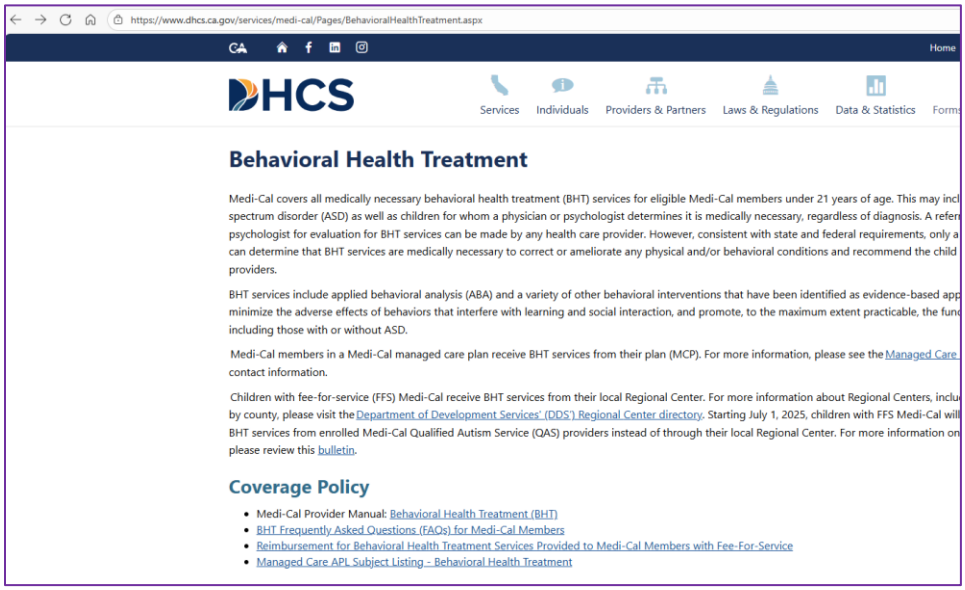
Step 5: Click any of the ABA training materials to download and utilize in supporting Kern Family Heath Care members.



KERN HEALTH SYSTEMS

How to Access Department of Health Care Services (DHCS) Behavioral Health Treatment (BHT) Materials

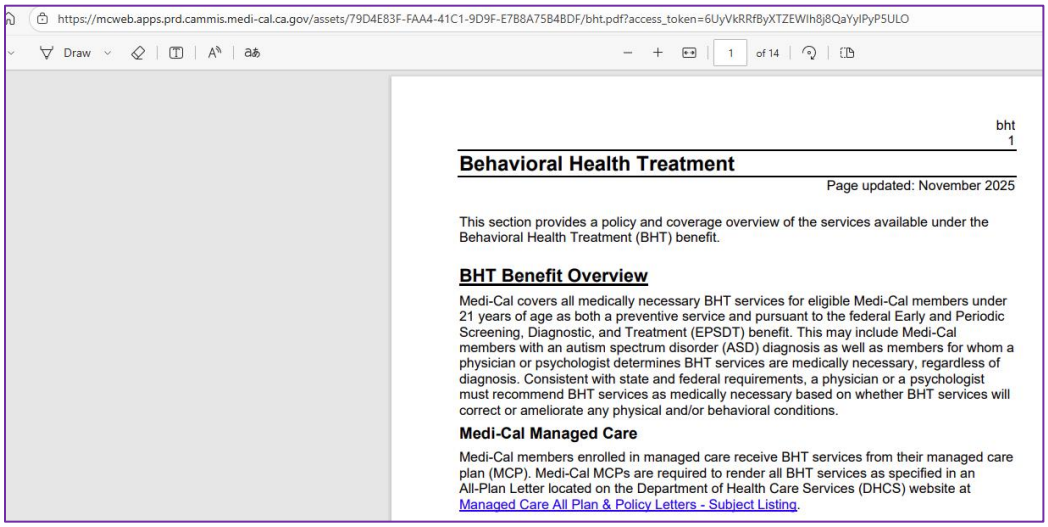
Step 1: Access the DHCS Behavioral Health Treatment page at https://www.dhcs.ca.gov/services/medi-cal/Pages/BehavioralHealthTreatment.aspx



Step 2: Navigate to the **Coverage Policy** Section, then click on the link for the **Medi-Cal Provider Manual: Behavioral Health Treatment**, to download the Provider Manual.



Step 3: Review the Provider Manual or any other included documents from the DHCS page.



Note: If you have any questions or concerns related to the Applied Behavioral Analysis (ABA) Services, please contact your KFHC Provider Representative at (661) 664-5000 or (800) 391-2000, or the KFHC Behavioral Health Department Leadership team.

KERN HEALTH SYSTEMS

Behavioral Health Advisory Committee

Quarter 1

Melinda Santiago

Director of Behavioral Health

3/17/2026

Behavioral Health Advisory Committee

The **Behavioral Health Advisory Committee (BHAC)**, delegated by the Executive Quality Improvement Health Equity Committee (EQIHEC), serves as a collaborative forum to align Kern Health Systems (KHS) with the County Behavioral Health Plan (BHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). The committee supports, reviews, and evaluates behavioral health interventions with the goal of ensuring continuity of care, reducing barriers to access, strengthening linkages to appropriate services, integrating behavioral and medical care, and providing resources for members living with mental illness and/or substance use disorders.

Quality Monitoring & Performance	• Review quality monitoring activities (compliance, corrective actions, delegation oversight) • Evaluate network accessibility and provider compliance • Monitor Medi-Cal Managed Care Accountability Set (MCAS) targets for BH • Track member complaints, appeals, and experience (quantitative & qualitative analysis) • Review quality performance and improvement initiatives
Clinical Guidelines & Innovation	• Provide feedback on BH clinical guidelines and UM criteria • Assess new BH technologies and treatment innovations • Review monitoring tools, site/chart reviews, and access to care standards • Ensure culturally appropriate service and program design
Coordination & Integration of Care	• Review processes for continuity and coordination of medical and behavioral health services • Oversee methods of information exchange across systems • Address carved-out services to improve coordination and reduce fragmentation
Member Experience & Engagement	• Provide feedback based on direct interactions with BH members • Review and integrate member satisfaction survey results • Support priorities for behavioral health education and outreach programs • Advance health equity and improve accessibility of services
Governance & Compliance	• Review and approve the BH Program Description annually • Monitor compliance with Memorandum of Understanding (MOU) with KBHRS • Provide structured support to KHS management on BH service delivery

BH Updates Q4 2025

Strategy 1: Internal Behavioral Health Department Development

•Highlight **Key Accomplishments**:

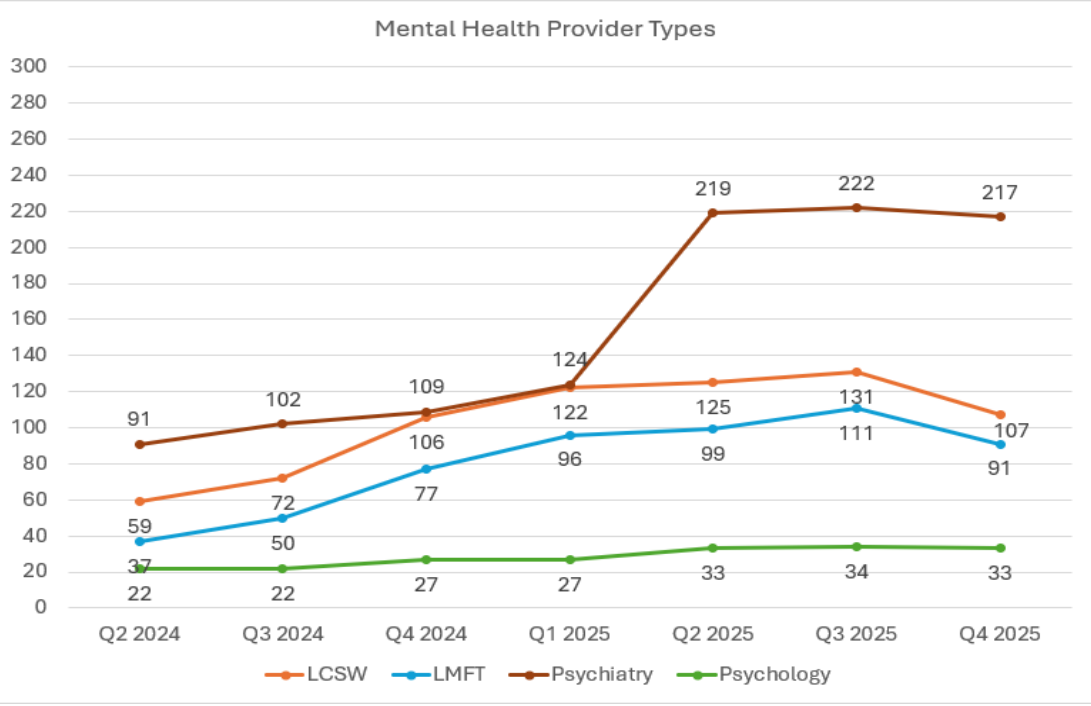
- **BH Program Quality Improvement Framework**
  - Strengthened QI infrastructure through improved data reporting, performance monitoring, and outcome tracking
  - Finalized key governance policies, including DSNP BH Integration Oversight and ABA Medical Necessity Review
  - Continued provider training and technical assistance, reinforcing TOC compliance and documentation standards
  - Completed Q3 ABA chart audits and submitted NCQA ME-7E (Grievances & Appeals)
- **Expansion of the BHT Program:**
  - Enhanced UM–BH–PNM collaboration and transitioned Peer-to-Peer ownership to BH
  - Expanded BCBA clinical oversight, including P2P participation and provider outreach
  - Implemented structured AMR Independent Medical Review workflows
  - Conducted targeted provider support and denial trend analysis to improve authorization outcomes

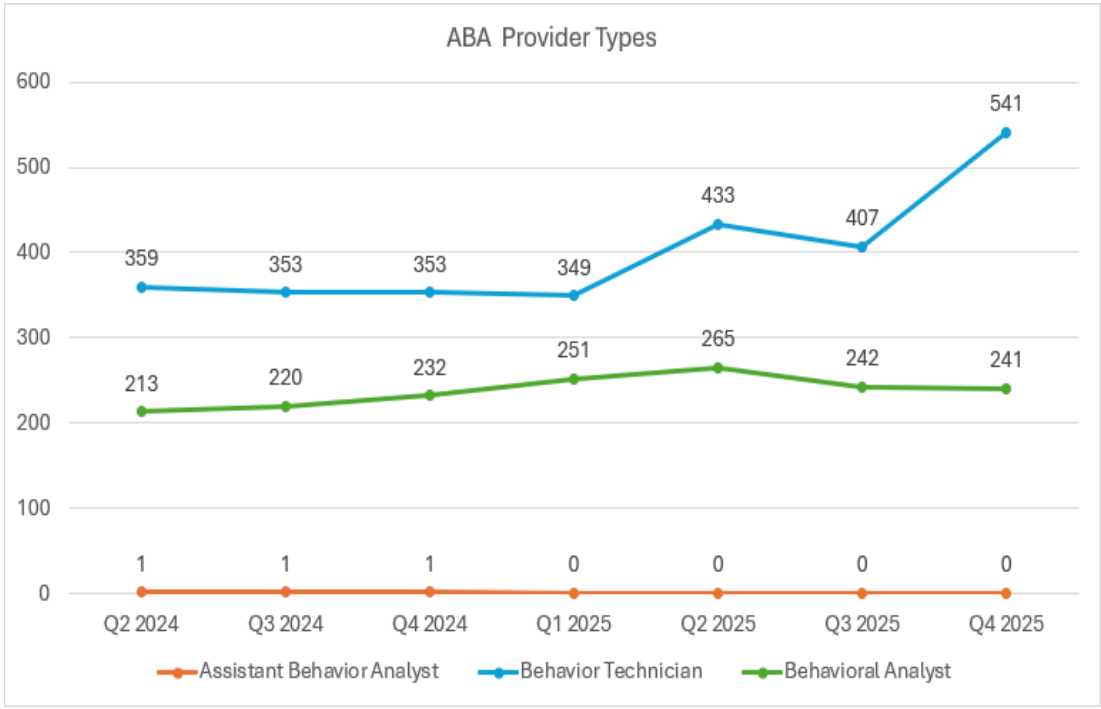
BH Updates Q4 2025

Strategy 2: Mental Health Provider Network Evaluation

•Key Accomplishments:

- Ongoing recruitment and support to expand provider network.
- Ongoing efforts to address provider gaps, particularly in ABA services and in-person care.
- There was a slight decrease in providers in both areas from Q3 to Q4





BH Q4 Updates

14,974 inbound/outbound calls

- 3082 total episodes per quarter
  - MH: 1959
  - SUD: 143
  - BHT: 980
- 2100 Referrals
  - Difference of Referrals and Episodes
    - 982
    - Barriers in Data

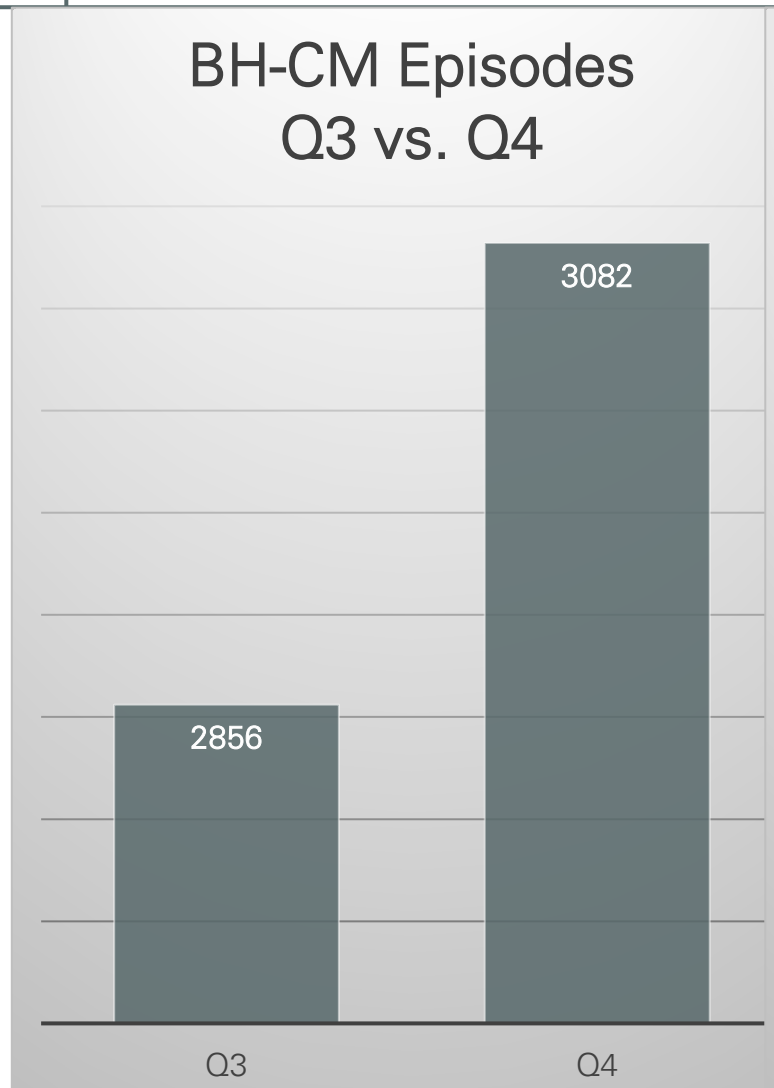
BH Total Calls	Oct	Nov	Dec	Q4 Totals
Inbound	1986	1520	1362	4868
Outbound	4355	2985	2766	10106
Total	6341	4505	4128	14974

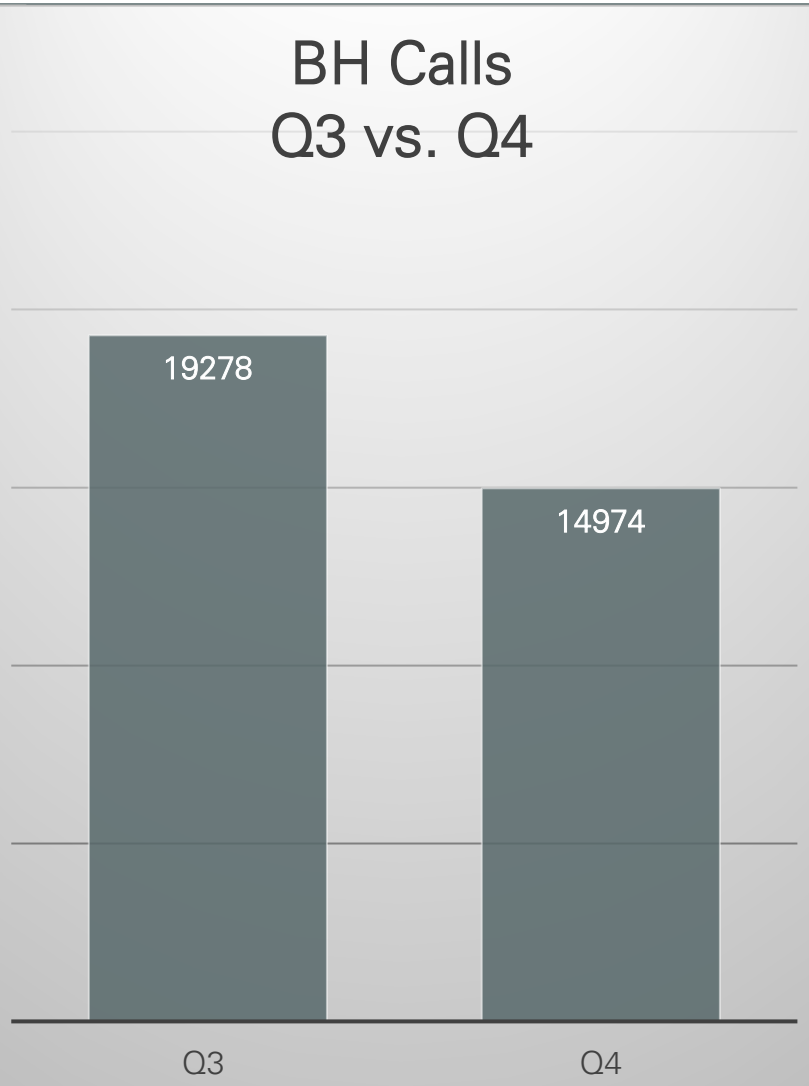
Referrals Received	Oct	Nov	Dec	Q4 Totals
Nurses Portal	173	111	83	367
Provider Portal	321	289	203	813
BH Grievances	2	3	1	6
TOC	113	88	85	286
Other Referral	252	127	249	628
Total	861	618	621	2100

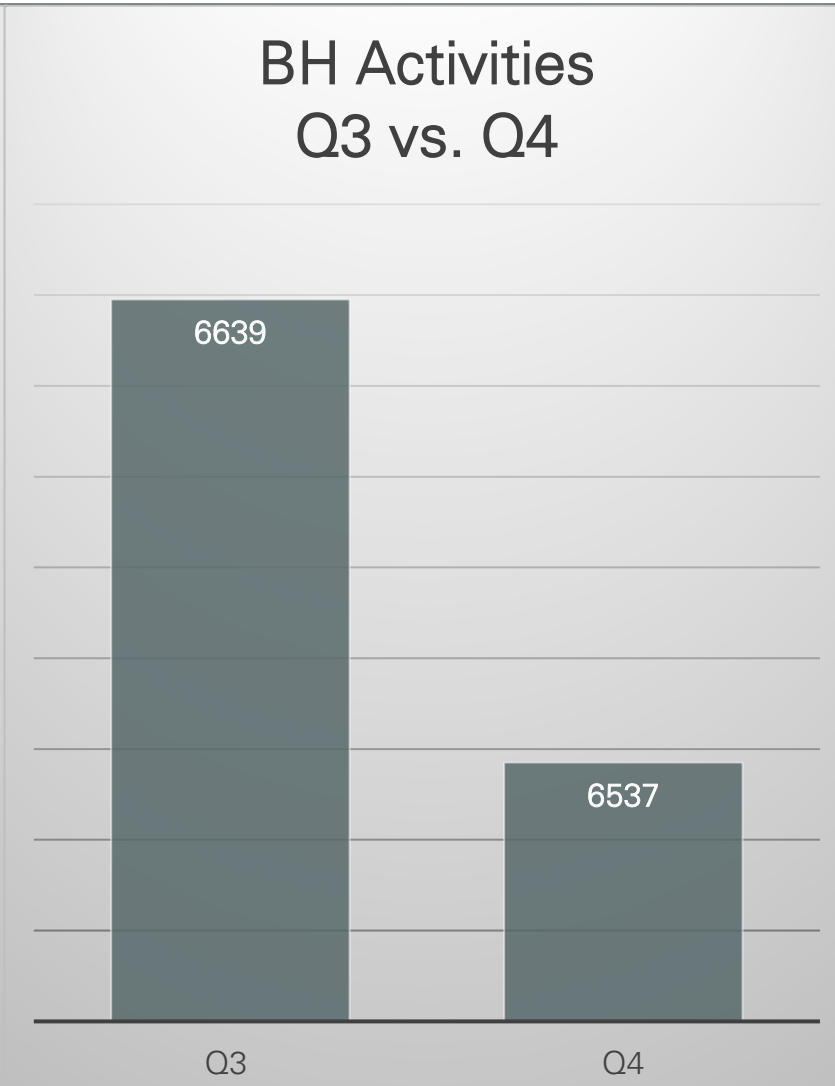
BH Episode Created per month	Oct	Nov	Dec	Q4 Totals
MH	799	568	592	1959
SUD	63	50	30	143
BHT	410	299	271	980
Total	1272	917	893	3082

Closed Activities	Oct	Nov	Dec	Q4 Totals
NSMHS/SUD	2535	1877	1632	6044
BHT/ABA	104	71	116	291
CHW	117	66	19	202
Total	2756	2014	1767	6537

BH Updates: 2025 YTD Highlights







BH Updates

- **BH CHW efforts pivoted from FUM/FUA outreach to supporting BHT/ABA efforts**
    - **Scheduling P2Ps**
    - **Monitoring & Tracking ABA auths through determination process**
    - **Assisting with Uploads for AMR review**

- **What BH CHW data is most important to share with the committee?**

Q4 Scheduled ABA P2P Call

Date Range:10/1/2025 – 12/31/2025

*Distinct count

Oct: 32
Nov: 70
Dec: 148
Total Scheduled: 250

Q4 Scheduled ABA P2P Call

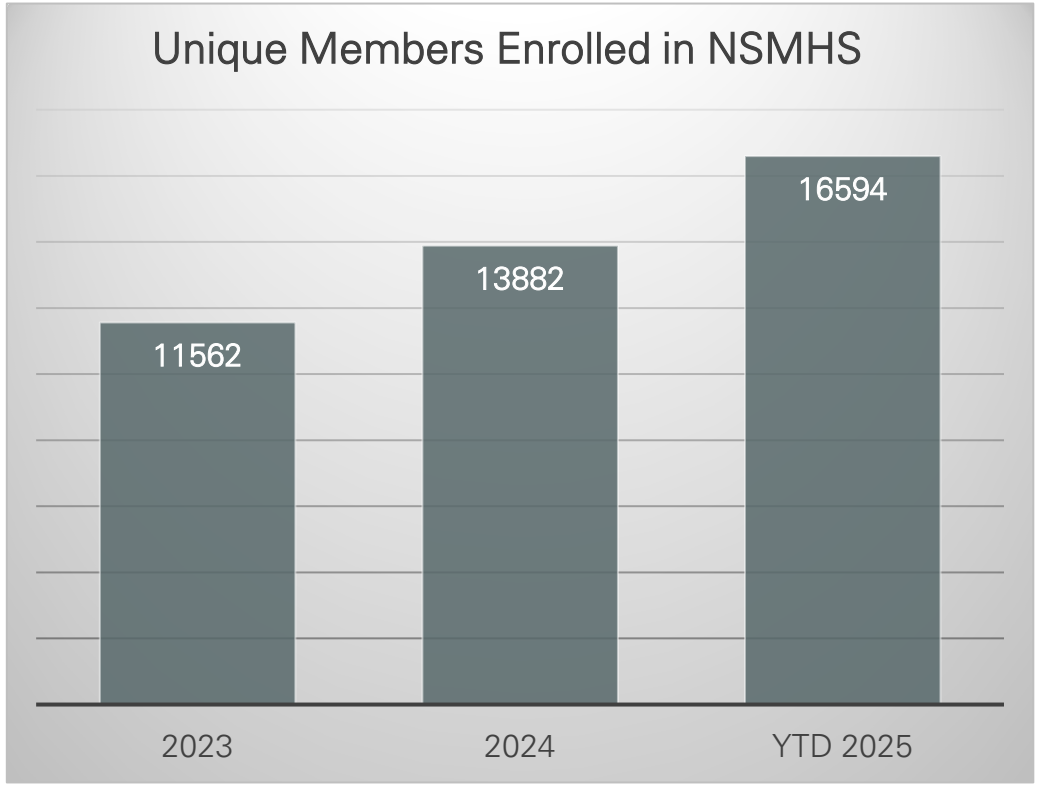
Date Range:10/1/2025 – 12/31/2025

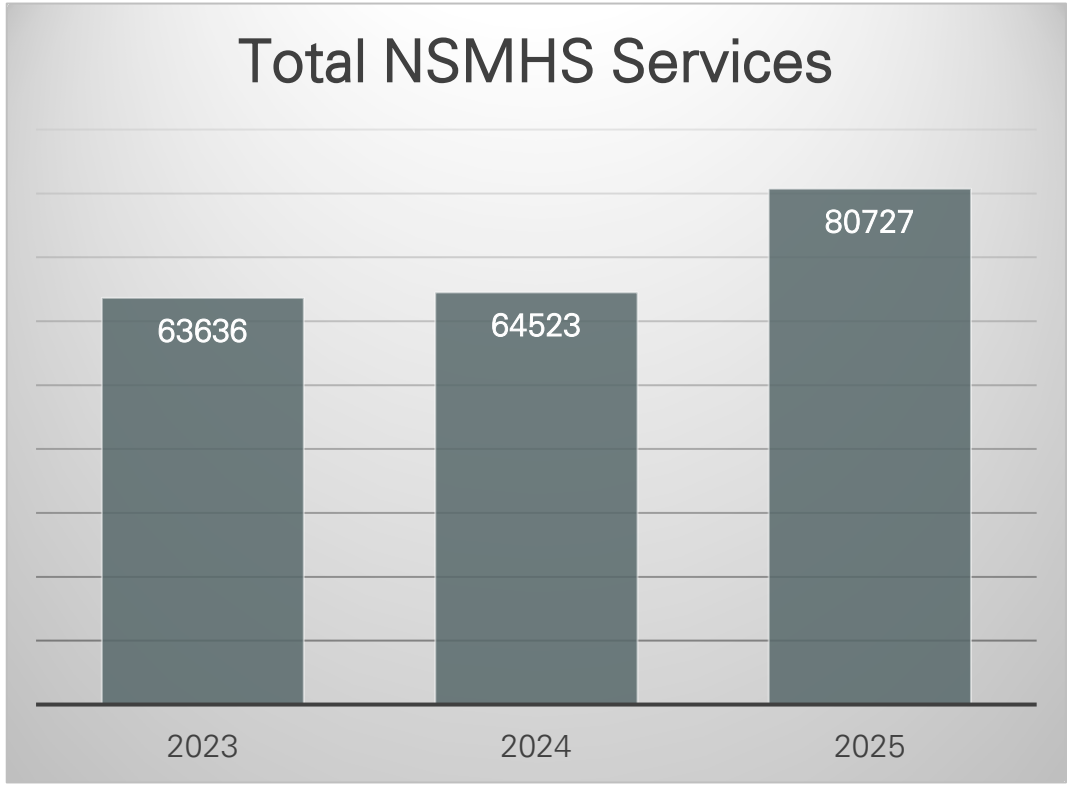
*Distinct count

Oct: 32
Nov: 70
Dec: 148
Total Scheduled: 250

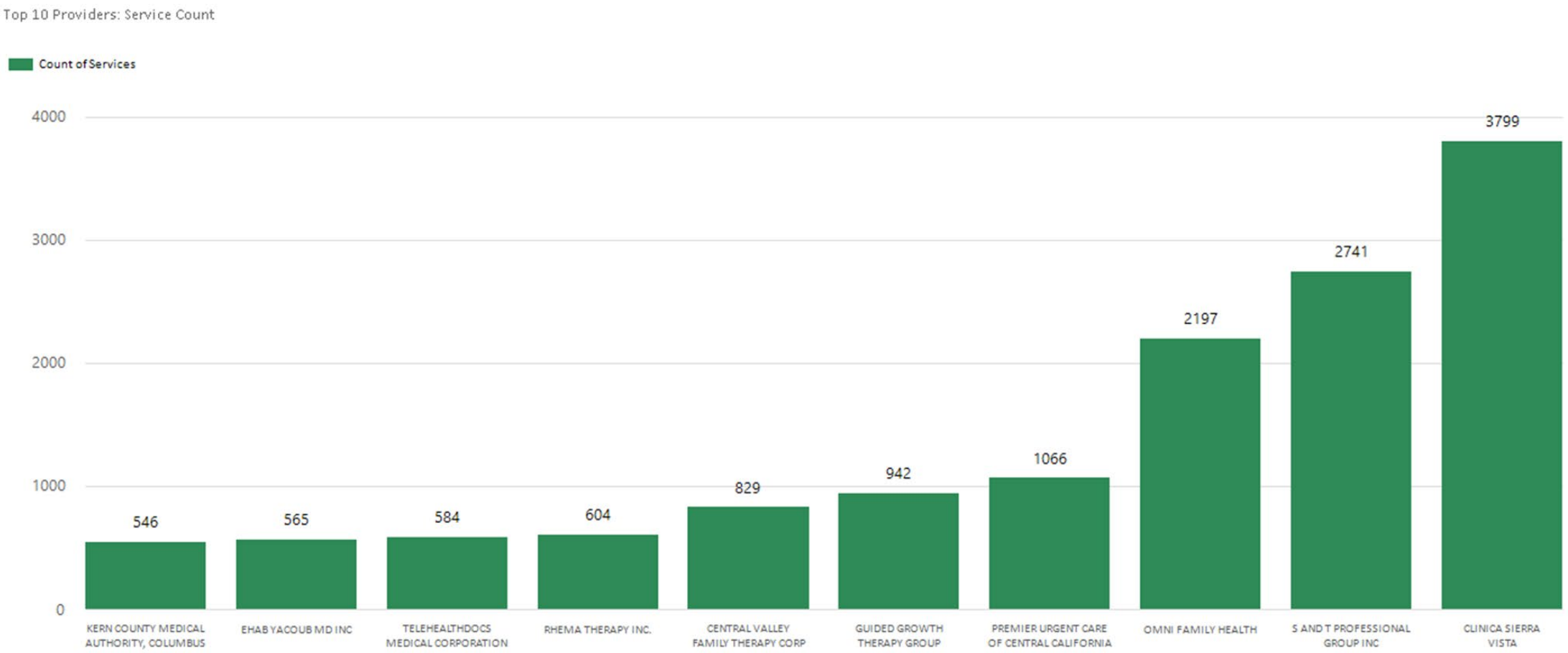
BH Q4 Updates

Utilization for Non-Specialty Mental Health Services



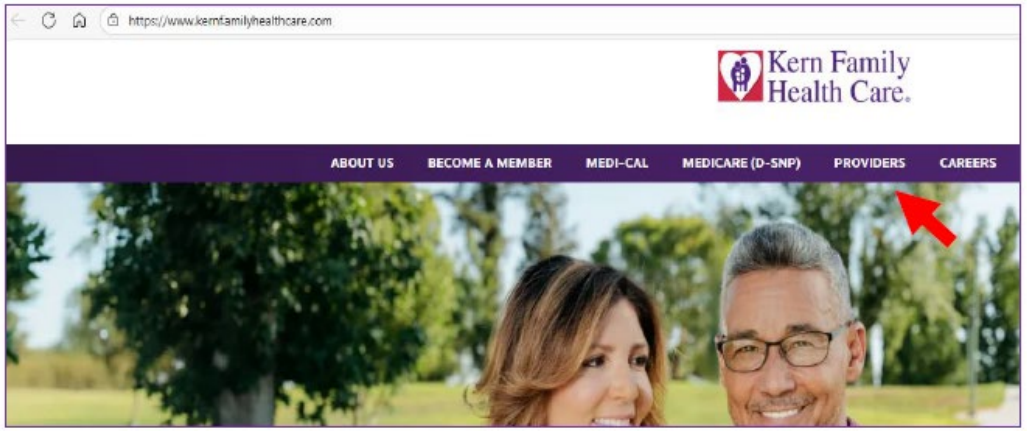


BH Updates for Q4 2025



How to Access Outreach and Education Plan

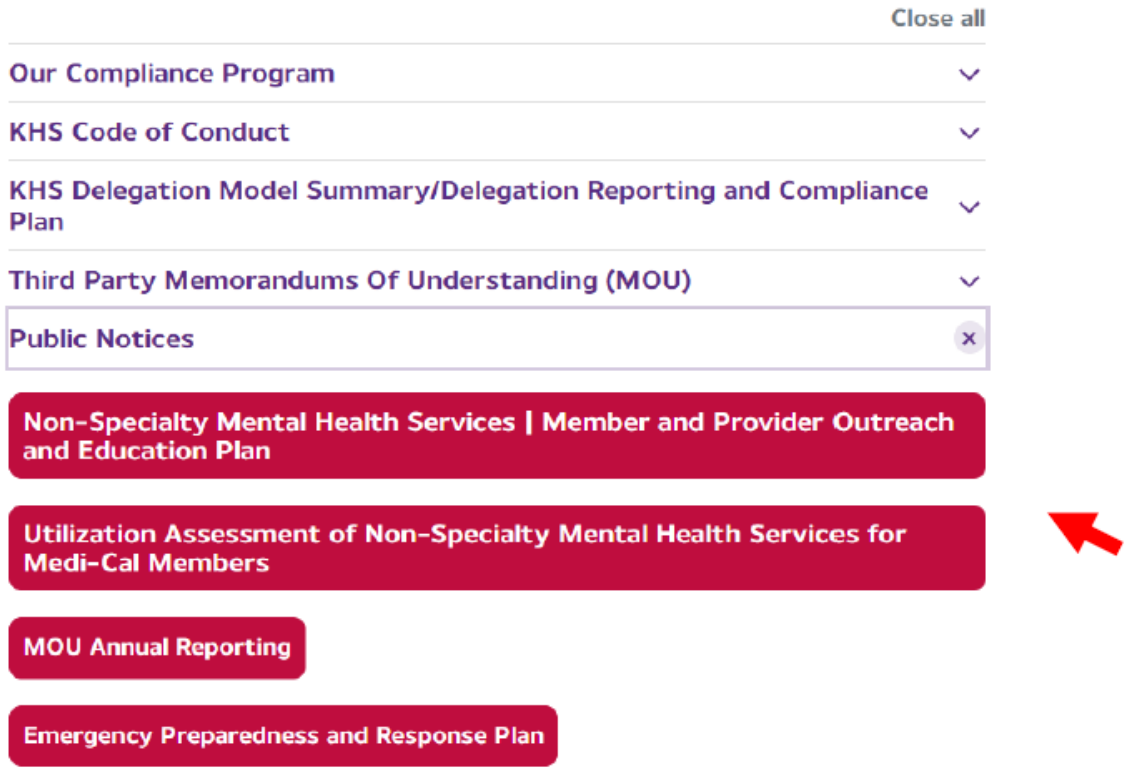
Step 1: Access the Kern Family Health Care website at https://www.kernfamilyhealthcare.com/



Step 2: Navigate to the About tab located in the top dark purple menu running across the top the Kern Family Health Care webpage, then click to access the Compliance page.



Step 3: From the Compliance Page, click on the ⌄ for Public Notices, and click on the Non-Specialty Mental Health Services | Member and Provider Outreach and Education Plan and the Utilization Assessment of Non-Specialty Mental Health Services for Medi-Cal Members



Behavioral Health Complaints & Appeals

2024 vs. 2025 Performance Comparison

Complaints

Year	Total	Per 1,000 Members	Goal Met?
2024	135	0.03	Yes
2025	79	0.02	Yes

Appeals

Year	Total	Per 1,000 Members	Goal Met?
2024	4	<0.01	Yes
2025	118	<0.02	Yes

Top Complaint Themes:

- **Access to Care** – Wait times, provider availability, rural/in-person access gaps
- **Attitude & Services** – Communication, professionalism, empathy concerns
- **Quality of Care** – Treatment effectiveness & care plan alignment

Consolidated Q3 Audit Finding – ABA Records Review

Scope

- 25 records reviewed
- 5 providers (5 records each)
- Evaluated for documentation, clinical standards, and regulatory compliance

Provider Compliance Scores

A: **90%** | B: **89%** | C: **84%** | D: **80%** | E: **72%**

System-Wide Findings:

High-Risk / Universal Gaps

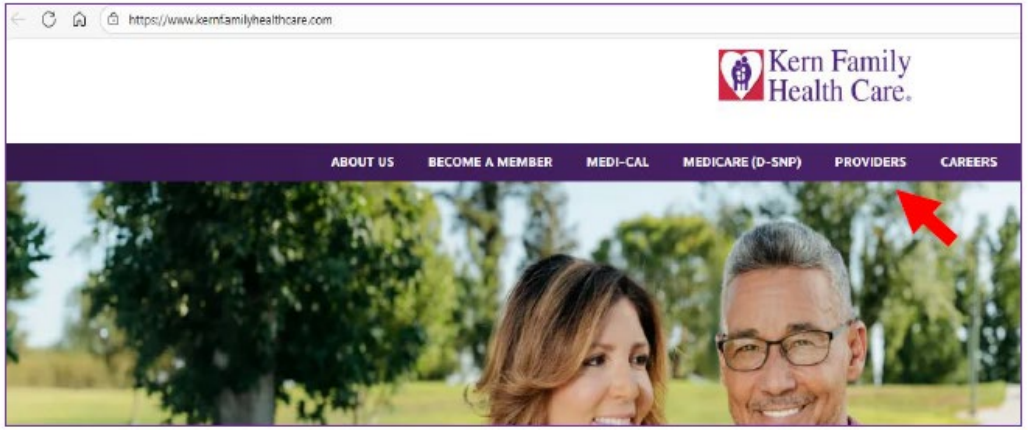
- Missing informed consent documentation
- FBAs/progress reports lack measurable baselines
- Session notes do not clearly support billed hours
- Incomplete supervision documentation
- Missing or generalized discharge/transition plans

Recurring Documentation Deficiencies

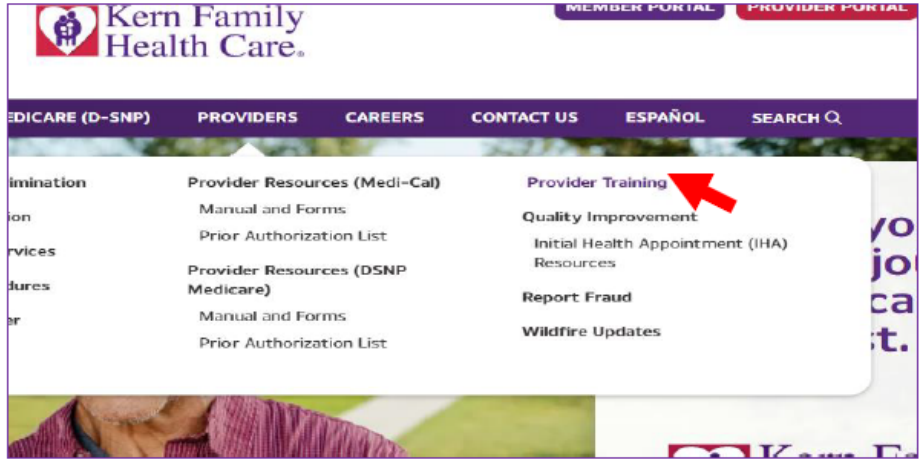
- Caregiver participation not documented
- Goals misaligned with baseline data
- Limited care coordination with schools/PCPs
- Missing daily routine/schedule documentation
- 2:1 staffing justification absent

How to Access Training Materials

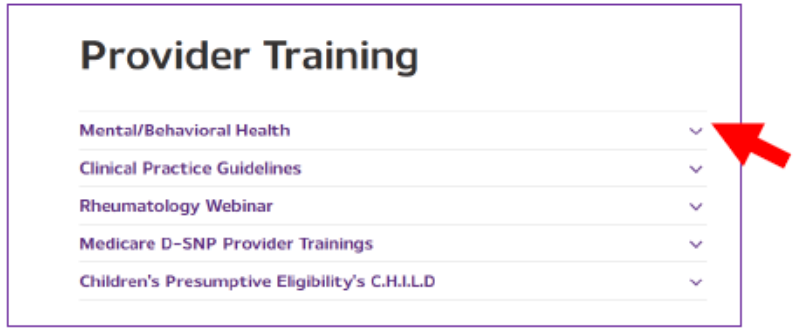
Step 1: Access the Kern Family Health Care website at https://www.kernfamilyhealthcare.com/



Step 2: Navigate to the Providers tab located in the top dark purple menu running across the top th Kern Family Health Care webpage, then click to access the Provider Training page.



Step 3: From the Provider Training Page, click on the ⌄ for Mental/Behavioral Health

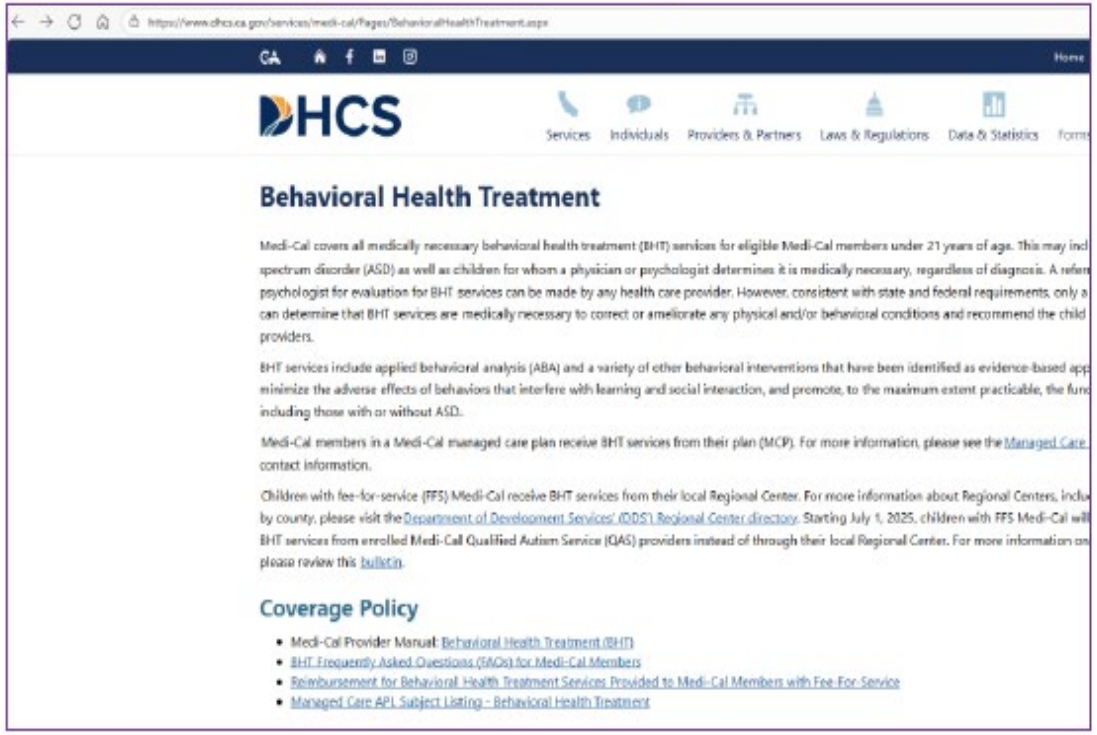


Step 4: Scroll Down to the ABA Training Materials.



How to Access DHCS and BHT Materials

Step 1: Access the DHCS Behavioral Health Treatment page at https://www.dhcs.ca.gov/services/medi-cal/Pages/BehavioralHealthTreatment.aspx



Step 2: Navigate to the **Coverage Policy** Section, then click on the link for the **Medi-Cal Provider Manual: Behavioral Health Treatment**, to download the Provider Manual.



THANK YOU!

Questions?

KERN HEALTH SYSTEMS

To: Executive Quality Improvement Health Equity Committee (EQIHEC)

From: Isabel Silva, Senior Director of Wellness and Prevention

Date: March 17, 2026

Re: Wellness and Prevention (W&P) Department 2025 Year End Highlights Report

---

Background

KHS's contract with DHCS requires the implementation of evidence-based wellness and prevention programs, including a comprehensive health education system comprised of the programs, services, functions, and resources necessary to deliver high-quality, equitable health education and health promotion to all members. These efforts are designed to advance health equity and improve overall quality of care and outcomes.

The contract further mandates that KHS maintain a Cultural and Linguistic Services Program and actively monitor, evaluate and take appropriate action to ensure the effective delivery of culturally and linguistically appropriate services. This includes a continued focus on quality improvement and the advancement of health equity to ensure that all members can communicate effectively with their health care team and receive culturally competent care.

Discussion

Enclosed are the Annual Wellness and Prevention Department Report summarizing the key activities and accomplishments carried out in 2025 to fulfill KHS's contractual requirements with DHCS for wellness, prevention, health education, and cultural and linguistic services. The report also highlights the department's continued commitment to delivering high-quality, equitable services to members across the county.

Fiscal Impact

None.

Requested Action

Review for approval.

KERN HEALTH SYSTEMS

To: Executive Quality Improvement Health Equity Committee (EQIHEC)

From: Isabel Silva, Senior Director of Wellness and Prevention

Date: March 17, 2026

Re: Wellness & Prevention (W&P) Department Reports Q4 2025

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 4th quarter of 2025:

- Q4 2025 Wellness & Prevention Activities Report
- Q4 2025 Cultural and Linguistic Services Activities Report

Fiscal Impact

None.

Requested Action

Review for approval.

Kern Health Systems
Member Wellness & Prevention Activities Report
4th Quarter 2025

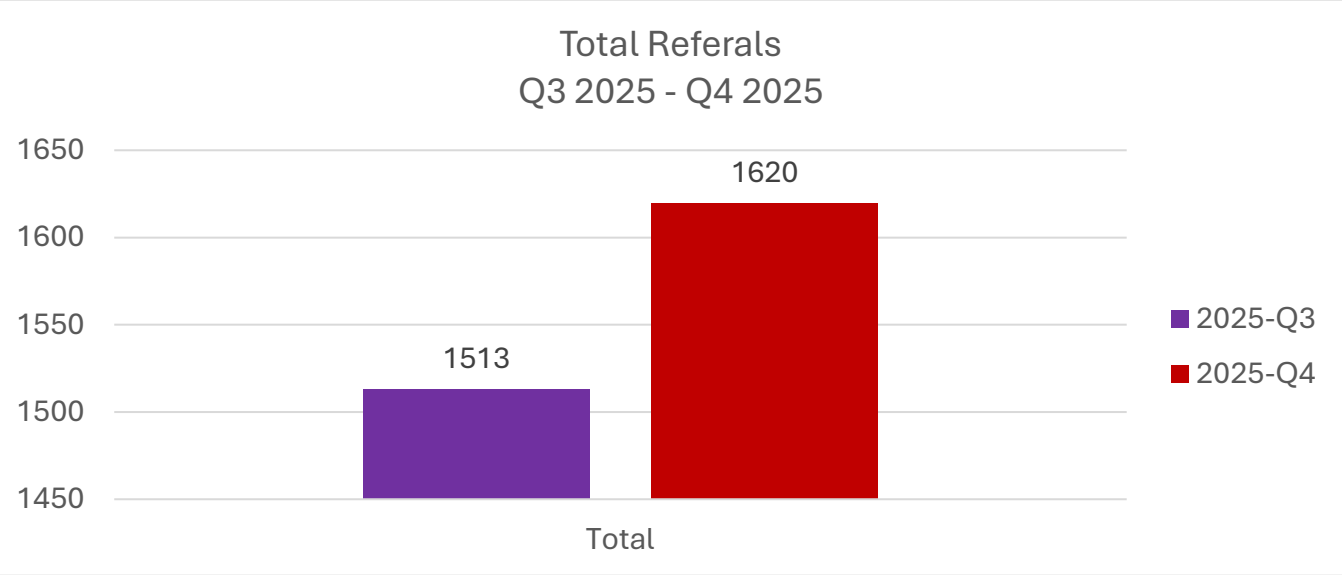
Member Wellness and Prevention

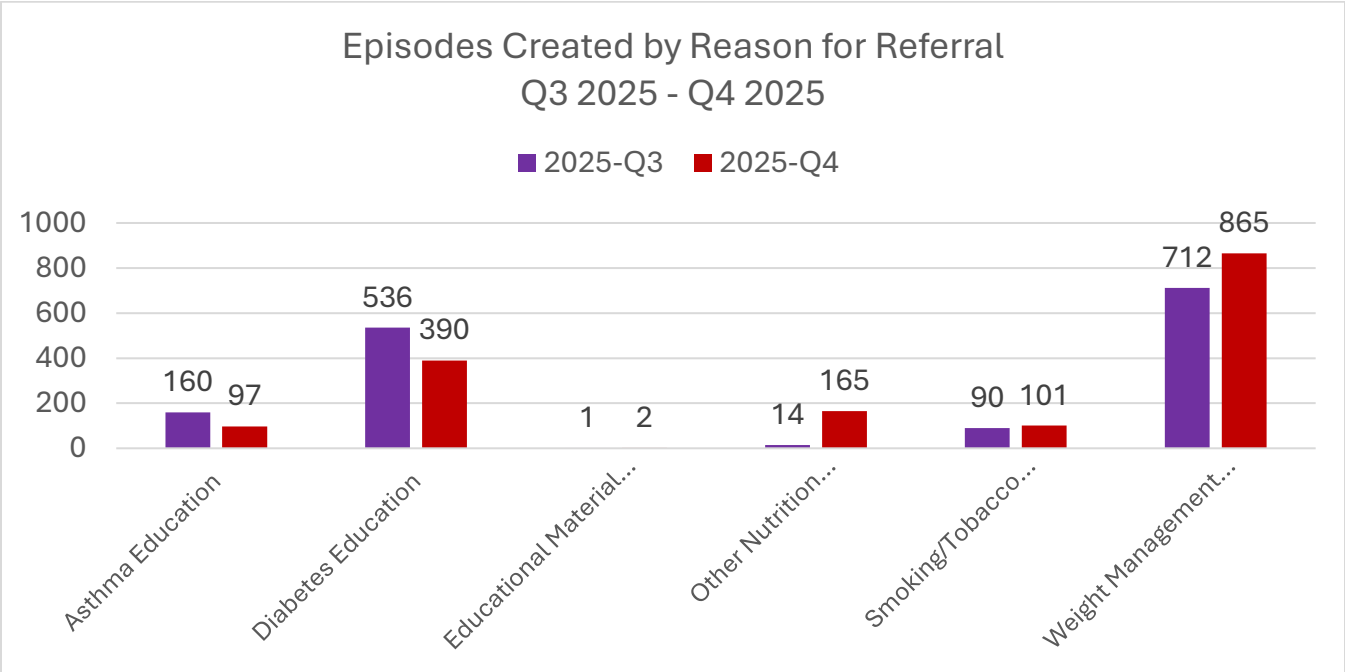
In 2025, 5,861 referrals were processed. This represents a 34% increase compared to 2024 (3,889 referrals). The increase was mostly due to focused outreach efforts managed by Wellness & Prevention, with support from Member Services, and Niles Primary Care through the Comprehensive Obesity Management Program.

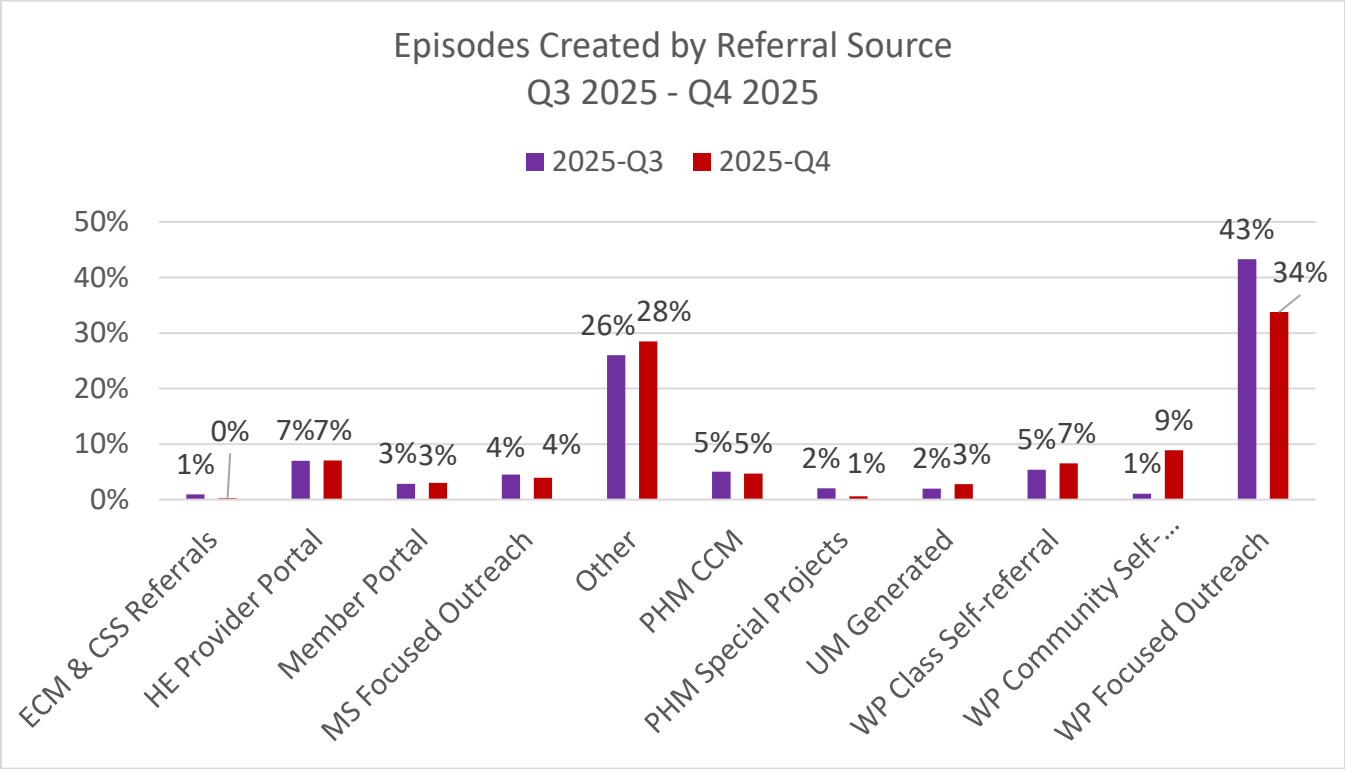
Health Education Referrals

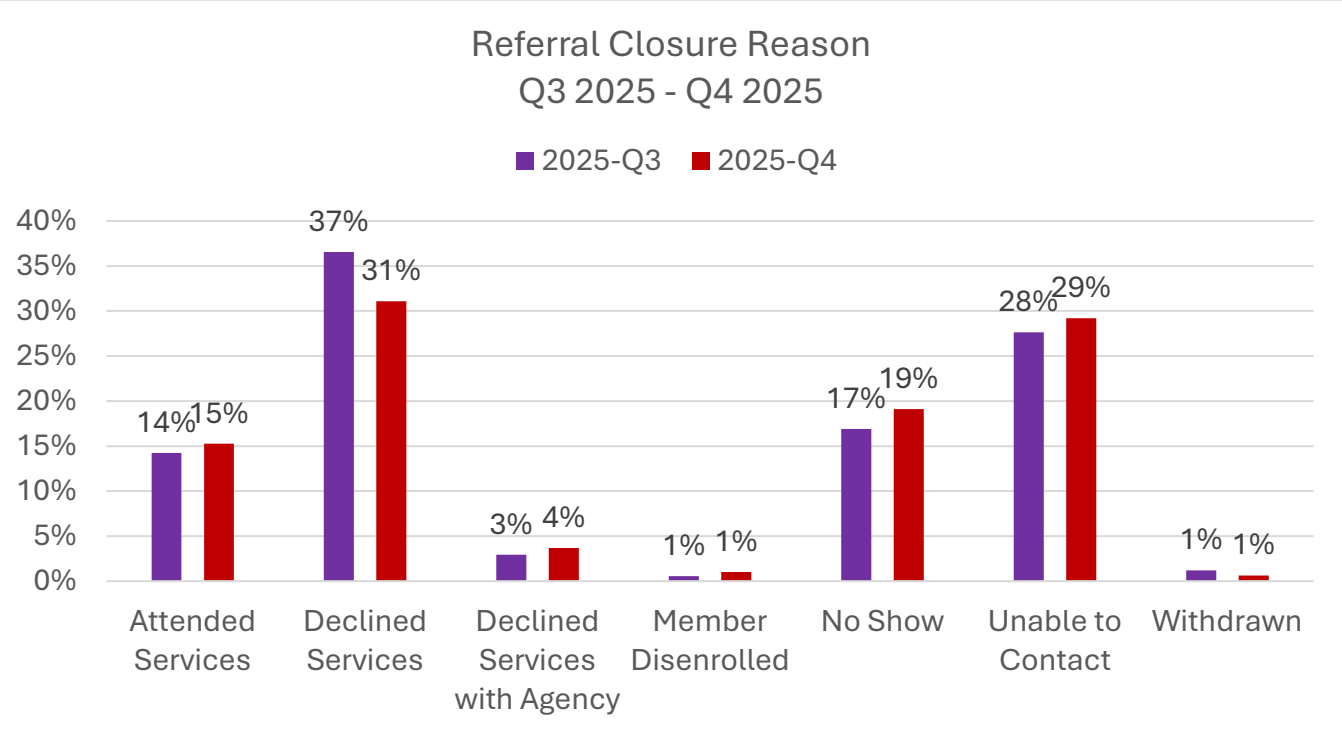
In Q4, there were 1,620 referrals, a 6-percentage point increase from Q3, where referrals totaled 1,513. Weight management remained the leading category at 53.4% of Q4 referrals, followed by Diabetes Education at 24.1% and Other Nutrition Education at 10.2%. The acceptance rate also increased in Q4 (52.9%) compared to Q3 (46.8%), with a total of 857 members accepting services in Q4. In Q4, 203 referrals were closed for members attending services, compared to 167 in Q3, a 9.2% increase.

Metric	Q3 2025	Q4 2025	Change
Total Referrals	1,513	1,620	6.6%
Accepted Service %	46.8%	52.9%	6.1 pp
Attended Count	167	203	36
Attended Service %	19.5%	28.7%	9.2 pp




Episodes Created by Reason for Referral
Q3 2025 - Q4 2025
2025-Q3
2025-Q4
1000
800
600
400
200
0
160
97
536
390
1
2
14
165
90
101
712
865
Asthma Education
Diabetes Education
Educational Material...
Other Nutrition...
Smoking/Tobacco...
Weight Management...


Episodes Created by Referral Source
Q3 2025 - Q4 2025
2025-Q3
2025-Q4
50%
40%
30%
20%
10%
0%
1%
0%
7%
7%
3%
3%
4%
4%
26%
28%
5%
5%
2%
1%
2%
3%
5%
7%
1%
9%
43%
34%
ECM & CSS Referrals
HE Provider Portal
Member Portal
MS Focused Outreach
Other
PHM CCM
PHM Special Projects
UM Generated
WP Class Self-referral
WP Community Self-...
WP Focused Outreach

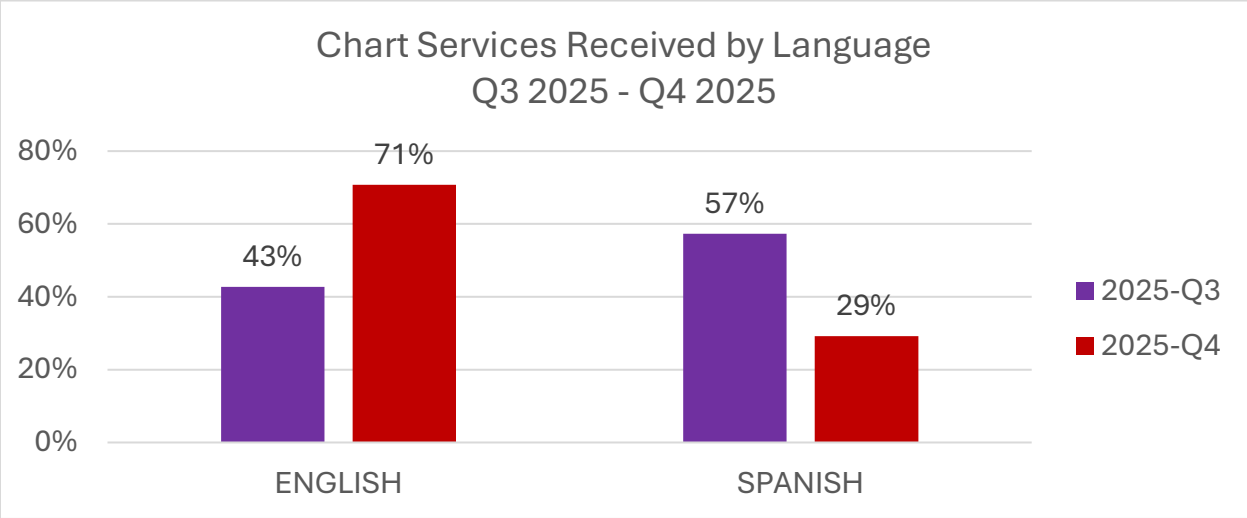


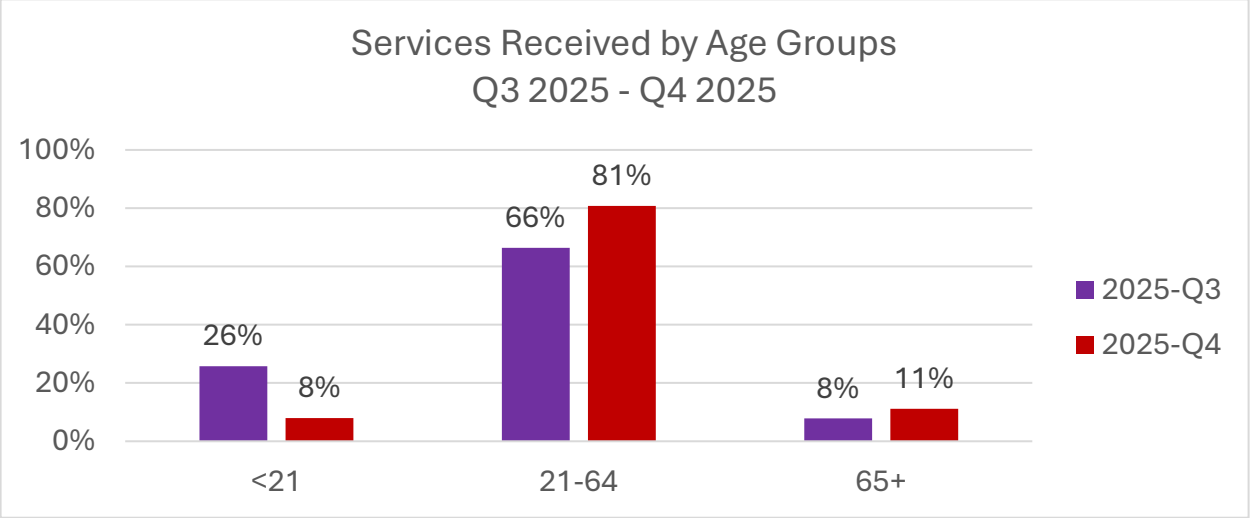
Demographics of Members

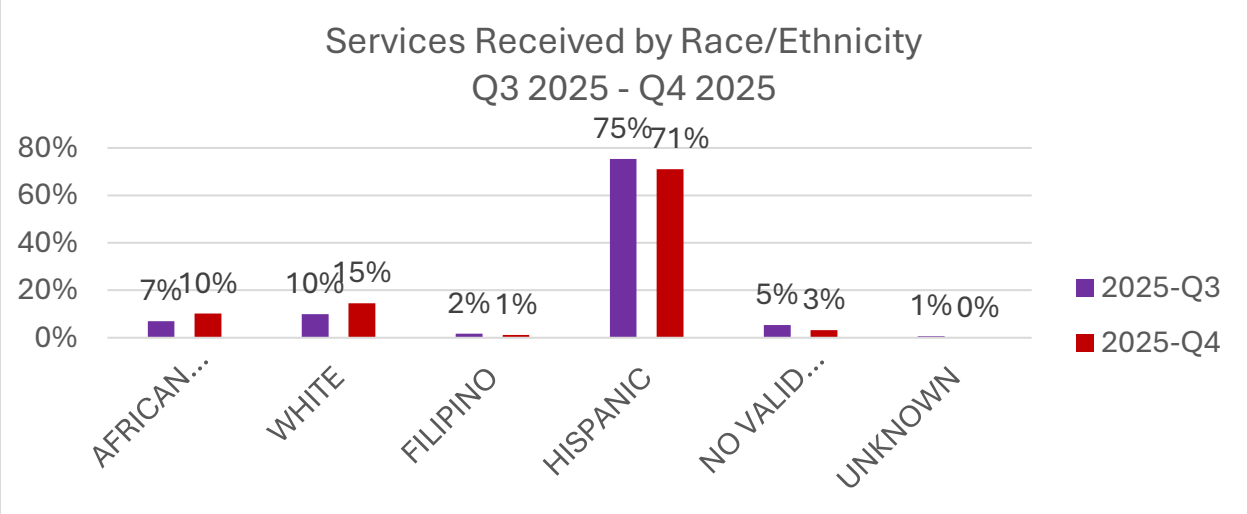
Kern Health Systems (KHS) continues to provide services to a culturally and linguistically diverse member population in Kern County. Attendance patterns in Q4 2025 show notable shifts compared to Q3 2025. English-speaking members represented 70.8% of attendees in Q4, while Spanish-speaking members decreased to 29.2%.

Age distribution also shifted in members who received services. While the 21–64 age group remained the largest group with 80.8%, the 21-and-under group dropped from 25.8% to 8.0% becoming the lowest group with attended in Q4, and the 65+ age group attendance increased from 7.8% to 11.2%.

Metric	Q3 2025	Q4 2025
Language – English	42.7%	70.8%
Language – Spanish	57.3%	29.2%
Age – 21–64	66.4%	80.8%
Age – <21	25.8%	8.0%
Age – 65+	7.8%	11.2%

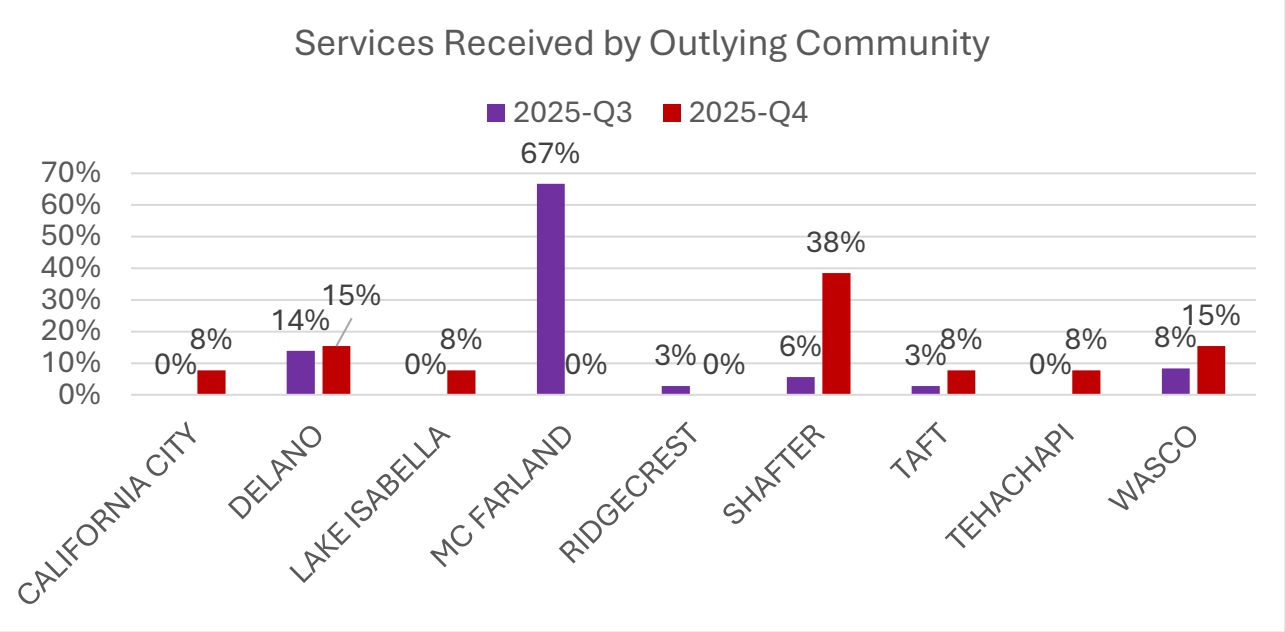

Chart Services Received by Language
Q3 2025 - Q4 2025
80%
60%
40%
20%
0%
43%
71%
57%
29%
ENGLISH
SPANISH
2025-Q3
2025-Q4

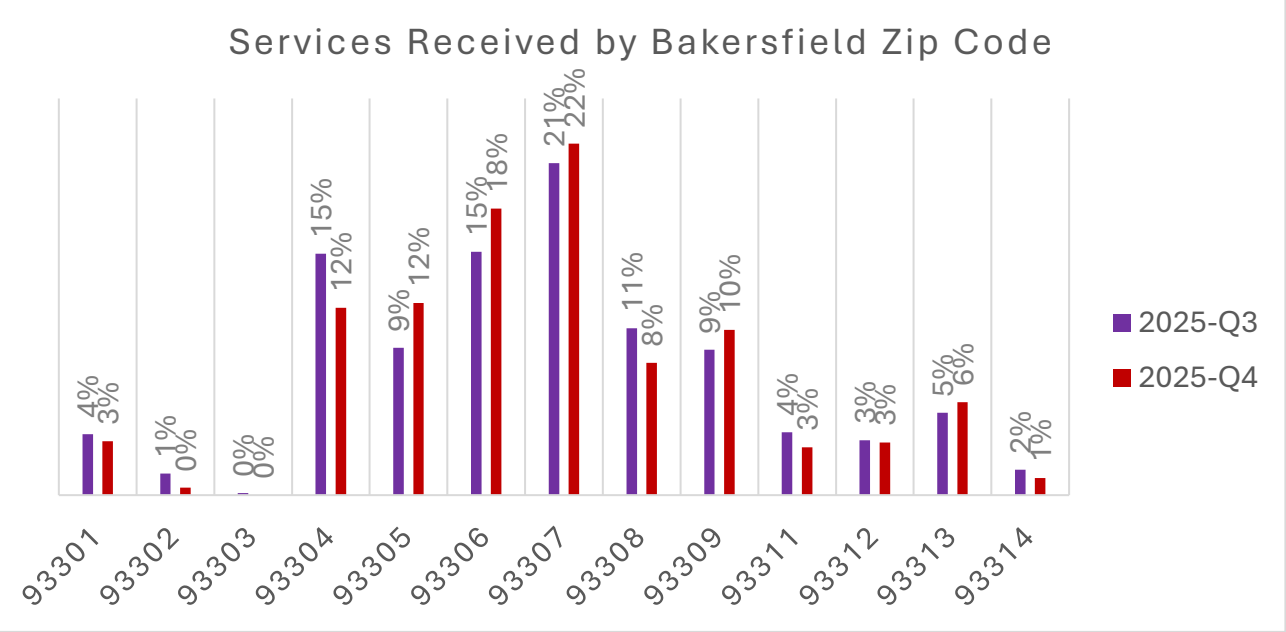

Services Received by Age Groups
Q3 2025 - Q4 2025
100%
80%
60%
40%
20%
0%
26%
8%
66%
81%
8%
11%
<21
21-64
65+
2025-Q3
2025-Q4


Services Received by Race/Ethnicity
Q3 2025 - Q4 2025
80%
60%
40%
20%
0%
7%
10%
10%
15%
2%
1%
75%
71%
5%
3%
1%
0%
AFRICAN...
WHITE
FILIPINO
HISPANIC
NO VALID...
UNKNOWN
2025-Q3
2025-Q4

Race and ethnicity trends indicate Hispanic members remain the largest segment at 71%, followed by White at 15% and African American with 10%.

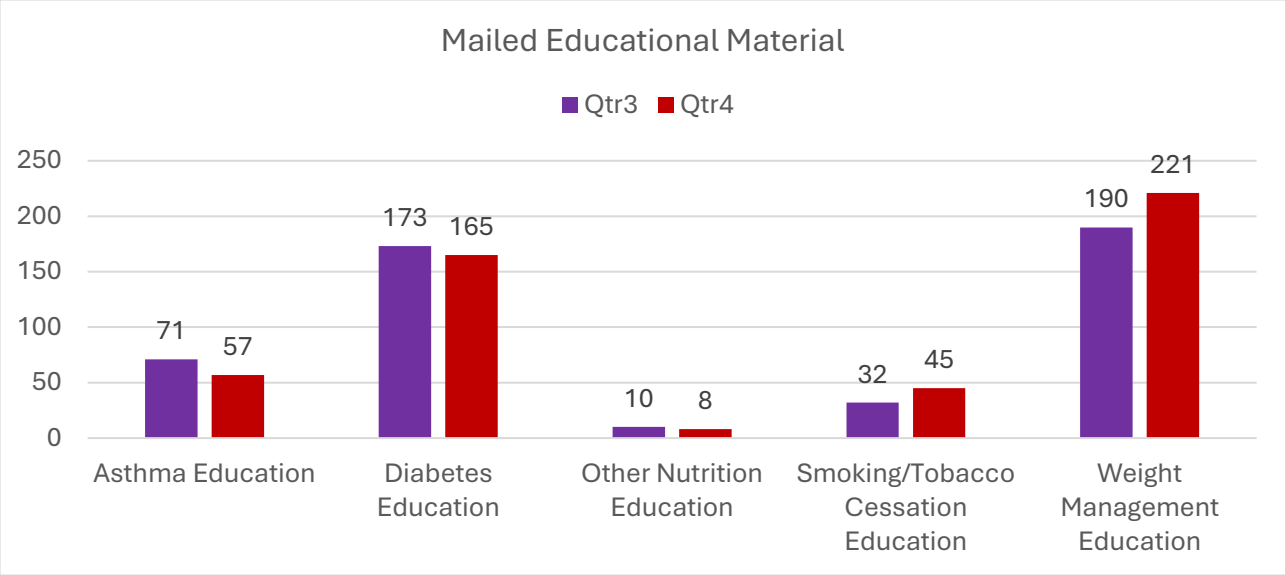
As far as geographical representation, Q4 had more members represented from Shafter (38%), Wasco (15%), and Delano (15%). In Bakersfield, distribution was consistent with 93307 (22%) and 93306 (18%) having the most members attend in both Q3 and Q4.
These demographic shifts are related to class locations in Q4 and targeted outreach efforts for these communities.





Healthwise Care Collections

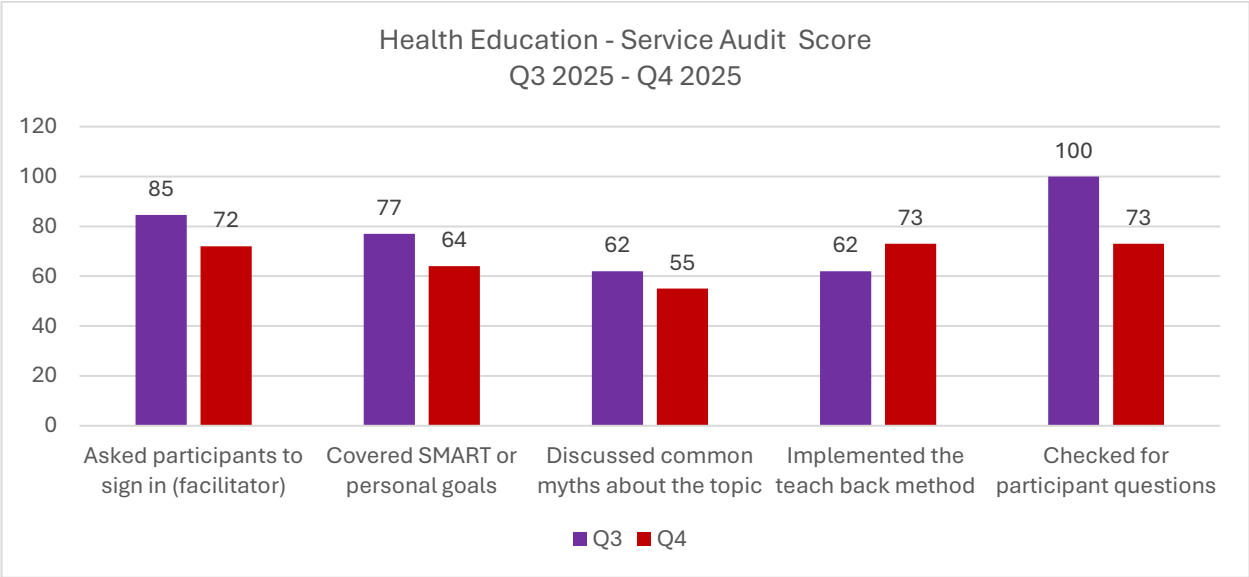
Kern Health Systems contracts with WebMD Ignite to provide health education material. WebMD Ignite material is mailed to all members who accept health education services and is offered to members who decline services. In Q4, 496 members were mailed educational material, a 4% increase from Q3 when 476 members were mailed educational material. In Q4, members who were referred to smoking/tobacco cessation or weight management education services were more likely to accept mailed educational material compared to other programs.



Health Education Class Service Audit

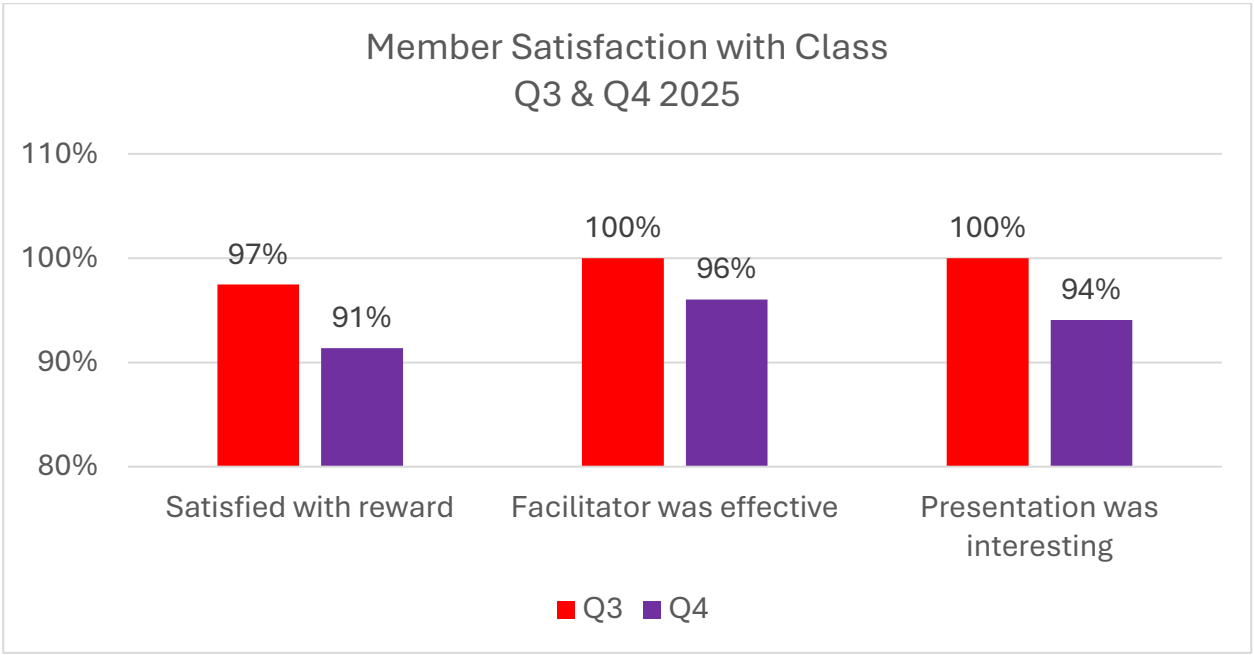
The Health Education Class Service Audit Tool considers a variety of markers to determine the quality of Health Education Class Services being provided to members. It includes observations on planning and preparation, implementation and delivery, and member engagement during health education classes.

In Q4, class facilitators scored 100% in several areas including, giving participants examples for health topics or concepts, explaining, or demonstrating activities, completing planned activities, responding to questions, covering all topics, and engaging participants in diverse ways. No areas fell below the 50% mark. Areas of improvement for next quarter are discussing myths around class topics, applying the teach-back method, checking for participant questions, and covering SMART goals.



Health Education Class Evaluation: Member Satisfaction

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 the classes for Q3 and Q4 of 2025.



Below is an analysis of the findings from open-ended questions for Q4 2025.

What did you like most about the class?

At least 94% percent of participants who responded expressed satisfaction with how the facilitators presented information and the quality of the presentation (was it interesting and easy to follow?) and 91% of respondents were satisfied with the rewards.

Members shared that they:

- Appreciated learning about nutrition, diabetes, asthma, smoking cessation, and general wellness.
- Valued practical tips for food choices, label reading, physical activity, and lifestyle changes.
- Enjoyed activities, games, and opportunities to ask questions.
- Felt motivated to make healthier choices and understood the relevance to their personal goals.
- Enjoyed meeting others and building community with other members.

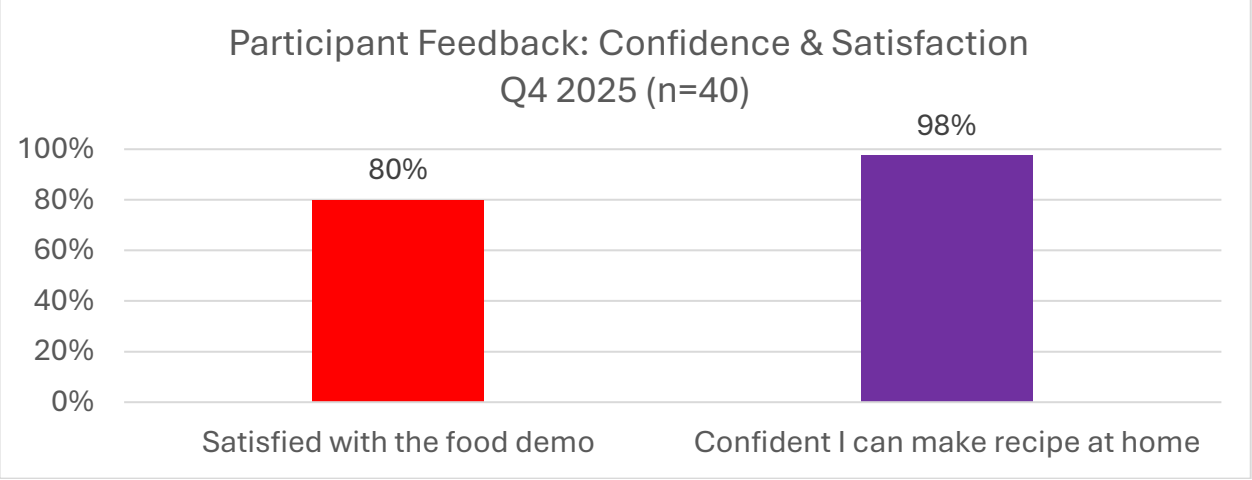
How can we improve the class?

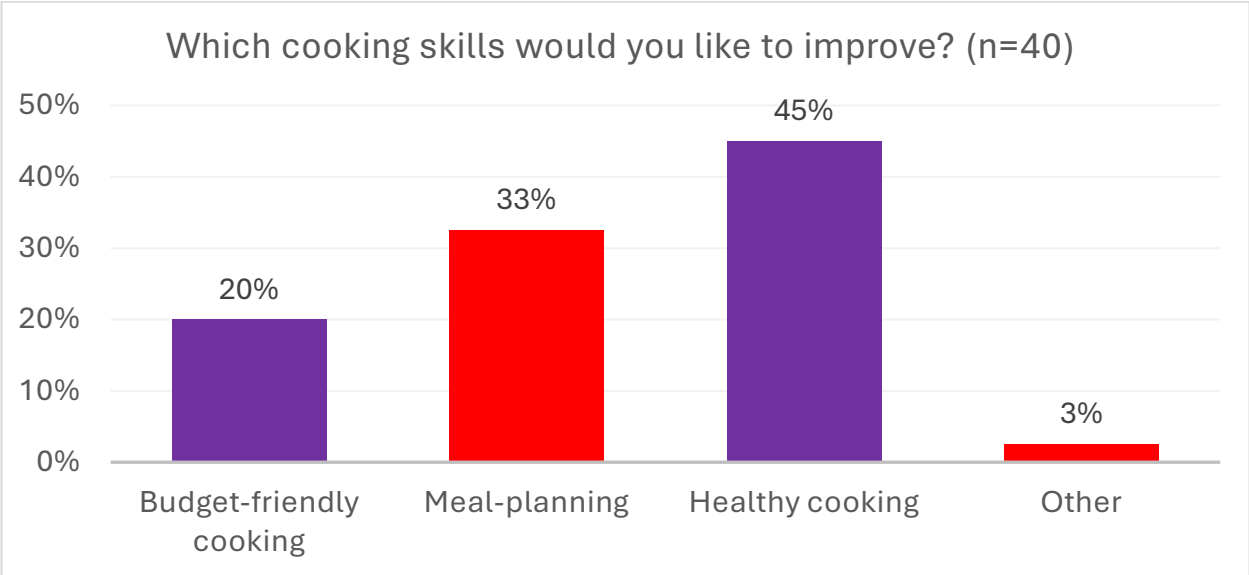
Comments from members who responded included:

- Desire for more recipes, health tips, and deeper exploration of topics.
- Suggestions for clearer visuals, mailed materials, and simplified communication.
- Desire for more movement-based components (exercise).
- Interest in guest speakers or specialists in health fields.
- Suggestions for culturally relevant recipes and activities.

Food Demo Class Evaluation

This section presents findings from the Blue Zones food demonstration, which was evaluated separately to understand program satisfaction, recipe confidence, and preferred cooking skills demonstrations.



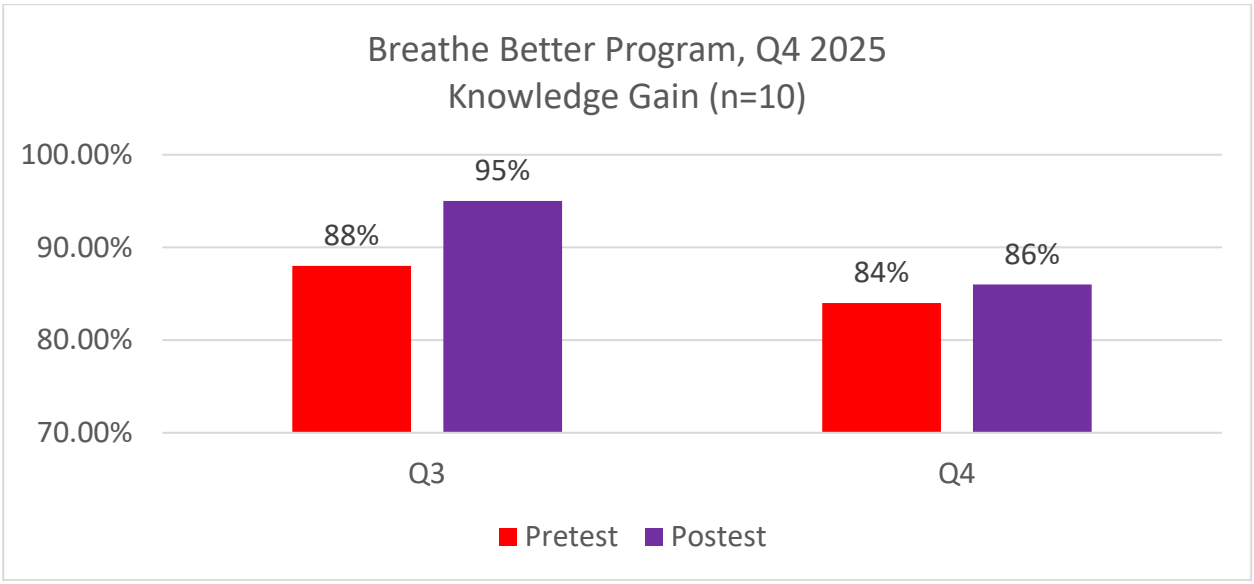


Survey responses found that 80% of members were satisfied with the food demo, and 98% of members were confident in being able to create the recipes from the food demonstration at home. Most class respondents expressed that they would like to learn healthy cooking skills (45%), followed by meal planning (33%), budget-friendly cooking skills (20%), and "other" at 3%.

Health Education Class Evaluation: Knowledge Change

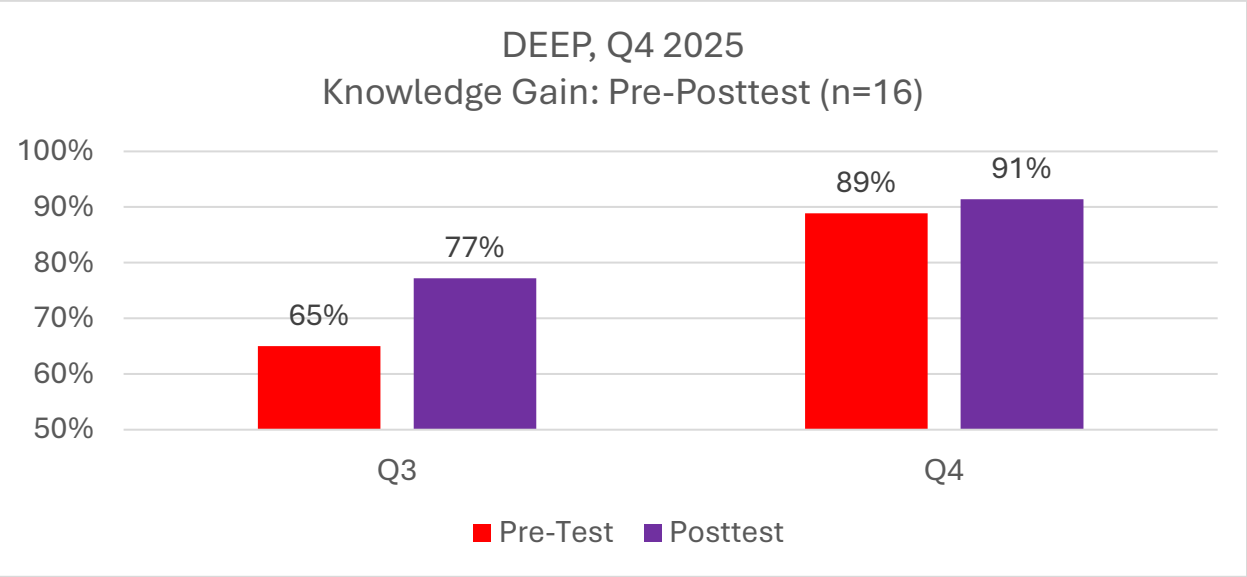
Asthma: Breathe Better Program

The asthma education program consists of two classes and at least two follow-up calls. A pre and posttest knowledge questionnaire is distributed per series. During Q4, the findings revealed there was a 2-percentage point increase in average knowledge test score after completing the series. The largest increase in knowledge was in understanding when to use controller inhalers as directed by their health care provider.



Diabetes Empowerment Education Program (DEEP)

DEEP is a diabetes self-management program that has been shown to be successful in helping participants take control of their disease and reduce the risk of complications. The program was developed for low-income, racial, and ethnic minority populations. During Q4, findings revealed a 2-percentage point increase in average knowledge test score when comparing members who completed a pretest (average 89% correct answers) to members who completed a posttest (average 91% correct answers).



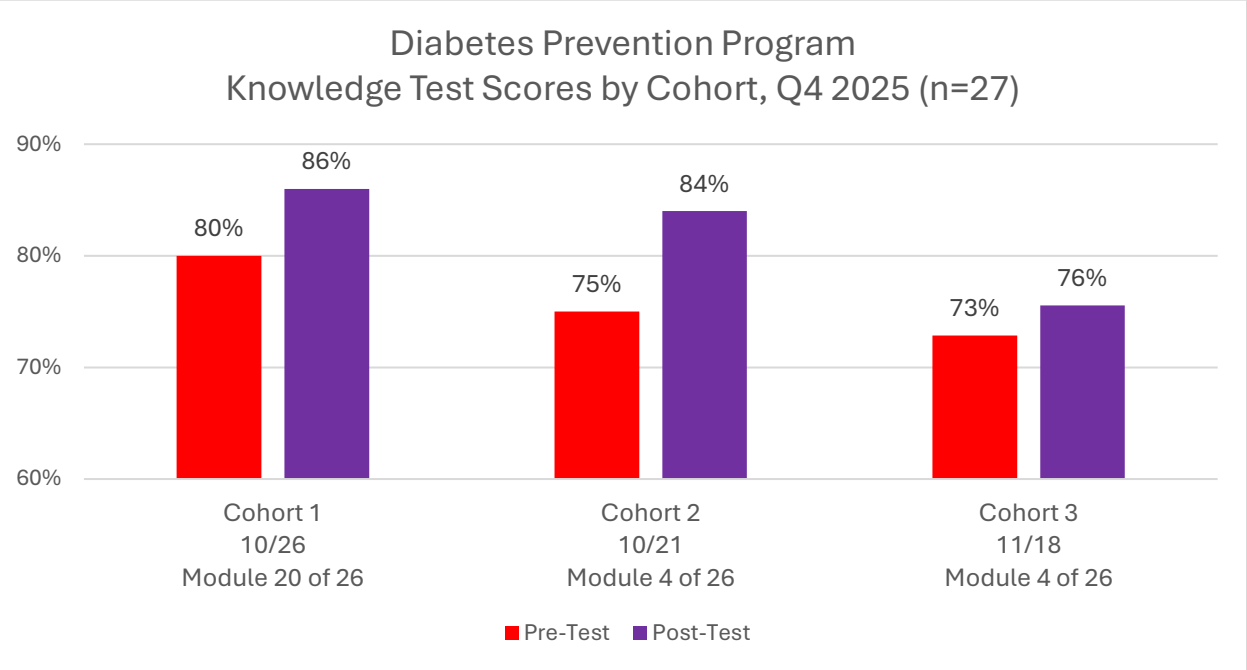
Diabetes Prevention Program (DPP)

The National DPP aims to simplify access to an affordable, high-quality lifestyle change program for individuals with prediabetes or those at risk of type 2 diabetes. The program helps lower their chances of developing type 2 diabetes and enhances their overall health. In Q4, 25 members completed pretests and posttests.

The Diabetes Prevention Program's Q4 knowledge test results (n=27) show consistent improvement across all three cohorts.

- **Cohort 1** improved from **80% (pre-test)** to **86% (post-test)**.
- **Cohort 2** improved from **75%** to **84%**.
- **Cohort 3** improved from **73%** to **76%**.

All cohorts demonstrated learning gains, with Cohort 2 showing the largest improvement (+9 percentage points) and Cohort 3 showing the smallest (+3 points). The results indicate positive knowledge growth across modules.



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

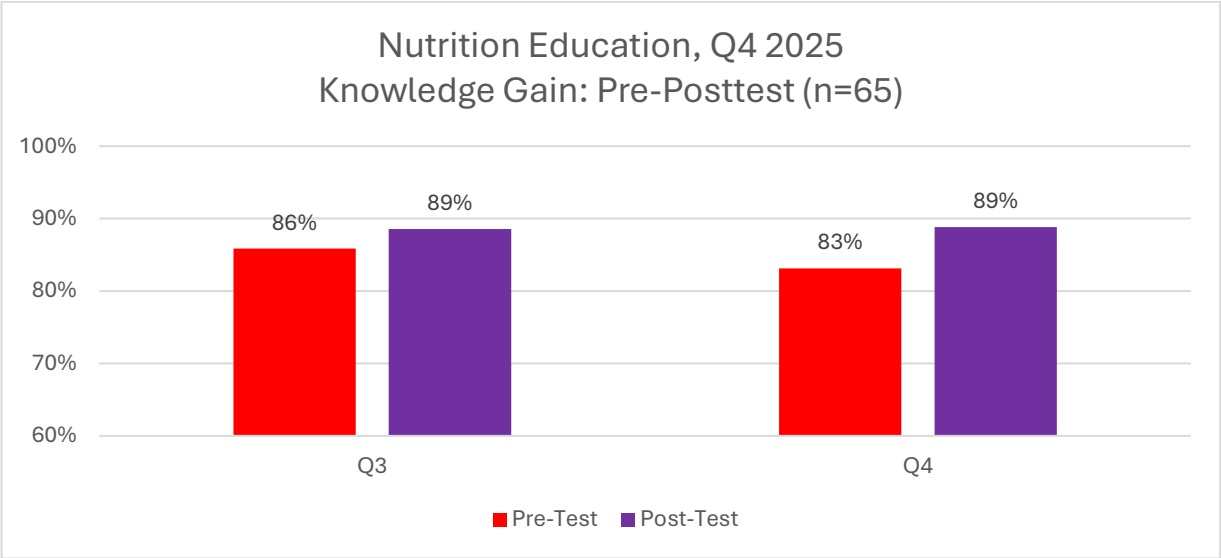
The nutrition and weight managed program include two curriculums that focus on creating healthy habits around eating and physical activity to reduce the risk of chronic illness among the KFHC members and Kern County population. Eat Healthy, Be Active is a 6-class series and Activity & Eating is a one-time class. Evidence shows that these programs can positively impact behavior around physical activity and nutrition. A pre and post test questionnaire is distributed per class.

During Q4, the findings revealed that among those members who completed the pre and posttest for both programs, there was an average 6-percentage point increase in knowledge gained after completing the program.

- Members who completed a pre-test scored an average of 83% in correct answers.
- Members who completed a posttest scored an average of 89%.

The largest increase in knowledge from pre- to posttest was observed among members who attended the Eat Healthy Be Active (EHBA) classes – a 6-percentage point increase.

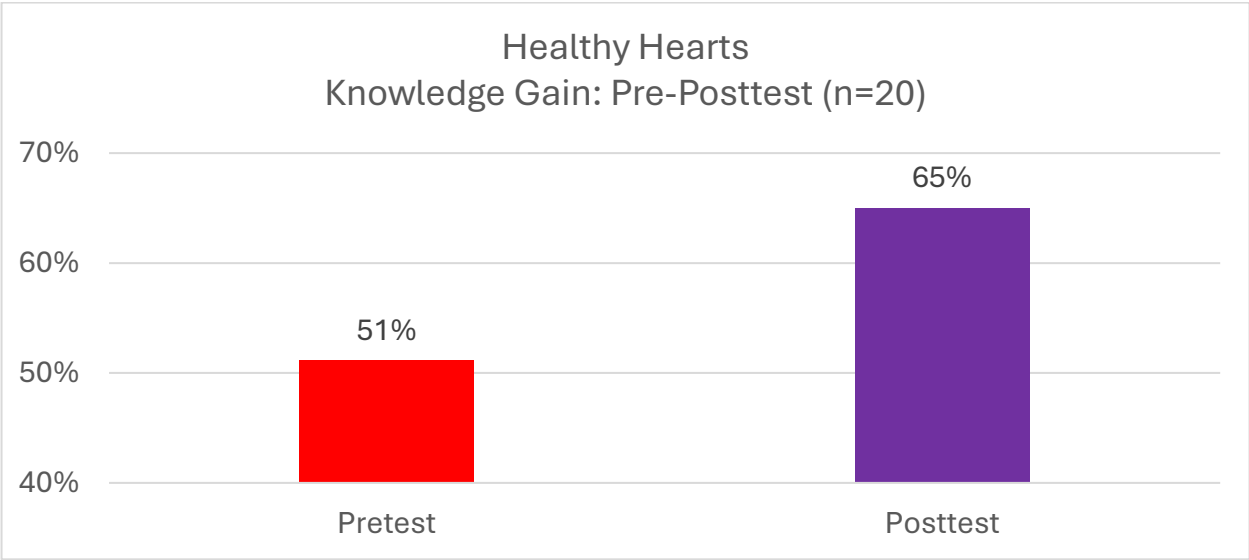
There was also an increase in knowing tips on how to save money when buying healthy food, the five recommended food groups, and daily recommended exercise for adults. Total responses were n=21 from A+E and n=44 from EHBA.



Cardiovascular Health: Healthy Hearts Program

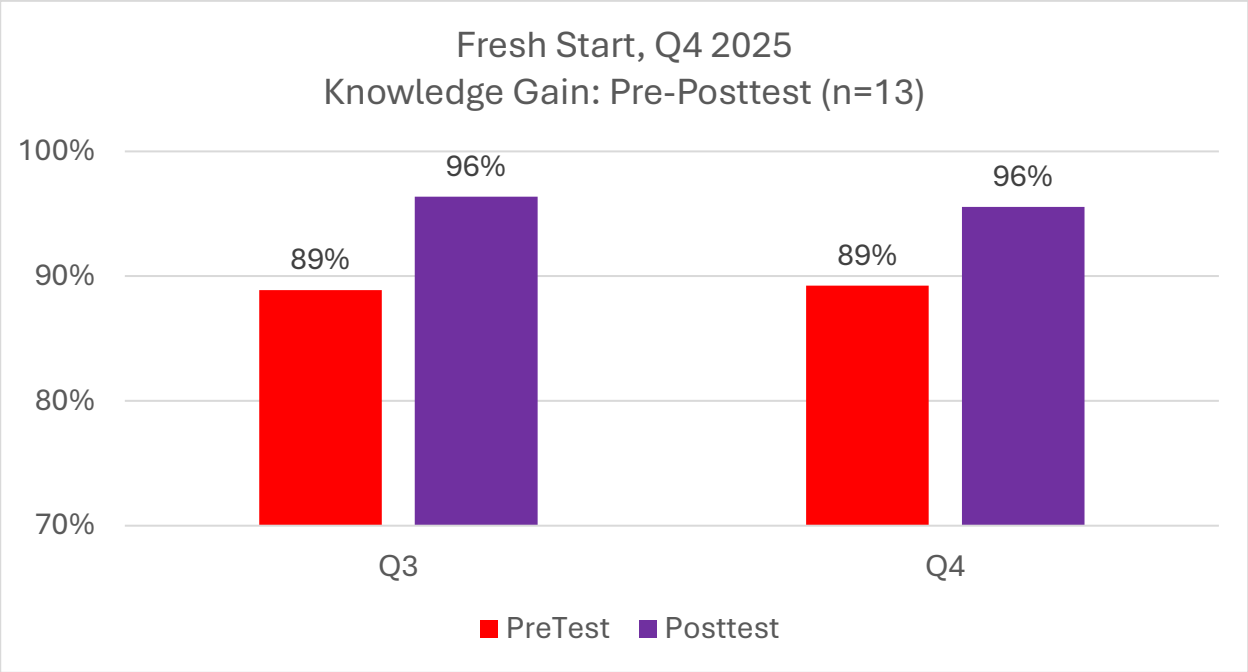
A new evidence-based program through the American Heart Association was piloted in Q4 of 2025. Class 1 covers the basics of cholesterol, including the difference between LDL and HDL, who is at risk, and how to manage cholesterol through lifestyle changes and medical guidance. Class 2 focuses on understanding blood pressure numbers and what they mean, risk factors, how to measure it, and healthy habits that help prevent high blood pressure. Both classes help participants communicate better with their health care providers and make informed decisions about their cardiovascular health.

During Q4 findings show that there was a 14 percent-point increase in knowledge gain with an average of 51% correct answers at pretest compared to members who completed a posttest (average 65% correct answers).



Smoking/Tobacco Cessation: Fresh Start

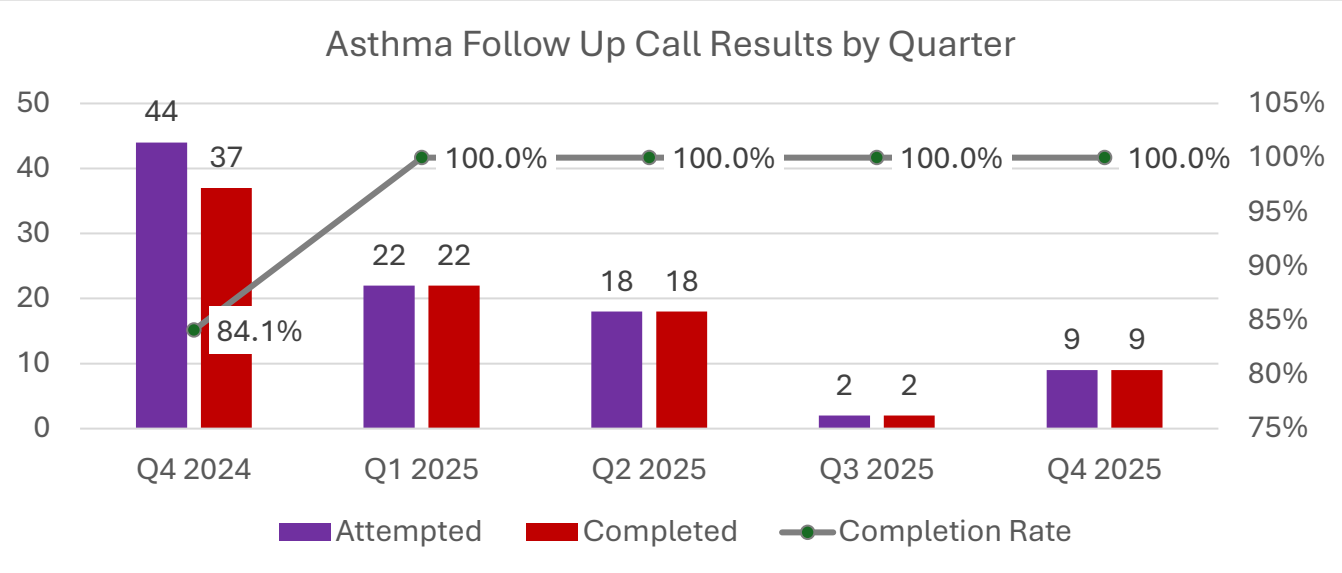
The Fresh Start program has the goal of reducing harm from tobacco products. Knowledge tests are implemented in each series. In Q4, 13 members completed a pretest and/or posttest, with a total of twenty-two tests completed during this period. There was a 7-percentage point increase in average knowledge score between pretest and posttest responses. Members appear to have gained knowledge on the concept of how ambivalence affects their emotions, understanding their triggers, and creating a personal quit plan.



Health Education Program Evaluation: Outcomes

Chronic Disease Management: *Asthma Education Effectiveness*

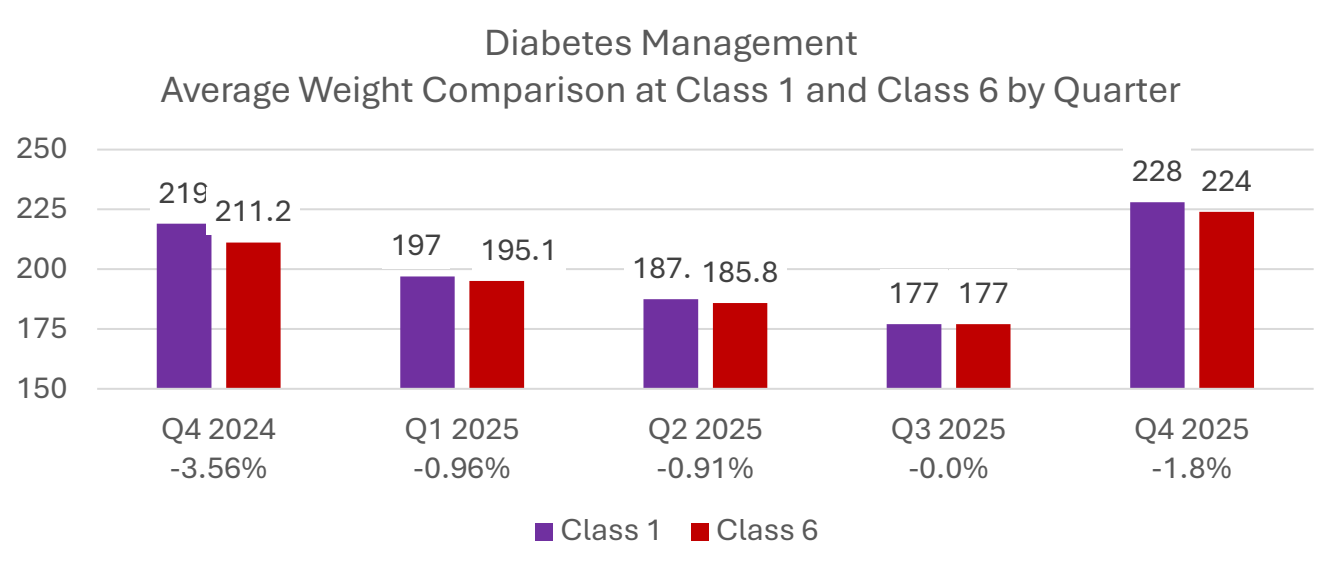
Members who have attended the KFHC Breathe Better Asthma Classes are offered asthma follow-up calls. These calls occur at 1 month, 3 months, and 6 months (optional or only if needed) after completing the program. During the follow up call, members are screened to determine if asthma symptoms are well controlled using the Asthma Control Test (ACT) screening tool. An ACT score of 20 or higher is an indicator of well controlled asthma. During Q4 2025, 100% of members completed an asthma follow-up call. This remained constant from the previous quarter. There was an improvement in average ACT score for both members under 12 years of age and those 12 years older when comparing the initial assessment to the 3-month follow-up call.



Q4 2025 Average ACT Scores During Asthma Follow Up Calls		
Call Month	<12 years of age	12+ years of age
Initial	15	16
3	22	17

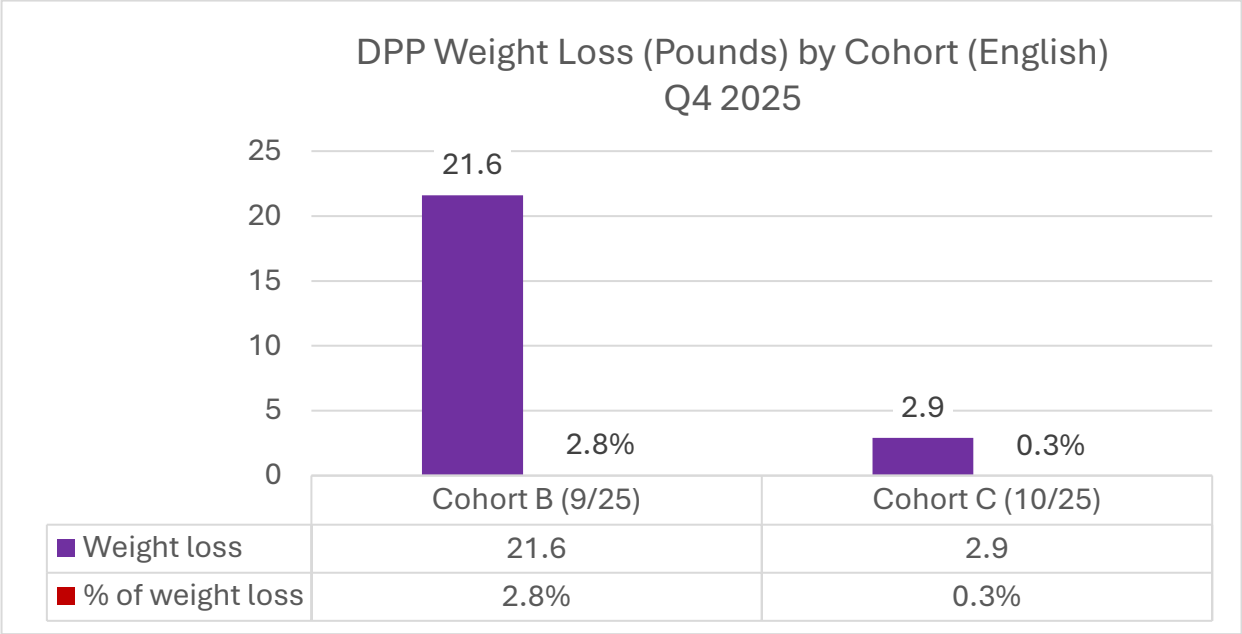
Chronic Disease Management: Diabetes Empowerment Education Program

Members who participate in DEEP are weighed in at every class as one way to measure program impact. The bar chart below compares the average weight of participants before and after attending the DEEP program, for class 1 and class 6 during Q4 2024, Q1 2025, Q2 2025, Q3 2025 and Q4 2025. Overall, the data shows that behavior modifications and recommendations presented during the series are effective by at least maintaining or losing weight.

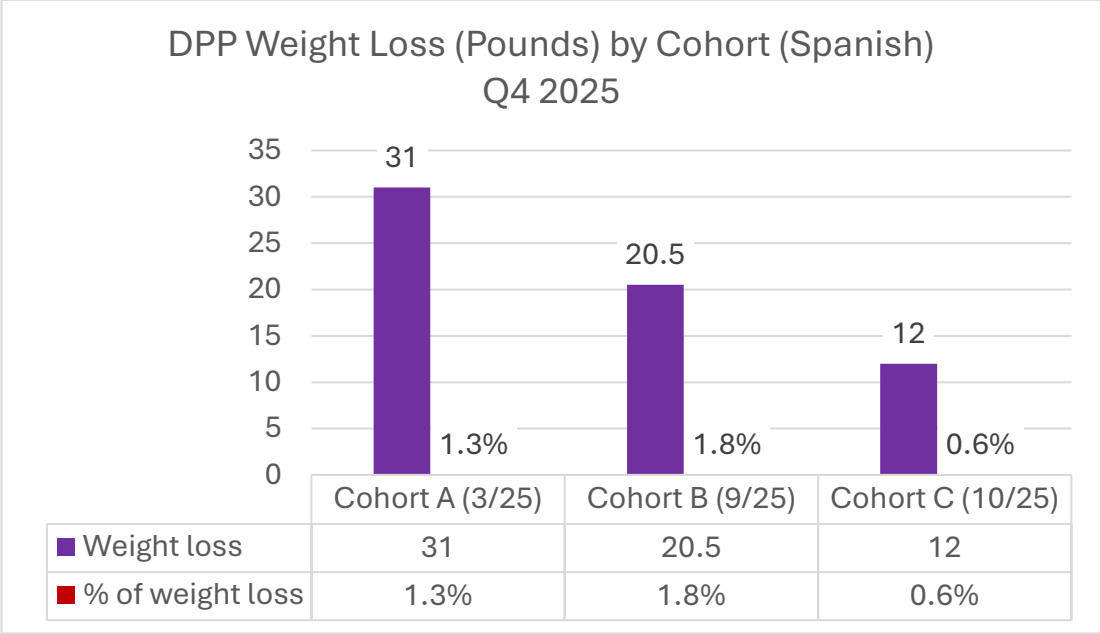


Chronic Disease Prevention and Management: Diabetes Prevention Program

Members who participate in DPP are weighed in at every class as one way to measure impact. The initial combined cohort weight is compared with the combined weight at the end of each month to calculate average weight loss per member each quarter. For the English cohorts, cohort B had the highest weight loss and weight loss percentage. For the Spanish cohorts, although cohort A had higher weight loss, cohort B had the higher weight loss percentage.



	Cohort B (9/25)	Cohort C (10/25)
Weight loss	21.6	2.9
% of weight loss	2.8%	0.3%



	Cohort A (3/25)	Cohort B (9/25)	Cohort C (10/25)
Weight loss	31	20.5	12
% of weight loss	1.3%	1.8%	0.6%

Member Wellness Campaign

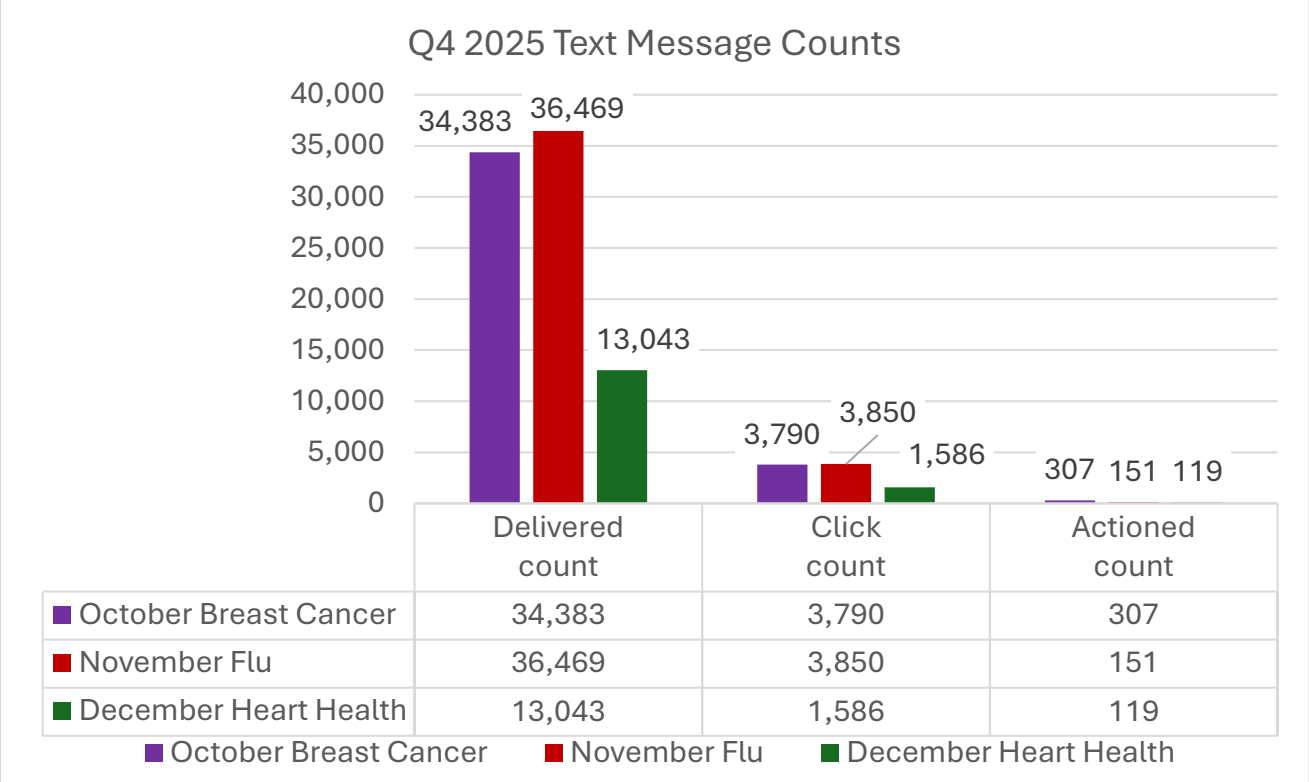
Member Newsletter

The Winter 2025 Newsletter was mailed to homes November 13 - 17. There was a total of 80,936 newsletters mailed. This edition of the newsletter focuses on adult/senior population health. For households who have opted in to text, the newsletter was sent out by text November 20 - 26. The newsletter was texted out to 41,023 households. 29,399 members were English speaking, and 11,624 members were Spanish speaking.

Prevention Messaging - Text

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

- In October, the topic was breast cancer. This message went out to all households that were opted in text messaging. There was a total of 34,383 members who were outreached and **11.0%** clicked on the message.
- In November, the topic was the flu. This message went out to all households that were opted in text messaging. There was a total of 36,469 members who were outreached and **10.6%** clicked on the message.
- In December, the text message topic was heart health. This message went out to all households with a member of 40 years old or older and were opted in text messaging. There was a total of 13,043 members who were outreached and **12.2%** clicked on the message.



Prevention Messaging – Social Media

MWP staff collaborates with the KHS Marketing team to develop messaging on wellness and prevention for Kern Family Health Care members. The messages are shared on the social media platforms Facebook and Instagram.

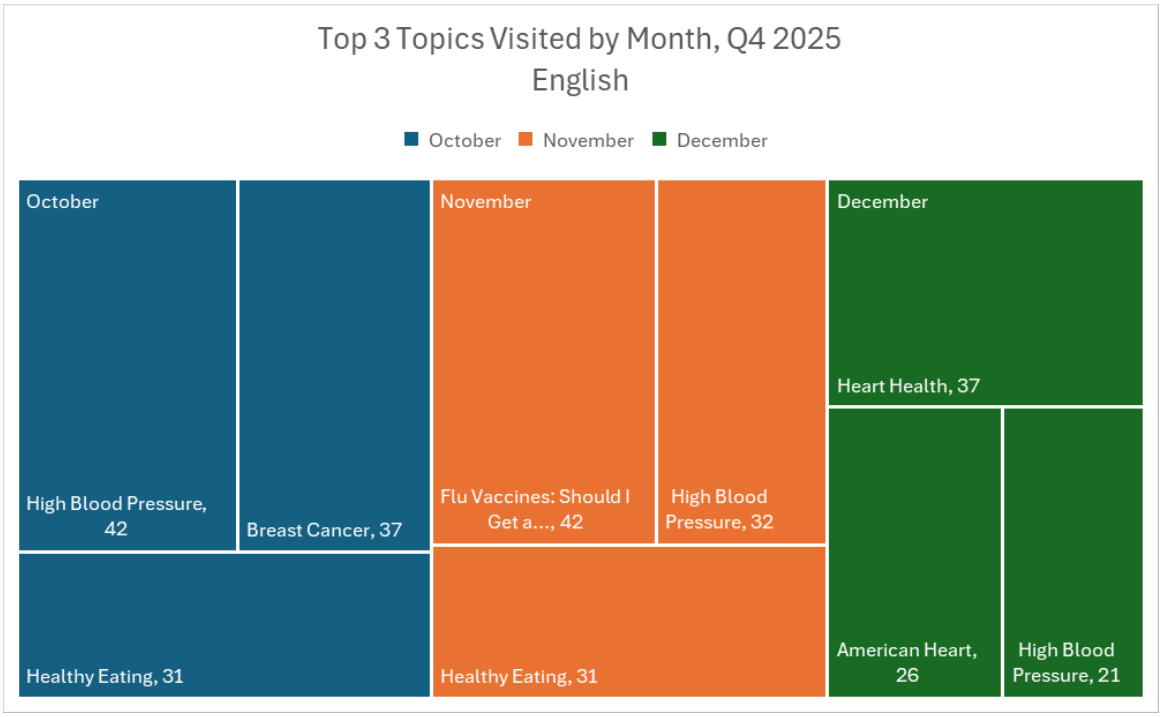
In Q4 messages were about breast cancer, flu, and diabetes Awareness. These were for the months of October and November. No messages were posted for the month of December. These messages were posted in English and various in Spanish with the hashtag *#KFHCWellness #BienestarConKFHC* to identify the collaborative campaign messages and increase message visibility with our members.

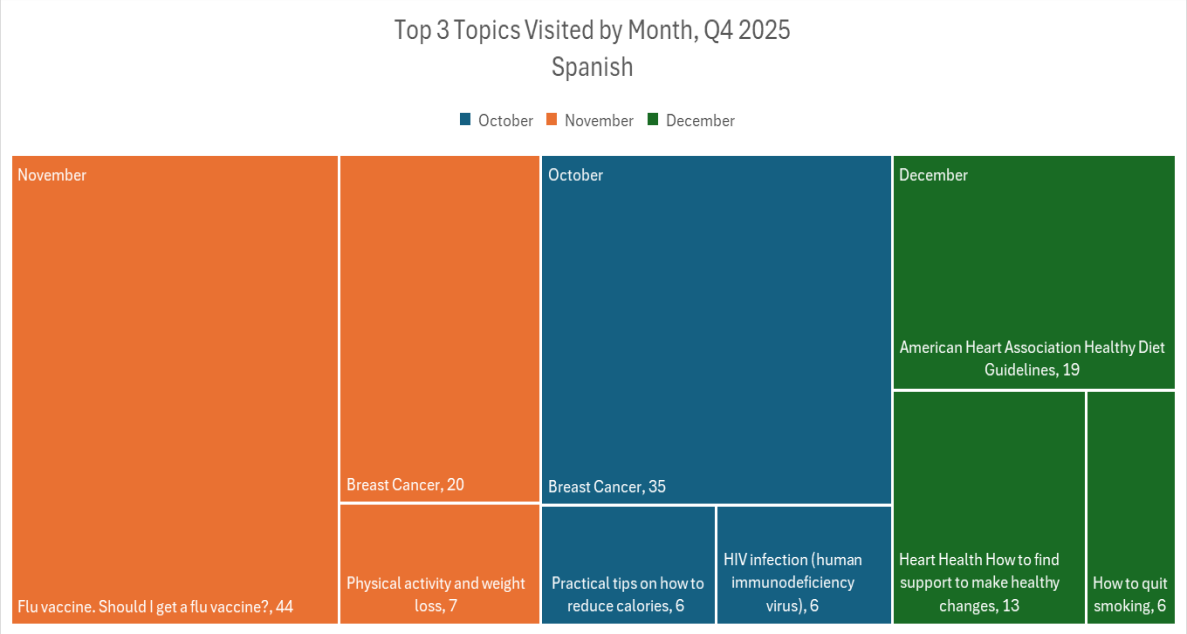
- The following posts have the highest engagement rates for their corresponding month. Breast Cancer Awareness: Via Facebook, with a 4.6% engagement rate, the post is headlined as "Regular breast cancer screenings are one of the most important steps..."
- Flu: Via Facebook with a 0.6% engagement rate, the post is headlined as "Flu is NOT just a cold. It can cause high fever, headaches, and body..."
- Diabetes Awareness: Via Facebook with a 3.1% engagement rate, the post is headlined as "Take control of your health and prevent or delay type 2 diabetes!" This post highlights our Diabetes Prevention Program (DPP).

Month	Oct	Oct	Nov
Topic	Breast cancer	Flu	Diabetes
Posts	16	14	16
Impressions	7,276	3,225	7,420
Avg Engagement rate	1.20%	0.40%	1.60%
Average engagements	5.2	2.3	7.2
Reactions, comments, shares	47/0/16	9/0/0	68/3/14

Prevention Messaging - Self-Management Care Collections

Kern Health Systems contracts with WebMD Ignite to provide self-management tools on the corporate website. The self-management tools provide health and wellness information at members' fingertips. The charts below show the highest number of topics visited per month by language in October, November, and December of 2025.


Top 3 Topics Visited by Month, Q4 2025
English
October
November
December
October
High Blood Pressure, 42
Breast Cancer, 37
Healthy Eating, 31
November
Flu Vaccines: Should I Get a..., 42
High Blood Pressure, 32
Healthy Eating, 31
December
Heart Health, 37
American Heart, 26
High Blood Pressure, 21


Top 3 Topics Visited by Month, Q4 2025
Spanish
October
November
December
November
Flu vaccine. Should I get a flu vaccine?, 44
Breast Cancer, 20
Physical activity and weight loss, 7
October
Breast Cancer, 35
Practical tips on how to reduce calories, 6
HIV infection (human immunodeficiency virus), 6
December
American Heart Association Healthy Diet Guidelines, 19
Heart Health How to find support to make healthy changes, 13
How to quit smoking, 6

Kern Health Systems
Cultural & Linguistic Services Activities Report
4th Quarter 2025

Executive Summary

Report Date: February 9th, 2026
Reporting Period: October 2025 – December 2025

OVERVIEW

Kern Health Systems' Cultural and Linguistic (C&L) Services Program helps ensure that comprehensive, culturally, and linguistically competent services are provided to plan members with the intent of improving health outcomes, reducing risk for disease and empowering plan members to be active participants in their health care. The Executive Summary below highlights the larger efforts currently being implemented by the C&L Team. Following this summary reflects the statistical measurements for the C&L Services Program detailing the ongoing activity for Q4 of 2025.

Interpreter Requests

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

Service Monitoring

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

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

C&L Trainings

- Interpreter Access Survey Provider Training
- KHS Bilingual Staff Training
- C&L Grievance Provider Training
- Bridge to Better Care Interpreter Training Program

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

Kern Health Systems
Cultural & Linguistic Services Activities Report
4th Quarter 2025

Cultural and Linguistic Services

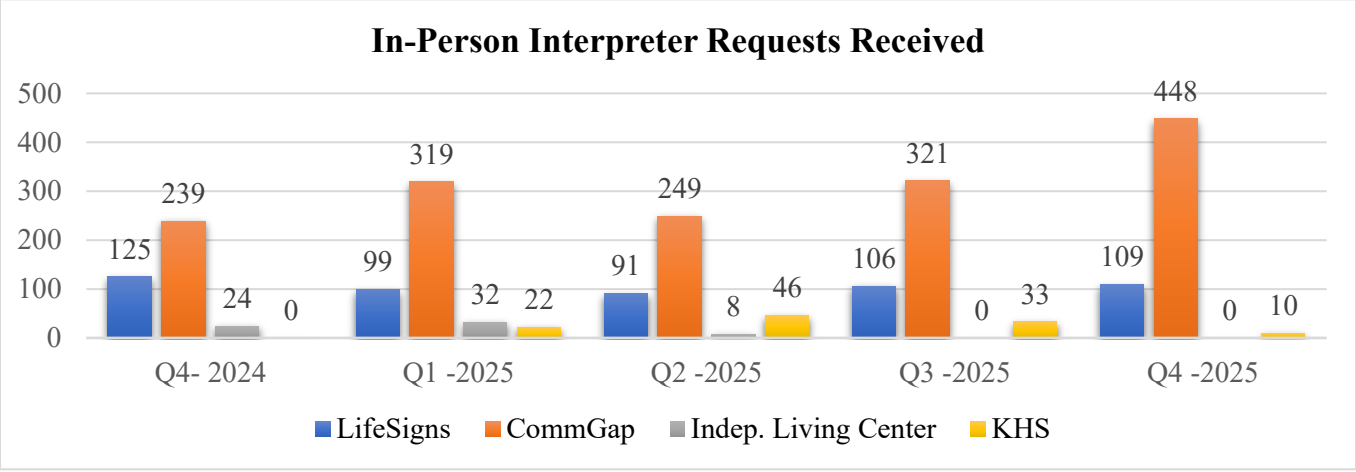
Interpreter Requests

During this quarter, the Cultural and Linguistic Services department received a total of 2,880 interpretation service requests, categorized as follows:

- 448 Face-to-Face Interpreting requests
- 2100 Telephonic Interpreting requests
- 223 Video Remote Interpreting (VRI) requests
- 109 American Sign Language (ASL) Interpreting requests

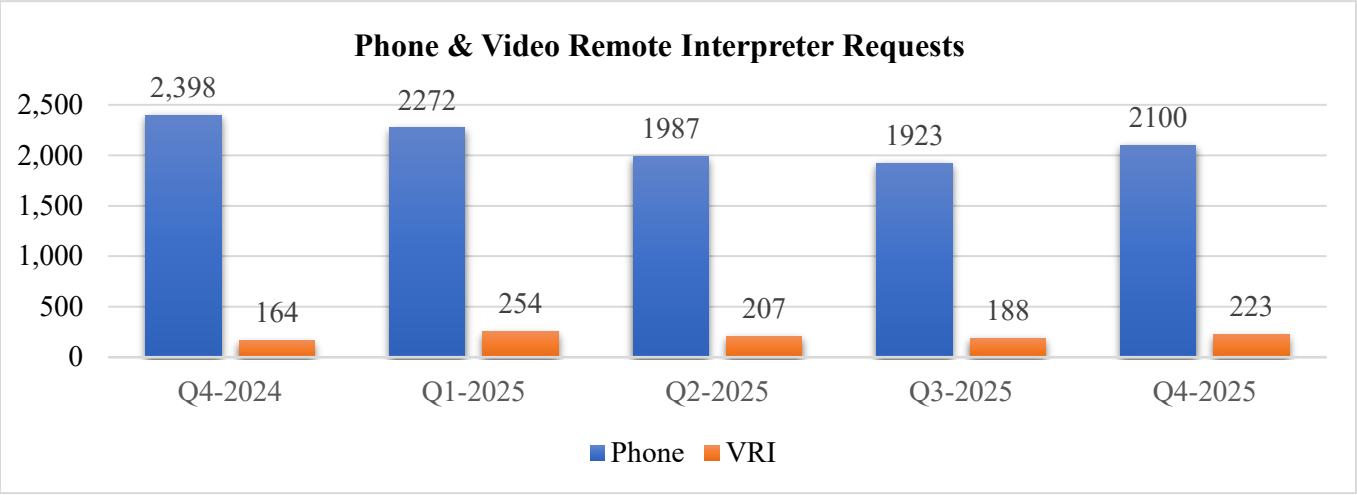
The top three languages requested are shown as follows:

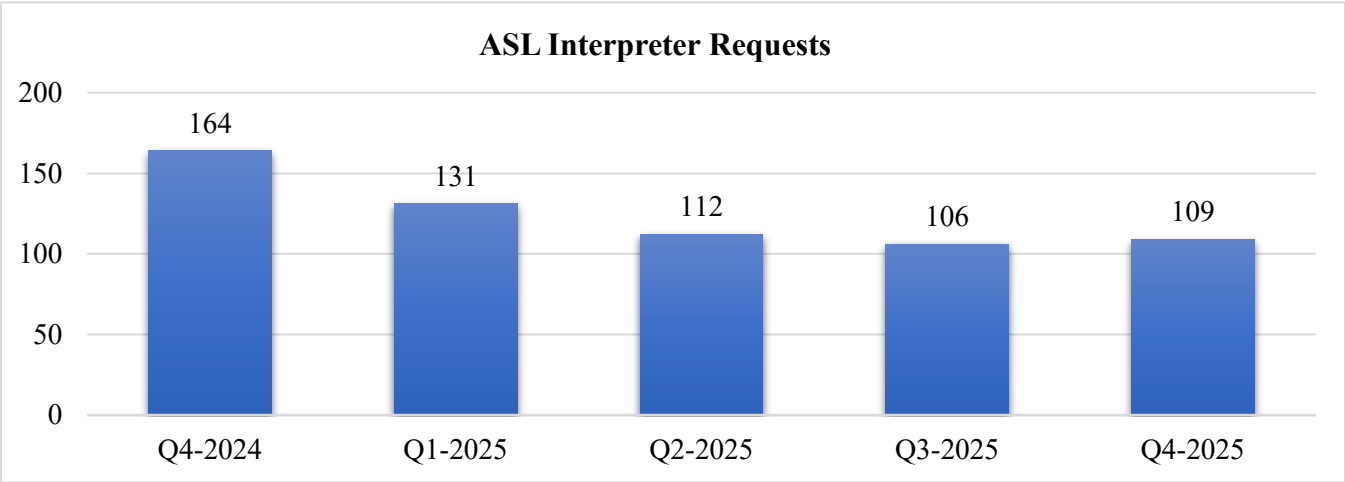
Interpreting Languages Requested	
Phone (OPI) & Video Remote (VRI)	**In-person (Onsite)**
Spanish	Spanish
Punjabi	ASL
Arabic	Punjabi/Arabic



Kern Health Systems
Cultural & Linguistic Services Activities Report
4th Quarter 2025

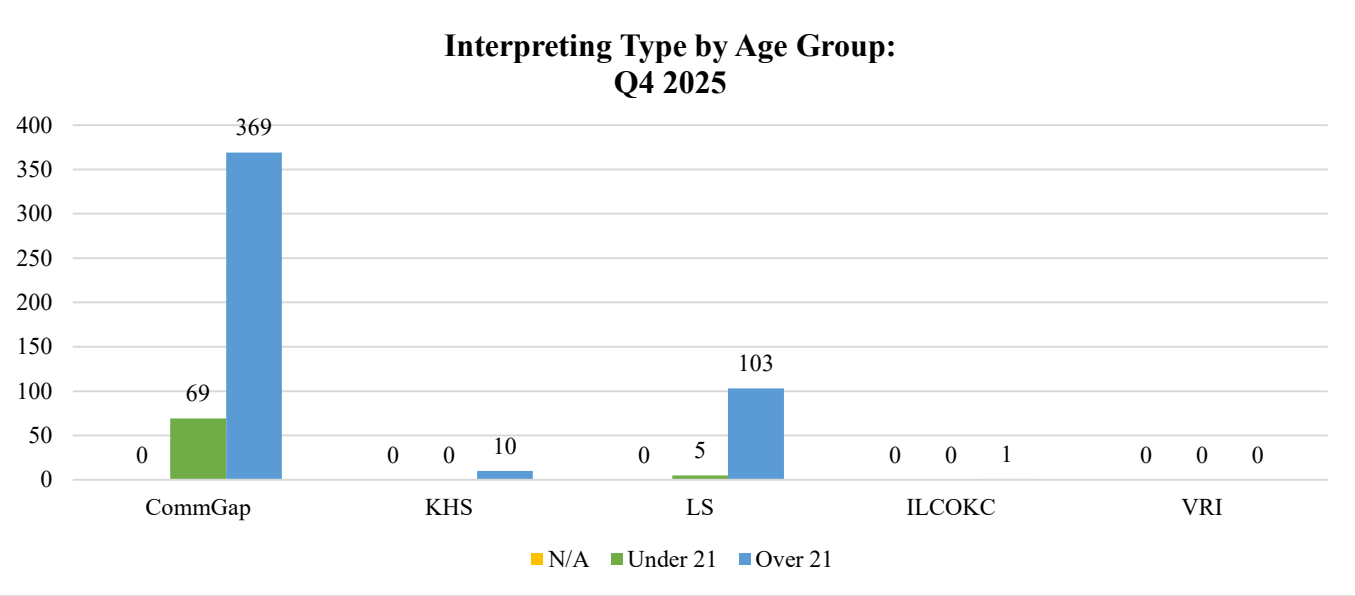
Languages Offered by Agency				
LifeSigns (LS)	**CommGap**	**Independent Living Center of Kern County (ILCOKC)**	**Kern Health Systems (in house)**	**Language Line**
American Sign Language	Over 140 languages on-demand	American Sign Language	Spanish	Over 240 languages OPI and 45 Languages for VRI, including ASL.





A total of 557 in person, Video Remote Interpreting (VRI), and American Sign Language (ASL) interpreting service sessions were provided during Q4 2025. Of these sessions:

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



Written Translations

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

Written translation requests are categorized into five major types:

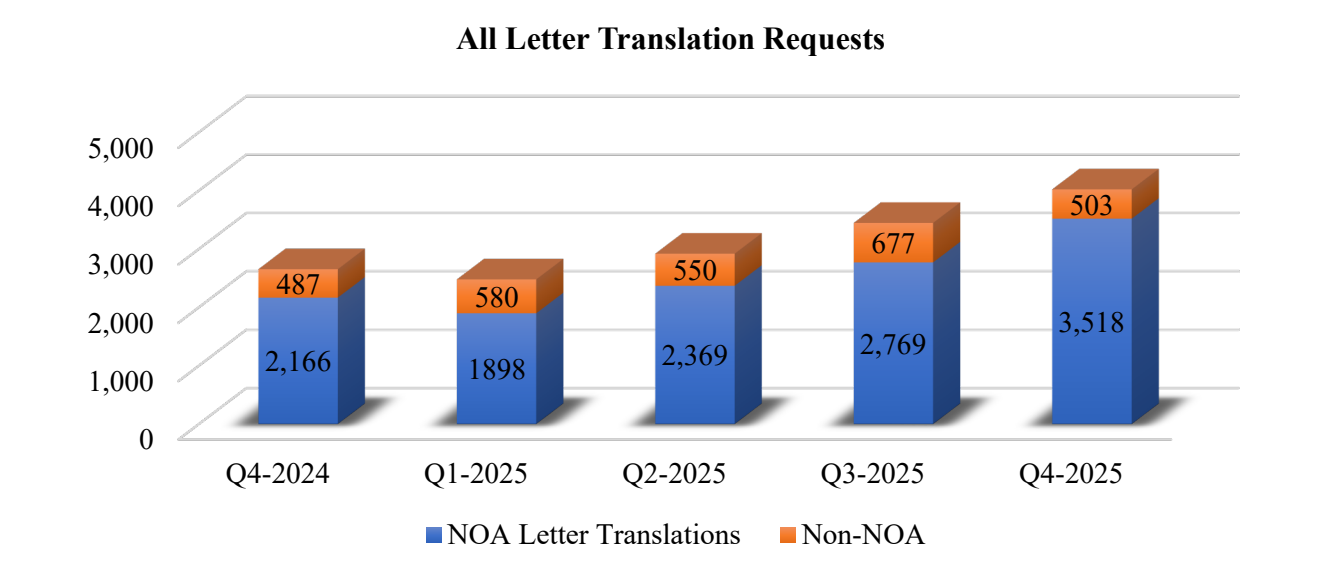
- Notice of Action (NOA) Letters
- Grievance Letters (GTLs)
- Provider Termination Letters (PTLs)
- Language Line Services (LLS)
- Non- NOA Letters – include all other translation types not classified above, such as fliers, consent letters, educational materials, slide decks, surveys, and more.

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

- Braille
- Large Print

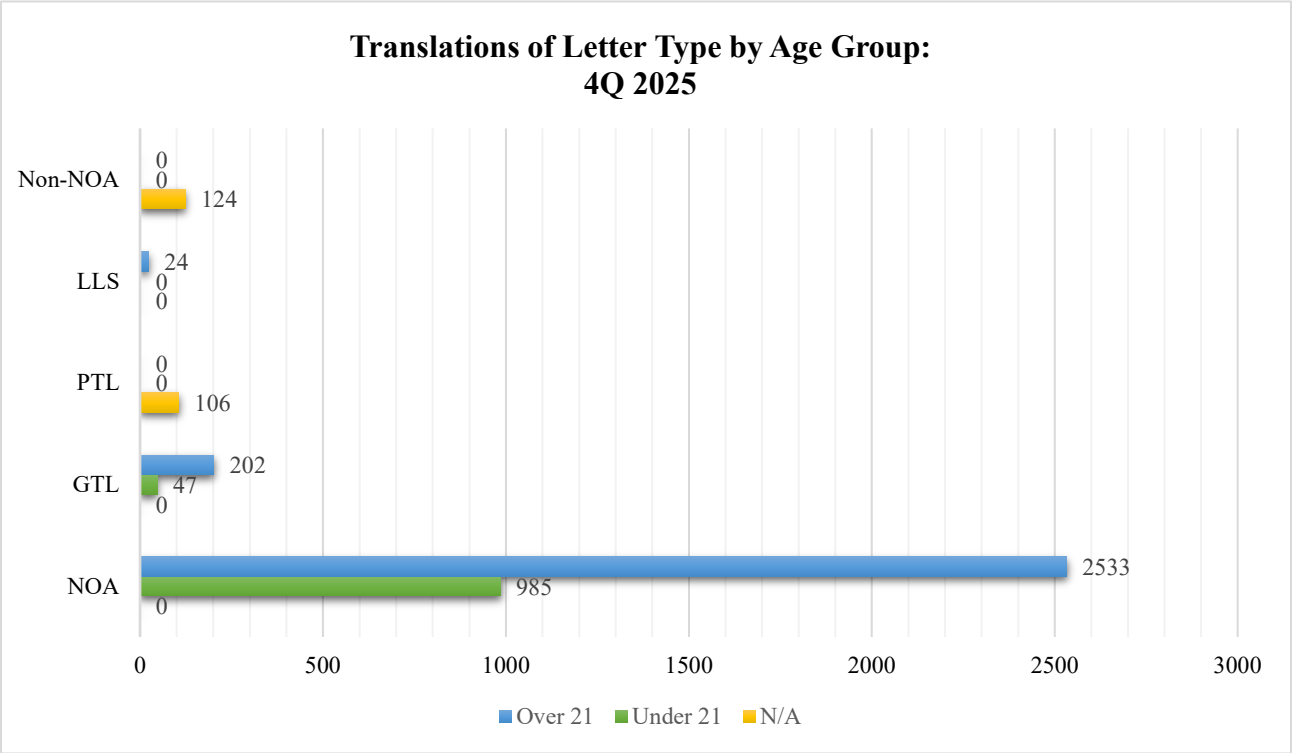
- Audio
- Data CD

During this reporting period, the department received and completed 4,021written translation requests, along with all associated alternative format requests.



Translations were further classified by member age group:

- 2759 translations were provided for members 21 and older
- 1,032 for members under the age of 21
- 230 were classified as “Not Applicable” due to the nature of the content.



Cultural and Linguistic Services Audits

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

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

Calls were evaluated on the following items:

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

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

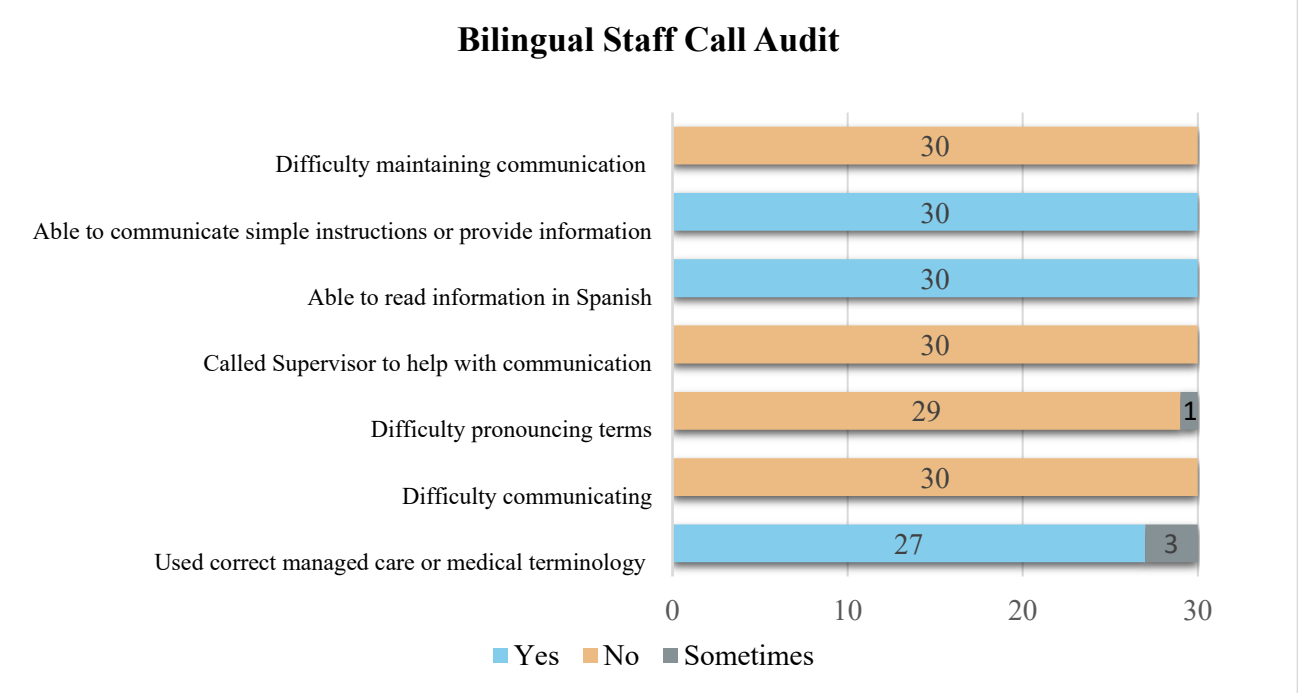
Call Number	Interpreter ID	Language	Medical Interpreter Skills Assessment Date	Medical Interpreter Skills Assessment Result	QA Observation Date	QA Observation Score
CR-0581039701	477434	SPANISH	7/14/2025	Pass		
CR-	367684	ARABIC	1/28/2021	Pass	12/11/25	3/3
CR-	459336	ARABIC	11/16/2024	Pass	10/28/25	3/3
CR-	447674	TAGALOG	7/16/2024	Pass	12/23/25	3/3
CR-	401260	TAGALOG	9/22/2025	Pass	10/08/25	2/3
CR-	395379	SPANISH	11/29/2022	Pass	11/26/25	3/3
CR-	357545	TAGALOG	3/4/2020	Pass	12/29/25	3/3
CR-0589751557	472949	THAI	4/29/2025	Pass	10/30/25	3/3
CR-0589764795	477628	MANDARIN	7/15/2025	Pass	11/10/25	3/3
CR-0590457216	477331	DARI	6/10/2025	Pass	10/28/25	3/3
CR-0590443020	480368	SPANISH	8/28/2025	Pass	12/11/25	3/3
CR-0590472510	474967	SPANISH	6/2/2025	Pass	12/29/25	3/3
CR-0590467557	435711	SPANISH	12/10/2024	Pass	11/19/25	3/3
CR-	438465	SPANISH	11/15/2024	Pass	11/06/25	3/3
CR-	409406	KAREN	2/17/2023	Pass	12/03/25	3/3
CR-	456943	SPANISH	10/31/2024	Pass	12/12/25	3/3
CR-	389133	FARSI	2/25/2022	Pass	12/30/25	3/3
CR-0596461760	474831	VIETNAMESE	6/2/2025	Pass	11/11/25	3/3
CR-	453880	TAGALOG	9/23/2024	Pass	12/09/25	3/3
CR-	368379	YEMENI ARABIC	12/23/2020	Pass	11/26/25	3/3
CR-0603199774	481493	SPANISH	9/8/2025	Pass	11/03/25	3/3
CR-	410909	SPANISH	5/12/2023	Pass	12/19/25	3/3
CR-	410297	SPANISH	4/5/2023	Pass	12/08/25	3/3
CR-0603205935	470401	SPANISH	3/10/2025	Pass	10/24/25	3/3
CR-0603209705	475120	SPANISH	6/3/2025	Pass	10/13/25	3/3
CR-0603213101	485729	SPANISH	11/3/2025	Pass	12/05/25	3/2
CR-	409298	SPANISH	4/17/2023	Pass	10/31/25	3/3
CR-0603212522	483500	SPANISH	10/3/2025	Pass	11/05/25	3/3

Bilingual Staff Call Audit

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

Findings:

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



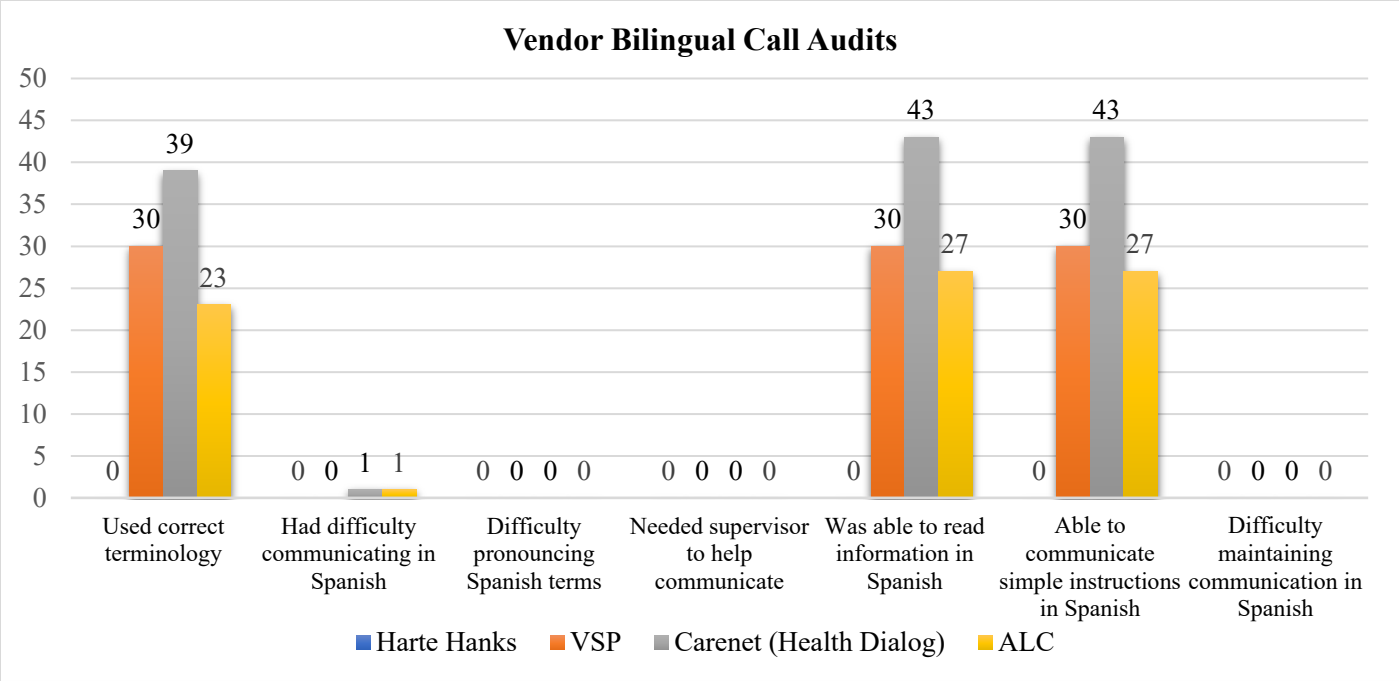
Post Call Survey

During this quarter, a total of 9,895 Spanish Post Call Survey responses were collected from members across all KHS member-facing departments. The survey is designed to assess members' experiences with bilingual staff, specifically evaluating the linguistic performance during calls conducted in Spanish. Findings revealed that 99% of surveyed members reported satisfaction with the bilingual staff's ability to communicate effectively in Spanish.



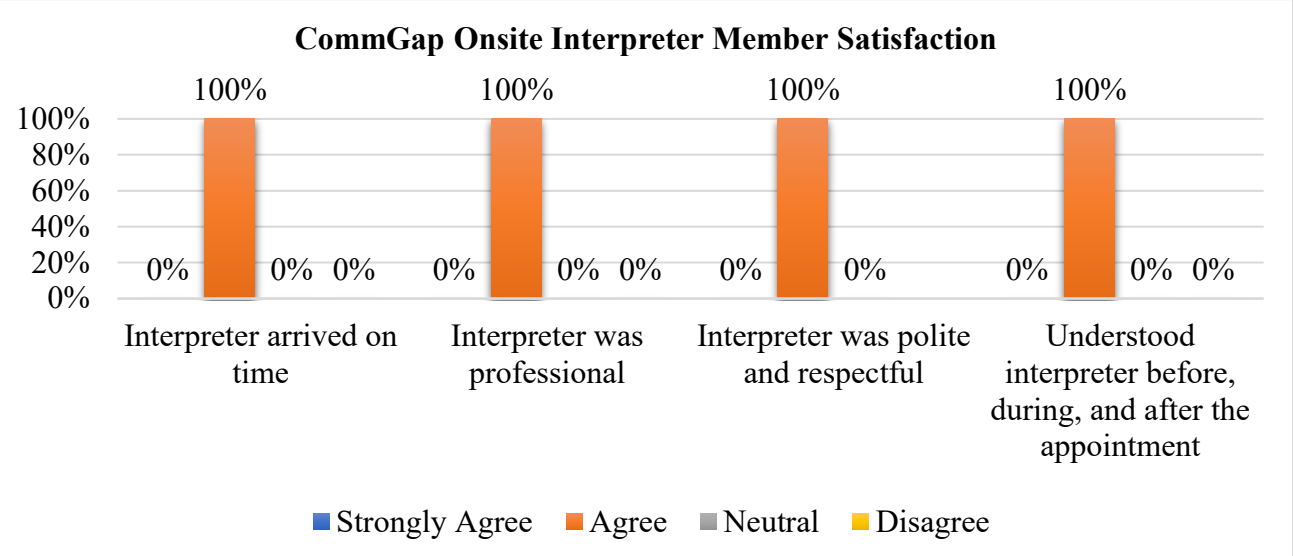
Vendor Bilingual Call Audits

During this quarter, a total of 100 Spanish audio calls were received from contracted vendors with KHS. These vendors include: VSP, Carenet, Harte Hanks, and ALC. These audio calls were reviewed to assess the linguistic performance of the vendor's bilingual staff. Findings revealed that 98% of bilingual staff did not have difficulty communicating with members in a non-English language.



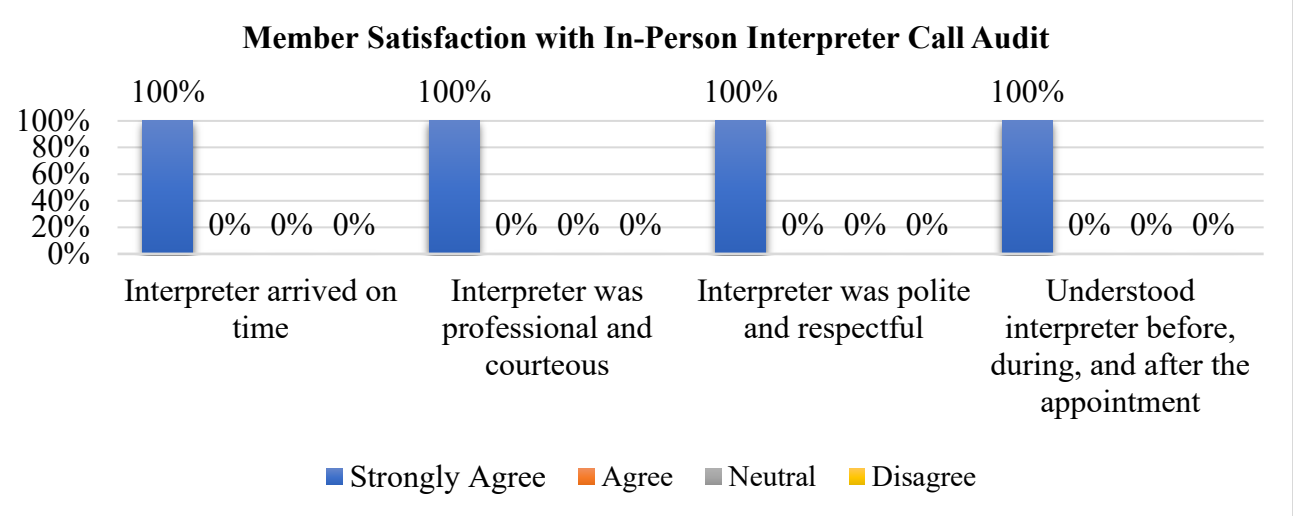
CommGap Onsite Interpreting Member Satisfaction Survey

During this quarter, an interpreter satisfaction survey was conducted by KHS's vendor, CommGap, targeting members who received onsite interpreter services during provider visits. A total of 18 members were surveyed following their in-person encounters. Of the 18 surveys sent out, 100% of respondents "Agreed" that they were satisfied with the interpreter services they received from the CommGap.



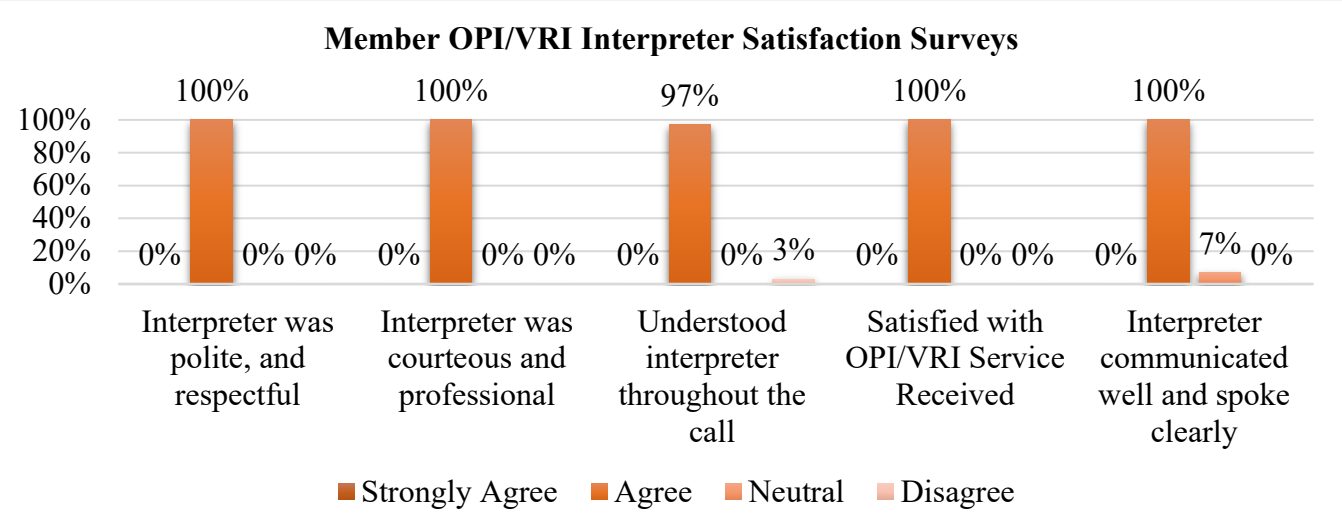
Member In-person Interpreting Satisfaction Call Surveys

During this quarter, a total of 34 satisfaction survey calls were conducted by the C&L specialists with members who received in-person interpreting services, either from KHS interpreters or through our vendor, CommGap. The survey results revealed a 98% satisfaction rate, indicating that members were highly satisfied with both the interpreters and the services they received.



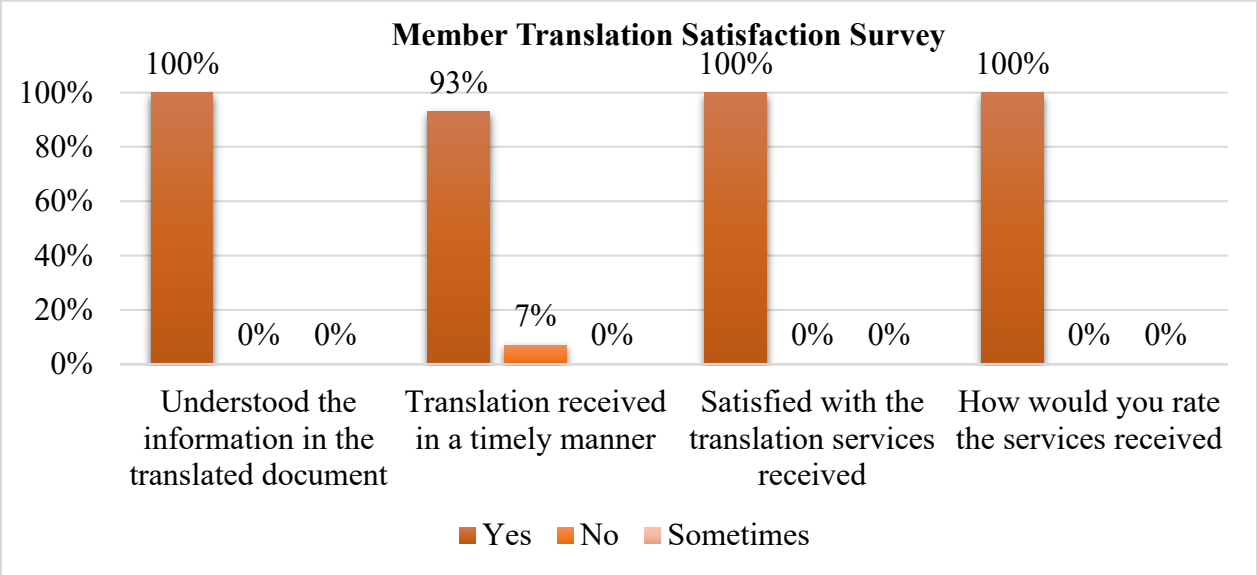
Member OPI & VRI Interpreting Satisfaction Call Survey

During this quarter, a total of 31 satisfaction survey responses were collected from members who received Over-The-Phone (OPI) and Video Remote (VRI) interpreting services. Of the 31 survey responses, 22 responses were for OPI services, and 9 responses were for VRI services. The survey concluded with 99% of members reporting they "Strongly Agreed" with being satisfied with the OPI/VRI interpreter services they received.



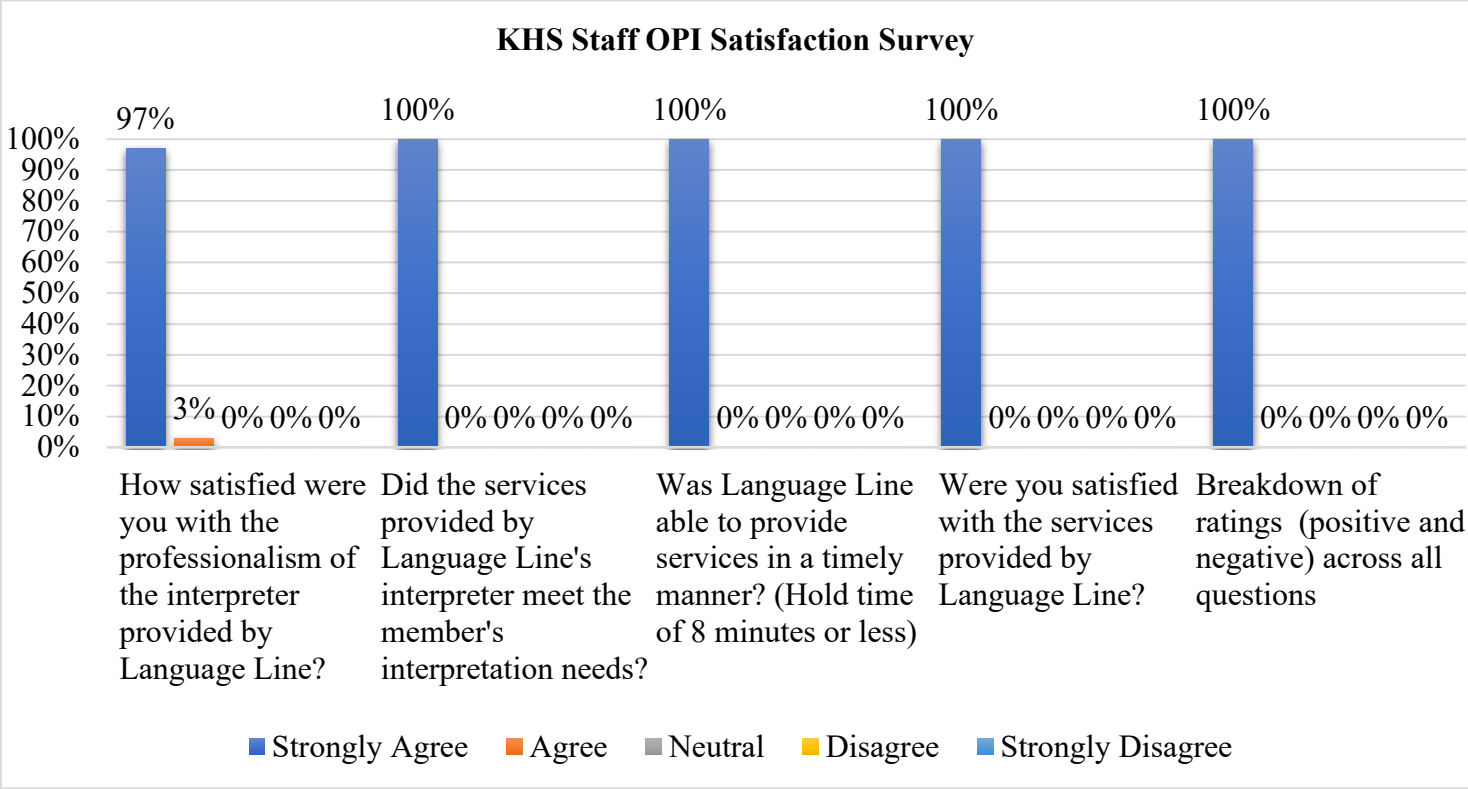
Translation Member Satisfaction Survey

During this quarter, a total of 30 translation satisfaction interviews were conducted for members who received a translation completed by C&L translators and by our vendor Language Line Solutions. The purpose of this survey is to determine the members' satisfaction regarding our translation services. Of the 30 calls completed, 98% of members were satisfied with the services received.



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

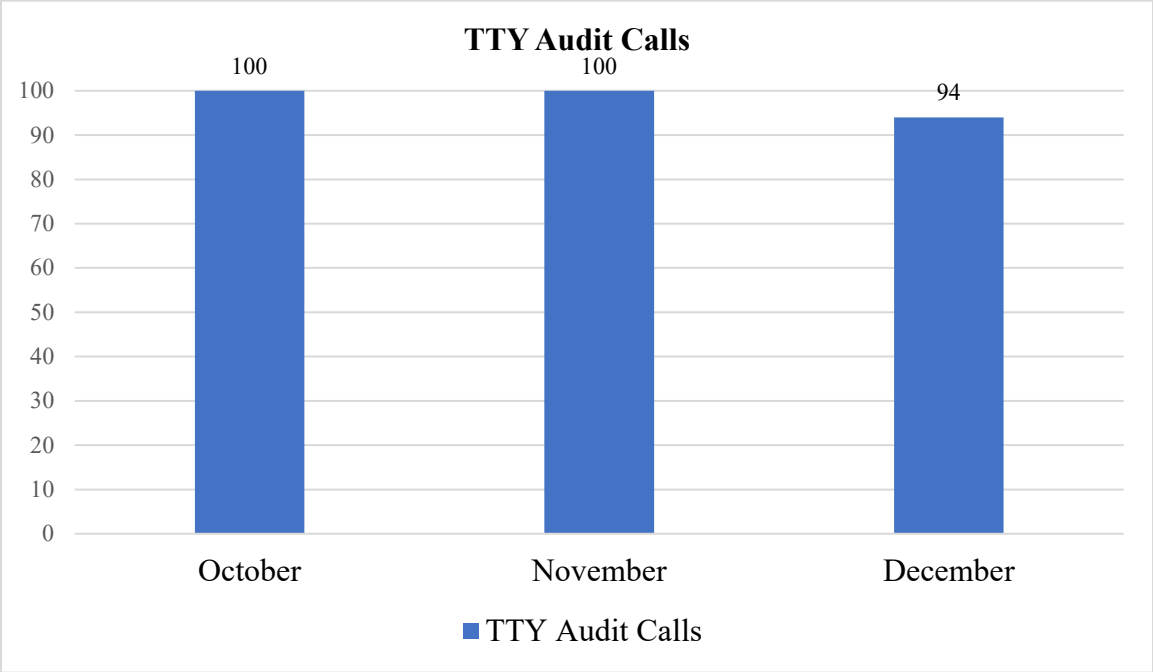
During this quarter, a total of 39 survey responses were received from KHS member-facing department staff regarding their satisfaction with our vendor Language Line Services concerning over-the-phone interpretation. Findings revealed that 100% of KHS staff are satisfied with the linguistic performance of our vendors' interpreters.

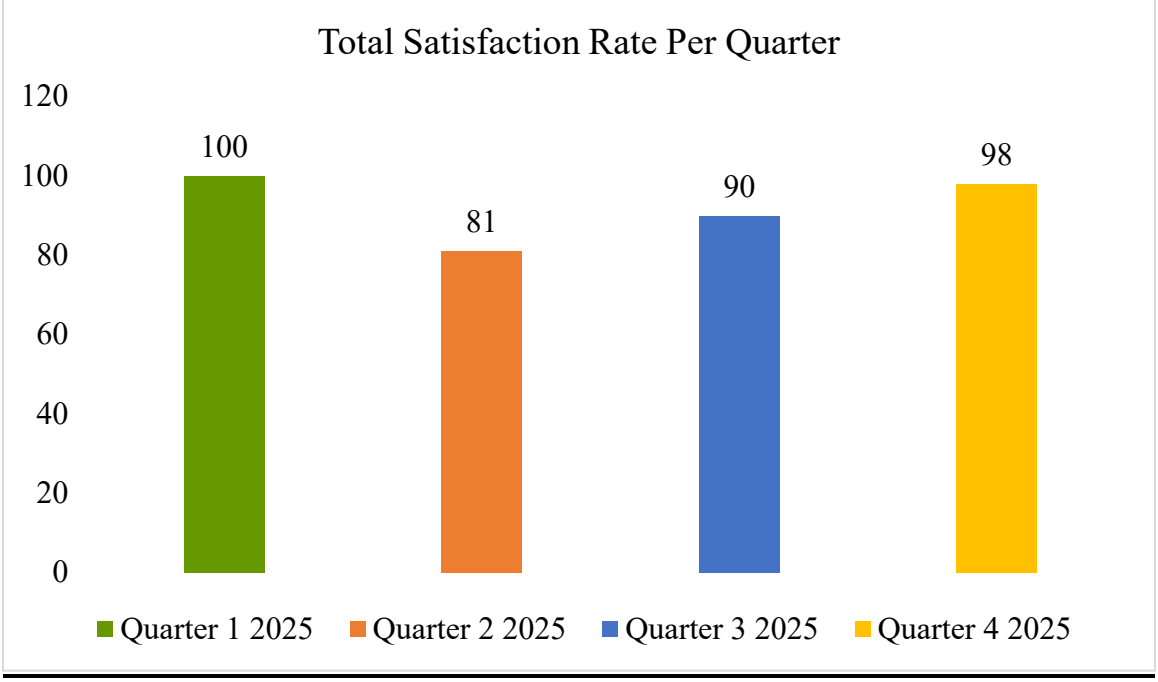


TTY (711 Relay)

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

In Quarter 4 of 2025, the TTY system audit calls showed 1 unsuccessful call out of 31 total call attempts. This represents a 98% success rate. Similarly, testing was conducted for the numbers of 31-711, 3-711.

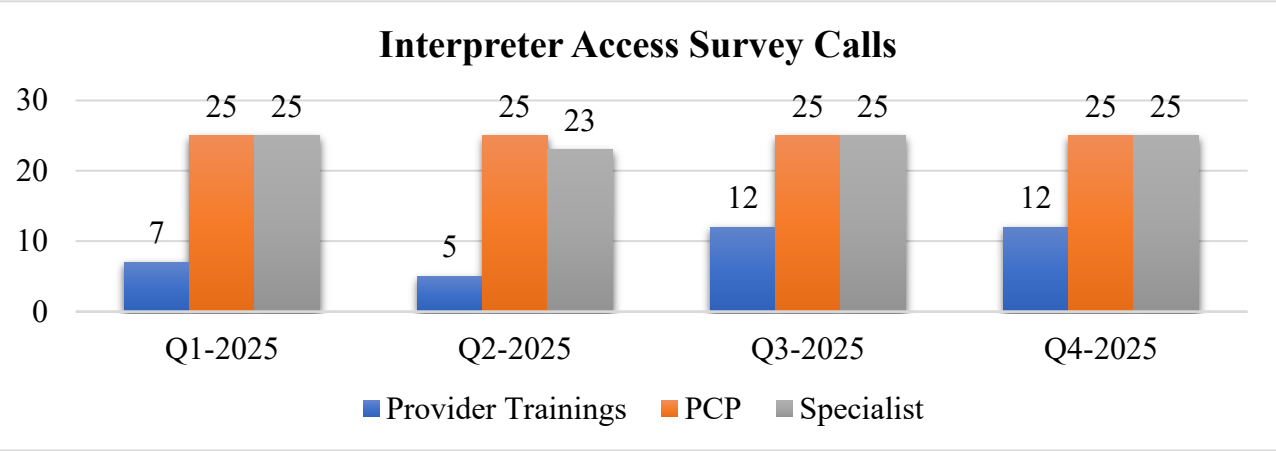

TTY Audit Calls
100
100
94
100
90
80
70
60
50
40
30
20
10
0
October
November
December
TTY Audit Calls


Total Satisfaction Rate Per Quarter
120
100
80
60
40
20
0
100
81
90
98
Quarter 1 2025
Quarter 2 2025
Quarter 3 2025
Quarter 4 2025

C&L Trainings

Interpreter Access Survey Calls

Each quarter, the Provider Network Management (PNM) department conducts an interpreter access survey among KHS providers. During Q4, 25 PCPs and 25 Specialists participated in this survey. Of these providers, 12 needed refresher training on KHS C&L services.



KHS Bilingual Staff Training

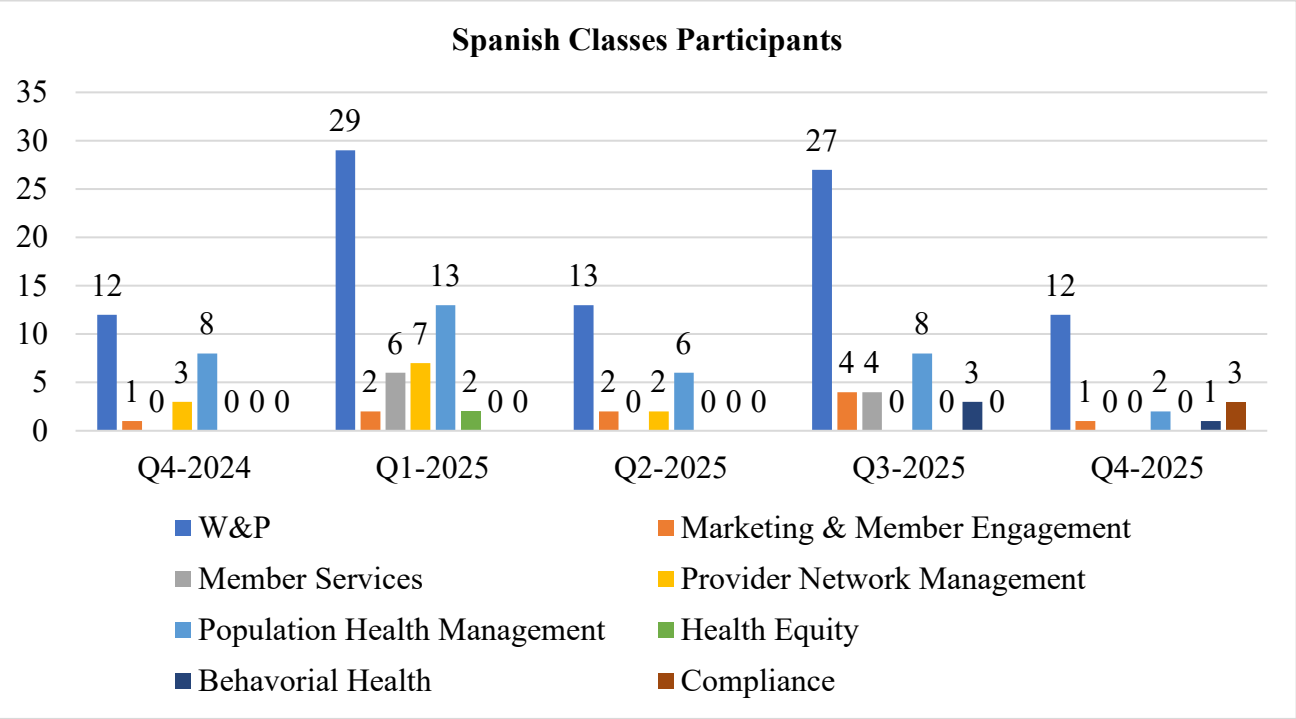
Spanish Classes for Bilingual Staff

The C&L Department supports the professional development of all KHS internal staff, with the focus on bilingual employees, by offering a series of Spanish language training sessions to enhance their skills. During Q4 2025, two classes were held in person with a total of 19 participants, representing several KHS departments, including PHM, C&L, W&P, Member Engagement, Behavioral Health, and Compliance.

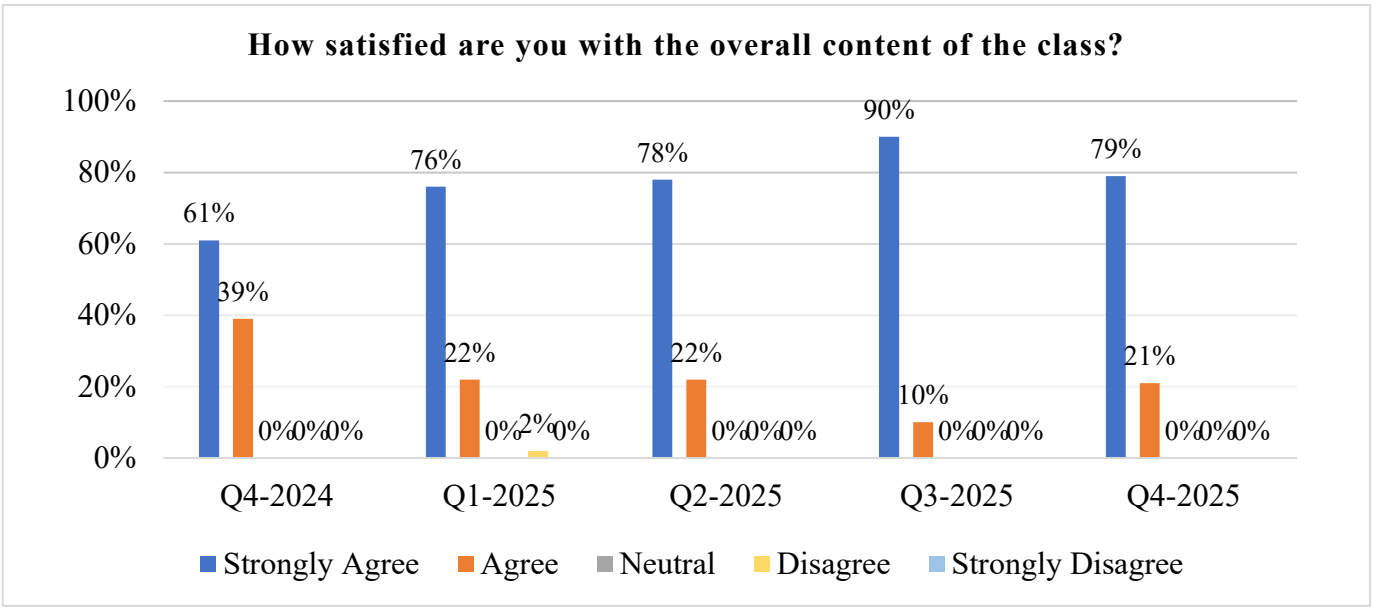
The classes provide participants with the opportunity to practice the four skills of a language: reading, writing, speaking, and listening. This quarter's classes focused on Spanish pronouns and articles. Participants engaged in listening, reading, and writing exercises, as well as speaking activities that involved practicing conversations using the correct Spanish pronouns and articles.

Compared to the four classes offered in Q3, attendance decreased by 29 participants due to the reduction in classes for this quarter. All attendees completed a pre-and-a-post survey, which provided valuable insights into their expectations, satisfaction levels, and areas of improvement.

Spanish Class Participants:



Spanish Class Satisfaction Survey



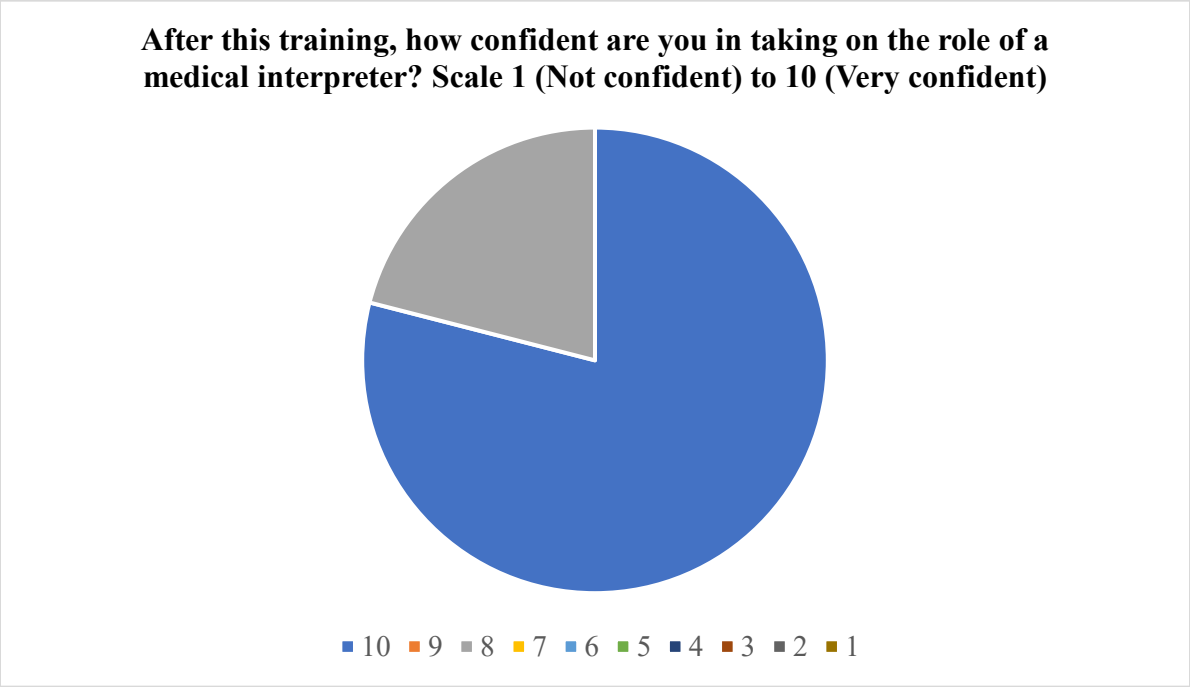
Bridge to Better Care Interpreter Training Program

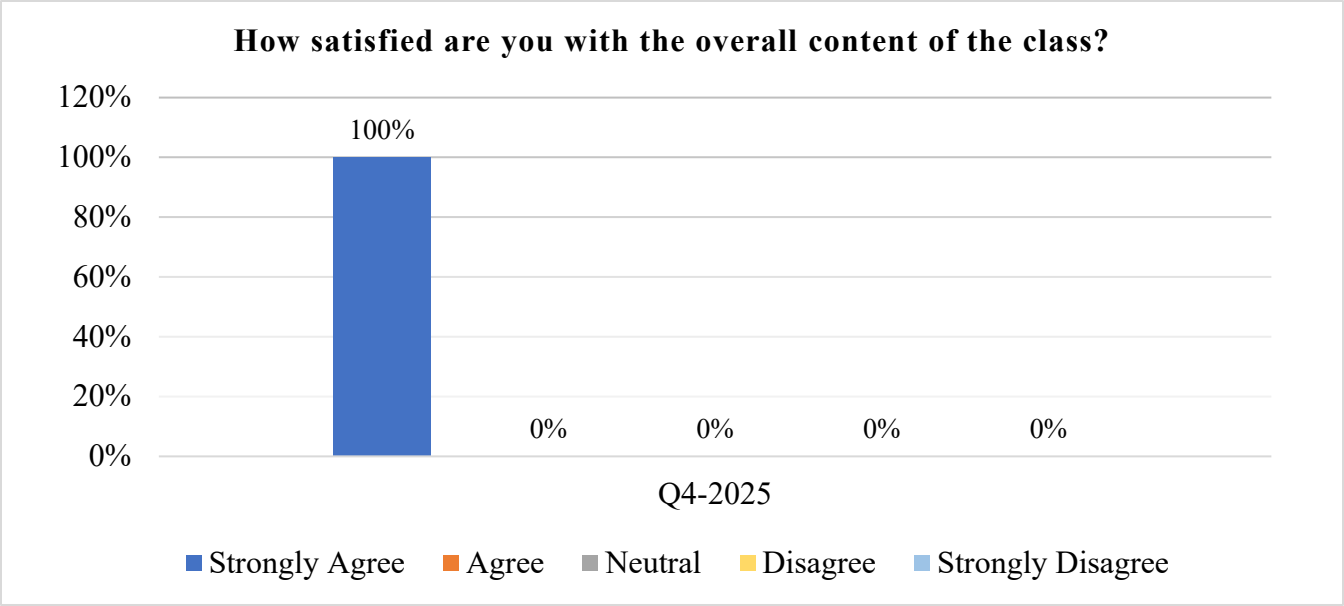
On Saturday, October 25th, 2025, Kern Family Health Care proudly hosted its first-ever **Bridge to Better Care Interpreter Training Program**—a full-day, hands-on learning experience designed specifically for our bilingual provider staff to strengthen language access and advance health equity across our community.
This innovative program reflects our ongoing commitment to ensuring that language is never a barrier to safe, respectful, and effective care.

Through this specialized training, 26 bilingual provider staff members gained essential interpreting skills, cultural awareness, and medical terminology knowledge, empowering them to serve as a vital link between patients and providers with greater confidence and professionalism.
Throughout the day, participants explored a wide range of topics designed to strengthen both technical expertise and cultural competency, including:

- **Language Access & Requirements** – Understanding why language matters and the laws that guide equitable access in health care.
- **Code of Ethics & Ethical Challenges** – Reviewing national standards and ethical frameworks from IMIA, NCIHC, and CCHI.
- **Interpreter Types & Credentials** – In-depth knowledge of interpreter categories, certification processes, qualifications, and credentialing requirements.
- **Localization Principles** – Engaging in interactive activities focused on culture, localization, and effective communication.
- **Interpreter Protocols & Skills** – Practicing interpreting stages, memory and message transfer skills, and professional note-taking techniques.
- **Medical Terminology** – Building a strong foundation in anatomy, medical tests, terminology, and abbreviations for accurate interpretation.
- **Professional Development** – Accessing valuable resources for ongoing growth as professional interpreters.

The success of the **Bridge to Better Care program** highlights Kern Family Health Care's dedication to serving the diverse communities of Kern County with equity, compassion, and excellence. By investing in our bilingual provider staff and empowering them through professional interpreter training, we are ensuring that every patient feels heard, understood, and cared for—regardless of the language they speak.



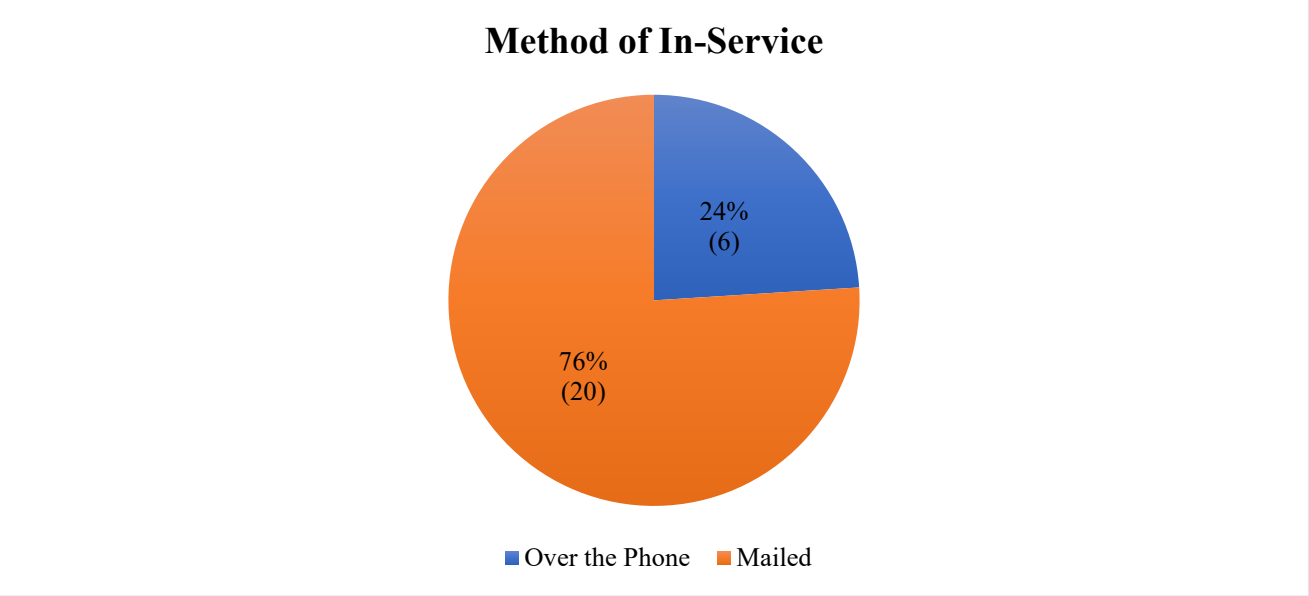


C&L Grievances - Provider In – Service Results:

In the third quarter of 2025, 19 Cultural and Linguistic (C&L) related grievances were filed against providers contracted with Kern Family Health Care (KFHC) due to a lack of language access. The Member Services (MS) Grievance department provides the Cultural and Linguistics (C&L) team with a quarterly member grievance report. For this quarter, 19 contracted providers were contacted, and a C&L Services in-service was provided. The Cultural & Linguistics team conducted 19 calls to providers. These call attempts were tracked and marked "complete" once all attempts were made. Those that were marked

"complete," were provided with an in-service via telephone, mail, and/or email. An in-person training is also available and offered to providers should they feel they would benefit from one.

Data was collected during the reporting period from July 2025 to September 2025 and the in-services were performed on December 2025, which consisted of informing providers who have received a language access related grievance of the cultural and linguistic services KFHC offers. The data collected from the calls were: number of call attempts, outcome of the call, and method of in-service provided.



Wellness and Prevention Department – 2025 Year End Highlights

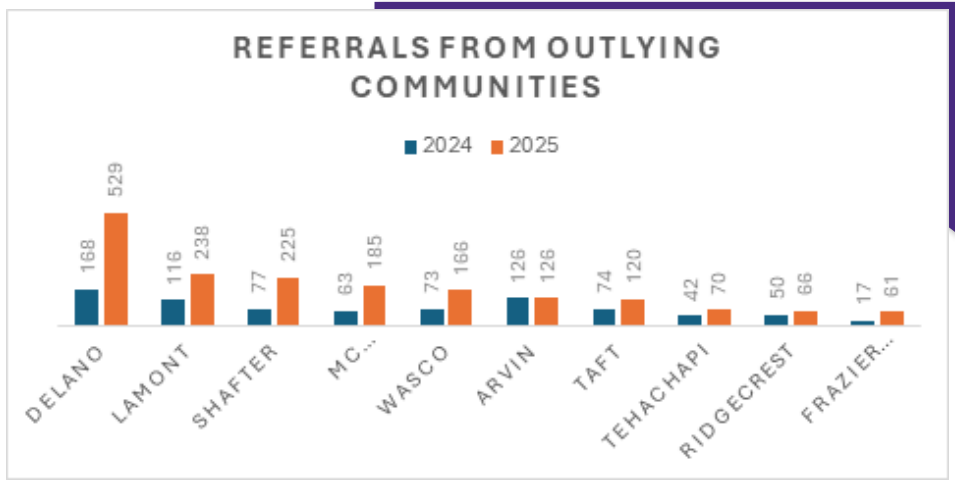
March 17, 2026

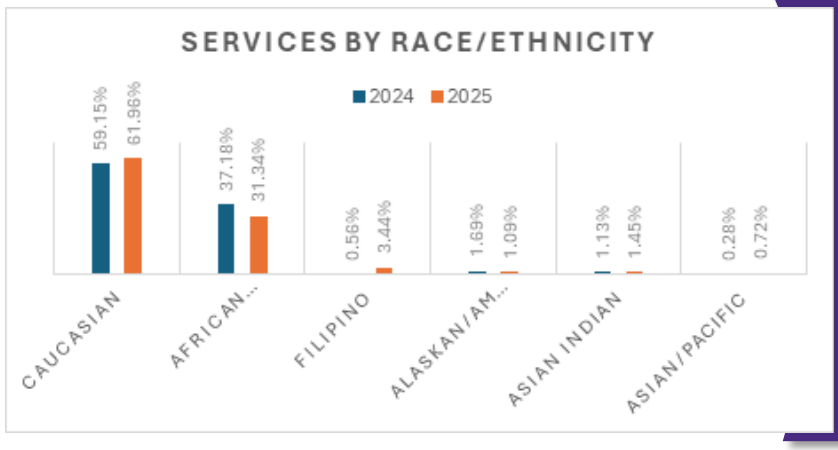
KERN HEALTH SYSTEMS

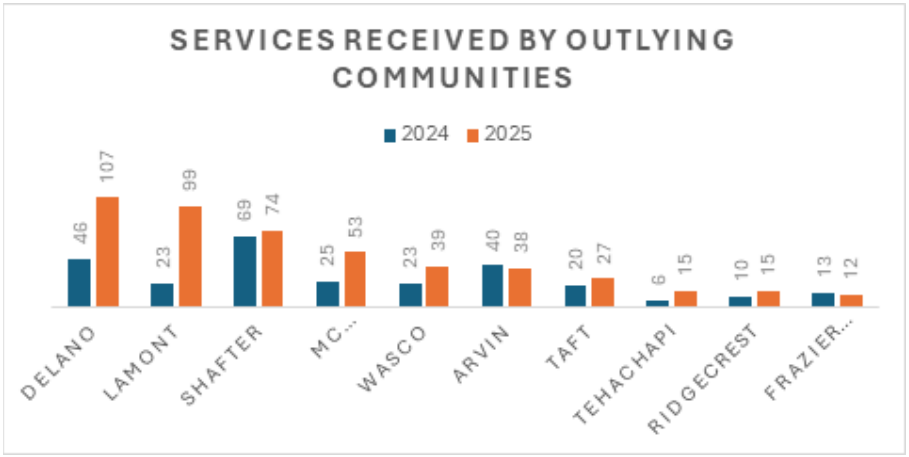
Member Wellness Program Participation Highlights

- **Expanded Virtual Outreach**
  - Broadening access to health education via digital platforms has enhanced member engagement and learning opportunities.
  - 30% increase in referrals compared to 2024

- **Regional Impact and Equity**
  - Not including Hispanics, increase in participation among top 5 races/ethnicities
  - Targeted expansion boosted program participation in Delano, Shafter, McFarland ad Wasco.
  - Rotating program locations with county library system
    - Nearby public transit stops reduced transportation barriers

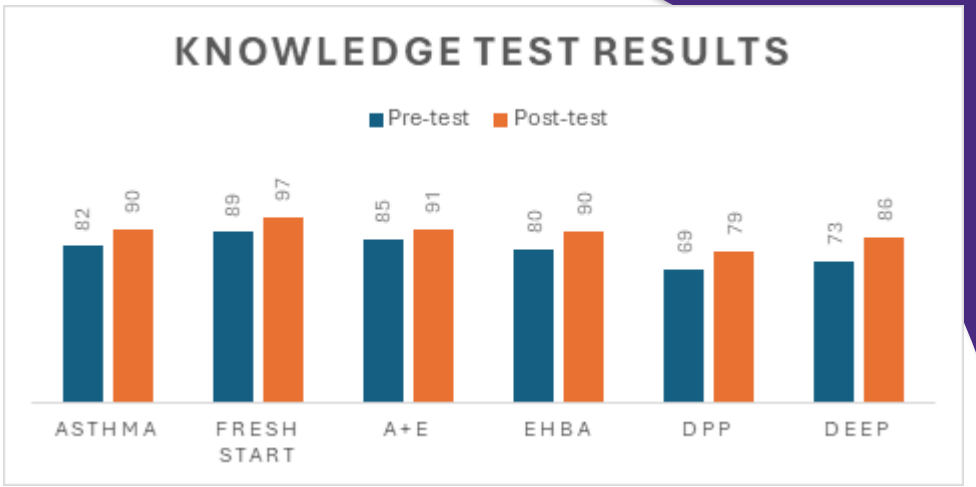


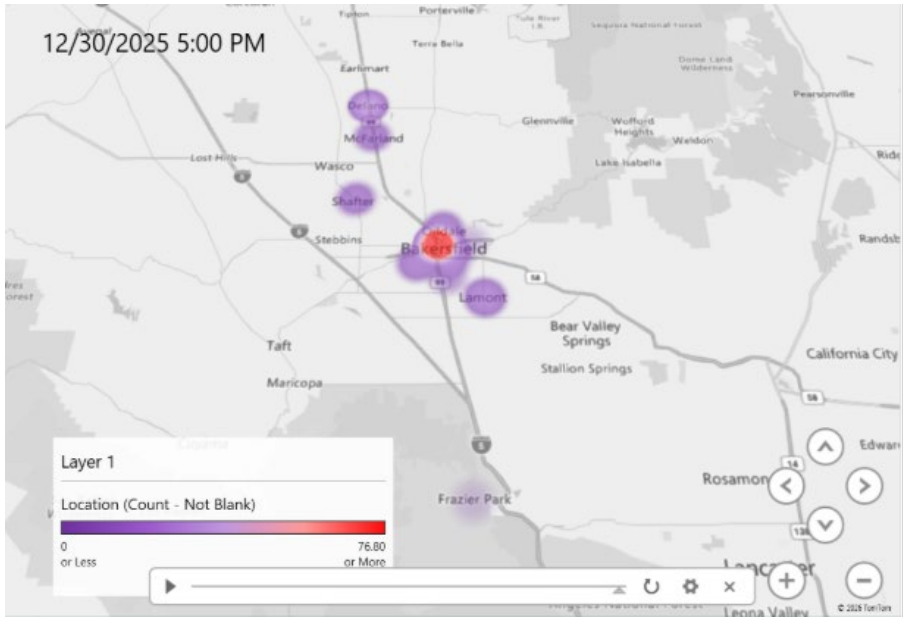




Member Satisfaction and Improved Program Accessibility Highlights

- **High Member Satisfaction**
  - Member satisfaction remains above 90% with 97% reporting positive experiences with wellness and prevention services.
- **Enhanced Health Literacy**
  - Both virtual and in-person educational programs improved members' knowledge of healthy lifestyle practices.
- **Accessible Program Design**
  - Flexible participation with in-person and virtual classes
  - Bilingual and interpreter services to remove language access barriers.
- **Technical Support for Virtual Access**
  - Technical assistance reduced digital literacy barriers.
  - Enables members to access virtual health education effectively.

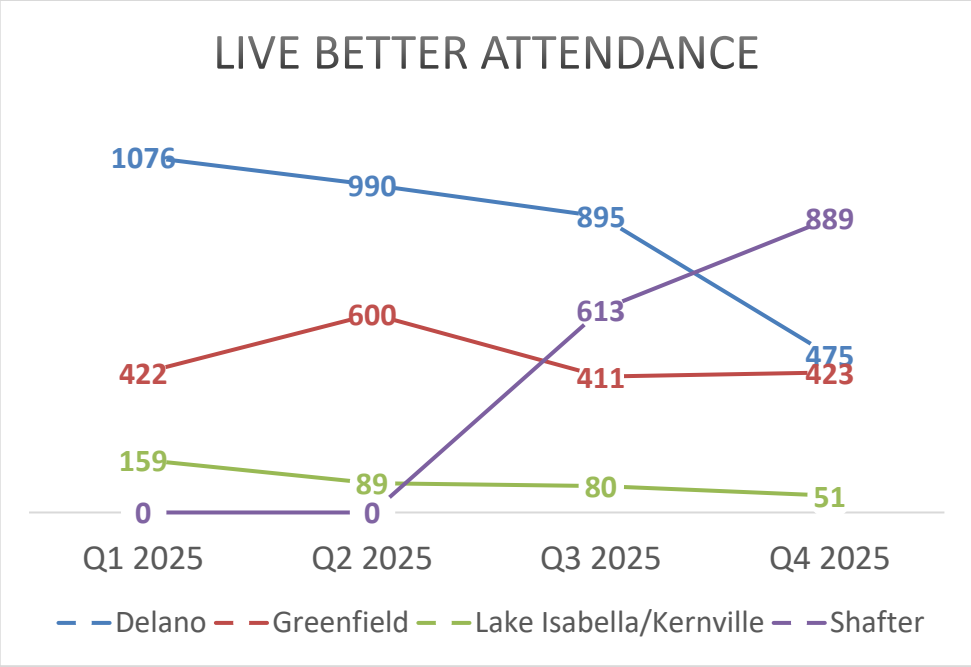




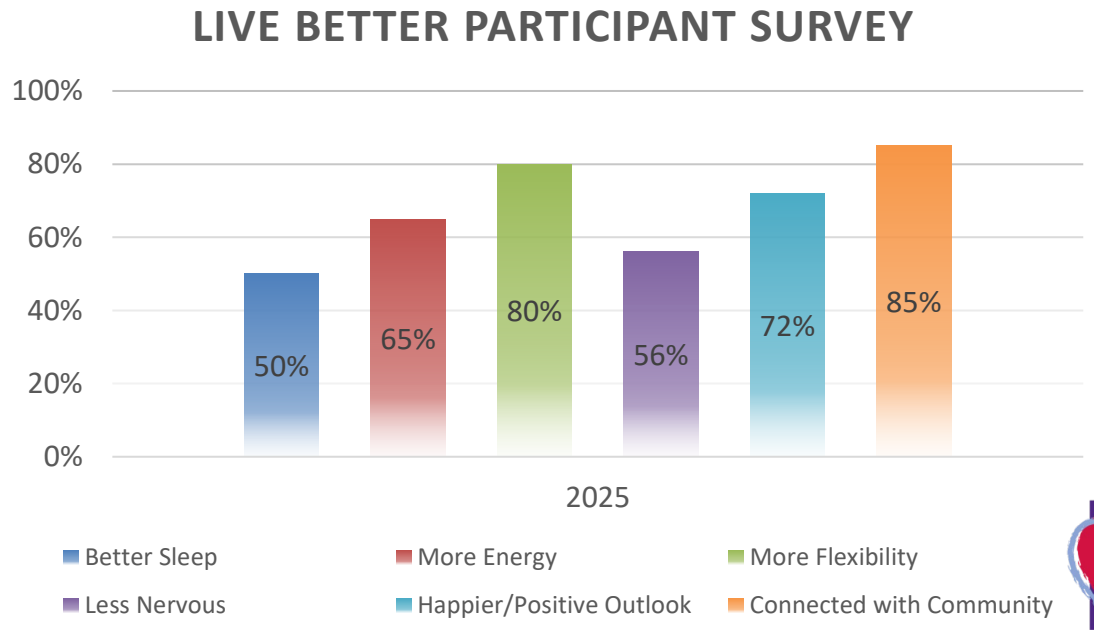
Community Health and Wellness

Highlights

- **Live Better Program**
  - 6 sites now open
  - Newes sites: Shafter and Wasco Parks and Recreation
  - 7,000+ community participants



- **Satisfaction Survey (June – August 2025)**
  - Areas of focus: Physical health, Mental health, Sleep, Human connection
  - 66 respondents (Delano, Greenfield, Lake Isabella)
  - Length in program: 55% joined 6+ months ago
  - Average weekly visits: 76% visit 3-5 times



School Wellness Grant

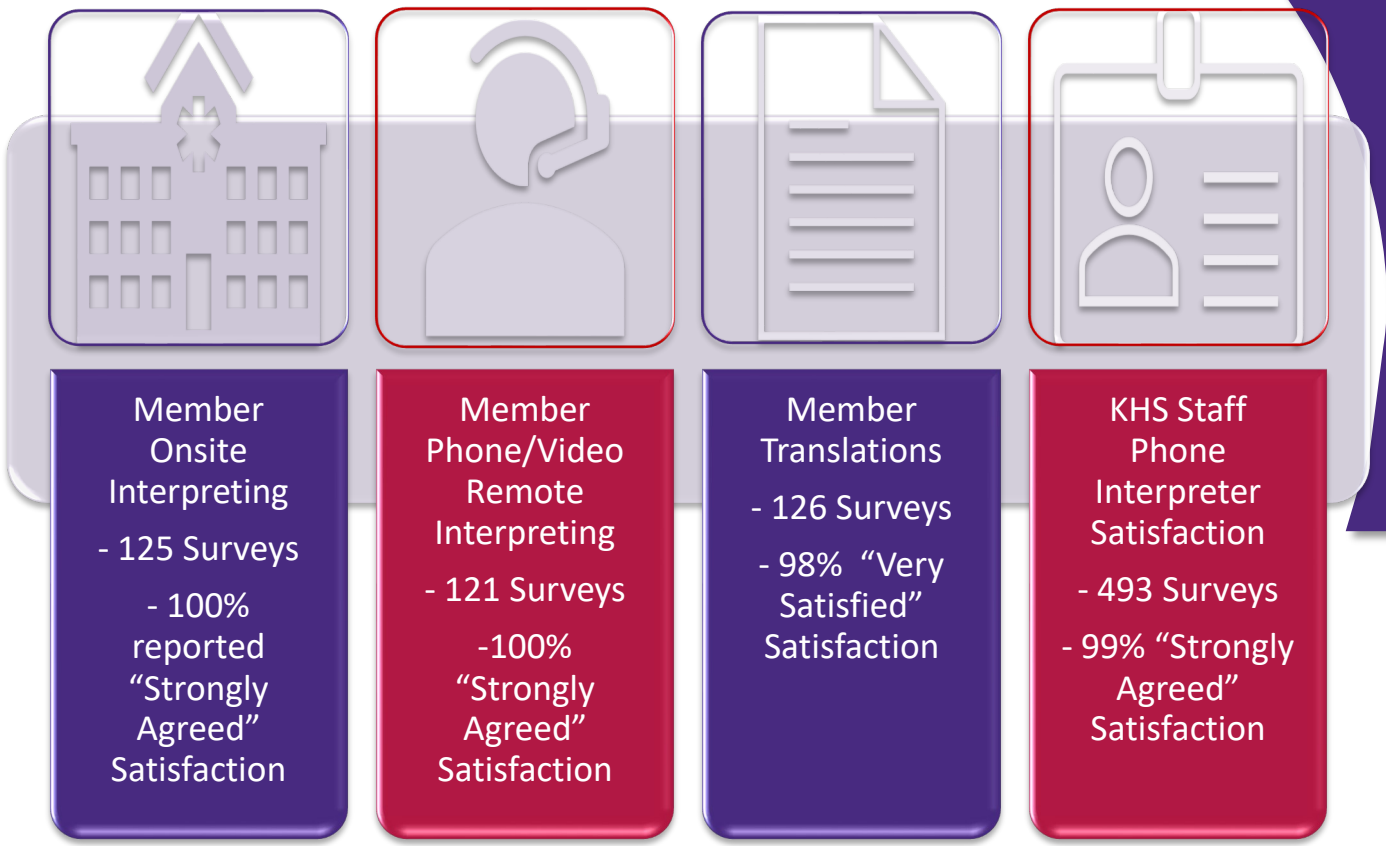
Highlights

10 Schools Awarded/8,000+ Students Impacted = $386,000 Total Funding
Clemens Elementary (Wasco) – Caring Closet + parent nights
Harding Elementary – Water filtering systems in classrooms, portable sun shades
Las Flores Elementary (Ridgecrest) – school gardens, new recess equipment and reduction in discipline referrals
McAuliffe Elementary – Adaptive/sensory accessible playground equipment and zen garden
Nueva High School (Lamont) – Cooking and Zumba classes, Parent education nights
Pierce Elementary (Ridgecrest) – High parent engagement at Monthly Family STEAM Nights
Richland School District (Shafter) – Zumba and nutrition classes + 300 lbs of food distributed
Vineland School District – Vision Clinic
Wasco Union High School – Student Wellness Corner
Wasco Independence High – Outdoor gym equipment

Cultural and Linguistic Services

Highlights

- 12,680 written translations completed
- 1,920 onsite interpreter requests fulfilled
- 1,000 audits conducted with 94% compliance
- 14 Spanish communication classes for bilingual KHS staff
- 23 provider staff attended the Bridge to Better Care Interpreter Training Program



THANK YOU!

Questions?

Isabel Silva, MPH

Senior Director of Wellness & Prevention

661-664-5117

isabel.silva@khs-net.com

KERN HEALTH SYSTEMS

To: Executive Quality Improvement Health Equity Committee (EQIHEC)

From: Nate Scott, Director of Member Services

Date: March 17, 2026

Re: Grievance Report – Operation Board Update Q4 2025

Background:

When compared to the previous four quarters, the following grievance trends were identified.

There was a notable decrease in the Plan's overall grievance volume in the fourth quarter of 2025 compared to the third quarter, with total grievances declining by 25.45%. This aligns with the Plan's historical trend of reduced grievance activity during fourth quarters. Exempt grievances experienced a similar decrease, dropping 26.6% from the previous quarter.

Despite these reductions, Appeals increased by 31.5% from quarter three to quarter four. This rise continues to be driven by changes to eligibility criteria for several Community Support Services (CSS) benefits and Applied Behavioral Analysis (ABA) therapy services. Additional details regarding these appeals are provided in the following sections.

Access to Care, Quality of Service, and Quality of Care remained the top three grievance categories for the quarter.

For CSS appeals, KHS conducted a comprehensive evaluation of its Community Support Services, focusing on utilization trends, cost-effectiveness, and member outcomes. The analysis identified consistently high utilization rates across several services but demonstrated a less-than-favorable return on investment. In response, implemented additional oversight for Medically Tailored Meals (MTM) between late May and early June 2025 to better align the service with DHCS eligibility requirements. These refinements ensure that only members with medically sensitive conditions are approved for the benefit. Given the high volume of referrals historically received for this service, KHS anticipated an increase in grievances/appeals from members who no longer qualified under the updated criteria and the additional oversight.

For ABA appeals, when KHS reviewed clinical services, an audit showed possible overuse of ABA services. A random sample of cases was sent to an Independent Review Organization approved by the Department of Health Care Services. These files were reviewed by a provider trained in ABA services. Most of the records in the sample did not meet medical necessity. The Department of Health Care Services requires us to investigate possible overuse and put processes

in place to prevent it. To meet this requirement, KHS partnered with AllMed, an organization with trained providers who review ABA services for other health plans in California. Since starting this process, we have seen more denials of ABA services. We take this issue very seriously and are making sure denials are appropriate. We are also giving training to ABA providers and to AllMed reviewers to prevent inappropriate denials that could cause more grievances and appeals.

KHS Grievance and Appeals per 1,000 members = 2.93 per month.

Requested Action:
Review for approval.

4th Quarter 2025 Operational Report

Alan Avery
Chief Operating Officer

4rd Quarter 2025 Grievance Report

Category2	Q4 2025	Status	Issue	Q3 2025	Q2 2025	Q1 2025	Q4 2024
Access to Care	**660**		Appointment Availability	897	832	713	603
Coverage Dispute	**0**		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	**562**		Questioning denial of service	385	220	192	241
Other Issues	**125**		Miscellaneous	201	165	141	134
Potential Inappropriate Care	**502**		Questioning services provided. All PIC identified cases forwarded to Quality Dept.	587	493	535	476
Quality of Service	**564**		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	785	702	654	509
Discrimination (New Category)	**63**		Alleging discrimination based on the protected characteristics	81	78	81	71
Total Formal Grievances	**2476**			2936	2490	2316	2034
Exempt	**799**		Exempt Grievances-	1088	985	683	644
Total Grievances (Formal & Exempt)	**3275**			4024	3475	2999	2678

KERN HEALTH SYSTEMS

Additional Insights-Formal Grievance Detail

Issue	Q4 2025 Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	272	182	0	81	9
Coverage Dispute	0	0	0		
Specialist Access	388	207	0	141	40
Medical Necessity	562	421	0	136	5
Other Issues	125	94	0	14	17
Potential Inappropriate Care	502	375	0	85	42
Quality of Service	564	397	0	103	64
Discrimination	63	52	0	3	8
Total	2476	1728	0	563	185

KERN HEALTH SYSTEMS

To: Executive Quality Improvement Health Equity Committee (EQIHEC)

From: Nate Scott, Director of Member Services

Date: March 17, 2026

Re: Grievance Summary Report Q4 2025

Background:
For the fourth quarter of 2025, Kern Health Systems received a total of three thousand, two hundred seventy-five (3,275) Grievances and Appeals (G&A). The top three grievance categories were as follows:

- Access to Care/Difficulty Accessing Specialists – 20.2% of all grievances received
- Quality of Service – 17.2% of grievances received
- Quality of Care – 15.3% of grievances received

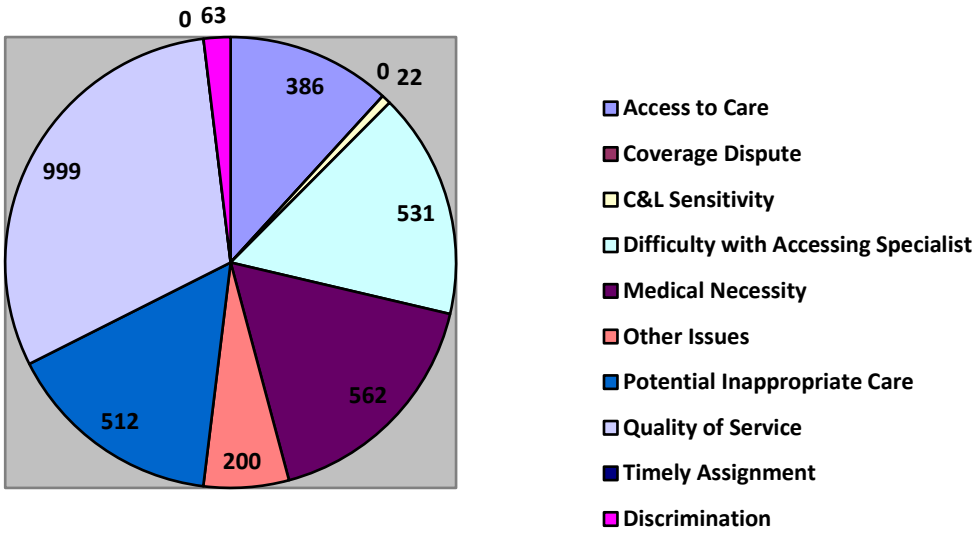
Of the 3,275 G&A received:

- 2,476 (75.6%) were Standard Grievances, which required up to 30 days for investigation and resolution
- 799 (24.4%) were Exempt Grievances, resolved within one business day
- 1,321 (40.33%) were closed in favor of the enrollee
- 1,774 (54.17%) were closed in favor of the plan/provider
- 180 (5.5%) remain open and under review

Requested Action:
Review for approval.

4th Quarter 2025 Grievance Summary

Issue	Number	In Favor of Health Plan	In favor of Enrollee	Still under review
Access to care	386	167	210	9
Coverage dispute	0	0	0	0
Cultural and Linguistic Sensitivity	22	11	11	0
Difficulty with accessing specialists	531	191	300	40
Medical necessity	562	427	135	0
Other issues	200	100	83	17
Potential Inappropriate care	512	384	86	42
Quality of service	999	442	493	64
Timely assignment to provider	0	0	0	0
Discrimination	63	52	3	8



Type of Grievances

KHS Grievances and Appeals per 1,000 members = 2.93 /month

During the 4th quarter of 2025, the Plan received 3,275 grievances and appeals.

- 2,476 were standard cases.
- 799 were exempt and closed within one business day.
- 1,774 cases closed in favor of the Plan because they received the appropriate services.
- 1,321 cases closed in favor of the Enrollee because they may not have received the appropriate services.
- 180 cases are still under review.
- 2,745 cases closed within 30 days, and 350 took longer than 30 days.

Access to Care

4th Quarter 2025 Grievance Summary

There were 386 grievances about access to care.

- 249 were standard cases.
- 137 were exempt cases.
- 167 closed in favor of the Plan.
- 210 closed in favor of the Enrollee.
- 9 are still under review.

The following is a summary of these issues:

160 members had trouble getting an appointment with their Primary Care Provider (PCP).

- 55 closed in favor of the Plan.
- 102 closed in favor of the Enrollee.
- 3 are still under review.

31 members complained about long wait times at PCP visits.

- 16 closed in favor of the Plan.
- 14 closed in favor of the Enrollee.
- 1 is still under review.

86 members had trouble reaching their PCP by phone.

- 37 closed in favor of the Plan.
- 47 closed in favor of the Enrollee.
- 2 are still under review.

105 members said their provider did not submit a referral request quickly enough.

- 57 closed in favor of the Plan.
- 45 closed in favor of the Enrollee.
- 3 are still under review.

3 members complained about geographic access.

- 1 closed in favor of the Plan.
- 2 closed in favor of the Enrollee.

1 member complained about access to an out-of-network provider.

- Closed in favor of the Plan.

.

Coverage Dispute

There were no grievances in this category.

Cultural and Linguistic Sensitivity

There were 22 grievances about interpreting services.

- 16 were standard cases.
- 6 were exempt cases.
- 11 closed in favor of the Plan.
- 11 closed in favor of the Enrollee.

4th Quarter 2025 Grievance Summary

Difficulty with Accessing a Specialist

There were 531 grievances in this category.

- 364 were standard cases.
- 167 were exempt cases.
- 191 closed in favor of the Plan.
- 300 closed in favor of the Enrollee.
- 40 are still under review.

The following is a summary of these issues:

86 members said referral requests were not submitted on time.

- 37 closed in favor of the Plan.
- 44 closed in favor of the Enrollee.
- 5 are still under review.

135 members had trouble with scheduling transportation services.

- 43 closed in favor of the Plan.
- 86 closed in favor of the Enrollee.
- 6 are still under review.

90 members said drivers did not arrive on time.

- 39 closed in favor of the Plan.
- 43 closed in favor of the Enrollee.
- 8 are still under review.

101 members had trouble getting specialist appointments.

- 31 closed in favor of the Plan.
- 60 closed in favor of the Enrollee.
- 10 are still under review.

92 members had trouble reaching specialist offices by phone.

- 32 closed in favor of the Plan.
- 52 closed in favor of the Enrollee.
- 8 are still under review.

23 members reported long wait times for specialist appointments.

- 8 closed in favor of the Plan.
- 13 closed in favor of the Enrollee.
- 2 are still under review.

1 member had trouble with physical access.

- It closed in favor of the Enrollee.

3 members complained about geographic access to specialists.

- 1 closed in favor of the Plan.
- 1 closed in favor of the Enrollee.
- 1 is still under review.

4th Quarter 2025 Grievance Summary

Medical Necessity

There were 562 appeals.

- 427 closed in favor of the Plan. 12 were partially overturned.
- 135 closed in favor of the Enrollee.

Other Issues

There were 200 grievances that did not fit into other categories.

- 129 were standard cases.
- 71 were exempt cases.
- 100 closed in favor of the Plan.
- 83 closed in favor of the Enrollee.
- 17 are still under review.

Potential Inappropriate Care

There were 512 standard grievances in this category. These cases were sent to the Quality Improvement (QI) Department for their due process.

- 384 closed in favor of the Plan.
- 86 closed in favor of the Enrollee.
- 42 are still under review.

Quality of Service

There were 999 grievances in this category.

- 581 were standard cases.
- 418 were exempt cases.
- 442 closed in favor of the Plan.
- 493 closed in favor of the Enrollee.
- 64 are still under review.

Timely Assignment to Provider

There were no grievances in this category.

Discrimination

There were 63 standard grievances in this category.

- 52 closed in favor of the Plan.
- 3 closed in favor of the Enrollee.
- 8 are still under review.

All discrimination grievances are sent to the DHCS Office of Civil Rights.

KERN HEALTH SYSTEMS

To: Executive Quality Improvement Health Equity Committee (EQIHEC)

From: Christine Pence, Director of Health Services

Date: March 17, 2026

Re: Utilization Management (UM) Department Reporting Q4 2025

Background:
Utilization Management (UM) continues to be focused on ensuring KHS members receive medically necessary care at the right time in the most appropriate setting. To achieve this goal, UM works diligently to ensure all department processes are regulatorily compliant, staff is well trained, and all decision are made based on medical necessity and in accordance with regulatory directive and the Plan contract with DHCS.

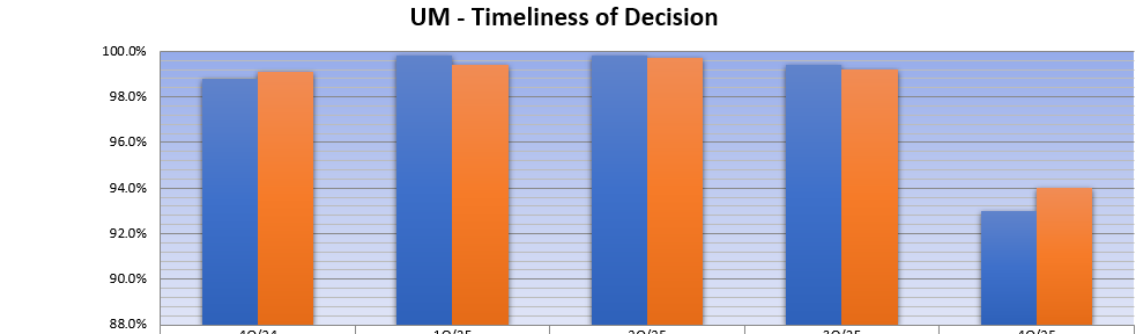
Discussion Items:
This report contains a synopsis of both quantitative and qualitative analytics that reflect the performance of the Utilization Management Department's in the 4th quarter of 2025.

Fiscal Impact:
None.

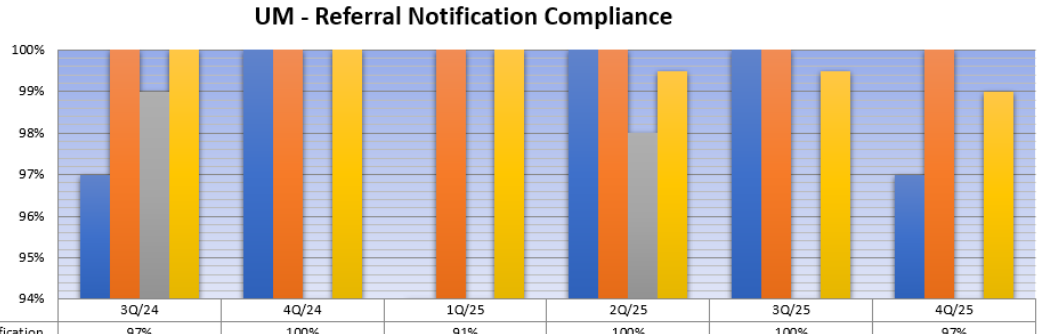
Requested Action:
Review for approval.

UM 2025 Quarter 4 KPI Report

Key Objective #1: Timeliness of decision making and notification to ensure compliance with regulatory standards



	4Q/24	1Q/25	2Q/25	3Q/25	4Q/25
Urgent Compliance %	98.8%	99.8%	99.8%	99.4%	93.0%
Routine Compliance %	99%	99%	100%	99%	94%



	3Q/24	4Q/24	1Q/25	2Q/25	3Q/25	4Q/25
Member Notification	97%	100%	91%	100%	100%	97%
Provider Notification	100%	100%	100%	100%	100%	100%
Criteria Included	99%	93%	92%	98%	79%	91%
MD Signature Included	100%	100%	100%	100%	100%	99%

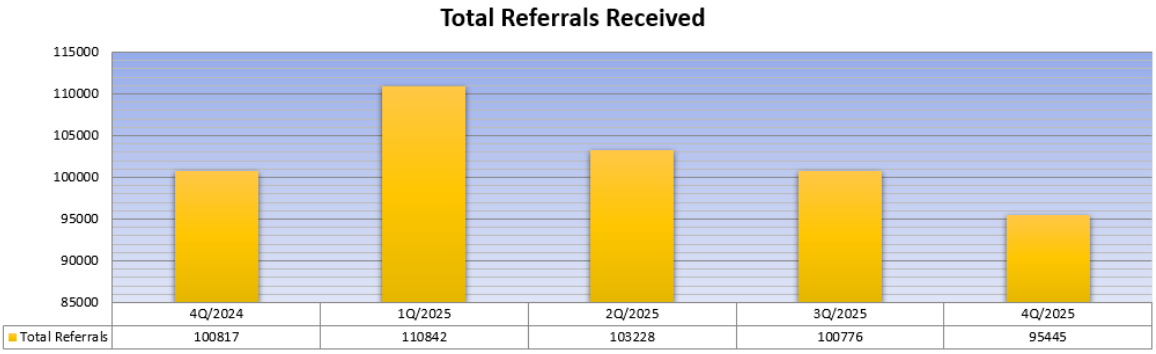
Maintaining the timeliness of decision making (aka turnaround times) in the 4th quarter was challenging. This was primarily due to the addition of services to the Prior Authorization list, and reductions in UM staffing.

The UM team made significant improvement in the percentage of audited reviews that have the criteria included. The goal is to continue to improve to ensure at least 95% compliance.

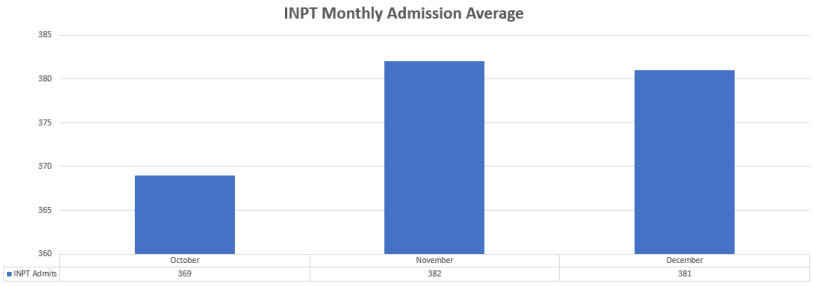
Inpatient and Outpatient Referral Summary :

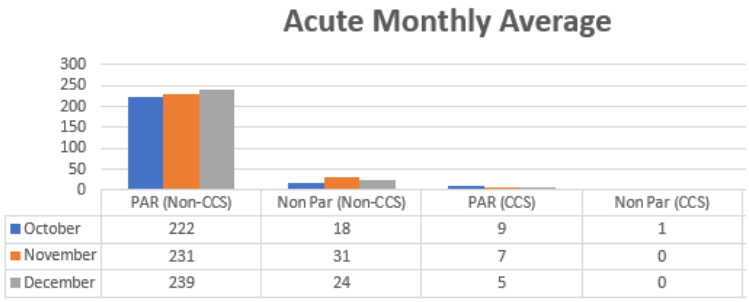
Key Objective #2: Evaluate service utilization and monitor for trends.

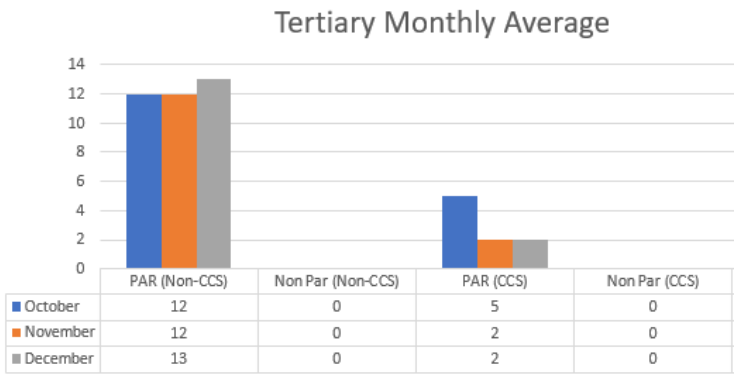
Outpatient Referrals Received:



Inpatient Utilization





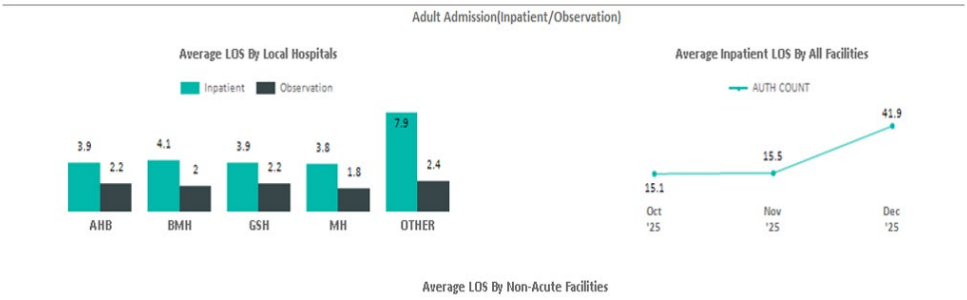


	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)
October	12	0	5	0
November	12	0	2	0
December	13	0	2	0

KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(Inpatient/Observation)

Dates of Discharge Between : 10/1/2025-12/31/2025

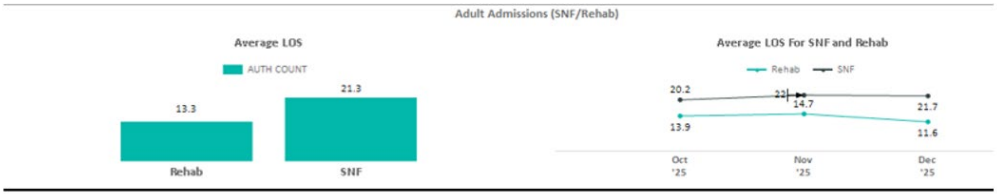


Post-Acute Statistics:

KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(SNF/Rehabilitation)

Dates of Discharge Between : 10/1/2025-12/31/2025



2025 4th Quarter Denial Percentage

	October 2025	November 2025	December 2025
Total referrals processed for the entire month: (total number of referrals approved, modified, denied etc. during the month)	36,205	29,192	32,984
Total referrals denied for medical necessity:	2,346	2,028	2,930
Percent of referrals denied:	6.5%	6.2%	8.8%

Prior authorization requests are consistent with previous quarters. There was a slight reduction in the number of average acute admissions and tertiary admissions compared to the 3rd quarter. The average admissions and length of stay for Skilled Nursing Facilities and Rehabilitation also had a slight reduction compared to the 3rd quarter. The average length of stay for all admissions increased from the 3rd quarter.

The 4th quarter had a higher percentage of referrals denied compared to other quarter, which reflects prior authorization reviews of Behavioral Health Therapy services, and changes in Community Support Service criteria to reflect revised DHCS guidance.

Key Objective #3: Ensure compliance with regulatory requirements for appropriate processing and communication of decision to provider and member.

Below is a summary of the 2025 Quarter 4 audits from the sample reviewed. A summary of 2024 is also included for comparison and to trend progress.

- Five percent (5%) fewer referrals were requested from Quarter 3. The percentage of modified and delayed referrals remained consistent with an increase in the percentage of denied referrals. The increase in percentage of denied referrals is related to adding services that needed to be added to the PA list. Services added to the PA list were identified based on our review of services that are outliers and associated medical necessity chart reviews.
- Looking at 2025 Quarter 4 and comparing the trends to 2025 Quarter 3, the errors in mailing within 2 days has increased, while it is less than in 2025 Quarter 1 and 2024. Errors in NOA and in processing the referral has improved from 2025 Quarter 3.
    - The UM team, Medical Directors, and Physician Reviewers have continued to focus on the quality of our NOA letters. Our weekly meetings with the Medical Directors continue, where we address specific NOA letter concerns and questions.
    - UM Leadership has reviewed the deficiencies with the specific team members that had errors.

Utilization Management Department Internal Audit

Quarter 4 2025

	Quarter 4 Summary
Total Referrals Processed	93,663
Total Referrals Modified	1657
Percent Referrals Modified	1.8%
Total Referrals Denied	6,979
Percent Referrals Denied	7.5%
Total Referrals Delayed	1202
Percent Referrals Delayed	1.3%

Quarter 3 2025

	Quarter 3 Summary
Total Referrals Processed	98,045
Total Referrals Modified	1431
Percent Referrals Modified	1.5%
Total Referrals Denied	5,644
Percent Referrals Denied	5.8%
Total Referrals Delayed	245
Percent Referrals Delayed	0.2%

Quarter 2 2025

	Quarter 2 Summary
Total Referrals Processed	98,956
Total Referrals Modified	1443
Percent Referrals Modified	1.5%
Total Referrals Denied	3,815
Percent Referrals Denied	3.9%
Total Referrals Delayed	290
Percent Referrals Delayed	0.3%

Quarter 1 2025

	Quarter 1 Summary
Total Referrals Processed	104,505
Total Referrals Modified	1,395
Percent Referrals Modified	1.3%
Total Referrals Denied	2,599
Percent Referrals Denied	2.5%
Total Referrals Delayed	214
Percent Referrals Delayed	0.2%

2024 Summary	2024 Summary
Total Referrals Processed	383,407
Total Referrals Modified	6502
Percent Referrals Modified	2%
Total Referrals Denied	9,326
Percent Referrals Denied	2.4%

Total Referrals Delayed	643
Percent Referrals Delayed	0.17%

Quarter 4 2025

	Quarter 4 Summary	Quarterly Percentage Noncompliant
Total Referrals Audited	150	
Mailed > 2 days after decision	5	3.3%
Error in NOA (including > 6th grade)	2	1.3%
Missing citation or criteria	2	1.3%
Errors in processing referral	9	6.0%
Signatures missing	1	0.7%

Quarter 3 2025

	Quarter 3 Summary	Quarterly Percentage Noncompliant
Total Referrals Audited	90	
Mailed > 2 days after decision	1	1.1%
Error in NOA (including > 6th grade)	4	4.4%
Missing citation or criteria	0	0.0%
Errors in processing referral	9	10.0%
Signatures missing	0	0.0%

Quarter 2 2025

	Quarter 2 Summary	Quarterly Percentage Noncompliant
Total Referrals Audited	150	
Mailed > 2 days after decision	2	1.3%
Error in NOA (including > 6th grade)	0	0.0%
Missing citation or criteria	2	1.3%
Errors in processing referral	11	7.3%
Signatures missing	1	0.7%

Quarter 1

	Quarter 1 Summary	Quarterly Percentage Noncompliant
Total Referrals Audited	150	
Mailed > 2 days after decision	13	8.7%
Error in NOA (including > 6th grade)	8	5.3%
Missing citation or criteria	5	3.3%
Errors in processing referral	8	5.3%
Signatures missing	0	0.0%

2024 Summary

2024 Summary	Total Referrals Audited	1124	Percentage Noncompliant
	Mailed > 2 days after decision	48	4.3%
	Error in NOA	73	6.5%
	Missing citation or criteria	35	3.1%
	NOA above 6th grade reading level	90	8.0%
	Errors in processing referral	62	5.5%
	Signatures missing	0	0.0%

Key Objective #4: Ensure quality utilization management reviews and consistency between utilization management team members

All Utilization Management (UM) staff reviewers must complete and successfully pass quarterly MCG Inter-Rater Reliability (IRR) testing to demonstrate competency and ensure compliance with regulatory standards and guidelines.

All licensed clinical reviewing staff members are given three (3) attempts to complete the assigned case studies with a minimum passing score of 95% or higher.

Outpatient clinical staff reviewers are given a total of five (5) Ambulatory Care (AC) case studies with a minimum of fifteen (15) questions.

Inpatient clinical staff reviewers are given one (1) General Recovery Care (GRC) case study and one (1) Inpatient and Surgical Care (ISC) case study with a minimum of twenty (20) questions.

Medical Directors, Management, and clinical trainers are given four (4) AC cases and one (1) ISC or GRC case with a minimum of twenty (20) questions.

	Number of Staff	Total Questions	Percentage that scored 95% or higher
OP Nurses	12	3	12/12 =100%
IP Nurses	17	10	15/17= 88%
Physician Reviewers	6	10	83%, 1 pending completion
Director/Management/Supervisor	3	10	3/3 = 100%

Policies approved by UM Committee on February 25, 2026

- 3.09 – Second Opinions
- 3.20 – Sensitive Services
- 3.31 – Emergency Services
- 3.40 – Continuity of Care for New Members

- 30.51 – Standing Referrals
- 30.72 – Down Grading UM Referrals Requests
- 30.79 – UM Monthly Audits
- 30.80 – Discharge Planning
- 30.91 – DSNP Continuity of Care
- 30.92 – Prior Authorization Referrals
- 30.93 – Applied Behavior Analysis (ABA) Medical Necessity Review Process

KERN HEALTH SYSTEMS

COMMITTEE: ***UTILIZATION MANAGEMENT COMMITTEE***
DATE OF MEETING: ***DECEMBER 4, 2025***
CALL TO ORDER: ***12:37 PM BY MANINDER KHALSA, MD, UM MEDICAL DIRECTOR - CHAIR***

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements were met as the composition described in the committee charter.	N/A
Call to Order	Dr. Maninder Khalsa, KHS UM Medical Director called the meeting to order at 12:03 PM.		N/A
Committee Minutes	**Approval of Minutes** The minutes of August 13, 2025 were presented for review and approval.	☑ **ACTION**: Dr. Sharma moved to approve minutes of August 13, 2025, seconded by Dr. Parmar. Motion carried.	12/04/25
OLD BUSINESS	There was no old business to present.	N/A	N/A
NEW BUSINESS	**Welcome & Introduction** **Introductions:** Dr. Khalsa welcomed the members of UM Committee.	☑ **CLOSED**: Informational only.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	UM Report 3rd Quarter 2025 Dr. Khalsa presented the 3rd Quarter 2025 UM Report. The following highlights were noted: • UM Timeliness of Decisions – KHS remains consistent with Urgent compliance at 99.4% and Routine compliance timelines at 99%. • UM Referral Notification is compliance remains at 100% for member notification and 100% provider notification and MD Signature. • Outpatient Referrals – slightly decreased in numbers to 100776 from last quarter which was 103228. • Adult & Pediatric Referrals – remain consistent in comparison to past quarters. • Denial Percentage – 3rd Quarter denied referrals are 6.3% for Sept, 6.6% for August and 3.7% July. • Quarterly Clinical Audits were also completed with no significant issue to report.	☑ **CLOSED**: Report accepted as presented with no further discussion or questions from the committee members.	*12/4/25*
	D-SNP Policies Christine Pence reported the D-SNP Policy and Procedures were previously sent electronically for review: • Separate policies from Medi-cal • 002 Separation of Financial Decision Making • 003 Application of Medical Necessity and Clinical Criteria • 005 Referral Processing Turn Around Times • 006 Adverse Determinations • 007 Specialty Referrals and Use of Board Certified Practitioners • 008 Standing Referrals • 013 Reopening Service Determinations • 016 Emergency and Post Stabilization Requirements • 017 Inter-Rater Reliability Audits • 018 Downgrading UM Referral Requests • 019 Canceling, Withdrawing, or Dismissing a UM Service Request • 020 Request for Medical Policies • 022 Medicare Certified Facilities • 023 Reconstructive Procedures	☑ **ACTION**: Dr. Sharma moved to approve the D-SNP Policy and Procedures as listed, seconded by Dr. Parmar. Motion carried.	*12/4/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• 027 Second and Third Opinions • 030 Retrospective Review • 032 Direct Access to Women's Services • 5 Discharge Planning • 11 Onsite Facility Review • 13 Interdisciplinary Care Rounds • 16 UM Monthly Audits • Concurrent Review • Medical Director Referral • Medical Director Peer –to Peer • Requests for Experimental Treatment • Lack of Clinical Information • Organization Determination Mail • Termination of Medicare Services • Continuity of Care Dr. Srivastava requested additional information regarding what services are being overutilized. Dr. Khalsa explained KHS's processes for identifying potential overutilization. Additional discussion ensued regarding the DSNP Line of Business and how membership is fluctuating for both Medi-Cal and DSNP. Christine informed the members that DSNP enrollment is steadily increasing to about 300+ members to date. Medi-Cal enrollment is seeing some changes primarily due to the State removing the auto-renewal process that was in place during the pandemic. DHCS is expected to provide guidance regarding DHCS's plans to comply with H.R. 1. Christine described the efforts KHS is undertaking to ensure members maintain their insurance coverage. Nate also provided an update that KHS is looking to get a scanner for our building to be able to upload documents from our office to the County Office as a way to renew member's state benefits without having to go to the county office.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED

	UM/Internal Auditing Activities
	Christine Pence reported on the UM Auditing Activities that included the following items:
	• 3rd Quarterly audits of the NOA Team are done to monitor for accuracy and 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
	  • July - 1 NOA Finding with formatting error and grammatical error.
	  • August there were no errors
	  • September there were 2-NOA formatting and verbiage errors and 1-timeframe error
	  • Errors will be discussed during staff 1:1 meetings.
		☑ **CLOSED**: Report accepted as presented with no further discussion or questions from the committee members.	*12/4/25*

	Epidural Steroid Injection Authorization Protocol Christine Pence reported the Epidural Steroid Injection Authorization Protocol was submitted to the Physician Advisory Committee and approved as presented.	☑ **CLOSED**: Protocol accepted as presented with no further discussion or questions from the committee members.	*12/4/25*
OPEN FORUM	**Open Forum**	☑ **CLOSED**: Informational discussion only.	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, February 25, 2026 at 12:00 PM	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 1:24 PM ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Utilization Management Committee Minutes 12/04/2025

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____

Date Name

KERN HEALTH SYSTEMS

To: Executive Quality Improvement Health Equity Committee (EQIHEC)

From: Christine Pence, Director of Health Services

Date: March 17, 2026

Re: Utilization Management (UM) Department 2026 Program Description

---

Background:
The Utilization Management (UM) Department is required to have a program description that identifies key components and key processes to ensure compliance with regulatory and accreditation standards.

Discussion Items:
The UM Program Description identifies the department's objectives, scope of services, authority and responsibility, personnel structure and responsibilities, associated committees, medical necessity criteria, department processes for inpatient and outpatient services, collaboration with partners, and requirements for delegation.

Fiscal Impact:
None.

Requested Action:
Review for approval.

UTILIZATION MANAGEMENT

2026 PROGRAM DESCRIPTION

Introduction **4**
Purpose **4**
UMP Objectives **5**
Statements and Protections **7**
Non-Discrimination Statement 7
Confidentiality Statement 7
Health Insurance Portability and Accountability Act (HIPAA) 8
Conflict of Interest Statements 8
SCOPE of Care Services **9**
Authority and Responsibility **10**
KHS Board of Directors 10
Program Structure **10**
Chief Medical Officer (CMO) 10
Medical Director 11
Director of Utilization Management 12
UM Clinical Manager 13
Health Services Manager 14
UM Inpatient Clinical Supervisor 15
UM Nurse and Clinical Intake Coordinators (RN) 17
Clinical Auditor/Trainer (RN) 17
Claims and Disputes Review Nurse (RN) ..... **Error! Bookmark not defined.**
Long Term Care Nurse Reviewer (RN) ..... **Error! Bookmark not defined.**
Analyst/Trainer ..... **Error! Bookmark not defined.**
Director of Pharmacy 18
Behavioral Health Director ..... **Error! Bookmark not defined.**
Behavioral Health Clinical Provider ..... **Error! Bookmark not defined.**
Committees **18**
Utilization Management Committee 18
Utilization Management Committee (UMC) Reports 20
Utilization Management and Quality Improvement Interface 20

Data Sources 21
Physician Advisory Committee (PAC) ..... **Error! Bookmark not defined.**
PAC- Credentialing and Peer Review ..... **Error! Bookmark not defined.**
PAC-Medical Technologies and Clinical Criteria Sets ..... **Error! Bookmark not defined.**
PAC-Code of Conduct, Confidentiality, and Fraud Waste and Abuse ..... **Error! Bookmark not defined.**
Reporting Relationship ..... **Error! Bookmark not defined.**
Drug Utilization Review Committee (DUR) Key Responsibilities 22
Membership 22
Reporting Relationship 23
Utilization Management Process 23
Medical Necessity and Clinical Criteria 23
Regulations and Criteria Guidelines (Hierarchy of Criteria) 23
Criteria Notifications 26
Referral Management 26
Emergency Room Visits 27
Pre-authorization 27
Concurrent Review ..... **Error! Bookmark not defined.**
Inpatient Concurrent Review and Continued Stay 28
Discharge Planning 29
Skilled Nursing/Sub acute/ Long-Term Acute/Rehabilitation Facility Review 29
Retrospective Review 29
Utilization Management Decision Timeframes 29
Inter-Rater Reliability (IRR) 30
Ongoing Training 30
UM Determinations 31
Denial Determinations 31
Appeals of Adverse Medical Necessity Denials and Benefit Determinations 32
Expedited Appeals of Adverse Benefit Determinations 33
Appeal Rights 34
Independent Medical Review 34
UM Programs and Service Descriptions 35
Mental (Behavioral) Health Services ..... **Error! Bookmark not defined.**
Behavioral Health Therapy (BHT) and Behavioral Intervention Services (BIS) ..... **Error! Bookmark not defined.**
Transitional Care Program ..... **Error! Bookmark not defined.**
Major Organ Transplant ..... **Error! Bookmark not defined.**

Long Term Care 35
Second Opinions 36
Telemedicine/Telehealth 36
Emergency Services 36
Emergency Services and Hospital Admissions Out of Plan Screening and Stabilization 37
Post-stabilization 37
Completion of Covered Services 37
Standing Referrals 37
Collaboration of Services 38
Continuity of Care 39
Continuity of Care – Terminated Providers 40
Delegation 40
Delegation of Utilization Management Functions 40
UM Delegation to Affiliated Providers ..... **Error! Bookmark not defined.**
Delegation of UM Activities 41
Delegation Agreement Process 41
Delegated Triage Services 42
Delegated Vision Care 42
Under and Over Utilization 42
Medical Loss Ratio ..... **Error! Bookmark not defined.**
Resource Management 43
Evaluation of New Medical Technologies 43
Medical Reviews and Audits by Regulatory Agencies 44
Integration of Study Outcomes with KHS Operational Policies and Procedures 44
Provider and Member Satisfaction 44
Annual Program Evaluation 44
Record Retention 45

Introduction

Kern Health Systems (KHS), d.b.a. Kern Family Health Care (KFHC), is the Local Initiative for the arrangement of medical, social, and behavioral health care for Medi-Cal enrollees in Kern County. KHS is a public agency formed under Section 14087.38 of the California Welfare and Institutions Code. KHS began full operations on September 1, 1996, under the Kern County Board of Supervisors. KHS currently serves approximately 400,000 Medi-Cal participants in Kern County. KHS aligns with the California Advancing and Innovating Medi-Cal Initiative by embracing CalAIM's three primary goals:

Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health,

Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility, and

KHS strives to be a leader in developing innovative partnerships with the safety net and community providers to support and elevate the health status of KHS members served.

Purpose

The KHS Utilization Management Program (UMP) serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all members, and to actively pursue identified opportunities for improvement.

The UMP is intended to outline the methods utilized by KHS to provide a supportive system of care arrangements and services in a standardized, simplified, and focused process to efficiently provide members with comprehensive Whole Person Approaches within available resources and achieve an optimum level of quality health care that is medically necessary.

The UMP is a formal Document supported by clinical, operational, and administrative policies and procedures (P&Ps) delineating how UM functions are performed. The UMP and P&Ps are written to adhere to federal and state regulatory requirements to include CA Health & Safety Code, Title 22, Welfare & Institutions Code, CMS Code of Federal Regulations, the CA Department of Health Care Services 22-20202 KHS Contractual Provisions, and current NCQA Standards and Guidelines. The UM documents are approved with the involvement of KHS providers in accordance with H&S Code sections 1363.5 and 1367.01 and 28 CCR sections 1300.70(b)(2)(H) and (c).

The UM Program and Policies &Procedures go through a formal process of UM Committee review approval and are reported up to the Executive Quality Improvement Health Equity Committee and the KHS Board of Directors for final review and approval. In turn the UMP and P&Ps are disbursed and or made available to KHS providers and members through various channels of accessibility including the KHS website.

All activities described in the UM Program are conducted with oversight by the Executive Quality and Health Equity Improvement Committee (EQIHEC).

The UMP is housed within the KHS Health Services Department and is supported through the

coordination between various internal departments to include:

- Population Health Management,
- Pharmacy,
- Enhanced Care Management,
- Cultural and Linguistics
- Quality Improvement
- Community Support Services
- Provider Network Management

UMP Objectives

KHS develops, implements, and updates as needed (at least annually), the utilization management (UM) program to ensure appropriate processes are used to review and approve the provision of medically necessary covered services for KHS Members. This process incorporates provider, input along with any regulatory and industry changes to maintain current standards of care and technological advances.

An annual evaluation of the UM Program is prepared and includes a description of the accomplishments of KHS. The UM Work plan & Evaluation will be submitted to the EQIHEC who is responsible for approving the updated UM program.

The UMP is intended to provide a reliable mechanism to review, monitor, evaluate, recommend, and implement actions on identification and correction of potential and actual under or over utilization and resource allocation issues.

The UMP and the UM Department are adequately supported by a designated medical director with sufficient knowledge of managed care and UM process requirements to serves as a departmental resource and oversee that the review process is conducted in accordance with H&S Code section 1367.01.

KHS UMP prohibits medical decisions to be influenced by fiscal and administrative management. Compensation of individuals or entities that conduct UM activities must not be structured to provide incentives to deny, limit, or discontinue medically necessary services.

The KHS UMP will define the methods by which utilization criteria and clinical practice guidelines are selected, developed, reviewed, and modified based upon appropriate and current standards of practice and professional review.

KHS will make available to network providers and members all relevant UM policies and procedures upon request: and, make available to members clinical criteria, for assessing medical necessity for covered services. The most recent UM Program description is shared and made available to subcontractors and downstream subcontractors through various channels of accessibility. Additionally, to ensure that outdated UM Program Description are not circulated or used the most current document will be identified with a current year and/or version number along with a memo that all other previous UM Programs are to not be utilized.

The UMP and processes are developed and carried out to ensure that policies, processes, strategies, evidentiary standards, and other factors used for UM or utilization review are consistently applied to medical, surgical, mental health, and substance use disorder services and benefits.

Through the UMP the monitoring of UM data is performed to detect potential under and over-utilization. Data are monitored across practices and provider sites of PCPs. Appropriate interventions are implemented whenever under- or over-utilization is identified. Interventions are measured to determine their effectiveness, and further strategies may be implemented to achieve appropriate utilization.

When UM processes are delegated under the UMP KHS will evaluate the ability of the delegates to perform UM activities and monitor performance continuously to ensure delegate compliance and adherence in alignment with the KHS UMP and policies and procedures.

The KHS UMP promotes and ensures the integration of utilization management with quality monitoring and improvement, risk management, credentialing, and population health management activities.

The UMP accommodates member access to Standing Referrals as outlined in H&S Code section, 1374.16.

The UMP accommodates member access to Second Opinions in accordance with 42 CFR section 438.206.

The UMP supports a process of thorough and timely investigations and responses to member and provider reconsideration and appeals associated with utilization issues.

There are mechanisms to evaluate the effects of the UM program and process using member and provider satisfaction data, staff interviews and/or other appropriate methods. Identified

sources of dissatisfaction are addressed. When opportunities for improvement are identified, the Utilization Management Committee (UMC) reviews and make recommendations for improvement.

Statements and Protections

Non-Discrimination Statement

KHS complies with applicable Federal Civil Rights Laws and does not discriminate, exclude people, or treat them differently on the discriminating based on race, color, national origin, religion, ancestry, ethnic group identification, sex, gender identity (including gender expression), sexual orientation, mental disability, medical disability, age, marital status, family/parental status, or income.

KHS will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily and exclusively available.

In accordance with the Americans with Disabilities Act, KHS will ensure that deliverables developed and produced shall comply with the accessibility requirements of Section 508 of the Rehabilitation Act and the Americans with Disabilities Act of 1973 as amended (29 U.S.C. § 794 (d), and regulations implementing that act as set forth in Part 1194 of Title 36 of the Federal Code of Regulations. In 1998, Congress amended the Rehabilitation Act of 1973 to require Federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California Government Code section 11135 codifies section 508 of the Act requiring accessibility of electronic and information technology.

KHS will provide persons with disabilities who require alternative means of communication for program information to the appropriate alternate format to support their communication needs (e.g., Braille, large print, audiotape, American Sign Language, etc.)

KHS provides free language services to people whose primary language is not English or those with limited English proficiency (LEP). These services include the following:

- Qualified sign language interpreters,
- Information written in other languages,
- Use of California Relay Services for hearing impaired.

Confidentiality Statement

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.

Confidentiality of provider and member information is ensured at all times in the performance of UM activities through enforcement of the following:

- Members of the UM, EQIHEC and PAC Committees are required to sign a confidentiality statement.
- UM documents are restricted solely to authorized Health Services Department staff, members of the UM, EQIHEC, and PAC Committees (PAC performs credentialing conducts Peer Review, Complaints and Grievance, and PQI reviews), and reporting bodies as specifically authorized.
- Confidential documents may include, but are not limited to: UM, EQIHEC, and PAC Committees meeting minutes and agendas, QI and Peer Review reports and findings, UM reports, or any correspondence or memos relating to confidential issues where the name of a provider or member are included.
- Confidential documents are stored in locked file cabinets with access limited to authorized persons only, or they are electronically archived and stored on protected drives.
- The 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.

Health Insurance Portability and Accountability Act (HIPAA)

KHS complies with all applicable HIPAA requirements supported by HIPAA compliance policies. All HIPAA related policies are accessible to UM Physicians and staff on Intranet compliance site. Ongoing mandatory education is required annually for all staff.

Conflict of Interest Statements

Any individual who has been personally involved in the care and/or service provided to a patient, an event or finding undergoing quality evaluation may not vote or render a decision regarding the appropriateness of such care. All members of the UM, EQIHEC, and PAC are required to review and sign a conflict-of-interest statement, agreeing to abide by its terms.

SCOPE of Care Services

The KHS UMP incorporates the monitoring and evaluation for prior authorization, concurrent review, retrospective review, exceptions to prior authorization services and reviews and updates policies and procedures as appropriate at least annually for the following.

- Acute hospital services,
- Subacute services,
- Long-term care including Skilled Nursing Facility (SNF) Care and Rehabilitation Facility services,
- Ambulatory Services,
- Rehabilitative services,
- Emergency and urgent care services,
- Durable Medical Equipment and supplies,
- Ancillary care services, including but not limited to home health care, skilled nursing care,
- Transportation services,
- Selected pharmaceutical services - physician administered drugs (medical drug benefit),
- Laboratory and radiology services,
- Transportation services-Medical and Non-Medical,
- Non-Specialty Mental Health and Substance Use Disorder Services as applicable to KHS contracted scope of coverage in accordance with DHCS KHS 23-30226 Contract Exhibit A. Attachment III,
- Out of Network Care.

Exceptions to the requirement of prior authorization include but are not limited to:

- Primary Care Provider Services,
- Specific OB/GYN services, including midwifes and free-standing birth center facility,
- Abortion Services,
- Dialysis,
- Outpatient Hospice Care,
- Sexually Transmitted Disease treatments,
- HIV Services,
- Family Planning Services,
- Mental Health evaluations,
- Maternity Care,
- Vision,
- Sensitive Services, both child and adult
- Emergent/Urgent Care, and,
- Other procedures as identified.

Authority and Responsibility

KHS Board of Directors

The Kern Health Systems, the County Health Authority, is an independent public agency that governs Kern Family Health Care. The Board of Directors are appointed by the Kern County Board of Supervisors and includes major healthcare stakeholders, such as physicians, safety-net providers, hospitals, pharmacies, and community representatives. Board meetings are held bi-monthly in: February, April, June, August, October, and December, and are open to the public. The Board of Directors (BOD) for KHS assigns the responsibility to lead, direct, and monitor the activities of the UM Program to the KHS Executive Quality Improvement Health Equity Committee.

The Board has oversight of the UM process in the following ways:

- Delegates responsibility for the day-to-day activities and execution of the UMP to the Kern Health Systems Chief Medical Officer (CMO),
- Approves and supports the UM Program direction, evaluate effectiveness, and resource allocation,
- Receive reports representing UMP activity outcomes, actions taken, and improvements made by the Utilization Management Committee (UMC), at a minimum on a quarterly basis through the EQIHEC workplan update
- Evaluate and approve the UM Program Description and UM Program Evaluation annually.

Program Structure

The UM Program is comprised of various systems and processes which interface with other departments and administrative systems in the delivery of care. The link between UM and other clinical and administrative systems must be collaborative

The utilization management team of physicians, licensed staff, and unlicensed staff are trained and qualified to assess the clinical information which is used to make utilization management decisions and provide the service within their respective scope of practice. Appropriately licensed health professionals supervise all review decisions.

This section outlines the individual program staff and their assigned activities, including approval authority and the involvement of designated physicians.

Chief Medical Officer (CMO)

The Chief Medical Officer, is responsible for oversight of the UMP and UM Department undertakings. He/she holds an unrestricted license to practice medicine in the State of California issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act. The CMO is responsible for ensuring that the process by which KHS reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to KHS members, complies with the requirements of H&S Code 1367.01. The CMO must have the ability to effectively function as a member of the UM team and serves a resource to the UM staff for clinical matters. The CMO provides medical direction for KHS, including professional

input and oversight of all medical activities of the UM Program to the Board of Directors. The CMO is the UM Committee Chair and or at his or her discretion assigns the UM Chair position to a qualified physician.

The CMO aids with study development and coordination of the UM Program in all areas to provide continued delivery of quality health care for members. The CMO assists the Senior Director of Provider Network Management with provider network development. Other responsibilities include but are not limited to:

- Provide direction for all medical aspects of KHS, preparation, implementation and oversight of the UM Program, medical services management, resolution of medical disputes and grievances,
- Principal accountabilities include development and implementation of medical policy for utilization functions, reviewing current medical practices so that that medical protocols and medical personnel of KHS follow rules of conduct, review of UM cases, participation in the UM committee,
- Ensures timely medical necessity review and decisions are made by daily staffing physicians for medical review consultation,
- Evaluates the overall effectiveness of the UM program,
- Evaluates and uses provider and member experience data when evaluating the UM program,
- Ensures that medical decisions are rendered by qualified medical personnel,
- Ensures UM decision making is not influenced by fiscal or administrative management considerations,
- Ensures that the medical care provided meets the current standards for acceptable care,
- Ensure that medical protocols and rules of conduct for practitioner or plan medical personnel are followed.

UM Medical Director

The Medical Director will provide clinical leadership and guidance in the development and measurement of UM performance improvements and patient satisfaction, and safety and serves as a resource to the UM Department in the day-to-day operations. As determined by the CMO, the Medical Director assists in short-and long-range program planning, , as well as develops and implements systems and procedures for the medical components of health plan UM and care coordination services.

Under the direction of the Chief Medical Officer and in collaboration with Director of UM, 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 utilization management to the CMO and UM and EQIHEC Committees.. The Medical Director provides medical oversight into the medical appropriateness and necessity of healthcare services provided to Plan members. Responsibilities include, but are not limited to:

- Participates in carrying out the organization's mission, goals, objectives, and continuous quality improvement of KHS,
- Develops and implements medical policy,
- Participates in the development and selection of medical necessity criteria sets used for UM processes,

- Responsible for monitoring and controlling the appropriate utilization of health care services to achieve high quality outcomes,
- Directly communicates with primary care physicians and other referring physicians to resolve referral issues, research treatment protocols, solicit advice on problem cases, and to assist in development of referral criteria and practice guidelines, and
- Supports, communicates, and collaborates with KHS UM Department staff to ensure efficient UM processes and decision-making practices are compliant with State, Federal and NCQA standards,
- Support case managers to resolve case management and referral issues,

Senior Director of Health Services

Under the direction of the Chief Medical Officer, the Senior Director of Health Services, is responsible for providing leadership to departments and ensuring alignment with DHCS contractual requirements, NCQA and evidence-based guidelines. In addition, oversees the activities to support KHS's strategic plan, clinical initiatives.

Director of Utilization Management

Under the direction of theSenior Director for Health Services, the Director of Utilization Management will oversee activities related to Utilization Management (UM) for the organization and membership by monitoring, assessing, and improving performance in ambulatory and inpatient health care delivery or health care related services. The UM Director will assist in the implementation of the KHS Utilization Management Program Plan and Evaluation 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 collaborative oversight of the Utilization Management functions for KHS. The UM Director will also be responsible for overseeing the production, analysis, and dissemination of contractually mandated reports. This position will assist in ensuring compliance with Medi-Cal contractual stipulations for UM programs. The UM Director will make an effective contribution to KHS's business planning and fiscal processes and will remain clear about departmental objectives and resource requirements. Responsibilities include, but are not limited to:

- Maintains delegated responsibility for activities within the Utilization Management departments,
- Prepares and implements the UM annual workplan
- Works closely with the Director of Population Health Management to facilitate needs for members identified as High Risk or requiring coordination of services,
- Ensure coordination of medically necessary services within the plan and with community,
- Coordinates UM activities and data collection between KHS departments and KHS contracted providers,
- Serves as a clinical liaison with contracted facilities and providers and participates in Joint Operations meetings to improve patient care and ensure access standards; 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,
- Implements and facilitate internal audit studies and work groups for continuous improvement within the organization.

UM Clinical Manager (Inpatient, Outpatient)

Under direction of the Director of Utilization Management, this position manages, leads, acts as a subject matter expert, to nurses and non-licensed staff by providing guidance on unit functions and departmental operations, supporting clinical health outcomes functions related to population health management, clinical data management and retrieval, reporting standards and State policy and procedure implementation and implements and evaluates compliance to KHS clinical programs related to Health Services initiatives. This position additionally manages, supervises, mentors and trains assigned staff. Other responsibilities include, but are not limited to:

- Direct activities of the Utilization Management staff,
- Provides day to day supervision of assigned UM staff. UM staff who are not qualified health care professionals may approve services when they meet explicit UM auto authorization guidelines under the supervision of a licensed professional
- Participates in staff training
- Monitors for consistent application of UM criteria by UM staff for each level of UM decision
- Monitors documentation for adequacy of relevant clinical information to support non-behavioral, behavioral and/or pharmacy UM decision making.
- Be available to UM staff on site or by telephone
- A non-licensed staff may review an authorization request against the UM auto approval matrix where no clinical judgement is warranted. If clinical review is warranted, it is routed to the nurse reviewer and to a physician reviewer when further review is needed to make the final determination. All adverse determinations are date and time stamped accompanied with the signature of the MD involved in the decision. Oversees staff performance regarding prior authorization, medical necessity determinations, concurrent review, retrospective review, continuity of care, care coordination, and other clinical and medical management programs. These responsibilities extend to behavioral health care services,
- Ensures effective daily operation of the Utilization Management Department utilizing all applicable statutory provisions, contracts and established policies and administrative procedures,
- Maintains optimal staffing patterns based on contractual obligations and current Utilization Management budget,
- Prepares reports and conduct analysis of operations / services as required by departmental, corporate, regulatory, and State requirements,
- Works collaboratively with KHS Departments on identifying required data for reporting,
- Assists in preparation, coordination, and follow up of Utilization Management audits, such as readiness review and DHCS site visits, pertaining to the Utilization

Management Department,

- Partners with community agencies and contracted vendors to develop and maintain collaborative contact to assure members have access to the appropriate resources and to avoid duplication of efforts,
- Acts as a liaison with outside entities, including but not limited to physicians, hospitals, health care vendors, social services agencies, member advocates, county, and other care entities,
- Participates in coordination of internal and external Provider and Member directed communication regarding issues impacting Utilization Management coordination and delivery, such as medication management, use of generic medications, etc.,
- Establishes action plan for assessment and resolution of identified issues,
- Oversees the collaborative efforts of the Supervisors to ensure that all new and existing staff are oriented to organizational and department policies and procedures,
- Ensures that credentials of all licensed staff are verified in accordance with licensing agency initially and prior to expiration date. Maintain current and accurate files of such licensure and ongoing education status,
- Ensure that staff meets minimal skill and clinical knowledge requirements to be successful in assigned role,
- Participate in current process review and development of new and / or revised work processes, policies and procedures relating to Utilization Management responsibilities,
- Provide input into the development of educational material and programs necessary to meet business objectives, members' needs, contractual and regulatory guidelines, and staff professional development,
- Comply with Corporate, Federal, and State confidentiality standards to ensure the appropriate protection of member identifiable health information.

Health Services Manager

The Health Services Manager reports to the Director of Utilization Management and is responsible for the daily management, evaluation, and operations of the health services administrative processes, provide supervisory support to Utilization Management (UM) staff and assist with defining and creation of reports in collaboration with the UM Analyst/Trainer and Non clinical staff.

This position will work with the administrative support staff to promote the delivery of quality health care to Kern Health System (KHS) members through comprehensive case management, compliance with KHS policies and procedures, and maintenance of a positive and safe work environment leading to maximum departmental efficiency, accuracy, and quality. Responsibilities include but are not limited to:

- Supervise the functions and activities of the clerical support staff,
- Monitors and reports production and quality of work by clinical and clerical staff,
- Works with clerical staff to achieve production, timeliness, and quality of work,
- Participate with Inter-departmental process improvement teams and planned quality management,
- Assist with development and formalization of departmental budget,
- Assist with development and updating of UM criteria, guidelines, and policies,

- Monitor UM processes for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes,
- Train staff, as appropriate, regarding use of the Medical Management systems,
- Generates reports for CMO and Senior Director of Health Services to support business decisions,
- Research and analyze qualitative and quantitative data, prepare statistical reports, and submit final report to the state contract manager in conjunction with KHS departmental analyst(s),
- Monitor production reports, provider facility activity, and department related quarterly summaries;
- Review and resolve provider, member, or KHS department complaints and escalate issues to higher level management if necessary;
- Educate and promote high standards of customer service with membership, provider network, community and other organizational departments;
- Create and develop monthly and ad hoc reports for UM Management staff;
- Create, collect, compile and evaluates departmental reports within specific programs or administrative information to oversee quality controls within UM routine and audit research to complete assignments within personnel and staffing utilization;
- Serves as departmental resource for clerical procedures and professional staffing in coordinating work throughout the department;
- Assist with developing access work standards, internal operating procedures, guidelines and utilization of resources;
- Provide Administrative supervision support to the Chief Medical Officer, Medical Directors and Director of Pharmacy, as appropriate, in the support and operations within the UM and Pharmacy departments;
- Management, coordination, and evaluation of health education and disease management services, including development of program descriptions and work plans.

- Lead departmental meetings, including the agenda as needed;

- Prepare and maintain program policies and procedures to meet regulatory/contractual compliance with DHCS.
- Research and analyze qualitative and quantitative data, prepare statistical reports, and submit final report to the state contract manager in conjunction with KHS departmental Business Analyst(s);
- Participate with all applicable regulatory documentation submissions and on-site audit interviews and reviews.
- Ensure the organization and its mission, programs, products, and services are consistently presented in a strong, positive image to relevant stakeholders.

UM Inpatient Clinical Supervisor

The UM Inpatient Clinical Supervisor reports to the Director of Utilization Management and is responsible for supervising the functions and activities for clinical level positions associated

with Inpatient Medical, Mental, Behavioral, and Social Services within the UM Department. The UM Inpatient Clinical Supervisor will work in a coordinated effort with the Director of UM to ensure smooth, efficient, and productive operations within the UM Department. This position will work closely with the KHS Chief Medical Officer and Medical Director(s) in the smooth and efficient operation of the referral and inpatient clinical decision-making process. Responsibilities include, but are not limited to:

- Educate and develop UM nursing staff regarding organizational policies, procedures and UM decision making skills,
- Monitor the UM process for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes,
- Participation on inter-departmental process improvement teams and KHS quality management,
- Monitor UM nursing staff referral and documentation for accuracy and appropriateness,
- Coordinate training of staff within the Interrater Reliability Review Tool to all inpatient clinical staff,
- Supervise the appropriate case management in compliance with UM guidelines and KHS Policies and Procedures,
- Monitors and reports production and quality of work by inpatient clinical staff,
- Reviews decisions regarding hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership as related to coordination of services upon discharge,
- Assists with coordinating discharge planning activities with facility discharge planners,
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan e.g., CCS, Mental Health, Long Term Care, State Waiver Programs,
- Works closely with the Transitional Care team to facilitate needs for members identified as High Risk or requiring coordination of services,
- Identify members who may quality for Enhanced Care Management, Behavioral Health, Complex Case Management and other specialty programs,
- Assist the UM clinical staff in the review of claims for the accuracy and appropriateness of billed charges,
- In coordination with the UM Clinical Auditor, perform periodic audits of the UM Nurse RN of inpatient clinical decisions for appropriateness and accuracy of documentation and summarize and report the results of the audit,
- Works with staff to achieve production, timeliness, accuracy, and quality of work,
- Summarize and prepare necessary production reports for management,
- Perform periodically scheduled audits of inpatient clinical decisions for appropriateness and accuracy of documentation,
- Serves as a clinical liaison with contracted facilities and providers and participates in Joint Operations meetings to improve patient care and ensure access standards,
- Ensure coordination of medically necessary services within the plan and with community,
- Remain current with Department of Health Care Services and Department of Managed Care policy implementation or revisions,
- Act as clinical liaison with KHS departments including, Member Services, Claims, MIS, and Provider Relations

UM Nurse and Clinical Intake Coordinators (RN)

Under the direction of the Kern Health Systems (KHS) Director of Utilization Management, the UM Nurse and Clinical Intake Coordinators will promote coordination and continuity of care and quality management in both the inpatient and ambulatory care settings by the review of referrals and authorization of payment for specialty care and ancillary services. The UM Nurse and Clinical Intake Coordinators are supported by a non-clinical team for administrative duties and coordination. The review will evaluate the appropriateness of care using established criteria and Plan benefit guidelines. Review will be conducted on a prospective, concurrent, and retrospective basis. The UM Nurse and Clinical Intake Coordinators manages the required caseload monthly. Responsibilities, include, but are not limited to:

- Promote coordination and continuity of care and in both the inpatient and ambulatory care setting,
- Evaluate the appropriateness of care using established criteria and KHS' benefit guidelines,
- Support KHS developed programs through member identification for participation, i.e., Enhanced Care Management, Complex Case Management, Recuperative, Palliative, Transitional Care, and Social Worker interventions,
- Review and approve specialty and ancillary service referrals using evidence-based criteria for purposes of pre-authorization,
- Review and approval of hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership,
- Coordinates discharge planning activities with facility discharge planners,
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan e.g., CCS, , State Waiver Programs,
- Participates in UM and QI data and statistical gathering, collation, and reporting; and
- Assess for over and underutilization and identify potential fraud, waste, and abuse.

Clinical Auditor/Trainer (RN)

- Under the direction of the Director of Utilization Management, the UM Clinical Auditor and Trainer RN is responsible for reviewing Utilization Management (UM) policy and guidelines to ensure staff compliance with policies. Perform audits on various project reports, Notice of Action notifications, and referrals for compliance. Responsible for reporting findings to management for review and possible corrective action. Provide recommendation for process improvement and assist with action plans for making those corrections. The Clinical Auditor and Trainer RN will work in a coordinated effort with UM Supervisor(s), Health Services Manager, to ensure smooth, efficient, and productive operations within the UM Department as directed by the Director of Utilization Management. This position will work closely with the Medical Director(s) in the smooth and efficient operation of the referral and inpatient clinical decision-making process. Responsibilities include, but are not limited to:

- Train other UM clinical licensed staff as appropriate regarding use of all platforms and core adjudication system as it relates to the UM process,
- Develop and implement staff training for new and existing employees along with internal findings,
- Responsible for written and verbal communication with contract providers and internal KHS staff to promote timely coordination of care and dissemination of KHS policies

and procedures,
- Assists in data collection and compilation, of various committee and quarterly reports; and
- Summarize and prepare necessary production reports for management.

Director of Pharmacy

Qualifications for the Pharmacy Director include possession of a California State Board of Pharmacy registered pharmacy license, two years of health plan related pharmacy experience at a supervisory level or four years of pharmacy practice in a similar setting as a hospital or group purchasing organization. This position reports to the Chief Medical Officer (CMO).

KHS performs drug utilization reviews (DUR) 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. Responsibilities include, but are not limited to:

- Participates and serves as the alternative Chairperson on the Drug Utilization Review (DUR) Committee,
- Medication coverage management Development of applicable policies and guidelines Drug utilization review,
- Drug prior authorization for medications covered under the medical benefit,
- Implementation of utilization management measures for medications covered under the medical benefit,
- Participation in provider education initiatives such as academic detailing with plan physicians,
- Assisting with development of Clinical Practice Guidelines,
- Other duties as assigned by the Chief Medical Officer,
- Coordination for opioid prescriptions and safeguards to prevent overutilization,
- Creation of clinically efficacious and cost-effective management programs,
- Development, implementation, and monitoring of clinical strategies to improve quality of care for members as well as provide clinical consultative services to contracting providers and KHS staff as necessary to support clinical programs,

Committees

Utilization Management Workgroup (Committee)

The Utilization Management (UM) workgroup (Committee) is established as a sub-workgroup of the KHS Executive Quality Improvement Health Equity (EQIHEC) Committee and reports to the Governing Board through the EQIHEC. The Committee structures and processes are

clearly defined, and responsibility is assigned to appropriate individuals. The Utilization Management Committee (UMC) is reliant on the involvement of appropriate, actively practicing practitioners representing primary and specialty care. A quorum of at least 3 physicians must be present at each meeting. The UM Committee meets on a regular basis, at least quarterly. Only physicians have voting privileges on the UM Committee.. The UM Committee members serve a two- year term with the possibility of reappointment, and terms are staggered to allow for continuity on the Committee. During the period of time between UM Committee meetings, the Medical Director or physician designee may function as an interim decision-maker to resolve any UM issues that may need expediting.

Minutes of committee actions are documented and maintained.

The Utilization Management Committee (UMC) oversees the implementation of the UMP and promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM Committee monitors continuity and coordination of care as well as under and overutilization of services. The responsibilities of the Utilization Management Committee (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. 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 and utilization patterns.

Key Activities include:

1. Review written utilization management protocols, workplan, and criteria applicable to the review of medical necessity for institutional, ambulatory, and ancillary services.
2. Ensure that UM decisions:
    - Are made independent of financial incentives or obligations,
    - Medical decisions, including those by delegated providers and rendering providers, are not unduly influenced by fiscal and administrative management,
    - Physician compensation plans do not include incentives for denial decisions,
    - 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. Identify specific services that are over-utilized or under-utilized and develop appropriate responses to these findings.
7. Continually monitor and evaluate utilization practice patterns of staff and contracted practitioners and vendors and identify variations in care.
8. Review state regulatory oversight of LTC and CBAS facilities.
9.
10. 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.
11. Facilitate and ensure continuity of care for members within and outside of KHS network.
12. Develop and implement performance measures to assure regulatory turn-around-time frames are met.

Utilization Management Committee (UMC) Reports

Oversight of Utilization of services through review of reports regarding major aspects of the Utilization Management Program of the Plan. The analysis of, and the actions taken in respect to, these reports are submitted quarterly to the Utilization Management Committee (UMC). They are prepared by various UM Department designees for presentation. Such reports may include, but are not limited to, the following:

a. Quarterly Utilization Management Work Plan Metrics with Quantitative and Qualitative analytics measured against industry and KHS internal benchmarks & Goals,
b. Summaries of UM Program updates,
c. Pharmacy,
d. Updates / revisions to UMP policies and procedures,
e. Criteria for UM decision-making,
f. Status of completed and on-going UM activities,
g. Organizational changes made throughout the year,
h. Inter-Rater Reliability Audits,
i. Response to new legislation that affect the UM process,
j. Analysis of the outcomes of improvement activities,
k. Under and Over Utilization Studies,
l. Barriers encountered which defer or delay the achievement of UM goals,
m. Evaluation of overall effectiveness of the UM program,
n. Satisfaction surveys,
o. UM auditing activities,
p. UM/QI Interface Activities,
q. .

Utilization Management and Quality Improvement Interface

The Utilization Management Committee and Executive Quality Improvement Health Equity Committee interact to ensure that services delivered and managed are of high quality and are appropriate, , efficient, and accessible. The Utilization Management Committee (UMC) employs a system of reporting utilization information. Through the aggregation and evaluation of UM data, when patterns of care or service issues suggest they are inappropriate or deviate from industry standard, they are reported for further evaluation to QI for potential QI concerns.

The QI Committee performs oversight of UM activities conducted by KHS to maintain quality health care and effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services. This committee also develops and enforces the quality improvement process with respect to contracting providers, and other health plan functional areas with oversight by the CMO. The QA program includes evaluating accessibility, availability and continuity of care while monitoring the provision and utilization of services meet standards of practice. The QI program description identifies the goals and objectives of the QI/QA program and includes all components of California Code Title 28 1300.70.

Key components of the QI Program structure and requirements include the continuous review of the quality of care provided to members, to assure that quality, comprehensive health care, and services are provided to KHS members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement to include:

- A level of care which meets professionally recognized standards of practice is being delivered to all members,
- Quality of care problems are identified and corrected for all provider entities,
- Physicians and appropriate licensed behavior providers to include psychologists are an integral part of the QA program,
- Appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan providers, and/or others; and
- KHS does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor to pressure health care providers or institutions to render care beyond the scope of their training or experience.

The scope of the UM licensed staff extends beyond the management of referrals. While performing UM activities, any quality-of-care concerns are referred to the QI department. Collaboration between UM and QI is essential to ensure the delivery of quality care to the plan's membership. The UM team supports QI efforts in the identification of potential quality of care issues, reporting adverse occurrences identified while conducting UM case review.

Through UM data aggregation and analytics when adverse QI patterns are discovered they will be submitted to the EQIHEC Committee through formal reports for review and to make recommendations and take action as are necessary to ameliorate the conditions. These activities will be documented in the meeting minutes.

Data Sources

KHS has identified the following as sources that may provide useful and meaningful data for analyzing compliance with standards of utilization as well as those of quality:

a. Access to care studies,
b. Medication utilization reports for prescription medications,
c. Institutional Data,
d. Claims Data,
e. Referral Patterns,
f. Timeliness of Service,
g. Ancillary Service utilization,
h. Outpatient Data,
i. Member Complaints/Grievances,
j. Appeals Review,
k. Provider surveys,
l. Satisfaction surveys,
m. Care follow-up, especially ER and Urgent Care facilities,
n. Medical Records Reviews.

1. .

Drug Utilization Review Committee (DUR) Key Responsibilities

- Objectively appraise, using principles of evidence-based medicine to evaluate and select pharmaceutical products. This is an ongoing process to ensure the optimal use of therapeutic agents. Products are evaluated based on efficacy, safety, ease of use and cost;
- Evaluate the clinical use of medications and develop policies for managing drug use and administration;
- Monitor for quality issues regarding appropriate drug use for KHS and members. This includes Drug Utilization Review (DUR) and Drug Use Evaluation (DUE) programs;
- Provide recommendations regarding protocols and procedures for the use of non-preferred medications;
- Provide recommendations regarding educational materials and programs about drug products and their use to contracting providers;
- Recommend disease state management or treatment guidelines for specific diseases or medical or behavioral health conditions. These guidelines are a recommended series of actions, including drug therapies, concerning specific clinical conditions;
- Monitor and assess contracting pharmacy activities as needed through review of audits and pharmacy profiling;
- Review elements and format of the preferred drug lists, including prior authorization lists;
- Review quality of care issues that arise pertaining to the prescribing and dispensing of medications;
- Report to the EQIHEC Committee situations that may indicate substandard quality of care.

Membership

1	KHS Chief Medical Officer (Chairperson)
2	Director of Pharmacy (Alternative Chairperson)
1	Psychiatric Pharmacist
1	Retail/Independent Pharmacist
1	Retail Chain Pharmacist
1	Specialty Practice Pharmacist
1	Geriatric Practice Pharmacist
1	Geriatric Practice Physician
1	Pediatrician
1	Psychiatric provider
1	Internist

1 PCP/General Practice Medical Doctor
1 OB/GYN Practitioner
1 Provider at Large

Reporting Relationship

- The DUR meets quarterly with additional meetings as necessary.
- The P&T/DUR reports recommendations to the EQIHEC Committee quarterly,

Utilization Management Process

Medical Necessity and Clinical Criteria

The KHS UM Program and contracted entities in accordance with KHS performing utilization management review functions utilize nationally recognized evaluation criteria and standards that are objective and based on medical evidence in making decisions to approve, modify, defer, deny, or terminate services. KHS has specific criteria to determine the medical necessity and clinical appropriateness of medical, behavioral, and pharmaceutical services requiring approval. The criteria or guidelines are:

- Reviewed and adopted with involvement from actively practicing health care providers (behavioral and non-behavioral), including non-staff network practitioners to apply, adopt, and review criteria

- All criteria sets will be reviewed and evaluated, updated, and modified as necessary, at least annually and when appropriate by the Physician Advisory Committee (PAC) and the QI/UM Committee.

- Any new criteria that KHS would like to adopt will be subjected to review and evaluation by the PAC, UM and the EQIHEC Committee prior to its approval and implementation by the organization.

- Criteria or guidelines used to determine whether to authorize, modify, or deny health care services are consistent with sound clinical principles and processes per Section 1363.5 (b)(2).

Regulations and Criteria Guidelines (Hierarchy of Criteria)

KHS Physician Reviewers will use the hierarchy of KHS UM criteria to make UM decision in the following order:

1. Health Plan eligibility and coverage
2. Federal and state mandated criteria

    - California Code of Regulations Title 22,
    - California Code of Regulations Title 28,
    - CMS Code of Regulations Title 42,
    - California Health and Safety Code §§1363.5; 1367.01; 1371.4; 1374.16,

- Medi-Cal Provider Manuals,
- CA DHCS All Plan Letters (APL),
- DMHC All Plan Letters,
- CA DHCS Policy and Procedure Letters (PPL),
- 42 CFR section 438.915, 438.206.
- Standardized Behavioral Health criteria (Title 9, DSM-V)

3. Nationally recognized criteria set
   - MCG Health LLC (Milliman Care Guidelines,)

4. Professional Society Organizations Examples:
   - American Academy of Pediatrics
   - American Academy of Orthopaedic Surgeons
   - American College of Cardiology

In January 2019, a new law was passed requiring the Medi-Cal pharmacy benefits and services to be administered by the Department of Health Care Services in the fee-for-service delivery system, known as "Medi-Cal Rx.". With the exception of medication submitted on a medical claim administered drugs, pharmacy is carved-out to DHCS.

KHS complies with Mental Health Parity requirements as required by Title 42 CFR Section 438.930. The policies and procedures are consistently applied to medical/surgical, mental health and substance use disorder benefits. KHS's Utilization Management program does not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medica/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.

UM decision making criteria shall be available to the public upon request. When making UM determinations KHS shall disclose the criteria or guidelines for the specific procedures or conditions requested. If it is determined to apply charges in disclosing criteria, the charges will be limited to reasonable fees for copying and postage costs when electronic communication means of disclosing criteria is not available.

For those instances when criteria are applied as the basis of a decision to modify, delay, or deny services in a specified case under review, the criteria shall be disclosed to the provider and the enrollee used in that specified case.

All criteria disclosures will be accompanied with the following clause, "The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

When making medical necessity decisions, UM staff obtain relevant clinical information such as patient medical records from the requesting provider and appropriate specialists by portal or by fax to finalize the UM decision. If UM staff requests medical information from providers in order to determine whether to approve, modify or deny requests for authorization, they shall request only the information reasonably necessary to make the determination. Requests for information are specific to a particular service, visit or diagnostic result. Clinical information is provided to the Chief Medical Officer or their designee to support the decision-making process. Examples of clinical information include the following but is not limited to:

- History and physicals,
- Office and ancillary service notes,
- Treatment plans and Progress notes,
- Health Risk Assessments,
- Psychosocial history,
- Risk Stratification,
- Diagnostic results, such as laboratory results, or radiology results,
- Specialty Consultation records, including photographs, operative, and pathology reports,
- Pharmacy profiles,
- Telehealth communications,
- Behavioral Health/Mental Health records,
- Information regarding benefits and any changes as required under the Department of Healthcare Services (DHCS) contract and Department of Managed Healthcare (DMHC) Knox Keene Licensure.

The review considers individual patient needs and the characteristics of the local delivery system. Based on patient circumstances, applicable UM criteria may be modified to a given instance. Medical judgment and decision making is individualized based on the member's condition and as applicable, discussed with the physician/practitioner reviewer, and requesting physician to render an appropriate decision relative to Kern Health Systems policies:

- Age,
- Sex/gender,
- Comorbidities,
- Complications,
- Home environment, as appropriate,
- Progress toward accomplishing treatment goals,
- Family support,
- Previous treatment regimens,
- Psychosocial situation and needs,
- Benefit structure including coverage for post-acute or home care services when needed.

Consideration of the delivery system and availability of services to include but not be limited to:

- Availability of inpatient, outpatient, and transitional services,
- Availability of highly specialized services, such as transplant facilities or cancer centers,

- Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge,
- Availability of outpatient services in lieu of inpatient services such as surgery-centers vs inpatient surgery,
- Local hospitals' ability to provide all recommended services within the estimated length of stay,

Criteria Notifications

Members are notified of the availability of UM criteria either in writing upon request or on the website and through the EOC Member Handbook mailed to all members.

Availability of the UM criteria upon request may be done in person or by telephone.

Practitioners are notified of the availability of UM criteria, either in writing upon request or on the website and through the provider manual upon onboarding, provider portal, and annual Provider network education. Providers are also notified, annually, through Plan newsletters and mailings, of the process by which such information may be obtained. KHS may also mail the criteria to practitioners who do not have fax, email or have internet access. KHS maintains a UM Criteria Disclosure log to document a criteria request made by a practitioner or a member & member representative. The UM Department maintains a UM Disclosure Log to document any criteria requests made by a member or its representative or practitioner and peer-to-peer review requests.

Members receive pertinent criteria information with every -Notice of Action (NOA)-denial letter, by mail.

KHS also contracts with a third-party independent medical review organization which provides objective, unbiased medical determinations to support effective decision making based only on medical evidence.

The reviewing practitioners base their determinations on the hierarchy of criteria, training, experience, the current standards of practice in the community, published peer-reviewed literature.

For complex specialty reviews the UM medical staff refers the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service.

Referral Management

Referral management is designed to determine medical necessity utilizing established criteria based on an assessment of the member's clinical condition, diagnosis and requested treatment plan. Each case is evaluated individually, and sound medical criteria is applied as appropriate.

Referrals and requests for prior authorization of services are to be submitted by the provider of service to the KHS UM department by fax, through KHS's Online Services portal, which is a Secure Electronic Internet system, or via telephone. The following information must be provided on all requests.

- Member demographic information,
- Provider demographic information,
- Requested service/procedure to include specific CPT/HCPCS code(s),
- Member diagnosis (Using current ICD Code sets),
- Clinical indications necessitating service or referral,
- Pertinent medical history, treatment, or clinical data,
- Location of service to be provided,
- Requested length of stay for all inpatient requests,
- Proposed date of procedure for all outpatient surgical requests.

Pertinent data and information are required to enable a thorough assessment of medical necessity. If information is missing or incomplete, the requestor will be notified and given an opportunity to submit additional information.

Contract providers are obligated to refer members to KHS network providers, and/or providers approved through the Utilization Management Letter of Agreement process, unless medical necessity or emergency dictates otherwise. Physician requested Out of Area/Out of Network referrals are processed through Provider Relations Department with Letters of Agreement (LOA) for financial reimbursement methodology. KHS utilizes a member centric medical management documentation platform, JIVA system by ZeOmega, to house all clinical information for each member.

KHS complies with Mental Health Parity requirements as required by Title 42 CFR Section 438.930. Prior Authorization requirements are consistently applied to medical/surgical, mental health and substance use disorder benefits. KHS's Utilization Management program does not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medica/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.

Emergency Room Visits

Emergency room visits where a prudent layperson, acting reasonably, would believe an emergency condition exists, DO NOT require prior authorization.

Prior-authorization

For those services requiring pre-authorization, only KHS UM Clinical Staff and/or KHS Chief Medical Officer or designee(s) including Physician Reviewers, may process authorizations for service requests.

For any Denials, delays/extended delay, modifications, and terminations are performed in accordance with the Knox Keene license and DHCS contract that stipulates "no individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the

specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity." If clinical review is warranted, it is routed to the nurse reviewer and to a physician reviewer when further review is needed to make the final determination. All adverse determinations are date and time stamped accompanied with the signature of the MD involved in the decision.

KHS utilizes qualified health care professionals with appropriate clinical expertise and training in treating medical or behavioral health conditions to review all medical necessity decisions that involve determinations of service reductions, modifications and denials made in whole or in part based on medical necessity.

KHS maintains a list of board-certified consultants that includes contact information, e.g., phone numbers, names, specialties) and makes the list available to all UM staff as a reference for contacting those consultants. When external consultants are not able to share their names for proprietary reasons, they will provide KHS with centralized contact information and a list of the specialties of all board-certified consultants

KHS will review prior authorizations for physician administered drugs, medical supplies, and enteral nutritional products billed on a medical claim.

Physician administered drugs (PAD) and others that are managed as part of the medical benefit will be managed by common pharmaceutical utilization management and coverage tools. Generic versions of the branded drug, biosimilars, and follow on drugs are the preferred drugs. Preferred drug lists and prior authorization lists are derived from this concept. Any limitations associated with these drugs will be communicated. Appropriate professionals of physicians and pharmacists the DUR committee will approve protocols and policies regarding this governance annually. KHS will monitor quality and safety measures for those drugs under its purview. PAD drugs and others that fall under the management of KHS as they apply, will be reviewed to enhance the safety and quality of our members. Drug recalls, those identified on the Beers list of potentially inappropriate for the elderly, and opioid and similar controlled drugs as identified in the SUPPORT Act are monitored.

Regular analytics are completed to reevaluate the need for prior authorization requirements as part of over and underutilization monitoring. KHS has a specialty referral system to track and monitor referrals requiring prior authorization. All network providers are made aware of the specialty referral processes and tracking procedures.

Inpatient Concurrent Review and Continued Stay

Concurrent review is the process of continual reassessment of the medical necessity and appropriateness of acute inpatient care during a hospital admission in order to ensure appropriate level of care that meets the member's needs. The concurrent review process is conducted by a California licensed Registered Nurses by review of the member's medical record, reviewing the hospital's case

management notes, dialoguing with the attending physician and other members of the health care team, and speaking with the patient and/or family or significant other, as needed.

Concurrent reviews are performed collaboratively with KHS contracted hospitalist groups and/or providers and KHS RN staff to determine medical necessity of admission, length of stay, and post discharge dispositions.

the UM Nurse can authorize referral requests for member discharge planning and coordination of services for post-acute care.

Discharge Planning

UM Nurse will assess member's post hospital continuing care needs and will collaborate with the provider organization's discharge planning staff to make arrangements for appropriate post-acute services pertinent to the member's recovery such as SNF, Acute Rehabilitation, DME, Home Health, specialist follow-up visits, community resources, and any other services identified. Recuperative Care and Transitional Care Clinics are designed to address potentially avoidable readmission, recidivism, and improve health through member empowerment and early intervention.

Skilled Nursing/Sub acute/ Long-Term Acute/Rehabilitation Facility Review

Review of all Skilled Nursing and Rehabilitation Facility confinements are performed by licensed professionals to ensure medical necessity of continued stay and the appropriateness of level and duration of care. This review is conducted telephonically using written KHS medical policy, Title 22 criteria, and/or MCG Criteria. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to KHS case management and social services as appropriate.

Consideration of available services in the local service area or delivery system, and the ability to meet the member's specific health care needs are evaluated as part of applying criteria and the development of an ongoing plan of care and discharge plan.

Retrospective Review

Retrospective review is also initiated for services performed by a non-contracted provider or when no authorization was obtained before completion of the non-emergent service that requires prior authorization. Members, practitioners, and provider organizations are notified by mail, fax, portal of the UM/ claims decision.

Utilization Management Decision Timeframes

Decisions to approve, modify, or deny a requested health care service are based on medical necessity and urgency of the request, and are appropriate for the nature of the member's condition. KHS remains compliant with the defined timelines under the DHCS contract. When the member faces an imminent and serious threat to his or her health, including, but not limited to, potential loss of life, limb, or other major bodily function, decisions to approve, modify or deny requests from provider, shall be made in

a timely fashion appropriate for the nature of the member's condition, not to exceed 72 hours after the Plan's receipt of the information reasonably necessary and requested by the Plan to make a determination.

- **Emergency Care**: no prior authorization is required.
- **Post-Stabilization**: KHS does not require prior authorization
- **Concurrent Review** of authorization for a treatment regimen: 5 working days or less, consistent with the urgency of the member's medical condition.
- **Retrospective Authorization**: retrospective authorization requests are processed within a reasonable established time limit, not to exceed 365 calendar days from the date of services; decisions to the provider and member are made within 30 calendar days of the receipt of information.
- **Routine Authorizations**: Decision and member notification not to exceed 7 calendar day from referral request.
- **Expedited Authorization:** Decision must not exceed 72 hours after receipt of the request for services.
- **Therapeutic Enteral Formula**: KHS complies with applicable DHCS PLs and APLs, W&I Code section 14103.6, and H&S Code section 1367.01.
- **Physician Administered Drugs**: KHS complies with same timeframes as other medical services.

Inter-Rater Reliability (IRR)

KHS assesses the consistency with which physician and non-physician reviewers apply UM criteria in decision making and evaluates Inter-Rater Reliability. An Inter-Rater Reliability (IRR) process is deployed to evaluate and ensure that UM criteria are applied consistently for UM decision-making. Bi-annually, both physicians and staff involved with making UM decisions participate in the IRR process. The Director of UM selects specific topics for completion by the UM clinical staff. The IRR training module records the completion for each user, along with the test results. KHS UM Management staff evaluates competency utilizing the MCG IRR training module for necessary remediation and education. Successful completion is required as a fulfillment of the clinical staff outlined job duties. The following types of reviews/reviewers are audited:

- Nurse Coordinator Review of Inpatient Services,
- Nurse Coordinator Review of Outpatient Services,
  Nurse Coordinator Review of Long-Term Care Services,
- Physician Reviewers,
- Behavioral Health Reviewer,
- Nurse Coordinator Review of Claims/Disputes and Appeals review for Outpatient Services and Inpatient Services.
- Non-licensed UM and Care Management Coordinators processing referral requests.

Ongoing Training

KHS provides and encourages ongoing staff training. Areas of opportunity includes seminars, conferences, workshops, training by KHS Learning and Development department, and specialty specific training by contracted practitioners and provider organizations. Network providers also

receive training on the procedures and services requiring prior authorization for medically necessary services including the necessary timeframes within 30 days of start of contract. The role of Analyst /Trainer and UM Clinical Auditor/Trainer receives direction on the training needs of specific staff members from the UM Department leaders where areas of improvement regarding error rates indicate the need for additional training of staff member(s).

The Clinical Intake Coordinators and UM Nurse staff utilize established criteria for referral review and determination. Quarterly random audits are conducted to ensure compliance of the referral process and are reported to UM Management for process improvement and staff education. Results of the findings are presented to the CMO and reported to the EQIHEC/UM Committee.

UM Determinations

Denial Determinations

Denial determinations may occur at any time during the review process. Denial decisions can only be made by a California licensed physician acting through the designated authority of the Chief Medical Officer, has the authority to render a denial determination based on medical necessity.

A denial determination may occur during continued stay/concurrent review in which case notification and/or discussion with the treating practitioner and the Health Plan physician adviser/Chief Medical Officer or physician designee is offered. (Peer to Peer)

Denial determinations may occur at different times and for various reasons including but not limited to:

- At the time of prior authorization when the requested service is not medically indicated.
- Or after services are rendered at claims review when the services were not authorized, or are medically unnecessary,

KHS offers the practitioner the opportunity to discuss any denial or potential denial determination based on lack of medical necessity with the Chief Medical Officer, or a physician reviewer designee.

The referring practitioner, provider and member are notified of the denial through a Notice of Action (NOA) letter, translated in both English and Spanish with non-discrimination clauses and tagline notations. NOA responses regarding decisions to deny, delay or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone, portal or facsimile, except with regard to decisions rendered retrospectively, and then in writing. Decisions shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours. Decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within 7 calendar days of the referral request. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care

plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. The UM team performs quarterly audits to monitor compliance with notification timeframes.

The denial notification states the reason for the denial in terms specific to the member's condition or service request and in language that is easy to understand and references the criterion used in making the determination, so the member and provider have a clear understanding of the rationale for the denial and enough information to file an appeal.

All potential denials are reviewed by the physician reviewers and only include medical information reasonably necessary to make a determination.

KHS notifies the requesting Provider of any decision to deny, approve, modify or delay a service request, a request by a Member or a Member's Provider for a covered service, or when authorizing a service in an amount, duration, or scope less than was requested. KHS communicates the decision to the Provider by written or verbal notice.

For grievances involving delay, modification, or denial of services based on a determination in whole or in part that the service is not medically necessary, KHS shall, per Rule 1300.68 (d) (4) and KHS policy 3.23-P Appeals Regarding Authorizations) include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to:

Department of Managed Health Care

HMO Help Center

980 Ninth Street, 5th floor
Sacramento, CA 95814.

In accordance with KHS policy 3.23-PAppeals Regarding Authorization and Rule 1300.68(d)(5), a response on a grievance involving a determination that the requested service is not a covered benefit, shall also include a notice that if the enrollee believes the decision was denied on ground that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review.

The Department of Health Care Services and Department of Managed Health Care provide direction to and oversight of the process of issuing written notification of non-coverage to KHS members.

KHS complies with DHCS Notice of Action Template requirements for Medi-Cal to include applicable inserts on how to file an appeal, DMHC information, translation services. This process is outlined in the KHS policies and procedures related to processing referrals.
The Health Plan does not compensate any individual involved in the utilization process to deny care or services for our members nor do we encourage or offer incentives for denials.

Appeals of Adverse Medical Necessity Denials and Benefit Determinations

A member, a member's authorized representative, or a provider acting on behalf of a member, has 60 calendar days from the date of determination to submit an appeal request in response to a Notice of

Action (NOA) letter. A member or a member's authorized representative may initiate an appeal by contacting KHS's Member Services department. An appeal initiated in this way is considered a Member Appeal and will be referred to the KHS Grievance and Appeals department for processing. A provider may also request an appeal on behalf of a member, with written consent from that member, by faxing or writing KHS's Member Services Department. Aid paid pending is available when the member requests within 10 days of NOA receipt.

After receipt of the request for appeal, KHS will provide written acknowledgement to the member and provider that is dated and postmarked within five (5) calendar days of receipt of the appeal. KHS has 30 calendar days from the receipt of the appeal request to render a determination.

The Chief Medical Officer or physician designee reviews the request for appeal if the determination was based on medical necessity. The Chief Medical Officer or physician designee may request further information from the provider such as:

- Diagnostic information,
- Clinical justification,
- Previous treatment,
- Opinions from specialists or other providers,
- Evidence from scientific literature prior to processing the request.

Only medical information that is reasonably necessary to make the determination will be requested

The provider is expected to respond to a request for further information within the 30-calendar day determination time frame for standard appeals and within 72 hours for expedited appeals

When a decision has been made, the provider and/or member, if applicable, are notified in writing with a Notice of Appeal Resolution (NAR) letter. KHS is not required to notify the member of a decision when the member is not at financial risk for the services being requested (post stabilization concurrent reviews).

If the provider or member is dissatisfied with the appeal determination, member can request a State Fair Hearing or Independent Medical Review through the California Department of Managed Health Care.

The response shall either identify the document and page where the provision is found, direct the provider and member to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applies to the specific health care service or benefit request.

<u>Expedited Appeals of Adverse Benefit Determinations</u>

Expedited appeals may be initiated by the member or the provider. A member may initiate an expedited appeal by calling the Member Services Department. A provider may initiate an expedited appeal on behalf of a member with written consent by faxing or writing the KHS Member Services Department. If the request for expedited appeal is not accompanied by written consent from the member, the Plan will not proceed with the request.

Expedited appeals are performed by KHS only when, in the judgment of the Chief Medical Director or Physician Designee, a delay in decision-making may seriously jeopardize the life or health of the member.

KHS refers the expedited appeal request to the Chief Medical Officer or Physician Designee for decision on the appeal. The Chief Medical Officer or Physician Designee is expected to make a decision as expeditiously as the medical condition requires, but no later than 72 hours after the receipt of the request for an expedited appeal.

Expedited reviews are also granted to all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.

KHS provides verbal confirmation of its decisions concurrent with mailing of written notification no later than 72 hours after receipt of an expedited appeal. If the expedited appeal involves a concurrent review determination, the member continues to receive services until a decision is made and written notification is sent to the provider. This care should not be discontinued until a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

Appeal Rights

A member may ask for assistance from a patient advocate, provider, ombudsperson, or any other person to represent them in their request.

A member may also request a State Hearing if a member has filed an appeal and received a "Notice of Appeal Resolution" letter upholding the initial denial of service or in instances of deemed exhaustion. Information on how to obtain an expedited State Hearing is included as a part of the "Notice of Appeal Resolution" letter to the member.

Member grievance and appeal information is included in the member handbook, distributed annually in the member newsletter, and is posted on the KHS website.

It is the responsibility of the Member Services Director and the Member Services Department to ensure:

- Member Rights and Responsibilities are included in the member handbook which is mailed to all new members and posted on the KHS website,
- Members are advised of their appeals rights when the adverse determination NOA is mailed to them.

Members are notified of all revisions to the Member Rights and Responsibilities statement in the member newsletter following revisions.

Independent Medical Review

Medi-Cal members can request independent medical review (IMR) on denied appeals involving medical necessity, including requests related to experimental/investigational services and receipt of out of Plan Emergency Department services. The DMHC administers the IMR program in the State of California at no cost to the member in compliance with applicable statutory requirements and accreditation standards. The IMR decision is binding on KHS.

Depending on the complexity of certain medical condition, KHS may require additional expertise in determining medical necessity for certain diagnosis and related procedures. Utilizing a nationally recognized and comprehensive review solution as a supplement to these difficult cases will provide the KHS CMO and Medical Directors with comprehensive medical recommendations utilizing case-specific patient information and history and industry standard guidelines including treatment protocols supported by current scientific evidence-based medicine to promote quality health care. Each review will be assigned to the IMR Reviewer who will be in an appropriate specialty or who will possess specific knowledge appropriate to the request of the treating provider. The IMR Physician Advisors will be specifically trained in Medicare/Medicaid rules and regulations based upon California state guidelines and remain well versed in the ongoing regulatory landscape to ensure up to date legislative rulings are current in the review process.

All services will be performed based on specific turnaround times which are calculated from the time the request and all related materials are received by the IMR reviewer. Submission of requests via a secure portal are completed by the KHS Clinical Intake Coordinator (CIC) on behalf of the CMO or designee at their direction only. It is the responsibility of the submitting CIC to track the progress of the review to ensure receipt based on the recommended turnaround timeline. The designated turnaround times will align with all DHCS timelines for medical decision making as outlined in KHS contract.

UM Programs and Service Descriptions

UM works collaboratively with the Behavioral Health and Population Health Management team to ensure appropriate services are provided to the member. Details of these departments are described in their respective Program Descriptions.

Long Term Care

Effective January 1, 2023, KHS began administering the Medi-Cal Long Term Benefit for qualifying members. Long term care may be required due to physical or mental conditions that need continuous skilled nursing services; for Medi-Cal managed care, the LTC benefit for these services includes room and board and other covered services medically necessary for care. Kern Health Systems ensures access to licensed long-term care facilities to members in need of long-term care services. These facilities may include, a. Skilled Nursing Facilities b. Sub-acute Facilities (pediatric and adult), and c. Intermediate Care Facilities. A member in need of long-term care is identified by his/her physician, health care clinician, acute care attending physician, case managers or discharge planners. To support appropriate utilization management, case management and service coordination to maintain the member at the LTC level of care, KHS follows specific protocols and standards for determining levels of care and authorizing services that are consistent with policies established by the Federal Centers for Medicare and Medicaid Services (CMS) and in accordance with: a. 22 CCR § 51335 Title 22. Social

Security Division 3. Health Care Services Subdivision 1. California Medical Assistance Program (Refs & Annos) Chapter 3. Health Care Services Article 4. Scope and Duration of Benefits § 51335. Skilled Nursing Facility Services.

Second Opinions

Members have a right to a second opinion by a qualified medical professional. A request for second opinion is reviewed to determine whether KHS has appropriately qualified medical professionals with knowledge and expertise in the member's condition who can evaluate the member and provide a second opinion. If so, the member is re-directed within the plan to obtain second opinion. When an appropriate, qualified physician is not available within the plan, an out of area/out of network referral with LOA is authorized. Please see KHS Second Opinion policy for specific requirements regarding decisions, timeliness, applicable enrollee copays, and etc.

Telemedicine/Telehealth

Telemedicine and other remote monitoring capability are a growing trend in the evaluation of a member's health. Telemedicine allows for HIPAA compliant medical information to be exchanged from one site to another via electronic communications to improve the member's clinical health status using two-way video, email, smart phones, wireless tools, and other virtual/telephonic communication modalities technology. No additional prior authorization is required for telemedicine, only the service is subject to those contained in the Prior Authorization list and limited to those KHS contracted providers who have demonstrated adequate office space, availability of a patient navigator, and suitable telemedicine equipment to connect with a remote medical group. This allows KHS additional options to serve members in both local and rural areas to improve primary care and specialty access and reduce wait times. Additional information and requirements can be found in KHS Telehealth policy.

Emergency Services

KHS complies with all applicable requirements of Consolidated Omnibus Budget Reconciliation Act (COBRA) and California Health and Safety Code Section 1371.4.
KHS shall reimburse providers for emergency services and care provided to members, until the care results in stabilization of the member. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention may be expected to result in any of the following:

- An imminent and serious threat to health including, but not limited to, the potential loss of life, limb, or other major bodily function.
- A delay in decision making would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function.

KHS strives to strengthen our collaborations with community entities to ensure appropriate utilization, improve the patient experience, and improve the health of the populations we serve. Strategies are reviewed annually to determine the best approach to reducing inappropriate ER utilization. These include:

- Broaden access to Primary Care Services,
- Focus/enroll high utilizers into Case Management programs,
- Target members with behavioral health problems.

Emergency Services and Hospital Admissions Out of Plan Screening and Stabilization

KHS does not require prior authorization for emergency services. Post-service claims review (for out of plan emergency care) considers whether the member's decision to Present to the Emergency Department was reasonable under the circumstance. Payment for emergency services and care may be denied only if the following circumstances apply:

1. If the KHS reasonably determines that the emergency services and care were never performed;
2. In cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist, a request for reimbursement to a provider for a medical screening examination may be denied.

Post-stabilization

KHS does not require prior authorization for post-stabilization care.

Completion of Covered Services

KHS, at the request of a member, provides for the completion of covered services by a terminated provider or by a nonparticipating provider. The completion of the covered service shall be provided by a terminated provider to a member who, at the time of the contract's termination, was receiving services to include:

- Acute Condition,
- Chronic Condition,
- Pregnancy,
- Terminal Illness,
- Care of a Newborn (between birth and 36 months of age),
- Performance of a surgery or other procedure authorized by the plan as part of a course of treatment,
- Applied Behavioral Analysis,
- Mental Health Condition.

The plan may require a non-participating provider, whose services are continued, to agree in writing to the same contractual terms and conditions that are imposed upon providers under current contract.

Standing Referrals

Occasionally a member will have a disease that requires prolonged treatment by or numerous visits to a specialty care provider. Once it is apparent that a member will require prolonged specialty services, UM may issue a standing referral and provide a determination within three working days from the request date made by the member or the PCP after obtaining all appropriate medical

records and information. The referral must be made within four working days of the date of the proposed treatment plan. A standing referral is an authorization that covers more visits than an initial consultation and customary follow-up visits and typically includes proposed diagnostic testing or treatment. Members are referred to providers who have completed a residency encompassing the diagnosis and treatment of the applicable disease entity.
A standing referral may be limited by number of visits and/or length of time. It is only valid during periods when the member is eligible with KHS. A standing referral may be issued to contracted or non-contracted providers as deemed appropriate by the Chief Medical Officer, or their designee(s). The Director of Provider Relations will negotiate letters of agreement for services not available within the network.

Collaboration of Services

The scope of the UM licensed staff extends beyond the management of referrals. While performing UM activities, any quality-of-care concerns may be addressed with the practitioners or provider organizations and are reported to the QI department. Collaboration between UM and QI is essential to ensure the delivery of quality care to the plan's membership.

Continuity of Care is provided upon enrollment for those members with established relationships with Primary Care Providers, Specialists, and ancillary providers to promote uninterrupted services that may have been initiated prior to the member's enrollment with KHS.

KHS is also required to provide beneficiaries with continuity of care from a non-participating provider or from a terminated provider, subject to certain conditions. The beneficiaries must be given the option to continue treatment for up to 12 months.

KHS must provide continuity of care with an out-of-network provider when KHS is able to determine that the beneficiary has an ongoing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider); the provider is willing to accept Medi-Cal Fee for Service rates; and the provider meets KHS's applicable professional standards and has no disqualifying quality of care issues.

Collaboration with other outside agencies such as Kern Regional Center, Department of Public Health, Department of Mental Health, Homeless Coalition and Housing Authority, Department of Aging and Health and Human Services, California Children Services, Denti-Cal, and other internal KHS departments and coordination of services for the KFHC membership is an important aspect of the UM process. The UM Nurse and Clinical Intake Coordinator assist the members in obtaining carved-out services and when necessary, coordinate and provide services not covered by the carved-out practitioner/provider.

The UM Nurse and Clinical Intake Coordinator coordinates Mental Health services with Kern Behavioral Health and Recovery Services through a Memorandum of Understanding pursuant to a contract between the County and the State. This coordination is essential to provide members with a seamless transition between mental health services beyond the scope of KHS responsibility to manage mild to moderate symptomatology and the more severe diagnosis under the responsibility of the County System of Care.

In addition, KHS UM staff also coordinates autism spectrum disorder (ASD) and Behavioral Intervention services with Kern Regional Center (KRC) through a Memorandum of Understanding. This coordination is essential in order to provide members with uninterrupted medical and supportive services as they transition between the systems of care.

The UM Nurse and Clinical Intake Coordinator also coordinates Specialty children's services with California Children's Services (CCS) through a Memorandum of Understanding. This coordination is essential in order to provide members with uninterrupted medical services as they transition between the systems of care.

Regularly scheduled quarterly (or more often if deemed necessary) Joint Operations Meetings are held with Mental Health, CCS, and Regional Center partners to promote coordination, quality, and timely decisions regarding member's identified needs.

The UM Nurse and Clinical Intake Coordinator also identifies members who are eligible and could benefit from KHS internal programs such as Enhanced Care Management, Complex Case Management, Disease Management, and Transitional Care programs in order to link them to additional supportive services to improve member health outcomes. KHS monitors utilization data to identify Members eligible for Enhanced Care Management (ECM), Community Support Services, and other KHS programs. Member health education and disease management are important components in member Case Management. Improvement of the member's health is a collaborative effort between the member and the member's practitioner

KHS monitors and tracks Non-Specialty mental Health Services utilization data for members. KHS will submit data to DHCS when requested.

Continuity of Care

Continuity of Care with an Out-of-Network Provider for Medi-Cal Members Transitioning into Medi-Cal Managed Care

Medi-Cal members assigned a mandatory aid code and who are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal managed care assigned to KHS have the right to request continuity of care in accordance with state law, DHCS All Plan Letter (APL18-008) and the DHCS-KHS contract, with some exceptions. All KHS members with pre-existing provider relationships who make a continuity of care request to KHS will be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another Managed Care Plan. The following guidelines will be applied:

1. KHS is able to determine that the member has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider):
    a. An existing relationship means the member has seen an out-of-network

primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment with KHS for a non-emergency visit, unless otherwise specified in the All-Plan Letter (APL18-008).

2. The provider is willing to accept Medi-Cal FFS rates,
3. The provider meets KHS's applicable professional standards and has no disqualifying quality of care issues (for the purposes of this APL, a quality-of-care issue means KHS can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other KHS members),
4. The provider is a California State Plan approved provider,
5. The provider supplies KHS with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

Continuity of Care – Terminated Providers

Continuity of care will be provided in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources: California Health and Safety Code §§ 1373.65; 1373.95; and 1373.96.

Upon member request, KHS' Utilization Management (UM) Department will utilize defined guidelines as outlined in California Health and Safety Code §§ 1373.65; 1373.95; and 1373.96 to authorize as appropriate continuity of care with a terminated provider who has been providing care for an acute condition or a serious chronic condition, for a high-risk pregnancy, or for a pregnancy that has reached the second or third trimester. In cases involving an acute condition or a serious chronic condition, KHS shall furnish the member with health care services on a timely and appropriate basis from the terminated provider for up to 90 days or a longer period if necessary for a safe transfer to another provider as determined by the plan in consultation with the terminated provider, consistent with good professional practice. In the case of a pregnancy, the plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider until postpartum services related to the delivery are completed or for a longer period if necessary for a safe transfer to another provider as determined by the plan in consultation with the terminated provider, consistent with good professional practice.

Continuity of care will not be authorized with a provider whose contract has been terminated or not renewed for reasons relating to quality cause or reason[i] or fraud or other criminal activity.

Delegation

Delegation of Utilization Management Functions

KHS has the discretion to delegate, and the responsibility to oversee, UM functions in support of the KHS UM goals and objectives. KHS also has discretion to delegate responsibility, in whole or in part, for UM to contracted affiliated providers. KHS retains accountabilities for all delegated Utilization Management activities conducted for members and ensures that delegated UM processes are designed to meet member service and access needs.

On an annual basis, KHS performs a comprehensive assessment of the delegated UM activities to include a compliance review. The entity's evaluation of delegated UM functions and assessment summaries of activities are presented to KHS Medical leadership for review and approval.

Should there be any concerns regarding failure of a delegated entity to carry out delegated activities, KHS will define corrective action plans up to and including revocation of the delegated activities. All submitted corrective action plans are monitored by the KHS Compliance department and evaluated until KHS determines that full correction action has been implemented.

Delegation of UM Activities

KHS has delegation oversight activities/processes for pre-delegation evaluation, delegation oversight activities, and regular reporting used to monitor delegates according to the standards established by KHS, licensing, and regulatory bodies. KHS may delegate Utilization Man DHCS KHS 22-20201 Utilization Management (UM) and Pharmacy functions/activities to entities with established Quality Improvement and Utilization Management programs and policies consistent with licensure and regulatory requirements.

KHS remains accountable for and has appropriate structures and mechanisms to oversee delegated activities even if it delegates all or part of these activities.

Delegation Agreement Process

KHS provides ongoing monitoring of UM activities that are delegated to contract providers. A comprehensive delegation audit is conducted by KHS at a minimum annually. A delegation agreement, including a detailed list of activities delegated and reporting requirements is signed by both the delegate and KHS. The delegation agreement outlines the responsibilities and activities of the physician network and the managed care organization that is delegated to provide utilization management services.
Delegates undergo a pre-delegation audit (survey) conducted by KHS to assure that the Medical Group/IPA is capable in its ability to meet the standards of the Plan and those of the Act and the rules there under and has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.

The delegation agreement includes the following:

- Mutually agreed upon before delegation starts,
- Describes the delegated activities and the responsibilities of KHS and those of the contracted entity and the delegated activities,
- For each activity, KHS has identified the documented reporting requirements at least semi-annually and delegated activities of the delegated entity to KHS,
- Describes the process by which KHS evaluates the delegated entity's performance for providing member experience and clinical performance data to its delegates when

requested,
- Describes the remedies available if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.

Joint Operations meetings are conducted quarterly in addition to an annual delegation audit to ensure compliance with DHCS regulatory requirements.

Delegated Triage Services

KHS contracts with a third-party vendor to provide 24/7, weekend and holiday triage services for all KHS members. The vendor provides not only triage services but also supports a member-initiated Health Library to promote education on a varying number of topics. Reports are generated monthly to monitor their activities as well as identify member patterns during execution of after hour services. Joint Operations meetings are conducted quarterly to ensure compliance with DHCS regulatory requirements.

Delegated Vision Care

Vision Care is delegated to a 3rd party vendor and capitated for all vision services. Reports are generated monthly to monitor their activities as well as identify utilization patterns. Joint Operations meetings are conducted quarterly to ensure compliance with DHCS regulatory requirements.

KHS contracts with a vendor, Care Net, to perform 24-hour Nurse Advice and triage call center activity and provides summary reports detailing the utilization of services at scheduled intervals. Monthly touchpoints are scheduled to address any issues or trends identified. Actions plans are developed if utilization patterns raise concerns for escalation. Care Net provides a Health Audio Library for member self-service of specific health topics or acute/chronic condition education.

All delegated entities are required to support and adhere to the same regulatory reporting and access standards as KHS. KHS has the responsibility to the Delegated or Subcontractor's agreement to revoke the delegation of activities or obligations or specify other remedies in instances where DHCS or KHS determine that the Subcontractor has not performed satisfactorily.

Complete delegated oversight audits are conducted at least annually, and more often if warranted, to ensure all aspects of KHS's contract are performed to the standards outlined by DHCS and DMHC.

KHS will determine corrective action plans up to and including revocation of the delegated activities. All submitted corrective action plans are monitored by the KHS Compliance department and evaluated until KHS determines that full correction action has been implemented.

Under and Over Utilization

KHS monitors under- and over-utilization of services through various aspects of the UM process including Behavioral Health Services. Through the referral authorization process, the UM Clinical Intake Coordinator/UM Nurse monitors under and over-utilization of services and intervenes

accordingly including non-specialty mental health services utilization data for both adult and pediatric members.

- The UM department monitors over and underutilization of health service activities through collaboration with the QI department, compliance, Quality Performace and Member Services.
- Over-utilization of services is monitored through several functions.
- Reports are reviewed to analyze unfulfilled authorizations or gaps in care to determine interventions directed to ameliorate any identified adverse trends, written communication is provided to providers to identify unfulfilled authorizations
- Upon request, KHS will report to DHCS all its internal reporting mechanisms used to detect member utilization and provider prescribing patterns,

Resource Management

Resource Management activities focus on the prudent and clinically appropriate allocation of resources for the provision of health care services. The UM department has the appropriate number of licensed and non-licensed staff to meet regulatory and accreditation requirements.

Evaluation of New Medical Technologies

UM Medical Directors have direct access to HAYES/Sympler research for review and reference for discussions on innovative methods not currently in use by KHS that may be implemented in the delivery of healthcare to KHS members.

KHS evaluates and addresses new developments in technology and new applications of existing technology to ensure members have equitable access to safe and effective care.

Written process includes an evaluation of the following:

- Medical Procedures,
- Behavioral healthcare procedures,
- Pharmaceuticals,
- Devices.

The following information is gathered, documented, and considered for determination:

- Proposed procedure/treatment/medication device,
- Privileging or certification requirements to perform this procedure,
- Outcome review: mortality during a global period, one year out and five years out; other known complications, actual and anticipated,
- Identification of other treatment modalities available,
- Consideration as to whether Medicare/Medi-Cal approves the service/procedure,

- Whether the medication/procedure is FDA approved,
- Literature search findings,

Medical Reviews and Audits by Regulatory Agencies

KHS' Chief Compliance and Regulatory Affairs Officer, in collaboration with the CMO, Senior Director for Health Services, and other Health Services clinical leadership, provides direct oversight to all KHS medical audits and other inquiries by our regulatory agencies, DHCS and DMHC. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QI and UM Program. CAPs for medical matters are approved and monitored by the UM Committee and EQIHEC.

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.

Provider and Member Satisfaction

Satisfaction Surveys are conducted annually by the KHS Member Services and Provider Relations Department. Results are shared with the Executive leadership and other KHS departments. Any unsatisfactory areas of the UM process are re-evaluated by the KHS Chief Medical Officer or designee, Senior Director for Health Services, and the Director of Utilization Management to develop and implement strategies to ameliorate deficiencies.

KHS participates in the Consumer Assessment of Health Plan Survey (CAHPS) Member Satisfaction Survey and utilizes these results in the assessment of member experience with the UM program. Analysis of grievance and appeal data related to UM is also monitored as a part of the member experience review.

Annual Program Evaluation

On an annual basis, KHS evaluates and revises as necessary, the UM Program Description and Evaluation. The Chief Medical Officer, in collaboration with the Senior Director for Health Services, UM Director and Medical Directors documents a yearly summary of all completed and ongoing UM 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 UM summary also includes the program scope, processes, information sources used to determine benefit coverage and medical necessity, and the level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program. A written evaluation of the UM Program is prepared and reported to the UM Committee, and EQIHEC.

As Part of the annual evaluation an Executive Summary is developed to analyze and evaluate the

annual undertakings and effectiveness of the UM Program where the evaluation shows that the program has not met its goals, the organization recommends appropriate changes incorporated into the subsequent annual UM Program Descriptions.

Record Retention

KHS maintains all records and documents necessary to disclose how it discharges its obligations under the state contract. These records and documents will disclose the quantity of Covered Services provided, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the way KHS administered its daily business, and the cost thereof.

In addition, and in accordance with 42 CFR section 438.3(u), KHS will retain the following information for no less than ten years and allow auditing entities to inspect and audit:

- Member Grievance and Appeal records as required in 42 CFR section 438.416,
- Base data as defined in 42 CFR section 438.5(c),
- MLR reports as required in 42 CFR section 438.8(k), and
- Data, information, and documentation specified in 42 CFR section 438.604, 438.606, 438.608, and 438.610.
- Records relating to prior authorization requests, including any Notices of Action (NOA) will meet the retention requirements as described in Exhibit E, Section 1.22 (Inspection and Audit of Records and Facilities).
- Names and last known addresses of all subscribers to the plan, all contracts specified in section 1300.85(b)(1)
- All contracts required to be submitted to the Department and all other contracts entered into by the plan specified in section 1300.85(b)(3)
- All requests made for payments for health care services, date of requests, and the dispositions thereof specified in section 1300.85(b)(3)
- Current list of the names and addresses of solicitor firm with which KHS contracts section1300.85(b)(4)
- Current list of all the names and address of all of the plan's officers, directors, principal shareholders, general managers, and other principal persons section 1300.85(b)(5)
- The amount of any commissions paid to persons who obtain members for plan and the manner of which commissions are determined section 1300.85(c)
- Records of last 2 years should be easily accessible, and after 2 years may be warehoused or stored subject to the availability to the director within not more than 5 days after the request thereof section 1300.85.1
- Comply with statutes and regulations regarding books and records and right to inspection and audits under Sections 1381, 1382 (a), 1385 and Rules 1300.81, 1300.85, and 1300.85.1

_____ Date _____

KHS Board of Directors (Chair/Designee)

_____ Date _____

Chief Executive Officer

_____ Date _____

Chief Medical Officer

[i] As defined in B&P Code §805(a)

EQIHEC UM Department Evaluation 2025

The Utilization Management Department implemented several process changes in 2025 to improve effectiveness and efficiency. Some of those changes include improving collaboration with our local acute facilities by having joint meetings weekly for care coordination, placing a KHS inpatient RN at facilities to improve discharge planning, and meeting monthly with our hospitalist partners. These changes have improved the effectiveness of discharge planning to ensure members receive the right care after an acute hospital admission. The UM team also initiated daily rounds, to discuss the needs of our members in acute and long-term care facilities. This has led to better care coordination that is based on medical necessity tailored to unique member needs.

Additionally, KHS Business Intelligence team created an outlier dashboard that is used to identify services that are potentially over utilized. Using this dashboard allows us to identify potential overutilization and initiate the associated process to review the quality of services and potentially adjust the need for prior authorization to ensure services meet medical necessity. One of the services identified as potentially overutilized was BHT. After an independent medical review identified 50% of the services did not meet medical necessity, KHS partnered with AllMed who has qualified professionals to review BHT medical necessity. The implementation of adding medical necessity review for BHT services revealed opportunities for improvement. Additional training and clearer communication with ABA providers prior to implementation would have facilitated a smoother transition. KHS continues to work with our ABA providers to ensure medical necessity is demonstrated.

These efforts have strengthened UM's ability to ensure that services are medically necessity, timely and delivered in the most appropriate setting. We are more closely working with our partners to provide coordinated care when our members need it the most.

For 2026, the Utilization Management team will continue to focus on quality improvement. Areas of particular focus are implementing the new CMS rule for interoperability and the regulatory changes in referral turnaround times. These goals will require new processes and efficiencies to ensure medically necessary services are provided.

KERN HEALTH SYSTEMS

To: Executive Quality Improvement Health Equity Committee (EQIHEC)

From: Michelle Curioso, Director of Population Health Management

Date: March 17, 2026

Re: Addressing Comprehensive Care for High-Risk Members through Population Health Management

---

Background:
The 2025 Population Health Management (PHM) Strategy advanced whole-person, data-driven care for Medi-Cal members in alignment with the National Committee for Quality Assurance (NCQA) standards and the Department of Health Care Services (DHCS) Managed Care requirements. The strategy focused on four priorities: keeping members healthy, managing emerging risk, improving patient safety across settings, and managing multiple chronic illnesses. In 2025, measurable progress included reduced emergency and inpatient utilization among high-risk members in Complex Case Management, successful execution of the Long-Term Care transition, and strengthened care coordination infrastructure. Opportunities for improvement included increasing timely Initial Health Appointment completion and enhancing analytics capabilities. The 2026 PHM Strategy builds on these results by advancing risk stratification through Medi-Cal Connect, strengthening transitions of care for pregnant and postpartum members, enhancing readmission prevention efforts, and reinforcing regulatory compliance and health equity initiatives.

Discussion Items:
Review of 2025 outcomes demonstrates that enrollment of high-risk members in Complex Case Management significantly reduced high-cost emergency and inpatient utilization while maintaining preventive care engagement. Efforts to ensure 100% access to required programs focused on addressing incomplete Health Risk Assessments, improving primary care follow-up, and strengthening referral oversight, resulting in improved preventive access and reduced disparities. The Long-Term Care transition was successfully implemented, with dedicated SNFist oversight and strengthened reporting processes ensuring compliance and continuity of care. Annual evaluation of utilization, transitional care, and member experience measures supported a structured, data-driven quality improvement process. Committee feedback will guide refinement of the 2026 PHM Strategy to ensure continued performance improvement, accountability, and alignment with regulatory and organizational priorities.

Fiscal Impact:
None.

Requested Action:
Review for approval.

PHM Strategy 2025 Evaluation and 2026 Strategic Plan Overview

Michelle Curioso

Director of Population Health Management

March 17, 2026

KERN HEALTH SYSTEMS

PHM Strategy Overview – 2025 Evaluation

Four NCQA PHM Strategic Priorities



KERN HEALTH SYSTEMS

Goal 1: Managing Multiple Chronic Illnesses Complex Case Management (CCM)

Goal: Enroll High-Risk Members in CCM



Key Outcomes After CCM Enrollment



Emergency utilization decreased by approximately 26%



Inpatient admissions decreased by approximately 41%



Preventive and outpatient care remained stable



CCM significantly reduced high-cost emergency and inpatient utilization while maintaining engagement in preventive care — demonstrating improved care coordination and cost efficiency.

KERN HEALTH SYSTEMS

Goal 2: Keeping Members Healthy
Basic PHM (BPHM)



Goal: 100% Access to Required Programs & Services

Monitoring Efforts

- Address incomplete Health Risk Assessments (HRAs)
- Ensure members are seen by their PCP within 12 months
- Follow up on referrals & authorizations
- Address incomplete Initial Health Appointments (IHAs)

Outcome

Improved preventive care access and reduced health disparities through proactive outreach and primary care engagement.

KERN HEALTH SYSTEMS

Goal 3: Managing Members with Emerging Risk – Long-Term Care (LTC) Transition

Objective: Execute LTC transition in compliance with DHCS



Enrollment & Engagement

- 889 members enrolled in LTC
- 772 in SNFs,
- 80 in ICF/DD facilities,
- 45 in subacute adult facilities, and
- 2 in subacute pediatric facilities.

Key Accomplishments

•100% of LTC members receive SNFist visits

•Dedicated SNFist providers hired

•Developed ICF/DD policy aligned with DHCS

•Strengthened reporting systems with BI and COSA

•Ongoing monitoring and monthly DHCS submissions

Outcome

Full identification, continuity of care, regulatory compliance, and strengthened clinical oversight.

KERN HEALTH SYSTEMS

Goal 4: Patient Safety & Outcomes
Comprehensive Analysis of the PHM Strategy

Quantitative and Qualitative Report



Utilization / Cost Measure



Clinical Measure



Member Feedback



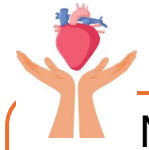
Reduction in Hospital Readmissions



Improving Well-Child Visit within the First 15 months



Complex Case Management (CCM) Program



Major Organ Transplant (MOT) Program

KERN HEALTH SYSTEMS

Population Health Management Strategy 2026

1. Implement the DHCS Risk Stratification, Segmentation, and Tiering (RSST) data into the KHS data model to enhance identification and engagement of high-risk members, supporting case management and care coordination in compliance with DHCS requirements.
2. Improve the health and well-being of all (100%) members living with chronic conditions within the next 12 months, particularly ESRD members.
3. Provide support to 100% of members who experienced a transition, ensuring continuity and quality of care within 30 days –Prenatal and Postpartum.
4. Conduct an annual comprehensive analysis of the PHM Strategy's impact, ensuring alignment with PHM NCQA Standard 6 Requirements.



KERN HEALTH SYSTEMS

Population Health Management (PHM) 2025 Strategy

Area of Focus: Managing Multiple Chronic Illnesses				
Measurement Period: January 1, 2025 – December 31, 2025				
Lead: Hasting				
Goals	Target Population	Program or Service	Numerator/ Denominator	Interventions
Develop and implement processes to enroll all high-risk members in Complex Care Management (CCM).	Seniors & People with Disabilities (SPDs) Adults with Multiple Chronic Illnesses	Complex Care Management (CCM)	Numerator: Total # of enrolled members Denominator: Total # of eligible members	1. Promote communication campaigns aimed at increasing awareness among members and providers about care management services (e.g., newsletter, website, etc.). • Use multiple channels such as email, phone calls, newsletters, and social media to reach out effectively. 2. Modify PHM referral process to ensure compliance with opt-out options for high-risk members in CCM. 3. Refer members to appropriate PHM services (care coordination, CCM and PHM Special Programs), and KHS benefits (e.g., Community Support Services, Health Education, etc.). 4. Monitor and track CCM goals and metrics aligned with HICE and NCQA: • Percentage of members eligible for CCM who are successfully enrolled in CCM Program. • Total # of CM Members Identified • Total # of CM Cases Enrolled and Managed • % CCM Cases Open and Closed / Enrollment • # of CCM Large claimant cases (>$75K) Identified/Accepted CM- as required by Health Plan • % CCM Large claimant cases (>$75K) reviewed within 30 days - as required by Health Plan.

Population Health Management (PHM) 2025 Strategy

Area of Focus: Managing Multiple Chronic Illnesses				
Measurement Period: January 1, 2025 – December 31, 2025				
Lead: Hasting & Buena				
Meet 100% of all PHM NCQA CCM Standard requirements for Health Plan and Health Equity Accreditation.	Seniors & People with Disabilities (SPDs) Adults with Multiple Chronic Illnesses	CCM	Numerator: Total # of NCQA Standards Completed Denominator: Total # of NCQA Standards	1. Utilize evidence-based clinical guidelines or algorithms to conduct assessment and management. 2. Review and update Case Management Process aligned with NCQA standards (Element C, Factors 1-17) 3. Ensure Initial Assessment is completed within sixty calendar days (Element D, Factors 1-12) and provide ongoing management including summary of changes (Element E, Factors 1-5) 4. Provide monthly monitoring and auditing of case files to ensure adherence to NCQA requirements. Ensure staff achieves a minimum score of 85% of each episode audit.
Implement all required health and psychosocial screening tools for all members, adhering to DHCS requirements within the next 12 months.	Seniors & People with Disabilities (SPDs) Adults with Multiple Chronic Illnesses Children with Special Health Care Needs (CSHCN) All Pregnant Individuals	CCM Major Organ Transplant Program (MOT) CSHCN (Kids & Youth Program) Baby Steps Plus Program Basic Population Health Management (BPHM)	**ACEs** Numerator: Members who completed an ACEs screening during the measurement period. Denominator: Members eligible for ACEs screening (based on age and periodicity schedule). **CSCHN** Numerator: Children who completed a CSHCN screening during the measurement period. Denominator: Eligible pediatric members (based on age 0–21 and plan policy). **GPCOG** Numerator:	1. Monitor implementation of screening tools and ensure members' needs are addressed following positive screenings. • Adverse Childhood Experiences (ACEs) Screening Tool • Children with Special Health Care Needs (CSHCN) Screening Tool • General Practitioner Assessment of Cognition (GPCOG) Screening Tool • Pearls Screening Tools (Children and Teens) 2. Implement screening tools and share results to providers via HealthX Provider Portal.

			Members who completed a GPCOG screening during the measurement period. Denominator: Eligible adult members (typically older adults meeting the age or risk criteria). **PEARLS** Numerator: Children/teens who received a PEARLS screening during the measurement period. Denominator: Eligible pediatric/teen members based on age guidelines and periodicity.	3. Explore other multichannel approaches to access screening tools (e.g., iPads) in collaboration with Member Engagement Department.
Area of Focus: Managing Multiple Chronic Illnesses				
Measurement Period: January 1, 2025 – December 31, 2025				
Lead: Buena				
Improve the health and well-being of all (100%) members living with chronic conditions within the next 12 months.	Seniors & People with Disabilities (SPDs) Adults with Multiple Chronic Illnesses	COPD Clinics Major Organ Transplants (MOT) Program ER Frequent Users Program End Stage Renal Disease (ESRD) Clinics Basic Population Health Management (BPHM) Palliative Care Program KM Diabetes Clinic	<u>COPD Clinics</u> Target: More than 75% of COPD members getting in the program will avoid ER visit within 90 days of enrollment. Numerator 1: Total # of ER Visits made by COPD members Denominator 1: Total # of enrolled members in the COPD Clinics <u>MOT</u> Target: 100% of post-transplant members will avoid hospital readmission within 30 days of hospital discharge. Numerator 2: Total # of post-transplant members with hospitalization readmission within 30 days Denominator 2:	1. Review and analyze ER Visits before and after enrolled to the COPD, ESRD, and Palliative Care Program. 2. Review and analyze percentage of members who had at least 1 PCP visits within 12 months period, as part of Basic Population Health Management. 3. Review and analyze post-transplant members with hospitalization readmission within 30 days. 4. Improve reporting process/procedure for MOT Program and COPD Clinics aimed at managing high-risk members with chronic conditions. This includes dashboard to monitor and evaluate special programs performance/deliverables. 5. Continue to enroll all members eligible for MOT and COPD Program. 6. Continue to monitor and evaluate enrollment and

			Total # of post-transplant members in MOT <u>ER Frequent Users Program</u> Numerator 1: Total # of adult members who visited the ER. Denominator 1: Total # of adult KHS members <u>ESRD Clinics</u> Target: More than 75 % of ESRD members getting in the program will avoid ER visit within 90 days of enrollment. Numerator 1: Total # of ESRD members who visited the ER Denominator 1: Total # of enrolled members in the ESRD Program <u>Basic Population Health Management (BPHM)</u> Numerator 1: Total # of members who had at least 1 PCP visits within 12 months period Denominator 1: Total # of KHS enrolled members <u>Palliative Care Program</u> More than 75 % of Palliative Care members getting in the program will avoid ER visit within 90 days of enrollment. Numerator 1: Total # of Palliative Care Members who visited the ER Denominator 1: Total # of enrolled members in the Palliative Care Program <u>KM Diabetic Clinic</u>	program impact of ER Frequent Users Program. 7. Develop new special program(s) to address high-risk members with chronic conditions. • End Stage Renal Disease (ESRD) by December 2025. 8. Continue to strengthen partnership with providers to provide comprehensive quality care and coordination for members with chronic illnesses. 9. Facilitate quarterly meetings with KM DM Clinic to review clinical outcomes 10. Monitor total number of referrals made to Community Support Services (CSS) and ensure closed loop referral. 11. Monitor total number of referrals made to the Diabetic Prevention Program (DPP) and ensure closed loop referral.

			Target: 30 % of members are able to show improvement in the A1C level in the post enrollment test. Measure A1c level on patients before enrollment to KM DM Clinic versus after enrollment Numerator 1: Sum of all individual changes in A1c levels (post-enrollment A1c - Pre-enrollment A1c) for all patients. Denominator 1: Total number of patients with both pre-enrollment and post-enrollment A1c levels available.	
Area of Focus: Keeping Members Healthy				
Measurement Period: January 1, 2024 – December 31, 2024				
Lead: Hasting & Buena				
Goals	**Target Population**	**Program or Service**	**Numerator/ Denominator**	**Interventions**
Achieve access for all (100%) members to required programs and services as part of Basic Population Health Management (BPHM), ensuring timely delivery in appropriate settings within the next 12 months.	All new members	Complex Care Management (CCM) Major Organ Transplant Program (MOT) CSHCN (Kids & Youth Program) Baby Steps Plus Program Basic Population Health Management (BPHM)	100 % of members getting an IHA within 120 days of enrollment. Numerator: Newly enrolled members who got an IHA within 120 days of enrollment. Denominator: Total # of newly enrolled members	1. Send reminder letter to providers regarding new members needing IHAs within 120 days of enrollment. 2. Member Services Department will send letters to new members informing them about IHAs.

	Seniors & People with Disabilities (SPDs) Adults with Multiple Chronic Illnesses Children with Special Health Care Needs (CSHCN) All Pregnant Individuals	CCM MOT CSHCN (Kids & Youth Program) Baby Steps Plus Program BPHM	<u>PCP:</u> Numerator 1: Total # of members seen by PCP Denominator1: Total # of members referred to PCP <u>Gaps in Care:</u> Total # of members referred to community resources and KHS benefits <u>Education:</u> Total # of HealthWise Education sent to members	1. Refer to PCP if member has not been seen within 12 months. 2. Screen members for gaps in care. 3. Educate members on the importance of wellness and preventive services using HealthWise (evidence-based) educational platform.
	Seniors & People with Disabilities (SPDs) Adults with Multiple Chronic Illnesses Children with Special Health Care Needs (CSHCN) All Pregnant Individuals	CCM MOT CSHCN (Kids & Youth Program) Baby Steps Plus Program BPHM	<u>PHM Services for Care Coordination</u> Numerator: Total # of members enrolled in PHM services for care coordination Denominator: Total # of members referred to PHM services for care coordination <u>KHS Benefits</u> Numerator: Total # of members who received KHS benefits Denominator Total # of members referred KHS benefits	1. Refer members to appropriate PHM services (care coordination, CCM and PHM Special Programs), and KHS benefits (e.g., CSS, Health Education). • Ensure closed-loop referrals to social service organizations have been completed and ensure any home service needed have commenced. • Ensure members keep appointments with specialists (if applicable) and follow up with referrals.

	Seniors & People with Disabilities (SPDs) Adults with Multiple Chronic Illnesses Children with Special Health Care Needs (CSHCN) All Pregnant Individuals	CCM MOT CSHCN (Kids & Youth Program) Baby Steps Plus Program BPHM	Numerator: Total # of members (new and existing) who have completed HRA within 90 days of enrollment. Denominator: Total # of members who are due for an HRA (existing and new members) IHA for adults and children: 100 % of members getting an IHA within 120 days of enrollment. Numerator: Newly enrolled members who got an IHA within 120 days of enrollment. Denominator: Total # of newly enrolled members	Monitor and Evaluate BPHM Dashboard and Address Deficiencies: 1. HRA, PCP Assigned Verify accuracy of Health Risk Assessment (HRA) completion status. 2. ED Visit Track Emergency Department utilization trends. Flag high-frequency users and coordinate follow-up or case management as needed. 3. IHA – Adult Monitor completion of Initial Health Assessments for adult members. Address missing or overdue assessments. 4. IHA – Child Track IHA completion for pediatric members. Ensure timely follow-up and documentation per guidelines.

Area of Focus: Managing Members with Emerging Risk				
Measurement Period: January 1, 2025 – December 31, 2025				
Lead: Buena				
Goals	**Target Population**	**Program or Service**	**Numerator/ Denominator**	**Interventions**

Population Health Management (PHM) 2025 Strategy

Implement the Bold Goals 50X2025 initiatives to achieve specific and accelerated improvements in identified Clinical Focus Areas within the next 12 months. • 75% of women enrolled in Baby Steps Plus receive postpartum care in a timely care. • 100% of women enrolled in Baby Steps Plus who tested positive in PHQ-9 will be referred to Behavioral Health.	All Pregnant Individuals Children with Special Health Care Needs (CSHCN)	Baby Steps Baby Steps Plus CSHCN (Kids & Youth Program) BPHM	Baby Steps Plus Numerator 1: Women who received postpartum visit within the appropriate timeframe Denominator 2: Women who had a delivery in the measurement period Postpartum Numerator 1: Women who received postpartum visit within the appropriate timeframe Denominator 1: Women who had a delivery in the measurement period Positive PHQ-9 Screening Numerator 2: Women who was referred to Behavioral Health Denominator 2: Women who tested positive in PHQ-9 CCS Adult Transition (Kids and Youth Transition Program) Measure: Percentage of eligible youth enrolled in the CCS Transition Program. Numerator: Youth enrolled in the CCS Adult Transition Program. Denominator: Total eligible youth identified for transition. Kids and Youth Program Measure: Percentage of eligible children enrolled in the Kids & Youth Program.	1. Continue to provide care coordination, case management, and integrate wellness and preventive care, focusing on children. • CCS Adult Transition (aka Kids and Youth Transition) • Kids and Youth Program • Children with Special Health Care Needs • Early Periodic Screening and Developmental Testing (EPSDT) 2. Continue to provide care coordination, case management, and integrate wellness and preventive care, focusing on maternal health. • High Risk Pregnancy (aka Baby Steps Plus) 3. Partner with children's health organizations in their local communities, including First 5 County Commissions, Early Start, and other community-based organizations.

			Numerator: Children enrolled in the Kids and Youth Program. Denominator: Total eligible children identified for program enrollment. Children with Special Health Care Needs (CSHCN) Measure: Percentage of eligible children identified and enrolled in CSHCN. Numerator: Children identified and enrolled as CSHCN. Denominator: Total eligible children (based on screening or referral criteria). Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Measure: Percentage of eligible members enrolled for EPSDT Care Coordination Numerator: Members enrolled for EPSDT Care Coordination services. Denominator: Total eligible pediatric members (age-based: 0–21).	
Execute the transition of Long-Term Care (LTC) services for members in Skilled Nursing Facilities, Intermediate Care Facilities (ICF) / Developmentally Disabled (DD) facilities for adult and pediatric population	Long Term Care (LTC) eligible members	LTC	<u>Continuity of Care</u> Numerator: Total # of LTC provided continuity of care Denominator: Total # of LTC Eligible Member	1. Identify all LTC KHS members to ensure continuity of care. 2. Collaborate with the following agencies to discuss partnership, roles, and responsibilities: • Kern Regional Center • Subacute Adult and Pediatric Care • ICF/DD Facilities (Home, Habilitative and Nursing)

in compliance with DHCS requirements by January 2024.				3. Develop ICF/DD policy aligned with DHCS requirements. 4. Continue to work with BI and COSA and other KHS internal departments to establish reporting system to ensure monthly reports validity and timely submission to DHCS. 5. Continue to monitor and evaluate LTC Program's deliverables/activities and outcomes aligned with DHCS requirements.

Area of Focus: Patient Safety or Outcomes Across Settings

Measurement Period: January 1, 2025 – December 31, 2025

Lead: Buena

Goals	Target Population	Program or Service	Numerator/ Denominator	Interventions
Provide support to 100% of members who experienced a transition, ensuring continuity and quality of care within 30 days	Seniors & People with Disabilities (SPDs) Adults with Multiple Chronic Illnesses Children with Special Health Care Needs (CSHCN) All Pregnant Individuals	TCS CCM MOT CSHCN (Kids & Youth Program) Baby Steps Plus Program LTC Program BPHM TOC Clinics	Numerator 1: Total # of high-risk transitioning members enrolled for TCS services Denominator 1: Total # of high-risk transitioning members successful contacts Numerator 2: Target: 100% of members are seen on a follow-up visit within 7 days of discharge. Total # of members seen for follow up appointment within 7 days post-discharged Denominator 2:	1. Assign/notify a single point of contact/care Manager –High Risk 2. Ensure transitioning members have a dedicated number to call to connect to a dedicated TCS team who can access discharge documents, if needed –Low Risk. 3. Directly notify transitioning members of the dedicated team and how to contact. 4. Ensure discharge risk assessment is completed and coordinate with discharging facility. 5. Share discharge planning documents to patients, PCP, and other providers, coordinated with discharging facility. 6. Ensure follow-up ambulatory visit within 7 days post hospital discharge. 7. Ensure ambulatory follow up appointment with medication reconciliation is completed within 30 days. 8. Offer TCS support through dedicated telephonic team for at least 30 days post-discharge and refer to appropriate services/benefits (e.g., ECM, CCM, etc.). 9. Refer high-risk members to Transition of Care (TOC) Clinics for follow-up post-discharge (if needed).

			Total # of transitioning members Numerator 3: Total # of letters mailed to transitioning members Denominator 3: Total # of transitioning members	
Area of Focus: Patient Safety or Outcomes Across Settings				
Measurement Period: January 1, 2025 – December 31, 202				
Lead: Curioso				
Conduct an annual comprehensive analysis of the PHM Strategy's impact, ensuring alignment with PHM NCQA Standard 6 Requirements.	Seniors & People with Disabilities (SPDs) Adults with Multiple Chronic Illnesses	CCM MOT	100% completion of required quantitative and qualitative report: • 1 Clinical Outcome • 1 Utilization Cost • 2 Member Experience	1. Complete and submit annual comprehensive analysis of PHM Strategy impact and include the following measures to consulting agency, CMO and Medical Director. • Quantitative results for relevant clinical, cost/utilization and experience measures. • Comparison of results with a benchmark or goal. • Interpretation of result. 2. Complete and document process, reports, or materials on action taken to address identified opportunities.

Population Health Management (PHM) 2026 Strategy

Executive Summary

The 2026 PHM Strategy outlines a coordinated, data-driven approach to improve health outcomes, reduce avoidable utilization, and ensure full regulatory compliance. The strategy focuses on high-risk populations, including Seniors and Persons with Disabilities (SPDs), adults with multiple chronic conditions, pregnant individuals, and children with special health care needs.

Key Priorities

1. Manage Multiple Chronic Illnesses
    - Enroll 100% of eligible high-risk members into Complex Care Management (CCM).
    - Achieve full compliance with NCQA CCM standards (timely assessments, ≥85% audit scores, life-planning documentation).
    - Reduce ER utilization and 30-day readmissions.
    - Improve chronic disease outcomes (e.g., diabetes A1c control).
    - Ensure closed-loop referrals to social and community supports.
2. Keep Members Healthy
    - Ensure 100% of new members receive an Initial Health Assessment within 120 days.
    - Increase annual PCP visits and close preventive care gaps.
    - Strengthen referrals to PHM programs and benefits with tracking and follow-up.
3. Identity and Manage Emerging Risk
    - Achieve 75% timely postpartum visits.
    - Ensure 100% behavioral health referrals for positive depression screenings.
    - Implement DHCS Risk Stratification, Segmentation, and Tiering (RSST) to identify and engage high-risk members.
    - Monitor engagement and outcomes through dashboards.
4. Ensure member safety or/and outcomes across settings
    - Provide transition support to 100% of high-risk members post-discharge.
    - Ensure 7-day follow-up visits and medication reconciliation within 30 days.
    - Coordinate care across hospitals, PCPs, and specialty programs.

Expected Outcomes

By December 2026, the PHM Strategy will achieve:

- Full NCQA PHM/CCM compliance.
- Expanded high-risk member engagement.
- Reduced avoidable ER visits and readmissions.
- Improved maternal and chronic disease outcomes.
- Stronger integration of medical, behavioral, and social care services.

Population Health Management (PHM) 2026 Strategy

Area of Focus: Managing Multiple Chronic Illnesses				
Measurement Period: January 1, 2026 – December 31, 2026				
Lead: Hasting & Buena				
Goals	**Target Population**	**Program or Service**	**Numerator/ Denominator**	**Interventions**
Develop and implement processes to enroll all high-risk members in Complex Care Management (CCM).	Seniors & People with Disabilities (SPDs) Adults with Multiple Chronic Illnesses	Complex Care Management (CCM)	Numerator: Total # of enrolled members Denominator: Total # of eligible members	1. Promote communication campaigns aimed at increasing awareness among members and providers about care management services (e.g., newsletter, website, etc.). • Use multiple channels such as email, phone calls, newsletters, and social media to reach out effectively. 2. Modify PHM referral process to ensure compliance with opt-out options for high-risk members in CCM. 3. Refer members to appropriate PHM services (care coordination, CCM and PHM Special Programs), and KHS benefits (e.g., Community Support Services, Health Education, etc.). 4. Monitor and track CCM goals and metrics aligned with HICE and NCQA: • Percentage of members eligible for CCM who are successfully enrolled in CCM Program. • Total # of CM Members Identified • Total # of CM Cases Enrolled and Managed • % CCM Cases Open and Closed / Enrollment • # of CCM Large claimant cases (>$75K) Identified/Accepted CM- as required by Health Plan • % CCM Large claimant cases (>$75K) reviewed within 30 days - as required by Health Plan.

Population Health Management (PHM) 2026 Strategy

Area of Focus: Managing Multiple Chronic Illnesses				
Measurement Period: January 1, 2026 – December 31, 2026				
Lead: Hasting & Buena				
Meet 100% of all PHM NCQA CCM Standard requirements for Health Plan and Health Equity Accreditation.	Seniors & People with Disabilities (SPDs) Adults with Multiple Chronic Illnesses	CCM	Numerator: Members who completed a documented initial assessment addressing all required NCQA factors within 60 calendar days of CCM enrollment. Denominator: All members newly enrolled in the CCM program during the measurement period. Numerator: Case files achieving a minimum audit score of ≥85% based on NCQA-aligned audit criteria. Denominator: Total number of CCM case files audited during the measurement period. Numerator: Members with documented evidence in the case management record that at least one of the following occurred during the initial assessment: Denominator: All members newly enrolled in the CCM program during the measurement period. Numerator: Number of quarters in which a documented CCM mock chart review was completed. Denominator: Total number of quarters in the measurement year.	1. Implement Initial Assessment completed within sixty calendar days (Element D, Factors 1-12) and provide ongoing management including summary of changes (Element E, Factors 1-5). 2. Continue to provide monthly monitoring and auditing of case files to ensure adherence to NCQA requirements. Ensure staff achieves a minimum score of 85% of each episode audit. 3. Assess life-planning activities during the initial assessment and document member status, appropriateness, and actions taken, or provide life-planning information to all CCM members (Element E, Factor 6). 4. Conduct quarterly chart mock reviews of CCM case files to evaluate compliance with NCQA PHM/CCM standards and identify gaps prior to recertification NCQA review.
Within the next 12 months, ensure that all implemented health and	Seniors & People with Disabilities (SPDs)	CCM Major Organ Transplant	Numerator: Number of members whose care plans reflect identified needs from	1. Ensure care plans are reviewed and updated within a defined timeframe (e.g., 30 days) following

psychosocial screening tools are consistently administered, accurately documented, and used to inform individualized care planning in compliance with DHCS standards.	Adults with Multiple Chronic Illnesses Children with Special Health Care Needs (CSHCN) All Pregnant Individuals	Program (MOT) CSHCN (Kids & Youth Program) Baby Steps Plus Program Basic Population Health Management (BPHM)	health and psychosocial screening results. Denominator: Total number of members with completed DHCS-required screenings. Numerator: Number of members with positive screening results who received appropriate referrals within required timeframes. Denominator: Total number of members with positive findings on health or psychosocial screenings.	completion of health and psychosocial screenings. 2. Include a mandatory section in the care plan to document screening-identified needs and related goals. 3. Conduct routine reviews of care plans to confirm screening results are addressed. 4. Provide corrective feedback when screening-identified needs are missing or insufficiently documented. 5. Implement a referral tracking log or EHR functionality to monitor: • Date of positive screening • Date referral was made • Type of service referred • Follow-up status 6. Ensure follow-up with members to address barriers to accessing services. 7. Partner with Member Engagement to explore other multichannel approaches to access screening tools (e.g., iPads).
Area of Focus: Managing Multiple Chronic Illnesses				
Measurement Period: January 1, 2026 – December 31, 2026				
Lead: Hasting & Buena				
Improve the health and well-being of all (100%) members living with chronic conditions within the next 12 months.	Seniors & People with Disabilities (SPDs) Adults with Multiple Chronic Illnesses	COPD Clinics Major Organ Transplants (MOT) Program ER Frequent Users Program End Stage Renal Disease (ESRD) Clinics	<u>COPD Clinics</u> Numerator 1: Total # of ER Visits made by COPD members Denominator 1: Total # of enrolled members in the COPD Clinics <u>MOT</u> Numerator 2: Total # of post-transplant members with hospitalization readmission within 30 days Denominator 2:	1. Review and analyze ER Visits before and after enrolled to the COPD, ESRD, and Palliative Care Program. 2. Review and analyze percentage of members who had at least 1 PCP visits within 12 months period, as part of Basic Population Health Management. 3. Review and analyze post-transplant members with hospitalization readmission within 30 days. 4. Improve reporting process/procedure for MOT

		Basic Population Health Management (BPHM) Palliative Care Program KM Diabetes Clinic	Total # of post-transplant members in MOT <u>ESRD Clinics</u> Numerator 1: Total # of ESRD members who visited the ER Denominator 1: Total # of enrolled members in the ESRD Program <u>Homebound Program</u> Numerator 1: Total # of adult homebound members who visited the ER Denominator 1: Total # of enrolled members in the Homebound Program <u>Basic Population Health Management (BPHM)</u> Numerator 1: Total # of members who had at least 1 PCP visits within 12 months period Denominator 1: Total # of KHS enrolled members <u>Palliative Care Program</u> Numerator 1: Total # of Palliative Care Members who visited the ER Denominator 1: Total # of enrolled members in the Palliative Care Program <u>KM Diabetic Clinic</u> Measure A1c level on patients before enrollment to KM DM Clinic versus after enrollment Numerator 1: Sum of all individual changes in A1c levels (post-enrollment A1c - Pre-enrollment A1c) for all patients. Denominator 1: Total number of patients with both pre-enrollment	Program and COPD Clinics aimed at managing high-risk members with chronic conditions. This includes dashboard to monitor and evaluate special programs performance/deliverables. 5. Enroll all members eligible for MOT and COPD Program. 6. Develop new special programs to address high-risk members with chronic conditions. • End Stage Renal Disease (ESRD) by December 2026 • Homebound Program by December 2026 7. Track ER utilization rates monthly for the Palliative Care Program. • Compare performance against internal benchmarks or historical data. • Implement corrective actions when ER utilization exceeds targets. 8. Establish partnership with providers to provide comprehensive quality care and coordination for members with chronic illnesses 9. Provide access to chronic disease self-management education (Health Wise platform) for individuals identified with chronic diseases (e.g., diabetes, asthma) 10. Quarterly meeting with KM DM Clinic to review clinical outcomes 11. Monitor total number of referrals made to Community Support Services (CSS) and ensure closed loop referral.

			and post-enrollment A1c levels available.	12. Monitor total number of referrals made to the Diabetic Prevention Program (DPP) and ensure closed loop referral.
Area of Focus: Keeping Members Healthy				
Measurement Period: January 1, 2026 – December 31, 2026				
Lead: Hasting & Buena				
Goals	**Target Population**	**Program or Service**	**Numerator/ Denominator**	**Interventions**
Achieve access for all (100%) members to required programs and services as part of Basic Population Health Management (BPHM), ensuring timely delivery in appropriate settings within the next 12 months.	All new members	Complex Care Management (CCM) Major Organ Transplant Program (MOT) CSHCN (Kids & Youth Program) Baby Steps Plus Program Basic Population Health Management (BPHM)	100 % of members getting an IHA within 120 days of enrollment. Numerator: Newly enrolled members who got an IHA within 120 days of enrollment. Denominator: Total # of newly enrolled members	1. Send reminder letter to providers regarding new members needing IHAs within 120 days of enrollment. 2. Member Services Department will send letters to new members informing them about IHAs.
	Seniors & People with Disabilities (SPDs) Adults with Multiple Chronic Illnesses Children with Special Health Care Needs (CSHCN) All Pregnant Individuals	CCM MOT CSHCN (Kids & Youth Program) Baby Steps Plus Program BPHM	<u>PCP:</u> Numerator 1: Total # of members seen by PCP Denominator1: Total # of members referred to PCP <u>Gaps in Care:</u> Total # of members referred to community resources and KHS benefits <u>Education:</u> Total # of Health Wise Education sent to members	1. Refer to PCP if member has not been seen within 12-months. 2. Screen members for gaps in care 3. Educate members on the importance of wellness and preventive services using Health Wise (evidence-based) educational platform
	Seniors & People with Disabilities (SPDs)	CCM MOT	<u>PHM Services for Care Coordination</u> Numerator:	1. Refer members to appropriate PHM services (care coordination, CCM and PHM Special Programs), and KHS

	Adults with Multiple Chronic Illnesses Children with Special Health Care Needs (CSHCN) All Pregnant Individuals	CSHCN (Kids & Youth Program) Baby Steps Plus Program BPHM	Total # of members enrolled in PHM services for care coordination Denominator: Total # of members referred to PHM services for care coordination <u>KHS Benefits</u> Numerator: Total # of members who received KHS benefits Denominator Total # of members referred KHS benefits	benefits (e.g., CSS, Health Education). • Ensure closed-loop referrals to social service organizations have been completed and ensure any home service needed have commenced. • Ensure members keep appointments with specialists (if applicable) and follow up with referrals.

Area of Focus: Managing Members with Emerging Risk				
Measurement Period: January 1, 2026 – December 31, 2026				
Lead: Michelle and Desiree				
Goals	**Target Population**	**Program or Service**	**Numerator/ Denominator**	**Interventions**
Implement the Bold Goals 50X2025 initiatives to achieve specific and accelerated improvements in identified Clinical Focus Areas within the next 12 months. • 75% of women enrolled in Baby Steps Plus receive postpartum care in a timely care. • 100% of women enrolled in Baby Steps Plus who tested positive in PHQ-9 will be referred to Behavioral Health.	All Pregnant Individuals Children with Special Health Care Needs (CSHCN)	Baby Steps Plus CSHCN (Kids & Youth Program) BPHM	<u>Maternal Outcomes</u> Numerator 1: Women who received postpartum visit within the appropriate timeframe Denominator 2: Women who had a delivery in the measurement period Numerator 2: Women who was referred to Behavioral Health Denominator 2: Women who tested positive in PHQ-9	1. Identify women with high-risk pregnancies (e.g., gestational diabetes, hypertension, preterm birth) and prioritize outreach for postpartum care within 2–6 weeks of delivery. 2. Assign care coordinators navigators to assist women in scheduling, and transportation to attend postpartum visits. 3. Provide culturally tailored education to women and families about the importance of timely postpartum care. Include materials on warning signs, preventive care, and available resources. 4. Track postpartum visit completion rates monthly. 5. Audit charts monthly to ensure all positive PHQ-9 screenings resulted in referrals. 6. Address any gaps immediately through staff coaching or process improvement. 7. Partner with children's health organizations in their local communities, including First 5 County Commissions, Early Start, and other community-based organizations.
By 2026, implement the DHCS Risk	All Members	All KHS Programs	Numerator: Number of	1. Map RSST data fields into the KHS data model for accurate population identification.

Stratification, Segmentation, and Tiering (RSST) data into the KHS data model to enhance identification and engagement of high-risk members, supporting case management and care coordination in compliance with DHCS requirements.		(e.g., CCM, MOT, LTC, MOT, Baby Steps Plus, CSCHN, KAY-T).	members identified as high-risk using RSST data after implementation. Total number of members in the MCP at baseline. Numerator: Number of high-risk members (RSST-identified) who participate in at least one care coordination or case management interaction during the measurement period. Denominator: Total number of high-risk members identified via RSST data after implementation.	2. Ensure secure, HIPAA-compliant data transfer from DHCS to the MCP systems. 3. Provide guidance on using analytics dashboards and risk stratification tools. 4. Use RSST data to identify high-risk members who were previously unengaged. 5. Stratify members into tiers to prioritize outreach and interventions based on risk level. 6. Develop protocols for outreach, follow-up, and intervention for newly identified high-risk members. 7. Assign case managers and care coordinators based on risk tier to ensure timely engagement. 8. Establish monthly dashboards tracking high-risk membership, engagement rates, and care coordination activities. 9. Compare baseline metrics to post-implementation metrics to monitor progress toward targets. 10. Use findings from dashboards to refine risk stratification criteria and engagement strategies. 11. Address gaps in engagement or data quality as identified through ongoing audits.

Area of Focus: Patient Safety or Outcomes Across Settings				
Measurement Period: January 1, 2026 – December 31, 2026				
Lead: Desiree				
Goals	**Target Population**	**Program or Service**	**Numerator/ Denominator**	**Interventions**
Provide support to 100% of members who experienced a transition, ensuring continuity and quality of care within 30 days	Seniors & People with Disabilities (SPDs) Adults with Multiple Chronic Illnesses Children with Special Health	TCS CCM MOT CSHCN (Kids & Youth Program)	Numerator 1: Total # of high-risk transitioning members enrolled for TCS services Denominator 1: Total # of high-risk transitioning members successful contacts	1. Assign/notify a single point of contact/care Manager –High Risk 2. Ensure transitioning members have a dedicated number to call to connect to a dedicated TCS team who can access discharge documents, if needed –Low Risk 3. Directly notify transitioning members of the dedicated team and how to contact 4. Ensure discharge risk assessment is completed and coordinate with discharging facility 5. Share discharge planning document to patient, PCP, and other providers, coordinated with discharging facility

	Care Needs (CSHCN) All Pregnant Individuals	Baby Steps Plus Program LTC Program BPHM TOC Clinics	Numerator 2: Total # of members seen for follow up appointment within 7 days post-discharged Denominator 2: Total # of transitioning members Numerator 3: Total # of letters mailed to transitioning members Denominator 3: Total # of transitioning members	6. Ensure follow-up ambulatory visit within 7 days post hospital discharge 7. Ensure ambulatory follow up appointment with medication reconciliation is completed within 30 days 8. Offer TCS support through dedicated telephonic team for at least 30 days post-discharge and refer to appropriate services/benefits (e.g., ECM, CCM, etc.). 9. Refer high-risk members to Transition of Care (TOC) Clinics for follow-up post-discharge (if needed)
Area of Focus: Patient Safety or Outcomes Across Settings				
Measurement Period: January 1, 2026 – December 31, 2026				
Lead: Curioso				
Conduct an annual comprehensive analysis of the PHM Strategy's impact, ensuring alignment with PHM NCQA Standard 6 Requirements.	Seniors & People with Disabilities (SPDs) Adults with Multiple Chronic Illnesses	CCM MOT	100% completion of required quantitative and qualitative report: • 1 Clinical Outcome • 1 Utilization Cost • 2 Member Experience	1. Complete and submit annual comprehensive analysis of PHM Strategy impact and include the following measures to consulting agency, CMO and Medical Director: • Quantitative results for relevant clinical, cost/utilization and experience measures. • Comparison of results with a benchmark or goal. • Interpretation of result. 2. Complete and document process, reports, or materials on action taken to address identified opportunities.

Kern Family Health Care™

Population Health Management (PHM) Strategy Evaluation 2025
Measurement Period: January 1, 2025 – December 31, 2025

Introduction

The Population Health Management (PHM) Department focuses on improving quality of care and health equity for all Medi-Cal members by expanding access to coordinated and whole person care and addressing social determinants of health (SDOH). The key to PHM is to engage members with their health care and address SDOH and gaps in care while reducing costs. The primary care physician (PCP) is the quarterback who catches problems early with screening and refers patients to specialists, if needed. Kern Health System (KHS) PHM has identified and prioritized four strategic priorities with the emphasis on National Committee for Quality Assurance (NCQA) focus areas:

1. *Manage members with chronic conditions*
2. *Keep members healthy*
3. *Identify and manage members with emerging risk*
4. *Ensure member safety or/and outcomes across settings*

These four priorities within each focus areas further delineate and communicate the most pressing needs of our populations. The priorities were utilized to create goals and objectives aligned with the NCQA PHM standards, Department of Health Care Services (DHCS) requirements and 2023-2025 KHS Strategic Plan. NCQA is the predominant accreditation organization for Medi-Cal Plans. NCQA developed HEDIS (Health Plan Employer Data and Information Set) as a standard tool to assess health plan performance for purchasers and consumers to compare health plans.

Area of Focus: Managing Multiple Chronic Illness
Goal 1: Ensure High-Risk Members Are Enrolled in Complex Case Management (CCM)

Target Population: Seniors & People with Disabilities (SPDs) and adults with multiple chronic illnesses

Objective: Ensure that all high-risk members are enrolled in CCM and actively engaged, measured using a numerator/denominator approach:

- Numerator: Total number of members successfully enrolled in CCM
- Denominator: Total number of eligible members

Strategies:

1. Multi-channel communication campaigns to raise awareness among members and providers via the Provider Newsletter, KHS website, and phone outreach.
2. A structured PHM referral process compliant with opt-out requirements to identify and refer to high-risk members.
3. Direct members to the full range of PHM services, including care coordination, CCM, special programs, and additional benefits such as Community Support Services and Health Education.
4. Monitor program performance using key metrics aligned with Health Insurance Care Effectiveness (HICE) and NCQA standards, including enrollment rates, active case management, and high-cost case review.

Table 1: Utilization Summary

Business Intelligence

CM Enrolled Members - 422 Unique Members

Utilization Summary June 2024 - May 2025

	Office	Outpatient	Emergency	Inpatient	Urgent Care
6 Months Before Case Management					
Encounters	1,900	7,644	796	299	187
per Episode	4.50	18.11	1.89	0.71	0.44
Member %	91%	94%	59%	39%	23%
per Member	4.56	18.33	1.91	0.72	0.45
During Case Management					
Encounters	2,106	8,295	629	208	202
per Episode	4.99	19.66	1.49	0.49	0.48
Member %	84%	94%	47%	25%	23%
per Member	5.05	19.89	1.51	0.50	0.48
6 Months After Case Management					
Encounters	1,772	7,036	587	177	189
per Episode	4.20	16.67	1.39	0.42	0.45
Member %	82%	82%	40%	19%	20%
per Member	4.25	16.87	1.41	0.42	0.45

Utilization Analysis:
Claims data from June 2024 through May 2025 were analyzed for members enrolled in CCM who completed at least one goal. Utilization was tracked across six months before enrollment, during enrollment, and six months after enrollment.

Findings:

1. Outpatient visits were consistently the most frequent, followed by office, emergency department, inpatient, and urgent care visits.
2. Slight increases were observed for outpatient and office visits (outpatient: 7,644 → 8,295; office: 1,900 → 2,106) while high-cost services decreased (emergency: 796 → 629; inpatient: 299 → 208), reflecting proactive care coordination.
3. Total encounters decreased across all service settings after CCM enrollment, particularly inpatient and emergency visits (inpatient: 208 → 177; emergency: 629 → 587). Per-member averages also declined (inpatient: 0.72 → 0.42; emergency: 1.91 → 1.41), while outpatient and office visits decreased modestly, showing continued engagement in preventive care.
4. Emergency and inpatient utilization declined significantly (emergency: 59% → 40%; inpatient: 39% %), demonstrating effective targeting of high-risk members. Office and outpatient engagement remained high.

Conclusion:
Implementation of CCM was associated with a meaningful reduction in high-intensity service utilization among high-risk members. While preventive and routine care remained consistent, emergency, and inpatient encounters declined significantly, indicating improved care management, better access to appropriate services, and downstream reductions in medical costs.

Area of Focus: Managing Multiple Chronic Illness
Goal 2: Meet 100% of PHM NCQA CCM Standard Requirements

Target Population: Seniors & People with Disabilities (SPDs) and adults with multiple chronic illnesses

Objective: Achieve full compliance with all PHM NCQA CCM standards for Health Plan and Health Equity Accreditation.

Standards Monitored:

1. Utilize evidence-based clinical guidelines or algorithms for assessment and management.
2. Review and update Case Management processes in alignment with NCQA standards (Element C, Factors 1–17).
3. Complete Initial Assessment within sixty calendar days (Element D, Factors 1–12) and provide ongoing management including summary of changes (Element E, Factors 1–5).
4. Conduct monthly monitoring and auditing of case files to ensure adherence to NCQA requirements, with staff achieving a minimum score of 85% on each episode audit.

Results:
All NCQA CCM standards were successfully completed, achieving 100% compliance. As a result, KHS met all PHM NCQA requirements and received Health Plan and Health Equity Accreditation in July 2025, demonstrating excellence in care management and regulatory compliance.

Conclusion:
In 2025, the PHM strategy for managing multiple chronic illness successfully achieved both operational and quality objectives. High-risk member enrollment in CCM reduced high-intensity service utilization while sustaining preventive care. Compliance with NCQA standards was fully met, resulting in Health Plan and Health Equity Accreditation. Together, these outcomes reflect effective care management, regulatory adherence, and improved member health engagement.

Area of Focus: Managing Multiple Chronic Illness
Goal 3: Implement Required Health and Psychosocial Screening Tools

Target Populations:

- Seniors & People with Disabilities (SPDs)
- Adults with Multiple Chronic Illnesses
- Children with Special Health Care Needs (CSHCN)
- All Pregnant Individuals

Programs:

- Complex Case Management (CCM)
- Major Organ Transplant Program (MOT)
- CSHCN (Kids & Youth Program)
- Baby Steps Program & Baby Steps Plus Program
- Basic BPHM

Objective: Implement all required health and psychosocial screening tools for eligible members, adhering to DHCS requirements within a 12-month period. These tools allow staff to identify members' physical, behavioral, and social needs and ensure appropriate referrals to care coordination, clinical services, or community-based resources.

Table 2: Screening Tools and Purpose

Screening Tool	Purpose / What It Measures	Population
ACEs (Adverse Childhood Experiences)	Identifies early-life trauma and psychosocial risk factors to guide interventions and referrals	All members
CSHCN (Children with Special Health Care Needs)	Assesses children's special health care needs for care coordination and referral to appropriate services	Children & teens
GPCOG (General Practitioner Assessment of Cognition)	Screens older adults for cognitive impairment to support care planning and interventions	Adults (older adults)
PEARLS (Pediatric/Teen Screening)	Evaluates psychosocial wellbeing and depression risk in children and teens to connect to appropriate services	Children & teens

Strategies:

1. Monitor implementation of screening tools and ensure members' needs are addressed following positive screenings.
2. Share results with providers via the HealthX Provider Portal to facilitate timely follow-up and appropriate referrals.
3. Explore multichannel approaches to access screening tools (e.g., iPads) in collaboration with the Member Engagement Department.

Results:
All required health and psychosocial screening tools were successfully integrated into the Jiva ZeOmega EHR system. Staff began using these tools as part of CCM and care coordination workflows. Since program implementation in 2024, case management staff administered 26,053 psychosocial screenings (e.g., GAD-7, PHQ-9, LTSS) to members enrolled in case management services. Screening type and completion varied based on member needs and consent, demonstrating effective adoption and flexible application of the tools.

Conclusion:
Goal 3 was successfully achieved. The screening tools now enable staff to identify members' physical, behavioral, and social needs and refer them to the appropriate services. Integration into the EHR and consistent use in CCM workflows ensures timely interventions, supports care coordination, and strengthens overall PHM.

Area of Focus: Managing Multiple Chronic Illness
Goal 4: Improve the Health and Well-Being of Members Living with Chronic Conditions

Target Populations: Seniors & People with Disabilities (SPDs), adults with multiple chronic illnesses

Programs:

- COPD Clinics
- Major Organ Transplant (MOT) Program
- ER Frequent Users Program
- End Stage Renal Disease (ESRD) Clinics
- Basic BPHM
- Palliative Care Program
- KM Diabetes Clinic
- Enhanced Case Management (ECM)

Objective:
Improve health outcomes and reduce high-intensity service utilization among members with chronic conditions within a 12-month period. The goal is for all members enrolled in targeted programs to achieve measurable improvements in health, including reduced ER visits, hospital readmissions, and improved clinical indicators.

Program-Specific Targets:

1. COPD, ESRD, Palliative Care Programs: >75% of members avoid ER visits within 90 days of enrollment
2. MOT Program: 100% of post-transplant members avoid hospital readmission within 30 days
3. KM Diabetes Clinic: 30% of members show improved A1C post-enrollment
4. BPHM: Members have at least one PCP visit annually

Strategies:

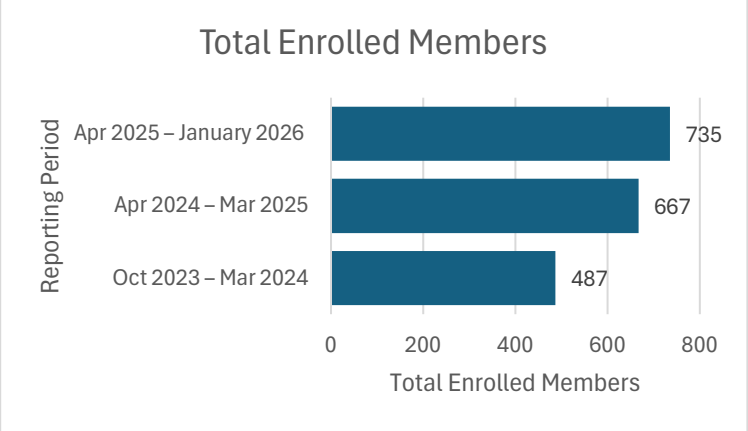
- Review and analyze ER visits, hospital readmissions, and PCP engagement across programs
- Enhance reporting dashboards for COPD and MOT programs to monitor outcomes and performance
- Continue enrolling eligible members in high-risk programs
- Strengthen partnerships with providers for comprehensive care coordination
- Monitor referrals to Community Support Services (CSS) and Diabetes Prevention Program (DPP), ensuring closed-loop tracking
- Facilitate quarterly clinical outcome reviews with KM Diabetes Clinic
- Develop new special programs for high-risk populations, including ESRD by December 2025

Chronic Obstructive Pulmonary Disease (COPD) Outcomes

Reporting Period: April 2025 – Present

Program Overview:
The COPD Program is designed to improve health outcomes and reduce high-intensity service utilization for members with COPD. Members receive care coordination, disease management, and support for primary and preventive care, enabling better management of chronic conditions and reducing reliance on acute services.

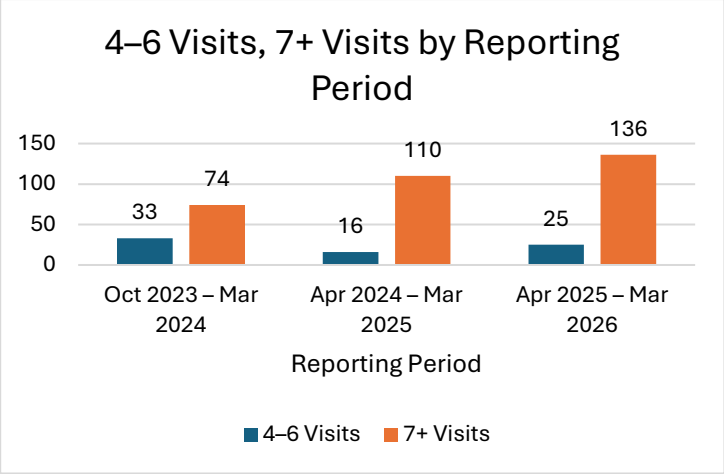
Table 3 Total Enrolled Members



*Note: The COPD Program continues to scale, with enrollment increasing **51%** from Oct 2023–Mar 2024 to Apr 2025–Jan 2026.*

This growth reflects expanded program reach and greater engagement of high-risk members, providing more opportunities for preventive interventions.

Table 4: 4-6 Visits and 7+ Visits



Note:

- *Members with 7+ visits increased steadily across all reporting periods*
- *Report 4 (April 2025 – March 2026) has the highest number of high-utilizing members (25 members with 4-6 visits and 135 members with 7+ visits).*

Utilization Outcomes

Emergency Room (ER) Visits:

- Total ER visits decreased slightly: 683 → 640 (-6.2%)
- Visits per 1,000 members increased: 141.2 → 160.08 (+13.3%), reflecting enrollment growth and a higher proportion of members receiving frequent monitoring

Inpatient Hospital Visits:

- Total inpatient visits decreased: 414 → 349 (-15.7%)
- Visits per 1,000 members remained stable: 85.59 → 87.29 (+2%), indicating effective reduction of high-intensity utilization despite a larger cohort

Other Observations:

- 136 members currently fall into the 7+ visit category, allowing targeted interventions for high-use members through intensified care coordination

Analysis:

- The program successfully expanded enrollment while maintaining or reducing utilization rates, indicating that care coordination efforts are effectively preventing unnecessary ER and hospital admissions.
- The slight increase in visits per 1,000 members reflects a growing cohort, but the overall trend in total visits shows improved management of high-risk members.
- Targeted support for members with 7+ visits ensures resources are focused on those most at risk for acute utilization, aligning with program goals of proactive disease management.

The COPD Program demonstrates successful growth in member enrollment alongside reductions in total ER and inpatient hospital visits, highlighting effective engagement, improved chronic care management, and targeted monitoring of high-risk members.

Major Organ Transplant (MOT) Program Outcomes

Overview
The MOT Program is within the PHM Department in KHS. The MOT Program was launched in 2022. The MOT Program offers care management and coordination services to members, starting from the referral phase and continuing through one-year post-transplant, with the goal of improving their clinical and psychosocial outcomes.

Table 5: Major Organ Transplant Cumulative (2022 through Current)

Organ	No Listed Phase	Referral without Assessment	MOT Evaluation	MOT Listed Phase	MOT Transplant	MOT Post Transplant Phase	Grand Total
MOT - Bone Marrow	0	0	29	3	1	35	68
MOT - Bone Marrow,MOT - Kidney	0	0	0	0	0	1	1
MOT - Bone Marrow,MOT - Liver	0	0	1	1	0	0	2
MOT - Bone Marrow,MOT - Lung	0	0	1	0	0	0	1
MOT - Cornea	0	0	2	1	0	0	3
MOT - Heart	0	0	14	0	0	11	25
MOT - Heart and Lung,MOT -	0	0	1	0	0	0	1
MOT - Heart,MOT - Kidney	0	0	1	0	0	1	2
MOT - Intestinal	0	0	0	1	0	0	1
MOT - Kidney	1	0	275	136	2	65	479
MOT - Kidney - Pancreas	0	0	0	1	0	0	1
MOT - Kidney - Pancreas,MOT -	0	0	2	0	0	0	2
MOT - Kidney,MOT - Kidney -	0	0	0	1	0	3	4
MOT - Kidney,MOT - Liver	0	0	1	6	1	6	14
MOT - Liver	0	0	141	26	2	28	197
MOT - Lung	0	0	8	0	0	5	13
Grand Total	**1**	**0**	**476**	**176**	**6**	**155**	**814**

Note: The table summarizes the cumulative data of major organ transplants from 2022 to present. There are 814 total transplants across all organ types. In 2025, there were a total of 238 members enrolled in the MOT Program.

Table 6: Summary of Post-Transplants Claims and Payments 2025

Organ	2025 Transplants
MOT - Bone Marrow	3
MOT - Heart	2
MOT - Kidney	3
MOT - Kidney, MOT - Liver	2
MOT - Liver	3
MOT - Lung	1
Grand Total	14

Table 7: Transplant Members with 30-Days Hospital Readmissions

	2025 Totals
Readmitted within 30 days post-discharged	1

Note: In 2025, 14 members received transplants. Of these, only one (7%) member was readmitted within 30 days post-discharge.

ESRD Outcomes

Launch Date: August 1, 2025
Current Enrollment: 190 members (as of January 2026)

Program Overview:
The ESRD Program establishes a nephrologist-led care coordination and case management model in partnership with dialysis providers. Nephrologist teams meet directly with members both on-site at dialysis centers and in their offices to provide:

- Case management and chronic disease management
- Medication reconciliation and adherence support
- Screening for social drivers of health

Core Activities:

- Comprehensive assessment within 7 days of referral
- Weekly face-to-face or telehealth encounters at dialysis centers and offices
- Monitoring of key laboratory values (hemoglobin, albumin, calcium, phosphorus)
- Support for dialysis adequacy, vascular access management, and transplant referrals

Impact on Hospital Utilization:
A random sample of 20 members was reviewed to evaluate hospital admissions and ER visits before and after enrollment.

Table 8: ER and Hospital Admissions (ESRD)

Measure	Before ESRD Enrollment	After ESRD Enrollment	% Change
Hospital Admissions	6	4	↓ 33%
ER Visits	30	14	↓ 53%

Summary of Results:

- Hospital admissions showed moderate improvement with a 33% reduction on post-enrollment.
- ER visits showed significant improvement with a 53% reduction on post-enrollment.
- Weekly nephrologist-led encounters, lab monitoring, and social needs support contributed to these outcomes, demonstrating improved continuity of care and reduced avoidable hospital utilization for high-risk members.

Expected Outcomes:

- Sustained reductions in ER visits and hospital readmissions
- Increased engagement with primary and preventive care services
- Improved clinical outcomes, including glycemic control for diabetic members
- Strengthened care coordination and targeted interventions for high-risk populations
- Use of data-driven program evaluation to guide continuous quality improvement and the development of new initiatives

Palliative Care Program Outcomes

Reporting Period: June 2024 – May 2025

Program Overview: The Palliative Care Program aims to improve health outcomes and reduce high-intensity service utilization for members with serious or chronic conditions. Members receive care coordination and support across all care settings, including inpatient, outpatient, office, urgent care, and emergency services.

Table 9: Utilization Outcomes

Utilization Summary June 2024 - May 2025

	Office	Outpatient	Emergency	Inpatient	Urgent Care
6 Months Before Case Management					
Encounters	610	2,350	128	51	79
per Episode	3.77	14.51	0.79	0.31	0.49
Member %	85%	94%	41%	19%	20%
per Member	3.77	14.51	0.79	0.31	0.49
During Case Management					
Encounters	513	2,062	71	26	41
per Episode	2.26	9.08	0.31	0.11	0.18
Member %	64%	79%	20%	9%	11%
per Member	2.26	9.08	0.31	0.11	0.18
6 Months After Case Management					
Encounters	646	2,259	120	27	63
per Episode	3.99	13.94	0.74	0.17	0.39
Member %	91%	91%	35%	11%	20%
per Member	3.99	13.94	0.74	0.17	0.39

During Case Management:

- Emergency visits: 128 → 71 (–45%)
- Inpatient stays: 51 → 26 (–49%)
- Urgent care visits: 79 → 41 (–48%)
- Outpatient visits: 2,350 → 2,062 (–12%)
- Office visits: 610 → 513 (–16%)

6 Months After Case Management:

- Utilization remained improved compared to baseline:
    - Inpatient stays: 27 vs 51 (–47%)
    - Emergency visits: 120 vs 128 (–6%)
    - Urgent care visits: 63 vs 79 (–20%)
    - Outpatient visits: 2,259 vs 2,350 (–4%)
    - Office visits: 646 vs 610 (+6%)

Analysis:

- Case management significantly reduces high-intensity utilization, particularly inpatient and emergency services.
- Reductions during case management are sustained post-program, showing that care coordination has a lasting impact on member health outcomes and care patterns.
- Office and outpatient visits remain stable, reflecting continued engagement with routine and preventive care while reducing acute service use.

Conclusion: The Palliative Care Program demonstrates meaningful reductions in hospitalizations, emergency visits, and urgent care utilization, improving alignment of care to appropriate settings and supporting better overall care management for high-risk members.

KM Diabetes Clinic

Monitoring HbA1c is a critical component of diabetes management, as it provides a measure of a patient's average blood glucose levels over the past 2–3 months. To improve outcomes for members with diabetes, KHS partnered with Kern Medical Hospital to establish a dedicated Diabetes Management Clinic**,** providing comprehensive care and care coordination for patients with elevated HbA1c levels. Regular HbA1c testing allows clinicians to assess disease control, identify patients at risk for complications, and guide timely interventions. Tracking changes in HbA1c before and after clinic enrollment is essential for evaluating the effectiveness of the clinic and improving patient outcomes.

HbA1c Outcome Analysis – KM DM Clinic 2025

Target: 30% of members demonstrate improvement in A1c levels post-enrollment. Improvement is measured as the change in HbA1c from pre-clinic to post-clinic assessments.

Table 10: KM Diabetic Clinic HbA1c

Outcome Measure	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Target	Outcome Achieved
Patients with baseline HbA1c >8% achieving ≥1% decrease	267	286	295	270	≥30%	Yes
% of patients achieving ≥1% decrease	91%	90%	88%	88%	30%	Yes
Patients maintaining HbA1c ≤8%	308	326	336	292	≥30%	Yes
% maintaining HbA1c ≤8%	75%	76%	74%	73%	30%	Yes
Mean HbA1c Pre-Clinic	9.51	9.59	9.60	9.68	N/A	N/A
Mean HbA1c Post-Clinic	7.35	7.33	7.46	7.45	N/A	N/A
Mean Δ HbA1c	2.15	2.26	2.14	2.22	≥1%	Yes
Patients with poor control (HbA1c >9%) Pre-Clinic	59%	60%	59%	61%	≤35.8%	No*
Patients with poor control (HbA1c >9%) Post-Clinic	16%	16%	19%	14%	≤35.8%	Yes

Notes:

- The clinic consistently exceeded the improvement target of 30% of patients achieving HbA1c improvement.
- Post-clinic reductions show clinically meaningful improvement, with mean HbA1c reductions of ~2 points per patient.
- The proportion of patients with poor control dropped well below the national benchmark of 35.8% after clinic enrollment.

Results

1. Patients with ≥1% HbA1c decrease (baseline >8%):
    - The number of patients achieving at least a 1% reduction in HbA1c remained strong across all quarters of 2025, ranging from 267 to 295 patients per quarter.
    - The percent of patients meeting this outcome ranged from 88% to 91%, well above the 30% target.

- Outcome was consistently achieved (Y) each quarter, demonstrating substantial improvement among higher-risk patients.

2. Patients maintaining HbA1c ≤8%:
   - Across 2025, 73%–76% of patients maintained HbA1c at or below 8%, exceeding the national benchmark of 55.4%.
   - This indicates strong disease control and effective clinic management for patients already near target ranges.
   - Outcome was achieved each quarter.

3. Mean HbA1c changes (pre- vs post-clinic):
   - Mean pre-clinic HbA1c ranged 9.51–9.68, while mean post-clinic HbA1c ranged 7.33–7.46, reflecting a mean reduction of 2.14–2.26 points, statistically significant (P<0.0001).
   - These results demonstrate meaningful clinical improvement for patients enrolled in the clinic.

4. Patients with poor HbA1c control (HbA1c >9%):
   - Pre-clinic, 59%–61% of patients were above 9%; post-clinic, only 14%–19% remained above 9%, well below the benchmark of 35.8%.
   - Outcome was achieved in all quarters, highlighting significant improvement in patients with poorly controlled diabetes.

Summary:
The KM DM Clinic consistently exceeded the target of 30% improvement in HbA1c across all four quarters of 2025. Both high-risk patients (HbA1c >8%) and those maintaining levels ≤8% demonstrated positive outcomes. Clinic interventions resulted in clinically meaningful reductions in mean HbA1c and significant decreases in the proportion of patients with poorly controlled diabetes.

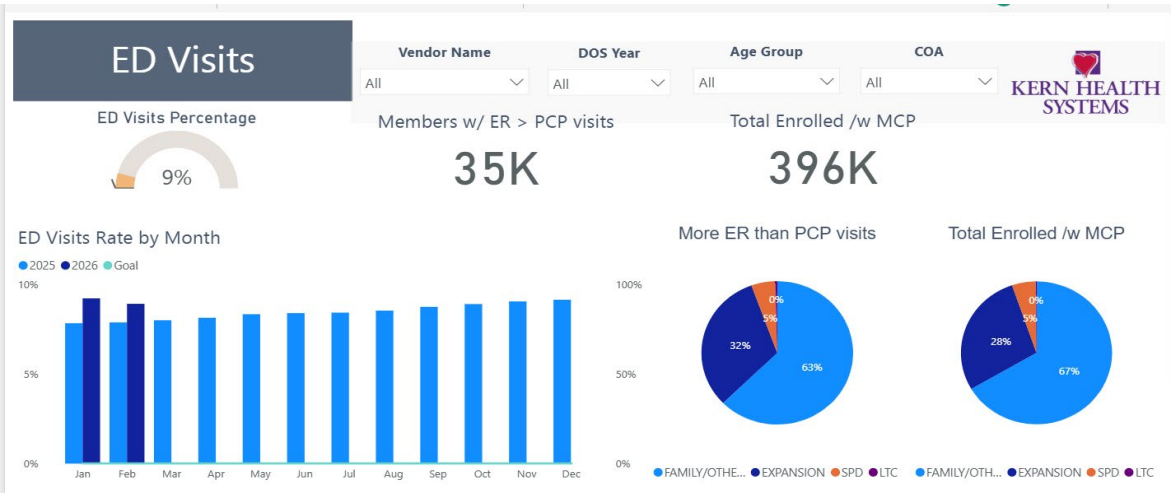
Enhanced Case Management (ECM)

Enhanced Case Management (ECM) will be excluded from the PHM Strategy document, as it is comprehensively addressed and monitored through the ECM Department's established reporting processes.

ER Frequent Users Outcomes

In 2025, the Emergency Department (ED) visit rate averaged 9%, indicating that one in ten enrolled members utilized ED services during the measurement period. Monthly ED visit rates showed a gradual upward trend, starting just under 8% in January and rising steadily to approximately 9%–9.5% by December. This trend suggests increasing ED utilization over the course of the year, potentially reflecting seasonal patterns, access-to-care challenges, or gaps in primary care engagement. We will continue to monitor ED utilization trends, identify high-frequency users, and coordinate follow-up or case management interventions as needed.

Table 11: ED Visits



Note: A total of 35,000 members had more ER visits than PCP visits, out of 396,000 total enrolled members, indicating a subset of the population may be relying on ED services over primary care. The distribution across lines of business shows the majority of ED utilization occurring within the Family/Other category, followed by Expansion, with smaller percentages in SPD and LTC.

Overall, while the 9% ED rate is moderate, the steady monthly increase and the volume of members using the ED more frequently than primary care highlight opportunities to strengthen preventive care engagement, improve timely PCP access, and enhance care coordination interventions to reduce avoidable ED utilization.

Area of Focus: Keeping Members Healthy
Achieve access for all (100%) members to required programs and services as part of Basic Population Health Management (BPHM), ensuring timely delivery in appropriate settings within the next 12 months.

Overview

Basic PHM encompasses the full range of programs and services available to all KHS members. This includes care coordination, comprehensive wellness, and preventive programs, all of which rely on strong connections to primary care. BPHM is offered to all members in a way that addresses individual needs and preferences while working to reduce health disparities. Its approach ensures that all necessary programs and services, including primary care, are accessible to each member at the right time and in the right setting, regardless of the member's risk tier.

Key Components of BPHM

1. Access, utilization, and engagement with primary care
2. Care coordination, navigation, and referrals across all health and social services, including community support
3. Information sharing and referral support infrastructure
4. Integration of Community Health Workers (CHWs) into PHM
5. Wellness and prevention programs
6. Programs addressing chronic disease
7. Programs addressing maternal health outcomes

We will continue to monitor and evaluate the BPHM Dashboard and address deficiencies, such as incomplete Health Risk Assessments (HRAs) or missing PCP assignments. This includes monitoring provider follow-ups, sending reminders to ensure members complete requested authorizations, keeping appointments with specialists, and following up on referrals.

Initial Health Appointment (IHA) Outcomes

As part of BPHM, KHS members are entitled to timely access to an Initial Health Appointment (IHA) with a primary care provider. The IHA allows the provider to assess and manage the member's acute, chronic, and preventive health needs.

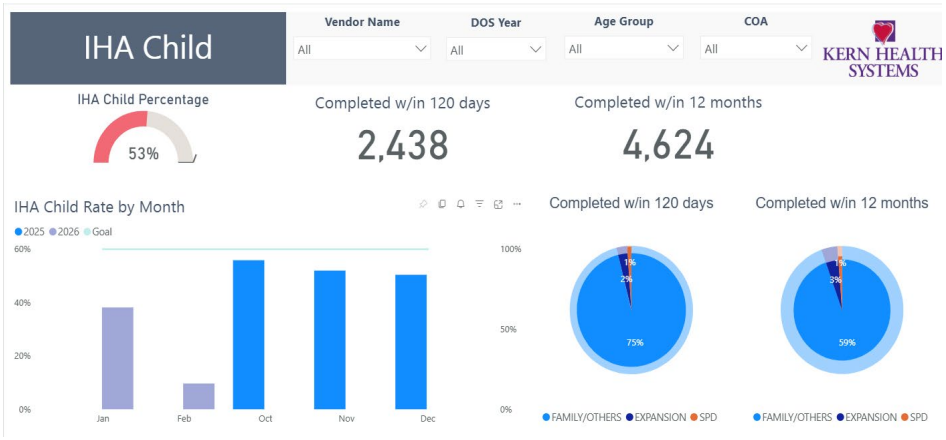
- All new members aged 21 years and older will receive an IHA within 120 days of enrollment.
- Members under 21 will receive an IHA within 120 calendar days of enrollment or in accordance with the AAP Bright Futures periodicity for children 18 months and younger, whichever comes first.
- IHAs are completed for all members and are periodically re-administered when a member's condition changes, as outlined in the PHM Policy Guide and MCP contract requirements.

Monitoring and Follow-Up:

- Reminder letters are sent to providers regarding new members needing IHAs within 120 days of enrollment.
- The Member Services Department sends letters to new members to inform them about IHAs.
- The Quality Improvement Department conducts regular chart reviews to ensure IHAs, and related services are provided in accordance with DHCS APL requirements.

The IHA for adult members was not analyzed for 2025 due to data analytics issues; evaluation of this measure will be conducted in 2026. However, the IHA for child members was successfully analyzed and evaluated for 2025. We will continue to monitor completion of Initial Health Assessments for adult members and address missing or overdue assessments by sending reminder letters to their primary care providers. Work collaboratively with Quality Improvement Department to ensure timely follow-up and documentation per guidelines.

Table 12: Initial Health Appointment (IHA) Child



Note: Among the 4,624 child members who completed an Initial Health Appointment within 12 months, only 2,438 (53%) completed the appointment within the required 120-day timeframe, indicating an opportunity to improve timely access to care.

Primary Care Physicians (PCPs) Outcomes

As part of Case Management and Care Coordination, members are referred to their PCP if they have not been seen within the past 12 months, and they are screened for gaps in care. We continue to educate members on the importance of wellness and preventive services through HealthWise, an evidence-based educational platform. Members are also referred to appropriate PHM services, including care coordination, Complex Case Management (CCM), PHM Special Programs, and KHS benefits such as CSS and Health Education. Integration of closed-loop referrals within the Jiva EHR is planned for implementation in 2026.

Table 13: Primary Care Physician (PCP) Visits in 2025



Note: Among the 439,000 KHS members, only 53% (230,000 members) had a visit with their primary care physician within a 12-month period, indicating that nearly half of the membership did not receive an annual primary care visit.

Health Wise Education

The following represents the top health education materials distributed to members through HealthWise, an evidence-based health education platform. These materials are generated based on member needs, clinical conditions, and care coordination activities. The highest-volume topics reflect key areas of focus, including advanced care planning and chronic disease management, particularly diabetes. This data helps inform ongoing PHM efforts and member engagement strategies.

Based on the episode counts provided, the top 5 health education handouts sent to members are:

1. Advance Care Planning: Writing an Advance Directive – 49 episodes
2. Diabetes Complications – 16 episodes
3. Advance Care Planning: Advance Directives – 15 episodes
4. Diabetes: High Blood Sugar – 15 episodes
5. Diabetes Care Plan – 14 episodes
   (Note: There is a tie at 14 episodes with "Diabetes, Type 2: Taking Care of Yourself," "Diabetes: Coping with Your Feelings About Your Diet," and "Diabetes: Differences Between Type 1 and 2.") T

Table 14: Educational Material Report

Episodes where members accepted program enrollment and education materials were mailed out. The educational mat
(language, age, gender, demographic area) for Episode Dates between Jan 1st and Jan 31st, 2026

Educational Material	Episodes
Advance Care Planning: Advance Directives	15
Advance Care Planning: Writing an Advance Directive	49
Jaundice in Newborns	1
Jaundice in Newborns (Hyperbilirubinemia): Conditions Basics	1
Regular Checkup for a Child	1
Respiratory Syncytial Virus (RSV) in Children: Care Instructions	1
Your Child's Health: Using the Emergency Room Wisely: Overview	3
After a Hospital Stay: Managing Appointments	1
General Discharge: Care Instructions	1
Learning About Safe Sleep for Babies	2
Child's Well Visit, 2 Months: Care Instructions	1
Child's Well Visit, 4 Months: Care Instructions	1
Autism and Autism Spectrum Disorder (ASD)	1
Autism Spectrum Disorder (ASD) in Children: Care Instructions	2
Autism Spectrum Disorder (ASD): Behavioral Training and Management: Overview	2
Learning About Water Safety for Children	1
Open Reduction with Internal Fixation of a Limb in Children: What to Expect	1
Alimentacio´n saludable: Consejos para nin~os y adolescentes - [Healthy Eating]	9
Alimentacio´n saludable: Ha´bitos para los nin~os - [Healthy Eating]	7
Alimentacio´n saludable: Opciones alimentarias para nin~os - Healthy Eating	7
Ha´bitos saludables para nin~os	9
Genetic Testing and Screening	1
Asthma Action Plan for Your Child	3
Asthma Attack in Children: Care Instructions	3
Asthma in Children 0 to 4 Years: Care Instructions	3
Asthma in Children 12 Years and Older: Care Instructions	3
Asthma in Children 5 to 11 Years: Care Instructions	3
Tips for Reducing Indoor Pollutants in Your Home	3
Wheezing in Children: Care Instructions	3
Child's Well Visit, 9 to 11 Years: Care Instructions	1
Well Visit, 9 to 11 Years	2
Asthma Action Plan: Red Zone	1
Asthma in Children: Knowing How Bad an Attack Is	2

Asthma Zones	1
Asthma: Helping Your Child Measure Peak Flow	1
Aprenda sobre la deteccio´n del trastorno del espectro autista - [Learning Autism]	1
Autismo y trastorno del espectro autista - [Autism and Autism Spectrum Disorder]	1
Diabetes Care Plan	14
Diabetes Complications	16
Diabetes, Type 2: Taking Care of Yourself	14
Diabetes: Coping With Your Feelings About Your Diet	14
Diabetes: Differences Between Type 1 and 2	14
Diabetes: High Blood Sugar	15

Note: The total number of health education handouts sent to members is 235 episodes based on the data provided.

In summary, HealthWise continues to be an effective tool for delivering evidence-based health education to members. The data shows that advance care planning and diabetes management are the most frequently accessed topics, reflecting key member needs and priorities. Ongoing monitoring of education handouts will help guide population health initiatives and support improved member engagement and outcomes.

Gaps in Care and KHS Benefits

Since we are still in the process of implementing closed-loop referrals, the monitoring of Gaps in Care and KHS Benefits referrals and follow through will be postponed until 2026.
Numerator: Total number of members who received KHS benefits
Denominator: Total number of members referred for KHS benefits

Health Risk Assessment (HRA)

The Health Risk Assessment (HRA) is a key screening tool used by KHS to help members identify and understand their health risks. HRAs cover a range of areas, including demographic characteristics such as age, gender, and ethnicity; lifestyle behaviors like diet, exercise, smoking, and alcohol use; mental health and emotional well-being; physical health and overall fitness; current and previous health conditions, including chronic diseases, surgeries, and hospitalizations; and preventive screenings such as immunizations and screenings for cancer, diabetes, and heart disease.

The HRA plays a critical role in patient care by enabling providers to assess each member’s health risks comprehensively, identify potential health issues, and develop personalized care plans. Accurate HRA data also allows KHS to match members with the most appropriate health programs and interventions, ensuring timely and effective care.

Timely completion of the HRA is essential. Members identified as higher-risk are expected to complete the HRA within 45 calendar days of enrollment, while lower-risk members have a target of 105 calendar days. Completion of the HRA allows KHS to reclassify members as higher- or lower-risk, supporting effective allocation of resources and services.

KHS staff play an active role in helping members complete the HRA accurately, whether online via a computer or tablet, or over the phone. Staff assist members in understanding questions related to mental

health, daily activities, and living conditions, and provide additional support for those who face challenges completing the form online. Staff also ensure that the HRA is completed within the required timelines.

For reporting purposes, the HRA measure is defined as the total number of members (both new and existing) who complete the HRA within 90 days of enrollment, divided by the total number of members due to an HRA. Monitoring HRA completion has presented challenges, particularly after the contract with Cotiviti, which previously tracked and monitored HRAs, was discontinued. KHS has contracted with a new vendor and is currently working to achieve full interoperability for accurate tracking.

Area of Focus: Managing Members with Emerging Risk
Implement the Bold Goals 50X2025 initiatives to achieve specific and accelerated improvements in identified Clinical Focus Areas within the next 12 months.

Quality of Care for Children

KHS provides a comprehensive set of programs designed to support children under the age of 21 with chronic medical conditions and special health care needs. These programs aim to improve health outcomes and ensure the successful coordination of care through a range of services provided by the PHM Department. The goal is to enhance the quality of life for members and their families by assisting them with navigating the healthcare system and achieving their life goals, particularly during transitions from pediatric to adult care.

Programs Overview

KFHC operates three main programs for children and youth:

1. KAY (Kids and Youth Program):
   This program serves members from birth to 20 years old with chronic medical conditions who are not eligible for California Children's Services (CCS). It provides care coordination to manage their medical needs and link them to necessary community resources.
2. KAY-T (Kids and Youth Transition Program):
   Focused on KFHC and CCS members aged 18 to 20, the KAY-T program specifically targets transitioning adolescents. It helps these members move from pediatric to adult medical care providers, ensuring they have the necessary support to make this transition before the age of 21.
3. CSHCN (Children with Special Health Care Needs Program):
   For members with complex medical conditions, this program serves children from birth to 20 years old who have chronic conditions and meet specific criteria, such as a positive score on the CSHCN screener, a RUB score of 4 and above, or having four or more chronic conditions.

Services Provided

KHS's programs provide a range of services aimed at improving the health and wellbeing of children and their families, including:

- Care Coordination: Assisting with medical appointments (PCP, specialty care, DME providers), transportation, lodging, and community resources.
- Life Goal Assistance: Helping families successfully implement their care plans and achieve life goals.
- Transition Support: Assisting adolescent members in the KAY-T program with transitioning from pediatric care to adult healthcare providers.

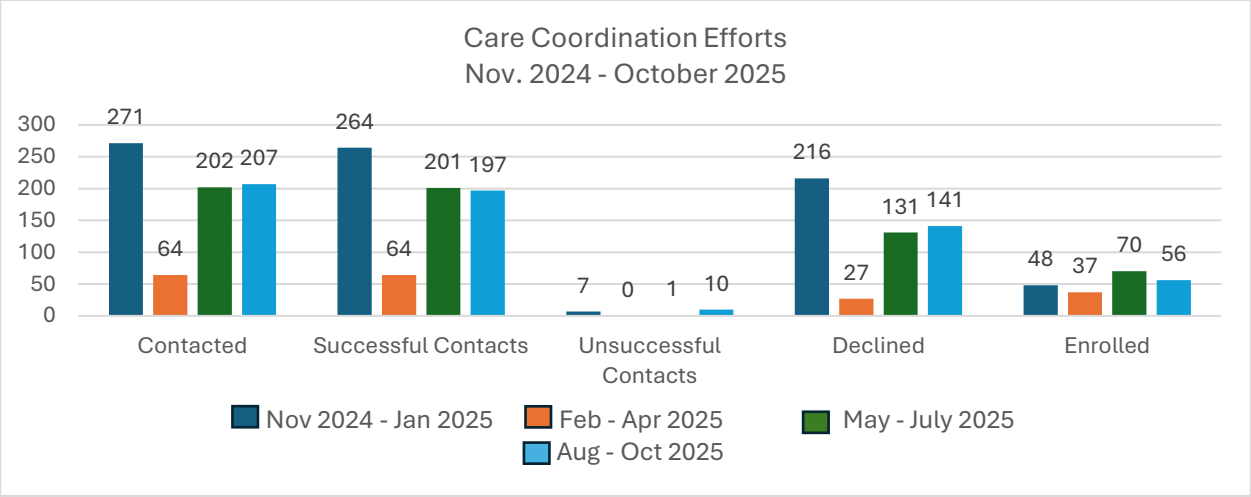
Health Outcomes and Care Coordination Efforts

The following data highlights the success and ongoing efforts of the KHS programs in managing children's health outcomes and care coordination:

Table 15: Children with Special Health Care Needs (CSCHN)

Quarter	Nov 2024-Jan 2025	Feb-Apr 2025	May-Jul 2025	Aug-Oct 2025
Referrals	410	130	242	212
Contacted	271	64	202	207
Successful Contacts	264	64	201	197
Unsuccessful Contacts	7	0	1	10
Declined	216	27	131	141
Enrolled	48	37	70	56

Table 16: CSCHN Engagement



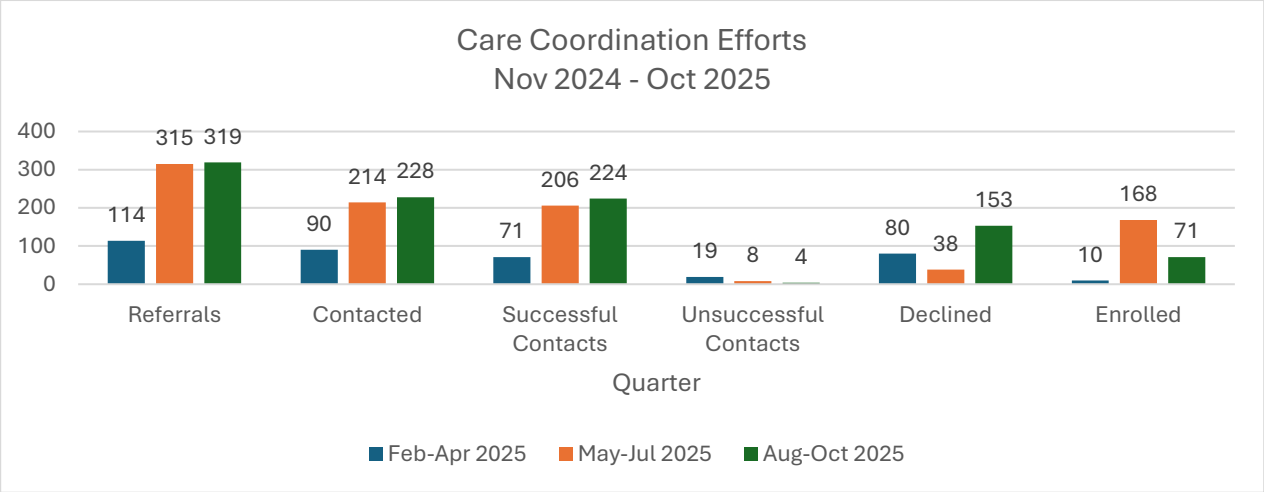
The data for the Children with Special Health Care Needs (CSHCN) program across the four quarters (Nov-Jan 2024/2025, Feb-Apr 2025, May-Jul 2025, and Aug-Oct 2025) shows fluctuations in referrals, successful contacts, and enrollments, with notable trends in outreach and engagement.

a. There is a drop in referrals in Feb-Apr 2025 which needs to be further explored.
b. The consistently high decline rate, particularly in the Nov-Jan and May-Jul periods, suggests that families may be hesitant to enroll. Barriers to enrollment should also be explored, such as concerns over eligibility, the complexity of program requirements, or potential lack of understanding of program benefits.
c. While successful contacts are high, the unsuccessful contact rate increased in the Aug-Oct 2025 quarter.

Table 17: Kids and Youth Program

Quarter	Nov-January 2024/2025	Feb-Apr 2025	May-Jul 2025	Aug-Oct 2025
Referrals	5	114	315	319
Contacted	3	90	214	228
Successful Contacts	3	71	206	224
Unsuccessful Contacts	0	19	8	4
Declined	2	80	38	153
Enrolled	1	10	168	71

Table 18: KAY Care Coordination Efforts



The data for the Kids and Youth Program (KAY) highlights both challenges and successes in the program's outreach and enrollment efforts across the four quarters (Nov-Jan 2024/2025, Feb-Apr 2025, May-Jul 2025, and Aug-Oct 2025).

a. The steady increase in referrals over time indicates growing awareness of the program and a potential increase in demand, particularly in the May-Jul and Aug-Oct quarters. This may reflect improved outreach strategies, partnerships, or community needs.
b. The successful contact rate remains high, which suggests that the program is effective in reaching out to families once a referral is made. This is a positive indicator of the program's outreach capacity and its ability to communicate effectively with families.
c. The decline in referrals, especially in the Aug-Oct 2025 quarter, could be a significant concern. Better understanding of why families are opting out needs to be explored.
d. While there is an increase in enrollments, the decline in enrollments in Aug-Oct 2025 (down from 168 in May-Jul 2025 to 71**)**. This may require a review of the enrollment process to identify potential barriers (e.g., timing issues, or family reluctance).

Table 19: Kids and Youth Program (KAY) Transition Program Engagement (Nov-Dec 2024)

Kids and Youth Transition (KAY T)	**Nov 2024**	**Dec 2024**	Total
Total # of members contacted	31	19	50
Total # of members accepted KAY-T	5	1	6
Total # of members declined	2	4	6
Total # of members provided Care Notebooks	4	1	5
Total # of members referred for Case Management to CSHCN	2	0	2

Table 20: Kids and Youth Program (KAY) Transition Program Engagement (January through October 2025)

Kids and Youth Transition (KAY T)	Jan 2025	Feb 2025	March 2025	April 2025	May 2025	June 2025	July 2025	Aug 2025	Sept 2025	Oct 2025	Total
Total # of members contacted	21	20	24	12	29	20	18	18	21	22	205
Total # of members accepted KAY-T	4	4	4	2	9	2	3	3	4	2	37
Total # of members declined	7	3	5	1	1	3	2	6	4	8	40
Total # of members provided Care Notebooks	4	3	4	1	7	2	3	1	4	0	29
Total # of members referred for Case Management to CSHCN	2	0	0	0	1	1	2	1	1	0	8

The Kids and Youth Transition (KAY-T) program provides care coordination services to youth aging out of California Children's Services (CCS), focusing on ensuring that they have access to primary care physicians, specialists, and other necessary resources. Here is a breakdown of the data and key insights:

- 255 youth were contacted, with monthly totals fluctuating between 12 to 31 members.
- In total, 37 members accepted the services.
- 40 members declined to participate in the program overall.
- 29 notebooks were distributed across the year.
- 8 referrals were made over the entire period to CSCHN.

Opportunities

Based on the program objectives and available data for KHS, there are opportunities to enhance care coordination, outreach, and overall health outcomes for children and youth. Key areas for improvement include:

1. Increase Engagement and Enrollment
Outreach strategies can be strengthened through targeted communication—calls, texts, and emails—to families, clearly explaining program benefits and addressing potential barriers to participation. Partnerships with local community organizations can help raise awareness and reach families who may not be aware of available services. Educating families on the importance of early care coordination and the long-term benefits of programs such as Kids and Youth Transition (KAY-T) and Children with Special Health Care Needs (CSHCN), particularly regarding transitions to adult care, can further improve engagement.

2. Reduce Declines in Referrals
Conducting referral feedback surveys or outreach to families who decline referrals can help identify reasons behind their decisions. Common concerns, such as misunderstandings about program benefits, eligibility, or perceived stigma, can then be addressed to improve acceptance rates.

3. Focus on High-Risk Cases
For families with children in the CSHCN program, increasing the availability of dedicated case managers

can provide more frequent check-ins and individualized support, improving care outcomes for high-risk members.

4. Strengthen Ongoing Care Coordination and Community Partnerships
KHS continues to provide comprehensive care coordination, case management, and integration of wellness and preventive care for children through programs including:

- CCS Adult Transition (Kids and Youth Transition)
- Kids and Youth Program
- Children with Special Health Care Needs
- Early Periodic Screening and Developmental Testing (EPSDT)

We also maintain strong partnerships with children's health organizations in local communities, including First 5 County Commissions, Early Start, and other community-based organizations, to ensure families have access to comprehensive services and support.

Conclusion
KHS's programs have made significant progress in coordinating care for children with complex health needs and chronic conditions. Despite some fluctuations in the number of successful contacts and declines, the overall enrollment and engagement rates demonstrate that the programs are effectively meeting the needs of children and families in Kern County. By tracking these outcomes and continuously adapting their care coordination services, KHS strives to ensure that children receive timely, appropriate care and that their families are supported throughout their care journey.

The programs are continually monitored to ensure that they are meeting the goals of improving health outcomes, facilitating transitions to adult care, and providing families with the necessary resources to manage their child's healthcare needs effectively.

EPSDT Program Outcomes

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, established under Medicaid in 1967, ensures children under 21 receive preventive, diagnostic, and treatment services. In California, it is administered as Medi-Cal for Kids & Teens and uses the Bright Futures/AAP Periodicity Schedule to guide age-appropriate screenings and assessments.

Each month, a list of screened members is sent to PHM, Quality Improvement (QI), and Behavioral Health (BH) departments for follow-up. PHM addresses medical, dental, vision, hearing, and lead screening needs; BH manages behavioral health concerns such as depression, anxiety, and substance use; and QI conducts chart reviews to ensure timely referrals and follow-up care.

All departments are responsible for timely outreach, connecting members with appropriate services, and documenting all actions. Continuous monitoring and reporting support care coordination, compliance with EPSDT guidelines, and ongoing quality improvement.

Although we have not yet tracked EPSDT care coordination numerators and denominators, we have established a formal process with clearly defined roles and responsibilities for each department—PHM, Behavioral Health, and Quality Improvement. This structure ensures that each member identified through EPSDT screenings will receive timely follow-up and appropriate referrals once tracking is implemented. With these processes in place, we are positioned to accurately monitor the EPSDT measure (Numerator:

members enrolled in EPSDT care coordination; Denominator: total eligible pediatric members aged 0–21) and ensure compliance going forward. Documenting outreach, follow-up, and referrals within each department will allow us to report on this measure consistently and reliably in future measurement periods.

Area of Focus: Managing Members with Emerging Risk
75% of women enrolled in Baby Steps Plus receive postpartum care in a timely care.

We continue to provide care coordination, case management, and integrate wellness and preventive care, focusing on maternal health.

- High Risk Pregnancy (aka Baby Steps Plus)
- Maternal Mental Health (aka Baby Steps)

The table summarizes the Baby Steps Program ROI data by quarter for 2025, including enrollments, contacts, screenings, and referrals for pregnant and postpartum members. It shows the total number of members enrolled, declined, contacted, and successfully screened for PHQ-9 and GAD-7, along with positive referrals to behavioral health. The data highlight the program's activity across the year, with higher numbers in the first three quarters and a significant drop in the last quarter. This decline reflects the transition of the Baby Steps Program to another provider to continue supporting members.

Table 21: Baby Steps Engagement

Quarter	Total Members Enrolled	Total Members Declined	Total Members Contacted	Total Successful Contacts	Total Unsuccessful Contacts	Total Members Screened	PHQ-9 Screened	PHQ-9 Positive & Referred	GAD-7 Screened	GAD-7 Positive & Referred
Jan-Mar 2025	196	27	500	726	-	270	270	-	-	-
Apr-Jun 2025	134	24	346	473	1,024	196	605	16	444	11
Jul-Sep 2025	94	8	367	409	225	146	115	5	115	2
Oct-Dec 2025	17	-	43	-	-	8	5	0	3	0

Note: The lower numbers in Oct-Dec 2025 reflect the transition of the Baby Steps Program to another provider for continued support.

Postpartum Measurements

KHS evaluates performance using Disparities Rate Sheet Indicators to identify health disparities among members. These quality metrics, established by the DHCS, track specific health outcomes and services within the Medi-Cal population. Results are stratified by demographic characteristics to highlight inequities and inform targeted interventions. The indicators are based on the Managed Care Accountability Set (MCAS) and are reported annually in DHCS's Health Disparities Reports.

For Measurement Year (MY) 2024, racial and ethnic disparities varied across women's and perinatal health indicators. Native American members had the lowest rates for slightly more indicators than other racial or

ethnic groups. Among language groups, English and Spanish speakers had the lowest rates for prenatal and postpartum care indicators (PPC–Pre and PPC–Pst) compared to other languages. For other women's or perinatal health measures, disparities by language varied depending on the indicator.

Table 22: MY 2024 Health Disparities KHS Rate Sheet Indicators: Perinatal and Women's Health

Indicator	American Indian/Alaska Native	Asian	Black/African American	Hispanic/Latino	Native Hawaiian/Other Pacific Islander	White	Unknown
PPC–Pre	N/A	87.50%	87.10%	88.37%	N/A	80.77%	88.75%
PPC–Pst	N/A	100.00%	70.97%	83.72%	N/A	80.77%	84.38%

In MY 2024, prenatal (PPC–Pre) and postpartum (PPC–Pst) care rates varied across racial and ethnic groups, highlighting disparities in perinatal care. Native American members had the lowest rates for several indicators, while Black/African American and White members also showed lower rates for postpartum care. Language disparities were evident, with English and Spanish speakers having lower prenatal and postpartum care rates compared to other languages. These results underscore the need for targeted interventions to improve equity in perinatal and women's health services.

Area of Focus: Managing Members with Emerging Risk
100% of women enrolled in Baby Steps who tested positive in PHQ-9 will be referred to Behavioral Health.

Screening for depression using the PHQ-9 is a critical component of prenatal and postpartum care because early identification of mental health concerns can prevent worsening symptoms and improve outcomes for both mother and baby. Pregnant and postpartum individuals are at increased risk for depression, which can affect maternal health, infant development, and family well-being if left unaddressed. By routinely administering the PHQ-9, healthcare providers can identify those at risk, provide timely referrals to behavioral health services, and deliver targeted education and support. Early detection and intervention through structured screening help reduce complications, promote recovery, and support positive long-term health for both mother and child.

PHQ-9 Screening and Positive Referrals Analysis (2025)

1. Across the year, a total of 995 members were screened for PHQ-9 (summing all quarters), with the highest volume in Apr-Jun 2025 (605 screenings). Screening activity was robust in the first three quarters, reflecting active program engagement.
2. The total number of members identified as positive on PHQ-9 and referred to behavioral health was 21. The highest number of positive cases occurred in Apr-Jun 2025 (16 referrals), followed by Jul-Sep 2025 (5 referrals). No positive cases were reported in Oct-Dec 2025, consistent with the program transition to another provider.
3. Overall, the proportion of positive PHQ-9 results was low—about 2.1% of those screened. This suggests either a lower prevalence of depressive symptoms in the population served or effective early intervention and education during prior contacts.
4. Quarterly Trends and Observations:
    - Jan-Mar 2025: Screening data were collected (270 screened), but specific positives were not reported.
    - Apr-Jun 2025: Screening peaked (605 screened), with most referrals (16/21) identified this quarter, indicating targeted identification during intensive program engagement.

- Jul-Sep 2025: Screening and referrals declined alongside reduced program activity.
- Oct-Dec 2025: Minimal activity occurred due to the transition, and no positive cases were recorded.

Conclusion:
The PHQ-9 screening shows that the Baby Steps Program effectively identified at-risk members during active engagement months, with the largest impact in the second quarter. The low positive-to-screen ratio suggests early detection and prevention efforts were working, but the drop-in activity in the last quarter reflects the transition to the new provider.

Area of Focus: Managing Members with Emerging Risk
Execute the transition of Long-Term Care (LTC) services for members in Skilled Nursing Facilities, Intermediate Care Facilities (ICF) / Developmentally Disabled (DD) facilities for adult and pediatric population in compliance with DHCS requirements.

PHM successfully executed the transition of Long-Term Care (LTC) services for members residing in Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICF/DD), and subacute facilities serving both adult and pediatric populations in compliance with DHCS requirements. A total of 889 members are enrolled in LTC, including 772 in SNFs, 80 in ICF/DD facilities, 45 in subacute adult facilities, and 2 in subacute pediatric facilities, demonstrating full identification and continuity of care oversight for this population.

To strengthen clinical management and care coordination, KHS hired dedicated SNFist providers to deliver routine on-site services in SNFs, ensuring enhanced clinical oversight, improved communication with facility staff, and continuity of care. As a result, 100% of LTC members receive regular SNFist visits, reinforcing consistent monitoring and proactive intervention.

Operationally, KHS collaborated with Kern Regional Center, subacute adult and pediatric providers, and ICF/DD facilities (home, habilitative, and nursing) to clearly define roles, responsibilities, and partnership expectations. The organization developed an ICF/DD policy aligned with DHCS requirements and continues to work closely with Business Intelligence (BI), COSA, and internal departments to strengthen reporting systems, ensuring accurate monthly reporting and timely DHCS submissions. Ongoing monitoring and evaluation of LTC program deliverables and outcomes ensure sustained compliance and continuous quality improvement.

Area of Focus: Patient Safety or Outcomes Across Settings
Provide support to 100% of members who experienced a transition, ensuring continuity and quality of care within 30 days

Over the past several years, PHM has focused on strengthening and fully implementing its existing CalAIM programs. The Transition of Care Services program to ensure members receive timely, coordinated care without gaps. Dedicated teams, streamlined workflows, and stronger oversight were established to improve consistency and accountability. Provide and support timely and safe transitional care coordination to all members undergoing a transition from one setting or level of care to another without interruptions in care. Since launching in 2024, TCS has served approximately 27,573 members through outreach efforts**.**

Table 23: Annual ROI Summary

Quarter	Member Category	Metric	Month 1	Month 2	Month 3	Quarterly Total
Q1 (Jan–Mar)	Low Risk	Letters Mailed	404	626	743	1,773
		Undeliverable	124	80	82	286
		Call Backs	44	19	26	89
	High Risk	Received Case Management	0	0	0	0
		Member Outreach	0	0	0	0
	TCS Enrolled	HSAG Discharge Risk Assessment Completed	611	906	1,134	2,651
Q2 (Apr–Jun)	Low Risk	Letters Mailed	814	732	621	2,167
		Undeliverable	79	94	77	250
		Call Backs	38	20	25	83
	TCS Enrolled	HSAG Discharge Risk Assessment Completed	1,335	1,176	1,090	3,601
Q3 (Jul–Sep)	Low Risk	Letters Mailed	753	517	637	1,907
		Undeliverable	54	84	72	210
		Call Backs	15	12	16	43
	TCS Enrolled	HSAG Discharge Risk Assessment Completed	1,355	1,103	1,268	3,726
Q4 (Oct–Dec)	Low Risk	Letters Mailed	638	574	565	1,777
		Undeliverable	94	66	82	242
		Call Backs	16	17	11	44
	TCS Enrolled	HSAG Discharge Risk Assessment Completed	1,326	1,072	1,157	3,555

Note: Across all four quarters, low-risk outreach remained consistent, with quarterly mailings ranging from 1,773 to 2,167 letters, while undeliverable rates remained stable. Member engagement, measured by call backs, was highest in Q1 (89) and Q2 (83) and declined in Q3 (43) and Q4 (44), indicating variability in response despite steady outreach volume. Transitional Care Services (TCS) activity remained strong throughout the year, with HSAG Discharge Risk Assessments completed increasing from 2,651 in Q1 to a peak of 3,726 in Q3, demonstrating sustained post-discharge engagement and care transition support.

Area of Focus: Patient Safety or Outcomes Across Settings
Conduct an annual comprehensive analysis of the PHM Strategy's impact, ensuring alignment with PHM NCQA Standard 6 Requirements.

Programs Evaluated

Complex Care Management (CCM)

Launched within the PHM Department in January 2023, CCM provides intensive, individualized care coordination for members with complex medical and psychosocial needs, including barriers related to social determinants of health (SDOH). Services are delivered in accordance with NCQA and DHCS standards by a multidisciplinary team consisting of Registered Nurses (RNs), Social Workers (SWs), and Certified Medical

Assistants (CMAs). The program emphasizes whole-person care, improved care transitions, and enhanced member engagement.

Major Organ Transplant (MOT) Program
The MOT Program delivers specialized care coordination for members undergoing major organ transplantation. Care managers support members from referral through one year post-transplant. Services include coordination with transplant centers and providers, discharge planning, medication reconciliation, addressing SDOH barriers, and promoting adherence to post-transplant treatment plans to optimize clinical outcomes and reduce complications.

Member Experience Evaluation
In 2023, PHM implemented a Member Feedback Survey for both CCM and MOT participants to evaluate program effectiveness, service quality, communication, care coordination, and overall member satisfaction. Survey results were analyzed to identify strengths, areas for improvement, and opportunities to enhance member-centered service delivery. Qualitative feedback provided insight into member perceptions of care manager accessibility, responsiveness, and support in navigating complex healthcare needs.

Clinical Measure: Well-Child Visits
Compliance with well-child visits remains a clinical priority due to their critical role in preventive care, immunizations, developmental screenings, and early intervention. Missed visits represent lost opportunities to identify and address emerging health concerns. Performance data were analyzed to assess rates of completed well-child visits among eligible members and to determine the impact of care coordination outreach efforts. Findings informed targeted interventions to improve scheduling support, member education, and provider collaboration.

Utilization Measure: Transitional Care
Transitions of care are high-risk periods that may result in readmissions due to communication gaps, medication discrepancies, and inadequate follow-up. Transitional care performance was reviewed and analyzed as part of the quantitative and qualitative evaluation report. Metrics included post-discharge follow-up timeliness, care manager outreach, and readmission trends. Findings were used to identify process improvement opportunities to strengthen discharge coordination, enhance provider communication, and reduce avoidable utilization.

This comprehensive annual evaluation ensures that KHS's PHM Strategy remains data-driven, member-centered, and aligned with NCQA standards while promoting continuous quality improvement across clinical outcomes, utilization management, and member experience.

Conclusion

The PHM Department continues to advance its mission of improving quality of care, promoting health equity, and expanding access to coordinated, whole-person care for Medi-Cal members. Through its four strategic priorities—Access and Engagement, Care Coordination and Navigation, Integration of Health and Clinical Data, and Wellness and Prevention—KHS remains aligned with NCQA PHM standards, DHCS requirements, and the 2023–2025 KHS Strategic Plan.

While progress has been made in strengthening primary care engagement, enhancing care coordination, and addressing social determinants of health, ongoing opportunities remain to improve data integration, referral tracking, member outreach, and preventive care utilization. Continued monitoring of performance measures, including NCQA and HEDIS metrics, will support data-driven decision-making and targeted interventions to

address gaps in care. Moving forward, PHM will focus on optimizing systems, strengthening provider and community partnerships, and enhancing member engagement to ensure sustainable improvements in health outcomes, cost containment, and overall member experience.

KERN HEALTH SYSTEMS

To: Executive Quality Improvement Health Equity Committee (EQIHEC)

From: Lela Criswell, Member Engagement Manager

Date: March 17, 2026

Re: 2025 Member Satisfaction Survey Summary

Background:

For the past nine years, KHS has engaged Press Ganey to conduct our Member Satisfaction Survey. Press Ganey is a National Committee for Quality Assurance (NCQA) certified HEDIS® Survey Vendor.

2025 was the sixth year KHS selected Press Ganey to conduct the KHS MY 2024 CAHPS® Medicaid Adult Simulation Survey for the 2025 Member Satisfaction Survey. NCQA requires health plans to submit CAHPS survey results in compliance with HEDIS® accreditation requirements. The objective of the study is to capture accurate and complete information about member-reported experiences with health care to measure how well health plans meet their members' expectations.

Members may respond to the 40 questions in the survey tool through mail or electronically. Press Ganey provides comparative analysis of member responses utilizing the scores from several benchmarks. The final report provides two sets of benchmarks to consider – (1) National NCQA Accredited Adult Medicaid Health Plans and (2) Regional Health and Human Services Region 9 health care plans which includes California, Hawaii, Arizona, and Navada. As KHS is now NCQA accredited, we use the analysis of both benchmarks to determine a path forward for improvement where opportunities are identified.

Noteworthy, the 2025 Member Satisfaction Survey results show that KHS has rated in the 100th percentile under the Rating of Health Plan category from the NCQA benchmark. This is an outstanding accomplishment that reflects the fruit of our labor to be the best Managed Care Plan in Kern County. As we meet the challenges of an ever-changing health care landscape, we strive to keep our good ratings and work to improve where opportunities are presented.

Discussion:

2025 Member Satisfaction Survey Results.

Fiscal Impact:

None.

Requested Action:

Receive and file.

2025 Member Satisfaction Survey

Kern Family Health Care®

Introduction and Objectives

Kern Health Systems conducted its MY 2024 CAHPS®5.1H Medicaid Adult Simulation Survey in compliance with HEDIS® accreditation requirements for 2025.

01 Capture accurate and complete information about consumer-reported experiences with health care.

02 Measure how well plans are meeting their members' expectations and goals.

03 Determine which areas of service have the greatest effect on members' overall satisfaction.

04 Identify opportunities for improvement, which can aid plans in increasing the quality of provided care and service.

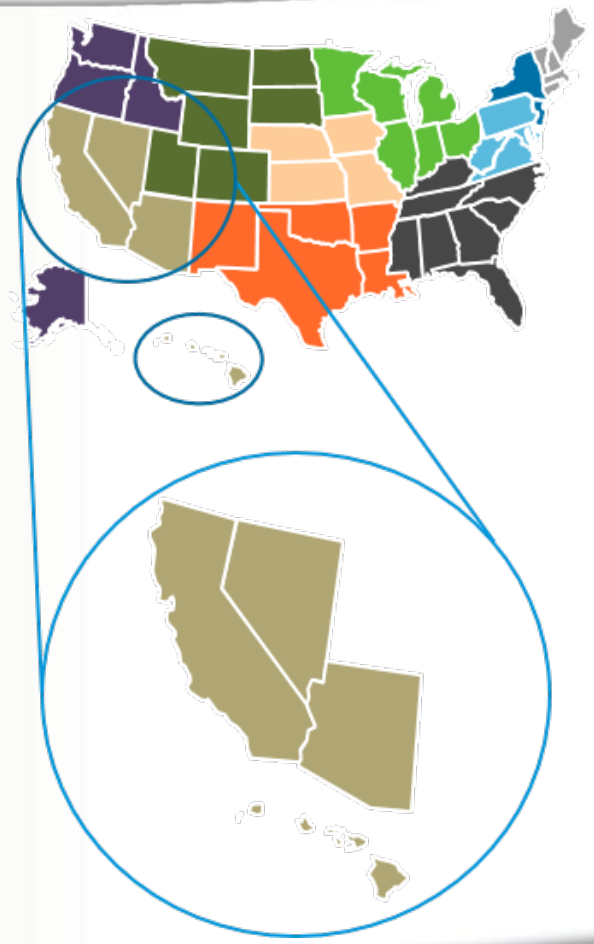
Kern Family Health Care®

Methodology

- A sampling of 5,000 KFHC eligible member households was selected and 4,997 were eligible.
  - Qualified respondents:
    - 18 years and older (as of December 31st of the measurement year)
    - Continuously enrolled in the plan for at least five of the last six months of the measurement year
  - There were a total of 526 completed responses.
    - 315 completed responses by mail.
    - 211 completed responses on the internet.
    - 10.5% response rate.
- Results were measured in comparison with other plan survey data for the Region.
  - Region 9: San Francisco includes American Samoa, California, Hawaii, Arizona, Guam, and Nevada

Region 9: San Francisco

- American Samoa (not shown)
- California
- Hawaii
- Arizona
- Guam (not shown)
- Nevada



Kern Family Health Care®

Regional Performance

KHS scored significantly higher than the regional rate in key elements as compared to the 2025 Press Ganey Book of Business for Region 9 rates.

Patient Experience	KHS Summary Rate (%)	2025 SPH BoB Region (%)	Performance Indicator
Rating of Health Plan	87.9	78.0	↑
Rating of Health Care	81.1	74.5	↑
Rating of Personal Doctor	87.9	82.8	↑
Getting Needed Care	81.0	77.7	
Getting Care Quickly	83.3	76.3	↑
Customer Service	92.2	88.1	↑
Coordination of Care	89.0	82.2	↑
How Well Doctors Communicate	93.8	91.4	

Significance Testing

Current year score is significantly higher/lower (↑/↓) than the 2024 PG BoB Region score.

Kern Family Health Care®

2025 Dashboard

MEDICAID ADULT



526
Completed surveys

10.5%
Response Rate

Stars: PG Estimated NCQA Rating
NA = Denominator < 100

Scores: All scores displayed are Summary Rate Scores
- Rating: % 9 or 10
- Composites: % Usually or Always
- Smoking: % Always, Usually, or Sometimes

Significance Testing: Current score is significantly higher/lower than 2024 (↑/↓) or 2023 (↟/↡).

Percentiles: Based on the 2025 PG Book of Business

Health Plan Key Driver Classification: Details can be found in the KDA section.

Rating of Health Plan ★★★★★				
Rating of Health Plan	76.7%		100th	---

Rating of Health Care ★★★★				
Rating of Health Care	61.1%		77th	Power

Rating of Personal Doctor ★★★★★				
Rating of Personal Doctor	77.8%	↟	93rd	Power

Advised to Quit Smoking: 2YR				
Advised to Quit Smoking: 2YR	77.1%		69th	---

Rating of Specialist				
Rating of Specialist	65.1%		24th	Opportunity

Coordination of Care				
Coordination of Care	89.0%		72nd	Retain

Customer Service				
Composite	92.2%		79th	---
Q24. Provided information or help	88.5%		83rd	Retain
Q25. Treated with courtesy and respect	95.9%		62nd	Retain

Getting Needed Care ★★★				
Composite	81.0%		36th	---
Q9. Getting care, tests, or treatment	85.3%		43rd	Power
Q20. Getting specialist appointment	76.7%	↟	30th	Wait

Getting Care Quickly ★★★★				
Composite	83.3%		60th	---
Q4. Getting urgent care	86.0%		65th	Power
Q6. Getting routine care	80.5%		50th	Power

Ease of Filling Out Forms				
Ease of Filling Out Forms	94.9%		44th	Retain

How Well Doctors Communicate				
Composite	93.8%		51st	---
Q12. Dr. explained things	93.9%		50th	Retain
Q13. Dr. listened carefully	93.9%		47th	Power
Q14. Dr. showed respect	96.5%		68th	Retain
Q15. Dr. spent enough time	91.0%	↑	40th	Opportunity

PressGaney

©2025 Press Ganey. All rights reserved. a PG Forsta company.

2025 Performance Improvement Review

In 2024 the results of the study provided recommended strategies to address deficient ratings in key areas identified as "Opportunity". Listed are the strategies and subsequent efforts adopted by KHS. Regional rate scores saw great improvement based on 2025 survey results.

2024 Recommended Strategy	2025 Result
Evaluate current member and provider education pertaining to coordination of care to improve collaborative health practices between provider disciplines and member understanding of the needed inter-provider communication relationship.	• The introduction of an Artificial Intelligence (AI) Interactive Voice Response (IVR) software improved and made efficient outreach efforts to assist members in scheduling appointments where gaps in care were identified • Expanded educational benefit presentations to engage members in rural communities • Provider bulletins and trainings available on the website keep providers up-to-date on best practices and benefit changes • Significantly higher regional rate score than our regional peers in the coordination of care category • Improved regional rate scores in the area of "How Well Doctors Communicate" including significantly higher regional rate scores for how well their doctor explained things and how well their doctor shows respect
Analyze grievances and call tracking to identify key causes of the low scores for *Rating of Specialist* and strategize ways to improve member satisfaction.	• The survey question (Q22) for this category provided a 0 to 10 rating scale with 0 being the worst specialist and 10 being the best. • Of the 276 members who answered the question, 26 provided a 6 or below rating. • Review of grievances indicated the main complaint was customer service • Review of call tracking data indicated the main concern was referral submission

Kern Family Health Care®

2026 Performance Improvement Strategy

KHS will implement the following improvement strategies in 2026 based on the 2025 MSS responses.

- Opportunity: Rating of Specialist
  - Identify specific trends not addressed in the 2025 strategy
  - Collaborate with Provider Network Management to create a strategy of improvement

- Opportunity: Doctor Spent Enough Time
  - Evaluate grievance and call center call tracking to identify trends
  - Collaborate with Provider Network Management and Quality Improvement to create a strategy of improvement

Kern Family Health Care®

Questions?

KERN HEALTH SYSTEMS

To: Executive Quality Improvement Health Equity Committee (EQIHEC)

From: James Winfrey, Deputy Director of Provider Network

Date: March 17, 2026

Re: 2025 Provider Satisfaction Survey, CY 2024

Background:

Kern Health Systems (KHS) performs an annual Provider Satisfaction Survey to evaluate the level of engagement and satisfaction within our network of providers. KHS engaged a third-party vendor, Press Ganey, to conduct the survey and provide baseline survey data and national industry benchmark comparison to other Medi-Cal plans.

The provider types surveyed are Primary Care Providers, Specialists, Behavioral Health, Hospitals, Urgent Care Facilities, and Ancillary Providers. The survey was conducted over three waves during Q2 2025 and measured the Plan's Calendar Year (CY) 2024 performance.

The survey is broken down into eight (8) attributes: Overall Satisfaction, Comparison to Other Plans, Compensation/Finance, Utilization Management & Quality Improvement, Network/ Coordination of Care, Call Center, Provider Relations, and Providers' likelihood to recommend to other providers.

Discussion:

Included is a presentation that summarizes the CY 2024 Provider Satisfaction Survey results and outlines efforts to maintain the Plan’s favorable rating within our Provider Network

One key rating to highlight is Kern Health Systems' overall satisfaction rating of 90.5%. The Medicaid Line of Business overall satisfaction rate for like plans surveyed was 72.3% satisfaction. KHS also scored much higher when compared to local competitors.

Fiscal Impact:

None.

Requested Action:

Receive and file.

KERN HEALTH SYSTEMS

2025 Provider Satisfaction Survey,

Calendar Year 2024

Survey Results

BACKGROUND/METHODOLOGY

On an annual basis, Kern Health System's Provider Network Management Department conducts a Provider Satisfaction Survey to gauge the level of satisfaction and engagement amongst our network of contracted providers. The 2025 Provider Satisfaction Survey asked providers to answer survey questions based on their experiences with KHS during Calendar Year 2024. We engaged an independent survey company, Press Ganey (PG) Analytics, formerly SPH Analytics, to conduct the survey on behalf of the Plan. PG Analytics is able to benchmark KHS performance against other organizations within the industry, by comparing our results against their National Medicaid and Aggregate Books of Business. The PG 2024 Medicaid Book of Business is made up of 108 plans with a total of 17,393 respondents. The PG 2024 Aggregate Book of Business is made up of 201 plans with a total of 27,031 respondents. This is eighth annual Provider Satisfaction Survey that PG Analytics has completed for the Plan.

The 2025 Provider Satisfaction Survey was conducted across three waves, in April, May, and June of 2025. Two waves of mailing outreach were conducted, followed by a third outreach via telephone. The survey is sent to and categorized by provider type, including PCP, Specialist, Behavioral Health, and Other (Facilities, Ancillary providers). All statistical testing is performed at the 95% confidence level.

For 2025, 150 total surveys were received, down from 175 surveys received the prior year. KHS utilizes incentives for provider offices to try and promote survey participation.

RESULTS

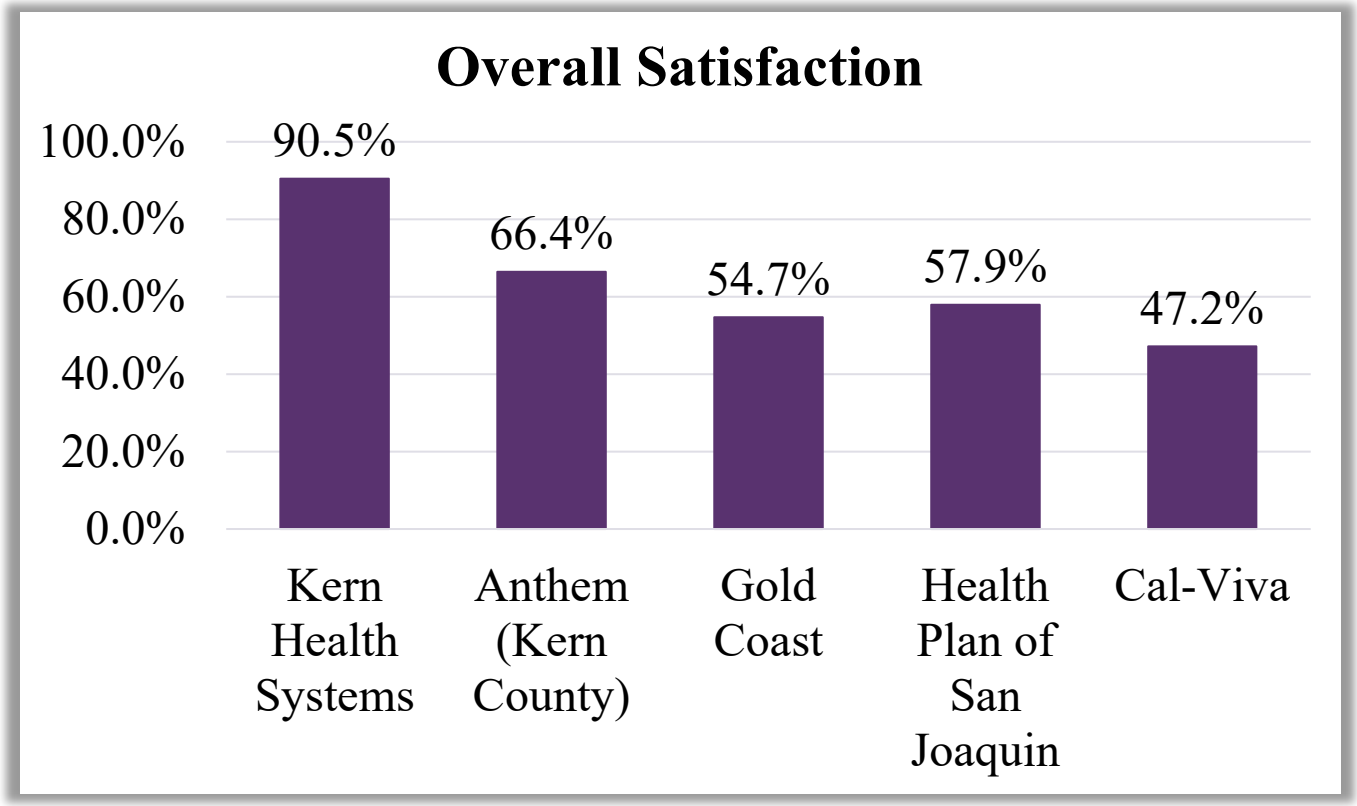
In the tables below, summary rate represents the most favorable response percentages. KHS scores remained in line with prior year’s scores (+/- 5%) in all composites/attributes. KHS scored within the 75th percentile or higher in all scoring composites/attributes when compared against PG's 2024 Medicaid Book of Business.

KHS' Year over Year Summary Rates				
Composites/ Attributes	**KHS CY 2021 Summary Rate**	**KHS CY 2022 Summary Rate**	**KHS CY 2023 Summary Rate**	**KHS CY 2024 Summary Rate**
Overall Satisfaction	85.20%	90.50%	90.00%	**90.50%**
Compared to Other Plans	62.10%	70.80%	68.40%	**79.90%**
Compensation	53.50%	58.30%	59.10%	**73.80%**
UM & Quality	51.50%	64.20%	61.40%	**72.70%**
Network/COC	55.70%	50.60%	53.10%	**62.10%**
Health Plan Call Center	50.60%	64.50%	61.40%	**68.20%**
Provider Relations	70.80%	73.30%	65.30%	**75.40%**
Recommend to Other MDs	95.30%	98.30%	98.80%	**98.60%**

Composite Scores: KHS vs SPH 2023 Medicaid Book of Business				
Composites/Attributes	**KHS 2024 Summary Rate**	**2023 National Medicaid Summary Scores**		**Percentile Ranking (At or Above 75th)**
Overall Satisfaction	90.50%	72.30%	**Favorable**	**99th**
Other Local Plans	79.90%	39.50%	**Favorable**	**100th**
Compensation	73.80%	35.70%	**Favorable**	**100th**
UM & Quality	72.70%	36.30%	**Favorable**	**100th**
Network/COC	62.10%	32.90%	**Favorable**	**99th**
Health Plan Call Center	68.20%	38.90%	**Favorable**	**100th**
Provider Relations	75.40%	34.50%	**Favorable**	**100th**
Would Recommend	98.60%	86.60%	**Favorable**	**99th**

Respondents were asked to rate their overall satisfaction in comparison to other plans they worked with in 2024. KHS scored well above all other listed plans.

Health Plan Comparison



STRENGTHS

The Plan's survey vendor, PG Analytics, reviewed KHS results and identified key measures that drove provider's overall satisfaction scores. The Plan found that the identified strength/power metrics fell into two general fields, Provider Experience/Service and Clinical Program Support. These key power metrics were:

Provider Experience/Service

- Quality of provider orientation process
- Representative's ability to answer questions and resolve problems
- Quality of written communications, policy bulletins and manuals

Clinic Care Support:

- Health plan's facilitation/support of appropriate clinical care for patients
- Degree to which the plan covers and encourages preventive care and wellness

LANGUAGE ASSISTANCE PROGRAM ASSESSMENT

As required by the Department of Managed Health Care, KHS has additional questions included as part of Provider Satisfaction Survey to conduct a Language Assistance Program (LAP) Assessment. The questions included as part of this assessment aim to evaluate provider perspectives and concerns with the health plan's language assistance program, including coordination of appointments with an interpreter, availability of an appropriate range of interpreters, and training and competency of available interpreters. KHS is in the process of finalizing this report for submission to the DMHC in May 2026.

NEXT STEPS

The Provider Network Management Department met with KHS Department leadership individually to review the survey results. Overall, the results reflect strong performance across all internal departments, with each area receiving high satisfaction scores from providers. These findings demonstrate continued organizational commitment to provider engagement, responsiveness, and operational support.

The Plan will continue to monitor provider feedback and maintain ongoing review processes to support sustained performance across departments. Despite significant organizational changes, the Plan will continue to maintain high provider satisfaction scores throughout 2025 and 2026. Key initiatives during this period include the transition to a new payment processing system in October 2025, the launch of the D-SNP line of business in January 2026, and the implementation of a new Provider Portal in April 2026. Maintaining strong provider satisfaction during this time reflects the organization's commitment to effective communication, provider support, and minimizing disruption to the provider experience.

2025 Provider Satisfaction Survey Results

Calendar Year 2024

KERN HEALTH SYSTEMS

Background & Timeline

- KHS conducts an annual provider satisfaction survey
- The 2025 survey measured the CY 2024 KHS performance with network providers
- Press Ganey (PG) Analytics conducted the survey on behalf of KHS
- KHS Performance is benchmarked to HMO industry performance for similar measures
- Survey was conducted over three (3) waves during Q2 2025

Survey Panel

Surveys were sent to the following provider types:

- **Primary Care Providers**
- **Specialists**
- **Behavioral Health**
- **Hospitals & Urgent care Facilities**
- **Ancillary Provider Types**

- 150 Total Surveys received in CY2024
  - *CY 2023: 175* surveys received
  - Provider offices incentivized for survey completion
- Confidence Level
  - Survey sample at 95% confidence level.

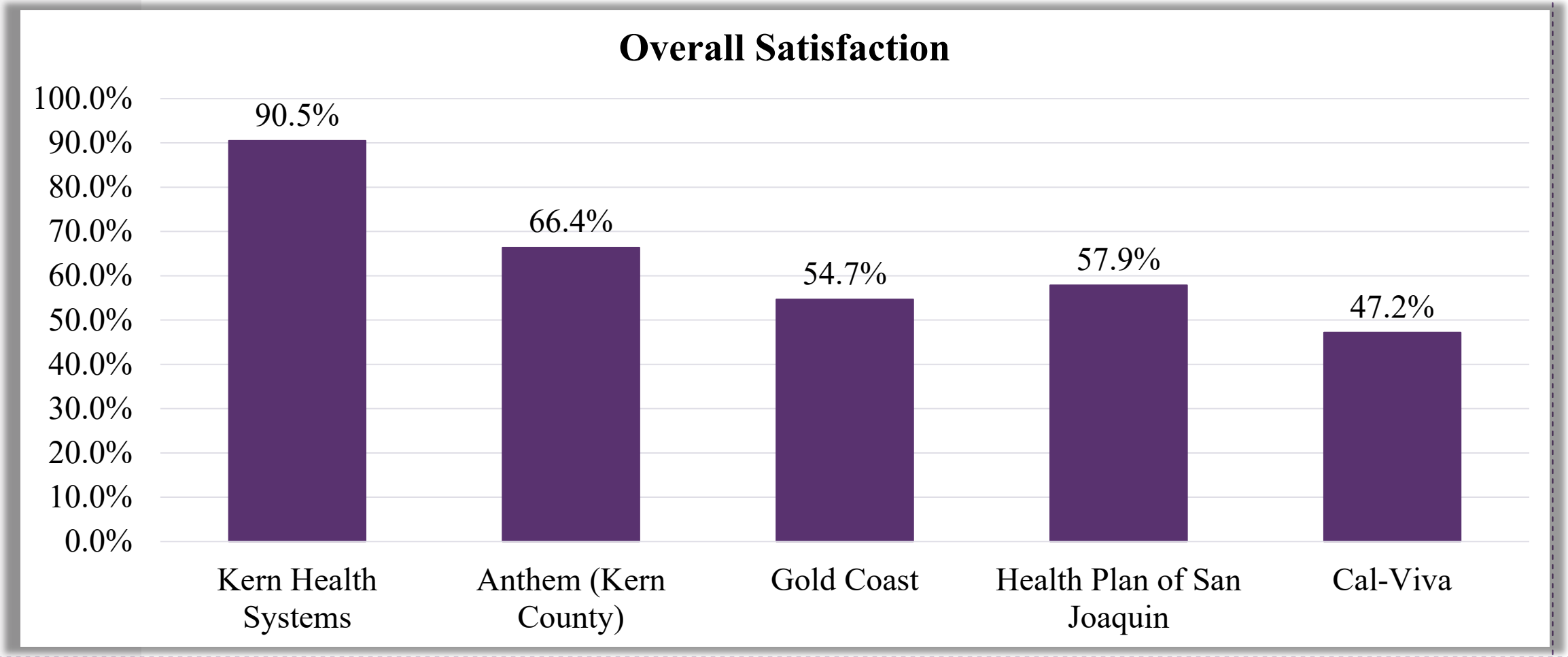
Report Highlights

Composites/ Attributes	KHS CY 2021 Summary Rate	KHS CY 2022 Summary Rate	KHS CY 2023 Summary Rate	KHS CY 2024 Summary Rate
Overall Satisfaction	85.2%	90.5%	90.0%	**90.5%**
Compared to Other Plans	62.1%	70.8%	68.4%	**79.9%**
Compensation	53.5%	58.3%	59.1%	**73.8%**
UM & Quality	51.5%	64.2%	61.4%	**72.7%**
Network/COC	55.7%	50.6%	53.1%	**62.1%**
Health Plan Call Center	50.6%	64.5%	61.4%	**68.2%**
Provider Relations	70.8%	73.3%	65.3%	**75.4%**
Recommend to Other MDs	95.3%	98.3%	98.8%	**98.6%**

Report Highlights

Composites/ Attributes	KHS Summary Rate	2024 National Medicaid Summary Scores		Percentile Ranking (At or Above 75th)
Overall Satisfaction	90.5%	72.3%	Favorable	99th
Other Local Plans	79.9%	39.5%	Favorable	100th
Compensation	73.8%	35.7%	Favorable	100th
UM & Quality	72.7%	36.3%	Favorable	100th
Network/COC	62.1%	32.9%	Favorable	99th
Health Plan Call Center	68.2%	38.9%	Favorable	100th
Provider Relations	75.4%	34.5%	Favorable	100th
Would Recommend	98.6%	86.6%	Favorable	99th

Health Plan Comparison



Strengths

Survey vendor identified which measures drove provider's overall satisfaction with KHS:

Provider Experience/Service

- Quality of provider orientation process
- Representative's ability to answer questions and resolve problems
- Quality of written communications, policy bulletins, and manuals

Clinical Program Support

- Health plan's facilitation/support of appropriate clinical care for patients
- Degree to which the plan covers and encourages preventive care and wellness

Next Steps

- Reviewed survey results/provider feedback with KHS Department leadership

- Continue to maintain high provider satisfaction scores through organizational changes in 2025 and 2026:
  - Transition to new payment processing system (October 2025)
  - Launch of D-SNP line of business (January 2026)
  - New Provider Portal (April 2026)

- Continue to work with third party vendor, PG Analytics to gauge provider satisfaction. CY 2025 survey will kick-off Q2 2026

Questions

For additional information, please contact:

James Winfrey
Deputy Director of Provider Network

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

To: Executive Quality Improvement Heath Equity Committee (EQIHEC)

From: John Miller, M.D.

Date: March 17, 2026

Re: QIHEP Annual Documents

Background:

As part of KHS Quality Improvement Health Equity Program (QIHEP), three foundational documents are developed and reviewed annually to guide oversight of quality, safety, and health equity activities: the Annual Program Evaluation, the Program Description, and the Work Plan.

The Annual Program Evaluation provides a retrospective assessment of the prior year's QIHEP activities. It evaluates performance across key domains such as quality and safety of clinical care, quality of service, member and provider satisfaction, and efforts to address cultural, racial, ethnic, and linguistic needs of members. The evaluation reviews performance measures, monitoring activities, and outcomes to determine whether program objectives were met and identifies opportunities for improvement.

The Program Description outlines the structure and operational framework of the QIHEP. It describes the program's purpose, governance structure, committee oversight, roles and responsibilities, and the methodologies used for data collection, analysis, and quality monitoring. The Program Description also defines how QIHEP activities align with regulatory requirements and organizational priorities.

The QIHEP Work Plan translates program goals into actionable activities for the upcoming year. The Work Plan establishes specific quality improvement initiatives, performance measures, and monitoring strategies that address priority areas identified through the Annual Evaluation, population needs assessments, and regulatory requirements. Progress on Work Plan activities is monitored throughout the year and reported to the EQIHEC and other oversight committees.

Fiscal Impact:

None

Requested Action:

Approval of:

1. 2025 Quality Improvement Health Equity Program Evaluation
2. 2026 Quality-Health Equity Program Description
3. 2026 Quality Improvement Work Plan

Annual QIHEP Documents

Kern Family Health Care®

For review today:

- 2025 QIHEP Evaluation
- 2026 QIHEP Program Description
- 2026 QIHEP Work Plan

KERN HEALTH SYSTEMS

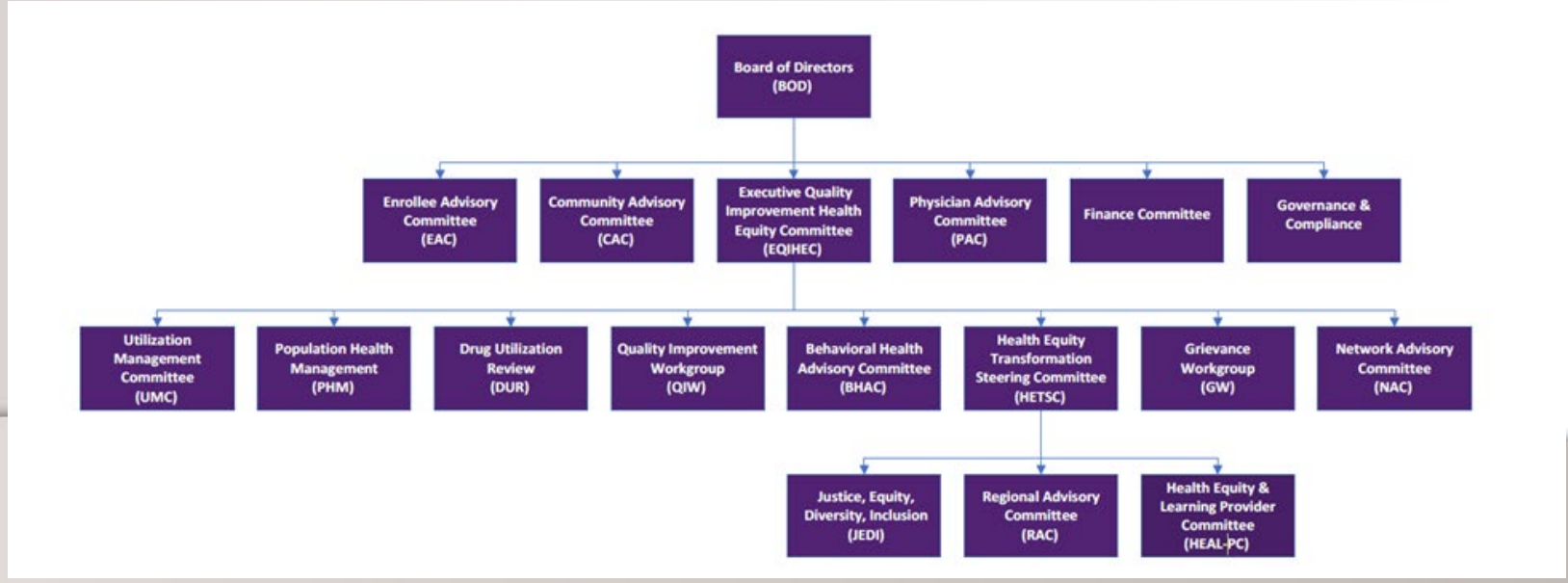
2025 QIHEP Evaluation

- Quality Program Governance
- Quality Department Changes
- 2025 Workplan Summary
- Quality Program Structure
- Quality of Clinical Care
- Safety of Clinical Care
- Quality of Service
- Member Experience
- Provider Engagement

KERN HEALTH SYSTEMS

2025 QIHEP Evaluation

- Quality Program Governance
  - Board of Directors
  - CEO
  - CMO
  - CHEO
  - EQIHEC
    - All committees & subcommittees parameters for membership and meeting frequency were met for 2025.



KERN HEALTH SYSTEMS

Member Feedback

Strengths

- **Strong issue identification and data transparency**
  - Effective use of data and discussion to surface health equity and quality issues
  - Willingness to name inequities and highlight disparities that may otherwise go unseen
- **Targeted focus on health equity priorities**
  - Meaningful attention to vulnerable populations, including immigrant families and underserved communities
  - Emphasis on access to care, education, and services in rural and remote areas of Kern County

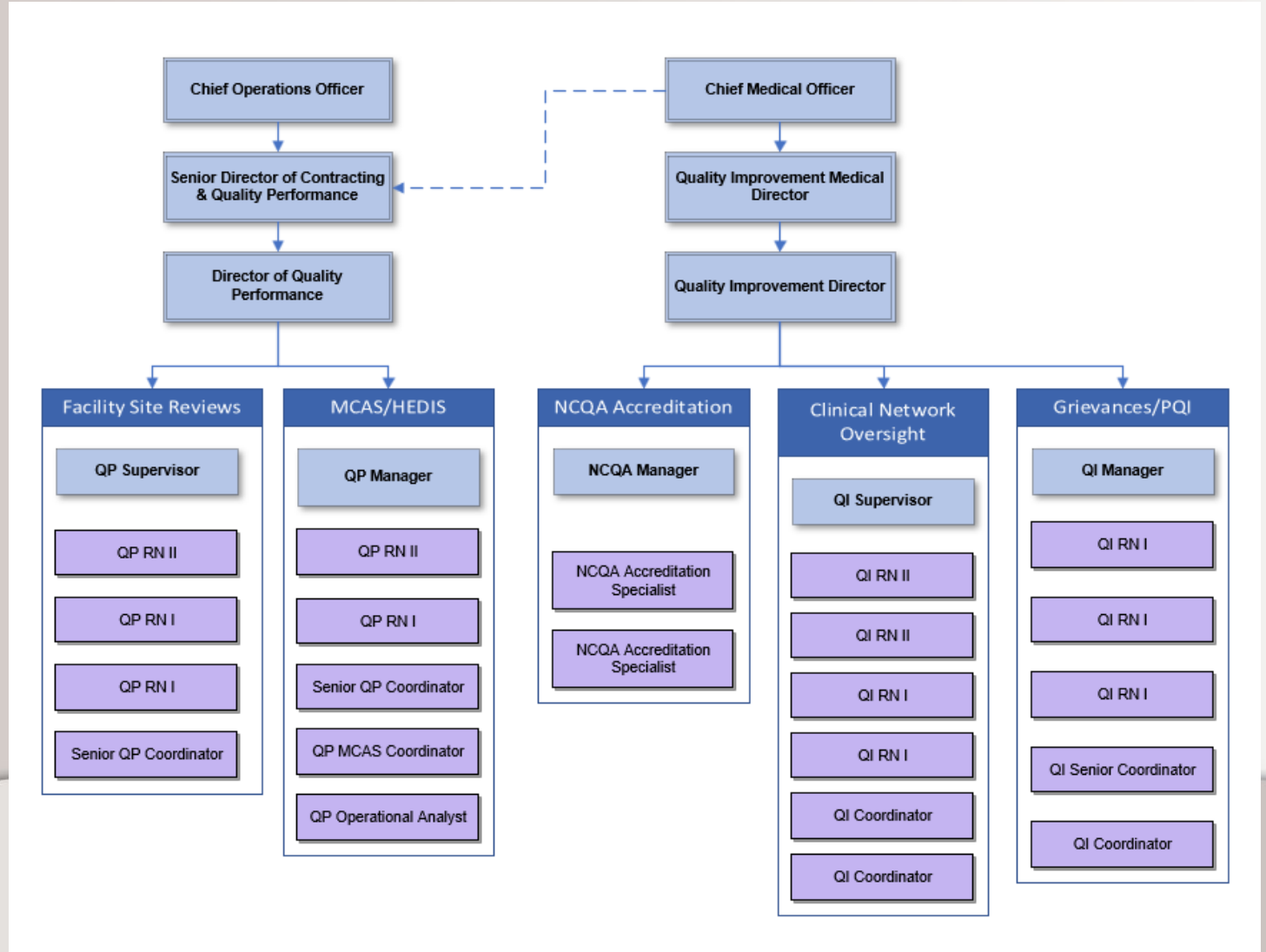
Member Feedback

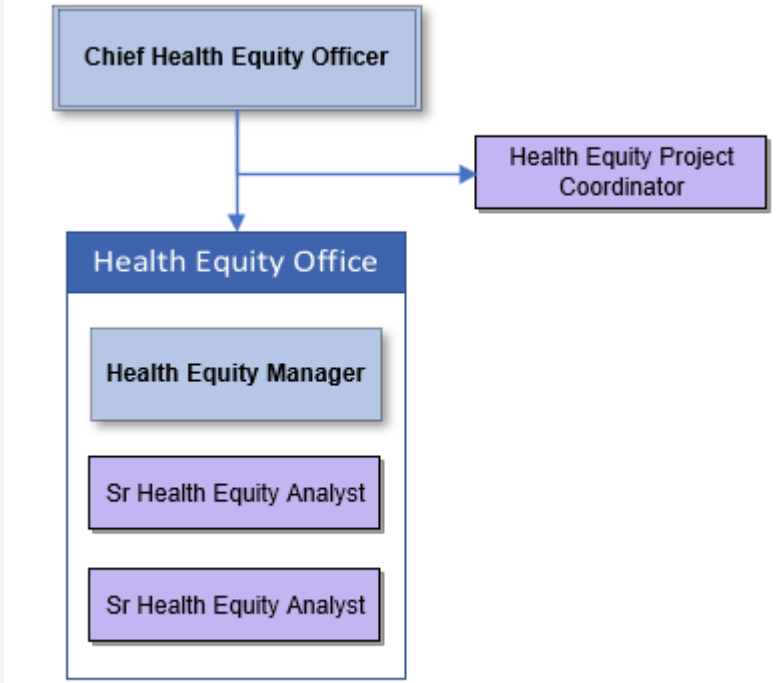
Opportunities for Improvement

- Improve time management during meetings
- Focus agendas on fewer priority topics to allow deeper discussion
- Provide clear follow-up actions and accountability for action items
- Explore opportunities to include additional subject matter experts or operational staff when relevant

2025 QIHEP Evaluation

- Quality-HE Department Changes

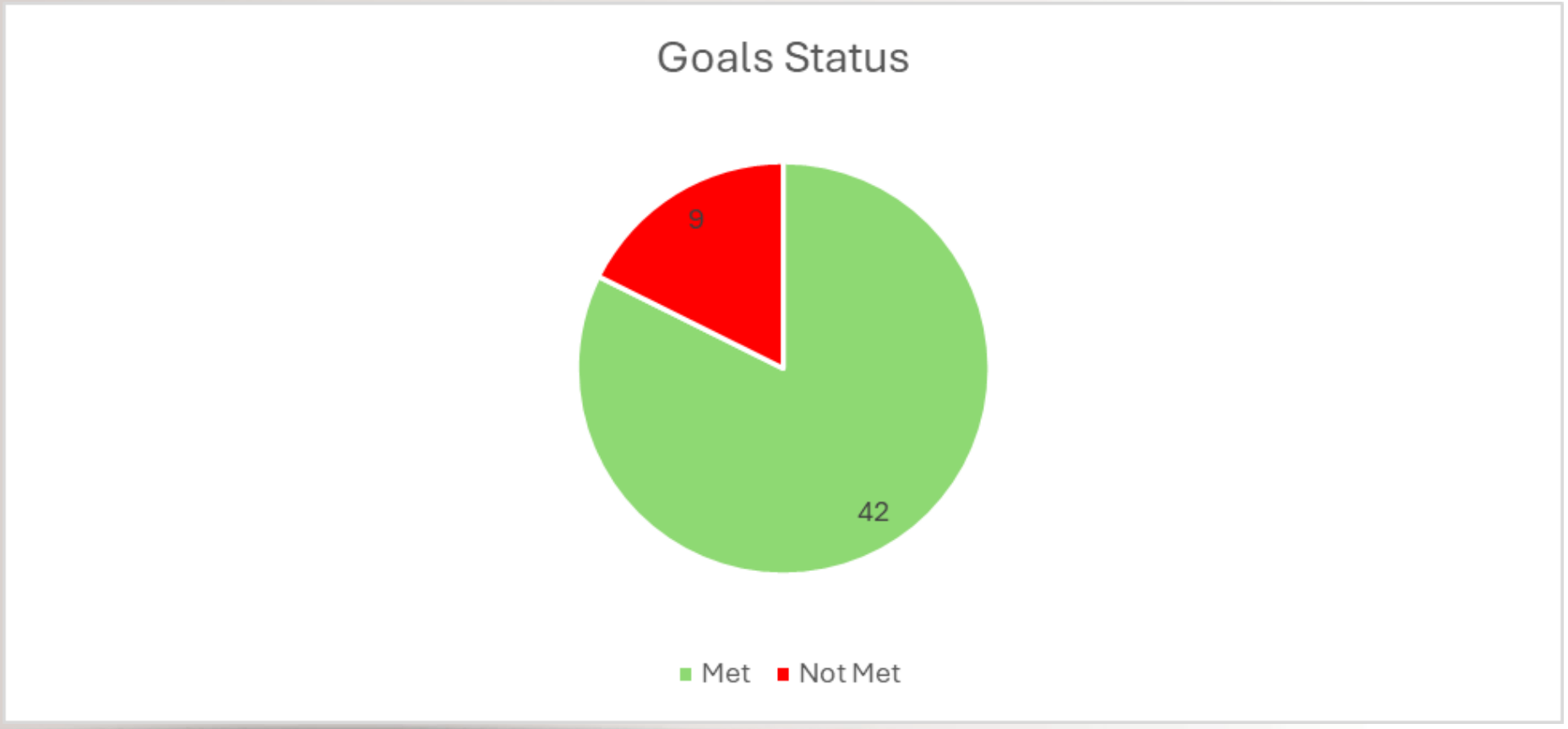




KERN HEALTH SYSTEMS

2025 QIHEP Evaluation

- 2025 Workplan Summary



KERN HEALTH SYSTEMS

2025 QIHEP Evaluation

- **Quality Program Structure**

	Metric	Goal	Result
1	QIHE Governance – EQIHEC Meetings	Met quorum of voting members at every meeting	Met
2	Annual QI Evaluation of 2024	Annual approval by the EQIHEC and the BOD	Met
3	2025 QIHE Program Description	Annual approval by the EQIHEC and the BOD	Met
4	2025 Annual QI Work Plan	Annual approval by the EQIHEC and the BOD	Met
5	Annual review of KHS Quality Improvement P&Ps	100% of policies reviewed and updated as needed	Met
6	NCQA Health Plan Accreditation	Attain full health plan accreditation	Met
7	NCQA Health Equity Accreditation	Attain full health equity accreditation	Met

KERN HEALTH SYSTEMS

2025 QIHEP Evaluation

- **Quality of Clinical Care**

	Metric	Goal	Result
8	AMR Asthma Medication Ratio	Meet minimum performance levels (MPLs)	Met
9	BCS Breast Cancer Screening	Meet minimum performance levels (MPLs)	Met
10	CHL Chlamydia Screening in Women	Meet minimum performance levels (MPLs)	Met
11	CCS Cervical Cancer Screening	Meet minimum performance levels (MPLs)	Met
12	CIS-10 Childhood Immunization Status	Meet minimum performance levels (MPLs)	Not Met
13	CBP Controlling High Blood Pressure	Meet minimum performance levels (MPLs)	Met
14	DEV Developmental Screenings in The First Three Years of Life	Meet minimum performance levels (MPLs)	Not Met
15	IMA-2 Immunizations for Adolescents	Meet minimum performance levels (MPLs)	Met
16	LSC Lead Screening In Children	Meet minimum performance levels (MPLs)	Met
17	FUA Follow-Up After ED visit for Substance Abuse - 30 Days	Meet minimum performance levels (MPLs)	Not Met
18	FUM Follow-Up After ED visit for Mental Illness - 30 Days	Meet minimum performance levels (MPLs)	Not Met
19	GSD Hemoglobin A1c Control for patients with diabetes	Meet minimum performance levels (MPLs)	Met
20	PPC-Pre Prenatal Care	Meet minimum performance levels (MPLs)	Met
21	PPC-Post Postpartum Care	Meet minimum performance levels (MPLs)	Met
22	TFL-CH Topical Fluoride for Children	Meet minimum performance levels (MPLs)	Met
23	W30(0-15M) Well-Child Visits 0-15 months	Meet minimum performance levels (MPLs)	Not Met
24	W30(15-30M) Well-Child Visits 15-30 months	Meet minimum performance levels (MPLs)	Met
25	WCV – Child and Adolescent Well-Care Visits	Meet minimum performance levels (MPLs)	Not Met
26	Clinical PIP	Get Annual Approval by HSAG	Met
27	Non-Clinical PIP	Get Annual Approval by HSAG	Met
28	Health Equity Sprint Collaborative	2 provider partnerships and 1 CBO partnership in support of well-care visits	Met

KERN HEALTH SYSTEMS

2025 QIHEP Evaluation

- **Quality of Clinical Care**

Measurement Year	MY2020	MY2021	MY2022	MY2023	MY2024
KHS MEMBERSHIP	277,616	299,864	334,078	346,049	348,225
MPL PERCENTILE	50th	50th	50th	50th	50th
TOTAL HELD to MPL	19	15	15	18	18
MET MPL	2	5	5	8	12
Did Not Meet MPL	17	10	10	10	6

KERN HEALTH SYSTEMS

2025 QIHEP Evaluation

- **Safety of Clinical Care**

	Metric	Goal	Result
29	Patient Safety Program/Clinical Network Oversight: Conduct Quarterly Audits of select Measures	Baseline Monitoring	Met
30	Monitoring of PQI volume month over month	<30/month	Met
31	PQI Rates by Provider	Baseline Monitoring	Met
32	PQI Rates by ethnicity, English as a second language, sexual orientation, gender identity	Baseline Monitoring	Met
33	PQI Timeliness of resolution	Within 120 Days	Met
34	Facility Site Review	Complete FSR and medical record audit of 100% of practitioners due for credentialing or recredentialing	Met
35	Physical Accessibility Review Surveys	Complete the PARS audit of 100% of practitioners due for credentialing or recredentialing	Met
36	Medical Record Reviews	Achieve medical record review score of 85% for each practitioner	Met
37	DUR – Physician Administered Drugs	72 hrs for urgent, 5 days for routine	Met
38	Credentialing/Recredentialing	100% timely credentialing/recredentialing of practitioners	Met

KERN HEALTH SYSTEMS

2025 QIHEP Evaluation

- **Quality of Service**

	Metric	Goal	Result
39	Grievances & Appeals Timeliness of acknowledgement letters	90% within 5 calendar days	Not Met
40	Grievances & Appeals Timeliness of resolution	90% within 30 calendar days and 72 hours for expedites	Not Met
41	Access to Care – PCP Urgent Care within 48 hours	80% of routine care within 48 hours	Met
42	Access to Care – PCP Routine Care within 10 days	80% of routine care within 10 business days	Met
43	Access to Care – SCP Urgent Care	80% of specialty care within 48 hours	Met
44	Access to Care – SCP Routine Care	80% of specialty care within 15 business days	Met
45	Telephone Access to Member Services Speed of Answer	<30 seconds	Not Met
46	Telephone Access to Member Services Call abandonment rate	<5%	Met

Metric	Goal	Result
Grievances & Appeals Timeliness of acknowledgement letters	Within 5 calendar days	87.1%
Grievances & Appeals Timeliness of resolution	Within 30 calendar days	74.0%

Activity	Goal	Q1-2024	Q2-2024	Q3-2024	Q4-2024
Speed of Answer	<0:30	0:11	0:21	0:46	0:42

KERN HEALTH SYSTEMS

2025 QIHEP Evaluation

- Member Experience
- Provider Engagement

	Metric	Goal	Result
47	Adult and Child CAHPS Survey	Establish baseline for Getting Care needed measure	Met

	Metric	Goal	Result
48	Provider Satisfaction Survey – Would Recommend	Maintain 98th Percentile	Met
49	Provider Satisfaction Survey – Utilization and Quality Management	Maintain 97th Percentile	Met
50	Provider Satisfaction Survey – Degree to which the plan covers and encourages preventative care and wellness	Maintain 96th Percentile	Met
51	Provider Education – Host educational conference for Providers	Host one education conference for Providers	Met

KERN HEALTH SYSTEMS

2025 QIHEP Evaluation

- **Conclusion**
  - **Effectiveness of the QIHEP**
    - The QIHEP was effective in supporting continuous quality improvement activities across clinical care, service quality, and patient safety domains.

Opportunities for 2026

- MCAS gaps in preventive care and behavioral health follow-up
- Member engagement barriers (access, transportation, health literacy)
- Address socioeconomic barriers impacting access to care
- Enhance cross-department collaboration to close care gaps
- Improve Member Services timeliness for grievance resolution

KERN HEALTH SYSTEMS

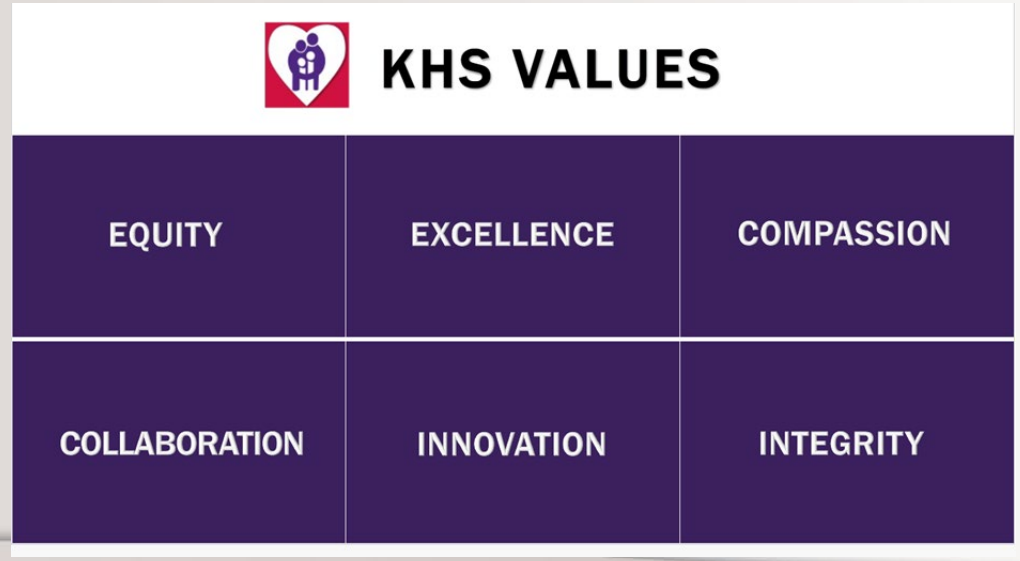
2026 QIHEP Program Description

- Mission & Values
- QIHEP Program Overview, Purpose, Scope, Goals
- Authority & Responsibility
- Organizational Structure & Resources
- Role of Participating Providers
- Program Documents
- 2026 QIHEP Work Plan

KERN HEALTH SYSTEMS

2026 QIHEP Program Description

- **Mission & Values**
  - KHS is committed to improving the health and well-being of our members and the community of Kern County through an integrated, equitable, and member-centered healthcare delivery system.



KERN HEALTH SYSTEMS

2026 QIHEP Program Description

- **QIHEP Program Overview, Purpose, Scope**
  - The QIHEP is a written description of the overall scope and responsibilities of the program. The QIHEP 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.
  - QIHEP is composed of several systematic processes that monitor and evaluate the quality of clinical care and health care service delivery to KHS members. The QIHEP scope includes regular needs assessments based on race/ethnicity, language, cultural preferences, health disparities, and stakeholder engagement.

KERN HEALTH SYSTEMS

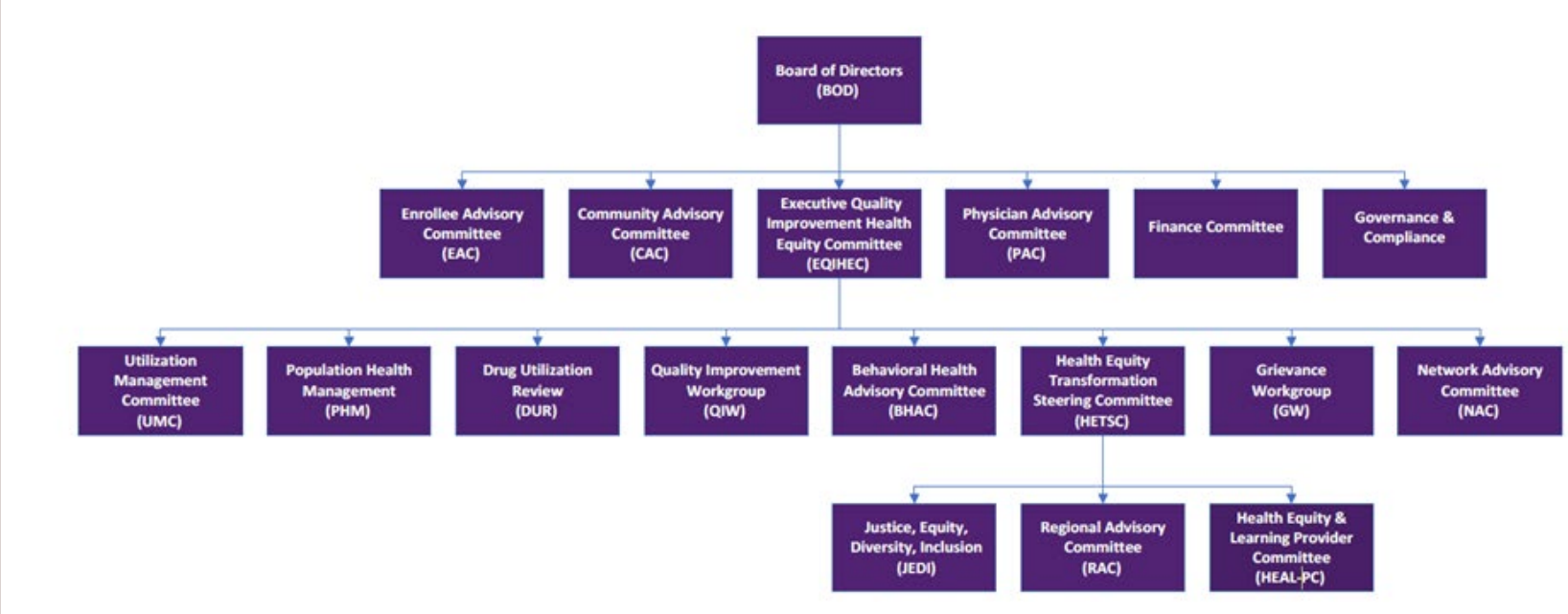
2026 QIHEP Program Description

- **QIHEP Goals**
  - Enhancing Member Health
  - Guidelines & Education
  - Practice Standards
  - Open Communication
  - Data-Driven Improvement
  - Quality & Safety Commitment
  - Regulatory Compliance
  - Performance Evaluation
  - Address Health Disparities

KERN HEALTH SYSTEMS

2026 QIHEP Program Description

- Authority & Responsibility
- Organizational Structure & Resources



KERN HEALTH SYSTEMS

2026 QIHEP Program Description

- Role of Participating Providers

  - **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 Performance** – KHS requires contracted providers to comply with DHCS' Managed Care Accountability Set (MCAS) and participate in quality-based initiatives aimed at improving, access, quality, and health equity for our members. Routine meetings are conducted with a subset of participating providers to ensure monitoring, communication, and supporting of achieving MPLs and maintaining high quality care.

KERN HEALTH SYSTEMS

2026 QIHEP Work Plan

- **Quality Program Structure**
  - EQIHEC, QIHEP, NCQA
- **Quality of Clinical Care**
  - MCAS, PIPs, Health Equity Sprint Collaborative
- **Safety of Clinical Care**
  - Clinical Network Oversight, PQIs, FSR, Drug Utilization, Credentialing/Recredentialing
- **Quality of Service**
  - Grievance & Appeals Timeliness, Access to Care, Telephone Access
- **Member Experience**
- **Provider Engagement**

KERN HEALTH SYSTEMS

Your Role

- **Review and approve** 2025 QIHEP Evaluation, 2026 QIHEP Program Description & 2026 Workplan
- **Monitor KHS Quality-Health Equity Plan** throughout the year
- **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

KERN HEALTH SYSTEMS

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



KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

2025 Quality Improvement Health Equity Program Evaluation

Executive Quality Improvement Health Equity Committee (EQIHEC)
Approval Date: 03/17/26

Table of Contents

I. Introduction 3

II. Quality Program Governance 3

III. Quality Departmental Changes 14

IV. 2025 QI Work Plan Summary 15

V. Quality Program Structure 15

VI. Quality of Clinical Care 17

A. Quality Measures & Performance Improvement 17

B. Performance Improvement Projects (PIPs) 25

C. Health Sprint Collaborative 28

VII. Safety of Clinical Care 29

A. Clinical Network Oversight 29

B. Potential Quality of Care Issues (PQI) 30

C. Facility Site Review (FSR) 35

D. Physical Accessibility Review Surveys (PARS) 36

E. Medical Records Review (MRR) 37

F. Drug Utilization Review 38

G. Credentialing & Recredentialing 38

VIII. Quality of Service 38

A. Grievance & Appeals 38

B. Access to Care 39

C. Telephone Access to Member Services 44

IX. Member Experience 44

A. Consumer Assessment of Healthcare Providers and Systems (CAHPS) 45

X. Provider Engagement 46

A. Provider Satisfaction Survey 46

B. Provider Education 47

XI. Health Equity 48

XII. Conclusion 49

XIII. Appendix 50

Appendix A: Population Needs Assessment September 2025 50

I. Introduction

Kern Health Systems (KHS), operating as Kern Family Health Care (KFHC), was established in 1993 by the Kern County Board of Supervisors as a local initiative Medi-Cal managed care health plan. KFHC is the largest health plan in Kern County, serving the majority of Kern County's Medi-Cal beneficiaries through a contract with the State of California Department of Health Care Services (DHCS).

KHS is a special county health authority governed by a 16-member Board of Directors. This diverse board includes representatives such as the Chief Executive Officer of the local safety net hospital, a safety net care provider, ten community representatives nominated by the County Supervisors, two Medi-Cal primary care physicians, one representative from a rural acute care general hospital, and one pharmacist. Board members must work or reside in Kern County and meet the minimum age requirement of 21. The Board oversees the establishment and operation of a comprehensive managed care system, ensuring access to high-quality medical care, promoting cost efficiency, and adhering to the principles of Chapter 7, Part 3 of Division 9, Section 14000 of the California Welfare and Institutions Code.

As of 2025, KHS serves approximately 404,842 members, with 49% receiving care through the County Hospital system and two large Federally Qualified Health Centers (FQHCs). While 54.7% of the population resides in Bakersfield, the remainder is spread across rural areas of Kern County. The largest racial and ethnic group is Hispanic, accounting for 63.3% of membership. Language diversity is a key factor, with 69.7% of members speaking English as their primary language, 30% speaking Spanish, and 0.3% speaking other languages.

Kern County faces significant health challenges compared to statewide statistics, including higher rates of adult smoking, obesity, physical inactivity, alcohol-impaired driving deaths, sexually transmitted infections, and teen births. However, the county ranks favorably in food environment indices due to fewer low-income residents with limited access to grocery stores and lower rates of excessive drinking.

II. Quality Program Governance

KHS has multiple provider specialties, as well as members from the KHS community and population, represented in the following committees:

Board of Directors (BOD)

The KHS Board of Directors (BOD) seeks to improve access to quality healthcare, maintain and preserve a healthcare safety net for Kern County, and ensure the fiscal integrity of KHS. The BOD has accountability, authority, and responsibility for the overall QI program. The BOD has delegated coordination of the QI Program to the Executive Quality Improvement Health Equity Committee (EQIHEC). Members of the BOD are appointed by the County Board of Supervisors and have backgrounds in business, finance, managed care, hospital administration, information technology, medicine, healthcare policy, and law. The BOD meets at least four times per year.

Chief Executive Officer

The KHS Chief Executive Officer (CEO) is responsible for the implementation of the QI Program. The CEO provides organizational leadership and direction, participates in prioritization and organizational oversight of quality improvement activities, and ensures the availability of resources necessary to implement the approved QI Program. The Executive Team provides oversight, accountability, and support for NCQA, HEDIS, and related quality improvement initiatives. The CEO's level of involvement in quality improvement activities was appropriate to ensure executive level accountability in support of the organizational goals.

Chief Medical Officer

The Chief Medical Officer (CMO) is responsible for the day-to-day oversight of Medical Management, Quality Improvement, Utilization Management, Case Management, Behavioral Health, Community Based Programs, and Peer Review activities. The CMO serves as the Co-Chair of the EQIHEC and is involved in all QI and Health Services activities. The CMO provides oversight for the QI Program on a day-to-day basis and participates in EQIHEC meetings.

The Health Services team is comprised of:

• Medical Directors – Assist the CMO with utilization management review, review of appeal decisions, and review of Potential Quality of Care Issues (PQI). The Medical Directors also provide physician support for various activities within the Quality department, including Performance Improvement, Member Safety, and Peer Review. The time allocated and scope of responsibilities for quality activities were set appropriately to meet the needs of the QI department.

• Senior Director for Health Services – Reports to the CMO and works collaboratively with the CMO and Director of Quality Improvement on the QIHEP. Responsible for the day-to-day implementation of Quality Improvement, Utilization Management, Pharmacy, Case Management, Community Based Programs, and Behavioral Health programs. This role provides oversight, guidance, and evaluation of ongoing UM activities and programs.

• Director of Quality Improvement – Reports to the QI Medical Director and works collaboratively to define strategy, develop programs and services, and evaluate the effectiveness of the QIHEP. Along with the QI Management Team, including Medical Directors, provides oversight of PQIs, compliance with DHCS and NCQA standards, and other performance measures, data collection, and performance reporting.

The number of associated Health Services staff and the level of involvement of the CMO were appropriate for meeting the objectives of the QIHEP for 2025.

Chief Health Equity Officer

The Chief Health Equity Officer (CHEO) oversees development, implementation, review, and revision of health equity policies and procedures; maintains the QIHEP description and work plan; coordinates implementation activities; and ensures reporting to the EQIHEC. The CHEO also serves as the primary liaison between KHS and regulatory agencies on health equity issues and programs. The CHEO serves as the co-chair alongside the CMO on the EQIHEC and provides a health equity perspective for all non-clinical areas; the CHEO seat may not be delegated. The CHEO oversees the development, evaluation, and revision of the QIHEP description. The CHEO also oversees how health

equity is embedded into the KHS culture for all non-clinical aspects (i.e., marketing, member engagement, member services, community supports, etc.). The level of involvement of the CHEO was appropriate for meeting the objectives of the QIHEP for 2025.

Executive Quality Improvement Health Equity Committee (EQIHEC)

The Executive Quality Improvement Health Equity Committee (EQIHEC) reports to the Board of Directors (BOD) and retains oversight of the QIHEP with direction from the CMO. The EQIHEC provides overall direction for continuous improvement and evaluation of activities, including efforts to improve member outcomes. Additionally, the EQIHEC is responsible for monitoring and ensuring that all QIHEP activities are implemented to improve care and services for KHS members through a health equity lens.

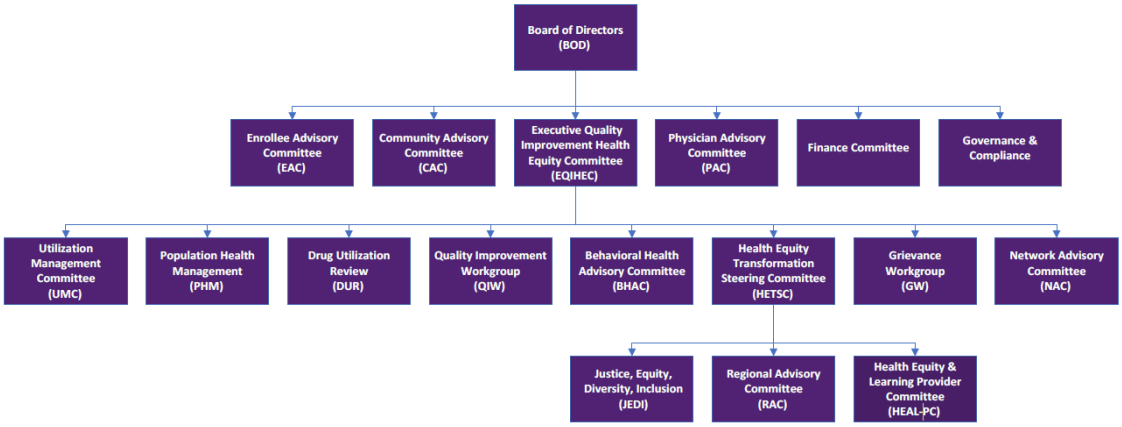
Thirteen (13) positions are filled; four (4) EQIHEC meetings were held in 2025 with attendance from the CMO, CHEO, primary care practitioners, specialists, a pharmacist, home health and hospice representatives, DME providers, the County Public Health Department, and members of the Community Advisory Committee (CAC). Quorum was met at every meeting. Overall, the EQIHEC structure was sufficient and provided appropriate oversight and support to the QIHEP. The parameters for membership and meeting frequency were met for 2025, and activities included discussion, review, and approval of reports and policies and procedures related to QI and accreditation activities.

As part of the annual evaluation of the EQIHEC, feedback was solicited from committee members regarding meeting effectiveness, structure, and opportunities for improvement. Overall, respondents indicated that EQIHEC meetings are well organized and conducive to discussion and feedback from committee members. Members reported that the committee structure supports meaningful dialogue related to quality improvement and health equity activities.

Opportunities for improvement identified through the feedback included strengthening time management during meetings, focusing agendas on a smaller number of priority topics to allow for deeper discussion, and ensuring clear next steps and accountability for action items. Respondents also suggested continuing to provide meeting materials in advance and considering structured questions to guide discussion and solicit feedback from committee members. Additional recommendations included limiting meeting length and exploring opportunities for broader participation from individuals working closely with KHS members.

The feedback will be used to inform ongoing improvements to EQIHEC meeting structure and facilitation to support meaningful discussion, decision-making, and follow-through on quality improvement initiatives.

EQIHEC Sub-committees



There are KHS sub-committees in place to support the EQIHEC and QIHEP objectives and goals. The activities of the sub-committees are formally documented in transcribed minutes, which summarize each agenda item, the discussion, actions taken, and follow-up required. This information is reported to the EQIHEC in the form of formal reports at four times annually.

Behavioral Health Advisory Committee (BHAC)

The KHS Behavioral Health Advisory Committee (BHAC) is a subcommittee of the EQIHEC and is charged with facilitating collaborative coordination of medical, behavioral health, and substance use disorder services between KHS, the Kern County Medi-Cal Behavioral Health Organization (MBHO), and certified Substance Use Disorder (SUD) providers caring for KHS members. The goal of the committee is to maintain continuity of care and reduce barriers to appropriate access and ongoing treatment.

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 services, KHS typically provides treatment for mild to moderate impairment, also referred to as Non-Specialty Mental Health Services (NSMHS). Kern County MBHO manages severe mental health impairment, referred to as Specialty Mental Health Services.

For substance use disorders, KHS provides screening, brief intervention, and referral to treatment (SBIRT) services and refers members for treatment for misuse of alcohol or other substances. Active treatment for Medi-Cal members with substance use disorders must be rendered by a Drug Medi-Cal certified program. KHS also covers Behavioral Health Treatment (BHT), including Applied Behavior Analysis (ABA) therapy, for Medi-Cal beneficiaries under the age of 21.

The BHAC is chaired by a KHS credentialed and participating behavioral health provider. Committee attendees include community providers, external stakeholders, and internal KHS staff from Population Health Management, Utilization Management, Health Equity, Pharmacy, and Quality Improvement. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2025, and committee activities included discussion, review, and approval of policies and procedures related to behavioral health services.

In 2025, Kern Health Systems advanced QIHEP efforts within Behavioral Health through coordinated activities aligned with the Non-Specialty Mental Health Services (NSMHS) Member and Provider Outreach and Education Plan. The plan focused on improving access to care, reducing disparities, and strengthening community partnerships. Efforts were informed by Population Needs Assessment findings and utilization data stratified by race, ethnicity, language, age, gender identity, sexual orientation, and geography.

Key 2025 activities included:

- Implementation of the NSMHS Outreach and Education Plan using population health and utilization data to guide equity-focused interventions.
- Engagement in Regional Advisory Committees across Kern County to identify barriers to care, including stigma, transportation challenges, and culturally responsive service needs. Feedback from these committees informed outreach strategies and targeted engagement with underserved rural communities.
- Collaboration with the Community Advisory Committee to support behavioral health education, access initiatives, and community-informed program planning.
- Strengthened Tribal engagement through partnership with the Bakersfield American Indian Health Project, including a multi-tribal stakeholder meeting to support development of culturally responsive behavioral health strategies.
- Quarterly presentations to the EQIHEC to provide executive oversight, review NSMHS utilization trends, and support data-informed quality improvement and health equity initiatives.
- Expansion of provider education, primary care outreach, stigma-reduction efforts, and multiple access pathways for members, along with enhanced demographic data collection, including sexual orientation and gender identity (SOGI), to support health equity monitoring.

Collectively, these activities supported increased NSMHS utilization, improved care coordination with the County Mental Health Plan, and targeted outreach to populations experiencing access gaps. These efforts demonstrate KHS's ongoing commitment to advancing behavioral health equity through community-informed, data-driven quality improvement initiatives.

Drug Utilization Review Committee (DUR)

The Drug Utilization Review (DUR) Committee is a subcommittee that reports to the EQIHEC. The DUR is comprised of the KHS CMO, Director of Pharmacy, and network pharmacists and providers from the community who serve KHS members. The DUR is responsible for reviewing matters related to the use of medications provided to KHS members.

The primary objectives of the DUR are to support appropriate medication management for members to improve health outcomes and safety in the outpatient setting, assist with case management activities, and monitor for potential fraud, waste, and abuse (FWA). Rx Medi-Cal retains responsibility for formulary drugs carved out by the Department of Health Care Services (DHCS). KHS may address therapeutic alternatives, based on safety and efficacy, and work to minimize therapeutic redundancies for medications dispensed under the Medi-Cal Rx program.

Four (4) DUR meetings were held during the reporting period with attendance from the CMO, independent and retail pharmacy representatives, a pediatrician, an Rx representative (board member), pharmacy specialty practice representatives, a pharmacy and geriatric specialist, a general practice and geriatrics provider, and the KHS Pharmacy Director, who serves as the Alternate Chairperson. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2025, and activities included discussion, review, and approval of policies and procedures related to medication management and pharmacy services.

Grievance Workgroup (GW)

Under the direction and oversight of the CMO and physician designee, individual and aggregate data on member grievances are reviewed by the Grievance Workgroup (GW). The GW is a subcommittee of the EQIHEC. The workgroup is charged with evaluating and analyzing grievance data to identify systemic patterns related to service issues, denials, and other trends impacting health care delivery to members, and to recommend necessary changes and process improvements for any adverse trends identified.

All complaints, grievances, investigations, follow-up activities, tracking, and trending reports are prepared by the KHS Member Services Department and submitted to the GW for review. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2025.

Health Equity Transformation Steering Committee (HETSC)

The Health Equity Transformation Steering Committee (HETSC) is a subcommittee of the EQIHEC. The HETSC was established to ensure that KHS remains an organization that understands and addresses social and racial justice and health equity in order to meet member needs. The HETSC is responsible for supporting the implementation of organization-wide initiatives that promote social and racial justice and health equity through various internal and external activities and training.

The HETSC participates in the EQIHEC by assigning HETSC designees to regularly attend and provide input during EQIHEC meetings. The HETSC is responsible for submitting and presenting regularly scheduled summaries of formal reports to the EQIHEC that reflect planned activities, goals, interventions, and ongoing progress toward health equity goals. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2025, and activities included discussion, review, and approval of policies and procedures related to health equity initiatives.

Network Advisory Committee (NAC)

The Network Advisory Committee (NAC) is charged with implementing industry best practices related to KHS contracted providers and delegates, and ensuring network practitioner participation in the QIHEP through planning, design, and review of programs, quality improvement activities, interventions, and evidence-based clinical practice guidelines designed to improve performance. Access and availability standards include geographic distance, timeliness of appointments, network adequacy, and cultural and linguistic considerations to meet the needs of the KHS membership.

Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2025, and activities included discussion, review, and approval of policies and procedures related to network adequacy and provider participation.

Physician Advisory Committee (PAC)

The Physician Advisory Committee (PAC) serves as the KHS Peer Review and Credentialing Committee on health care issues, including peer review, provider discipline, and the evaluation of practitioner qualifications, competency, and professional conduct in credentialing and recredentialing decisions. This committee meets at least ten times per year and is responsible for reviewing practitioner and provider grievances and appeals, practitioner and provider quality issues, and other peer review matters as directed by the KHS CMO.

The PAC had a total of nine (9) active voting members in 2025. Ten (10) PAC meetings were held during the reporting period with attendance from the CMO, a pediatrician, cardiologist, ophthalmologist, OB-GYN, pain medicine provider, family practitioner, and internal medicine provider. Quorum for voting members was met at each meeting.

The parameters for membership and meeting frequency were met for 2025. Activities included review and approval of credentialing policies and procedures; evaluation of the credentials of current and prospective practitioners and providers in a non-discriminatory manner; delegated credentialing oversight; conducting performance monitoring from quality improvement activities and member complaints as part of the recredentialing decision-making process; and recommending corrective or disciplinary action concerning participation in the KHS Provider Network, when applicable.

Population Health Management Committee (PHMC)

The Population Health Management Committee (PHMC) is a subcommittee of the EQIHEC. The PHMC oversees the Population Health Management (PHM) Model of Care (MOC), which addresses members' health needs across the continuum of care, including community-based settings, through participation, engagement, and targeted interventions for defined populations. The goal of the PHMC is to maintain or improve the physical and psychosocial well-being of members and address health disparities through cost-effective and tailored health solutions. Population health management activities are informed by data analytics, risk stratification, and Population Needs Assessment findings to identify priority populations, guide targeted interventions, and monitor outcomes.

The PHMC is a collaborative committee that engages community providers and partners, along with internal business units from multiple KHS departments across the organization that are involved in the development, implementation, monitoring, and evaluation of programs serving members across the continuum of care. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2025, and activities included discussion, review, and approval of policies and procedures related to population health management programs.

In 2025, KHS continued to advance PHM initiatives aimed at delivering high-quality, equitable care across the lifespan by proactively addressing access barriers, supporting vulnerable populations, and monitoring outcomes to reduce disparities and improve member experience. Key programs reviewed by the PHMC included the following:

Baby Steps and Baby Steps Plus Programs

The Baby Steps and Baby Steps Plus Programs support pregnant and postpartum members by promoting early and consistent prenatal and postpartum care through risk-stratified care

management. Members are identified through claims data and multiple referral pathways and receive individualized care plans, routine reassessments, and screenings for psychosocial needs, behavioral health conditions, and social determinants of health. High-risk pregnancies receive RN-led intensive case management, while low-risk pregnancies receive CMA-led care coordination. Program performance is monitored through measures such as early prenatal care initiation, timely postpartum visit completion, psychosocial screening rates, and doula referrals and acceptance. Qualitative member feedback and success stories are also reviewed to highlight improved engagement, access to care, and member experience.

Community Health Workers (CHWs)

The Community Health Worker (CHW) program supports care quality by re-engaging members who are difficult to reach through traditional communication methods. Trained CHWs conduct in-home visits to provide basic health education, assess barriers to care, and reconnect members with healthcare services and community resources. Program performance is monitored using measures such as the number of members successfully re-engaged and the number of referrals made following home visits. The program advances health equity by addressing structural barriers such as limited phone access, transportation challenges, and social isolation. Qualitative feedback indicates that in-person outreach improves trust, communication, and acceptance of referrals and follow-up care.

CCS Transition Support Program

The CCS Transition Support Program supports continuity of care for adolescents aging out of pediatric services by providing structured transition planning beginning between ages 18 and 20. PHM staff conduct outreach, transition readiness assessments, and individualized planning to support continuity of health coverage, linkage to adult primary and specialty care providers, and access to long-term services and supports. Program performance is monitored through measures such as successful member contact, completion of transition assessments, referrals to adult care providers, and enrollment in care management services following transition. This program supports health equity by assisting members with complex medical or developmental needs who are at increased risk for care disruption. Member and family feedback indicates increased confidence navigating adult healthcare systems and reduced anxiety during the transition to adulthood.

Collectively, these programs demonstrate KHS's continued commitment to population health management through proactive outreach, coordinated care management, and targeted interventions designed to improve member outcomes and reduce disparities.

Community Advisory Committee (CAC)

The Community Advisory Committee (CAC) meets quarterly and reports to the Board of Directors (BOD). The CAC has fourteen (14) committee positions, all of which were filled during the reporting period. Four (4) CAC meetings were held in 2025 with attendance from the Kern County Department of Public Health, Kern County Department of Human Services, community representatives, participating healthcare providers, members of the KHS Board of Directors, and KFHC members.

Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2025, and activities included discussion, review, and approval of policies and procedures related to member engagement and community health initiatives.

Quality Improvement Workgroup (QIW)

The Quality Improvement Workgroup (QIW) is a subcommittee of the EQIHEC. The QIW focuses on clinical quality, patient safety, and member and provider experience across four functional areas: HEDIS performance measures, Medi-Cal Managed Care Accountability Set (MCAS) measures, NCQA Accreditation requirements, and Network Clinical Oversight activities.

The QIW is responsible for monitoring performance to ensure KHS meets or exceeds minimum performance levels (MPLs) and regulatory requirements. The workgroup also oversees Department of Health Care Services (DHCS) required studies, including Performance Improvement Projects (PIPs) selected by KHS. Through regular review of performance data, quality initiatives, and intervention outcomes, the QIW works to ensure KHS members receive high quality health care and that any outcomes deviating from established standards are identified and addressed through targeted quality improvement activities. Four (4) QIW meetings were held during the reporting period. Quorum was met at each meeting. The parameters for membership and meeting frequency were met for 2025.

The Wellness and Prevention Department continued to support the QIHEP through targeted outreach and community-based programming. In 2025, focused outreach efforts, including virtual and remote learning opportunities for outlying communities with limited access to services, resulted in a 30% increase in total referrals compared to 2024.

Service utilization increased among the top five racial and ethnic groups compared to the previous year, excluding Hispanic members who already represent the largest proportion of the membership. Increased participation was also observed in the communities of Delano, Shafter, McFarland, and Wasco. Within Bakersfield, more members from ZIP codes 93306, 93304, and 93301 received services compared to 2024.

Member satisfaction with Wellness and Prevention services remained high, with overall satisfaction exceeding 90%. In 2025, 97% of members reported satisfaction with program incentives and the effectiveness of class facilitators and presentations. Knowledge test results demonstrated that members participating in programs gained greater understanding of healthy behaviors and health condition management.

To expand access to prevention programs, the department offered both in-person and virtual classes across Kern County covering topics such as nutrition, diabetes management, and diabetes prevention education. Programs were also offered at multiple Kern County Library locations, which helped reduce transportation barriers due to proximity to public transit routes. Wellness and Prevention programs continued to be offered in both English and Spanish, with live interpreters coordinated upon request. Members participating in virtual sessions were assisted in accessing classes through online platforms such as Zoom or by telephone.

To further strengthen community engagement and increase access to physical activity opportunities, the Live Better Program expanded from three to six locations across the county in 2025, doubling geographic access in Delano, Shafter, Wasco, Lake Isabella, Kernville, and Greenfield. More than 6,500 community members participated in the program in 2025, representing a 245% increase compared to the previous year. Program outcomes demonstrated positive health impacts, with more

than 50% of participants reporting improved sleep, 65% reporting increased energy, and over 80% reporting improved flexibility and body movement. Mental health findings indicated that 56% of participants felt less nervous and 72% reported feeling happier and more positive. Additionally, 85% of participants reported feeling more connected to their community as a result of participation in the program.

School wellness grants totaling $386,000 were awarded to ten school sites across Kern County, reaching approximately 8,000 students through wellness initiatives such as fitness and cooking classes, social and emotional learning curriculum implementation, school gardens, chronic condition management education, parent education programs, access to on-campus health services, and caring closets that provide basic needs supplies such as hygiene products and food.

Additional community outreach initiatives included two Read Your Beats programs implemented in Shafter and Bakersfield during the last quarter of 2025, engaging more than 50 participants in blood pressure screenings with an average reading of 123/78. A community baby shower held in Lamont and Arvin welcomed 19 pregnant KHS members who received health education, newborn supply kits, and information on supportive community resources. All participants reported high satisfaction with the event and educational materials.

The Cultural and Linguistic Services (C&L) team within the Wellness and Prevention Department supported the delivery of quality and equitable care by ensuring members had timely, accurate, and culturally appropriate access to health information and services. The team managed translation and interpreter requests across the health plan, supporting members with limited English proficiency in navigating their care safely and effectively.

During 2025, the C&L team processed 12,680 written translation requests and facilitated 1,920 onsite interpreter encounters across multiple languages, with Spanish accounting for the highest volume of services. Turnaround times consistently met contractual and regulatory requirements, helping prevent delays in care and supporting positive member outcomes.

To maintain quality and compliance, the C&L team conducted routine audits of language service vendors and bilingual staff to validate linguistic competency, translation accuracy, and regulatory compliance. In 2025, more than 1,000 vendor and bilingual staff audits were completed, resulting in an overall compliance rate of 94%. Retraining was implemented when gaps were identified.

The team also expanded internal language access capacity by offering 14 Spanish language classes to KHS staff, strengthening direct communication with Spanish-speaking members and reducing reliance on third-party interpretation services. Additionally, the C&L team launched the Bridge to Better Care Interpreter Training Program for Spanish-speaking provider staff. Twenty-three participants completed the training, gaining the skills necessary to serve as qualified interpreters within their practice settings.

Collectively, these efforts strengthened member communication, improved access to culturally and linguistically appropriate services, and reinforced KHS's commitment to delivering equitable, high-quality care to its diverse member population.

Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) is a subcommittee of the EQIHEC and focuses on oversight of Utilization Management (UM) activities. The UMC supports the EQIHEC in ensuring the appropriate provision of medical services and provides recommendations regarding UM program activities and performance.

The UMC consists of actively participating KHS network practitioners, including primary care providers (PCPs), specialists, and a behavioral health practitioner. The responsibilities of the UMC include developing, recommending, and refining the UM program and related policies and procedures. This includes review of medical necessity criteria, establishment of thresholds for acceptable utilization levels, and evaluation of the reliability and appropriateness of clinical information with the involvement of actively practicing practitioners. Voting on clinical matters is limited to physicians.

Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2025, and activities included discussion, review, and approval of policies and procedures related to utilization management.

In 2025, the UM Department implemented several process improvements to enhance operational effectiveness, strengthen care coordination, and ensure medically necessary services are delivered in the most appropriate setting.

Collaboration with local acute care facilities was strengthened through weekly joint care coordination meetings and monthly meetings with hospitalist partners. Additionally, a KHS inpatient RN was placed at local facilities to support discharge planning and facilitate coordination of post-acute services. These changes improved discharge planning processes and helped ensure members receive appropriate care following acute hospital admissions.

The UM team also implemented daily interdisciplinary rounds to review the needs of members receiving care in acute and long-term care facilities. These discussions improved coordination among care teams and supported medical necessity-based decision-making tailored to individual member needs.

To enhance utilization monitoring, the KHS Business Intelligence team developed an outlier dashboard designed to identify services that may be potentially overutilized. This dashboard allows the UM team to review service utilization patterns, assess the quality and appropriateness of services, and determine whether additional prior authorization requirements or clinical review processes are necessary to ensure services meet medical necessity criteria.

One service identified for further review was Behavioral Health Treatment (BHT). An independent medical review determined that approximately 50% of reviewed services did not meet medical necessity criteria. In response, KHS partnered with AllMed to conduct medical necessity reviews for BHT services using qualified clinical reviewers. Implementation of this process identified opportunities for improvement, including the need for additional training and clearer communication with Applied Behavior Analysis (ABA) providers. KHS continues to work collaboratively with providers to ensure documentation clearly demonstrates medical necessity for services.

Collectively, these efforts strengthened the UM program's ability to ensure that services provided to members are medically necessary, timely, and delivered in the most appropriate setting. Enhanced

collaboration with provider partners and improved data analytics capabilities have supported more effective coordination of care for KHS members.

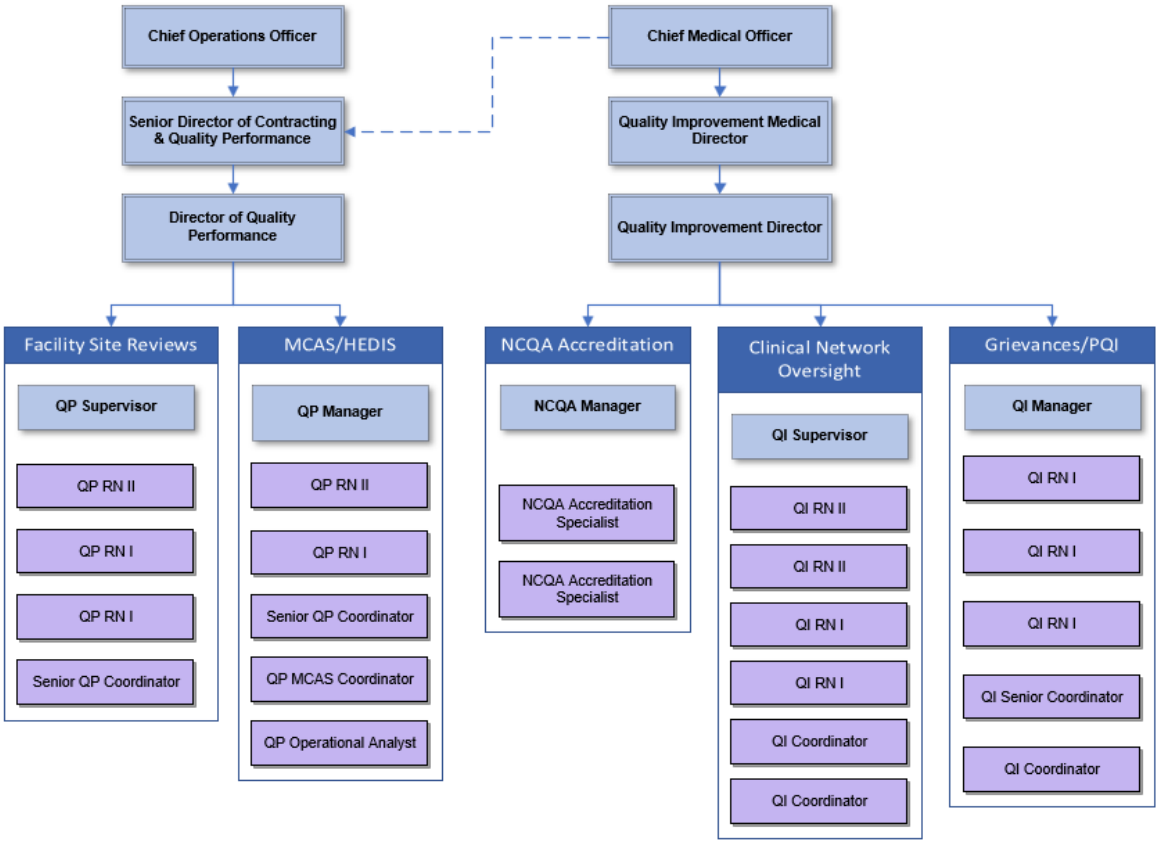
In 2026, the UM Department will continue to focus on quality improvement initiatives, including implementation of new CMS interoperability requirements and regulatory changes related to referral turnaround times. These efforts will require the development of new processes and operational efficiencies to ensure members continue to receive medically necessary services in a timely manner.

III. Quality Departmental Changes

The structure of the Quality Departments, including committee structure, position changes, staffing levels, and team roles and responsibilities, are periodically assessed. Consideration is given to new state and regulatory directives and requirements, member safety and network needs, general business needs and operational capabilities, staff growth and development, and fiscal responsibility.

The following changes were made in 2025:

- Personnel
    - The following positions were added to meet the needs of the organization:
        - Quality Performance Manager
        - QP Clinical Supervisor

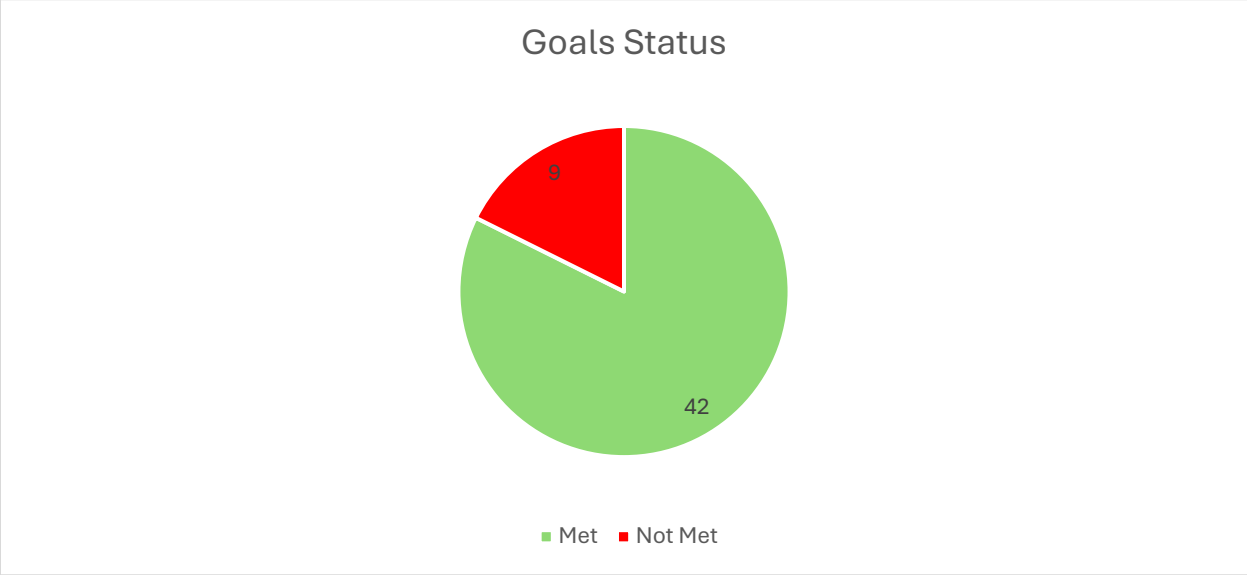


IV. 2025 QI Work Plan Summary

The QI Work Plan tracks progress on key quality improvement activities and initiatives throughout the year. Approved by the EQIHEC and the Governing Board, the Work Plan includes progress updates on planned activities and objectives aimed at improving the quality of clinical care, the safety of clinical care, and the quality of service provided to members. This summary reflects activities conducted from January 1, 2025 through December 31, 2025.

Goals were assessed based on the level of completion reported by the responsible departments and stakeholders. For 2025, KHS achieved forty-two (42) goals as "Met" and nine (9) goals as "Not Met." Overall, resources and operational processes were sufficient to support implementation of the QI Work Plan and the Quality Improvement Health Equity Program.

Activities that did not meet established targets were evaluated to identify contributing factors and opportunities for improvement. Findings from this evaluation will inform future quality improvement strategies and guide ongoing efforts to strengthen performance across clinical quality, patient safety, and member service domains.



V. Quality Program Structure

	Metric	Goal	Result
1	QIHE Governance – EQIHEC Meetings	Met quorum of voting members at every meeting	Met
2	Annual QI Evaluation of 2024	Annual approval by the EQIHEC and the BOD	Met
3	2025 QIHE Program Description	Annual approval by the EQIHEC and the BOD	Met
4	2025 Annual QI Work Plan	Annual approval by the EQIHEC and the BOD	Met
5	Annual review of KHS Quality Improvement P&Ps	100% of policies reviewed and updated as needed	Met
6	NCQA Health Plan Accreditation	Attain full health plan accreditation	Met
7	NCQA Health Equity Accreditation	Attain full health equity accreditation	Met

KHS maintains a comprehensive Quality Improvement Health Equity Program (QIHEP) designed to enhance member health outcomes, ensure regulatory compliance, and support continuous improvement in healthcare services. The program is guided by structured policies, strategic planning, and oversight from key governance bodies, ensuring that quality improvement activities align with organizational priorities and regulatory standards.

The EQIHEC plays a central role in overseeing quality improvement and health equity efforts across KHS. The committee convened four times, as outlined in the QI Program, to review performance reports, monitor program activities, and guide strategic decision-making related to quality and health equity initiatives. During 2025, quorum was met at each meeting, and the committee provided consistent oversight of program activities.

The Annual QI Evaluation assesses the effectiveness of the Quality Improvement Health Equity Program by reviewing program activities, analyzing performance data, and evaluating progress toward established goals. The evaluation identifies areas of success and opportunities for improvement, providing a data-driven approach to program oversight and continuous improvement. This evaluation undergoes annual review and approval by the EQIHEC and BOD, reinforcing accountability and supporting ongoing program development. In 2025, the 2024 evaluation was approved by the EQIHEC and BOD.

The QIHEP Program Description serves as the foundational document outlining the scope, objectives, and key components of the Quality Improvement Health Equity Program. It defines the framework for monitoring performance, identifying opportunities for improvement, and implementing interventions that enhance member care and promote health equity. The Program Description was reviewed and approved by the EQIHEC and BOD, ensuring alignment with organizational strategy and regulatory requirements.

The Annual QI Work Plan provides a structured roadmap that outlines the initiatives and activities planned to achieve quality improvement objectives. The Work Plan includes performance measures, responsible departments, and timelines for implementation. The plan was reviewed and approved by the EQIHEC and BOD to ensure that quality initiatives remained aligned with organizational priorities and responsive to member needs.

To maintain compliance and consistency across quality initiatives, KHS maintains and regularly updates Quality Improvement policies and procedures. These policies establish clear standards for quality-related processes and ensure alignment with regulatory requirements and best practices. During the reporting period, the QI Department conducted an annual review of all policies to ensure they remained current and reflective of operational and regulatory requirements.

In 2025, KHS successfully attained National Committee for Quality Assurance (NCQA) Health Plan Accreditation and NCQA Health Equity Accreditation. Achievement of these accreditations reflects the organization’s commitment to high standards in quality management, regulatory compliance, and health equity. The successful accreditation outcomes demonstrate the effectiveness of the organization’s governance structure, interdisciplinary collaboration, and continuous quality improvement efforts.

Through these governance processes, KHS continued to demonstrate its commitment to excellence in healthcare delivery, continuous quality improvement, and equitable health outcomes for its members.

VI. Quality of Clinical Care

	Metric	Goal	Result
8	AMR Asthma Medication Ratio	Meet minimum performance levels (MPLs)	Met
9	BCS Breast Cancer Screening	Meet minimum performance levels (MPLs)	Met
10	CHL Chlamydia Screening in Women	Meet minimum performance levels (MPLs)	Met
11	CCS Cervical Cancer Screening	Meet minimum performance levels (MPLs)	Met
12	CIS-10 Childhood Immunization Status	Meet minimum performance levels (MPLs)	Not Met
13	CBP Controlling High Blood Pressure	Meet minimum performance levels (MPLs)	Met
14	DEV Developmental Screenings in The First Three Years of Life	Meet minimum performance levels (MPLs)	Not Met
15	IMA-2 Immunizations for Adolescents	Meet minimum performance levels (MPLs)	Met
16	LSC Lead Screening In Children	Meet minimum performance levels (MPLs)	Met
17	FUA Follow-Up After ED visit for Substance Abuse - 30 Days	Meet minimum performance levels (MPLs)	Not Met
18	FUM Follow-Up After ED visit for Mental Illness - 30 Days	Meet minimum performance levels (MPLs)	Not Met
19	GSD Hemoglobin A1c Control for patients with diabetes	Meet minimum performance levels (MPLs)	Met
20	PPC-Pre Prenatal Care	Meet minimum performance levels (MPLs)	Met
21	PPC-Post Postpartum Care	Meet minimum performance levels (MPLs)	Met
22	TFL-CH Topical Fluoride for Children	Meet minimum performance levels (MPLs)	Met
23	W30(0-15M) Well-Child Visits 0-15 months	Meet minimum performance levels (MPLs)	Not Met
24	W30(15-30M) Well-Child Visits 15-30 months	Meet minimum performance levels (MPLs)	Met
25	WCV – Child and Adolescent Well-Care Visits	Meet minimum performance levels (MPLs)	Not Met
26	Clinical PIP	Get Annual Approval by HSAG	Met
27	Non-Clinical PIP	Get Annual Approval by HSAG	Met
28	Health Equity Sprint Collaborative	2 provider partnerships and 1 CBO partnership in support of well-care visits	Met

A. Quality Measures & Performance Improvement

MCAS measures are selected by DHCS and typically include a combination of HEDIS and Medicaid's Adult and Child Health Care Quality Measures. The previous calendar year is the standard measurement year for MCAS data. Therefore, the MCAS Report Year (RY) 2025 results reflect Measurement Year (MY) 2024 data. MCAS RY 2026 results are not available until June 1, 2026, following the timeline for submission of these rates to NCQA and DHCS. The Minimum Performance Level (MPL) is set by DHCS, and the percentile benchmarks are provided by NCQA in their annual

Quality Compass Report. All Managed Care Plans (MCPs) are required to exceed the 50th percentile for each measure benchmark.

Results:

Summary	Measurement Year	MY2023			MY2024		
	Total Measures Held to MPL	18			18		
	Met MPL	8			12		
	Did not meet MPL	10			6		
	KHS Membership	346,049			348,225		
	Measure	Rate	MPL	Rate Vs MPL	Rate	MPL	Rate Vs MPL
	Behavioral Health Domain						
FUA - 30 Day Follow-up*	Follow-Up After Emergency Department Visit for Substance Use	18.85	36.34	-17.49	33.81	36.18	-2.37
FUM - 30 Day Follow-up*	Follow-Up After Emergency Department Visit for Mental Illness	19.12	54.87	-35.75	31.93	53.82	-21.89
	Childrens Health Domain						
CIS	Childhood Immunization Status Combo 10	24.82	30.9	-6.08	25.06	27.49	-2.43
IMA-2	Immunizations for Adolescents (Combo 2)	34.06	34.31	-0.25	36.98	34.3	2.68
LSC	Lead Screening in Children	58.64	62.79	-4.15	66.67	63.84	2.83
DEV	Developmental Screening in the First Three Years of Life	25.94	34.7	-8.76	35.64	35.7	-0.06
TFL-CH	Topical Fluoride for Children	16.44	19.3	-2.86	25.08	19	6.08
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.	39.21	58.38	-19.17	52.18	60.38	-8.2
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.	63.74	66.76	-3.02	69.43	69.43	0
WCV	Child and Adolescent Well-Care Visits	46.55	48.07	-1.52	51.08	51.81	-0.73
	Cancer Prevention Domain						
CCS	Cervical Cancer Screening	57.18	57.11	0.07	58.88	57.18	1.7
BCS-E	Breast Cancer Screening	59.3	52.6	6.7	58.78	52.68	6.1
	Reproductive Health Domain						
CHL	Chlamydia Screening in Women Ages 16 – 24	56.87	56.04	0.83	57.17	55.95	1.22
PPC-Pre	Timeliness of Prenatal Care	87.1	84.23	2.87	87.59	84.55	3.04
PPC-Pst	Postpartum Care	86.37	78.1	8.27	83.21	80.23	2.98
	Chronic Disease Management Domain						
CBP	Controlling High Blood Pressure	65.21	61.31	3.9	65.21	64.48	0.73
GSD*	Hemoglobin A1c Testing & Control for Patients With Diabetes	32.85	37.96	-5.11	32.36	33.33	0.97
AMR	Asthma Medication Ratio	71.2	65.61	5.59	73.87	66.24	7.63

MY2024/RY2025 the measures held to MPL are as follows;

- Asthma Medication Ratio (AMR)
- Breast Cancer Screening (BCS-E)
- Controlling High Blood Pressure (CBP)
- Cervical Cancer Screening (CCS)
- Chlamydia Screening in Women (CHL)
- Children Immunization Status-Combination 10 (CIS-10)
- Developmental Screening in the First Three Years of Life (DEV-CH)
- Follow-Up After ED Visit for Mental Illness-30 Days (FUM)
- Follow-Up After ED Visit for Substance Use (FUA)
- Glycemic Status Assessment for Patients with Diabetes (GSD)
- Immunization for Adolescents-Combo 2 (IMA-2)
- Lead Screening in Children (LSC)
- Prenatal and Postpartum Care: Postpartum Care (PPC-Post)

- Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)
- Topical Fluoride for Children (TFL-CH)
- Well Child visits in the First 30 months of life
    - 0-15 Months-Six or more Well-Child Visits (W30 6+)
    - 15-30 Months-Two or more Well-Child Visits (W30 2+)
- Child and Adolescent Well-Care Visits (WCV)

For MY2024/RY2025 the measures not held to MPL are as follows;

- Adults Access to Preventative/Ambulatory Health Services (AAP)
- Colorectal Cancer Screening (COL-E)
- Contraceptive Care-All Women: Most or Moderately Effective Contraception (CCW-MMEC)
- Contraceptive Care-Postpartum Women: Most or Moderately Effective Contraception (CCP-MMEC)
- Depression Remission or Response for Adolescents and Adults (DRR-E)
- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)
- Follow-Up After ED Visit for Mental Illness-7 Days (FUM)
- Follow-Up After ED Visit for Substance Abuse-7 Days (FUA)
- Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase (ADD-E-C&M)
- Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase (ADD-E-Int)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)
- Low-Risk Cesarean Delivery (LRCD)
- Pharmacotherapy for Opioid Use Disorder (POD)
- Plan All-Cause Readmission (PCR)
- Postpartum Depression Screening and Follow Up (PDS-E)
- Prenatal Depression Screening and Follow Up (PND-E)
- Prenatal Immunization Status (PRS-E)
- Antidepressant Medication Management: Acute Phase Treatment (AMM-Acute)
- Antidepressant Medication Management: Continuation Phase Treatment (AMM-Cont)

QUANTITATIVE ANALYSIS: Based on the results for MY2024/RY2025:

KHS Met MPL in 12 out of 18 MCAS Measures: an additional 4 measures met MPL compared to the Year Prior:

- Immunization for Adolescents-Combo 2 (IMA-2)
- Lead Screening in Children (LSC)
- Topical Fluoride for Children (TFL-CH)
- Well Child visits in the First 30 months of life

    - 15-30 Months-Two or more Well-Child Visits (W30 2+)
- Cervical Cancer Screening (CCS)
- Breast Cancer Screening (BCS-E)
- Chlamydia Screening in Women (CHL)
- Prenatal and Postpartum Care: Postpartum Care (PPC-Post)
- Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)
- Controlling High Blood Pressure (CBP)
- Glycemic Status Assessment for Patients with Diabetes (GSD)
- Asthma Medication Ratio (AMR)

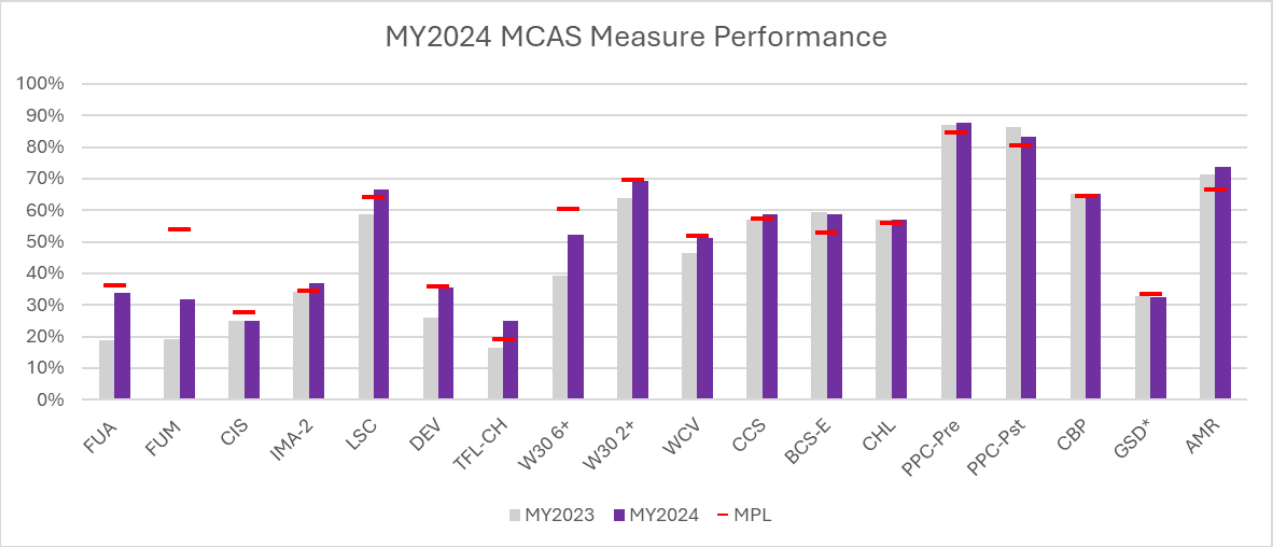
15 of 18 Measures showed improvement from the Year Prior:

- Asthma Medication Ratio (AMR) +2.67%
- Cervical Cancer Screening (CCS) +1.7%
- Chlamydia Screening in Women (CHL) +.3%
- Children Immunization Status-Combination 10 (CIS-10) +.24%
- Developmental Screening in the First Three Years of Life (DEV-CH) +9.7%
- Follow-Up After ED Visit for Mental Illness-30 Days (FUM) +12.81%
- Follow-Up After ED Visit for Substance Use (FUA) +14.96%
- Glycemic Status Assessment for Patients with Diabetes (GSD) +.49%
- Immunization for Adolescents-Combo 2 (IMA-2) +2.92%
- Lead Screening in Children (LSC) +8.03%
- Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre) +.49%
- Topical Fluoride for Children (TFL-CH) +8.64%
- Well Child visits in the First 30 months of life
    - 0-15 Months-Six or more Well-Child Visits (W30 6+) +12.97%
    - 15-30 Months-Two or more Well-Child Visits (W30 2+) +5.69%
- Child and Adolescent Well-Care Visits (WCV) +4.53%

3 of 18 Measures had lower performance rates compared to the Year Prior

- Controlling Blood Pressure (CBP) 0%
- Breast Cancer Screening (BCS-E) -.52%
- Prenatal and Postpartum Care: Postpartum Care (PPC-Post) -3.16%

No measures are added or removed for MY2024/RY2025, however HBD transitioned to GSD.

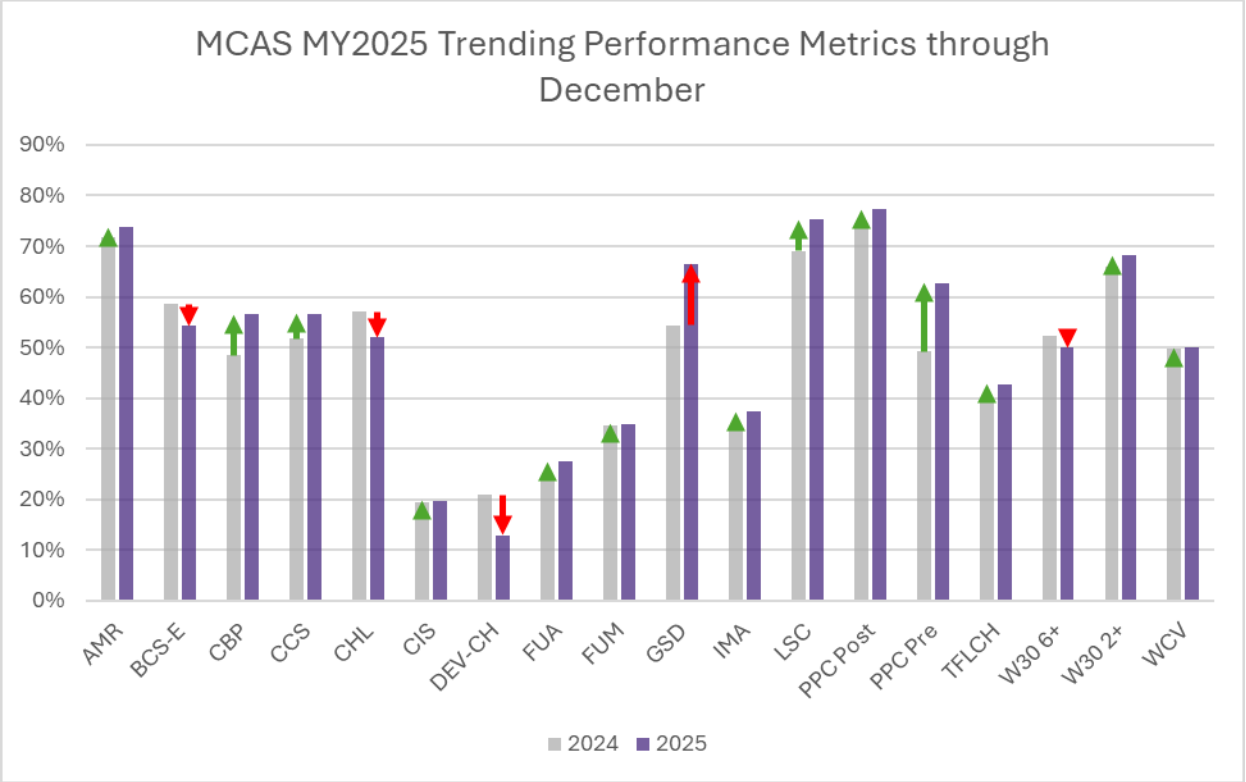


As illustrated above, the measures that surpassed or met the minimum performance levels (MPL) include IMA-2, LSC, TFL-CH, W30 2+, CCS, BCS-E, CHL, PPC-Pre, PPC-Post, CBP, GSD, and AMR. We, KHS, have seen significant improvements in the Behavioral Health Domain as well as the Children's Health Domain. Our Behavioral Domain Measures saw an increase of at least 12% compared to the year prior, and we met the MPL for 4 of the 8 Children's Health Domain when the year prior we met 0 of the 8.

Year over Year MCAS Performance

Measurement Year	MY2020	MY2021	MY2022	MY2023	MY2024
KHS MEMBERSHIP	277,616	299,864	334,078	346,049	348,225
MPL PERCENTILE	50th	50th	50th	50th	50th
TOTAL HELD to MPL	19	15	15	18	18
MET MPL	2	5	5	8	12
Did Not Meet MPL	17	10	10	10	6

MY2025 MCAS Trending Performance



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

- Asthma Medication Ratio
- Controlling Blood Pressure
- Cervical Cancer Screening
- Childhood Immunization Status
- Follow-Up After Emergency Department Visit for Substance Use
- Follow-Up After Emergency Department Visit for Mental Illness
- Immunization for Adolescents
- Lead Screening in Children
- Prenatal and Postpartum Care – Pre
- Prenatal and Postpartum Care – Post
- Topical Fluoride for Children
- Well-Child Visits in the First 30 Months of Life – 0-15months
- Well-Child Visits in the First 30 Months of Life – 15-30months
- Child and Adolescent Well-Care Visits

5 measures are trending lower than the previous year at the same point in time:

- Breast Cancer Screening

- Chlamydia Screening in Women
- Developmental Screening in the First Three Years of Life
- Glycemic Status Assessment for Patients with Diabetes
- Well-Child Visits in the First 30 Months of Life – 0-15months

QUALITATIVE ANALYSIS:

The primary factors impacting compliance with MCAS measures:

1. **Member Engagement and Health Literacy**
    a. Increase in vaccine hesitancy
    b. Lack of education of parents/caregivers in understanding the importance of preventative care
    c. Lack of engagement among teen and adolescent members
    d. Low health literacy among members
    e. Socioeconomic barriers such as transportation
2. **Population Complexity and SDOH Factors**
    a. Prioritization of social needs (housing, food, behavioral) over preventative care
    b. Members with complex medical needs focus on condition management
    c. Members in rural areas have limited access to care
    d. Transportation barriers
3. **Operational and Workflow Inefficiencies**
    a. Delays in updating real-time dashboards to monitor trends and implement timely interventions
    b. Opportunities to collaborate with other departments to support MCAS initiatives.
    c. Initiative implementations are often timely and cause delays
4. **Technology Gaps**
    a. Opportunities to expand access to real-time data from providers, hospitals, and laboratories for timely interventions
    b. Delayed delivery of encounter data
    c. Opportunities to improve internal technical processes
5. **Provider Engagement**
    a. Coding errors and lack of exclusion documentation
    b. Lack of outreach for gap in care closure
    c. Missed opportunities to close gaps in care during sick visits
    d. Increase of telehealth visits and missed documentation of blood pressures and A1Cs.

CORRECTIVE ACTION REQUIRED BY DHCS

Failure to meet MPL resulted in corrective actions and financial penalties. DHCS established a new Performance Tier System effective for MY2024 MCAS compliance results with follow-up corrective actions and sanctions based on overall performance, domains of care, and improvements compared to previous performance years.

Strategies and Action Plan:

Goals: Improve the following QI Gaps and meet 50th percentile or minimum performance level.

1. Provider Engagement
2. Collaboration
3. Member Engagement
4. Collaboration and Partnerships

Strategies	Action Items
# 1 Provider Engagement Objective: Coordinate with providers to address appointment availability challenges with PCPs and BH within timeframe of 7 and/or 30 days of ED visit.	**1.a.** Identify 3 providers who are low performing for FUA and FUM MCAS measures and meet with them bi-monthly to develop interventions to support improvement. **1.b.** Leverage mobile units to increase appointment options.
# 2 Collaboration Objective: Increase timely ED visit notifications to providers and support outreach to members for timely follow-ups.	**2.a.** Update internal dashboard and provider portal for ease of access to members requiring follow-up visit. **2.b**. Focused outreach specialist to contact members with ED visits identified in dashboard and assist with scheduling appointment with PCP or BH.
# 3 Member Engagement Objective: Leveraging internal (Marketing, Health Equity, Health Education) and external stakeholders to develop specific initiatives/engagement of efforts to the children's domain of care.	**3.a.** Work with Marketing and Member Engagement to develop a routine text message campaign for mobile unit notification for KHS members. **3.b.** Leverage mobile units to close gaps in care in coordination with 5 mobile unit providers. **3.c.** Evaluate effectiveness of text messaging campaign
#4 Collaboration/Partnerships Objective: Improved communication and collaboration between MCP, providers, and parents/guardians. (Parent square, provider meetings, mobile units at schools).	**4.a.** Identify top 20 providers by membership volume and schedule routine joint operations meetings to support overall education and improvement of MCAS performance. **4.b.** Collaborate with school districts to promote school based mobile events via electronic parent communication systems.

Action Plan for 2026:

Ensuring access to high quality and equitable care is part of KHS' mission. The Quality Performance team will continue with initiatives that have led to positive outcomes and gaps in care closed for our members. This includes:

- Diabetic Management program led by a contracted Endocrinologist
- A dedicated Member Outreach team solely focused on telephonic outreach to close gaps in care
- Collaboration and partnerships with local providers to offer extended hours and weekend appointments for children and adolescents

- Mobile Unit partnerships across Kern County with school districts and various community-based organizations
- Improved data quality and increased data sources
- Monthly campaigns for preventive services in collaboration with Marketing and member facing departments

B. Performance Improvement Projects (PIPs)

Performance Improvement Projects (PIPs) are federally required quality initiatives used by the California Department of Health Care Services (DHCS) as part of the External Quality Review (EQR) process for Medi-Cal Managed Care Plans (MCPs). For the 2023–2026 PIP cycle, DHCS requires MCPs to conduct two PIPs aligned to State-identified priority areas: Children's Health and Behavioral Health. Each PIP spans approximately three years and is designed to systematically improve quality, access, and outcomes for Medi-Cal members.

KHS initiated its current PIP cycle in September of 2023 under the oversight of the External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG). Both active PIPs have completed a Baseline submission, and a Remeasurement Period 1 submission, which were accepted by DHCS. The final Remeasurement Period 2 submissions will be completed in August of 2026.

Quality Improvement Framework

Each PIP follows quality improvement methodology utilizing Plan-Do-Study-Act (PDSA) cycles. This approach supports small-scale testing of interventions, real-time evaluation, and data-informed refinement to ensure interventions remain responsive to identified barriers and member needs.

KHS initiated a cycle of PIPs for 2023-2026 in September of 2023 through the External Quality Review Organization (EQRO), HSAG, acting on behalf of DHCS. The two active PIPs during 2023 included:

1. **Clinical PIP: Improving W30 Measure Rates Among Black/African American Infants 0 -15 Months Old.**

This clinical Performance Improvement Project is three years in length, with a baseline measurement period of 2023 and remeasurements in 2024 and 2025. Yearly submissions are conducted the September of the following year, meaning the last submission will occur in September of 2026.

This PIP has the potential to improve member health, functional status, and/or satisfaction:

This State-mandated Clinical PIP focuses on improving performance on the Well-Child Visits in the First 15 Months of Life (W30–6) measure for Black/African American infants enrolled in KHS. Pre-baseline data identified a significant opportunity for improvement, with a MY2022 rate of 20.47%, which was below the DHCS-established Minimum Performance Level (MPL).

Completion of recommended well-child visits supports preventive care delivery, early identification of developmental or health concerns, caregiver education, and continuity of care during a critical period of early childhood development. Improving W30 performance has the potential to enhance

member health outcomes, reduce avoidable emergency department utilization, and strengthen trust-based relationships between caregivers and pediatric providers.

Aim Statement

Do targeted interventions improve the percentage of Black/African American children who complete six (6) or more well-child visits on or before fifteen (15) months of life?

PIP Population and Measurement

The PIP population follows HEDIS/MCAS specifications for the W30 measure and is further drilled to specifically support Black/African American infants who turned fifteen (15) months of age during the applicable measurement year and met continuous enrollment requirements. Standard exclusions, including hospice use or death during the measurement period, apply.

Performance is measured using administrative claims and encounter data in accordance with NCQA technical specifications. KHS monitors rates through internal HEDIS trending reports and submits final audited rates following standard claims lag.

Performance Results

• MY2022 (Pre-Baseline): 20.47%

• MY2023 (Baseline): 33.33% (34/102)

• MY2024 (Remeasurement 1): 35.21% (25/71)

While improvement was observed between the baseline and first remeasurement period, the change was not statistically significant ($p = 0.7977$). No threats to data validity or comparability were identified.

Interventions and Progress

KHS implemented and expanded targeted interventions addressing barriers to well-child visit completion identified through data analysis, stakeholder input, and collaborative learning activities:

• Mobile Pediatric Clinics to reduce transportation, scheduling, and childcare barriers by delivering services in community-based settings.

• Member Services Outreach to identify care gaps, assist with appointment scheduling, and support transportation needs.

• Participation in the DHCS/IHI Children's Health Collaborative to inform intervention refinement and align with statewide best practices.

• Innovative Member Rewards to address logistical and motivational barriers through timely, accessible incentives.

• Targeted Member Education and Outreach to reinforce the importance, frequency, and components of well-child visits.

Early qualitative feedback indicates improved member engagement and satisfaction. Continued testing and refinement are ongoing to support sustained and measurable improvement.

Next Steps

Remeasurement Period 2 activities continued PDSA testing, refinement of higher-impact interventions, and deeper analysis of population-specific barriers. The final submission for Remeasurement Period 2 will also provide a comprehensive assessment of outcomes, lessons learned, and recommendations to support sustainability and potential spread of successful strategies.

2. Non-Clinical PIP: Improve the percentage of provider notifications for members with SMH/SUD diagnoses following or within 7 days of emergency department (ED) visit.

This state-mandated Non-Clinical PIP specifically focuses on improving timely notification to providers following eligible emergency department (ED) visits that meet Follow-Up After Hospitalization for Mental Illness (FUA) or Follow-Up After Emergency Department Visit for Mental Illness (FUM) criteria. Notification-specific performance data was not tracked prior to the initiation of this PIP in 2023. Selection of this topic was informed by historical FUA and FUM MCAS performance, which demonstrated opportunities to improve post-emergency department care transitions for members with behavioral health needs.

The period immediately after the ED visit is important for engaging individuals in treatment and establishing continuity of care. Provider notification of ED visits has the potential to improve care coordination and ensuring timely follow-up care. Timely follow-up care after an ED visit for mental illness or substance use disorder may reduce repeat ED visits, prevent hospital admissions, improve physical and mental function, and increase compliance.

Aim Statement

Do targeted interventions improve the percentage of provider notifications for members with SMH/SUD diagnoses following or within 7 days of ED visit?

PIP Population and Measurement

The Non-Clinical PIP applies to ED visits for members aged six (6) years and older with a principal diagnosis of mental illness or intentional self-harm (SMH), and members aged thirteen (13) years and older with a principal diagnosis of substance use disorder or a diagnosis of drug overdose (SUD). **Measurement is limited to the timeliness of provider notification following eligible FUA/FUM ED visits.**

Performance Results

- MY2022 (Pre-Baseline): Not applicable. Provider notification performance was not tracked prior to initiation of this PIP.
- MY2023 (Baseline): 39.09%
- MY2024 (Remeasurement 1): 19.65%

A statistically significant decrease in performance was observed between the baseline and first remeasurement period (p = 0.0001). No threats to data validity or comparability were identified.

Interventions and Progress

KHS has undertaken targeted non-clinical efforts to address process gaps affecting timely provider notification following eligible FUA/FUM ED visits. These efforts were informed by data review, cross-departmental collaboration, and ongoing quality improvement activities.

We are leveraging the following resources during this phase:

- Daily Admission, Discharge, and Transfer (ADT) report from participating EDs.
- Participating Providers are provided the ADT report through secure email or SFTP files.
- The ADT report is uploaded to the Provider Portal, offering an additional option to Providers to obtain this information.
- Using the ADT report, the KHS Behavioral Health (BH) team has been performing Member outreach.
- Provider meetings are performed regularly to share updates and education regarding the notification process.
- KHS Provider Network Management is notified and educated on updates to the notification process to also assist Providers with questions/issues.

Feedback from operational review and stakeholder input continues to inform monitoring and refinement of provider notification processes to support consistent and timely notification following eligible FUA/FUM ED visits.

Next Steps

Remeasurement Period 2 activities will include ongoing monitoring of provider notification processes, targeted refinement of notification workflows, and review of operational feedback. The final submission will provide an assessment of outcomes, lessons learned, and sustainability considerations.

C. Health Sprint Collaborative

In 2025, KHS has continued participation in the DHCS and Institute for Healthcare Improvement (IHI) Children's Health Equity Collaborative (CHEC) to advance early childhood preventive care and reduce disparities. In phase 2 of this work (Sept 2025 - Sept 2026), focus is narrowed in on well-child visit completion for Medi-Cal members ages 0–3.

The initiative focuses on improving specific MCAS measures related to this age group: particularly Well-Child Visits in the First 15 Months (W30-6+), Well-Child Visits in the First 15–30 Months (W30-2+), and, secondarily, Childhood Immunization Status Combination 10 (CIS-10), with the broader goal of strengthening early childhood health outcomes across California.

Kern Health Systems partnered with Omni Family Health and Niles Children's Clinic to test and implement quality improvement strategies designed to address barriers families face in accessing

preventive pediatric care. We've applied a health equity lens by focusing on families experiencing barriers related to scheduling, health education, transportation, and care navigation. Using rapid Plan-Do-Study-Act (PDSA) cycles and real-time data review, the team is testing and scaling practical interventions that improve these barriers to care.

A core aim of the project is to increase W30-6 well-child visit completion from 49% to 54% across Kern Health Systems by September 2026, representing more than 200 additional infants completing the full series of recommended early childhood visits.

Through strong partnerships with our pilot clinics, data-driven improvement methods, and family-centered interventions, the collaborative is striving to build sustainable systems that improve access to preventive pediatric care and advance health equity for young children in Kern County.

VII. Safety of Clinical Care

	Metric	Goal	Result
29	Patient Safety Program/Clinical Network Oversight: Conduct Quarterly Audits of select Measures	Baseline Monitoring	Met
30	Monitoring of PQI volume month over month	<30/month	Met
31	PQI Rates by Provider	Baseline Monitoring	Met
32	PQI Rates by ethnicity, English as a second language, sexual orientation, gender identity	Baseline Monitoring	Met
33	PQI Timeliness of resolution	Within 120 Days	Met
34	Facility Site Review	Complete FSR and medical record audit of 100% of practitioners due for credentialing or recredentialing	Met
35	Physical Accessibility Review Surveys	Complete the PARS audit of 100% of practitioners due for credentialing or recredentialing	Met
36	Medical Record Reviews	Achieve medical record review score of 85% for each practitioner	Met
37	DUR – Physician Administered Drugs	72 hrs for urgent, 5 days for routine	Met
38	Credentialing/Recredentialing	100% timely credentialing/recredentialing of practitioners	Met

A. Clinical Network Oversight

KHS maintains a Clinical Network Oversight Program designed to promote safe, high-quality clinical care across the provider network. Patient safety activities are integrated within the Quality Improvement Health Equity Program (QIHEP) and supported through clinical network oversight and routine monitoring of key quality indicators. Oversight activities focus on identifying potential risks to patient safety, evaluating provider compliance with clinical standards, and implementing improvements to strengthen care delivery.

During the reporting period, the Quality Improvement Department conducted quarterly clinical network oversight audits of select measures to monitor adherence to clinical and regulatory requirements. The audits included reviews of the Initial Health Appointment (IHA), telehealth

services, and Lead Screening in Children (LSC). These reviews evaluated provider documentation, adherence to clinical guidelines, and compliance with program and regulatory requirements.

Findings from these audits were analyzed to identify trends and opportunities for improvement across the provider network. As a result of the audit findings, applicable policies and procedures were updated to ensure alignment with current standards and regulatory guidance. In addition, educational letters were distributed to providers to reinforce documentation requirements, clarify clinical expectations, and support improved compliance with preventive care and telehealth service standards.

These clinical oversight activities strengthened the organization's ability to monitor patient safety risks, support provider education, and ensure consistent application of quality standards across the network. Through ongoing monitoring and targeted interventions, KHS continued to promote safe, high-quality care for its members.

B. Potential Quality of Care Issues (PQI)

PQI Identification and Review Process

KHS maintains a structured process for identifying, investigating, and resolving Potential Quality Issues (PQIs) to support patient safety and continuous quality improvement. PQIs may be identified through several sources including member grievances, direct referrals from internal departments or the Medical Director, hospital discharge and readmission reviews, provider preventable condition monitoring, and death notifications.

Upon receipt of a PQI notification, a Quality Improvement (QI) Registered Nurse conducts an initial review to determine whether a potential quality-of-care concern exists. Cases identified as potential PQIs are escalated to the QI Medical Director for further investigation and final determination. Confirmed PQIs are entered into the KHS Medical Management System where a formal investigation is conducted and a severity level is assigned.

Follow-up actions are determined based on severity. Level 1 cases are tracked and trended for potential provider education or monitoring, while Level 2 and Level 3 cases may result in corrective actions as directed by the Medical Director and Physician Advisory Committee.

PQIs are classified using the following severity levels:

- **Level 0** – No quality of care concern
- **Level 1** – Potential for harm
- **Level 2** – Actual harm
- **Level 3** – Actual morbidity or mortality failure

PQI Volume Month over Month

Severity Level	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Level 0 - No Quality Concern	14	26	33	18	23	29	13	6	45	23	25	23
Level 1 - Potential for Harm	16	31	25	24	23	38	9	27	56	26	18	29
Level 2 - Actual Harm	0	0	0	0	0	0	0	0	1	1	2	0
Level 3 - Actual Morbidity	0	0	0	0	0	0	0	0	0	0	1	0
Total	30	57	58	42	46	67	22	33	102	50	46	52

Severity Level	Median	Average
Level 0 - No Quality Concern	23	23.2
Level 1 - Potential for Harm	25.5	26.8
Level 2 - Actual Harm	0	0.33
Level 3 - Actual Morbidity	0	0.08
Total	48	50.4

Quantitative Analysis:

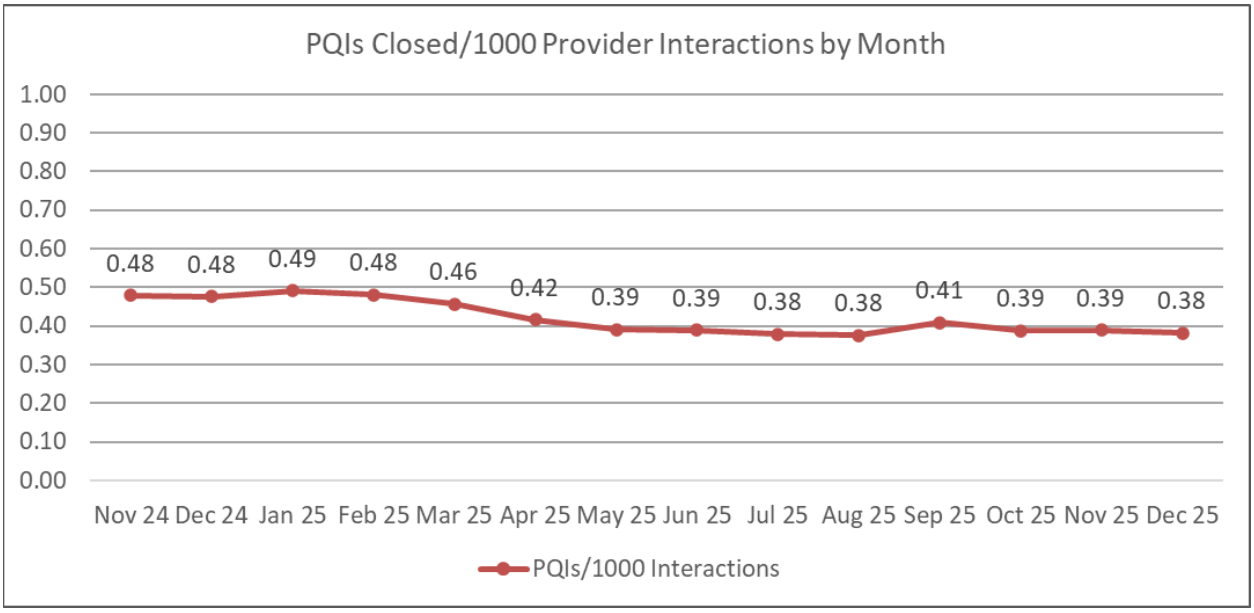
KHS monitored Potential Quality Issues (PQIs) on a monthly basis during the reporting period to identify trends and ensure timely investigation and resolution of cases. The established performance goal was to maintain fewer than 30 Level 1 and above PQIs per month and to resolve all cases within 120 days.

PQI volumes varied throughout the year. Monthly totals of Level 1 and above PQIs ranged from a low of 9 cases in July 2025 to a high of 57 cases in September 2025. Although several months exceeded the monthly target, overall trend analysis demonstrated a median monthly volume of 26 Level 1 and above PQIs and an average of 27.3 cases during the reporting period. The median is used as the primary indicator of performance because it reduces the impact of outlier months and provides a more representative measure of typical monthly PQI volume. Based on the distribution of PQIs and the predominance of lower-severity classifications, the measure was determined to have met the program's monitoring objective for tracking and patient safety oversight.

The majority of PQIs closed during the reporting period were classified as Level 0 or Level 1, indicating no confirmed quality-of-care concern or potential for harm without adverse outcomes. Only a small number of cases were classified as Level 2 (actual harm) and only one case was classified as Level 3 (actual morbidity). These results indicate that serious quality-of-care concerns remained rare within the KHS provider network.

PQIs were also analyzed by source of notification. Internal grievances and hospital discharge reviews accounted for the largest proportion of cases. Monitoring multiple notification sources allows KHS to identify potential quality concerns through several oversight mechanisms.

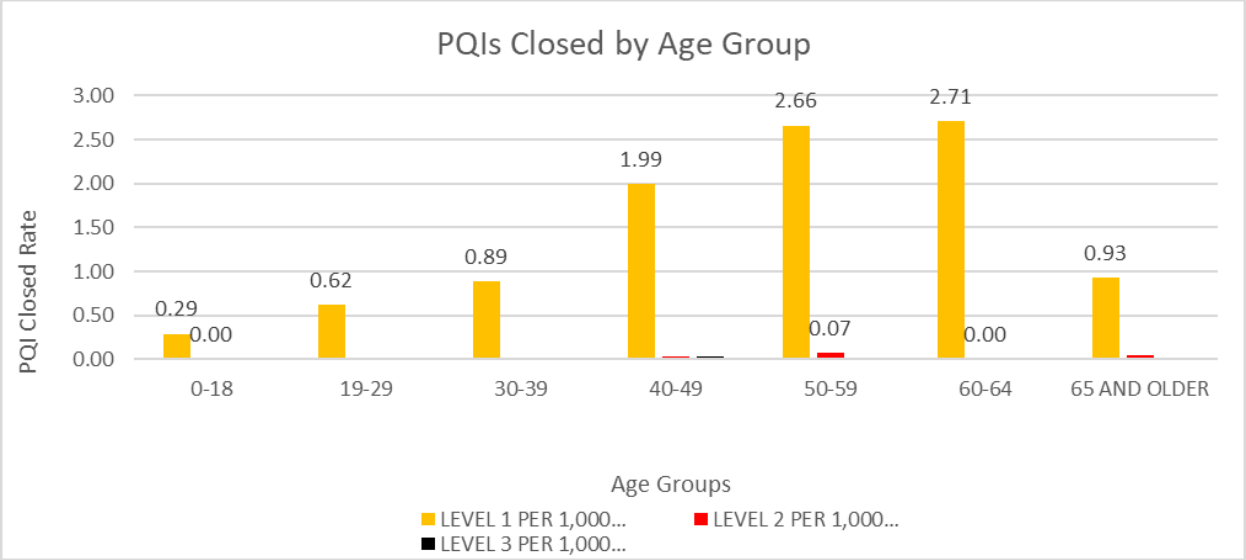
Provider-level trending analysis was conducted to identify practitioners with higher PQI rates relative to visit or discharge volume. No providers were identified with systemic quality concerns. Among outpatient providers, two providers had one Level 2 PQI each, while all other PQIs were classified as Level 0 or Level 1. Among inpatient providers, only one Level 1 PQI was identified and no Level 3 PQIs occurred. Overall, the rate of PQIs per 1,000 provider interactions remained consistently below 1.00 throughout the reporting period, indicating a low rate of potential quality-of-care concerns across the provider network relative to total provider activity.

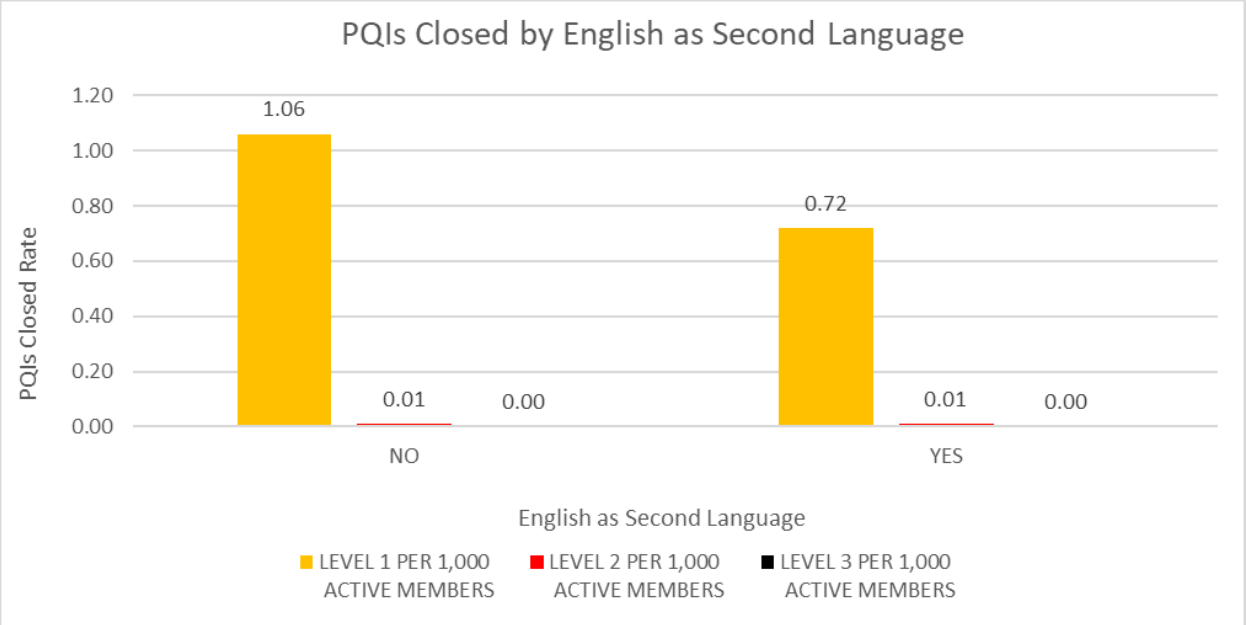


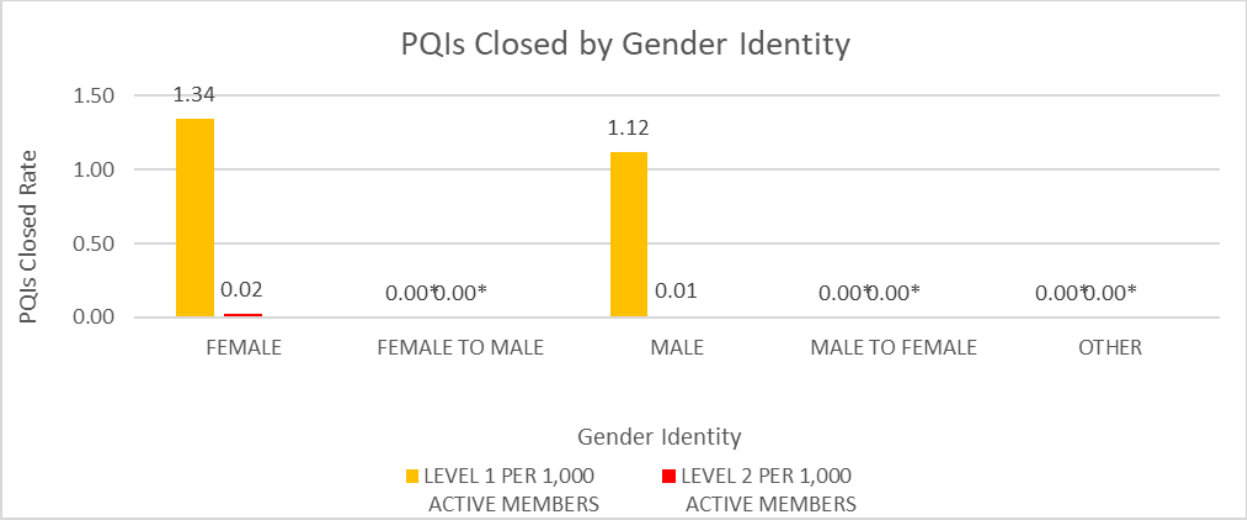
Qualitative Analysis:

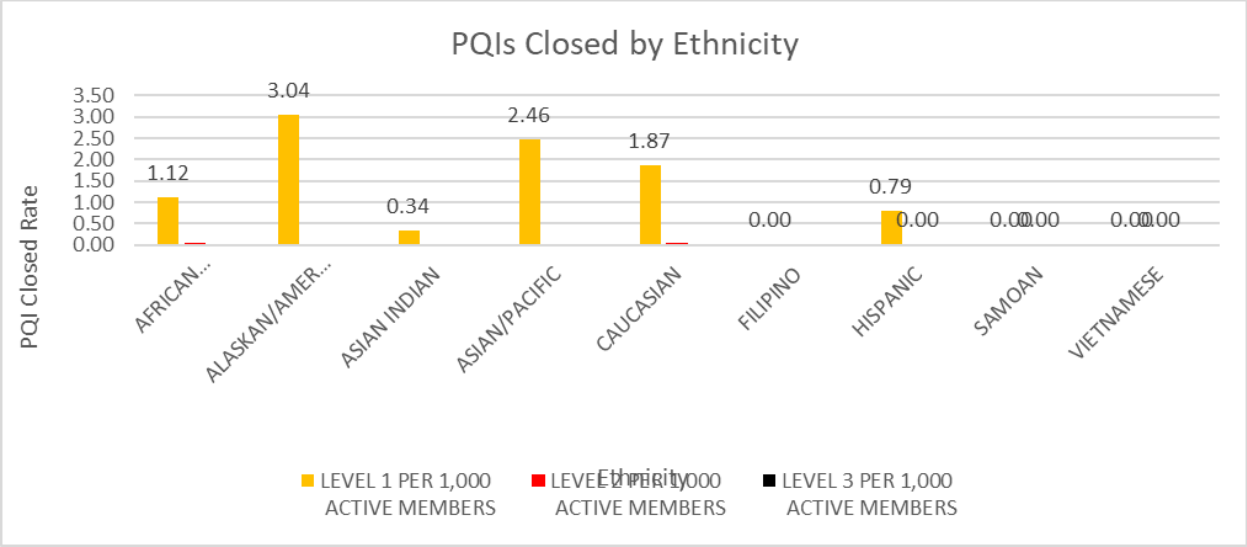
PQI data were stratified by demographic factors including age, ethnicity, English as a second language, gender identity, and sexual orientation where available. These analyses support KHS's commitment to monitoring potential disparities in quality-of-care outcomes.

Analysis by ethnicity showed that the majority of PQIs occurred within the largest membership populations, including Hispanic and Caucasian members. Smaller population groups occasionally showed higher rates per 1,000 members due to small denominators; however, no concerning trends or disparities were identified. Across all demographic groups, the majority of PQIs were classified as Level 1, with Level 2 and Level 3 cases remaining rare.


PQIs Closed by Age Group
PQI Closed Rate
3.00
2.50
2.00
1.50
1.00
0.50
0.00
0.29
0.00
0.62
0.89
1.99
2.66
0.07
2.71
0.00
0.93
0-18
19-29
30-39
40-49
50-59
60-64
65 AND OLDER
Age Groups
LEVEL 1 PER 1,000...
LEVEL 2 PER 1,000...
LEVEL 3 PER 1,000...


PQIs Closed by English as Second Language
PQIs Closed Rate
1.20
1.00
0.80
0.60
0.40
0.20
0.00
1.06
0.01
0.00
0.72
0.01
0.00
NO
YES
English as Second Language
LEVEL 1 PER 1,000 ACTIVE MEMBERS
LEVEL 2 PER 1,000 ACTIVE MEMBERS
LEVEL 3 PER 1,000 ACTIVE MEMBERS





Timeliness of PQI resolution met program expectations during the reporting period. All PQI investigations were completed within the established 120-day resolution timeframe, meeting the program's performance goal.

Overall PQI monitoring demonstrated effective oversight of potential quality-of-care concerns across the provider network. Most PQIs involved documentation issues, communication concerns, or isolated clinical events rather than systemic quality failures.

Collaboration between the Grievance Team, QI Department, and Medical Directors strengthened the identification and review of PQIs. Provider-level monitoring and health equity stratification supported proactive identification of potential risks and informed targeted provider education when appropriate.

Although no significant trends requiring corrective action were identified during the reporting period, KHS will continue monitoring PQI trends and provider performance to ensure early detection of emerging quality concerns and to support ongoing improvements in patient safety and quality of care.

C. Facility Site Review (FSR)

KHS Quality Performance (QP) nurses who are DHCS-certified site reviewers perform Facility Site Reviews (FSR) and Medical Record Reviews (MRR) for all contracted primary care providers (PCPs) upon contracting and at least every three years thereafter. This includes Internal Medicine, General and Family Practice, OB/GYN, and Pediatricians serving in a PCP capacity in free-standing offices, Independent Practice Associations (IPAs), or clinics.

Personnel performing site reviews are trained by a DHCS-certified Master Trainer nurse on the required criteria for site compliance. All contracting plans within a county share responsibility for coordinating and consolidating provider site reviews. KHS maintains a Memorandum of Understanding (MOU) with Anthem Blue Cross and Kaiser to share site review responsibilities and results.

The purpose of conducting site reviews is to ensure that all contracted PCP sites used by managed care plans for the delivery of services to members have sufficient capacity to:

1. Provide appropriate primary health care services.
2. Support continuity and coordination of care.
3. Maintain patient safety standards and practices.
4. Operate in compliance with applicable federal, state, and local laws and regulations.

Quantitative Analysis:
In 2025 year-to-date, 100% of Initial and Periodic Facility Site Reviews passed. A total of 63 Facility Site Reviews were completed, and all received a passing score. Two sites scored below 90% and were issued Corrective Action Plans (CAPs). Both CAPs were completed and closed within required timelines.

The top three deficiencies identified during site reviews were:

1. Failure to utilize the California Immunization Registry (CAIR).
2. Standardized procedures, practice agreements, and supervisory guidelines not being updated or signed when scope-of-service changes occurred.
3. Storage areas for regulated medical waste not properly labeled or secured, including signage not posted in both English and Spanish.

Site Review Timeliness:

A tracking system is used to monitor reviews due and completed. Following CAP closure, providers receive education and Focus Reviews are conducted three months later to ensure compliance.

Review Type	# Reviews Due	# Reviews Completed	# Reviews Not Completed
Initial Facility Site Review	17	17	0
Initial Medical Record Review	8	8	0
Periodic Facility Site Review	41	41	0

Periodic Medical Record Review	41	41	0
Interim Review	26	26	0
Focused Facility Site Review	0	0	0
Focused Medical Record Review	13	13	0
Annual Review Medical Record Review	3	3	0
Annual Facility Site Review	5	5	0

In 2025 year-to-date, 95% of Initial and Periodic Medical Record Reviews passed. A total of 62 medical record reviews were completed, and three reviews failed.

The top three deficiencies identified during medical record reviews were:

1. Annual HIV screenings not documented for pediatric and adult members.
2. Member risk assessments not completed for pediatric and adult members.
3. Hepatitis B screenings not documented for pediatric and adult members.

Qualitative Analysis:
Provider outreach and education prior to scheduled site reviews significantly improved provider readiness and contributed to improved compliance rates. QP nurses conduct outreach approximately one month prior to scheduled reviews to provide education and ensure providers understand current requirements. This proactive approach contributed to achieving a 100% pass rate for Facility Site Reviews in 2025. Ongoing education and collaboration with providers will continue to support improvements in documentation and compliance with regulatory requirements.

Barriers:
Implementation of DHCS All Plan Letter (APL) 22-017 introduced updated Facility Site Review tools and standards. The revised tools became fully effective January 1, 2024. The updated standards resulted in increased documentation requirements and contributed to higher initial failure rates for some Medical Record Reviews.

Additional challenges included staff turnover at provider offices, which required repeated training and education for new office personnel. QP nurses provided continued education and support to address these challenges.

D. Physical Accessibility Review Surveys (PARS)

The Physical Accessibility Review Survey (PARS) evaluates the accessibility of provider sites for seniors and persons with disabilities (SPDs). PARS assessments focus exclusively on physical accessibility and are not scored reviews. PARS are conducted for PCP sites and high-volume specialists, ancillary providers, and Community-Based Adult Services (CBAS) providers serving KHS SPD members. PARS are performed for new PCP sites during initial credentialing or contracting and every three years thereafter in accordance with Medi-Cal Managed Care Division (MMCD) requirements. In 2025, 65 PARS assessments were completed.

E. Medical Records Review (MRR)

Quantitative Analysis:

During the reporting period, all required Medical Record Reviews were completed within established timelines:

1. Initial Reviews: 8 due and 8 completed
2. Periodic Reviews: 41 due and 41 completed
3. Annual Reviews: 3 completed
4. Interim Reviews: 26 due and 26 completed

Qualitative Analysis:

Although improvement was observed compared to the previous year, some provider offices continued to experience challenges meeting documentation standards for medical record reviews.

To support provider compliance, the QP team developed a KHS FSR and MRR binder for contracted offices. The binder includes APL 22-017 guidance, current review tools and standards, interim review requirements, assessment templates, age-specific documentation checklists, and contact information for support. This resource has been incorporated into provider education sessions and has proven to be an effective intervention for improving compliance.

Barriers

One of the most common deficiencies identified during 2025 medical record reviews involved member risk assessments not being completed for both pediatric and adult members. This issue is partly attributed to the sunset of the Staying Healthy Assessment (SHA) in 2023. Providers are now required to complete Social Determinants of Health (SDOH), Adverse Childhood Experiences (ACEs), and Pediatric ACEs and Related Life Events Screener (PEARLS) assessments in place of the SHA.

To address these challenges, the QP team implemented targeted provider education sessions prior to scheduled site reviews. Although participation in these sessions was voluntary, many provider offices requested assistance, particularly newly contracted offices. These educational efforts significantly reduced medical record review failure rates.

Additional focus during 2025 included implementation of the Children's Presumptive Eligibility (CPE) program. Managed Care Plans assumed responsibility for this program, and MCPs statewide collaborated to standardize training materials. This effort resulted in the development of four training videos with voice-over and attestation requirements. Materials will be reviewed and updated annually to ensure compliance with program standards.

The QP team also participated in quarterly meetings with a local Federally Qualified Health Center (FQHC) to provide updates on review findings and highlight opportunities for improvement with provider staff.

F. Drug Utilization Review

DUR – Physician Administered Drugs

The metric evaluating timeliness of authorization for physician administered drugs requires decisions within 72 hours for urgent requests and within five calendar days for routine requests. Performance for the measurement year met the established benchmark. Requests for physician administered drugs were processed through established prior authorization procedures and monitored to ensure adherence to regulatory and internal timeliness standards. Oversight of these processes occurs through pharmacy management and DUR Committee review of pharmacy operations and program updates. During the evaluation period, the plan maintained compliance with required turnaround times and no systemic issues affecting timeliness were identified.

G. Credentialing & Recredentialing

Credentialing of new applicants are processed within 120 calendar days and recredentialing is processed every 36 months. In 2025, 100% of the providers were credentialed or recredentialed timely. KHS has hired a Provider Network Specialist to assist in the recruitment of specialty providers where access challenges exist within the provider network. KHS continues to also work with its delegated groups and network providers to identify opportunities to improve access.

VIII. Quality of Service

	Metric	Goal	Result
39	Grievances & Appeals Timeliness of acknowledgement letters	90% within 5 calendar days	Not Met
40	Grievances & Appeals Timeliness of resolution	90% within 30 calendar days and 72 hours for expedites	Not Met
41	Access to Care – PCP Urgent Care within 48 hours	80% of routine care within 48 hours	Met
42	Access to Care – PCP Routine Care within 10 days	80% of routine care within 10 business days	Met
43	Access to Care – SCP Urgent Care	80% of specialty care within 48 hours	Met
44	Access to Care – SCP Routine Care	80% of specialty care within 15 business days	Met
45	Telephone Access to Member Services Speed of Answer	<30 seconds	Not Met
46	Telephone Access to Member Services Call abandonment rate	<5%	Met

A. Grievance & Appeals

Metric	Goal	Result
Grievances & Appeals Timeliness of acknowledgement letters	Within 5 calendar days	87.1%
Grievances & Appeals Timeliness of resolution	Within 30 calendar days	74.0%

KHS continuously monitors and reports on member grievances related to access to care, coverage determinations, medical necessity, quality of care and services, cultural and linguistic sensitivity, and other concerns. In 2025, a total of 13,773 grievances were received. Of these, 3,555 were exempt (resolved within one day), while the remainder were processed as formal grievances.

Quantitative Analysis:

KHS achieved 87.1% compliance rate for acknowledgment letters within the required 5-day timeframe, demonstrating strong performance in initial response timeliness. However, only 74% of grievances were resolved within the 30-day resolution period, indicating a 26% gap in compliance. This suggests potential challenges in case complexity, resource allocation, and operational workflows.

Qualitative Analysis:

A review of grievance trends reveals that Quality of Service, Access to Care, and Quality of Care remain the most frequently cited issues among members. Further analysis suggests that delays in provider access, care coordination issues, and administrative barriers contribute to member dissatisfaction. Additionally, cultural and linguistic sensitivity concerns continue to emerge, indicating opportunities to enhance language access services and culturally competent care delivery. Member feedback also highlights inconsistencies in communication regarding grievance resolutions, which may contribute to confusion or dissatisfaction with outcomes.

Opportunities for Improvement

- Enhance Resolution Timeliness – Address the 26% gap in resolution compliance by optimizing workflow efficiencies, increasing staffing resources, and implementing automated case management tools.
- Improve Member Communication – Strengthen member education on grievance processes to set expectations and ensure clear, transparent communication throughout the resolution process.
- Expand Provider and Staff Training – Focus on cultural competency training and grievance resolution best practices to improve service delivery and reduce the volume of avoidable grievances.
- Strengthen Data-Driven Interventions – Conduct root cause analyses on delayed resolutions to identify operational bottlenecks and implement targeted process improvements.

By leveraging these improvement strategies, KHS can enhance compliance, member satisfaction, and overall service quality, ensuring equitable and timely grievance resolution in 2025.

B. Access to Care

Access and Availability

The Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS) maintain accessibility, availability, and adequacy standards the KHS Health System is required to meet. KHS' standards and monitoring activities are outlined in policy and procedure 4.30-

P accessibility standards. KHS utilizes the Provider Network Management Network Review to monitor accessibility, availability, and adequacy standards.

The Provider Network Management Network Review provides the overview and results for the Plan's After-Hours Survey, Provider Accessibility Monitoring Survey, Accessibility Grievance Review, Geographic Accessibility and DHCS Network Certification, Network Adequacy and Provider Counts, and DHCS Quarterly Monitoring Report Template Review.

A. After-Hours Survey

As required by the Department of Managed Health Care (DMHC) Health & Safety Code 1348.8, Kern Health Systems (KHS) uses an after-hours caller program to assess compliance with access standards for Kern Family Health Care (KFHC) Members. KHS policy requires that:

1.) Provider's answering machine or answering service must instruct the member to call 911 if the purpose of the call is a medical emergency.
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

An initial survey is conducted by CareNet; the results are forwarded to KHS' Provider Network Analysts who make additional follow up calls based on compliant/noncompliant data received from the survey vendor. The goal is to achieve above 90%.

Results:

The Plan utilizes the after-hours survey calls to monitor compliance at a network-wide level. The Plan was found compliant with Emergency Access and Urgent Access remaining in line with prior quarters, with percentages in Q4 2025 above 90%.

Compliance with After-Hours Standard	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Emergency Access	99%	97%	99%	100%
Urgent Care Access	98%	96%	99%	99%

Quantitative and Qualitative Analysis:

Overall, the goal of 90% was met each quarter. For those offices that were identified as non-compliant, the Provider Relations Representatives conducted targeted education and sent letters notifying the provider groups of the survey results and Plan policy.

Upon review, KHS has found that the outreach and education conducted via both letter and the Provider Relations Representatives/Provider Relations Manager/Deputy Director of Provider Network has seen success.

Plan for 2025:

Continue tracking and trending the quarterly after-hour calls survey and conducting outreach and education for those offices identified as non-compliant.

B. Provider Accessibility Monitoring Survey

As required by the Department of Health Care Services (DHCS) and Title 28 CCR Section 1300.67.2.2, Kern Health Systems (KHS) uses a Provider Accessibility Monitoring Survey to assess compliance with access standards for Kern Family Health Care (KFHC) Members. In line with KHS policies and procedures and Department regulation, the quarterly appointment availability survey monitors:

Type of Appointment	Time Standard
Urgent primary care appointment	Within 48 hours of a request
Non-urgent primary care appointment	Within 10 business days of a request
Urgent appointment with a specialist	Within 96 hours of a request
Non-urgent appointment with a specialist	Within 15 business days of a request
Non-urgent appointments with a non-physician Mental health provider	Must offer the appointment within 10 business Days of request
Non-urgent appointment for ancillary services	Within 15 days of request
First prenatal OB/GYN visit	The lesser of 10 business days or within 2 weeks upon request

The survey was conducted internally by KHS staff; the Plan's survey/compliance methodology is based on a survey/compliance methodology utilized by the Department of Health Care Services (DHCS) during their 2017 Medical Audit of the Plan.

The Provider Network Management Department randomly selects 25 primary care provider offices and 25 specialty care offices. Additionally random samples of 5 non-physician mental health offices, 5 ancillary offices, and 5 OBGYN offices were also contacted to monitor network compliance with regulatory accessibility metrics. Annually, the Provider Network Management Department will select five primary care provider offices and five specialist offices in each of the five geographic regions determined by the Health Equity Department to monitor network compliance by region.

Results:

KHS utilizes the quarterly appointment availability survey to monitor compliance at a network-wide level. KHS reviewed the results of the Q4 2025 Provider Accessibility Monitoring Survey against the results of prior quarters. KHS recognized an increase in the wait time for Non-Urgent NPMH and OB/GYN appointments. KHS recognized decreases in wait time for Non-Urgent PCP, Specialist, Ancillary, Urgent PCP, and Urgent Specialist appointments. KHS does not consider this increase as a trend currently, as the results are in line with prior quarters. KHS' average wait time remains well within regulatory standards for all appointment types.

Average Urgent Wait Time in Hours	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Primary Care (48 Hours)	29.8	12.2	13.8	13.2
Specialist (96 Hours)	75.6	39.6	31.0	34.5

Average Wait Time in Days	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Primary Care (10 Days)	3.6	2.5	2.2	1.9
Specialist (15 Days)	7.1	6.7	9.2	10.6
Non-Physician Mental Health (10 Days)	5.4	1.2	3.6	2.4
Ancillary (15 Days)	0.2	1.6	1.0	1.8
OB-GYN (10 Days)	3.2	9.4	8.4	5.2

Quantitative and Qualitative Analysis:
The timeframes for appointment waiting times for PCPs, specialists, Non-Physician Mental Health, OBGYN, and ancillary providers were all met for each quarter of study. For providers who remained noncompliant with Plan appointment availability standards, KHS' Provider Relations Representatives conducted targeted outreach and education to the identified providers regarding their contractual obligation to meet regulatory access standards.

Plan for 2025:
Continue the ongoing quarterly tracking and trending for Provider Accessibility

C. Geographic Accessibility and DHS Network Certification

Per Section 1300.51 (d)(H) of the California Code of Regulations, KHS shall ensure, "all enrollees have a residence or workplace within thirty (30) minutes or fifteen (15) miles of a contracting or plan-operated primary care provider" as well as "within thirty (30) minutes or fifteen (15) miles of a contracting or plan operated hospital". Further, per Section 1300.67.2.1(b), if "a plan's standards of accessibility [...] are unreasonable restrictive [...] the plan may propose alternative access standards of accessibility for that portion of its service area.

Per Exhibit A, Attachment 6 of the KHS contract with the DHCS states that KHS "shall maintain a network of Primary Care Physicians which are located within thirty (30) minutes or ten (10) miles of a member's residence unless [KHS] has a DHCS-approved alternative time and distance standard."

For all geographic areas in which KHS does not currently meet the regulatory accessibility standard, KHS monitors and maintains an alternative access standard that has been reviewed and approved by the DMHC and/or DHCS.

DHCS Annual Network Certification – 2023-2024

DHCS Network Adequacy Standards	
Primary Care (Adult and Pediatric)	10 miles or 30 minutes
Specialty Care (Adult and Pediatric)	45 miles or 75 minutes
OB/GYN Primary Care	10 miles or 30 minutes
OB/GYN Specialty Care	45 miles or 75 minutes
Hospitals	15 miles or 30 minutes

Pharmacy	10 miles or 30 minutes
Non-Specialty Mental Health (Adult and Pediatric)	45 miles or 75 minutes

Results:
In Q1 2025, the DHCS provided accessibility analysis for all plans for the 2024 Annual Network Certification (ANC). The methodology utilized by the DHCS resulted in the Plan having 232 non-compliant "population points", 77 were newly identified for the 2024 ANC and 155 remained the same from the 2023 ANC. The Plan submitted the 232 AAS requests to the DHCS on March 20, 2025. In Q3 2025, the Plan received one resubmission request for Adult and Pediatric services in the 93285 Zip code. The Plan resubmitted the requested ANC on August 14th, 2025. In Q4 2025, the DHCS completed review of the ANC and found no deficiencies. On December 18th, 2025, the Plan passed the 2024 Annual Network Certification.

As part of its ongoing monitoring, the Plan reviews additions/deletions in the provider network against the most recently completed geographic accessibility analysis. As of the end of Q4 2025, the Plan did not identify any terminations that would affect the Plan's ability to provide access within required time or distance standards.

Plan for 2025:
In compliance with the Annual Network Certification requirement outlined in APL 23-001, KHS will submit geographic access analysis assessing compliance with DHCS Network Adequacy Standards.

D. Network Adequacy and Provider Counts

Per CCR § 1300.67.2, Kern Health Systems (KHS) shall maintain, "at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and [...] approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees."

In 2020, KHS contracted with SPH Analytics to conduct our annual Provider Satisfaction Survey; as a part of that survey, responding providers were asked, "What portion of your managed care volume is represented by Kern Health Systems?" Outreach for the survey was placed to every contracted provider within the KHS network. Responses received, and FTE calculations based on those responses, do not account for providers who refuse to participate in the survey. KHS used the responses collected combined with the most recent available Medi-Cal membership market share data to calculate an average FTE percentage which will be applied to the Plan's network of providers when calculating physician-to-enrollee compliance ratios.

KHS utilized SPH Analytics, an NCQA certified survey vendor, to conduct the survey for 2025. SPH's methodology involved two waves of mail and Internet, with a third wave of phone follow up to administer the survey.

Results:
Based on the results of 2025 survey, KHS calculated a network-wide FTE percentage of 71.44% for Primary Care Providers and 67.85% for Physicians.

PCP to Member Ratio:
As of the end of Q4 2025, KHS was contracted with 572 Primary Care Providers, a combination of 276 physicians and 296 mid-levels. Based on the FTE calculation process outlined above, with a 71.44% PCP FTE percentage, KHS maintains a total of 302.92 FTE PCPs. With a membership enrollment of 397,446 utilizing KHS contracted PCPs, KHS currently maintains a ratio of 1 FTE PCP to every 1,312.05 members; KHS is compliant with state regulations and Plan policy.

Physician to Member Ratio:
As of the end of Q4 2025, the Plan was contracted with 2,482 Physicians. Based on the FTE calculation process outlined above, with a 67.85% Physician FTE percentage, KHS maintains a total of 1,683.97 FTE Physicians. With a total membership enrollment of 397,446 utilizing KHS contracted Physicians, KHS currently maintains a ratio of 1 FTE Physician to every 236.02 members; KHS is compliant with state regulations and Plan policy.

C. Telephone Access to Member Services

Activity	Goal	Q1-2024	Q2-2024	Q3-2024	Q4-2024
Abandonment Rate	<5%	1%	2%	3%	4%
Speed of Answer	<0:30	0:11	0:21	0:46	0:42

Ensuring timely access to KHS Member Services is essential to helping members obtain information, resolve issues, and access needed services. KHS monitors key performance indicators including call abandonment rate and speed of answer to ensure members are able to reach representatives in a timely manner.

The call abandonment rate remained consistently below the established target of less than 5% throughout the year. These results demonstrate that the vast majority of members who contacted Member Services were able to remain connected and receive assistance.

The speed of answer goal of less than 30 seconds was achieved in the first two quarters, with response times of 11 seconds in Q1 and 21 seconds in Q2. Response times increased during the second half of the year to 46 seconds in Q3 and 42 seconds in Q4, which exceeded the established target. Despite the increase in response time later in the year, call abandonment rates remained low, indicating that members continued to successfully connect with Member Services representatives. KHS continues to monitor these metrics to support timely access to Member Services and maintain a high level of responsiveness to member inquiries and service needs.

IX. Member Experience

	Metric	Goal	Result
47	Adult and Child CAHPS Survey	Establish baseline for Getting Care needed measure	Met

A. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

KHS conducted the Measurement Year (MY) 2024 Consumer Assessment of Healthcare Providers and Systems (CAHPS® 5.1H) Medicaid Adult Simulation Survey in preparation for 2025 HEDIS reporting and accreditation requirements. The survey was administered by an NCQA-certified vendor and is designed to measure members' experiences with the healthcare system, evaluate whether member expectations are being met, and identify opportunities for improving the quality of care and service delivery.

The survey methodology included a random sample of 5,000 eligible member households, of which 4,997 were determined to be eligible. Eligible respondents were adults aged 18 years or older who were continuously enrolled in the health plan for at least five of the six months during the measurement year. A total of 526 completed responses were received, including 315 responses by mail and 211 responses through an online survey, resulting in a 10.5% response rate. Survey results were benchmarked against other health plans within Region 9, which includes California and several western states.

Patient Experience	KHS Summary Rate (%)	2025 SPH BoB Region (%)	Performance Indicator
Rating of Health Plan	87.9	78.0	↑
Rating of Health Care	81.1	74.5	↑
Rating of Personal Doctor	87.9	82.8	↑
Getting Needed Care	81.0	77.7	
Getting Care Quickly	83.3	76.3	↑
Customer Service	92.2	88.1	↑
Coordination of Care	89.0	82.2	↑
How Well Doctors Communicate	93.8	91.4	

Quantitative Analysis

Overall survey results demonstrated strong performance compared with regional benchmarks. KHS achieved 100th percentile performance for the Rating of Health Plan, representing the highest ranking since the organization began conducting the CAHPS survey. Several survey domains scored significantly higher than regional averages, including Coordination of Care and How Well Doctors Communicate, indicating strong member satisfaction with provider communication and care coordination.

Qualitative Analysis

Findings from the survey indicate that improvements in member outreach, provider communication, and care coordination contributed to higher satisfaction scores. Several initiatives implemented during the reporting period supported these improvements, including the implementation of an

Artificial Intelligence (AI) Interactive Voice Response (IVR) system to improve outreach efforts and assist members with scheduling appointments when gaps in care were identified. Additional efforts included expanded educational benefit presentations for members in rural communities and provider bulletins and trainings to keep providers informed of best practices and benefit updates. These efforts contributed to improved regional rate scores in several key survey domains.

Opportunities for Improvement

While overall results were strong, analysis of survey responses identified opportunities for improvement in specific areas, including Rating of Specialist and Doctor Spent Enough Time with Members. Review of grievance data and call tracking identified customer service concerns and referral submission processes as contributing factors affecting specialist ratings.

Based on survey findings, KHS will continue to monitor member experience metrics and implement targeted improvement strategies. Planned initiatives include collaboration with Provider Network Management and the Quality Improvement Department to address trends related to specialist satisfaction and appointment experience. These efforts will support continued improvement in member experience and help ensure that members receive timely, high-quality, and coordinated care.

X. Provider Engagement

	Metric	Goal	Result
48	Provider Satisfaction Survey – Would Recommend	Maintain 98th Percentile	Met
49	Provider Satisfaction Survey – Utilization and Quality Management	Maintain 97th Percentile	Met
50	Provider Satisfaction Survey – Degree to which the plan covers and encourages preventative care and wellness	Maintain 96th Percentile	Met
51	Provider Education – Host educational conference for Providers	Host one education conference for Providers	Met

A. Provider Satisfaction Survey

BACKGROUND/METHODOLOGY

On an annual basis, Kern Health System's Provider Network Management Department conducts a Provider Satisfaction Survey to gauge the level of satisfaction and engagement amongst our network of contracted providers. The 2025 Provider Satisfaction Survey asked providers to answer survey questions based on their experiences with KHS during Calendar Year 2024. We engaged an independent survey company, Press Ganey (PG) Analytics to conduct the survey on behalf of the Plan. PG Analytics is able to benchmark KHS performance against other organizations within the industry, by comparing our results against their National Medicaid and Aggregate Books of Business. The PG 2024 Medicaid Book of Business is made up of 108 plans with a total of 17,393 respondents. The PG 2024 Aggregate Book of Business is made up of 201 plans with a total of 27,031 respondents. This is eighth annual Provider Satisfaction Survey that PG Analytics has completed for the Plan.

The 2025 Provider Satisfaction Survey was conducted across three waves, in May and June of 2025. Two waves of mailing outreach were conducted, followed by a third outreach via telephone. The survey is sent to and categorized by provider type, including PCP, Specialist, Behavioral Health, and Other (Facilities, Ancillary providers). All statistical testing is performed at the 95% confidence level.

RESULTS

KHS experienced increases amongst seven (7) of the eight (8) scoring composites (Overall Satisfaction, Compared to Other Plans, Compensation, UM & Quality Improvement, Network and Continuity of Care, Health Plan Call Center, Provider Relations, and Recommend to Other Providers) when compared to the prior year's Provider Satisfaction Survey. KHS scored within the 90th percentile or higher in all scoring composites/attributes, with Compared to Other Plans, Compensation, UM & Quality Improvement, Health Plan Call Center, and Provider Relations in the 100th percentile when compared against PG's 2024 Medicaid Book of Business.

As KHS scored within the 90th percentile or higher in all scoring composites/attributes, discussion focused on how to increase provider participation with the survey.

B. Provider Education

The Quality Performance (QP) team continued its structured provider engagement activities during the reporting period through routine meetings and targeted educational initiatives. The QP team maintained quarterly meetings with assigned providers to support collaboration, address operational concerns, and discuss quality performance measures. These meetings provided a forum to review quality initiatives, identify barriers to care, and share best practices that support improved clinical outcomes for KHS members.

In addition to routine provider engagement activities, KHS hosted a provider education conference during the reporting period, meeting the established performance goal for this metric. The educational conference focused on rheumatology and provided clinical education for network providers on evidence-based approaches to the diagnosis and management of rheumatologic conditions in the primary care setting. The session supported provider knowledge development and reinforced appropriate referral and treatment practices to improve care coordination and patient outcomes. The conference recording was made available to providers for ongoing reference and continuing education.

Qualitatively, provider engagement through educational programming and regular meetings strengthened collaboration between KHS and network providers and supported dissemination of clinical best practices. These efforts helped improve provider awareness of quality initiatives, enhance clinical knowledge, and support delivery of high-quality care to members.

As part of ongoing quality improvement efforts, KHS plans to continue provider education activities in the upcoming year. The planned topic for the next provider education conference will focus on the medical management of obesity for primary care providers.

XI. Health Equity

KHS continued to advance health equity as a core component of its organizational strategy and quality improvement efforts. During the reporting period, the Health Equity Office strengthened its role in integrating health equity into routine operations, including quality improvement activities, data analysis, and provider engagement. Rather than operating as a stand-alone initiative, health equity was incorporated into existing governance structures, operational processes, and performance monitoring activities to ensure that equity considerations were embedded throughout the organization.

KHS expanded its use of both quantitative and qualitative data to inform health equity strategies. Data sources included demographic and Social Determinants of Health (SDOH) indicators, Sexual Orientation and Gender Identity (SOGI) data collection, member experience feedback, provider engagement activities, and community input. These data sources were used to identify disparities in access, quality of care, and member experience, and to guide targeted interventions designed to improve outcomes for underserved populations.

In mid-2025, KHS achieved National Committee for Quality Assurance (NCQA) Health Equity Accreditation with a score of 100%, representing a significant organizational milestone. The Health Equity Department was established in 2023 and achieved full accreditation in less than two years. This accomplishment reflects strong cross-departmental collaboration, disciplined implementation of health equity initiatives, and a sustained organizational commitment to equitable care delivery. The accreditation validates the organization's ability to operationalize health equity practices and incorporate equity considerations into quality improvement and clinical operations.

KHS also administered the California Department of Health Care Services (DHCS) Equity Practice Transformation (EPT) Payment Program, which supports provider practices in implementing health equity initiatives within clinical settings. During the reporting period, $8,037,160 was distributed to 12 participating provider practices to support activities such as data standardization, staff training, disparity analysis, and targeted interventions to address gaps in care. These efforts supported the integration of health equity principles into provider workflows and quality improvement activities across the network.

To further strengthen understanding of member and community needs, KHS expanded mechanisms for capturing qualitative insights from members, providers, employees, and community partners. Structured listening sessions, provider interviews, community partnerships, employee engagement surveys, and participation in regional collaboratives were implemented to capture lived experiences and identify barriers to care not always visible in administrative data. These efforts supported the development of durable feedback mechanisms that inform targeted operational and clinical interventions aimed at improving access, quality of care, and member experience.

KHS also implemented initiatives designed to address maternal health disparities, including the expansion of the Medi-Cal doula benefit. Outreach, training, and onboarding activities were conducted to support community-based doulas in becoming contracted providers, resulting in the successful contracting of 14 doulas. Additional operational improvements, including documentation

and billing workflow support and hospital access coordination, were implemented to facilitate timely doula services for members.

Finally, KHS introduced a Health Equity and Quality Performance recognition program to acknowledge providers demonstrating leadership in advancing equitable care and improving quality performance. This initiative promotes provider engagement, highlights best practices, and supports system-wide improvement in health outcomes.

Collectively, these efforts demonstrate KHS's continued commitment to advancing health equity by integrating equity-focused strategies into clinical operations, provider partnerships, and quality improvement activities. Through these initiatives, KHS continues to strengthen its ability to identify disparities, implement targeted interventions, and improve health outcomes for members across Kern County.

XII. Conclusion

The 2025 QIHEP demonstrated continued progress in advancing quality of care, patient safety, member experience, and health equity for KHS members. Through structured governance, data-driven monitoring, and collaboration across departments and provider partners, the program supported ongoing improvement in clinical outcomes, network oversight, and access to care.

During the reporting period, the QIHEP Work Plan included fifty-one (51) goals, of which forty-one (41) were achieved and ten (10) were not met. These results demonstrate overall positive performance across the program while identifying areas requiring continued monitoring and targeted quality improvement efforts.

In 2025, KHS also successfully attained NCQA Health Plan Accreditation and NCQA Health Equity Accreditation, reflecting the organization's commitment to maintaining high standards for quality management, regulatory compliance, and equitable healthcare delivery. The program continued to support improvement across clinical quality measures, patient safety monitoring, member engagement, and provider network oversight.

Effectiveness of the QIHEP

The QIHEP was effective in supporting continuous quality improvement activities across clinical care, service quality, and patient safety domains.

Governance structures functioned as intended, with the EQIHEC providing oversight and strategic direction for program activities. Required meetings were held with quorum achieved at each meeting, and program documentation including the QIHEP Program Description, QIHEP Work Plan, and annual program evaluation were reviewed and approved in accordance with program requirements.

Performance monitoring demonstrated improvements across several MCAS clinical quality measures and increased engagement in preventive care initiatives. Targeted interventions such as provider education, mobile unit partnerships, outreach campaigns, and community-based programs supported gap closure and increased access to care for members.

Patient safety oversight activities, including clinical network audits, Potential Quality of Care Issue (PQI) monitoring, Facility Site Reviews (FSR), Medical Record Reviews (MRR), and credentialing activities, were conducted in accordance with program standards. These activities strengthened monitoring of provider performance and supported timely identification and mitigation of potential risks to member safety.

Member experience and engagement initiatives also demonstrated positive outcomes. Programs focused on outreach, education, and community partnerships helped improve member awareness of preventive services and access to care. Continued monitoring of grievances, appeals, satisfaction surveys, and access metrics provided valuable feedback to guide service improvements.

Collectively, these activities demonstrate that the QIHEP structure, governance, and monitoring processes were effective in supporting quality improvement and advancing equitable healthcare delivery for KHS members.

Opportunities for 2026

While the QIHEP demonstrated strong performance in many areas, opportunities remain to further strengthen quality outcomes and program effectiveness.

Several MCAS clinical quality measures did not meet minimum performance levels, particularly in areas related to preventive services and behavioral health follow-up care. Contributing factors include member engagement challenges, socioeconomic barriers affecting access to care, documentation and workflow variations within provider practices, and opportunities to improve the timeliness and completeness of encounter data.

Operational opportunities were also identified related to data integration and real-time monitoring of quality metrics. Enhancing access to timely data from providers, hospitals, and laboratories will support earlier identification of care gaps and more effective implementation of targeted interventions.

Additional opportunities include strengthening collaboration with network providers to support documentation accuracy, gap closure during patient encounters, and improved coordination following emergency department visits. Expanding partnerships with community-based organizations and schools may also support outreach efforts targeting children, adolescents, and vulnerable populations.

In 2026, KHS will continue to focus on provider engagement, member outreach, enhanced data analytics, and cross-departmental collaboration to improve performance across identified gap areas. These initiatives will further support the organization's commitment to delivering high-quality, accessible, and equitable care to members throughout Kern County.

XIII. Appendix

Appendix A: Population Needs Assessment September 2025

KERN HEALTH SYSTEMS

2026 Quality Improvement Health Equity Program Description

Executive Quality Improvement Health Equity Committee (EQIHEC)
Approval Date: 03/17/26

Table of Contents

I. Introduction 5

A. Mission & Values 5

B. Background 8

C. KHS Population 9

II. QIHEP Overview 13

A. QIHEP Purpose 13

B. QIHEP Scope 14

C. QIHEP Goals 19

III. Authority and Responsibility 23

A. KHS Board of Directors (BOD) 23

B. Chief Executive Officer (CEO) 24

C. Chief Medical Officer (CMO) 24

D. Chief Health Equity Officer (CHEO) 25

E. Chief Operating Officer (COO) 25

F. Quality Improvement Medical Director 26

G. Behavioral Health Provider 27

H. Executive Quality Improvement Health Equity Committee (EQIHEC) 28

I. Quality Subcommittees 31

1. Behavioral Health Advisory Committee (BHAC) 31

2. Drug Utilization Review Committee (DUR) 33

3. Grievance Workgroup (GW) 34

4. Health Equity Transformation Steering Committee (HETSC) 35

5. Network Adequacy Committee (NAC) 37

6. Population Health Management Committee (PHMC) 38

7. Quality Improvement Workgroup (QIW) 41

8. Utilization Management Committee (UMC) 41

J. QI Support Committees 43

1. Community Advisory Committee (CAC) 43

2. Delegation Oversight Committee 43

3. Physician Advisory Committee (PAC) 45

4. Compliance Committee 47

5. Health Equity Advisory Board 48

6. Health Equity and Learning (HEAL) 49

7. Regional Advisory Committee (RAC) 50

IV. Organizational Structure and Resources 50
A. Clinical Oversight of QIHEP 50
B. Quality Improvement Department (QI) 51
C. Quality Performance Department (QP) 54
D. Health Equity Department 57
E. Appeals and Grievances 58
F. Credentialing 59
G. Member Services 59
H. Pharmacy Department 60
I. Population Health Department (PHM) 61
J. Human Resources Department 62
1. Hiring Initiatives 62
2. KHS Bilingual Workforce 63
K. Provider Network Management (PNM) 63
L. Utilization Management Department (UM) 66
M. Behavioral Health Department (BH) 66
N. Wellness and Prevention Department 67
O. Enhanced Care Management Department (ECM) 69
P. Community Support Services (CSS) Department 69
Q. Business Intelligence (BI) 69
R. Information System & Data Management 69
S. Marketing 70
V. Role of Participating Providers 71
A. Provider Participation 71
B. Provider and Hospital Contracts 71
C. Conflict of Interest 72
VI. Program Documents 73
A. Work Plan 73
B. Work Plan Evaluation 73
VII. Quality Improvement Processes 75
A. KHS Quality Improvement (QI) Initiatives 75
1. Plan-Do-Study-Act Cycle 75
2. Data Collection Methodology 75
3. Measurement Process 76
4. Evaluation Process 76

5. Communication and Feedback 77
6. Improvement Processes 77
VIII. Quality Improvement Work Plan 78
A. Quality of Clinical Care 78
1. MCAS Measures 78
2. Performance Improvement Projects (PIPs) 78
B. Safety of Clinical Care 79
1. Patient Safety Program 79
2. Potential Quality Issues (PQIs) 80
3. Facility Site Review, Medical Record and Physical Accessibility Reviews 80
4. Credentialing and Recredentialing 80
C. Quality of Service 81
1. Grievance and Appeals 81
2. Access to Care 81
D. Member and Provider Satisfaction 81
E. Addressing Cultural, Ethnic, Racial and Linguistic Needs of Members 82
IX. External Audits/Regulatory Audits and Delegation Oversight 84
A. Auditing and Monitoring Activities 84
B. Delegation 85
X. Conflict of Interest 85
XI. Confidentiality 86
XII. Information Security 86
XIII. Communication of Quality and Health Equity Activities 87
XIV. Annual Evaluation 87
XV. Appendix 90
Appendix A: Population Needs Assessment September 2025 90
Appendix B: Quality Departments Organization Structure 90
Appendix C: Health Equity Office Organization Structure 91

I. Introduction

Kern Health Systems (KHS), operating as Kern Family Health Care (KFHC), was established in 1993 by the Kern County Board of Supervisors as a local initiative Medi-Cal managed care health plan. KFHC is the largest health plan in Kern County, serving the majority of Kern County's Medi-Cal beneficiaries through a contract with the State of California Department of Health Care Services (DHCS).

KHS is a special county health authority governed by a 16-member Board of Directors. This diverse board includes representatives such as the Chief Executive Officer of the local safety net hospital, a safety net care provider, ten community representatives nominated by the County Supervisors, two Medi-Cal primary care physicians, one representative from a rural acute care general hospital, and one pharmacist. Board members must work or reside in Kern County and meet the minimum age requirement of 21. The Board oversees the establishment and operation of a comprehensive managed care system, ensuring access to high-quality medical care, promoting cost efficiency, and adhering to the principles of Chapter 7, Part 3 of Division 9, Section 14000 of the California Welfare and Institutions Code.

As of 2025, KHS serves approximately 404,842 members, with 49% receiving care through the County Hospital system and two large Federally Qualified Health Centers (FQHCs). While 54.7% of the population resides in Bakersfield, the remainder is spread across rural areas of Kern County. The largest racial and ethnic group is Hispanic, accounting for 63.3% of membership. Language diversity is a key factor, with 69.7% of members speaking English as their primary language, 30% speaking Spanish, and 0.3% speaking other languages.

Kern County faces significant health challenges compared to statewide statistics, including higher rates of adult smoking, obesity, physical inactivity, alcohol-impaired driving deaths, sexually transmitted infections, and teen births. However, the county ranks favorably in food environment indices due to fewer low-income residents with limited access to grocery stores and lower rates of excessive drinking.

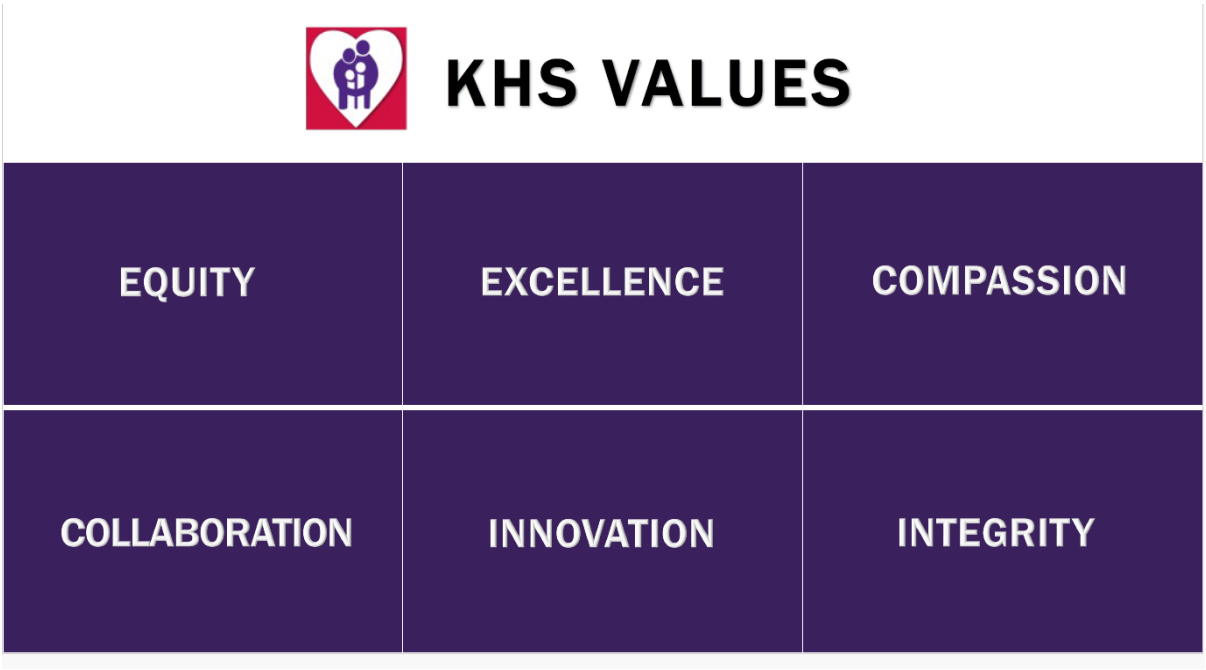
A. Mission & Values

Mission

KHS is committed to improving the health and well-being of our members and the community of Kern County through an integrated, equitable, and member-centered healthcare delivery system. The Quality Improvement Health Equity Program (QIHEP) is designed to objectively monitor, systematically evaluate, and effectively improve the quality, safety, and outcomes of care delivered to our members. By prioritizing health equity and addressing social determinants of health, KHS strives to meet members where they are, empowering them to achieve optimal health outcomes.

The KHS Quality Improvement Department, in collaboration with the Quality Performance and Health Equity Departments, oversees the program's initiatives and activities, working closely with contracting providers to deliver high-quality care to the populations we serve.

Values



- **Equity**

We foster a culture of fairness and inclusion, ensuring all members and employees are supported, regardless of their zip code, race, ethnicity, preferred language, cultural preferences, or personal history. Equity is at the core of what we do because every person matters. We celebrate diversity and strive to create opportunities for everyone to thrive and contribute their unique gifts.

- **Excellence**

We uphold the highest standards in all that we do, aiming for outstanding results that resonate with the community we serve. Through continuous improvement and dedication, we achieve quality outcomes that lead to a stronger and healthier community. Excellence is reflected in our pride, commitment, and measurable impact.

- **Compassion**

We seek to understand and empathize with others' experiences, extending care and kindness to everyone we serve. Compassion drives our actions and shapes our solutions, ensuring we respond meaningfully to the needs of our members and colleagues.

- **Collaboration**

We harness the collective expertise of our team, providers, and community partners to solve problems and achieve shared goals. Collaboration brings diverse perspectives and strengths together, driving creativity and producing impactful, sustainable results.

- **Innovation**

We embrace new ideas, methods, and solutions to expand possibilities and improve outcomes. Through experimentation and forward thinking, we adapt to the changing needs of our members and create innovative strategies that maximize efficiency and value.

- **Integrity**

We act with honesty and accountability, staying true to our commitments and values. Integrity builds trust and provides a strong foundation for performance and meaningful impact, ensuring we consistently do the right thing, even when it is not the easy thing.

KHS is committed to delivering on its values by:

- Ensuring all members obtain equal access to socioeconomic and environmental resources,
- Applying a health equity lens at all levels of and in all services provided by KHS,
- Embracing new knowledge and new ways of providing services,
- Practicing tolerance (accepting differences), embracing diversity (celebrating differences where possible), and pursuing inclusivity (finding commonalities and soliciting voice),
- Identifying and challenging historic assumptions and biases,
- Collaborating across programs, divisions, and community agencies/organizations to address community needs and barriers and obtain recommendations to improve services,
- Managing fiscal resources and the use of resources for greatest impact,
- Keeping consumers informed of Health Equity activities and outcome summaries by making them publicly available on the KHS website. Updates and ongoing information are posted at a minimum, on a quarterly basis,
- Leveraging our financial resources to help historically under-supported businesses and communities of color to build stronger capacity and economic health,
- Holding itself accountable through measurement and quality improvement/assurance,

- Building strong internal leaders in the health equity field that demonstrate a sustained, resolute commitment to DEI and collaboration with all stakeholders,
- Committing to eliminating health inequities in Kern County.

B. Background

Kern County is very diverse, with many residents identifying as Hispanic. As the racial and ethnic composition of Kern County continues to change, it is important to create culturally sensitive systems, policies, and environments while protecting the health of the public.

Spanish-language education, documents, and services will continue to be needed as the Hispanic population grows. Additionally, while the total number of non-Hispanic Asians in Kern County remains small, the proportion of residents identifying as non-Hispanic Asian has increased by 21 percent since 2009. In comparison, during the same time frame, the Hispanic population in Kern County grew by 11 percent.

In Kern County, children age 17 and under are at higher risk of living below the poverty level than adults age 18 and older. Overall, 26% of children live below the poverty level, while 19.2% of all Kern County residents live below the poverty level. Studies have shown that children living in poverty are more likely to have physical and mental health problems than their peers. This includes lower achievement in test scores, which could limit an individual's ability to earn a living wage.

Moreover, Kern County continues to have a smaller proportion of residents with a high school diploma or equivalency than the California average. However, Kern County is expected to have the largest increase in high school graduates in the state by 2028.

Due to the diverse geography of Kern County, from arid high desert to mountains to the valley, climate conditions also vary. In the summer, heat exhaustion, heat stroke, and heat-related deaths are concerns in Kern County (for example, dehydration can exacerbate underlying conditions). Additionally, high winds and dust storms in certain parts of the county can aggravate respiratory disorders and contribute to infectious diseases such as Valley Fever (coccidioidomycosis).

Kern County's service area has been challenged by provider shortages. Large portions of the county are designated as Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas or Populations (MUA/P). These issues are more severe and prevalent in Kern County than in many other counties within California. The following four rural areas fall within these classifications:

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

C. KHS Population

The population served by KHS, operating as Kern Family Health Care (KFHC), reflects the diverse demographic, geographic, and socioeconomic characteristics of Kern County. As of 2026, KHS serves approximately 392,000 Medi-Cal members, encompassing a wide range of health and social needs.

Demographics

- Geographic Distribution:
    - Over 54% of KHS members reside in Bakersfield, the county's largest metropolitan area.
    - The remaining members are distributed across rural areas, highlighting the need for geographically equitable access to healthcare services.

Area	Rural Portions per HRSA	KHS Population	Percentage
Bakersfield	N	223,973	66.9%
Delano & North Kern	Y	30,610	9.1%
Arvin/Lamont	Y	21,978	6.6%
Shafter/Wasco	Y	21,596	6.4%
California City & Southeast Kern	Y	9,434	2.8%
Taft & Southwest Kern	Y	8,897	2.7%
Tehachapi	Y	5,632	1.7%
Ridgecrest & Northeast Kern	Y	4,883	1.5%
Lake Isabella & Kern River Valley	Y	4,023	1.2%
Lost Hills & Northwest Kern	Y	2,194	0.7%
Frazier Park & South Kern	Y	1,244	0.4%
Outside Service Area	N/A	465	0.1%

- Racial and Ethnic Composition:
    - The Hispanic population represents 63.3% of KHS membership, emphasizing the importance of culturally relevant care and services.
    - Other racial and ethnic groups include White, African American, Asian, Native American, and individuals identifying as multiracial, reflecting the diversity of the community served.

Ethnic or Racial Group	% KHS Enrollment
Hispanic	63.3%
Caucasian	16.1%
No valid data	9.8%
Black/African American	5.7%
Asian Indian	1.4%
Filipino	1.1%
Hawaiian/Pacific Islander	0.06%
Native American	0.21%
Other Asian	1.0%
Unknown	1.3%

- Language Diversity:
  - 66.6% of members identify English as their primary language.
  - 32.3% primarily speak Spanish, underscoring the need for language assistance services.
  - Less than 1% speak other languages, requiring culturally and linguistically appropriate services to ensure equitable access to care.

Socioeconomic Characteristics

- Many KHS members face significant socioeconomic challenges, including:
  - Poverty: A large proportion of the population lives at or below the federal poverty level.
  - Unemployment: Economic instability affects access to housing, transportation, and other basic needs.
  - Educational Barriers: Limited education levels impact health literacy and the ability to navigate the healthcare system.

Health Risk Factors

- Kern County exhibits a higher prevalence of health risks compared to statewide averages, including:
  - Chronic Conditions: High rates of diabetes, hypertension, and obesity among the population.
  - Lifestyle Factors: Elevated smoking rates, physical inactivity, and alcohol use disorders.
  - Maternal and Child Health: Teen births and limited access to prenatal care contribute to poorer maternal and child health outcomes.

Social Determinants of Health (SDOH)

- KHS actively identifies and addresses social determinants that impact the health of its members, including:
    - Housing Insecurity: A significant portion of the population experiences unstable or unsafe housing conditions.
    - Food Insecurity: Access to affordable and nutritious food remains a concern for many families.
    - Transportation Barriers: Limited public transportation options impede access to healthcare facilities, particularly in rural areas.
    - Access to Technology: Digital inequities hinder member engagement in telehealth services and health education initiatives.

Behavioral Health Needs

The mental health and substance use disorder needs of KHS members are significant, with many individuals requiring coordinated care for mild-to-moderate behavioral health conditions. KHS partners with Kern County Behavioral Health and Recovery Services (KBHRS) to address the needs of members requiring specialty mental health services.

Vulnerable Subpopulations

KHS tailors its programs and services to address the unique needs of vulnerable groups, including:

- Seniors and Persons with Disabilities (SPDs): Older adults and individuals with disabilities require specialized care and enhanced care management services.
- Homeless Individuals: Outreach efforts target unsheltered populations, including street medicine initiatives that deliver care in nontraditional settings.
- Children and Adolescents: Programs focus on preventive care, developmental screenings, and health education for younger members.

Kern County ranks lower compared to other California counties for a variety of public health indicators. Kern County ranks in the bottom ten California counties for age-adjusted death rates due to diabetes, Alzheimer's disease, coronary heart disease, chronic lower respiratory disease, homicide, and drug-induced deaths[1]. It is also among the bottom ten California counties for the incidence of chlamydia and gonorrhea among individuals aged 15 to 44 years, congenital syphilis, primary and secondary syphilis, infant mortality, and persons under age 18 living in poverty.
In Kern County's most recent Community Health Assessment, asthma and other respiratory diseases were identified as top community health problems. According to the California Health Interview Survey, 15.7% of the Kern County population has been diagnosed with asthma. In 2019, the emergency department visit rate due to asthma was 46.1

per 100,000, compared to the state average of 42.6 per 100,000. Black/African American residents in Kern County experience significant asthma disparities, with an asthma emergency department visit rate of 181.5 per 100,000 people. This rate is more than four times the rate of the next highest racial or ethnic group in Kern County and more than double the rate of any age group in the county.

Additional health disparities identified within Kern County include the teen birth rate (21.0 per 1,000 live births), which is more than double the state average (10.2 per 1,000 live births) among females aged 15 to 19. The percentage of pregnancies accessing early prenatal care is also below the state average (Kern County: 79.6%; California: 85.1%). The obesity rate in Kern County is 35.5%, compared to 30.3% statewide.

Regarding mental health, Kern County's age-adjusted mortality rate due to suicide is 13.5 per 100,000, which is higher than the statewide average (10.7 per 100,000).

In accordance with the World Health Organization definition, social determinants of health (SDOH) are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the broader set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems.

Improving long-term health outcomes, particularly for populations experiencing the greatest health inequities over time, requires a shift in focus to upstream factors that are the underlying causes of ill health (Harris County Public Health: Health Equity Policy, 2015). Such inequities include disparate rates of disease, disability, and premature death. Addressing upstream factors (Appendix A) provides all individuals, regardless of socioeconomic or environmental conditions, the opportunity to attain their full health potential.

Addressing health disparities among identified populations is a priority for KHS. To ensure robust insights regarding disparities, KHS leverages the External Quality Review (EQR) Technical Report and the KHS Population Needs Assessment (PNA). An annual analysis of the EQR is used to identify disparities and targeted areas of focus to incorporate into strategies that improve member satisfaction, close gaps in care, and address other identified needs within the KHS population. Findings from the PNA are incorporated into the annual Quality Improvement Work Plan to address identified disparities and priority health needs.

KHS utilizes EQR recommendations to develop strategies that improve the timeliness and quality of services provided to members and reduce barriers to accessing preventive and other healthcare services. The KHS PNA uses internal and external data sources to identify and assess vulnerable member groups by race or ethnicity, age, sex, language, and other member characteristics, including cultural and linguistic needs. The PNA builds upon previous needs assessments and uses multiple data collection methods and sources.

The goal of the PNA is to improve health outcomes for KHS members and ensure that KHS is meeting the needs of its members through:

1. Identification of member health needs and health disparities
2. Evaluation of current health education (HE), cultural and linguistic (C&L), and quality improvement (QI) activities and available resources to address identified concerns
3. Implementation of targeted strategies for HE, C&L, and QI programs and services to address member needs

Population Health Management (PHM) services, including basic population health management and enhanced care management, are offered to all KHS members and delivered in a manner that addresses member needs, preferences, and health disparities.

Opportunities for Improvement

KHS leverages insights from its annual Population Needs Assessment to identify gaps in care and develop targeted interventions. Key opportunities include:

- Expanding provider networks to improve access in underserved areas
- Reducing health disparities by addressing inequities in chronic disease management and preventive care
- Enhancing member engagement through culturally competent health education and communication strategies
- Strengthening partnerships with community organizations to address social determinants of health and improve overall member well-being

II. QIHEP Overview

A. QIHEP Purpose

The KHS Quality Improvement Health Equity Program (QIHEP) is a written description of the overall scope and responsibilities of the program. The QIHEP actively monitors, evaluates, and takes effective action to address needed improvements in the quality, appropriateness, safety, and outcomes of covered healthcare services delivered by all contracting providers rendering services to members.

KHS recognizes that a strong program must serve as 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 services provided by contracting providers across all aspects of healthcare delivery, consistent with applicable standards and laws. The QIHEP operates in

compliance with requirements established by DHCS, DMHC, NCQA, and applicable federal and state regulations governing Medi-Cal managed care organizations.

The mission of the KHS Health Equity Program is to improve the health and well-being of the community through the delivery of trusted, high quality, cost-effective, and accessible healthcare to all members regardless of race, ethnicity, language spoken, or cultural or personal preferences. In partnership with the county it serves, KHS seeks to provide whole person-centered care that reflects current best practices. The KHS program is built on a foundation of trusted communication, high quality care, culturally sensitive member engagement, collaboration with community partners, continuous improvement, and coordinated service delivery with providers. KHS acknowledges an ongoing shared responsibility with its providers, facilities, community stakeholders, and other provider organizations to deliver trusted, effective, and timely care and services for its members.

At a high level, the program seeks to align with the guidance outlined in the California Department of Health Care Services' 2022 Comprehensive Quality Strategy, which emphasizes helping Medi-Cal members achieve longer, healthier, and more fulfilling lives through both clinical healthcare services and non-clinical supports. The program integrates clinical and non-clinical services to create a holistic healthcare environment that improves member health outcomes. Disparate impacts from the COVID-19 pandemic have underscored the need for urgency and the importance of building partnerships with trusted community stakeholders to strengthen trust with members. These priorities, including expanding non-clinical supports and strengthening community partnerships, are key strategies designed to improve health outcomes.

KHS staff continually evaluate member differences and preferences related to race, ethnicity, culture, gender identity, sexual orientation, and language. Through its QIHEP, KHS implements standards for culturally and linguistically appropriate services to achieve the following key objectives:

- Respond to current and projected demographic changes in the populations served
- Understand the impact of race, ethnicity, culture, gender identity, sexual orientation, and language on whole person health
- Improve the quality of services and outcomes for members

B. QIHEP Scope

KHS QIHEP is composed of several systematic processes that monitor and evaluate the quality of clinical care and healthcare service delivery to KHS members. The QIHEP scope includes regular needs assessments based on race and ethnicity, language, cultural preferences, health disparities, and stakeholder engagement. This expanded scope covers both clinically focused and non-clinically focused areas. These areas of program scope include, but are not limited to, the following:

- Monitor and identify opportunities to 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 issues and a corrective action process for resolution across provider entities.
- Promote efficient use of health plan financial resources.
- Identify health disparities and implement actions to support health equity.
- Oversee and direct processes affecting the quality of covered healthcare 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 healthcare in accordance with federal and state regulations and contractual obligations with the California Department of Health Care Services (DHCS).

This is accomplished through the development and maintenance of an integrated healthcare system that includes the following elements:

1. Development and implementation of a structure for monitoring, evaluating, and taking effective action to address needed improvements in the quality of care delivered by KHS network providers rendering services to members.
2. A process and structure for quality improvement with contracting providers, including identification of quality-of-care issues and implementation of corrective action processes for provider entities.
3. Oversight and direction of processes affecting the quality of covered healthcare services delivered to members, either directly or indirectly.
4. Assurance that members have access to covered healthcare in accordance with federal and state regulations and contractual obligations with DHCS.
5. Monitoring and improvement of the quality and safety of clinical care for covered services for members.

The KHS QIHEP applies to all programs, services, facilities, and individuals that have a direct or indirect influence over the delivery of healthcare to KHS members. This may range from the selection of contracted providers to the implementation of activities that improve clinical quality of care, including behavioral health, the promotion of safe clinical practices, and enhancement of services to members throughout the organization.
The scope of the QIHEP includes the following elements:

1. The QIHEP is designed to monitor, oversee, and implement improvements that influence the delivery, outcomes, and safety of healthcare services provided to members, whether directly or indirectly.

a. KHS does 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 arranges covered services in a culturally and linguistically appropriate manner. The QIHEP reflects the population served and applies equally to covered medical and behavioral health services.

2. The QIHEP monitors the quality and safety of covered healthcare services administered to members through contracting providers. This includes contracting physicians, hospitals, vision care providers, behavioral health practitioners, pharmacists, and other applicable personnel providing healthcare services to members in inpatient, ambulatory, and home care settings. New this year is the inclusion of street medicine providers. A street medicine provider refers to a licensed medical provider who conducts patient visits outside of clinics or hospitals and directly in community environments where unsheltered individuals may be living.
3. QIHEP assessment activities encompass diagnostic and therapeutic activities and outcomes affecting members. This includes primary care and specialty practitioners, vision providers, behavioral health providers, pharmaceutical services, preventive services, prenatal care, and family planning services across applicable care settings, including emergency, inpatient, outpatient, and home health settings.
4. The QIHEP evaluates quality of service, including practitioner availability, accessibility of services, coordination, and continuity of care. Member input is obtained through participation in the Community Advisory Committee (CAC), member grievances, and member satisfaction surveys.
5. QIHEP activities are integrated internally across KHS departments through multi-departmental representation on the Executive Quality Improvement Health Equity Committee (EQIHEC) and its subcommittees.
6. KHS and the Kern County Department of Health jointly address mental health care needs. Specialty mental health services are arranged and covered in part through Kern County Behavioral Health and Recovery Services (KBHRS) pursuant to a contract between the County and the State.

Application of the QIHEP occurs across all procedures, care, services, facilities, and individuals with direct or indirect influence over the delivery of healthcare services to members.

Quality Improvement Integration: The QIHEP includes quality improvement, utilization management, risk management, credentialing, members' rights and responsibilities, and preventive health and health education.

As part of KHS' commitment to ensuring members' rights to quality healthcare, the following six rights to Quality Health Care have been adopted:

1. Right to Needed Care

- Members are accurately diagnosed and treated
- Care is coordinated across all physicians and specialists

2. Right to Equitable Care
    - All individuals, regardless of gender, race, ethnicity, geographic location, or socioeconomic status, receive the quality healthcare they need
    - Development of culturally competent care, including expanded translation services, after-hours appointments, mobile health clinics, and telehealth options
3. Right to Place of Care
    - Ensuring members receive care in the appropriate setting
    - Reducing unnecessary use of emergency departments for primary care
    - Supporting appropriate care transitions
4. Right to Timely Care
    - Timely access to care and appointments
    - Monitoring wait times for healthcare appointments and telephone advice
    - Ensuring members are up to date with preventive care
5. Right to Be Part of Your Care
    - Members and their families are active participants in the care team and decision-making process
    - Information is shared fully and in a timely manner to support informed decisions
6. Right to Safe Care
    - Continuous quality assurance and improvement activities
    - Customer and provider satisfaction surveys or interviews
    - Chart audits and site reviews
    - Safe medication administration

The QIHEP scope includes regular needs assessments based on race and ethnicity, language, cultural preferences, health disparities, and stakeholder engagement. The program addresses both clinically focused and non-clinically focused areas, including the following:

- Quality Improvement – Understanding health disparities is critical to identifying differences in treatment provided to members of different racial, ethnic, or cultural groups that are not justified by underlying health conditions or treatment preferences. KHS implements programs to monitor, assess, and improve healthcare services to reduce disparities within its membership.
- Quality Performance – Identification of gaps in care, opportunities to support providers and members, and oversight of high quality and equitable care for members. Quality Performance includes site reviews,

MCAS/HEDIS performance monitoring, performance improvement projects, and organizational quality initiatives.

- Health Education and Cultural and Linguistic Services – Ensuring members have access to language assistance services including bilingual services, oral interpretation, and written translations. Network providers have access to these services to ensure members receive information in their preferred language.
- Population Health Management – Promoting partnerships with providers, community organizations, public health agencies, and schools to improve data sharing and address social determinants of health. These efforts support prevention, wellness, disease management, and identification of members at risk for complex health conditions who may require specialized services.
- Member Engagement – Collecting and evaluating feedback from members, practitioners, and community groups through multiple mechanisms including member advisory committees, satisfaction surveys, and provider engagement activities.
- Provider Network Management – Evaluating cultural responsiveness within the provider network, including providers' ability to understand values, beliefs, and behaviors influenced by cultural factors. KHS provides annual education to providers on incorporating member preferences into healthcare delivery.
- Utilization Management – Facilitating communication and collaboration among members, practitioners, providers, and the organization to ensure appropriate utilization of healthcare services. Monitoring under- and over-utilization trends supports reduction of care variations and helps close gaps in care among vulnerable populations.
- Policies & Procedures – The following components are integrated into KHS policies and procedures across multiple areas:
    - Community input and advisement on cultural, linguistic, and Seniors and Persons with Disabilities (SPD) awareness through the Community Advisory Committee
    - Periodic Population Needs Assessments to evaluate cultural competency, linguistic sensitivity, and SPD awareness needs among practitioners and members
    - Recruitment and retention of staff reflective of the membership
    - Partnerships with vendors and community-based organizations reflective of the membership
    - Training and tools for KHS staff and network providers to promote cultural competency, linguistic sensitivity, and SPD awareness
    - Participation in government, community, and educational forums related to cultural competency and health equity
    - Systems that identify language and ethnicity-specific member data
    - Grant programs that prioritize organizations providing culturally and linguistically appropriate services to the community

C. QIHEP Goals

KHS has developed and implemented a plan of activities to support a progressive healthcare delivery system that operates in cooperation with contracting providers, members, community partners, and regulatory agencies. The QI Department annually evaluates program objectives and progress, making modifications based on guidance from the KHS Board of Directors. The results of this evaluation are considered in the subsequent year's program description. Specific objectives of the QIHEP include:

1. Improving the health status of members by identifying potential areas for improvement in the healthcare delivery system.
2. Developing, distributing, and promoting guidelines for care, including preventive healthcare and disease management, through education of members and contracting providers.
3. Developing and promoting healthcare 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 on matters related to quality improvement. This includes maintaining communication avenues between KHS, members, and contracting providers to identify solutions that lead to improved healthcare delivery systems.
5. Monitoring and providing oversight of delegated activities.
6. Tracking and trending a wide variety of information, including:
    a. Over- and under-utilization data
    b. Grievances
    c. Potential and actual quality-of-care issues
    d. Accessibility of healthcare services
    e. Compliance with Managed Care Accountability Set (MCAS) preventive health and chronic condition management services
    f. Pharmacy services
    g. Primary Care Provider facility site and medical record reviews to identify patterns that may indicate the need for quality improvement and ensure compliance with state and federal requirements
7. Promoting awareness and commitment within the healthcare community toward quality improvement in healthcare, safety, and service.
8. Continuously identifying opportunities for improvement in care processes, organizational structures, and service delivery systems that enhance safety and healthcare delivery for members.

9. Providing appropriate evaluation of professional services and medical decision making in order to identify opportunities for professional performance improvement.
10. Reviewing quality-of-care concerns for members identified through grievances, the Community Advisory Committee (CAC), or other internal, provider, or community resources.
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 QIHEP and its activities to determine:
    a. How effectively resources were deployed in the previous year to improve the quality and safety of clinical care
    b. The quality of services provided to members
    c. Modifications needed to the QIHEP

Results of the annual evaluation are presented to the EQIHEC and the Board of Directors. KHS acknowledges that culture change is necessary to achieve its health equity vision. As such, the vision and goals include a combination of qualitative and quantitative metrics. Some efforts are initiated because they align with KHS values and represent best practices for the organization. Other objectives include measurable outcomes directly connected to DHCS contract requirements, annual goals, or the KHS strategic plan. Some initiatives represent a blend of values-based goals and contractual obligations. Populations of focus include:

A. Members affected by health disparities

B. Limited English Proficiency (LEP) members

C. Children with special healthcare needs

D. Seniors and persons with disabilities

E. Persons with chronic conditions

Culture (Values-Based) Goals

• Provide leadership to staff and the provider network to support long-term culture change needed to address identified health disparities.

• Engage stakeholder groups including members, providers, staff, community stakeholders, contractors, and subcontractors to better understand and participate in health equity initiatives.

• Provide educational opportunities to stakeholders through multiple modalities, including:

o Online self-paced education

o In-person coaching and training

- o Live webinars
- o Distribution of educational materials

• Support workforce development, diversity, and training initiatives that increase cultural sensitivity, cultural awareness, and cultural humility among KHS staff and provider networks.

• Establish partnerships with community-based organizations that advance social and racial justice within the communities served.

• Continue to solicit and incorporate diverse stakeholder perspectives through surveys and stakeholder meetings.

Goals to Meet Members' Cultural and Linguistic Needs:

• Achieve 90% satisfaction among members who utilize interpreting and translation services as measured through satisfaction surveys.

• Deliver 90% of translation and interpretation service requests on or before the requested due date.

• Resolve 100% of cultural and language-related grievances within 30 business days.

Goals to Directly Address Health Disparities:

• Identify disparities in care for selected MCAS/HEDIS measures, including but not limited to:

- o Well Child Care (e.g., well-child visits, childhood immunizations)
- o Maternity Care (e.g., disparities affecting Black and Native American members)
- o Mental Health (e.g., maternal and adolescent depression screenings and follow-up for mental health and substance use disorders)
- o Cancer Screenings (e.g., breast, cervical, and colorectal screenings)
- o Management of Chronic Conditions (e.g., diabetes, hypertension, asthma)

• Address at least one disparity in care within each of the groups listed above by reducing the gap between the highest and lowest performing populations (with sufficient membership) by 5% by 2026. Examples include:

- o Increase well-child visits for Black children by 15% by 2026.
- o Increase maternal depression screenings for Black mothers by 15% by 2026.
- o Increase the rate of annual diabetes screening for members who speak an Asian language compared to English-speaking members.
- o Increase equity in member involvement in treatment planning for Black non-Hispanic (77%), Hispanic (66%), and other racial or ethnic populations (64%) to 85% or higher on member satisfaction surveys.

• MCAS Measures – KHS is accountable for exceeding the 50th percentile for measurement year (MY) 2026. Results for 2025 measures will be calculated and submitted in report year (RY) 2026. The applicable measures are presented in the following table:

#	Measure Required – MCAS	Measure Acronym	Measure Steward	Methodology	Held to MPL
Behavioral Health Domain Measures					
1	Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	FUM	NCQA	Administrative	Yes
2	Follow-Up After Emergency Department Visit for Substance Use – 30 Days	FUA	NCQA	Administrative	Yes
3	Depression Screening and Follow-Up for Adolescents and Adults – Screening	DSF-E-DS	NCQA	ECDS	Yes
Children's Health Domain Measures					
4	Child and Adolescent Well-Care Visits	WCV	NCQA	Administrative	Yes
5	Childhood Immunization Status – Combination 10	CIS-10-E	NCQA	ECDS	Yes
6	Developmental Screening in the First Three Years of Life	DEV-CH	CMS	Hybrid/Admin	Yes
7	Immunizations for Adolescents – Combination 2	IMA-2-E	NCQA	ECDS	Yes
8	Lead Screening in Children	LSC-E	NCQA	ECDS	Yes
9	Topical Fluoride for Children	TFL-CH	DQA	Administrative	Yes
10	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits	W30-6+	NCQA	Administrative	Yes
11	Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits	W30-2+	NCQA	Administrative	Yes
Chronic Disease Management Domain Measures					
12	Controlling High Blood Pressure	CBP	NCQA	Hybrid/Admin	Yes
13	Glycemic Status Assessment for Patients With Diabetes (>9%)	GSD	NCQA	Hybrid/Admin	Yes
Reproductive Health Domain Measures					
14	Prenatal and Postpartum Care – Postpartum Care	PPC-Post	NCQA	Hybrid/Admin	Yes
15	Prenatal and Postpartum Care – Timeliness of Prenatal Care	PPC-Pre	NCQA	Hybrid/Admin	Yes

16	Postpartum Depression Screening and Follow-Up – Screening	PDS-E-DS	NCQA	ECDS	Yes
17	Prenatal Depression Screening and Follow-Up – Screening	PND-E-DS	NCQA	ECDS	Yes
Cancer Prevention Domain Measures					
18	Breast Cancer Screening	BCS-E	NCQA	ECDS	Yes
19	Cervical Cancer Screening	CCS-E	NCQA	ECDS	Yes
20	Colorectal Cancer Screening	COL-E	NCQA	ECDS	Yes
Report Only Measures to DHCS					
21	Follow-Up After Acute and Urgent Care Visits for Asthma	AAF-E	NCQA	ECDS	No

III. Authority and Responsibility

The organizational structure includes the following personnel and committees:

A. KHS Board of Directors (BOD)

The KHS Board of Directors (BOD) has final authority and accountability for the KHS QIHEP. The Board has delegated responsibility for the development and implementation of the QIHEP to the Executive Quality Improvement Health Equity Committee (EQIHEC). The EQIHEC is chaired by the KHS Chief Medical Officer (CMO) and co-chaired by the KHS Chief Health Equity Officer (CHEO).

The KHS Board of Directors is the governing body of the organization and has ultimate responsibility for the quality of care and services delivered by KHS. The BOD:

- Approves the annual QIHEP Program Description.
- Approves the annual Quality Management Work Plan, which contains measures specific to the QIHEP.
- Reviews the annual QIHEP Evaluation.
- Reviews reports on QIHEP activities and performance measures as presented by the EQIHEC.
- Reviews and confirms the resources necessary to implement the QIHEP as recommended by the EQIHEC.

B. Chief Executive Officer (CEO)

Appointed by the Board of Directors, the Chief Executive Officer (CEO) has overall responsibility for the management and operational viability of KHS. Responsibilities include providing direction for the organization and overseeing KHS operations; developing strategies for each department, including the QIHEP; overseeing Human Resources direction and leadership appointments; ensuring fiscal efficiency; managing public relations; serving as a governmental and community liaison; and approving organizational contracts.

The CEO directly supervises the Chief Financial Officer (CFO), Chief Medical Officer (CMO), Compliance Department, and the Director of Marketing and Member Services. The Physician Advisory Committee (PAC) reports to the CEO and provides input regarding provider-related issues.

The CEO works closely with the CMO regarding ongoing QIHEP activities, progress toward program goals, and any identified healthcare problems or quality issues that require corrective action.

C. Chief Medical Officer (CMO)

KHS' Chief Medical Officer (CMO) is a physician who is board certified in a primary care specialty and holds a current, valid, unrestricted California Physician and Surgeon license. The CMO serves as an ex officio member of the Board of Directors and reports directly to the Chief Executive Officer (CEO).

The CMO is the senior clinical leader of KHS and has ultimate accountability for the QIHEP. The CMO assigns operational authority for components of the QIHEP to the CHEO and the Quality Medical Director while retaining overall medical oversight and responsibility to the Board of Directors.

The CMO provides medical direction for KHS and ensures that all medical, quality, utilization, and health equity activities meet or exceed applicable professional standards and regulatory requirements established by the California Department of Health Care Services (DHCS), the California Department of Managed Health Care (DMHC), and other applicable authorities. The CMO devotes the majority of professional time to quality improvement, health equity, and medical oversight activities.

Key responsibilities include:

- Providing clinical leadership for the development, implementation, and evaluation of the QIHEP.
- Ensuring that quality improvement, utilization management, pharmacy, wellness, prevention, and population health activities meet applicable professional standards and regulatory requirements.
- Supervising quality improvement activities performed by the Quality Improvement Department.

- Providing medical direction to the EQIHEC and associated committees, including the Physician Advisory Committee (PAC) and Drug Utilization Review (DUR) Committee.
- Developing, reviewing, and approving medical policies supporting utilization management, quality improvement, and health equity functions.
- Overseeing medical dispute resolution, quality-of-care reviews, peer review activities, and grievance trends.
- Providing oversight of delegated and non-delegated credentialing, recredentialing, and utilization management activities.
- Monitoring provider performance and assisting with provider network development in collaboration with Provider Network Management.
- Ensuring culturally and linguistically appropriate member and provider materials related to healthcare services and quality expectations.
- Coordinating with executive leadership to ensure financial or operational considerations do not compromise quality of care.
- Presenting the annual QIHEP Program Description and evaluation results to the Board of Directors and providing ongoing clinical reporting as required.

D. Chief Health Equity Officer (CHEO)

The Chief Health Equity Officer (CHEO) oversees the development, implementation, review, and revision of health equity policies and procedures; maintains the QIHEP Program Description and Work Plan; coordinates implementation activities; and ensures reporting to the EQIHEC. The CHEO also serves as the primary liaison between KHS and regulatory agencies on health equity issues and programs. The CHEO serves as a member of the EQIHEC and provides a health equity perspective for all non-clinical areas. The CHEO position on the EQIHEC may not be delegated. The CHEO oversees the development, evaluation, and revision of the QIHEP Program Description and ensures that health equity principles are embedded throughout the KHS organizational culture in non-clinical areas, including marketing, member engagement, member services, and community partnerships.

E. Chief Operating Officer (COO)

Under the direction of the CEO, the Chief Operating Officer (COO) plans, directs, monitors, coordinates, interprets, and administers all functional activities and policies related to the Claims, Provider Relations, 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. The COO maintains authority for establishing policies and procedures for these departments, consistent with the policies and procedures established by the KHS Board of Directors and the CEO, and in compliance with applicable regulatory requirements. The COO also has decision-making authority for organizational operations in the absence of the CEO.

F. Quality Improvement Medical Director

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 provides clinical leadership and guidance in the development and measurement of the strategic approach to quality, performance improvement, patient satisfaction, and safety. As determined by the plan's Chief Medical Officer (CMO), the Medical Director assists in short- and long-range program planning, total quality management including quality improvement, and external relationships, and develops and implements systems and procedures for the medical components of health plan operations.

In collaboration with the CMO and other leaders, the Medical Director develops and implements health plan medical policies and protocols. The Medical Director monitors provider network performance and reports clinical quality issues to the CMO and the EQIHEC. Additionally, the Medical Director represents the health plan on various committees and routinely reports to the Board of Directors regarding credentialing and recredentialing of network providers. The Medical Director provides medical oversight regarding the appropriateness and medical necessity of healthcare services provided to members and supports the organization in meeting medical cost and utilization performance targets.

Under the direction of the Chief Medical Officer, the Medical Director:

- Serves as a member of the following committees: EQIHEC, Physician Advisory Committee (PAC), Pharmacy and Therapeutics/Drug Utilization Review (P&T/DUR) Committee, Quality Improvement Committee, and Grievance Committee.
- Participates in carrying out the organization's mission, goals, objectives, and continuous quality improvement activities.
- Reviews and manages the utilization of healthcare services across all levels of care to achieve high quality outcomes in the most cost-effective manner.
- Provides clinical leadership to clinical department staff and works collaboratively with department directors across KHS to ensure compliance with contractual and regulatory requirements.

- Provides clinical support and education to the provider network regarding standards of care, evidence-based medicine, and the use of clinical criteria in decision making.
- Represents KHS within the medical community and in community relations activities.
- Participates in the implementation of the KHS Credentialing Program.
- Reviews performance data to identify areas for improvement and provides clinical leadership in implementing the KHS Quality Improvement Plan and Utilization Management Plan.
- Leads or participates in meetings and committees as assigned by the CMO.
- Participates as a member of the Health Services management team.
- Performs duties and responsibilities identified for the Medical Director under the Quality Improvement Plan and the Utilization Management Plan.

G. Behavioral Health Provider

The Behavioral Health (BH) Provider is a board-certified Psychiatrist (MD or DO) and/or Licensed Clinical Psychologist (PhD or PsyD) who maintains an active and unrestricted license to practice in the State of California. The BH Provider serves in a clinical advisory capacity and participates in behavioral health oversight activities in support of the Quality Improvement (QI) and Utilization Management (UM) Programs. The BH Provider provides clinical consultation, assists with the review of behavioral health performance data, and supports committee activities to promote safe, effective, equitable, and coordinated behavioral healthcare services.

The Director of Behavioral Health (BH), licensed through the California Board of Behavioral Sciences, has primary responsibility for behavioral health program oversight, implementation, monitoring, and reporting. The Director of BH serves as Chairperson of the KHS Behavioral Health Advisory Committee (BHAC) and reports to the EQIHEC. The Director of BH provides regular and ad hoc reports to EQIHEC that include analysis of performance metrics, utilization trends, access to care, continuity and coordination outcomes, disparities data, and quality improvement interventions.

Key responsibilities of the Director of BH include, but are not limited to:

- Monitoring and facilitating the exchange of clinical information between Primary Care Providers (PCPs) and behavioral health practitioners to ensure integrated and coordinated care delivery.
- Overseeing coordination between KHS and the Kern County Managed Behavioral Health Organization (MBHO), as well as certified Substance Use Disorder (SUD) providers, to promote continuity of care and appropriate transitions across levels of care.
- Ensuring appropriate clinical oversight of diagnosis, treatment planning, referrals, and follow-up for members with co-occurring medical and behavioral health conditions.

- Collaborating with Pharmacy Services to monitor the safe, effective, and evidence-based use of psychotropic medications, including adherence monitoring and medication reconciliation.
- Reviewing behavioral health access, availability, and timeliness data, and implementing corrective actions when performance does not meet established standards.
- Identifying and analyzing social determinants of health (SDOH), cultural and linguistic needs, and health disparities impacting behavioral health outcomes, and recommending targeted interventions to reduce inequities.
- Developing, implementing, and maintaining QI and UM policies and procedures related to behavioral healthcare to ensure regulatory compliance and alignment with NCQA and state requirements.
- Participating in quality improvement initiatives addressing continuity and coordination of care between medical and behavioral health providers, including data-driven performance improvement projects (PIPs), root cause analyses, and monitoring of corrective action plans.

Through a defined governance structure, ongoing monitoring, and structured reporting to EQIHEC, behavioral health services are supported by clinical expertise and administrative accountability, ensuring compliance with regulatory standards and alignment with organizational goals related to quality, access, member safety, and health equity.

H. Executive Quality Improvement Health Equity Committee (EQIHEC)

The Executive Quality Improvement Health Equity Committee (EQIHEC) provides overall direction for the continuous quality improvement process and ensures that activities are consistent with KHS strategic goals and priorities. The EQIHEC addresses equity, quality, and safety of clinical care and service, program scope, annual objectives, planned activities, timelines for each activity, responsible staff, and monitoring of previously identified issues from prior years. The committee also conducts an annual evaluation of the overall effectiveness of the QIHEP and its progress toward influencing network-wide safe clinical practices. The QIHEP utilizes a population health management approach for 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. Physicians serve as voting members for clinical decision making. Clinical matters brought before the EQIHEC require participation of licensed clinical practitioners. Voting on clinical issues is conducted by physician or licensed practitioner members of the committee. The committee includes both internal KHS leadership and community representatives. This structure promotes an interdisciplinary, interdepartmental, and community-based approach and drives action when opportunities for improvement are identified.

EQIHEC Membership

- Community Attendees:
    - 4 Providers (at least 2 must be participating network providers)
    - 1 Behavioral Health Provider
    - 2 Community Advisory Committee (CAC) members
    - 1 Pharmacy Provider
    - 1 Kern County Public Health Officer or representative
    - 1 Home Health or Hospice Provider
    - 1 Durable Medical Equipment (DME) Provider
- Internal KHS Attendees:
    - Chief Medical Officer (CMO)
    - Chief Health Equity Officer (CHEO)
    - Quality Improvement Medical Director
    - Quality Improvement Director
    - Quality Performance Director
    - Utilization Management Director
    - Population Health Management Director
    - Behavioral Health Director
    - Chief Operating Officer (Grievances and Appeals)
    - Pharmacy Director
    - Wellness and Prevention Director
    - Health Equity Manager
    - Provider Relations Director

The EQIHEC meets at least four times annually and more frequently as necessary. Activities of the EQIHEC and its QI subcommittees are formally documented in meeting minutes that summarize agenda items, deliberations, decisions, actions taken, recommendations, and required follow-up activities.

Key responsibilities of the EQIHEC include review and approval of the QIHEP Program Description, the annual QIHEP Work Plan, periodic work plan progress reports, and the annual QIHEP Program Evaluation. Findings and recommendations of the EQIHEC are reported at least annually, and more frequently as appropriate, by the CMO to the KHS Board of Directors.

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

EQIHEC Activities:

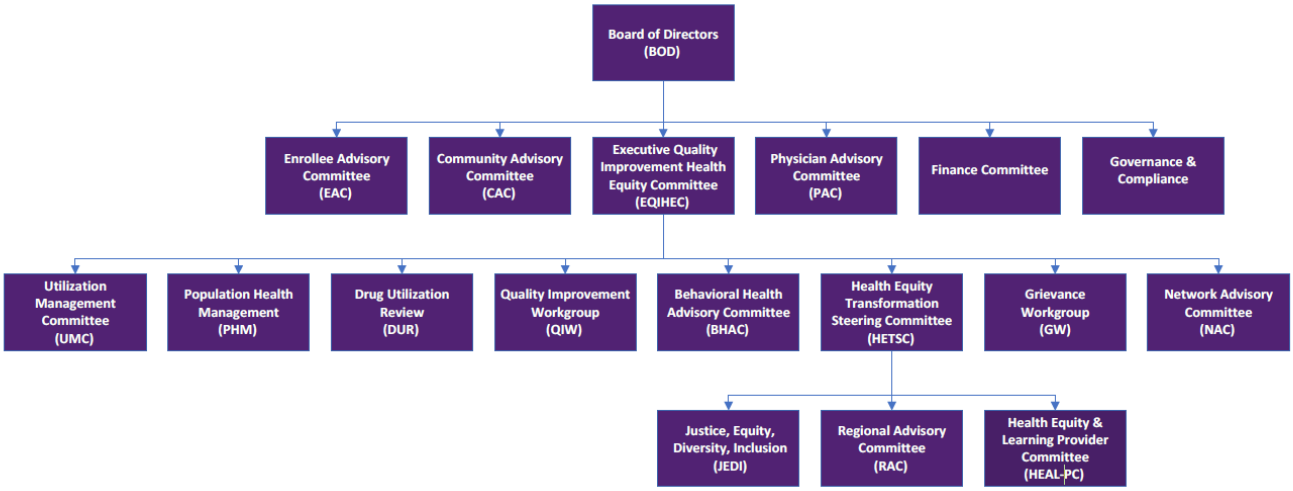
1. Formulate organization-wide improvement activities with support from EQIHEC subcommittees.
2. Identify appropriate performance measures, standards, and opportunities for performance improvement.
3. Ensure QIHEP activities comply with requirements of accrediting and regulatory agencies, including DHCS, DMHC, CMS, and NCQA.
4. Evaluate contract-specific interventions and outcomes.
5. Identify actions to improve quality and prioritize them based on analysis and significance, including determining how actions will ensure satisfactory outcomes.
6. Collaborate with the Information Technology Department on data collection strategies and analytics to support analysis of performance data and monitoring of program goals.
7. Ensure departments align project goals and clearly define responsibilities and timelines prior to implementation.
8. Ensure outcomes undergo quantitative and qualitative analysis, including aggregation of results over time and comparison with established goals and benchmarks.
9. Review analysis and evaluation of QIHEP activities conducted by subcommittees and identify required actions and follow-up activities.
10. Ensure root cause analyses and barrier analyses are conducted for identified underperformance and that targeted interventions are implemented.
11. Review and modify the QIHEP Program Description, annual QIHEP Work Plan, quarterly work plan reports, and annual program evaluation as necessary to maintain alignment with organizational goals and priorities.
12. Communicate the quality and health equity improvement process to practitioners, providers, and members through appropriate channels.
13. Ensure information regarding accessibility, availability, and continuity of care is reviewed and evaluated, including data obtained from member and provider surveys, grievances and appeals, and triage or screening services.
14. Ensure annual HEDIS, CAHPS, and Health Outcomes Survey (HOS) submissions are completed in accordance with technical specifications and deadlines.
15. Support practitioners and providers in improving patient safety within their practices.
16. Design and implement strategies to improve compliance with regulatory and contractual requirements.
17. Develop objective criteria and processes to evaluate and continually monitor adherence to clinical and preventive health guidelines.
18. Ensure program activities align with healthcare industry standards of practice.
19. Improve quality, safety, and equity of care and service provided to members.

20. Oversee facility site and medical record review processes to support safe, effective, and equitable clinical service delivery.
21. Review, evaluate, and make recommendations regarding oversight of delegated activities, including audit findings, trending analyses, and performance reports.

I. Quality Subcommittees

Multiple KHS subcommittees support the objectives and goals of the EQIHEC and the QIHEP. These subcommittees are responsible for monitoring, evaluating, and reporting on specific areas of quality, safety, utilization, and member services. Activities of the subcommittees are formally documented in meeting minutes that summarize each agenda item, the discussion, actions taken, and required follow-up. Information from these committees is reported at least quarterly to the EQIHEC through formal reports and committee presentations.

Committee Structure



1. Behavioral Health Advisory Committee (BHAC)

The Behavioral Health Advisory Committee (BHAC) is a subcommittee of the EQIHEC and serves as a collaborative forum to facilitate coordinated medical and behavioral health services. BHAC supports, reviews, and evaluates interventions that promote strategic alignment between KHS, as a Managed Care Plan (MCP), the County Behavioral Health Plan (BHP), and the Drug Medi-Cal Organized Delivery System (DMC-ODS).

Kern Behavioral Health and Recovery Services (KBHRS) administers the BHP and DMC-ODS and provides care for KHS members with mental health and/or substance use disorders (SUDs). BHAC's purpose is to maintain continuity

of care, reduce barriers to access, strengthen linkages to appropriate services, integrate behavioral and medical care, and provide resources for members receiving behavioral health services.

Functions

The BHAC supports the quality, safety, and effectiveness of behavioral health and substance use disorder services. Key functions include:

1. Quality Monitoring and Performance

- Review quality monitoring activities related to compliance, corrective actions, delegation oversight, and regulatory requirements.
- Evaluate network accessibility, provider compliance, and performance metrics.
- Monitor Medi-Cal Managed Care Accountability Set (MCAS) measures specific to behavioral health.
- Track and review member complaints, appeals, and overall member experience using both quantitative and qualitative analyses.
- Provide input on behavioral health quality improvement initiatives.

2. Clinical Guidelines and Program Design

- Provide feedback on behavioral health clinical guidelines and Utilization Management (UM) criteria.
- Assess emerging behavioral health technologies, treatment innovations, and monitoring tools.
- Review site and chart audits and access-to-care standards.
- Ensure services and programs are culturally and linguistically appropriate.

3. Coordination and Integration of Care

- Review processes supporting continuity and coordination of medical and behavioral health services.
- Evaluate methods of information exchange across systems and providers.
- Address coordination of carved-out services to reduce fragmentation of care.

4. Member Experience and Engagement

- Provide feedback based on interactions with members receiving behavioral health services.
- Review and incorporate member satisfaction survey results.
- Support behavioral health education and outreach initiatives.
- Promote health equity and improve accessibility of services.

5. Governance and Compliance

- Review and recommend approval of the Behavioral Health Program Description annually.
- Monitor compliance with Memoranda of Understanding (MOUs) with KBHRS.
- Provide structured recommendations to KHS leadership regarding behavioral health service delivery.

Composition

BHAC is co-chaired by the Chief Medical Officer (CMO) and the Director of Behavioral Health. Membership includes behavioral health practitioners and credentialed providers participating in the KHS network.

Appointed Members (minimum):

- 1 Participating Behavioral Health Network Practitioner (Licensed Clinician)
- 1 Participating Behavioral Health Network Practitioner (MD/Psychiatrist)
- 1 Participating Medication-Assisted Treatment (MAT) Provider (Primary Care Provider)
- 1 KBHRS Administrator or designee
- 1 Representative from a contracted FQHC, RHC, or Safety Net Provider
- 1 Local Education Authority representative

Other Attendees:

- Additional KHS clinical staff may attend for consultation but are not voting members.

Quorum: Two-thirds of voting members are required to establish quorum.

Meetings

BHAC meets at least four times annually, with additional meetings scheduled as necessary to address emerging issues, review performance metrics, or support quality improvement initiatives. All discussions, determinations, and recommendations are documented in formal meeting minutes and submitted to the EQIHEC.

2. Drug Utilization Review Committee (DUR)

The Drug Utilization Review (DUR) Committee is a subcommittee that reports to the EQIHEC. The DUR Committee is comprised of the KHS Chief Medical Officer (CMO), the Director of Pharmacy, and network pharmacists and providers who serve KHS members.

The DUR Committee is responsible for reviewing matters related to the use of medications provided to KHS members. The primary objectives are to support appropriate medication management to improve member health

and safety, oversee medications administered in outpatient settings under KHS responsibility, assist with case management, and monitor for potential fraud, waste, and abuse (FWA).

Medi-Cal Rx retains responsibility for formulary drugs carved out by the California Department of Health Care Services (DHCS). KHS may evaluate therapeutic alternatives, based on safety and efficacy, and identify opportunities to minimize therapeutic redundancies for medications dispensed under the Medi-Cal Rx program.

Activities:

a. Review and recommend pharmacy guidelines, policies, and procedures based on clinical evidence for medications covered under the medical benefit, commonly referred to as Physician Administered Drugs (PADs).
b. Monitor pharmacy utilization and medication safety measures.
c. Conduct drug utilization review activities.
d. Review reports to identify members and providers with potentially inappropriate or excessive utilization of medication therapy.

The DUR Committee meets at least four times annually. All reports, discussions, and determinations made by the committee are documented in formal meeting minutes. A summary of committee activities and reports is submitted to the EQIHEC.

3. Grievance Workgroup (GW)

KHS maintains a Grievance and Appeals (G&A) process through which a member, or a provider or Authorized Representative acting on behalf of a member and with the member's written consent (where applicable), may submit a grievance or appeal for review and resolution. The Grievance and Appeals process addresses the receipt, handling, and disposition of member grievances and appeals in accordance with the Department of Health Care Services (DHCS) contract and applicable state and federal statutes and regulations. KHS maintains written records of each grievance and appeal as required under Title 28, Section 1300.68(f)(2)(D) of the California Code of Regulations.

All complaints, grievances, investigations, follow-up activities, tracking, and trending reports are prepared by the KHS Member Services Department and submitted to the Grievance Workgroup. This workgroup functions as a subcommittee of the EQIHEC. The Grievance Workgroup meets at least twelve (12) times annually.

Under the direction and oversight of the Chief Medical Officer (CMO) or physician designee, individual and aggregate data related to member grievances and appeals are reviewed by the EQIHEC. The committee evaluates and analyzes grievance and appeal data to identify systemic patterns of improper service denials and other trends that may

impact health care delivery to members. When adverse trends are identified, the committee recommends and implements appropriate process improvements and corrective actions.

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

a. Difficulty obtaining an appointment
b. Customer service at the provider or practitioner office
c. Billing issues
d. Difficulty accessing specialists
e. Facility Conditions
f. Confidentiality issues
g. Refusal of a Primary Care Provider (PCP) to refer the member for care
h. Cultural or linguistic concerns

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

a. Appeals of denied Treatment Authorization Requests (TAR)
b. Appeals of level-of-care determinations
c. Appeals of KHS claims payment denials
d. Appeals of primary care physician requests for member disenrollment

All grievance and appeal review reports, discussions, and determinations conducted by the workgroup are documented in formal meeting minutes. A summary of activities and reports is submitted to the EQIHEC.

4. Health Equity Transformation Steering Committee (HETSC)

The Health Equity Transformation Steering Committee (HETSC) is an internal committee established to ensure that KHS remains an organization that understands and addresses social and racial justice and health equity to meet member needs. The committee is responsible for identifying and managing health equity efforts throughout the organization, including the planning, organization, and direction of the Health Equity Program.

The HETSC conducts systematic analyses to identify root causes of health disparities impacting KHS members and collaborates across the organization, with providers, and with community agencies to eliminate inequities among the members served. The committee reviews and updates relevant health equity policies and procedures and may review the annual Population Needs Assessment (PNA) to identify opportunities for advancing health equity and incorporating applicable findings into the QIHEP.

The HETSC monitors, evaluates, and takes timely action to address necessary improvements in the quality and equity of care delivered by network providers in all care settings and recommends appropriate actions to improve quality improvement and health equity goals.

This workgroup includes the areas of focus described below. Due to significant overlap and alignment, the KHS DEI/JEDI workgroup may serve as the steering workgroup for health equity activities.

1. Development of Internal Resources
    - Focus on providing learning opportunities and activities for staff that promote personal and professional growth and understanding related to social and racial justice, equity, diversity, inclusion, and cultural humility.
2. Provider Network Development
    - Assess regional needs and the existing capabilities of the provider network related to health equity.
    - Provide training, resources, and support to providers to strengthen their ability to deliver culturally responsive and equitable care to members.
3. Member Advocacy & Community Engagement
    - Identify and promote opportunities for members to be educated about and provide feedback on their experiences with providers, KHS, and other systems that impact their health.
    - Utilize member feedback to inform strategies that advocate for member needs.
    - Sponsor or participate in community events focused on social and racial justice, develop community engagement initiatives, address health disparities, and reduce stigma surrounding mental health and substance use.
4. Human Resources Enhancement
    - Focus on recruitment, retention, and promotion of a diverse workforce and maintaining a welcoming and inclusive work environment for employees.
    - The Human Resources Department is responsible for developing, implementing, and overseeing diversity, equity, and inclusion (DEI) policies and practices that impact the workforce and organizational stakeholders.
    - The workgroup partners with Human Resources to ensure the organization remains inclusive, equitable, and responsive to the needs of employees and the communities served.
5. Monitoring and Evaluation for Continuous Improvement
    - Evaluate how effectively staff apply internal QIHEP policies and procedures.
    - Identify staff development and training opportunities to ensure policies and procedures are applied equitably and without discrimination.

The Health Equity Department Manager reports to the CHEO and oversees the day-to-day operations of the Health Equity Department. The manager is responsible for organizing and preparing HETSC agendas, meeting minutes, reporting, and committee activities for submission to the EQIHEC.

The HETSC has established objectives to address health disparities, including:

a. Increase awareness of health equity and quality improvement and implement strengthened, expanded, or new health equity activities to support providers and members, ultimately reducing health inequities within the KHS membership.
b. Ensure services provided to members promote equity and are free of implicit bias or discrimination.
c. Implement programs that address causes of inequity experienced by members and their communities, including food insecurity, housing instability, tobacco use, and other social determinants of health.
d. Analyze the existence of significant health care disparities in clinical areas.
e. Reduce health disparities among members through targeted quality improvement initiatives.
f. Promote physician engagement in health equity and disparity reduction activities.
g. Conduct focus groups or key informant interviews with cultural or linguistic minority members to better understand and address their needs.
h. Address social determinants of health that affect member health outcomes.

5. Network Adequacy Committee (NAC)

The Network Adequacy Committee (NAC) supports the mission of KHS to improve the health status of members through an integrated managed health care delivery system. The NAC reports to the EQIHEC on KHS monitoring activities, corrective actions, and regulatory requirements related to provider network access, availability, and adequacy.

Functions

The functions of the NAC include the following:

1. **Establish Network Standards**: Ensure network accessibility standards (capacity and adequacy, appointment availability, geographic accessibility, and other access requirements) align with Department of 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 KHS to measure network compliance with established access and availability standards.

3. **Promote Health Equity**: Review network adequacy across diverse member populations to ensure equitable access to care across demographic and geographic groups.
4. **Steer Continuous Improvement:** Provide feedback on proposed corrective actions to address identified network access or adequacy issues and monitor progress of corrective action plans.

Composition

The NAC operates under the authority of the EQIHEC and is responsible for monitoring network adequacy activities and reporting findings and recommendations to the EQIHEC.

Meetings

The NAC meets at four times annually, with additional meetings scheduled as necessary.

6. Population Health Management Committee (PHMC)

KHS follows the National Committee for Quality Assurance (NCQA) definition of 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 (PHMC) oversees the Population Health Management (PHM) Model of Care (MOC), which addresses individuals' health needs across the continuum of care, including community settings, through participation, engagement, and targeted interventions for defined populations. The goal of the PHM Model of Care is to maintain or improve the physical and psychosocial well-being of members and reduce health disparities through cost-effective and tailored health solutions.

The PHMC is a collaborative group that engages multiple KHS departments across the organization, as well as community partners, in the development, execution, monitoring, and evaluation of programs that support members across the continuum of care.

Each year, KHS conducts a Population Needs Assessment (PNA). The annual PNA describes the overall health and social needs of KHS membership by analyzing service utilization patterns, disease burden, and gaps in care, taking into account member risk levels, geographic location, and age groups. PHMC members focus on strategies to address gaps identified in the PNA and target adverse patterns and outcomes to improve members' physical and psychosocial well-being through cost-effective and tailored solutions.

The following departments support the PHMC and are actively involved in the development, implementation, monitoring, and evaluation of PHM programs:

- Quality Improvement

- Quality Performance
- Utilization Management
- Member Services
- Behavioral Health
- Enhanced Care Management
- Health Equity
- Wellness and Prevention
- Community Support Services

These departments analyze service utilization patterns, disease burden, and the health and functional status of eligible members with chronic medical conditions, including those whose conditions may be exacerbated by significant psychosocial needs. They also identify and address gaps in care for KHS members.
The following programs are incorporated into Population Health Management and are administered by the respective departments:

- Basic Population Health Management (BPHM)
- Complex Care Management (CCM)
- Long-Term Services (LTC) and Supports (LTSS)
- Major Organ Transplants (MOT)
- Transitions of Care Services (TCS)
- Maternal Health Outcomes
- Children with Special Health Care Needs (CSHCN)
- Chronic Disease Programs
- Wellness and Prevention Programs

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

- Provide wellness services and interventions for the highest-risk members
- Improve clinical health outcomes
- Promote efficient and coordinated health care utilization
- Maintain cost-effective, high-quality care
- Improve access to essential medical, behavioral 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 care during transitions between healthcare settings, providers, and services
- Improve access to preventive health services

Activities

a. Lead strategic analytics, evaluation design, clinical and economic evaluations, and program optimization to ensure PHM addresses health needs across the continuum of care.
b. Ensure that medical care provided meets community standards for acceptable medical care.
c. Collaborate with behavioral health practitioners and organizations to ensure appropriate utilization of behavioral health services and continuity and coordination of medical and behavioral health care.
d. Improve communication and data sharing among primary care practitioners, specialists, behavioral health practitioners, health delivery organizations, and ancillary providers.
e. Monitor the appropriate use of and adherence to medication management practices.
f. Incorporate the PHM Model into policies, procedures, and operational workflows.
g. Improve member access to primary and specialty care, ensuring members with complex health conditions receive appropriate services.
h. Identify and reduce barriers to needed healthcare and social services for members with complex health conditions.
i. Improve member health status through wellness and disease prevention programs that educate and empower members to use primary and preventive health services, adopt healthier behaviors, and follow self-care regimens and treatment plans.
j. Ensure continuity of treatment access and follow-up for members with co-occurring medical, behavioral health, and substance use disorder conditions.
k. Promote routine depression, anxiety, trauma-informed care, and substance use disorder screenings, and ensure appropriate follow-up referrals are made for adolescent and adult members with chronic conditions and for women during pregnancy and the postpartum period.
l. Link members to Enhanced Care Management (ECM), Community Supports Services (CSS), behavioral health providers, and other community-based programs that provide comprehensive and holistic care.

7. Quality Improvement Workgroup (QIW)

The focus of the Quality Improvement Workgroup (QIW) is on clinical quality, patient safety, and patient and provider experience across four functional areas: HEDIS and the Medi-Cal Managed Care Accountability Set (MCAS), NCQA Accreditation, Quality Improvement, and Network Clinical Oversight. The QIW works to ensure KHS members receive high-quality health care by identifying and addressing outcomes that deviate from established standards within these areas.

Activities

1. Review and recommend approval of the QIHEP Program Description, the annual Work Plan, and the annual evaluation of the Work Plan.
2. Ensure compliance with Department of Health Care Services (DHCS) facility site review requirements.
3. Review aggregate data related to Potential Quality Issues (PQIs), identify opportunities for improvement, and oversee implementation of corrective actions.
4. Oversee the KHS patient safety program.
5. Identify quality-of-care trends and recommend corrective actions as needed.
6. Monitor evidence-based care through HEDIS and Medi-Cal Managed Care Accountability Set (MCAS) performance results and make recommendations for improvement.
7. Review and discuss year-to-date quality improvement initiatives.
8. Monitor member satisfaction by reviewing Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey results and address areas of member dissatisfaction.

8. Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) is a subcommittee of the EQIHEC and focuses on oversight of Utilization Management (UM) activities. The UMC supports the EQIHEC by monitoring the appropriate provision of medical services and providing recommendations related to UM activities.

The responsibilities of the UMC include developing, recommending, and refining UM program policies and procedures, including medical necessity criteria; establishing thresholds for acceptable utilization levels; ensuring the reliability of clinical information with the involvement of appropriate actively practicing practitioners; and developing and implementing monitoring systems to track, compile, and evaluate UM measures against established standards. The committee also evaluates utilization patterns to identify overutilization and underutilization of services.

Activities

a. Establish and implement written utilization management protocols and criteria applicable to the review of medical necessity for inpatient, outpatient, and ancillary services.
b. Ensure that UM decisions:
    1) Are made independent of financial incentives or obligations.
    2) Medical decisions, including those made by delegated providers and rendering providers, are not unduly influenced by fiscal or administrative management.
    3) Physician compensation plans do not include incentives related to denial decisions.
    4) Physicians and UM decision designees are not rewarded based on utilization review determinations.
c. 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.
d. Review nationally accepted utilization benchmarks, medical literature, and outcome data, as appropriate.
e. Develop and implement monitoring systems to track, compile, and evaluate patterns and variations in care.
f. Continually monitor and evaluate utilization practice patterns of staff, contracted practitioners, and vendors and identify variations in care.
g. Review state regulatory oversight of Long-Term Care (LTC) and Community-Based Adult Services (CBAS) facilities and coordinate with Quality and Credentialing teams to address identified quality concerns.
h. Develop and maintain effective relationships with linked and carved-out service providers available to members through county, state, federal, and community-based programs to support care coordination and service delivery.
i. Facilitate and ensure continuity of care for members within and outside of the KHS provider network.
j. Develop and implement performance measures to ensure regulatory turnaround time requirements are met.

J. QI Support Committees

1. Community Advisory Committee (CAC)

The Community Advisory Committee (CAC) provides a link between the community and Kern Family Health Care (KFHC) members to support the delivery of quality services and care that are accessible to all members. The CAC provides input, oversight, and recommendations regarding KFHC policies and member-facing activities as a delegated advisory body to the Board of Directors.

Functions

The functions of the CAC include the following:

1. Review proposed changes to policies or procedures that affect KFHC members.
2. Provide updates and feedback regarding state policies or issues that may impact KFHC members.
3. Provide input on matters that impact members, including member-facing materials and communications such as marketing materials, the KFHC website (including the Provider Directory and Doctor Search tools), the Evidence of Coverage, brochures, flyers, health education materials, radio, television, and billboard advertisements, and member incentive ideas or items.
4. Share member and community experiences that may help KFHC improve how care and services are delivered.
5. Advise KFHC on educational and operational issues affecting members who speak a primary language other than English.
6. Provide recommendations regarding cultural and linguistic considerations to improve accessibility and member experience.

2. Delegation Oversight Committee

The purpose of the KHS Delegation Oversight Committee (DOC) is to ensure adequate oversight of performance and adherence to regulatory contracts, requirements, and KHS standards related to subcontractors to which KHS delegates plan-required functions. This oversight includes the full delegation lifecycle, including pre-delegation audits, quarterly Joint Operating Meetings, routine oversight of delegate reporting and audits, and annual audits conducted by KHS department leads and staff.

The Compliance Department serves as the leader, facilitator, and coordinator of formal audits of delegated entities as outlined in the annual compliance monitoring and auditing work plans.

KHS may delegate Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Credentialing, Compliance, Claims, and other departmental activities and responsibilities to qualified entities where permitted by regulatory requirements. The DOC is responsible for overseeing the ongoing assessment of delegated entity performance to ensure adherence to contractual and regulatory requirements and to support achievement of organizational goals and delivery of high-quality outcomes for members.

Duties and Responsibilities

1. Evaluate prospective delegated vendors' ability to perform proposed delegated activities through pre-delegation audits conducted by the relevant business areas.
2. Ensure KHS departments delegating functions establish performance and reporting requirements designed to assess the effectiveness of health care delivery to members and compliance with regulatory requirements.
3. Review business owners' updates on monitoring and oversight activities and subcontractor performance and provide recommendations or feedback as appropriate.
4. Assist departments in establishing effective auditing tools designed to measure and report delegated entity performance and ensure compliance with regulatory requirements.
5. Review results of annual audits of delegated entities, coordinated by the Compliance Department in accordance with the annual compliance monitoring and auditing work plans.
6. In collaboration with the Delegation Oversight Department, ensure KHS business owners perform all necessary oversight of delegated functions as specified in written delegation agreements.

7. Review and evaluate delegated entity performance, including business owner updates regarding monitoring and oversight activities presented to the DOC.
8. Identify opportunities for performance improvement and recommend corrective action plans when deficiencies are identified.

9. Review audit findings, recommended changes to contracts and policies, and requested initiatives or project updates submitted by delegated entities.
10. Make recommendations to the Chief Compliance and Fraud Prevention Officer, Compliance Committee, Contract Business Owners, Governance and Compliance Committee, and/or Board of Directors regarding the compliance status of delegated entities in relation to regulatory requirements, performance expectations, and other contractual obligations.
11. Escalate unresolved issues from the DOC to the Compliance Committee and/or the KHS Board of Directors when appropriate.

12. Recommend and oversee corrective action plans (CAPs) to address deficiencies from initiation through closure.

13. Recommend sanctions, including revocation or termination of delegation, if delegated entity performance is inadequate and corrective action plans are not successful.

3. Physician Advisory Committee (PAC)

The Physician Advisory Committee (PAC) performs multiple functions, including serving as the KHS Credentialing and Peer Review Committee; overseeing the review and approval of medical technologies and clinical criteria sets; addressing and managing the review of sentinel events or adverse events identified as quality concerns; and evaluating the credentials of all current and prospective practitioners and providers seeking participation in the KHS network. Credentialing decisions are based on requirements established by the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA) accreditation standards, and other applicable laws and regulations.

The PAC also participates in the development and oversight of policies related to the KHS Code of Conduct, protection of Protected Health Information (PHI), and prevention of Fraud, Waste, and Abuse (FWA). The PAC is comprised of a broad spectrum of participating KHS physician representatives from primary and specialty care.

PAC Credentialing and Peer Review

Committee minutes are confidential and protected under California Evidence Code Section 1157. In accordance with state law, minutes containing confidential peer review information may be redacted.

The responsibilities of the Credentialing and Peer Review Committee include developing, monitoring, and maintaining credentialing standards; overseeing the credentialing program and delegated credentialing activities; and incorporating performance monitoring results from quality improvement activities and member complaints into recredentialing decisions for the KHS network of participating practitioners and health delivery organizations.

The PAC establishes and maintains credentialing and recredentialing policies and procedures that are consistent with NCQA standards and applicable state and federal laws and regulations. Credentialing decisions are not based on an applicant's race, ethnic or national identity, gender, age, sexual orientation, patient type, or the type of insurance coverage held by the practitioner's patients.

Activities

a. Maintain a well-credentialed network of providers and practitioners based on recognized and mandated credentialing standards.

b. Promote continuous improvement in the quality of care and services provided by KHS network providers.
c. Investigate patient, member, or practitioner complaints or concerns regarding the quality of clinical care or services and make recommendations for corrective actions when appropriate.
d. Provide guidance on the overall direction of the credentialing program.
e. Review the Credentialing Program Description at least annually to ensure the program remains comprehensive and effective in meeting KHS credentialing and recredentialing standards and supporting continuous quality improvement.
f. Evaluate quality concerns related to medical care and determine whether sufficient evidence exists that a practitioner failed to provide care consistent with generally accepted standards.
g. Monitor the reporting of provider preventable conditions.

PAC Medical Technologies and Clinical Criteria Sets

a. Apply principles of evidence-based medicine when evaluating clinical guidelines and monitoring the quality and cost-effectiveness of medical care provided to KHS members.
b. Review medical technologies for use by medical and behavioral health practitioners in the utilization review process.
c. Establish medical necessity criteria for coverage of specific technologies, services, or devices, incorporating applicable federal and state regulatory requirements.
d. Ensure KHS does not exert economic pressure on institutions to grant privileges to providers that would not otherwise be granted, nor pressure providers or institutions to render care beyond the scope of their training or experience.
e. Assess standards of health care as applied to members and providers, assist in the development of performance indicators for studies, and review clinical guidelines distributed to contracting providers.

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

The PAC participates in establishing and maintaining the following:

1. Confidentiality policies and procedures to protect confidential member, practitioner, and provider information in accordance with applicable state and federal regulations.
2. Protection of member identifiable health information by ensuring Protected Health Information (PHI) is disclosed only in accordance with federal, state, and other applicable regulatory requirements.

3. Oversight of strategies to prevent and reduce fraud, waste, and abuse within the provider network.

4. Compliance Committee

KHS is committed to preserving the integrity of its mission through adherence to contractual, legal, ethical, and regulatory standards and guidelines. All KHS employees are expected to comply with applicable laws, regulations, and ethical standards. Management is responsible for ensuring compliance with these requirements; therefore, compliance is an integral component of effective organizational governance.

The KHS Compliance Committee oversees and provides guidance related to integrity and ethical standards and supports KHS compliance with contractual obligations and all applicable laws and regulations. The Compliance Committee functions as an oversight committee.

Responsibilities

1. Determine appropriate strategies and approaches to promote compliance; prevent, detect, and correct potential violations; and advise the Chief Compliance and Fraud Prevention Officer, the Compliance Department, and operational departments accordingly.
2. Review and approve training related to the Compliance Program, Code of Conduct, Fraud, Waste, and Abuse (FWA), and privacy requirements, and ensure that training and education activities are effective and completed appropriately.
3. Review Fraud, Waste, and Abuse reports, including member- and provider-reported cases, through the Fraud, Waste, and Abuse Subcommittee.
4. Review reported HIPAA incidents, including prevention and education activities.
5. Review regulatory reporting deliverables.
6. Review delegated entities to ensure performance of delegated functions meets KHS standards through the Delegation Oversight Subcommittee.
7. Review internal and external audit reports and auditing tools, including outcomes and remediation efforts. Address situations where there is risk of program noncompliance or potential fraud, waste, and abuse, and ensure corrective action plans (CAPs) are implemented and monitored for effectiveness.
8. Review the effectiveness of internal controls designed to ensure compliance with applicable regulations in daily operations.
9. Review reports from the Compliance Department and other operational departments, as identified, on at least a quarterly basis regarding the overall Compliance Program and adherence to regulatory requirements.
10. Review reports received from regulators regarding monitoring of KHS compliance activities.

11. Monitor the Quality Improvement, Appeals, and Grievance processes, including identifying opportunities to improve quality and service through trend analysis.

12. Ensure that KHS maintains appropriate and current compliance policies and procedures.

13. Review the process for soliciting, evaluating, and responding to reports and disclosures received through the Compliance Program.

14. Oversee implementation of applicable federal and state programs, including contractual, legal, and regulatory requirements related to compliance risk, and coordinate with the Compliance Department and the Chief Compliance and Fraud Prevention Officer to ensure the Compliance Program is sufficient to manage organizational compliance oversight.

15. Review and address ad hoc compliance issues as needed.

5. Health Equity Advisory Board

The Health Equity Advisory Board serves as a regional advisory body supporting Quality Improvement (QI) and Health Equity initiatives in Kern County. The board recruits racially, ethnically, and culturally diverse individuals, including representatives from LGBTQI+ communities, from various stakeholder groups across the county.
Members may include, but are not limited to, general consumers representing racial and ethnic groups reflected in KHS membership, the Kern County Health Officer or a designated representative, representatives from County Behavioral Health and County Human Services, community-based organizations, community advocates, regional centers, Women, Infants, and Children (WIC) agencies, local education agencies, and traditional and safety net providers.
Advisory Board members focus on issues related to health equity, access, quality, diversity, and inclusion within KHS programs and performance metrics to improve health equity outcomes.

Activities

The Health Equity Advisory Board may:

- Participate in advising on public policy activities related to KHS programs and services that support the comfort, dignity, and accessibility of care for members, their families, and the broader community.
- Review and provide recommendations regarding marketing and member-facing materials.
- Review and provide recommendations regarding the member complaints and grievance process.
- Review and provide recommendations regarding member and provider satisfaction surveys.
- Review and provide recommendations on activities related to Quality Improvement, educational initiatives, operational issues, and cultural competency concerns affecting Limited English Proficiency (LEP) members.

- Review and provide recommendations regarding staff and provider training related to health equity.
- Review and provide recommendations regarding contracted vendors and community-based organizations (CBOs).

6. Health Equity and Learning (HEAL)

The mission of the Provider Health Equity and Learning (HEAL) Committee is to foster a collaborative environment among healthcare providers within KHS that advances health equity. The purpose of the committee is to:

1. Solicit Feedback: Serve as a platform for providers to share challenges experienced in practice and provide feedback on issues related to health equity. This feedback helps inform the development of KHS training programs, initiatives, and support for the provider network.
2. Resource Sharing: Facilitate the exchange of resources, funding opportunities, best practices, and innovative approaches to improve healthcare service delivery with a focus on health equity.
3. Training and Development: Identify, develop, and promote opportunities for training and professional development that enhance providers' knowledge and skills in delivering equitable healthcare.
4. Practice Expansion: Explore and discuss opportunities to expand access to services and support initiatives that advance health equity.

Composition

The HEAL Committee reports to the Health Equity Transformation Steering Committee (HETSC).

Membership

1. Membership in the Provider HEAL Committee is open to healthcare practices within the KHS provider network that express interest in promoting health equity.
2. Participation is voluntary and may include healthcare professionals, administrators, and other relevant stakeholders.
3. Members are expected to actively contribute to the mission and objectives of the committee.

Meetings

1. The committee meets at least quarterly, either in person or virtually.
2. Additional ad hoc meetings may be convened as necessary to address specific issues or opportunities.

7. Regional Advisory Committee (RAC)

The Regional Advisory Committee (RAC) meets quarterly across Kern County's five regions to engage members in discussions about their health and to gather direct community feedback. Each session focuses on a priority topic and is open to members and community stakeholders to share experiences, challenges, and opportunities for improvement.

Feedback and insights gathered during RAC meetings are synthesized at the county level to help inform policy and procedure enhancements, staff and provider training, and targeted outreach and education initiatives.

Findings and recommendations are elevated to the Health Equity Transformation Steering Committee (HETSC) and the EQIHEC to support strategic decision making and improve services for Kern Family Health Care members.

IV. Organizational Structure and Resources

A. Clinical Oversight of QIHEP

Under the direction of the Chief Medical Officer (CMO), the Medical Directors are responsible for clinical oversight and management of the Quality Improvement Health Equity Program (QIHEP). The program is implemented by the Quality Improvement (QI) and Health Equity (HE) departments, with input and collaboration from Quality Performance (QP), Utilization Management (UM), Behavioral Health (BH), Wellness and Prevention, and Population Health Management (PHM).

Medical Directors oversee clinical aspects of QIHEP activities for KHS and its participating practitioners, including oversight of credentialing functions and clinical quality initiatives.

Medical Directors must possess a valid Physician and Surgeon license issued by the State of California and be certified by one of the American Board of Medical Specialties (ABMS) member boards.

Principal Accountabilities

1. Develop and implement medical policies supporting Health Services department activities and Quality Improvement functions.
2. Review current medical practices to ensure clinical protocols are implemented and that KHS medical personnel adhere to established professional standards and rules of conduct.
3. Ensure assigned members receive appropriate healthcare services and medical attention across all service locations.

4. Ensure that medical care delivered by participating practitioners meets applicable professional standards for acceptable medical practice.

B. Quality Improvement Department (QI)

Quality Improvement Director

Under the direction of the Chief Medical Officer (CMO) and the Quality Improvement Medical Director, the Director of Quality Improvement is responsible for the development, implementation, and oversight of Quality Improvement (QI) initiatives that improve health outcomes and address health disparities among the KHS membership. The Director ensures alignment with the KHS QIHEP, Medi-Cal contractual requirements, and National Committee for Quality Assurance (NCQA) accreditation standards, while promoting a culture of continuous improvement across the organization.

Key responsibilities:

- QI Program Development: Develops and implements quality improvement initiatives aligned with KHS quality and health equity priorities, regulatory standards, and contractual obligations.
- Performance Monitoring & Reporting: Oversees data collection, medical record review activities, and performance monitoring to evaluate key quality indicators and inform improvement strategies.
- Provider & Community Collaboration: Engages contracted providers and community partners to support quality improvement initiatives, address disparities, and improve member health outcomes.
- Regulatory Compliance & Accreditation: Ensures compliance with Medi-Cal quality requirements and supports organizational readiness for regulatory reviews and accreditation activities.
- Interdepartmental Coordination: Facilitates collaboration across KHS departments and external partners to integrate quality improvement activities into operational workflows.
- Leadership & Workforce Development: Provides leadership, mentorship, and guidance to QI staff while supporting professional development and alignment with KHS quality and health equity objectives.

The Director of QI plays a central role in identifying disparities, implementing targeted interventions, and improving healthcare quality across the KHS provider network.

NCQA Manager

Under the direction of the Director of Quality Improvement, the NCQA Manager oversees activities that support the organization's NCQA accreditation and ensures alignment with state regulatory requirements related to the Quality Improvement Program. This role leads organizational efforts related to initial accreditation and reaccreditation activities and supports ongoing compliance with NCQA standards and contractual quality requirements.

Key responsibilities

- Accreditation & Regulatory Compliance: Leads the development, coordination, and implementation of policies and processes required to meet NCQA standards and Medi-Cal quality requirements.
- Quality Program Integration: Ensures NCQA standards and regulatory requirements are incorporated into organizational quality improvement processes.
- Policy and Process Development: Oversees development and revision of accreditation-related policies and procedures and coordinates updates based on regulatory guidance.
- Cross Department Collaboration: Works with KHS leadership and operational departments to embed quality improvement activities into organizational processes.

The NCQA Manager supports the organization's commitment to regulatory compliance, accreditation readiness, and continuous quality improvement.

NCQA Accreditation Specialist

Under the direction of the NCQA Manager, the NCQA Accreditation Specialist supports planning, coordination, and maintenance of NCQA Health Plan Accreditation and Health Equity Accreditation activities at KHS. This role assists with accreditation readiness and coordinates cross-departmental activities required to maintain compliance with NCQA standards.

Key responsibilities

- Accreditation Readiness and Compliance: Supports accreditation preparation activities and ensures documentation and processes align with NCQA standards and regulatory requirements.
- Process Coordination and Monitoring: Coordinates cross departmental activities related to accreditation work plans and monitors progress toward compliance milestones.
- Quality and Performance Support: Supports quality improvement initiatives that contribute to improved clinical performance and member experience.

The NCQA Accreditation Specialist supports the organization's efforts to maintain accreditation readiness and advance equitable and high quality care.

Quality Improvement Manager, RN

Under the direction of the Director of Quality Improvement, the Quality Improvement Manager ensures regulatory, contractual, and accreditation compliance for the QI Program.

Key responsibilities

- Regulatory and Audit Oversight: Manages delegation audits and external quality reviews to ensure compliance with Medi-Cal contractual and regulatory requirements.
- Quality Improvement Initiatives: Leads Performance Improvement Projects (PIPs), improvement plans, and other targeted quality initiatives designed to improve clinical outcomes and care delivery.
- Operational Leadership: Provides clinical and operational oversight for QI activities and supports implementation of data driven improvement strategies.

The QI Manager plays an important role in advancing quality improvement activities and supporting equitable, high quality care delivery.

Quality Improvement Supervisor, RN

The Quality Improvement Supervisor, RN oversees the daily operations of clinical and non clinical staff within the Quality Improvement Department. Responsibilities include oversight of clinical grievances, Potential Quality Issues (PQIs), Performance Improvement Projects (PIPs), and other quality initiatives.

The QI Supervisor provides leadership, guidance, and oversight to ensure compliance with regulatory requirements and supports implementation of quality improvement activities. The Supervisor collaborates closely with the QI Manager to optimize workflows, improve operational efficiency, and support department performance goals.

Quality Improvement Nurse, RN

The Quality Improvement Nurse supports clinical activities related to monitoring, evaluating, and improving healthcare delivery for KHS members in both ambulatory and inpatient settings. The QI Nurse assists with implementation of the QI Program through the following activities:

- Communicates with contracted providers regarding quality studies and audit findings
- Provides provider and member education related to quality improvement initiatives
- Conducts medical record reviews, audits, and HEDIS or HEDIS like chart reviews
- Investigates potential quality of care concerns and member grievances and prepares clinical summaries for Medical Director review
- Assists with development and monitoring of provider corrective action plans related to quality of care concerns or regulatory noncompliance
- Participates in performance improvement projects designed to improve preventive care and clinical outcomes

Quality Improvement Coordinator

Reporting to the Quality Improvement Manager, the Quality Improvement Coordinator supports data collection, documentation management, and regulatory compliance activities for the QI Program.

Key responsibilities

- Data Collection and Reporting: Supports Managed Care Accountability Set (MCAS) reporting, data tracking, and documentation of QI activities.
- Regulatory and Compliance Support: Assists with medical record requests, documentation preparation, and quality interventions in support of regulatory reviews and audits.
- Provider Site Review Support: Provides administrative coordination for facility site reviews and supports collaboration with internal departments and external partners involved in quality improvement initiatives.

The QI Coordinator supports the operational activities of the QI Program and contributes to implementation of data driven quality improvement and health equity initiatives.

C. Quality Performance Department (QP)

Senior Director of Contracting and Quality Performance

Under the direction of the Chief Operating Officer (COO) and Chief Medical Officer (CMO), the Senior Director of Contracting and Quality Performance oversees provider contracting, quality performance programs, and practice transformation initiatives at KHS. This position ensures provider agreements, value-based care initiatives, and quality improvement activities align with regulatory requirements, contractual obligations, and organizational strategic goals.

Key responsibilities

- Provider Contracting and Compliance: Develops and negotiates provider contracts and ensures compliance with regulatory requirements, contractual obligations, and organizational risk management standards.
- Quality and Performance Management: Oversees Pay-for-Performance (P4P) initiatives, Managed Care Accountability Set (MCAS) reporting, and provider quality improvement activities to improve clinical performance and provider engagement.
- Practice Transformation and Value-Based Care: Supports providers in transitioning to value-based care models through data analytics, performance reporting, and practice transformation initiatives.
- Provider Network Performance and Financial Oversight: Leads process improvement initiatives, rate development, and oversight of provider incentive and special funding programs.
- Credentialing and Compliance Coordination: Ensures facility site review processes, credentialing standards, and provider compliance with contractual and regulatory requirements.

The Senior Director plays a key role in strengthening provider network performance, improving quality outcomes, and supporting equitable access to high-quality care for KHS members.

Director of Quality Performance

Under the direction of the Senior Director of Contracting and Quality Performance, the Director of Quality Performance oversees the implementation and management of quality performance initiatives for the KHS provider network and membership. This includes oversight of HEDIS and Medi-Cal Managed Care Accountability Set (MCAS) activities and collaboration with providers to improve performance on quality measures.

The Director also oversees quality initiatives related to Performance Improvement Projects (PIPs), Facility Site Reviews (FSRs), and provider engagement activities. Responsibilities include coordinating with contracted providers on required studies, improvement initiatives, and quality reporting activities.

Key Responsibilities

- Develop and maintain collaborative relationships with internal departments and external provider partners.
- Support provider practice transformation efforts to improve value-based care performance, encounter data submission, and quality outcomes.
- Provide providers with performance feedback through scorecards, gap-in-care reports, risk reports, and satisfaction results.
- Monitor quality improvement activities and ensure timely completion of required reports and analyses.
- Evaluate program performance and identify opportunities for improvement.
- Provide leadership and oversight for Quality Performance staff and departmental processes.
- Develop physician performance profiling related to HEDIS, MCAS, and other quality metrics.
- Maintain tracking systems for quality improvement initiatives and regulatory reporting requirements.
- Monitor HEDIS and MCAS performance and identify barriers and improvement opportunities.
- Ensure staff maintain current knowledge of DHCS and DMHC regulatory requirements and quality measure specifications.
- Participate in development and revision of departmental policies and procedures.
- Coordinate quality performance activities with Utilization Management, Quality Improvement, Pharmacy, and Population Health Management departments.
- Support provider education related to HEDIS, MCAS, and quality program goals.
- Ensure compliance with applicable regulatory reporting and quality monitoring requirements.

Quality Performance Manager

The Quality Performance Manager oversees daily operations of MCAS and HEDIS activities, quality improvement projects, and departmental productivity. The Manager supervises MCAS and HEDIS staff and works closely with the Director of Quality Performance to ensure compliance with regulatory and contractual quality requirements.
Key responsibilities

- Maintain expertise in MCAS, HEDIS, and related quality measurement specifications.
- Lead planning and implementation of initiatives designed to improve quality performance.
- Serve as a key contributor to the annual HEDIS audit process.
- Develop programs that promote member engagement, improve health outcomes, and enhance member satisfaction.
- Support development of departmental policies, procedures, and program documentation.
- Provide staff training related to quality improvement processes and regulatory requirements.
- Collaborate with senior leadership to support communication with the provider network and other stakeholders.

Quality Performance Supervisor

The Quality Performance Supervisor oversees the daily operations of the KHS facility site review team. The Supervisor maintains certification as a DHCS Master Trainer for site reviews and has experience in quality improvement or healthcare operations.
Under the direction of the Director, the Supervisor plans, coordinates, and monitors quality special programs, including:

- DHCS facility site review requirements
- Department strategic goals and special quality programs related to provider site reviews and education

Quality Performance Nurse, RN

Quality Performance Nurses maintain a valid California Registered Nurse license and possess clinical experience in acute care or related healthcare settings. These nurses support implementation of the Quality Improvement Program and Work Plan through ongoing quality monitoring activities.
Primary responsibilities include supporting MCAS performance activities and the KHS facility site review program. QP Nurses also educate contracted providers on DHCS Managed Care Division standards and KHS policies and procedures to support regulatory compliance.

Quality Performance Operations Analyst

The Quality Performance Operations Analyst supports reporting and data management activities related to MCAS and facility site review programs. The Analyst serves as a subject matter expert for MCAS and HEDIS components of the KHS Quality Program.

Under the direction of the Director and Supervisor, the Analyst oversees validation and submission of data required for the annual DHCS MCAS and HEDIS audits. This role also serves as a liaison between the Quality Performance Department, vendors, and internal departments such as Information Technology.

Quality Performance Coordinator

Quality Performance Coordinators support operational activities related to data collection, data entry, report preparation, and documentation management for quality performance initiatives.

Under the direction of the Director or Supervisor, Coordinators assist with medical record retrieval, scheduling, provider outreach, and regulatory reporting activities. Coordinators also support MCAS data collection, medical record review activities, and other departmental quality improvement initiatives.

D. Health Equity Department

Chief Health Equity Officer (CHEO)

The Chief Health Equity Officer (CHEO) is responsible for the strategic leadership, development, implementation, and oversight of health equity initiatives across KHS. The CHEO oversees the development, implementation, evaluation, and revision of health equity policies, procedures, and programs that support the QIHEP.

The CHEO maintains the QIHEP Program Description and Work Plan, coordinates implementation activities, and ensures appropriate reporting to the EQIHEC. The CHEO serves as the primary liaison between KHS and regulatory agencies on health equity programs and initiatives.

The CHEO serves as a member of the EQIHEC and provides a health equity perspective for non-clinical areas of the organization. This position may not be delegated. The CHEO also ensures that health equity principles are integrated into organizational practices, including member engagement, marketing, member services, community partnerships, and community support programs.

Health Equity Manager

The Health Equity Manager is responsible for the day-to-day management and operational implementation of the QIHEP. This position oversees development and implementation of health equity initiatives, programs, and interventions designed to improve the delivery and quality of culturally and linguistically appropriate services for KHS members.

The Health Equity Manager supervises staff within the Health Equity Office (HEO) and supports operational activities including project management, process improvement initiatives, contract implementation, and performance monitoring related to health equity activities.

Senior Health Equity Analyst

The Senior Health Equity Analyst provides data analytics, reporting, project management support, and operational analysis for the Health Equity Office. This position supports the collection, validation, analysis, and interpretation of data related to health equity initiatives and organizational performance.

The Senior Health Equity Analyst works to identify disparities, operational gaps, and improvement opportunities through structured analysis of program data and stakeholder needs. The Analyst assists in defining analytical and reporting requirements for QIHEP initiatives and activities of the Health Equity Transformation Steering Committee (HETSC). The position may also facilitate analytical discussions and data interpretation activities across internal departments and external partners.

Health Equity Project Coordinator

The Health Equity Project Coordinator supports the coordination and implementation of projects and initiatives managed by the Health Equity Office. This position assists with project planning, scheduling, and tracking of health equity initiatives to ensure activities are completed within established timelines.

The Health Equity Project Coordinator also provides administrative and operational support for the EQIHEC and associated subcommittees, including coordination of meeting logistics, documentation, and reporting activities.

E. Appeals and Grievances

Member Grievance and Appeals System

KHS maintains a Member Grievance and Appeals system that complies with applicable federal and state regulatory requirements, including 42 Code of Federal Regulations (CFR) Sections 438.228 and 438.400–438.424, Title 28 California Code of Regulations (CCR) Sections 1300.68 and 1300.68.01, and Title 22 CCR Section 53858.

KHS utilizes all applicable notice templates included in DHCS All Plan Letter (APL) 21-011 and ensures that members receive timely written acknowledgment of grievances and appeals, as well as written notice of resolution within required regulatory timeframes.

Grievances that involve a Potential Quality Issue (PQI) are referred to the Quality Improvement (QI) Department for further investigation and follow-up. All potential quality of care concerns are reviewed by the Chief Medical Officer (CMO) or designee to determine the severity level and appropriate follow-up actions.

All PQI cases are tracked and incorporated into provider monitoring activities and may be reviewed during the

provider credentialing and recredentialing process. Additional actions may include tracking and trending providers for repeated PQIs and requesting corrective action plans (CAPs) when quality concerns are identified. When appropriate, the CMO or designee may present cases to the Physician Advisory Committee (PAC) for further review and recommendations.

KHS regularly analyzes grievance and appeals data to identify trends related to healthcare access, quality of care, and service delivery. Findings from grievance and appeal analyses are used to inform quality improvement activities and corrective actions when necessary.

Grievance Satisfaction Data

KHS also reviews member grievance trends and satisfaction survey results to identify potential patient safety issues and opportunities to improve member experience and quality of care.

F. Credentialing

The Credentialing Department operates under the direction of the Deputy Director of Contracting and Quality Performance, who reports to the Chief Operating Officer (COO) and is responsible for Provider Operations. Responsibilities include oversight of credentialing staff activities and credentialing processes for directly contracted practitioners, providers, and delegated Independent Practice Associations (IPAs).

The Chief Medical Officer (CMO), or the Medical Director designee, maintains overall clinical oversight of the credentialing program. The CMO participates in the development and review of the credentialing program, credentialing processes, and credentialing policies and procedures. The CMO or designee reviews and approves practitioner and provider credentialing and recredentialing files and reports credentialing actions to the Board of Directors.

Provider Operations includes Provider Contracting, Provider Network Management, Provider Relations, and Provider Training and Development. These functions support the development and maintenance of a culturally competent and linguistically accessible provider network that reflects the diversity of the KHS membership and is responsive to members' cultural practices and beliefs.

Provider Operations also contributes to the QIHEP by supporting initiatives that identify, assess, and address disparities in healthcare access and delivery. This includes analysis of provider demographic and profile data to help ensure alignment between the provider network and the cultural and linguistic needs of KHS members.

G. Member Services

KHS implements and maintains written policies and procedures that define member rights and responsibilities.

These policies are communicated to KHS members, providers, and prospective members upon request. KHS ensures that members are informed of their rights, including the right to confidentiality of personal health information, the right to establish advance directives, and the right to receive language assistance services and culturally appropriate communications. Member Services supports the QIHEP by assisting members with access to care, responding to member inquiries, and facilitating communication between members, providers, and KHS departments.

H. Pharmacy Department

The Pharmacy Department supports the QIHEP through medication safety monitoring, provider outreach, and collaboration with interdisciplinary teams to promote safe and effective medication use for KHS members.

Medication Safety Monitoring

KHS conducts ongoing monitoring of medication utilization to promote safe prescribing practices and reduce the risk of adverse drug events. The Pharmacy Department reviews pharmacy claims and prescribing patterns to identify potentially inappropriate medication use and opportunities for intervention.

Safety monitoring activities include:

- Monitoring opioid prescribing patterns, including high-dose opioid therapy, concurrent opioid and central nervous system depressant use (such as benzodiazepines or muscle relaxants), and members receiving opioids without naloxone. These activities align with federal opioid safety initiatives, including provisions of the SUPPORT Act.
- Conducting retrospective review of medications identified on the Beers Criteria for potentially inappropriate medication use among geriatric members.
- Monitoring and responding to drug recalls issued by the U.S. Food and Drug Administration (FDA) or pharmaceutical manufacturers.

When potential medication safety concerns are identified, KHS sends notification letters to the prescribing provider requesting evaluation of the medication regimen for clinical appropriateness.

Provider Collaboration and Interdisciplinary Review

The Director of Pharmacy, or designee, participates in interdisciplinary care review meetings to evaluate medication regimens for select members and identify opportunities for improved medication management. KHS also provides targeted communication to providers regarding member medication profiles when potential issues such as therapeutic duplication, drug interactions, or missing therapies are identified.

Quality Performance and Gap Closure

The Pharmacy Department supports quality performance initiatives by developing and maintaining reporting tools that identify members who may be non-compliant with quality measures related to medication adherence or pharmacy-related HEDIS and Medi-Cal Managed Care Accountability Set (MCAS) measures. These reports are used to support collaboration with internal departments and community pharmacies to conduct outreach to members and providers, improve medication adherence, and close identified care gaps.

I. Population Health Department (PHM)

The KHS Population Health Management (PHM) Department supports whole-person care by integrating and analyzing administrative, medical, behavioral health, dental, social service, and program data from multiple sources. This integrated approach enables risk stratification, population segmentation, tiering, screening and assessment processes, data analytics, and performance reporting.

Through the transformation of data into actionable insights, PHM identifies opportunities for continuous quality improvement and supports informed decision making. These efforts allow KHS to connect members with the appropriate services and supports at the right time and in the appropriate care setting based on their needs and preferences.

PHM also facilitates engagement with network providers, public health agencies, schools, and community-based organizations (CBOs) to strengthen data sharing across the healthcare delivery system. These partnerships support care coordination and help identify and address social determinants of health (SDOH) that contribute to health disparities.

Through these collaborative efforts, KHS works to ensure members are connected to primary care providers, preventive and wellness services, disease management programs, and other appropriate healthcare services. Members identified as having complex health needs are connected to specialized services and care management programs.

PHM collects, analyzes, and shares timely member data to identify opportunities for intervention and improvement. These activities include predictive analytics, identification of care gaps, standardized assessments, and risk stratification processes. This approach allows KHS to proactively identify members with rising health risks and implement targeted interventions to improve health outcomes and reduce disparities.

PHM activities also support identification and management of members with diverse health and social needs, including behavioral health, developmental health, physical health, and oral health needs. This includes members requiring Long-Term Services and Supports (LTSS), as well as members experiencing health-related social needs associated with social determinants of health (SDOH).

Findings from the Population Needs Assessment (PNA) inform PHM strategies and interventions designed to address identified gaps in care and improve the overall health of the KHS membership. Through these efforts, KHS remains committed to delivering comprehensive, coordinated, and equitable care across its service areas.

J. Human Resources Department

The KHS Human Resources Department supports the organization's commitment to diversity, equity, and inclusion within the workforce. The department includes Talent Acquisition, Employee Relations, Benefits and Wellness Programming, and Learning and Professional Development. Human Resources implements equitable and accessible recruiting, hiring, onboarding, professional development, and succession planning practices designed to support and sustain a diverse workforce.

To strengthen cultural and linguistic competency across the organization, the Human Resources Department promotes a culture of trust, empathy, and cultural humility. Through training, policy development, and leadership engagement, the department supports employees in developing a deeper understanding of cultural and linguistic diversity in their daily work. Human Resources also works to ensure policies and leadership practices support diversity, equity, and inclusion while remaining compliant with regulatory requirements, aligned with organizational values, and reflective of industry best practices. These efforts help ensure KHS remains responsive to the needs of employees, members, and the communities it serves.

1. Hiring Initiatives

As described in the KHS Diversity, Equity, and Inclusion (DEI) Program Charter, KHS is committed to building a workforce that is diverse, qualified, and engaged, and that reflects the diversity of the communities served throughout Kern County. KHS strives to maintain a workplace environment that is safe, inclusive, and strengths-based, providing opportunities for employees of all backgrounds, cultures, and linguistic abilities to contribute and succeed.

Human Resources and hiring managers are responsible for ensuring that recruiting, hiring, and succession planning practices promote inclusion and reflect the demographic needs of the communities served.

Health equity considerations in hiring and recruitment include:

- Posting job opportunities using inclusive language across a broad network of recruitment platforms and diversity-focused job boards.
- Incorporating inclusive language into job descriptions and position announcements.
- Conducting panel interviews that reflect community diversity.
- Utilizing standardized assessment tools to support equitable hiring practices.

These practices help ensure KHS maintains a workforce capable of delivering culturally responsive services to its diverse membership.

2. KHS Bilingual Workforce

Several KHS departments employ staff members who provide linguistic services to members, including Behavioral Health, Wellness and Prevention, Marketing, Member Engagement, Member Services, Utilization Management, Population Health Management, Enhanced Care Management, Community Support Services, Quality Improvement, and Pharmacy.

All bilingual staff must pass a verbal bilingual proficiency assessment either prior to hire or during employment. Certificates of linguistic proficiency are maintained and monitored by the Cultural and Linguistic Services team. Copies of bilingual certification documentation are maintained in the employee's personnel file by Human Resources.

KHS defines qualified bilingual staff as individuals who:

- Demonstrate proficiency in speaking and understanding a language other than English.
- Possess working knowledge of specialized vocabulary, terminology, and concepts required to communicate effectively in healthcare settings.
- Are able to communicate directly, accurately, and impartially with members who have limited English proficiency (LEP).

Member Services bilingual representatives provide oral interpretation services only. These staff are not permitted to provide written translation services, including editing or proofreading translated documents, or to perform sight translation.

K. Provider Network Management (PNM)

The Provider Network Management (PNM) Department is responsible for recruitment, management, and monitoring of the KHS provider network. The department includes Provider Relations, Provider Network Analytics, Provider Engagement, Grants and Special Programs, and the Homeless Management Information System (HMIS).

The Senior Director of Provider Network leads the PNM Department. The Deputy Director of Provider Network oversees Provider Relations, Provider Network Analytics, and Provider Engagement, and reports to the Senior Director. The Deputy Director of Grants and Special Programs oversees Grants and Special Programs and HMIS operations and also reports to the Senior Director of Provider Network.

Provider Relations

The Provider Relations Team consists of a Provider Relations Manager, two Provider Relations Supervisors, and eight Provider Relations Representatives. Provider Relations Representatives serve as the primary liaison between KHS and network providers. Responsibilities include provider onboarding, maintaining provider relationships, and addressing provider inquiries and operational issues. The team supports effective communication between KHS and contracted providers and assists providers in navigating plan policies, procedures, and operational requirements.

Provider Network Analytics

The Provider Network Analytics Team includes the Provider Network Analytics Program Manager and two Provider Network Analysts. This team is responsible for monitoring network accessibility and supporting regulatory reporting requirements, including Department of Managed Health Care (DMHC) Timely Access reporting, DMHC Annual Network Review, and Department of Health Care Services (DHCS) Annual Network Certification. The team also collaborates with the KHS Credentialing Department to maintain the accuracy of the provider directory.

Provider Engagement

The Provider Engagement Team consists of the Provider Engagement Manager, two Provider Network Specialists, and one Provider Network Coordinator. The team supports provider recruitment activities, maintains relationships with Enhanced Care Management (ECM) and Community Supports (CS) providers, and coordinates provider education and engagement initiatives. Responsibilities include development of provider training materials, coordination of provider outreach activities, and administration of the Provider Satisfaction Survey.

Grants and Special Programs

The Grants Team develops and administers grant programs designed to support innovative initiatives that improve access to care and strengthen community-based services. The team identifies providers who may qualify for grant funding and manages grant program milestones, monitoring, and reporting activities. These grant initiatives help support provider capacity and encourage innovative programs that benefit the communities served by KHS.

Homeless Management Information System (HMIS)

The HMIS Team consists of the Homeless Services Manager and a Provider Network Representative for Special Projects. As the HMIS Administrator, the team oversees configuration, data quality, and daily operations of the Homeless Management Information System to ensure compliance with U.S. Department of Housing and Urban Development (HUD) standards and Continuum of Care (CoC) policies. The team provides training, technical assistance, and ongoing support to participating agencies to promote accurate, consistent, and timely data entry. HMIS data are analyzed to support performance monitoring, reporting, and strategic planning efforts that strengthen

the community's response to homelessness.

Network Accessibility Monitoring

Provider network accessibility is primarily monitored through the Provider Network Management Quarterly Network Review. The review includes, but is not limited to:

- Access grievance review
- Provider Accessibility Monitoring Survey
- Geographic accessibility review
- Network adequacy and provider count analysis

These reports evaluate compliance with regulatory standards including:

- Primary Care Provider-to-member ratios
- Physician-to-member ratios
- Appointment availability standards
- Provider response times
- After-hours provider availability
- In-office wait times

The Provider Network Analytics Team also monitors members' geographic access to primary care providers, specialists, non-physician mental health providers, specialty obstetric/gynecology providers, and hospitals to ensure compliance with regulatory access standards. If regulatory standards are not met for a specific provider type or geographic region, the Provider Network Analytics Team may request an Alternative Access Standard and coordinate with recruitment teams to identify providers for contracting and network expansion. The Provider Network Analytics Team also reviews access grievance data to identify trends involving specific providers, provider groups, or specialties that may indicate ongoing access issues.

Governance and Reporting

The Provider Network Department hosts the Network Adequacy Committee (NAC) on a quarterly basis. During these meetings, access monitoring reports and network adequacy data are reviewed by executive leadership and senior directors. Committee findings and recommendations are reported to the EQIHEC to support oversight of network access, availability, and quality improvement activities.

L. Utilization Management Department (UM)

Please refer to the Utilization Management Program (UMP) Description for detailed information regarding Utilization Management (UM) activities. The UMP is a formal document supported by clinical, operational, and administrative policies and procedures that define how UM functions are implemented and monitored.

The UMP and associated policies and procedures are developed and maintained to ensure compliance with applicable federal and state regulatory requirements, including the California Health and Safety Code, Title 22 of the California Code of Regulations, the California Welfare and Institutions Code, the Centers for Medicare and Medicaid Services (CMS) Code of Federal Regulations, the Department of Health Care Services (DHCS) Medi-Cal Managed Care Contract provisions, and current National Committee for Quality Assurance (NCQA) Standards and Guidelines. UM activities support appropriate utilization of healthcare services and coordination of care for KHS members in alignment with regulatory requirements and organizational quality improvement objectives.

M. Behavioral Health Department (BH)

KHS is responsible for administering and managing behavioral health (BH) and substance use disorder (SUD) services for its members in accordance with Medi-Cal managed care requirements.

Mental Health Services

KHS provides behavioral health services for members with mild to moderate behavioral health conditions, also referred to as non-specialty mental health services. Members requiring Specialty Mental Health Services, including those with severe mental health conditions, are referred to and managed by the Kern County Medi-Cal Behavioral Health Plan, administered by the Kern Behavioral Health and Recovery Services Department.

Substance Use Disorder Services

KHS provides Screening, Brief Intervention, and Referral to Treatment (SBIRT) services to identify members at risk for substance use disorders. Members requiring treatment for alcohol or substance misuse are referred to certified Drug Medi-Cal Organized Delivery System (DMC-ODS) providers for appropriate treatment services.

Behavioral Health Treatment for Children

KHS covers Behavioral Health Treatment (BHT) services for Medi-Cal beneficiaries under the age of 21. Covered services include Applied Behavior Analysis (ABA) and other evidence-based behavioral interventions designed to support children with developmental or behavioral conditions.

Through these services, the Behavioral Health Department works to ensure that behavioral health and substance use disorder services are accessible, appropriate to the member's level of need, and coordinated with county behavioral health programs and community resources. These efforts support continuity of care, quality service delivery, and improved health outcomes for KHS members.

N. Wellness and Prevention Department

Please refer to the Cultural and Linguistic Services Program Description and the Health Education Program Description for detailed information regarding Cultural and Linguistic (C&L) and Health Education (HE) activities and related wellness and prevention initiatives. The Wellness and Prevention Department is responsible for providing comprehensive, culturally and linguistically appropriate wellness and prevention services designed to promote healthy behaviors, improve health outcomes, reduce risk for disease, and empower members to actively participate in their health care. The department also ensures members have access to quality language assistance services to effectively communicate with their health care providers. The Wellness and Prevention Department is led by the Senior Director of Wellness and Prevention and consists of three teams.

Cultural and Linguistic Services

The Cultural and Linguistic Services team consists of a Manager, Cultural and Linguistic Specialists, and a Cultural and Linguistic Coordinator. This team ensures that KHS members have access to culturally and linguistically appropriate services that improve access to care and health outcomes.

Services include, but are not limited to:

- Language interpretation services
- Translation of written member materials
- Cultural competency training and education for staff, providers, and contracted vendors
- Monitoring and evaluation of cultural and linguistic services provided by KHS, network providers, and contracted vendors

These activities help ensure that services are accessible to members with limited English proficiency and that communication barriers are minimized.

Member Wellness and Prevention

The Member Wellness and Prevention team consists of a Manager, Supervisor, Health Educators, Program Specialists, Lifestyle Coaches, and Health Education Assistants. This team develops and implements health

education, wellness, and prevention programs using evidence-based approaches. Services are delivered directly to members or through partnerships with community organizations and may include:

- One-on-one coaching
- Group classes and workshops
- Written health education materials such as newsletters and brochures
- Community outreach activities

The team collaborates with providers to enhance provider–member communication and increase awareness of members' health education needs. Member Wellness and Prevention is also responsible for oversight of readability and suitability standards for member materials, management of member incentive programs, and development of community-based health and wellness initiatives that promote health literacy and disease prevention among vulnerable populations in Kern County.

Wellness and Prevention Partnerships

The Wellness and Prevention Partnerships team consists of a Manager, Program Manager, and Program Liaisons. This team establishes and maintains partnerships with community organizations and providers to expand access to preventive services. Community partners include organizations such as local public health departments and Women, Infants, and Children (WIC) programs.

Responsibilities include:

- Promoting preventive service benefits among providers and community partners
- Supporting outreach activities that expand access to wellness and prevention programs
- Administering Community Health Worker services and Asthma Preventive Services programs
- Supporting initiatives related to the Population Needs Assessment (PNA)

Regulatory Compliance

KHS is committed to delivering culturally and linguistically appropriate health care services. Cultural and linguistic services are provided in compliance with applicable federal and state regulations, including Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act, 42 CFR §438.10, Medi-Cal Managed Care Contract requirements issued by the Department of Health Care Services (DHCS), and DHCS All Plan Letter 21-004.

The Senior Director of Wellness and Prevention serves as a standing member of the EQIHEC to ensure the integration of wellness, prevention, and cultural and linguistic initiatives within the Quality Improvement Health Equity Program.

O. Enhanced Care Management Department (ECM)

Please refer to the Enhanced Care Management Program Description for detailed information regarding Enhanced Care Management activities and program operations.

P. Community Support Services (CSS) Department

Please refer to the Community Support Services Program Description for detailed information regarding Community Support Services activities and related program operations.

Q. Business Intelligence (BI)

The Business Intelligence (BI) department supports the Quality Improvement Health Equity Program by providing advanced analytics, reporting, and data governance to inform organizational decision making and performance monitoring. BI establishes advanced health analytics capabilities to ensure leadership has comprehensive visibility into population health trends, enabling improvements in the individual experience of care, overall population health outcomes, and the cost of care.

The department is responsible for creating, managing, and continuously improving corporate Key Performance Indicators (KPIs) that support organizational goals and regulatory requirements. BI also works to reduce operational silos by providing integrated data insights that support proactive management and continuous operational improvement across departments.

BI provides and validates standardized metrics and reporting related to process improvement initiatives to ensure that project goals, objectives, and return on investment are achieved. In addition, the department establishes data governance practices across organizational systems to ensure that reliable, accurate data can be used for analytics and reporting purposes.

The department manages the organization's inventory of operational and regulatory reports and supports reporting requirements across multiple departments. BI also participates in the annual HEDIS audit process and supports routine HEDIS reporting needs, including maintenance of reporting dashboards, production of routine reports, and implementation of annual HEDIS technical specifications.

R. Information System & Data Management

KHS utilizes information provided through the Information Technology (IT), Operations, and Provider Network Management departments to support program oversight, operational management, and regulatory reporting. The

KHS Management Information System (MIS) has the capability to capture, edit, and utilize various data elements for both internal management purposes and to meet data quality and timeliness requirements. These capabilities include the collection and submission of encounter data, network provider data, program data, and required reporting templates to the Department of Health Care Services (DHCS). The MIS also supports Population Health Management data integration requirements and has the capacity to provide requested data to DHCS and the Centers for Medicare and Medicaid Services (CMS) as required.

The KHS Information Technology Division, which includes Data Analytics, Information Security, Technical Support Services, and Operational Systems, follows culturally and linguistically appropriate business practices as established by KHS leadership and Human Resources. The IT Division supports the implementation of new technologies and enhancement of existing systems to ensure that staff are able to perform their work in an accessible and culturally competent environment. This includes providing technologies and tools that comply with Americans with Disabilities Act (ADA) standards, assistive technologies, and website accessibility requirements.

The Data Analytics function supports the organization's Quality Improvement Health Equity operational initiatives by collecting, storing, and analyzing demographic data and profiles for both KHS members and providers. These activities include conducting statistical analyses and supporting the development and administration of assessments and surveys used to inform quality improvement and health equity initiatives.

KHS MIS has the capacity to enable interoperability for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks to support coordinated care and data sharing across the health care delivery system.

The MIS supports a wide range of operational and program data necessary for the administration and oversight of the Quality Improvement Health Equity Program. These include Medi-Cal eligibility data; enrollment information for members served by KHS; provider claims status and payment data; health care service delivery encounter data; network provider information; program and reporting data; screening and assessment data; referrals and tracking of referred services to confirm that services were rendered; electronic health record data; prior authorization requests and specialty referral tracking; care management and care coordination information; financial data; social drivers of health information; and grievance and appeal data used to monitor member experience and access to care.

S. Marketing

The Marketing Department operates under the direction of the Senior Director of Marketing, who reports to the CHEO. The department is responsible for conducting product and market research to support the development and implementation of marketing strategies and member communication plans across all KHS products. These activities include the development and dissemination of member-facing materials such as member newsletters, the Evidence of Coverage, website content, and other communication resources.

The Marketing Department collaborates closely with the Quality Performance, Health Equity, and Wellness and Prevention Departments to ensure that member communications are developed and distributed in a timely manner and align with organizational goals related to quality, health equity, and member engagement. These coordinated efforts support clear communication with members and promote access to information regarding available benefits, services, and health programs.

V. Role of Participating Providers

A. 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 Performance** – KHS requires contracted providers to comply with DHCS' Managed Care Accountability Set (MCAS) and participate in quality-based initiatives aimed at improving, access, quality, and health equity for our members. Routine meetings are conducted with a subset of participating providers to ensure monitoring, communication, and supporting of achieving MPLs and maintaining high quality care.

B. 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 QIHEP activities, standards, and review system.
Provider contracts include provisions for the following:

a. An agreement to participate in the KHS QIHEP 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 QIHEP 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 QIHEP, 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 QIHEP 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 QIHEP, including access to applicable records and information.

C. Conflict of Interest

Network practitioners serving on any QI and Health Equity program-related committee, who are or were involved in the care of a member under review by the committee, are not allowed to participate in discussions and determinations regarding the case. Committee members cannot review cases involving family members, providers, or suppliers with whom they have a financial or contractual affiliation or other similar conflict of interest issues. All required employees and committee participants sign a Conflict-of-Interest statement on an annual basis. Fiscal and clinical interests are separated. KHS and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage, services, or care. There are no financial incentives for UM decision-makers that could encourage decisions that result in under-utilization.

Confidentiality Statement

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.

VI. Program Documents

A. Work Plan

The annual QIHEP Work Plan is designed to target specific QIHEP activities, projects, and tasks to be completed during the upcoming year, as well as the monitoring and investigation of previously identified issues. A focal activity for the Work Plan is the annual evaluation of the QIHEP, including accomplishments and impact on members. Evaluation and planning of the QIHEP are conducted 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 and Health Equity Departments on an annual basis and is presented to the 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 may occur through specific mailings or KHS Provider Bulletins to contracting providers.
- The activities in the QIHEP Work Plan are annually evaluated for effectiveness.
- QIHEP Work Plan responsibilities are assigned to appropriate individuals.

Components of the QIHEP Work Plan:

- Quality and Safety of Clinical Care
- Quality of Service
- Member and Provider Satisfaction
- Addressing Cultural, Ethnic, Racial, and Linguistic Needs of Members

B. Work Plan Evaluation

An annual evaluation of the QIHEP shall be prepared based on the activities presented to the EQIHEC during the calendar year. The EQIHEC reviews and approves the QIHEP evaluation. The QIHEP evaluation shall also be reviewed

by the Board of Directors (BOD). The Chief Health Equity Officer, with support from the Chief Medical Officer and/or Directors of Quality, will develop an evaluation of the QIHEP based on activities that were presented to the EQIHEC and BOD during the calendar year.

The QIHEP evaluation includes the following:

- A description of completed and ongoing quality improvement activities.
- Trended performance data from indicators to assess quality of care and service.
- An analysis of demonstrated improvements in care and service.
- A thorough evaluation of the program structure and effectiveness of the QIHEP, including progress toward influencing safe clinical practices throughout the network.
- Monitoring efforts of medical groups and other subcontractors to ensure that delegated functions meet cultural, linguistic, and sensitivity standards.
- Evaluation of patterns and trends for member grievances and discrimination complaints related to cultural, linguistic, and sensitivity issues.
- A thorough evaluation of progress on non-clinical goals (for example, Human Resources, Marketing, Member Engagement, Community Engagement).

KHS will also utilize the following methods to conduct ongoing monitoring and evaluation of its cultural competency and SPD awareness programs, as well as annual sensitivity, diversity, cultural competency, and health equity training for all staff, providers, subcontractors, and downstream subcontractors at key points of contact:

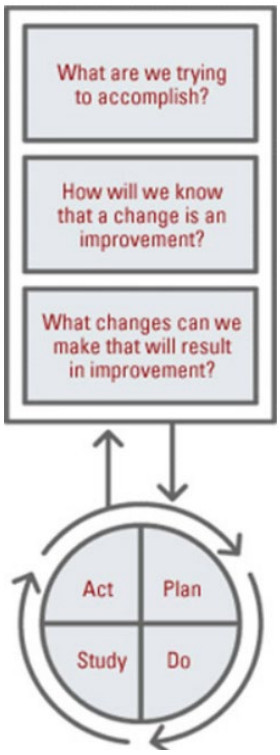
- Disenrollment data
- MCAS/HEDIS results by race, ethnicity, language, and other demographic factors
- Complaint and grievance reports
- Member satisfaction survey results by race, ethnicity, language, and other demographic factors
- Population Needs Assessment findings by race, ethnicity, language, and other demographic factors
- Performance Improvement Projects (PIPs)
- Health Education Activities Reports
- Training attendance reports, attestations of training completion, and/or completion of post-training quizzes

VII. Quality Improvement Processes

A. KHS Quality Improvement (QI) Initiatives

1. Plan-Do-Study-Act Cycle

The QIHEP quality activities and studies are developed using the Plan-Do-Study-Act (PDSA) model. The PDSA is an iterative, four-stage problem-solving model used for improving a process or carrying out change.



In accordance with the California Department of Health Care Services (DHCS) 2024 contract, KHS will conduct quality studies, quality review activities, results, and assessments and submit the outcomes in reports to DHCS at the reporting unit level and within the time frames directed by DHCS.

2. Data Collection Methodology

KHS collects and analyzes data from multiple internal and external sources to monitor the quality, safety, accessibility, and effectiveness of healthcare services provided to members. Data collection activities support the identification of trends, disparities, opportunities for improvement, and evaluation of quality improvement initiatives. Quality monitoring activities rely on multiple data sources including MCAS/HEDIS performance measures, member grievances and appeals, PQI investigations, facility site reviews, utilization data, member

satisfaction surveys, and External Quality Review reports. Data is obtained from administrative claims, encounter data, medical record reviews, member and provider surveys, regulatory reporting systems, and internal operational reports. These data sources are used to evaluate performance against established benchmarks, contractual requirements, and organizational goals.

Collected data are aggregated, validated, and analyzed by the Quality Improvement, Quality Performance, Business Intelligence, and other relevant departments to ensure accuracy and completeness. Results are reviewed by the EQIHEC and applicable subcommittees to identify trends, monitor progress toward quality improvement objectives, and determine appropriate interventions when opportunities for improvement are identified. Data collection activities also support monitoring of health disparities and identification of opportunities to improve equitable access to care and outcomes across the KHS membership.

3. Measurement Process

KHS systematically monitors and evaluates quality improvement initiatives to assess their effectiveness and compliance with internal policies and external regulatory requirements. Performance is reviewed at least quarterly, with benchmarks and standards derived from:

- Nationally recognized clinical guidelines
- Peer-reviewed research
- Regulatory and contractual requirements
- Internal trend analyses
- State and federal quality measures

KHS uses these metrics to assess accessibility, availability, and equity in healthcare services, ensuring that interventions align with best practices and community needs.

4. Evaluation Process

A comprehensive evaluation framework guides KHS in assessing the effectiveness of Quality Improvement (QI) initiatives. Both quantitative and qualitative methodologies are employed:

- Quantitative Analysis: Benchmark comparisons, trend assessments, and statistical testing are used to evaluate the impact of QI initiatives.
- Qualitative Analysis: Root cause and barrier analyses are conducted collaboratively with key stakeholders to understand systemic challenges and identify sustainable solutions.

Cross-departmental collaboration ensures that evaluation findings inform future quality initiatives, driving continuous improvement in health outcomes.

5. Communication and Feedback

KHS fosters a culture of transparency and engagement through proactive communication with internal teams and external partners, including providers and stakeholders. Key communication channels include:

- Internal Education and Engagement: Staff meetings, committee updates, and training sessions on QI initiatives.
- Provider Communication: Newsletters, targeted mailings, the KHS provider portal, and direct outreach via quality visits.
- Performance Feedback: Providers receive actionable insights, including:
    1. Member-specific service and intervention lists
    2. Clinical guideline recommendations
    3. Performance data from HEDIS, CAHPS, and other quality measures
    4. Recognition for quality improvement achievements
    5. Compliance feedback based on audits, grievances, and utilization trends.

These communications reinforce accountability and foster a collaborative approach to quality improvement.

6. Improvement Processes

Performance indicators are used to identify quality concerns and disparities in care delivery. When deficiencies are detected, KHS initiates corrective actions, which may include:

- Provider-level remediation plans (Corrective Action Plans - CAPs)
- Enhanced provider education and technical assistance
- Temporary restrictions on new member assignments for non-compliant providers
- Delegation oversight adjustments
- Contract terminations for persistent non-compliance

By integrating rigorous oversight, continuous evaluation, and data-driven decision-making, KHS ensures that quality improvement efforts translate into meaningful and sustainable healthcare enhancements for Medi-Cal members.

VIII. Quality Improvement Work Plan

A. Quality of Clinical Care

1. MCAS Measures

KHS is contractually required to submit data and measurement outcomes for specific health care measures identified by the Department of Health Care Services (DHCS). The measures are a combination of those selected by DHCS from the Healthcare Effectiveness Data and Information Set (HEDIS) library and the Core Measures set from the Centers for Medicare and Medicaid Services (CMS). An audit is performed by DHCS's EQRO and the licensed auditor for Department of Managed Health Care (DMHC) HEQMS requirements 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 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 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 at the 50th percentile or better for measurement year (MY) 2025. Results for the 2025 measures will be calculated and submitted in report year (RY) 2026. Please reference the table on page 22 for the list of MCAS measures.

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 notification 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 the Department of Health Care Services (DHCS), as outlined in their contract.

2. Performance Improvement Projects (PIPs)

KHS is mandated to participate in two (2) PIPs. These PIPs span an approximate 36-month time frame and are each divided 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 include annual submissions for three years from 2023 through 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, specifically the W30 measure for the 0–15 month African American population.

Non-Clinical PIP

The non-clinical PIP focuses on the FUA and FUM measures and relies heavily on support from the Behavioral Health Department for implementation of interventions. The Quality Performance Department will partner with the Behavioral Health Department, Utilization Management, Population Health Management, and other necessary stakeholders.

B. Safety of Clinical Care

1. Patient Safety Program

KHS recognizes that patient safety is a key component of delivering quality health care and focuses on promoting best practices aimed at improving patient safety. KHS engages members and providers to promote safety practices. KHS also focuses on reducing the risk of adverse events that can occur while providing medical care in different delivery settings. Some of the safety initiatives include:

1. Appropriate Medication Utilization
2. Review of Inpatient Admissions
    a. Readmissions
    b. Length of Stay
    c. Inappropriate Discharges
    d. Unexpected Mortalities
3. Provider Preventable Conditions (PPCs)
4. Potential Quality Issues (PQIs)
5. Initial Health Assessment Monitoring
6. Over-utilization and Under-utilization
7. Performance with healthcare outcomes and clinical processes
8. Adherence to clinical and preventive health guidelines
9. Effectiveness of chronic conditions, population health and care management programs

2. Potential Quality Issues (PQIs)

The QI Department reviews all Potential Quality Issues (PQIs) and adverse events involving practitioners and providers. Areas of review include primary and specialty care, hospitals, long-term care (LTC) facilities, skilled nursing facilities (SNF), and transportation providers. All identified PQIs are referred to the QI Department for investigation and evaluation, ensuring that timely and appropriate actions are taken to address potential concerns. The Medical Director oversees the process, ensuring alignment with recognized standards of care, evaluating all cases, and referring matters to the EQIHEC and/or Physician Advisory Committee for further assessment, as necessary.

3. Facility Site Review, Medical Record and Physical Accessibility Reviews

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 QP nurses review 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 reviews include an assessment for patient safety issues and sentinel events.
- Bloodborne pathogens and regulated wastes are handled according to established laws.

In collaboration with other Kern County health plans for site reviews, KHS coordinates reviews as described in APL 22-017, *Site Reviews: Facility Site Review and Medical Record Review*, and the applicable Memorandum of Understanding (MOU).

4. Credentialing and Recredentialing

KHS maintains a comprehensive pre-contractual and post-contractual assessment and monitoring system to ensure that contracting providers have the capacity and capability to perform required functions. The pre-contractual assessment requires providers seeking to contract with KHS to complete a detailed document covering key areas such as health care delivery systems, including clinical safety, access and waiting times, referral tracking,

medical records, and health education, as well as credentialing information.

Post-contractual monitoring includes ongoing evaluation to ensure continued compliance with contractual requirements, quality standards, and regulatory guidelines. Specific policies outline the standards, tools, and processes used to support these activities, ensuring accountability and quality in provider credentialing and recredentialing.

C. Quality of Service

1. Grievance and Appeals

KHS monitors performance areas affecting member experience. KHS has established categories and quantifiable standards to evaluate grievances received from members. All grievances are categorized into several different categories, including but not limited to the following: continuity of care, geographic access, language access, provider availability, timely access, discrimination, care coordination, and quality of care.

The organization's goal is to resolve all grievances within thirty (30) days of receipt. KHS grievance and appeals data are presented on a quarterly basis to the EQIHEC and PAC, as needed. KHS's goal is to maintain the overall complaint rate below thresholds established by regulatory agencies such as DHCS, DMHC, and CMS.

2. Access to Care

The Plan maintains ongoing monitoring efforts to ensure its network is able to provide appropriate access to health care services, in line with regulatory standards and member needs. The Plan's Provider Network Management department utilizes appointment availability surveys, capacity and adequacy analyses, grievance reviews, provider and member mapping, and other tools to conduct Plan monitoring. These efforts are presented to the Plan's Network Adequacy Committee (NAC) and EQIHEC on a quarterly basis. Areas monitored include, but are not limited to, appointment availability, access to after-hours care, time and distance (geographic) accessibility, provider type availability, and network capacity.

D. Member and Provider Satisfaction

Member Satisfaction

KHS conducts a comprehensive CAHPS survey and analysis annually to assess member satisfaction with the services and care received. CAHPS is a set of standardized surveys that ask health care consumers to report on and evaluate their care experience. The survey focuses on key areas such as getting needed care; getting appointments

with PCPs and Specialty Care Providers (SCPs); satisfaction with KHS and its practitioners; and other key areas of plan operations.

CAHPS surveys serve as a means to provide usable information about the quality of care received by members. KHS uses this tool as one of its key instruments to identify opportunities for improvement. As part of the annual evaluation, KHS reviews CAHPS results to identify relative strengths and weaknesses in performance, determine where improvement is needed, and track progress with interventions over time.

Provider Satisfaction

KHS monitors performance areas affecting provider satisfaction annually and submits the results to DHCS and CMS. This study assesses the satisfaction experienced by KHS's network of PCPs, SCPs, and behavioral health providers. Information obtained from these surveys allows the Plan to measure how well it is meeting providers' expectations and needs.

This study examines provider network satisfaction in the following areas: overall satisfaction; comparisons with other plans; financial issues; utilization and quality management; network coordination of care; pharmacy services; health plan call center service staff; and provider relations. Based on the data collected, KHS reports the findings to the QIW and EQIHEC. These committees review the findings and make recommendations regarding potential opportunities for improvement.

E. Addressing Cultural, Ethnic, Racial and Linguistic Needs of Members

Integrated KHS Resources and Documents Utilized to Support the QIHEP:

Population Needs Assessment

The Wellness and Prevention Department conducts a Population Needs Assessment of KHS members to determine health education and cultural and linguistic needs. The Population Needs Assessment is updated annually for the duration of the contract with the Department of Health Care Services (DHCS). The contents of the Population Needs Assessment define the goals and objectives, data sources and methodology, member demographics, member health status, disease prevalence and gap analysis, health education needs, cultural and linguistic service needs, and key recommendations, planned actions, and conclusions (APL 19-011). KHS uses the Population Needs Assessment (PNA) to inform its QIHEP priorities and to share pertinent information regarding PNA findings and identified targeted strategies with its providers.

CLAS

KHS assesses, identifies, documents, and reports members' demographic and linguistic needs annually. The goals of the Culturally and Linguistically Appropriate Services (CLAS) program align with KHS' mission to support the well-being of members through a commitment to accessible, high-quality health services and community-focused local care.

The CLAS program aims to help KHS identify inequities, address social determinants of health, and work toward removing systemic barriers that generate bias and discrimination in health care. KHS' CLAS objective is to advance health equity to improve the quality of health care and reduce health care disparities by assessing, respecting, and responding to the needs of the Plan's diverse multicultural members.

Population Health Model of Care

The KHS Population Health Management (PHM) Model of Care (MOC) provides a strategic roadmap defining the approach toward the provision of health care and preventive services. It focuses on collaborative partnerships with providers to assist in delivering high-quality care to all members in a timely and efficient manner while reducing costs.

The PHM Model of Care is designed to better coordinate members' care and utilize various data sources to generate insights on how to address each member's individual needs and make hospitals and clinics more accessible and effective.

PHM is a proactive, data-driven strategy focused on improving the health of a given population through a defined network of financially linked providers, achieved in partnership with the community (Health Catalyst, 2020). The Primary Care Physician (PCP) forms the backbone of PHM. The PCP serves as the central coordinator who identifies problems early through various clinical and socio-behavioral screenings and refers patients to specialists when appropriate. At the same time, KHS provides support to the PCP to ensure the patient receives high-quality, comprehensive health care in a timely manner. The Director of PHM is a standing member of the Health Equity Transformation Steering Committee.

Health Equity Education and Training

KHS does not delegate health equity activities. Providers are required to actively participate in and comply with health equity activities. To support this expectation, KHS provides annual training to employees, contracted staff, providers, subcontractors, and downstream subcontractors at key points of contact on sensitivity, diversity, cultural competency, effective communication, health equity, and inclusion as they relate to members.

Training promotes access to and delivery of services in a culturally competent manner for all members and potential members regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status,

marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56.

Training also considers structural and institutional racism, health inequities, and their impact on members, staff, providers, subcontractors, and downstream subcontractors. Trainings include, but are not limited to, the following topics:

- Beliefs about illness and health for identified cultural groups within KHS membership and Kern County
- The need for gender-affirming care
- Methods for interacting with providers and navigating the health care system
- Traditional home remedies that may impact provider-recommended treatment plans
- Skills and practices related to culture-specific health care issues among the membership
- How cultural competency relates to quality of care and access to care
- Appropriate use and provision of interpreters
- Translation processes for written informational documents
- Health literacy
- Population Needs Assessment findings and identified targeted strategies
- Culturally and linguistically appropriate community resources
- Required completion of continuing medical education on cultural competency and implicit bias

IX. External Audits/Regulatory Audits and Delegation Oversight

A. Auditing and Monitoring Activities

Enforcement and Compliance

The Director of Quality Improvement is responsible for the monitoring and oversight of the QIHEP, including ensuring compliance with KHS standards, regulatory requirements, and program activities. Compliance monitoring activities are described within the policies associated with each specific monitoring function. When deficiencies are identified, the process for obtaining compliance, including the development and implementation of Corrective Action Plans (CAPs), is outlined in applicable policies and procedures. Compliance activities that fall outside the oversight of the Quality Improvement Department are the responsibility of the Compliance Department.

Medical Reviews and Audits by Regulatory Agencies

The KHS Director of Compliance and Regulatory Affairs, in collaboration with the Chief Health Services Officer (CHSO) and the Director of Quality Improvement, manages medical reviews and regulatory audits conducted by external oversight agencies. Recommendations, findings, or sanctions issued by regulatory agencies related to medical matters are addressed through the QIHEP. Corrective Action Plans associated with medical review findings are presented to, approved by, and monitored through the EQIHEC.

B. Delegation

KHS does not delegate Quality Improvement or Performance-related functions, as defined in the 2024 DHCS Medi-Cal Managed Care Contract. Should delegation of quality-related activities occur in the future, KHS will maintain oversight through a formal delegation oversight process including pre-delegation assessment, performance monitoring, and corrective action as required. Relevant contractual definitions include the following:

- Downstream Subcontractor means an individual or entity that has a Downstream Subcontractor Agreement with a Subcontractor or another Downstream Subcontractor. A Network Provider is not considered a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
- Downstream Fully Delegated Subcontractor means a Downstream Subcontractor that contractually assumes all duties and obligations of the Contractor under the Contract, through the Subcontractor, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan may operate as a Downstream Fully Delegated Subcontractor.
- Fully Delegated Subcontractor means a Subcontractor that contractually assumes all duties and obligations of the Contractor under the Contract, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan may operate as a Fully Delegated Subcontractor.
- Subcontractor means an individual or entity that has a Subcontractor Agreement with the Contractor that relates directly or indirectly to the performance of the Contractor's obligations under the Contract. A Network Provider is not considered a Subcontractor solely because it enters into a Network Provider Agreement.

X. Conflict of Interest

All members of the EQIHEC and its subcommittees are required to review and sign a Conflict of Interest Statement affirming their commitment to ethical decision-making. Committee members must disclose any potential conflicts of interest and recuse themselves from discussions and voting on matters where they have a direct or

indirect interest. Individuals personally involved in the care or service provided to a patient, or in an event or finding undergoing quality evaluation, may not vote or render a decision regarding the appropriateness of such care. By signing the Conflict of Interest Statement, members agree to abide by its terms, ensuring transparency and integrity in the committee's decision-making process.

XI. Confidentiality

All members, participating staff, and guests of the EQIHEC and its 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 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 of 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 provisions 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 member confidentiality to their practitioners. KHS monitors contracting providers for compliance with KHS confidentiality standards during provider facility and medical record reviews and through the grievance process. The EQIHEC reviews practices regarding the collection, use, and disclosure of medical information.

XII. 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.

Health Insurance Portability and Accountability Act (HIPAA)

KHS complies with all applicable HIPAA requirements supported by HIPAA compliance policies. All HIPAA-related policies are accessible to all KHS contracted providers and KHS staff. HIPAA information is posted on the KHS website. Ongoing mandatory education is required annually for all staff.

XIII. Communication of Quality and Health Equity Activities

Results of performance improvement activities are communicated to the appropriate department and/or multidisciplinary committee as determined by the nature of the activity. The EQIHEC subcommittees report their summarized information to the EQIHEC quarterly to facilitate communication along the continuum of care. The EQIHEC reports activities to the Governing Board, through the CMO or designee, on a quarterly basis. EQIHEC participants are responsible for communicating pertinent, non-confidential QIHEP issues to all members of KHS staff. Communication of QIHEP trends to KHS contracted entities, members, practitioners, and providers occurs through the following:

- Practitioner participation in the EQIHEC and its subcommittees
- Health Network Forums, Medical Director meetings, and other ongoing ad hoc meetings
- Practitioner and member newsletters regarding relevant QIHEP topics
- The QIHEP program description, available to providers and members on the KHS website. This includes QIHEP goals, processes, and outcomes as they relate to member care and service
- Annual practitioner education through provider relations and the Provider Manual

XIV. Annual Evaluation

On an annual basis, KHS evaluates the effectiveness and progress of the QIHEP Program Description and Work Plan and updates the program as needed. The CMO, with assistance from the Quality Improvement Medical Director, Director of QI, Pharmacy Director, Director of Wellness & Prevention, Director of Marketing, Director of Member Services, Senior Director of Contracting & QP, and Director of QP, documents a yearly summary of all completed and ongoing QIHEP 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 QIHEP 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 QIHEP. 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 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 QIHEP Program Description and Work Plan are presented to the Board of Directors for assessment of covered health care rendered to members, comments, activities proposed for the upcoming year, and approval of changes to the QIHEP. The Board of Directors is responsible for the direction of the QIHEP and actively evaluates the annual plan to determine areas for improvement. Board of Directors 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 QIHEP activities and progress toward meeting QIHEP goals is available to members and contracting providers upon request by contacting KHS Member Services.

_____ Date _____

Chief Executive Officer

Emily Duran

_____ Date _____

Chief Medical Officer

_____ Date _____

Chief Health Equity Officer

_____ Date _____

Chief Operations Officer

_____ Date _____

Medical Director of Quality Improvement

_____ Date _____

Director of Quality Improvement

_____ Date _____

Senior Director of Contracting & Quality Performance

_____ Date _____

Director of Quality Performance

_____ Date _____

Senior Director of Wellness and Prevention

_____ Date _____

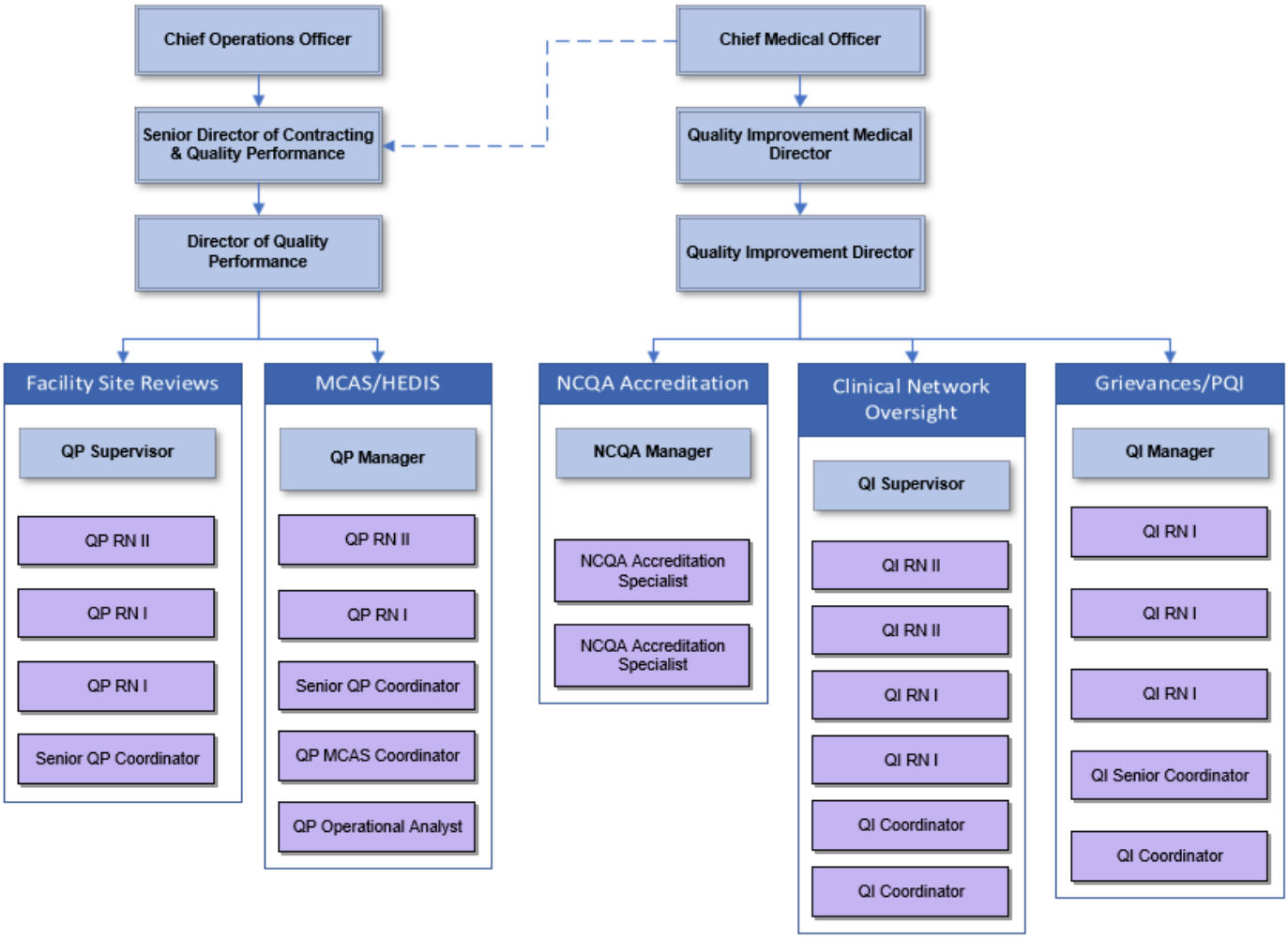
Director of Population Health Management

XV. Appendix

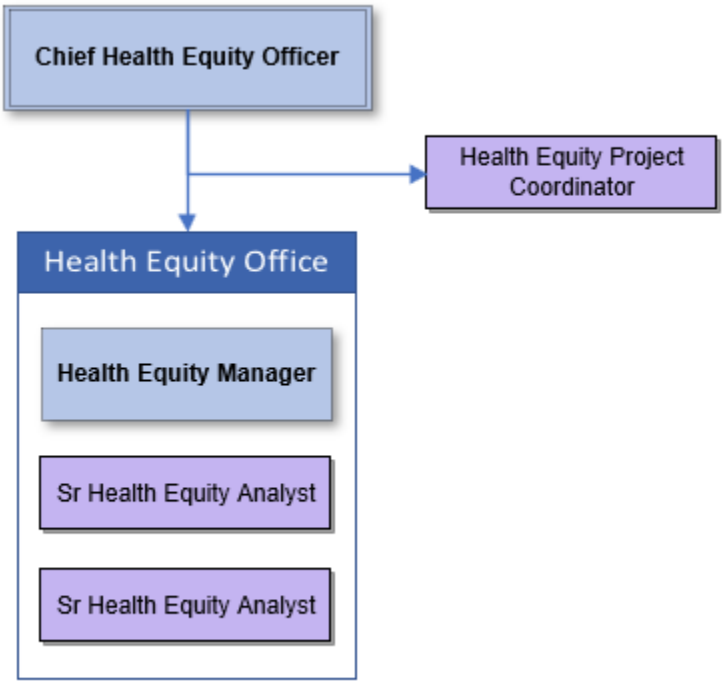
Appendix A: Population Needs Assessment September 2025

https://www.kernfamilyhealthcare.com/about-us/community-reports/

Appendix B: Quality Departments Organization Structure



Appendix C: Health Equity Office Organization Structure



KERN HEALTH SYSTEMS

~~2025~~

2026 Quality Improvement Health Equity Program Description

Executive Quality Improvement Health Equity Committee (EQIHEC)
Approval Date: 03/18/25

KERN HEALTH SYSTEMS

Executive Quality Improvement Health Equity Committee (EQIHEC)
Approval Date: 03/17/26

Table of Contents

I. Introduction 6

A. Mission & Values 6

B. Background 9

C. KHS Population 10

II. QIHEP Overview 15

A. QIHEP Purpose 15

B. QIHEP Scope 16

C. QIHEP Goals 21

III. Authority and Responsibility 29

A. KHS Board of Directors (BOD) 29

B. Chief Executive Officer (CEO) 30

C. Chief Medical Officer (CMO) 30

D. Chief Health Equity Officer (CHEO) 33

E. Chief Operating Officer (COO) 33

F. Quality Improvement Medical Director 33

G. Behavioral Health Provider 35

H. Executive Quality Improvement Health Equity Committee (EQIHEC) 36

I. Quality Subcommittees 39

1. Behavioral Health Advisory Committee (BHAC) 40

2. Drug Utilization Review Committee (DUR) 43

3. Grievance Workgroup (GW) 44

4. Health Equity Transformation Steering Committee (HETSC) 45

5. Network Adequacy Committee (NAC) 48

6. Population Health Management Committee (PHMC) 48

7. Quality Improvement Workgroup (QIW) 52

8. Utilization Management Committee (UMC) 53

J. QI Support Committees 54

1. Community Advisory Committee (CAC) 54

2. Delegation Oversight Committee 55

3. Physician Advisory Committee (PAC) 57

4. Compliance Committee 59

5. Health Equity Advisory Board 61

6. Health Equity and Learning (HEAL) 62

7. Regional Advisory Committee (RAC) 63

IV. Organizational Structure and Resources 63
A. Clinical Oversight of QIHEP 63
B. Quality Improvement Department (QI) 64
C. Quality Performance Department (QP) 68
D. Health Equity Department 73
E. Appeals and Grievances 75
F. Credentialing 76
G. Member Services 77
H. Pharmacy Department 77
I. Population Health Department (PHM) 78
J. Human Resources Department 79
1. Hiring Initiatives 80
2. KHS Bilingual Workforce 81
K. Provider Network Management (PNM) 81
L. Utilization Management Department (UM) 84
M. Behavioral Health Department (BH) 85
N. Wellness and Prevention Department 86
O. Enhanced Care Management Department (ECM) 88
P. Community Support Services (CSS) Department 88
Q. Business Intelligence (BI) 88
R. Information System & Data Management 89
S. Marketing 91
V. Role of Participating Providers 91
A. Provider Participation 91
B. Provider and Hospital Contracts 92
C. Conflict of Interest 93
VI. Program Documents 93
A. Work Plan 93
B. Work Plan Evaluation 94
VII. Quality Improvement Processes 95
A. KHS Quality Improvement (QI) Initiatives 95
1. Plan-Do-Study-Act Cycle 95
2. Data Collection Methodology 96
3. Measurement Process 97
4. Evaluation Process 97

5. Communication and Feedback 98
6. Improvement Processes 98
VIII. Quality Improvement Work Plan 99
A. Quality of Clinical Care 99
1. MCAS Measures 99
2. Performance Improvement Projects (PIPs) 99
B. Safety of Clinical Care 100
1. Patient Safety Program 100
2. Potential Quality Issues (PQIs) 101
3. Facility Site Review, Medical Record and Physical Accessibility Reviews 101
4. Credentialing and Recredentialing 101
C. Quality of Service 102
1. Grievance and Appeals 102
2. Access to Care 102
D. Member and Provider Satisfaction 102
E. Addressing Cultural, Ethnic, Racial and Linguistic Needs of Members 103
IX. External Audits/Regulatory Audits and Delegation Oversight 105
A. Auditing and Monitoring Activities 105
B. Delegation 106
X. Conflict of Interest 107
XI. Confidentiality 107
XII. Information Security 108
XIII. Communication of Quality and Health Equity Activities 108
XIV. Annual Evaluation 109
XV. Appendix 111
Appendix A: Population Needs Assessment September 2025 111
Appendix B: Quality Departments Organization Structure 111
Appendix C: Health Equity Office Organization Structure 113

I. Introduction

Kern Health Systems (KHS), operating as Kern Family Health Care (KFHC), was established in 1993 by the Kern County Board of Supervisors as a local initiative Medi-Cal managed care health plan. KFHC is the largest health plan in Kern County, serving the majority of Kern County's Medi-Cal beneficiaries through a contract with the State of California Department of Health Care Services (DHCS).

KHS is a special county health authority governed by a 16-member Board of Directors. This diverse board includes representatives such as the Chief Executive Officer of the local safety net hospital, a safety net care provider, ten community representatives nominated by the County Supervisors, two Medi-Cal primary care physicians, one representative from a rural acute care general hospital, and one pharmacist. Board members must work or reside in Kern County and meet the minimum age requirement of 21. The Board oversees the establishment and operation of a comprehensive managed care system, ensuring access to high-quality medical care, promoting cost efficiency, and adhering to the principles of Chapter 7, Part 3 of Division 9, Section 14000 of the California Welfare~~,~~ and Institutions Code.

As of ~~2024~~2025, KHS serves approximately ~~403,000~~404,842 members, with 49% receiving care through the County Hospital system and two large Federally Qualified Health Centers (FQHCs). While ~~66~~54.7% of the population resides in Bakersfield, the remainder is spread across rural areas of Kern County. The largest racial and ethnic group is Hispanic, accounting for 63.3% of membership. Language diversity is a key factor, with ~~70~~69.7% of members speaking English as their primary language, ~~29~~30% speaking Spanish, and ~~1~~0.3% speaking other languages.

Kern County faces significant health challenges compared to statewide statistics, including higher rates of adult smoking, obesity, physical inactivity, alcohol-impaired driving deaths, sexually transmitted infections, and teen births. However, the county ranks favorably in food environment indices due to fewer low-income residents with limited access to grocery stores and lower rates of excessive drinking.

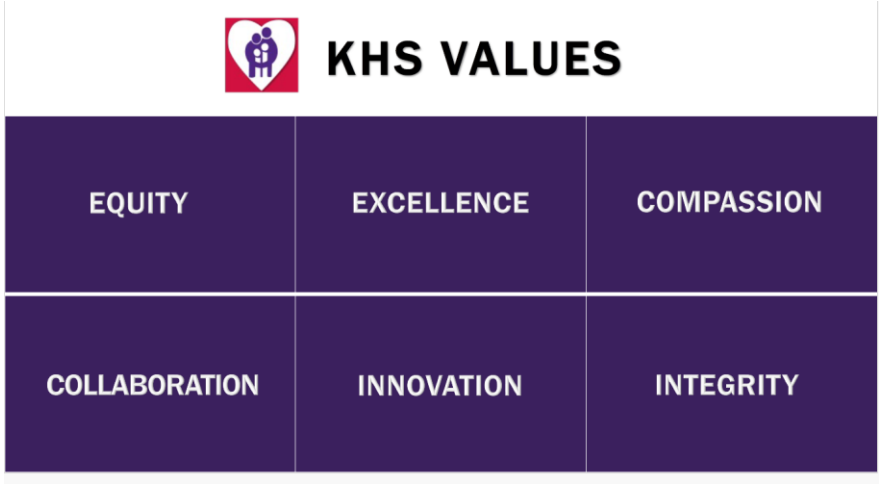
A. Mission & Values

Mission

KHS is committed to improving the health and well-being of our members and the community of Kern County through an integrated, equitable, and member-centered healthcare delivery system. The Quality Improvement Health Equity Program (QIHEP) is designed to objectively monitor, systematically evaluate, and effectively improve the quality, safety, and outcomes of care delivered to our members. By prioritizing health equity and addressing social determinants of health, KHS strives to meet members where they are, empowering them to achieve ~~their~~ optimal health outcomes.

The KHS Quality Improvement Department, in collaboration with the Quality Performance and Health Equity Departments, oversees the program's initiatives and activities, working closely with contracting providers to deliver high-quality care to the populations we serve.

Values



- **Equity**

We foster a culture of fairness and inclusion, ensuring all members and employees are supported, regardless of their zip code, race, ethnicity, preferred language, cultural preferences, or personal history. Equity is at the core of what we do because every person matters. We celebrate diversity and strive to create opportunities for everyone to thrive and contribute their unique gifts.

- **Excellence**

We uphold the highest standards in all that we do, aiming for outstanding results that resonate with the community we serve. Through continuous improvement and dedication, we achieve quality outcomes that lead to a stronger and healthier community. Excellence is reflected in our pride, commitment, and measurable impact.

- **Compassion**

We seek to understand and empathize with ~~others'~~others' experiences, extending care and kindness to everyone we serve. Compassion drives our actions and shapes our solutions, ensuring we respond meaningfully to the needs of our members and colleagues.

- **Collaboration**

We harness the collective expertise of our team, providers, and community partners to solve problems and achieve shared goals. Collaboration brings diverse perspectives and strengths together, driving creativity and producing impactful, sustainable results.

- **Innovation**

We embrace new ideas, methods, and solutions to expand possibilities and improve outcomes. Through experimentation and forward -thinking, we adapt to the changing needs of our members and create innovative strategies that maximize efficiency and value.

- **Integrity**

We act with honesty and accountability, staying true to our commitments and values. Integrity builds trust and provides a strong foundation for performance and meaningful impact, ensuring we consistently do the right thing, even when it is not the easy thing.

KHS is committed to delivering on its values by:

- Ensuring all members obtain equal access to socioeconomic and environmental resources,
- Applying a health equity lens at all levels of and in all services provided by KHS,
- Embracing new knowledge and new ways of providing services,
- Practicing tolerance (accepting differences), embracing diversity (celebrating differences where possible), and pursuing inclusivity (finding commonalities and soliciting voice),
- Identifying and challenging historic assumptions and biases,
- Collaborating across programs, divisions, and community agencies/organizations to address community needs and barriers and obtain recommendations to improve services,
- Managing fiscal resources and the use of resources for greatest impact,
- Keeping consumers informed of Health Equity activities and outcome summaries by making them publicly available on the KHS website. Updates and ongoing information are posted at a minimum, on a quarterly basis,
- Leveraging our financial resources to help historically under-supported businesses and communities of color to build stronger capacity and economic health,
- Holding itself accountable through measurement and quality improvement/assurance,

- Building strong internal leaders in the health equity field that demonstrate a sustained, resolute commitment to DEI and collaboration with all stakeholders,
- Committing to eliminating health inequities in Kern County.

B. Background

Kern County is very diverse, with many residents identifying as Hispanic. As the racial and ethnic composition of Kern County continues to change, it is important to create culturally sensitive systems, policies, and environments while protecting the health of the public.

Spanish-language education, documents, and services will continue to be needed as the Hispanic population ~~continues to grow.~~grows. Additionally, while the total number of non-Hispanic Asians in Kern County remains small, the proportion of residents identifying as non-Hispanic Asian has increased by 21 percent since 2009. In comparison, during the same time frame, the Hispanic population in Kern County grew by 11 percent.

In Kern County, children age 17 and under are at higher risk of living below the poverty level than adults age 18 and older. Overall, ~~31.3~~26% of children live below the poverty level, while ~~22.6~~19.2% of all Kern County residents live below the poverty level. Studies have shown that children living in poverty are more likely to have physical and mental health problems than their peers. This includes lower achievement in test scores, which could limit an individual's ability to ~~make~~earn a living wage.

Moreover, Kern County continues to have a smaller proportion of residents with a high school diploma or equivalency than ~~California's~~the California average. However, Kern County is expected to have the largest increase in high school graduates in the state by 2028.

Due to the diverse geography of Kern County, from arid high desert to ~~the~~ mountains to the valley, climate conditions also ~~varies~~vary. In the summer, heat exhaustion, heat stroke, and heat-related deaths are ~~of~~ concerns in Kern County (~~i.e.,~~for example, dehydration can exacerbate underlying conditions). ~~Another example~~Additionally, high winds and dust storms in certain parts of the county can aggravate respiratory disorders and contribute to infectious diseases ~~like~~such as Valley Fever (coccidioidomycosis).

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

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

C. KHS Population

The population served by ~~Kern Health Systems (~~KHS~~),~~ operating as Kern Family Health Care (KFHC), reflects the diverse demographic, geographic, and socioeconomic characteristics of Kern County. As of ~~2024~~2026, KHS serves approximately ~~403~~392,000 Medi-Cal members, encompassing a wide range of health and social needs.

Demographics

- Geographic Distribution:
  - Over ~~66~~54% of KHS members reside in Bakersfield, the county's largest metropolitan area.
  - The remaining members are distributed across rural areas, highlighting ~~a~~the need for geographically equitable access to healthcare ~~access~~services.

Area	Rural Portions per HRSA	KHS Population	Percentage
Bakersfield	N	223,973	66.9%
Delano & North Kern	Y	30,610	9.1%
Arvin/Lamont	Y	21,978	6.6%
Shafter/Wasco	Y	21,596	6.4%
California City & Southeast Kern	Y	9,434	2.8%
Taft & Southwest Kern	Y	8,897	2.7%
Tehachapi	Y	5,632	1.7%
Ridgecrest & Northeast Kern	Y	4,883	1.5%
Lake Isabella & Kern River Valley	Y	4,023	1.2%
Lost Hills & Northwest Kern	Y	2,194	0.7%
Frazier Park & South Kern	Y	1,244	0.4%
Outside Service Area	N/A	465	0.1%

- Racial and Ethnic Composition:
  - The Hispanic population represents 63.3% of ~~the~~KHS membership, emphasizing the importance of culturally relevant care and services.
  - Other racial~~/~~ and ethnic groups include White, African American, Asian, Native American, and individuals identifying as multiracial, reflecting the ~~community's~~ diversity of the community served.

Ethnic or Racial Group	% KHS Enrollment
Hispanic	63.3%
Caucasian	~~17~~16.1%
No valid data~~, unknown or other~~	~~11~~9.8%
Black/African American	~~6~~5.7%
Asian Indian	1.4%
Filipino	1.1%
~~Asian~~Hawaiian/Pacific Islander	~~1~~0.06%
Native American	0.21%
Other Asian	1.0%
Unknown	1.3%

- Language Diversity:
  - ~~70~~66.6% of members identify English as their primary language.
  - ~~29~~32.3% primarily speak Spanish, underscoring the need for language assistance services.
  - Less than 1% speak other languages, requiring culturally and linguistically appropriate services to ensure equitable access to care.

Socioeconomic Characteristics

- Many KHS members face significant socioeconomic challenges, including:
  - Poverty: A large proportion of the population lives at or below the federal poverty level.
  - Unemployment: Economic instability affects access to housing, transportation, and other basic needs.
  - Educational Barriers: Limited education levels impact health literacy and the ability to navigate the healthcare system.

Health Risk Factors

- Kern County exhibits a higher prevalence of health risks compared to statewide averages, including:
  - Chronic Conditions: High rates of diabetes, hypertension, and obesity among the population.
  - Lifestyle Factors: Elevated smoking rates, physical inactivity, and alcohol use disorders.
  - Maternal and Child Health: Teen births and limited access to prenatal care contribute to ~~poor outcomes in~~poorer maternal and child health outcomes.

~~Key health behaviors affecting the Kern population are reflected in the following table obtained from _:~~

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

Social Determinants of Health (SDOH)

- KHS actively identifies and addresses social determinants that impact the health of its members, including:
  - Housing Insecurity: A significant portion of the population experiences unstable or unsafe housing conditions.
  - Food Insecurity: Access to affordable and nutritious food remains a concern for many families.
  - Transportation Barriers: Limited public transportation options impede access to healthcare facilities, particularly in rural areas.
  - Access to Technology: Digital inequities hinder member engagement in telehealth services and health education initiatives.

Behavioral Health Needs

The mental health and substance use disorder needs of KHS members are significant, with many individuals requiring coordinated care for mild-to-moderate behavioral health conditions. KHS partners with ~~the~~ Kern County Behavioral Health and Recovery Services (KBHRS) to address the needs of members requiring specialty mental health services.

Vulnerable Subpopulations

KHS tailors its programs and services to address the unique needs of vulnerable groups, including:

- Seniors and Persons with Disabilities (SPDs): Older adults and individuals with disabilities require specialized care and enhanced care management services.
- Homeless Individuals: Outreach efforts target unsheltered populations, including street medicine initiatives ~~to~~that deliver care in nontraditional settings.

- Children and Adolescents: Programs focus on preventive care, developmental screenings, and health education for younger members.

Kern County ranks lower compared to other California counties for a variety of public health indicators. Kern County ranks in the bottom ~~10~~ten California counties for age-adjusted death rates due to diabetes, Alzheimer's disease, coronary heart disease, chronic lower respiratory disease, homicide, and drug-induced ~~deaths1.~~deaths[1]. It is also among the bottom ~~10~~ten California counties for the incidence of chlamydia~~,~~ and gonorrhea among ~~people~~individuals aged 15~~-~~ to 44 years ~~old~~, congenital syphilis, primary and secondary syphilis, infant mortality, and persons under age 18 living in poverty.

In Kern County's most recent Community Health Assessment, asthma and other respiratory diseases were identified as ~~the~~ top community health problems. According to the California Health Interview Survey, 15.7% of the Kern County population has been diagnosed with asthma. In 2019, the emergency department ~~(ED)~~visit rate due to asthma was 46.1 per 100,000, compared to the state average of 42.6 per 100,000. Black/African American ~~people~~residents in Kern County experience significant asthma disparities ~~as demonstrated by their~~, with an asthma ~~ED~~emergency department visit rate of 181.5 per 100,000 people. This rate is more than four times the rate of the next highest racial~~/~~ or ethnic group in Kern County and more than double the rate of any age group in the county.

~~Other~~Additional health disparities identified within Kern County include the teen birth rate (~~25.9~~21.0 per 1,000 live births~~)~~, which ~~was~~is more than double the state average (~~12.5~~10.2 per 1,000 live births~~);~~) among females aged 15 to 19. The percentage of ~~all~~ pregnancies accessing early prenatal care ~~which was~~is also below the state average (~~KC-~~ Kern County: 79.6%; ~~CA-~~California: 85.1~~%); and~~%). The obesity rate ~~which was~~in Kern County is 35.5~~%~~%, compared to 30.3 ~~for California~~% statewide.

Regarding mental health, Kern County's age-adjusted mortality rate due to suicide is 13.5 per 100,000, which is higher than the ~~state averages (CA-~~statewide average (10.7 per 100,000).

In accordance with the World Health Organization definition ~~of,~~ social determinants of health~~,~~ (SDOH) are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the ~~wider~~broader set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems.

~~The improvement of~~Improving long-term health outcomes, particularly for populations experiencing the greatest health inequities ~~in health~~ over time, requires a shift in focus to ~~the~~ upstream factors that are the underlying causes of ill health (Harris County Public Health: Health Equity Policy, 2015). Such ~~health~~ inequities include disparate rates of disease, disability, and premature death. ~~A shift to~~Addressing upstream factors (Appendix A) ~~factors~~ provides all individuals, regardless of socioeconomic or environmental conditions, the opportunity to attain their full health potential.

Addressing health disparities among identified populations is a priority ~~of~~for KHS. To ensure robust insights regarding disparities, KHS leverages the External Quality Review (EQR) Technical Report~~,~~ and the KHS Population Needs Assessment~~:~~ (PNA). An annual analysis of the EQR is used to identify ~~specific~~ disparities and~~/or~~ targeted areas of focus to incorporate into strategies ~~to~~that improve member satisfaction, close gaps in care, and ~~highlight~~address other ~~specific~~identified needs ~~for~~within the KHS population. Findings from the PNA are incorporated into the annual Quality Improvement Work Plan to address identified disparities and priority health needs.

KHS utilizes ~~the~~ EQR recommendations to develop strategies that ~~impact~~improve the timeliness and quality of services provided to members ~~as well as~~and reduce barriers to accessing preventive and other ~~health care~~healthcare services. The KHS PNA uses internal and external data sources to identify and assess vulnerable member groups by race or ethnicity, age, sex, language, and other member characteristics, including cultural and linguistic needs. The~~ KHS~~ PNA builds upon previous needs assessments and uses ~~various~~multiple data collection methods and sources.

The goal of the PNA is to improve health outcomes for KHS members and ensure that KHS is meeting the needs of its members through:

1. Identification of member health needs and health disparities~~.~~
2. Evaluation of current health education (HE), cultural and linguistic (C&L), and quality improvement (QI) activities and available resources to address identified concerns~~; and~~
3. Implementation of targeted strategies for HE, C&L, and QI programs and services to address member needs~~.~~

Population Health Management (PHM) services ~~(i.e.,~~, including basic population health management~~,~~ and enhanced care management, ~~etc.)~~ are offered to all KHS members~~,~~ and ~~provided~~delivered in a manner ~~to address~~that addresses member needs ~~and,~~ preferences, and ~~address~~ health disparities.

Opportunities for Improvement

KHS leverages insights from its annual Population Needs Assessment to identify gaps in care and develop targeted interventions. Key opportunities include:

- Expanding provider networks to improve access in underserved areas~~.~~
- Reducing health disparities by addressing inequities in chronic disease management and preventive care~~.~~
- Enhancing member engagement through culturally competent health education and communication strategies~~.~~
- Strengthening partnerships with community organizations to address ~~SDOH~~social determinants of health and improve overall member well-being~~.~~

II. QIHEP Overview

A. QIHEP Purpose

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

KHS recognizes that a strong program must ~~be~~serve as 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~~services provided by contracting providers ~~for~~across all aspects of ~~health care~~healthcare delivery, consistent with applicable standards and laws. The QIHEP operates in compliance with requirements established by DHCS, DMHC, NCQA, and applicable federal and state regulations governing Medi-Cal managed care organizations.

The mission of the KHS Health Equity Program is to improve the health and well-being of the community through the delivery of trusted, high quality, cost-effective, and accessible ~~health~~healthcare to all members regardless of race~~/~~, ethnicity, language spoken, or ~~their~~ cultural~~/~~ or personal preferences. In partnership with the county ~~KHS~~it serves, ~~the goal is~~KHS seeks to ~~offer~~provide whole person-centered care that reflects ~~the~~current best practices ~~available today. KHS's~~. The KHS program is built on a foundation of ~~dedication to~~ trusted ~~messaging~~communication, high ~~-~~ quality care, culturally sensitive member engagement ~~with members, regular,~~ collaboration with community partners, continuous improvement, and coordinated service ~~by working together~~delivery with providers. KHS acknowledges an ongoing shared responsibility with its providers, facilities, community stakeholders, and other provider organizations to deliver trusted, effective, and timely care and services for its members.

At a high level, the program seeks to ~~emulate~~align with the guidance ~~found~~outlined in the California Department of Health Care Services' 2022 Comprehensive Quality Strategy, which ~~summarizes the state's goal of~~emphasizes helping Medi-Cal members achieve longer, healthier, and ~~happier~~more fulfilling lives through both clinical ~~health care~~healthcare services and non-clinical ~~services. This~~supports. The program integrates clinical and non-clinical services to create a holistic healthcare environment~~, improving~~ that improves member health outcomes. Disparate impacts from the COVID-19 pandemic have underscored the need for urgency and the ~~necessity~~importance of building partnerships with trusted community stakeholders to ~~increase~~strengthen trust with members. These ~~two areas of providing additional~~priorities, including expanding non-clinical supports and ~~increasing trust~~strengthening community partnerships, are key ~~changes~~strategies designed to ~~catalyze different~~improve health outcomes.

KHS staff ~~are constantly evaluating~~continually evaluate member differences and preferences ~~regarding~~related to race, ethnicity, culture, gender identity, sexual orientation, and language. Through its ~~Quality Improvement Health~~

~~Equity Program (~~QIHEP~~),~~ KHS ~~intends to implement~~implements standards ~~on~~for culturally and linguistically appropriate services to achieve the following key objectives:

- Respond to current and projected demographic changes in the populations served~~.~~
- Understand the impact of race, ethnicity, culture, gender identity, sexual orientation, and language ~~in~~on whole person health~~.~~
- Improve the quality of services and outcomes for members~~.~~

B. QIHEP Scope

KHS QIHEP is composed of several systematic processes that monitor and evaluate the quality of clinical care and ~~health care~~healthcare service delivery to KHS members. The QIHEP scope includes regular needs assessments based on race~~/~~ and ethnicity, language, cultural preferences, health disparities, and stakeholder engagement. ~~Again, it should be noted that~~ This expanded scope covers both clinically focused and non-clinically focused areas. ~~Each of these defined~~These areas of program scope include, but are not limited to, the following:

- 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~~issues and a corrective action process for resolution ~~for all~~across provider entities.
- Promote efficient use of health plan financial resources.
- Identify health disparities and ~~take action~~implement actions to support health equity.
- Oversee and direct processes affecting the quality of covered ~~health care~~healthcare 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~~healthcare 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~~integrated healthcare 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~~, including identification of quality-of-care ~~problems~~issues and ~~a~~ implementation of corrective action ~~process~~processes for ~~resolution for all~~ provider entities.
3. Oversight and direction of processes affecting the quality of covered ~~health care~~healthcare services delivered to members, either directly or indirectly.
4. Assurance that members have access to covered ~~health care~~healthcare 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.

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

The scope of the ~~QIHE Program~~QIHEP includes the following elements:

1. The ~~QIHE Program~~QIHEP is designed to monitor, oversee, and implement improvements that influence the delivery, ~~outcome~~outcomes, and safety of ~~the health care of~~ healthcare services provided to members, whether ~~direct~~directly or ~~indirect~~indirectly.
    a. KHS does 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~~arranges covered services in a culturally and linguistically appropriate manner. The ~~QIHE Program~~QIHEP reflects the population served and applies equally to covered medical and behavioral health services.
2. The ~~QIHE Program~~QIHEP monitors the quality and safety of covered ~~health care~~healthcare services 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~~healthcare services to members in inpatient, ambulatory, and home care settings. New this year is the ~~addition~~inclusion of street medicine providers. A street medicine provider refers to a licensed medical provider who conducts patient visits outside of clinics or hospitals and directly ~~on the street,~~ in community environments where unsheltered individuals may be living.
3. ~~The QIHE Program~~QIHEP assessment activities encompass ~~all~~ diagnostic and therapeutic activities~~,~~ and outcomes affecting members~~, including~~. This includes primary care and specialty practitioners, vision

providers, behavioral health ~~care~~ providers, pharmaceutical services, preventive services, prenatal care, and family planning services ~~in all~~across applicable care settings, including emergency, inpatient, outpatient, and home health settings.

4. The ~~QIHE Program~~QIHEP evaluates quality of service, including ~~the~~practitioner availability ~~of practitioners~~, accessibility of services, coordination, and continuity of care. Member input is obtained through ~~member~~ participation ~~on~~in the Community Advisory Committee (CAC), member grievances, and member satisfaction surveys.
5. ~~The QIHE Program~~QIHEP activities are integrated internally across ~~appropriate~~ KHS departments~~. This occurs~~ through multi-departmental representation on the ~~QI/UM~~Executive Quality Improvement Health Equity Committee (EQIHEC) and its subcommittees.
6. KHS and the Kern County Department of Health jointly ~~cover~~address mental health care~~. It is~~ needs. Specialty mental health services are arranged and covered~~,~~ in part~~, by~~ through Kern County Behavioral Health and Recovery Services (KBHRS) pursuant to a contract between the County and the State.

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

Quality Improvement Integration: The ~~QIHE Program~~QIHEP includes quality improvement, utilization management, risk management, credentialing, ~~member's~~members' rights and responsibilities, and preventive health ~~&~~and health education.

As part of KHS' commitment to ~~ensure the~~ensuring members' rights ~~of our members~~ to quality ~~health care~~healthcare, the following six rights to Quality Health Care have been adopted:

1. Right to Needed Care
   - Members are accurately diagnosed and treated
   - Care is coordinated across all ~~the doctors~~physicians and specialists
2. Right to Equitable Care
   - All ~~people~~individuals, regardless of ~~their~~ gender, race, ethnicity, ~~geographical~~geographic location, or socioeconomic status, receive the ~~good~~ quality ~~health care~~healthcare they need
   - ~~Developing~~Development of culturally competent care~~; for example, by expanding medical~~, including expanded translation services, after-hours ~~appointment~~appointments, mobile health clinics ~~or~~, and telehealth~~, etc.~~ options
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~~Ensuring members receive care in the appropriate setting
- Reducing unnecessary use of emergency departments for primary care~~?~~
- ~~Is the patient transitioned to the right place for care?~~
- Supporting appropriate care transitions

4. Right to Timely Care
   - Timely access to care and appointments
   - ~~How long did the patient have to~~Monitoring wait ~~to get health care~~times for healthcare appointments and telephone ~~advise?~~advice
   - ~~Is the patient~~Ensuring members are up to date with ~~their preventative~~preventive care~~?~~
5. Right to Be Part of Your Care
   - ~~Patients~~Members and their families are ~~part of~~ active participants in the care team and ~~play a role in decisions.~~decision-making process
   - Information is shared fully and in a timely manner ~~so that patients and their family members can make~~to support informed decisions~~.~~
6. Right to Safe Care
   - ~~Conduct~~ Continuous quality assurance and improvement activities
   - Customer and provider satisfaction surveys or interviews
   - Chart audits and site reviews
   - ~~Administration of medications~~
   - Safe medication administration

The QIHEP scope includes regular needs assessments based on race~~/~~ and ethnicity, language, cultural preferences, health disparities, and stakeholder engagement. ~~Again, it should be noted that this expanded scope covers~~The program addresses both clinically focused and non-clinically focused areas~~. Each of these defined areas of program scope include, but are not limited to,~~, including the following:

- Quality Improvement – Understanding health disparities is critical to ~~identify the~~identifying 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~~implements programs to monitor, assess, and improve healthcare services to reduce ~~health~~ disparities within its membership.
- Quality Performance – Identification of gaps in care, opportunities to support providers and members, and ~~overall responsibility for~~ oversight of high quality and equitable care for ~~the~~ members ~~we serve~~. Quality

Performance ~~is comprised of~~ includes site reviews, MCAS/HEDIS performance monitoring, performance improvement projects, and organizational quality initiatives ~~related to quality~~.

- Health Education ~~&~~and Cultural ~~Linguistics~~and Linguistic Services – Ensuring members have access to ~~appropriate~~ language assistance services including bilingual services, oral interpretation, and written~~/sight~~ translations ~~as appropriate. The~~. Network providers have access to these services to ensure ~~the~~ members receive information in their preferred ~~method~~language.
- Population Health Management – Promoting ~~meaningful engagement and~~ partnerships with ~~network~~ providers, ~~communities~~community organizations, public health agencies, and schools ~~and community-based organizations (CBOs),~~ to ~~support the improvement of~~ improve data sharing ~~among delivery systems to identify~~ and ~~mitigate SDOH to reduce disparities and ensure that all members are connected to primary care, appropriate wellness,~~ address social determinants of health. These efforts support prevention, ~~and~~wellness, disease management ~~activities~~, and ~~to identify and connect those~~identification of members ~~who are~~ at risk for ~~developing~~ complex health ~~issues to more~~conditions who may require specialized services.
- Member Engagement – ~~Engaging all key stakeholders is a very critical process to collect and evaluate~~ Collecting and evaluating feedback from members, practitioners, and ~~other~~ community groups~~. The information is collected~~ through multiple ~~avenues~~mechanisms including member advisory committees, ~~ongoing~~satisfaction surveys ~~from members and practitioners, discussions with large~~, and provider ~~groups, etc.~~engagement activities.
- Provider Network Management – Evaluating ~~the network's~~ cultural responsiveness ~~is one of~~within the ~~key components of the health equity program. This includes the~~provider network, including providers' ability ~~of practitioners and providers~~ to understand ~~the individual~~ values, beliefs, and behaviors ~~shaped~~influenced by cultural factors ~~of diverse groups.~~. KHS ~~educates~~provides annual education to providers ~~and practitioners annually~~ on ~~how to consider and integrate these members~~incorporating member preferences into ~~the delivery of~~ healthcare ~~services~~delivery.
- Utilization Management – Facilitating~~, communicating,~~ communication and ~~collaborating~~collaboration among members, practitioners, providers, and the organization~~,~~ to ~~support cooperation and~~ensure appropriate utilization of ~~health care benefits.~~healthcare services. Monitoring ~~and reporting~~ under- and over-utilization trends ~~to eliminate~~ supports reduction of care variations ~~within~~ and helps close gaps in care among vulnerable populations ~~and proactively closing gaps in the care continuum~~.
- Policies & Procedures – The following components are integrated into ~~KHS'~~KHS policies and procedures across multiple areas:

- Community input and advisement on ~~relevant~~ cultural, linguistic, and Seniors and Persons with Disabilities (SPD) awareness ~~issues via~~through the ~~established~~ Community Advisory Committee
- ~~A~~Periodic Population Needs ~~Assessment is conducted periodically to assess the need for special initiatives regarding~~ Assessments to evaluate cultural competency, linguistic sensitivity, and SPD awareness ~~issues~~needs among practitioners and members~~.~~
- ~~Best efforts will be made to recruit and retain staffing that is~~ Recruitment and retention of staff reflective of the membership~~.~~
- ~~Creative efforts will be made to increase partnership~~Partnerships with vendors and community-based organizations ~~(CBOs) that are~~ reflective of the membership~~.~~
- ~~KHS staff and provider network will be provided with opportunities for~~ Training and tools for KHS staff and network providers to promote cultural competency, linguistic sensitivity, and SPD awareness~~.~~
- ~~KHS will participate with~~ Participation in government, community, and educational ~~institutions in symposiums~~forums related to cultural competency~~, linguistic sensitivity, and SPD awareness.~~ and health equity
- ~~KHS will maintain~~ Systems that ~~readily~~ identify language and ~~ethnic~~ ethnicity-specific member data~~.~~
- ~~Through~~ Grant programs~~, KHS gives preference to funding agencies that can provide~~ that prioritize organizations providing culturally and linguistically appropriate services ~~that are accessible to the membership and~~to the community~~.~~

C. QIHEP Goals

KHS has developed and implemented a plan of activities to ~~encompass~~support a progressive ~~health care~~healthcare delivery system ~~working~~that operates in cooperation with contracting providers, members, community partners, and regulatory agencies. The QI Department annually evaluates program objectives and progress, making modifications based on guidance from the KHS Board of Directors. The results of ~~the~~this evaluation are considered in the subsequent year's program description. ~~Specific objectives of the QIHE Program include:~~

Specific objectives of the QIHEP include:

1. Improving the health status of members by identifying potential areas for improvement in the ~~health care~~healthcare delivery system.
2. Developing, distributing, and promoting guidelines for care, including preventive ~~health care~~healthcare and disease management, through education of members and contracting providers.

3. Developing and promoting ~~health care~~healthcare 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~~on matters ~~of~~related to quality improvement. This includes maintaining communication avenues between KHS, members, and contracting providers to ~~seek~~identify solutions ~~to problems~~ that ~~will~~ lead to improved ~~health care~~healthcare delivery systems.
5. Monitoring and providing oversight of delegated activities.
6. ~~Performing~~ Tracking and trending ~~on~~ a wide variety of information, including:
    a. Over- and ~~underutilization~~under-utilization data~~,~~
    b. Grievances~~,~~
    c. Potential and actual quality-of-care issues~~,~~
    d. Accessibility of ~~health care~~healthcare services~~,~~
    e. Compliance with Managed Care Accountability Set (MCAS) preventive health and chronic condition management services~~,~~
    f. Pharmacy services~~, and~~
    g. 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~~within the ~~health care~~healthcare community toward quality improvement in ~~health care~~healthcare, safety, and service.
8. Continuously identifying opportunities for improvement in care processes, ~~organizations or~~organizational structures, and service delivery systems that ~~can improve~~enhance safety and healthcare delivery ~~of health care to~~for members.
9. Providing appropriate evaluation of professional services and medical decision making ~~and~~in order to identify opportunities for professional performance improvement.
10. Reviewing ~~concerns regarding~~ quality-of-care ~~issues~~concerns for members ~~that are~~ identified ~~from~~through grievances, the Community Advisory Committee (CAC), or ~~any~~ other internal, provider, or ~~other~~ community ~~resource~~resources.
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 ~~QIHE Program~~QIHEP and its activities to determine:

a. How ~~well~~effectively resources ~~have been~~were deployed in the previous year to improve the quality and safety of clinical care~~,~~
b. The quality of ~~service~~services provided to members~~, and~~
c. Modifications needed to the ~~QIHE Program.~~QIHEP

Results of the annual evaluation are presented to the ~~Executive Quality Improvement Health Equity Committee (~~EQIHEC~~)~~ and the Board of Directors. KHS acknowledges that culture change is necessary to achieve its health equity vision. As such, the vision and goals include a combination of qualitative and quantitative metrics. Some efforts ~~will be~~are initiated ~~simply~~ because they align with ~~KHS's~~KHS values and ~~are perceived as being the "right thing to do"~~represent best practices for the organization. Other objectives ~~will have discrete measurements that are~~include measurable outcomes directly connected to DHCS contract requirements ~~or KHS's,~~ annual goals, or the KHS strategic plan. Some ~~may be~~initiatives represent a blend of values-based goals and contractual obligations. Populations of focus ~~particularly~~ include:

A. Members affected by health disparities~~,~~
B. Limited English Proficiency (LEP) members~~,~~
C. Children with special ~~Health Care Needs,~~healthcare needs
D. Seniors and persons with disabilities~~,~~
E. Persons with chronic conditions~~.~~

Culture (Values-Based) Goals~~:~~

• Provide leadership to staff and the provider network to support ~~the~~ long-term culture change needed to address ~~any~~ identified health disparities.

• ~~Invite all~~Engage stakeholder groups ~~(i.e.,~~including members, providers, staff, community stakeholders, contractors, and subcontractors~~, etc.)~~ to better understand and ~~engage~~participate in health equity ~~work because it belongs to all of us~~initiatives.

• Provide educational opportunities to ~~all~~ stakeholders ~~(above). Trainings will be provided~~ through multiple modalities, including ~~not limited to:~~ :

o Online self-paced education ~~classes~~
o In-person coaching~~/~~ and training
o Live webinars
o ~~Dissemination~~Distribution of educational materials

• Support workforce development, ~~workforce~~ diversity, and training initiatives that increase cultural sensitivity, cultural awareness, and cultural humility ~~in KHS's staffing~~among KHS staff and provider ~~network~~networks.

• Establish partnerships ~~and collaborations~~ with community-based organizations that ~~elevate~~advance social and racial justice ~~in~~within the communities served.

• Continue to solicit and incorporate diverse stakeholder perspectives through surveys and stakeholder meetings.

Goals to Meet ~~Member's~~Members' Cultural and Linguistic Needs:

• ~~Target~~Achieve 90% ~~of~~satisfaction among members who ~~utilized~~utilize interpreting and translation services ~~are "satisfied"~~ as ~~indicated in~~measured through satisfaction ~~survey results~~surveys.

• Deliver 90% of translation and interpretation service requests on or before ~~or on~~ the requested due date.

• Resolve 100% of cultural and language-related grievances within 30 business days.

Goals to Directly Address Health Disparities:

• Identify disparities in care for selected MCAS/HEDIS measures~~. These may include:~~, including but ~~will~~ not ~~be~~ limited to~~, the following~~:

- o Well Child Care (~~i.~~e~~., Well~~.g., well-child visits, childhood immunizations~~, etc.)~~)
- o Maternity Care (~~i.~~e.g., disparities ~~for~~affecting Black and Native American ~~persons~~members)
- o Mental Health (~~i.~~e.g., maternal~~,~~ and adolescent depression screenings~~,~~ and follow-up for mental health and substance use ~~disorder~~disorders)
- o Cancer Screenings (~~i.~~e.g., breast, cervical, and colorectal screenings)
- o Management of Chronic Conditions (~~i.~~e.g., diabetes, hypertension, asthma~~, etc.)~~)

• Address at least one disparity in care ~~in~~within each of the groups ~~mentioned in the bullet~~listed above~~. Reduce~~ by reducing the ~~disparity~~gap between the highest and lowest performing populations (with ~~reasonable~~sufficient membership) by 5% by ~~2025. For example:~~2026. Examples include:

- o Increase well-child visits for Black children by 15% by ~~2025~~2026.
- o Increase maternal depression screenings for Black mothers by 15% by ~~2025~~2026.
- o Increase the rate of annual diabetes screening for members who speak an Asian language ~~in comparison~~compared to English-speaking ~~patients~~members.
- o Increase equity ~~of~~in member involvement in treatment planning for Black non-Hispanic (77%), Hispanic (66%), and other ~~race/~~racial or ethnic populations (64%) to 85% or higher on ~~the~~ member satisfaction ~~survey~~surveys.

• MCAS Measures ~~–~~ KHS is ~~held~~ accountable ~~to meet~~for exceeding the 50th percentile ~~or better~~ for measurement year (MY) ~~2025~~2026. Results for ~~the 2024~~2025 measures will be calculated and submitted in report year (RY) ~~2025~~2026. The applicable measures are presented in the following table:

#	Measure Required – MCAS	Measure Acronym	Measure ~~TYPE METHODOLOGY~~Steward	Methodology	Held to MPL~~?~~

Inserted Cells

Behavioral Health Domain Measures					
1	Follow-Up After ~~ED~~Emergency Department Visit for Mental Illness – 30 Days~~*~~	FUM	NCQA	Administrative	Yes
2	Follow-Up After ~~ED~~Emergency Department Visit for Substance ~~Abuse~~Use – 30 Days~~*~~	FUA	NCQA	Administrative	Yes
3	Depression Screening and Follow-Up for Adolescents and Adults – Screening	DSF-E-DS	NCQA	ECDS	Yes
Children's Health Domain Measures					
~~3~~4	Child and Adolescent Well-Care Visits~~*~~	WCV	NCQA	Administrative	Yes
~~4~~5	Childhood Immunization Status~~-~~ – Combination 10~~*~~	CIS-10-E	NCQA	ECDS	Yes
~~5~~6	Developmental Screening in the First Three Years of Life	DEV-CH	~~Administrative~~CMS	~~Yesiii~~Hybrid/Admin	Yes
~~6~~7	Immunizations for Adolescents~~-~~ – Combination 2~~*~~	IMA-2-E	NCQA	ECDS	Yes
~~7~~8	Lead Screening in Children	LSC-E	~~Hybrid/Admin**~~NCQA	ECDS	Yes
~~8~~9	Topical Fluoride for Children	TFL-CH	DQA	Administrative	~~Yesiii~~Yes
~~9~~10	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits~~*~~	W30-6+	NCQA	Administrative	Yes
~~10~~11	Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits~~*~~	W30-2+	NCQA	Administrative	Yes
Chronic Disease Management Domain Measures					
~~11~~	~~Asthma Medication Ratio*~~	~~AMR~~	~~Administrative~~		~~Yes~~
12	Controlling High Blood Pressure~~*~~	CBP	NCQA	Hybrid/Admin~~**~~	Yes
13	~~Hemoglobin A1c Control~~Glycemic Status Assessment for Patients With Diabetes ~~– HbA1c Poor Control (>~~(≥9%)~~*~~%)	GSD	NCQA	Hybrid/Admin~~**~~	Yes

Inserted Cells

Inserted Cells

Inserted Cells

Inserted Cells

Inserted Cells

Inserted Cells

Reproductive Health Domain Measures					
~~14~~	~~Chlamydia Screening in Women~~	~~CHL~~	~~Administrative~~		~~Yes~~
~~15~~14	Prenatal and Postpartum Care~~:~~ – Postpartum Care~~*~~	PPC-~~Pst~~Post	NCQA	Hybrid/Admin~~**~~	Yes
~~16~~15	Prenatal and Postpartum Care~~:~~ – Timeliness of Prenatal Care~~*~~	PPC-Pre	NCQA	Hybrid/Admin~~**~~	Yes
16	Postpartum Depression Screening and Follow-Up – Screening	PDS-E-DS	NCQA	ECDS	Yes
17	Prenatal Depression Screening and Follow-Up – Screening	PND-E-DS	NCQA	ECDS	Yes
Cancer Prevention Domain Measures					
~~17~~18	Breast Cancer Screening~~*~~	BCS-E	NCQA	ECDS	Yes
~~18~~19	Cervical Cancer Screening	CCS-E	NCQA	ECDS	Yes
20	Colorectal Cancer Screening	COL-E	NCQA	ECDS	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^^~~

Inserted Cells

Inserted Cells

~~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~~
~~26~~	~~Depression Remission or Response for Adolescents and Adults~~	~~DRR-E~~	~~ECDS~~	~~No^^~~
~~27~~21	~~Depression Screening and~~ Follow-Up After Acute and Urgent Care Visits for ~~Adolescents and Adults~~Asthma	~~DSF~~AAF-E	NCQA	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)~~	~~ADD-C&M~~	~~Administrative~~	~~No~~

Inserted Cells

	~~Medication: Continuation and Maintenance Phase~~			
~~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

III. Authority and Responsibility

The organizational structure includes the following personnel and committees:

A. KHS Board of Directors (BOD)

The Kern Health System (KHS) Board of Directors (BOD) has final authority and accountability for the KHS Quality Improvement Health Equity Program (QIHEP). The Board has delegated the responsibility for the development and implementation of the QIHEP to the Executive Quality Improvement Health Equity Committee (EQIHEC). The EQIHEC is chaired by the KHS's KHS Chief Medical Officer (CMO) and co-chaired by the KHS Chief Health Equity Officer (CHEO).

KHS's The KHS Board of Directors (BOD) is the governing body of the organization and has ultimate responsibility for the quality of care and service services delivered by Kern Health Systems KHS. The BOD:

- Approves the annual QIHEP Program Description.
- Approves the annual Quality Management Work Plan, which contains measures specific to the QIHEP.
- Reviews the annual QIHEP Evaluation.
- Reviews reports about on QIHEP activities and performance measures as provided presented by the Quality Improvement Health Equity Committee (described below). EQIHEC.

- Reviews and confirms the ~~appropriate~~ resources ~~needed~~necessary to implement the QIHEP as recommended by the ~~Quality Improvement Health Equity Committee~~EQIHEC.

B. Chief Executive Officer (CEO)

Appointed by the Board of Directors, the Chief Executive Officer (CEO) has ~~the~~ overall responsibility for ~~KHS~~the management and operational viability of KHS. Responsibilities include~~: KHS~~ providing direction~~,~~ for the organization~~,~~ and ~~operation~~overseeing KHS operations; developing strategies for each department, including the ~~QIHE Program;~~QIHEP; overseeing Human Resources direction and ~~position~~leadership appointments; ensuring fiscal efficiency; managing public relations; serving as a governmental and community liaison~~,~~; and ~~contract approval.~~ approving organizational contracts.

The CEO directly supervises the Chief Financial Officer (CFO), Chief Medical Officer (CMO~~,~~), Compliance Department, and the Director of Marketing and Member Services. ~~The~~ The Physician Advisory Committee (PAC) reports to the CEO and ~~contributes information~~provides input regarding provider-related issues.

The CEO ~~interacts~~works closely with the CMO regarding ongoing ~~QIHE Program~~QIHEP activities, progress ~~towards~~toward program goals, and any identified ~~health care~~healthcare problems or quality issues ~~requiring~~that require corrective action.

C. Chief Medical Officer (CMO)

KHS' Chief Medical Officer (CMO) is a physician~~,~~ who is board certified in ~~his or her~~a primary care specialty~~, holding~~ and holds a current, valid, unrestricted California Physician and Surgeon license. The CMO ~~is~~serves as an ex ~~-~~officio member of the ~~BOD~~ Board of Directors and reports directly to the Chief Executive Officer (CEO).

The CMO is the senior ~~healthcare clinician~~ clinical leader of KHS and has ~~the~~ ultimate ~~responsibility~~ accountability for the ~~QIHE Program and~~ QIHEP. The CMO assigns operational authority for ~~aspects~~components of the ~~program~~QIHEP to the ~~Chief Equity Officer~~ CHEO and the Quality Medical Director~~.~~

~~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~~ while retaining overall medical oversight and responsibility to the Board of Directors ~~to provide.~~

The CMO provides medical direction for KHS~~, including professional input and oversight of~~ and ensures that all medical, quality, utilization, and health equity activities ~~of the QIHE Program.~~

~~The CMO reports to the CEO~~ meet or exceed applicable professional standards and ~~communicates directly with the Board of Directors.~~regulatory requirements established by the California Department of Health Care Services

(DHCS), the California Department of Managed Health Care (DMHC), and other applicable authorities. The CMO devotes the majority of ~~the~~professional time to quality improvement, health equity, and medical oversight activities. ~~The~~Key responsibilities ~~of the CMO~~ include:

- ~~supervising the following Medical Services departments and related staff: Quality Improvement, Utilization Management, Pharmacy, Wellness & Prevention.~~
- ~~supervising all QI~~Providing clinical leadership for the development, implementation, and evaluation of the QIHEP.
- Ensuring that quality improvement, utilization management, pharmacy, wellness, prevention, and population health activities meet applicable professional standards and regulatory requirements.
- Supervising quality improvement activities performed by the Quality Improvement Department.
- ~~providing direction for all medical aspects of KHS, preparation, implementation, and oversight of the QIHE Program, medical services management, resolution of~~Providing 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 and associated committees, including the Physician Advisory Committee (PAC) and Drug Utilization Review (DUR) Committee.
- ~~providing assistance with study development~~Developing, reviewing, and ~~coordination of the QIHE Program in all areas to provide continued delivery of~~ approving medical policies supporting utilization management, quality improvement, and health equity functions.
- Overseeing medical dispute resolution, quality-of-care ~~for members~~reviews, peer review activities, and grievance trends.
- Providing oversight of delegated and non-delegated credentialing, recredentialing, and utilization management activities.
- Monitoring provider performance and assisting ~~the Director of~~ with provider network development in collaboration with Provider Network Management.

- Ensuring culturally and linguistically appropriate member and provider materials related to healthcare services and quality expectations.
- ~~Coordinating~~ with ~~provider network development~~
- ~~communicating with the CFO~~executive leadership to ensure ~~that~~ financial or operational considerations do not ~~influence the~~compromise 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 QIHE Program for KHS and an annual summary of the QIHE Program activities to be presented~~Presenting the annual QIHEP Program Description and evaluation results to the Board of Directors and providing ongoing clinical reporting as required.
- ~~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 QIHE Program and among KHS functional areas and staff.~~
- ~~providing direction for internal and external QIHE Program functions, and supervision of KHS staff including:~~
  - ~~Application of the QIHE Program by KHS staff and contracting providers~~
  - ~~Participation in provider quality activities, as necessary~~
  - ~~Monitoring and oversight of provider QIHE Programs, activities, and processes~~
  - ~~Oversight of KHS delegated and non-delegated credentialing and recredentialing activities~~
  - ~~Retrospective review of KHS credentialed providers for potential or suspected deficiencies related to quality of care~~
  - ~~Monitoring and oversight of any delegated UM activities~~
  - ~~Supervision of Health Services staff involved in the QIHE Program, including: Director of Quality Improvement, Director of Wellness & Prevention and Cultural & Linguistics Services, Population Health Management (PHM) Director, Utilization Management (UM) Director, Pharmacy Director, and other related staff~~
  - ~~Supervision of all Quality Improvement Activities performed by the QI Department~~
  - ~~Monitoring covered medical and behavioral health care provided to ensure they meet industry and community standards for acceptable medical care~~

- Active participation in the functioning of the plan grievance procedures

D. Chief Health Equity Officer (CHEO)

D.A. The Chief Health Equity Officer (CHEO)

The Chief Health Equity Officer oversees the development, implementation, review, and revision of health equity policies and procedures; maintains the QIHEP Program Description and Work Plan; coordinates implementation activities; and ensures reporting to the EQIHEC. The CHEO also serves as the primary liaison between Kern Health SystemsKHS and any regulatory agencies on health equity issues and programs. The CHEO sits onserves as a member of the EQIHEC and provides a health equity perspective for all non-clinical areas;. The CHEO seat position on the EQIHEC may not be delegated. The CHEO oversees the development, evaluation, and/or revision of the QIHEP description. The CHEO also oversees howProgram Description and ensures that health equity isprinciples are embedded intothroughout the KHS organizational culture for allin non-clinical aspects (i.e.,areas, including marketing, member engagement, member services, and community supports, etc.).partnerships.

E. Chief Operating Officer (COO)

Under the direction of the CEO, the Chief Operating Officer (COO) plans, directs, monitors, coordinates, interprets, and administers all functional activities and policies related to the Claims, Provider Relations, 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. The COO maintains authority for settingestablishing policies and procedures for thethese departments, which are consistent with the policies and procedures setestablished by the KHS Board of Directors and the CEO, and fall in compliance with applicable regulatory requirements. Executive is responsible for andThe COO also has decision-making authority regarding the organizationfor organizational operations in the absence of the CEO.

F. Quality Improvement Medical Director

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 provideprovides 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

plan's Chief Medical Officer (CMO~~,~~), the Medical Director assists in short- and long-range program planning, total quality management including quality improvement, and external relationships, ~~as well as~~and develops and implements systems and procedures for ~~all~~the medical components of health plan operations.

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

Under the direction of the Chief Medical Officer, the Medical Director:

- ~~Serve~~Serves as a member of the following committees ~~of the KHS Board of Directors:~~: EQIHEC, Physician Advisory Committee (PAC~~,~~), Pharmacy and Therapeutics/Drug Utilization Review (P&T/DUR) Committee, Quality Improvement Committee, and Grievance Committee.
- Participates in carrying out the ~~organization's~~organization's mission, goals, objectives, and continuous quality improvement ~~of KHS~~activities.
- ~~Is responsible for reviewing~~Reviews and ~~managing~~manages the utilization of ~~health care~~healthcare services ~~at~~across all levels of care to achieve high quality outcomes in the most cost-effective manner.
- Provides clinical leadership to ~~the~~ clinical ~~departments~~department staff and works collaboratively with ~~the~~department directors ~~of the other Departments of~~across KHS to ensure compliance with ~~the~~ contractual and regulatory requirements.
- ~~Provide~~Provides clinical support and education to the provider network ~~in support of~~regarding standards of care ~~and~~, evidence-based medicine, and the use of clinical criteria in decision ~~management~~making.
- Represents KHS ~~in~~within the medical community and in ~~general~~ community ~~public~~ relations activities.
- Participates in the implementation of the KHS Credentialing Program.
- ~~Responsible for Review and identification of area~~Reviews performance data to identify areas for improvement and ~~provide~~provides clinical leadership in implementing the ~~implementation of~~ KHS Quality Improvement Plan and ~~the~~ Utilization Management Plan.

- ~~Lead and/~~Leads or ~~attend and actively participate~~participates 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~~,~~ and the Utilization Management Plan.

G. Behavioral Health Provider

The Behavioral Health (BH) Provider is a ~~participating BH provider with an~~ board-certified Psychiatrist (MD or ~~PhD in Psychology~~DO) and ~~is licensed~~ /or Licensed Clinical Psychologist (PhD or PsyD) who maintains an active and unrestricted license to practice in the State of California. The ~~Behavioral~~BH Provider ~~is involved~~serves in a clinical advisory capacity and participates in ~~all~~ behavioral health ~~aspects of the~~ oversight activities in support of the Quality Improvement (QI) and Utilization Management (UM) Programs~~ and advises the BHAC Committee aimed at improving~~. The BH Provider provides clinical consultation, assists with the review of behavioral health performance data, and supports committee activities to promote safe, effective, equitable, and coordinated behavioral healthcare services. ~~Responsibilities include acting~~

The Director of Behavioral Health (BH), licensed through the California Board of Behavioral Sciences, has primary responsibility for behavioral health program oversight, implementation, monitoring, and reporting. The Director of BH serves as ~~the chairperson in~~Chairperson of the KHS Behavioral Health Advisory Committee (BHAC~~),~~) and reports to ~~EQIHEC and provides reports on the key BHAC monitoring activities including~~ the EQIHEC. The Director of BH provides regular and ad hoc reports to EQIHEC that include analysis of performance metrics, utilization trends, access to care, continuity and coordination outcomes, disparities data, and quality improvement interventions.

Key responsibilities of the Director of BH include, but are not limited to:

- Monitoring and facilitating the exchange of clinical information between Primary Care Providers (PCPs) and behavioral health ~~specialists~~practitioners to ensure integrated and coordinated care delivery.
- Overseeing coordination between KHS and the Kern County Managed Behavioral Health Organization (MBHO~~) and~~), as well as certified Substance Use Disorder (SUD) providers~~ for substance use disorder services~~, to promote continuity of care and appropriate transitions across levels of care.
- ~~Supervision~~Ensuring appropriate clinical oversight of diagnosis, treatment planning, referrals, and ~~referral~~follow-up for members with co-~~existing~~occurring medical and behavioral health conditions.

- ~~Collaboration~~Collaborating with Pharmacy ~~for~~Services to monitor the safe, effective, and evidence-based use of ~~psycho-pharmaceutical~~psychotropic medications, including adherence monitoring and medication reconciliation.
- ~~Identification of~~Reviewing behavioral health access, availability, and timeliness data, and implementing corrective actions when performance does not meet established standards.
- Identifying and analyzing social determinants of health~~, and other potential barriers~~ (SDOH), cultural and linguistic needs, and health disparities impacting behavioral health outcomes, and recommending targeted interventions to ~~receiving BH care, including access~~reduce inequities.
- ~~Actively participating in the BHAC Committee and related subcommittees in collaboration with the CMO.~~
- ~~Establishing~~Developing, implementing, and maintaining QI and UM policies and procedures ~~relating~~related to behavioral healthcare~~.~~ to ensure regulatory compliance and alignment with NCQA and state requirements.
- Participating in quality ~~activities related to~~ improvement initiatives addressing continuity and coordination of care between medical and ~~BH practitioners.~~ behavioral health providers, including data-driven performance improvement projects (PIPs), root cause analyses, and monitoring of corrective action plans.

Through a defined governance structure, ongoing monitoring, and structured reporting to EQIHEC, behavioral health services are supported by clinical expertise and administrative accountability, ensuring compliance with regulatory standards and alignment with organizational goals related to quality, access, member safety, and health equity.

H. Executive Quality Improvement Health Equity Committee (EQIHEC)

The Executive Quality Improvement Health Equity Committee (EQIHEC) provides overall direction for the continuous quality improvement process and ~~monitors~~ensures that activities are consistent with ~~KHS's~~KHS strategic goals and priorities. The EQIHEC addresses equity, quality, and safety~~,~~ of clinical care and service, program scope, ~~yearly~~annual objectives, planned activities, ~~timeframe~~timelines for each activity, responsible staff, and monitoring of previously identified issues from prior years~~, and~~. The committee also 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 health management approach ~~to~~for 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~~Physicians serve as voting members for clinical decision making. ~~The QIHEC~~Clinical matters brought before the EQIHEC require participation of licensed clinical practitioners. Voting on clinical issues is ~~comprised of~~ conducted by physician or licensed practitioner members of the committee. The committee includes both internal KHS leadership and community ~~participants.~~representatives. This ~~process~~structure promotes an interdisciplinary~~ and~~, interdepartmental, and community-based approach and drives ~~actions~~action when opportunities for improvement are identified.

~~The~~ **EQIHEC** ~~members consist of:~~**Membership**

- Community Attendees:
  - ~~2 Participating Primary Care Physicians 2 Participating Specialty Physicians~~
  - 4 Providers (at least 2 must be participating network providers)
  - 1 ~~Federally Qualified~~Behavioral Health ~~Center (FQHC)~~ Provider
  - ~~2~~ 2 Community Advisory Committee (CAC) members
  - ~~1 Member of Board of Directors consumer & 1 community consumer~~ 1 Pharmacy Provider
  - 1 Kern County Public Health Officer or representative
  - 1 Home Health~~/~~ or Hospice Provider
  - ~~1~~ 1 Durable Medical Equipment (DME) Provider
- Internal KHS Attendees:
  - ~~CMO~~
  - Chief Medical Officer (CMO)
  - Chief Health Equity Officer (CHEO)
  - Quality Improvement Medical Director
  - Quality Improvement Director
  - Quality Performance Director
  - Utilization Management Director
  - Population Health Management Director
  - ~~BH Committee~~ Behavioral Health ~~Provider~~Director
  - ~~KHS~~ Chief Operating Officer (Grievances ~~&~~and Appeals)
  - ~~P&T Committee Pharmacist~~
  - ~~Public Policy Physician Advisory Committee Physician~~
  - Pharmacy Director
  - Wellness ~~&~~and Prevention Director
  - Health Equity Manager

- Provider Relations Director

The EQIHEC ~~is required to meet~~meets at least four times annually and more frequently as ~~determined. The~~necessary. Activities of the EQIHEC and its QI subcommittees ~~providing information to the EQIHEC~~ are formally documented in ~~transcribed~~meeting minutes~~, which~~ that summarize ~~each~~ agenda ~~item, including~~items, deliberations, decisions, actions taken, recommendations, and required follow-up~~.~~ activities.

Key ~~activities~~responsibilities of the EQIHEC ~~are the~~include review and approval of the ~~QIHE~~QIHEP Program ~~and~~Description, the annual QIHEP Work~~-~~ Plan, periodic work plan progress reports, and ~~QIHE quarterly and~~the annual ~~evaluations. The EQIHEC's~~QIHEP Program Evaluation. Findings and recommendations of the EQIHEC are reported ~~quarterly~~at least annually, and more frequently as appropriate, by the CMO to the ~~BOD~~KHS Board of Directors.

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

EQIHEC Activities:

1. ~~Formulates~~Formulate organization-wide improvement activities with ~~QIHE subcommittee~~ support from EQIHEC subcommittees.
2. ~~Identifies~~Identify appropriate performance measures, standards, and opportunities for performance improvement~~;~~.
3. ~~Assures QIHE Program~~Ensure QIHEP activities ~~are compliant~~comply with ~~the~~ requirements of accrediting and regulatory agencies, including ~~but not limited to,~~ DHCS, DMHC, CMS, and NCQA~~;~~.
4. ~~Evaluates~~Evaluate contract-specific interventions and outcomes.
5. ~~Identifies~~Identify actions to improve quality and prioritize them based on analysis and significance~~; and indicate~~, including determining how ~~the Committee determines these~~ actions ~~to~~will ensure satisfactory outcomes~~;~~.
6. ~~Works closely~~Collaborate with the ~~IT~~Information Technology Department ~~for~~on data collection ~~of data strategy~~ strategies and analytics to ~~effectively analyze data related to the goals and objectives and establish~~ support analysis of performance data and monitoring of program goals ~~to monitor improvement;~~.
7. ~~Ensures all~~Ensure departments ~~can~~ align project goals and ~~map out~~clearly define responsibilities and ~~deadlines~~timelines prior to ~~project~~ implementation~~;~~.
8. ~~Ensures~~Ensure outcomes undergo quantitative and qualitative ~~analyses that incorporate aggregated~~ analysis, including aggregation of results over time and ~~compare results against~~comparison with established goals and benchmarks~~;~~.

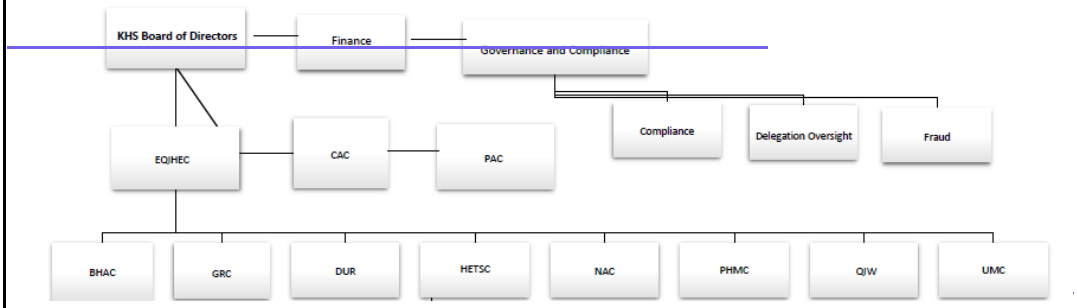
9. ~~Reviews the~~Review analysis and evaluation of ~~QIHE~~QIHEP activities ~~of~~conducted by subcommittees and ~~identifies needed~~identify required actions and ~~ensures~~ follow-up ~~as appropriate,~~activities.
10. ~~Ensures that~~Ensure root cause analyses and barrier analyses are conducted for identified underperformance ~~with appropriate~~ and that targeted interventions~~,~~ are implemented.
11. ~~Reviews~~Review and modify the ~~QIHE~~QIHEP Program Description, annual ~~QIHE~~QIHEP Work Plan, quarterly work plan reports, and annual program evaluation ~~of the QIHE program~~ as necessary to maintain alignment with organizational goals and priorities~~,~~.
12. ~~Communicates~~Communicate the quality and health equity improvement process to practitioners~~/~~, providers, and members through appropriate ~~persons and venues,~~channels.
13. ~~Ensures that the~~Ensure information ~~available to the Plan~~ regarding accessibility, availability, and continuity of care is reviewed and evaluated, including ~~but not limited to information~~data obtained ~~through enrollee~~from member and provider surveys, ~~enrollee~~ grievances and appeals, and triage or screening services~~,~~.
14. ~~Ensures the~~Ensure annual HEDIS, CAHPS, and Health Outcomes Survey (HOS) submissions are ~~delivered according to~~completed in accordance with technical specifications and deadlines~~,~~.
15. Support ~~and assist~~ practitioners and providers ~~to improve~~in improving patient safety within their practices~~,~~.
16. Design and implement strategies to improve compliance~~,~~ with regulatory and contractual requirements.
17. Develop objective criteria and processes to evaluate and continually monitor ~~performance and~~ adherence to ~~the~~ clinical and preventive health guidelines~~,~~.
18. ~~Meets~~Ensure program activities align with healthcare industry standards of practice~~,~~.
19. ~~Improves~~Improve quality, safety, and equity of care and service provided to members~~,~~.
20. ~~Conducts~~Oversee facility site and medical record ~~reviews~~review processes to ~~ensure and~~ support safe ~~and~~, effective ~~provision of~~, and equitable clinical service~~,~~ delivery.
21. ~~Reviews, evaluates~~Review, evaluate, and ~~makes~~make recommendations regarding oversight of delegated activities, ~~such as~~including audit findings, trending analyses, and performance reports.

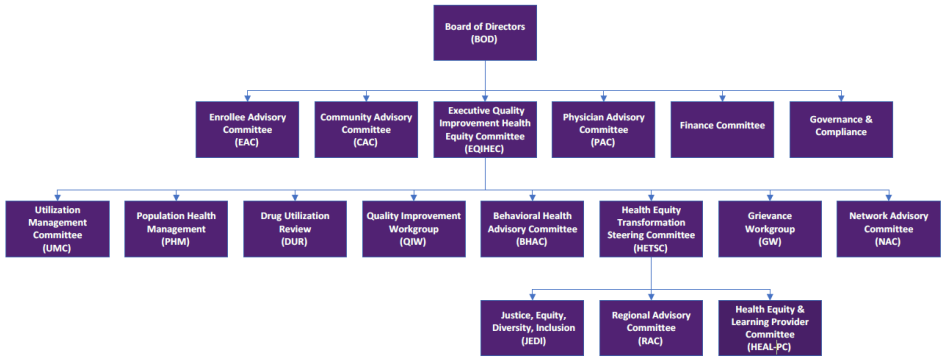
I. Quality Subcommittees

~~There are~~ Multiple KHS ~~sub-committees in place to~~ subcommittees support the ~~QIHEC and QIHEP~~ objectives and goals~~. The activities~~ of the EQIHEC and the QIHEP. These subcommittees are responsible for monitoring, evaluating, and reporting on specific areas of quality, safety, utilization, and member services. Activities of the subcommittees are formally documented in ~~transcribed~~meeting minutes~~, which~~ that summarize each agenda item, the discussion, ~~action~~actions taken, and required follow-up ~~required. This information~~. Information from these committees is

reported at ~~a minimum~~least quarterly to the ~~QIHEC in the format of~~ EQIHEC through formal reports and committee presentations.

Committee Structure





1. Behavioral Health Advisory Committee (BHAC)

~~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. In 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.~~

The ~~KHS~~ Behavioral Health Advisory Committee (BHAC) is a subcommittee ~~to~~of the EQIHEC and ~~is charged with facilitating~~ serves as a collaborative ~~coordination of~~forum to facilitate coordinated medical and behavioral health ~~and substance use disorder~~ services. BHAC supports, reviews, and evaluates interventions that promote strategic alignment between KHS, as a Managed Care Plan (MCP), the County Behavioral Health Plan (BHP), and the Drug Medi-Cal Organized Delivery System (DMC-ODS).

Kern ~~County MBHO~~Behavioral Health and ~~Certified SUD providers caring~~Recovery Services (KBHRS) administers the BHP and DMC-ODS and provides care for KHS members with ~~the goal~~mental health and/or substance use disorders (SUDs). BHAC's purpose is to maintain continuity ~~and~~of care, reduce barriers to access, strengthen linkages to appropriate ~~initial and continuity of care~~services, integrate behavioral and medical care, and provide resources for members receiving behavioral health services.

~~The BHAC is chaired by a KHS credentiated and participating behavioral health provider with an M.D. or Psychologist. Committee attendees include community providers and stakeholders, and internal KHS departmental staff in the Population Health Management, Utilization Management, Health Equity, Pharmacy, and Quality Improvement Departments.~~

~~The committee meets at a minimum four (4) times a year. The key activities of the committee include:~~

~~a. Methods to exchange information and data between KHS the MBHO, Certified SUD Providers, PCP, and Specialists.~~

~~b.~~a. ~~Appropriate diagnosis, treatment, and referral for members with coexisting medical, behavioral and SUDs for all levels of care.~~

~~c.~~a. ~~Management of treatment, access, and follow-up care for members with coexisting medical, behavioral and SUDs for all levels of care.~~

~~d.~~a. ~~Appropriate use of psycho-pharmaceuticals meds.~~

~~e.~~a. ~~Addressing access to care barriers, health inequities, social determinants of health, and cultural and linguistic needs differences for the BH and SUD populations.~~

~~All BHAC~~

Functions

The BHAC supports the quality, safety, and effectiveness of behavioral health and substance use disorder services. Key functions include:

1. Quality Monitoring and Performance

- Review quality monitoring activities related to compliance, corrective actions, delegation oversight, and regulatory requirements.
- Evaluate network accessibility, provider compliance, and performance metrics.
- Monitor Medi-Cal Managed Care Accountability Set (MCAS) measures specific to behavioral health.
- Track and review ~~reports, discussions,~~ member complaints, appeals, and overall member experience using both quantitative and qualitative analyses.
- Provide input on behavioral health quality improvement initiatives.

2. Clinical Guidelines and Program Design

- Provide feedback on behavioral health clinical guidelines and Utilization Management (UM) criteria.
- Assess emerging behavioral health technologies, treatment innovations, and monitoring tools.
- Review site and chart audits and access-to-care standards.
- Ensure services and ~~determination activities conducted by the committee~~programs are ~~recorded~~culturally and ~~summarized~~linguistically appropriate.

3. Coordination and Integration of Care

- Review processes supporting continuity and coordination of medical and behavioral health services.
- Evaluate methods of information exchange across systems and providers.
- Address coordination of carved-out services to reduce fragmentation of care.

4. Member Experience and Engagement

- Provide feedback based on interactions with members receiving behavioral health services.
- Review and incorporate member satisfaction survey results.
- Support behavioral health education and outreach initiatives.
- Promote health equity and improve accessibility of services.

5. Governance and Compliance

- Review and recommend approval of the Behavioral Health Program Description annually.
- Monitor compliance with Memoranda of Understanding (MOUs) with KBHRS.
- Provide structured recommendations to KHS leadership regarding behavioral health service delivery.

Composition

BHAC is co-chaired by the Chief Medical Officer (CMO) and the Director of Behavioral Health. Membership includes behavioral health practitioners and credentialed providers participating in the KHS network.
Appointed Members (minimum):

- 1 Participating Behavioral Health Network Practitioner (Licensed Clinician)
- 1 Participating Behavioral Health Network Practitioner (MD/Psychiatrist)
- 1 Participating Medication-Assisted Treatment (MAT) Provider (Primary Care Provider)
- 1 KBHRS Administrator or designee
- 1 Representative from a contracted FQHC, RHC, or Safety Net Provider
- 1 Local Education Authority representative

Other Attendees:

- Additional KHS clinical staff may attend for consultation but are not voting members.

Quorum: Two-thirds of voting members are required to establish quorum.

Meetings

BHAC meets at least four times annually, with additional meetings scheduled as necessary to address emerging issues, review performance metrics, or support quality improvement initiatives. All discussions, determinations, and recommendations are documented in formal meeting minutes~~. A summary of the activities and reports are~~ and submitted to the EQIHEC.

2. Drug Utilization Review Committee (DUR)

The Drug Utilization Review (DUR) Committee is a subcommittee that reports to the ~~(~~EQIHEC~~).~~ The DUR Committee is comprised of ~~KHS' CMO and~~ the KHS Chief Medical Officer (CMO), the Director of Pharmacy~~, along with,~~ and network pharmacists and providers ~~in the community serving~~who serve KHS members.

The DUR Committee is responsible for reviewing matters related to the use of medications provided to KHS members. The ~~basic~~primary objectives are to ~~provide~~support appropriate medication management ~~for members improving their~~to improve member health and safety~~(~~, oversee medications administered in ~~the~~ outpatient settings ~~by physicians~~ under ~~KHS' Division of~~KHS responsibility, assist with case management, and monitor for ~~possible~~ potential fraud, waste, and abuse (FWA).

~~RX~~ Medi-Cal Rx retains responsibility for formulary drugs carved out ~~to them by the~~ by the California Department of Health Care Services (DHCS~~).~~. KHS may ~~address~~evaluate therapeutic alternatives, based on safety and efficacy, and

identify opportunities to minimize therapeutic redundancies~~,~~ for ~~those drugs~~medications dispensed under the ~~MCRx~~Medi-Cal Rx program.

Activities:

a. Review and recommend pharmacy guidelines,~~ and~~ policies, and procedures based on clinical evidence for ~~those drugs~~medications covered under the medical benefit, ~~often~~commonly referred to as Physician Administered Drugs (PADs).
b. Monitor pharmacy utilization and medication safety measures.
c. ~~Drug Utilization~~ Conduct drug utilization review activities.
~~c.~~a. Review~~.~~
d. ~~Review of~~ reports to identify members and providers with potentially inappropriate~~/~~ or excessive utilization of medication therapy.

The DUR Committee meets at ~~a minimum (~~least four~~)~~ times ~~a year~~annually. All reports, discussions, and ~~determination activities conducted~~determinations made by the committee are ~~recorded and summarized~~documented in formal meeting minutes. A summary of ~~the~~committee activities and reports ~~are~~is submitted to the EQIHEC.

3. Grievance ~~Review Committee (GRC~~Workgroup (GW~~)~~

~~Kern Health System~~ KHS maintains a Grievance and Appeals ~~Process pursuant to~~(G&A) process through which a member, or a provider or Authorized Representative acting on behalf of a member and with the member's written consent~~,~~ (where applicable), may submit a grievance or appeal for review and resolution. The ~~Grievances~~Grievance and Appeals process addresses the receipt, handling, and disposition of member grievances and appeals~~,~~ in accordance with the Department of Health Care Services (DHCS) contract and applicable state and federal statutes~~,~~ and regulations ~~and DHCS All Plan Letters.~~. KHS maintains written records of each grievance and appeal as ~~detailed in~~required under Title 28, Section 1300.68(f)(2)(D) of the California Code of Regulations.

All complaints, grievances, investigations, follow-up activities, tracking, and trending reports are prepared by the KHS ~~Quality Improvement~~Member Services Department and submitted to the Grievance ~~and Appeals (G&A) Review Committee.~~Workgroup. This ~~committee is~~workgroup functions as a subcommittee of the EQIHEC. The ~~G&A Review Committee~~Grievance Workgroup meets at ~~a minimum four (4~~least twelve (12) times ~~a year~~annually.

Under the direction and oversight of the Chief Medical Officer (CMO) or physician designee, individual and aggregate data ~~on~~related to member grievances and appeals ~~is~~are reviewed by the ~~G&A Review Committee.~~EQIHEC. The committee ~~is charged with evaluating~~evaluates and ~~analyzing G&A~~analyzes grievance and appeal data to identify

systemic ~~patters~~patterns of improper ~~services~~service denials and other trends ~~impacting~~that may impact health care delivery to members~~ By implementing necessary changes and process improvements for any.~~ When adverse trends are identified, the committee recommends and implements appropriate process improvements and corrective actions.

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

a. Difficulty obtaining an appointment~~,~~
b. Customer service at the provider or practitioner office~~,~~
c. Billing issues~~,~~
d. Difficulty accessing specialists~~,~~
e. Facility Conditions~~,~~
f. Confidentiality issues~~,~~
g. ~~Refusals~~Refusal of a Primary Care Provider (PCP) to refer the member for care~~,~~
h. Cultural ~~Issues.~~or linguistic concerns

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

a. Appeals of denied Treatment Authorization Requests (TAR~~),~~)
b. Appeals of level-of-care determinations~~,~~
c. Appeals of KHS claims payment denials~~,~~
d. Appeals of primary care physician ~~request~~requests for member disenrollment~~.~~

All ~~G&A~~grievance and appeal review reports~~ and~~, discussions, and ~~determination activities~~determinations conducted by the ~~committee~~workgroup are ~~recorded and summarized~~documented in formal meeting minutes. A summary of ~~the~~ activities and reports ~~are~~is submitted to the EQIHEC.

4. Health Equity Transformation Steering Committee (HETSC)

The Health Equity Transformation Steering Committee (HETSC) is an internal committee established to ensure that KHS remains an organization that understands and addresses social and racial justice and health equity to meet member needs. The committee is responsible for ~~identification~~identifying and ~~management of~~ managing health equity efforts throughout the organization, including the planning, organization, and ~~the~~ direction~~,~~ of the Health Equity Program.

The HETSC ~~is charged with~~conducts systematic ~~analysis~~analyses to identify root causes of health disparities impacting KHS members and ~~collaborating~~collaborates across the organization, with providers, and with ~~other~~ community agencies to ~~eradicate~~eliminate inequities ~~for KHS~~among the members served. The ~~HETSC~~committee

reviews and updates relevant health equity policies and procedures and may review the annual Population Needs Assessment (PNA) to identify opportunities for advancing health equity~~.~~ and incorporating applicable findings into the ~~QIHE program.~~ QIHEP.

The HETSC~~, shall monitor, evaluate~~ monitors, evaluates, and ~~take~~takes timely action to address necessary improvements in the quality and equity of care delivered by network providers in ~~any setting,~~all care settings and ~~take~~recommends appropriate ~~action~~actions to improve ~~upon~~ quality improvement and health equity goals.

This workgroup includes the areas of focus described below. Due to significant overlap and alignment, the KHS DEI/JEDI workgroup may serve as the steering workgroup for health equity activities.

1. Development of Internal Resources~~:~~
   - ~~The focus is to provide~~Focus on providing learning opportunities and activities for staff that promote personal and professional growth and understanding ~~around issues of~~related to social and racial justice, equity, diversity, inclusion, and cultural humility.
2. Provider Network Development~~:~~
   - ~~Focus is to assess specific~~Assess regional needs and the existing ~~skills~~capabilities of the provider network ~~around~~related to health equity ~~and~~ .
   - Provide training, resources, and support to providers to ~~help build on their professional skills and help ensure they provide~~strengthen their ability to deliver culturally ~~sensitive~~responsive and equitable ~~treatment~~care to ~~all~~ members.
3. Member Advocacy & Community Engagement~~:~~
   - ~~Primary focus is to~~ Identify and promote ~~ways that~~ opportunities for members ~~can~~to be educated about and provide feedback ~~regarding~~on their experiences with providers, KHS, and other systems ~~in which~~that impact their health ~~is affected.~~.
   - Utilize member feedback ~~will be utilized~~ to inform strategies ~~developed to~~that advocate for ~~members'~~member needs. ~~The secondary focus is to sponsor and~~
   - Sponsor or participate in community events ~~that are geared toward~~ focused on social and racial justice, develop community engagement initiatives ~~that engage the community, impact~~, address health disparities, and ~~help erase the stigmas~~reduce stigma surrounding mental health and substance use.
4. Human Resources Enhancement~~:~~
   - ~~The focus is to work~~ Focus on recruitment, retention, and promotion of a ~~more~~ diverse workforce~~, as well as to ensure KHS has~~ and maintaining a welcoming and inclusive work environment for ~~all~~ employees.
   - The ~~HR~~Human Resources Department is responsible for ~~creating~~developing, implementing, and overseeing diversity, equity, and inclusion (DEI) policies and practices that ~~have a direct~~ impact ~~on~~ the workforce and

itsorganizational stakeholders. Also, the HR department is committed to upholding the highest standards for prioritizing equitable and inclusive practices and ensuring that

- The workgroup partners with Human Resources to ensure the organization is representative of the communities it serves. By working closely with all departments and stakeholders, this workgroup will partner with the HR department to help ensure that the organization isremains inclusive, equitable, and responsive to the needs of the employees and the communities it servesserved.

5. Monitoring and Evaluation for Continuous Improvement:
   - Focus is to identifyEvaluate how effectively staff apply internal QIHEP policies and procedures. The policy workgroup will determine areas of
   - Identify staff development and training opportunities to ensure discrimination is not present through the application of policies and procedures are applied equitably and without discrimination.

The Health Equity Department Manager reports to the Health Equity Officer and is charged with overseeingCHEO and oversees the day-to-day operations of the Health Equity Department and. The manager is responsible for organizing and preparing the HETSC agenda,agendas, meeting minutes, reporting, and committee activities for reporting to the Executive Quality Improvement Health Equity Committee (submission to the EQIHEC).

The HETSC has established objectives to address health disparities to include, including:

a. Increase the awareness of health equity and quality improvement and implement strengthened, expanded and/, or new health equity quality activities to support providers and members, ultimately reducing health inequities within KHS'the KHS membership.
b. Ensure services provided to members promote equity and are free of implicit bias or discrimination.
c. Implement programs that address the causes of inequity thatexperienced by members and their communities experience,, including food insecurity, housing problemsinstability, tobacco use, and other concernssocial determinants of health.
d. Analyze the existence of significant health care disparities in clinical areas.
e. Reduce health disparities among members by implementingthrough targeted quality improvement programsinitiatives.
f. Promote physician involvementengagement in health equity/ disparities and disparity reduction activities.
g. Conduct focusedfocus groups or key informant interviewinterviews with cultural or linguistic minority members to determine how to meetbetter understand and address their needs.
h. Address social determinants of health that affect member health outcomes.

5. Network Adequacy Committee (NAC)

The Network Adequacy Committee (NAC) ~~shall advance~~ supports the mission of ~~Kern Health Systems (~~KHS~~) of improving~~ to improve the health status of ~~our~~ members through an integrated managed health care delivery system. The NAC ~~will report~~reports to the ~~KHS Executive Quality Improvement Health Equity Committee (~~EQIHEC~~)~~ on ~~KHS'~~KHS monitoring activities, corrective actions, and regulatory requirements related to provider network access, availability, and adequacy.

~~**Function –**~~

Functions

The functions of the NAC ~~are as follows~~include the following:

1. **Establish Network Standards**: ~~Ensuring~~Ensure network accessibility standards (capacity~~/~~ and adequacy, appointment availability, geographic accessibility, ~~etc.)~~and other access requirements) align with Department of 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~~KHS to measure network compliance with established access and availability standards.
3. **Promote Health Equity**: ~~Implement review processes that monitor~~Review network adequacy ~~amongst~~across diverse member populations~~, focusing on~~ to ensure 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 network access or adequacy issues~~. Track~~ and monitor progress of ~~active~~ corrective action plans.

Composition

~~–~~The NAC ~~is delegated by~~operates under the authority of the EQIHEC ~~to monitor~~ and ~~report on~~is responsible for monitoring network adequacy~~. The committee will make~~ activities and reporting findings and recommendations ~~and report findings~~ to the EQIHEC.

~~**Cadance -**~~

Meetings

The NAC ~~will meet quarterly~~meets at four times annually, with additional meetings~~,~~ scheduled as necessary.

6. Population Health Management Committee (PHMC)

KHS follows the National Committee for Quality Assurance (NCQA) definition ~~for~~of 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"~~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 Population Health Management Committee (PHMC) oversees the Population Health Management (PHM) Model of Care (MOC), which addresses individuals' health needs across the continuum of care, including community settings, through participation, engagement, and targeted interventions for defined populations. The goal of the PHM Model of Care is to maintain or improve the physical and psychosocial well-being of members and reduce 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~~, as well as community partners, in the development, execution ~~and~~, monitoring, and evaluation of programs ~~for~~that support members across the continuum of ~~health.~~ care.

Each year, KHS conducts a Population Needs Assessment ~~is conducted by KHS.~~(PNA). The annual PNA describes the overall health and social needs of ~~KHS's~~KHS membership by analyzing service utilization patterns, disease burden, and gaps in care ~~of members, considering their~~, taking into account member risk ~~level~~levels, geographic location, and age groups. PHMC members focus on strategies ~~related~~ to address gaps identified in the PNA~~,~~ ~~addressing~~ and target adverse patterns and outcomes to improve ~~members'~~members' physical and psychosocial well-being through cost-effective and tailored solutions.

The following departments support the PHMC and are actively involved in the development, implementation, monitoring, and evaluation of PHM programs:

- Quality Improvement
- Quality Performance
- Utilization Management
- Member Services
- Behavioral Health
- Enhanced Care Management
- Health Equity
- Wellness and Prevention
- Community Support Services

These departments ~~provide the analysis of~~analyze service utilization patterns, disease burden, and the health and ~~functioning~~functional status of eligible members with chronic medical conditions ~~that~~ , including those whose conditions may ~~also~~ be exacerbated by significant psychosocial needs~~,~~. They also identify and ~~other~~address gaps in care for KHS members.

The following programs are incorporated into ~~PHM and fall under~~Population Health Management and are administered by the ~~administration of the afore mentioned~~respective departments:

- Basic Population Health Management (BPHM)
- Complex Care Management (CCM)
- Long-Term Services (LTC ~~&~~) and Supports (LTSS)
- Major Organ Transplants (MOT)
- Transitions of Care ~~(TOC~~Services (TCS)
- ~~PHM works collaboratively~~Maternal Health Outcomes

Children with ~~the following programs and Departments:~~

- ~~California Children's Services (CCS)~~
- ~~Enhanced~~Special Health Care ~~Management (ECM~~Needs (CSHCN)
- ~~Community Support Services (CSS)~~
- ~~Behavioral Health~~
- Chronic Disease Programs
- Wellness and Prevention Programs

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

- Provide wellness services and ~~intervene on~~ interventions for the highest-risk members~~,~~
- Improve clinical health outcomes~~,~~
- Promote efficient and coordinated health care utilization~~,~~
- Maintain cost ~~effectiveness, and~~ -effective, high-quality care~~,~~
- Improve access to essential medical, ~~mental~~behavioral 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~~ care during transitions ~~in~~between healthcare ~~setting~~settings, providers, and ~~health~~ services~~.~~
- Improve access to preventive health services~~.~~

- ~~Improve beneficiary health outcomes~~

Activities~~:~~

a. ~~Responsibilities of the committee include leading~~Lead strategic analytics, evaluation design, clinical and economic ~~evaluation, and optimizing programing, ensuring that~~evaluations, and program optimization to ensure PHM addresses health ~~at all points on~~ needs across the continuum of care~~;~~.
b. ~~Ensures~~Ensure that ~~the~~ medical care provided meets ~~the~~ community standards for acceptable medical care~~;~~.
c. ~~Collaborates~~Collaborate with behavioral health practitioners and ~~entities~~organizations to ensure appropriate utilization of behavioral health services and continuity and coordination of medical and behavioral ~~healthcare~~health care.
d. Improve ~~communications (exchange of information~~ communication and data sharing~~) between~~ among primary care practitioners, specialists, behavioral health practitioners, ~~and~~ health delivery organizations, and ancillary ~~care provider,~~providers.
e. ~~Monitors~~Monitor the appropriate use of and ~~monitoring of medications,~~adherence to medication management practices.
f. ~~Incorporates Population Health Management~~Incorporate the PHM Model into policies, procedures, and operational workflows~~;~~.
g. ~~Improving~~Improve member access to primary and specialty care, ensuring members with complex health conditions receive appropriate ~~service,~~services.
h. ~~Identifies~~Identify and ~~reduces~~reduce barriers to needed healthcare and social services for members with complex health conditions~~;~~.
i. Improve member health status through ~~the delivery of~~ wellness and disease prevention ~~services,~~ programs~~;~~ that educate and ~~resources by educating and empowering~~empower members to ~~effectively~~ use primary and preventive health ~~care~~ services, ~~modify personal health behaviors, achieve, and maintain~~adopt healthier ~~lifestyles~~behaviors, and follow self-care regimens and treatment ~~therapies for existing medical conditions,~~plans.
j. ~~Ensures~~Ensure continuity ~~in~~of treatment access and follow-up for members with co-occurring medical, behavioral health, and ~~SUD~~substance use disorder conditions.
k. ~~Promotes~~Promote routine depression, anxiety, trauma-~~based~~informed care, and substance use disorder screenings ~~are completed~~, and ensure appropriate follow-up referrals are made for adolescent and adult members with chronic ~~health~~ conditions and for women during pregnancy and the postpartum period.

~~i.~~~~a.~~ Link members to Enhanced Care Management (ECM~~,~~), Community Supports Services (CSS~~, SUD Providers~~), behavioral health providers, and other community-based programs ~~with~~that provide comprehensive and holistic ~~approaches.~~

~~7.~~1. ~~Community Advisory Committee (CAC)~~

~~The Community Advisory Committee (CAC) provides a mechanism for structured input from KHS members regarding how KHS operations impact the delivery of their care. The Board of Directors delegates the CAC to provide input in the development of public policy activities for KHS. The committee makes recommendations and reports findings to the Board of Directors. The role of the CAC is to implement and maintain community linkages.~~

~~**Function –** The functions of the CAC are as follows:~~

~~1. Review changes in policy or procedures that affect KHS Members.~~
~~2.~~1. ~~Provide updates on state policies or issues that affect Members.~~
~~3.~~1. ~~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.~~1. ~~Allow committee members to share experiences that will help KHS improve how care is delivered.~~
~~5.~~1. ~~Advise on educational and operational issues affecting members who speak a primary language other than English;~~

~~m.~~l. ~~Advise on cultural and linguistic issues~~care.

~~8.~~7. Quality Improvement Workgroup (QIW)

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

Activities~~:~~

1. Review and ~~approve~~recommend approval of the ~~QIHE~~QIHEP Program Description, the annual Work Plan, and the annual evaluation of the Work Plan.

2. Ensure compliance with Department of Health Care Services (DHCS) facility site review requirements.
3. Review aggregate data ~~of potential quality of care~~related to Potential Quality Issues (PQIs), identify ~~areas of~~ opportunities for improvement, and oversee implementation of ~~improvements~~corrective actions.
4. Oversee the KHS patient safety program.
5. ~~Oversee the identification of~~Identify quality-of-care trends and recommend corrective ~~action~~actions as needed.
6. Monitor evidence-based care through ~~the~~ HEDIS and Medi-Cal Managed Care Accountability Set (MCAS) ~~audit~~performance results and make recommendations for ~~areas of~~ improvement.
7. Review and discuss ~~YTD~~year-to-date quality improvement initiatives.
8. Monitor member satisfaction by reviewing ~~the~~ Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey ~~Outcomes~~results and address ~~measures~~areas of member dissatisfaction.

~~9.~~8. Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) is a subcommittee of the EQIHEC and focuses on ~~the~~ oversight of Utilization Management (UM) activities. The ~~UM Committee~~UMC supports the ~~QIHEC around~~EQIHEC by monitoring the appropriate provision of medical services and ~~provides~~providing recommendations ~~for~~related to 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 and utilization patterns~~.

The responsibilities of the UMC include developing, recommending, and refining UM program policies and procedures, including medical necessity criteria; establishing thresholds for acceptable utilization levels; ensuring the reliability of clinical information with the involvement of appropriate actively practicing practitioners; and developing and implementing monitoring systems to track, compile, and evaluate UM measures against established standards. The committee also evaluates utilization patterns to identify overutilization and underutilization of services.

Activities~~:~~

a. Establish and implement written utilization management protocols and criteria applicable to the review of medical necessity for inpatient, outpatient, and ancillary services.
b. Ensure that UM decisions:

1) Are made independent of financial incentives or obligations.
2) Medical decisions, including those made by delegated providers and rendering providers, are not unduly influenced by fiscal ~~and~~or administrative management.
3) Physician compensation plans do not include incentives ~~for~~related to denial decisions.
4) ~~Physician~~Physicians and UM decision designees are not rewarded ~~for~~based on utilization review ~~decisions~~determinations.

c. 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.
d. Review ~~established~~ nationally ~~acceptable~~accepted utilization benchmarks, medical literature, and outcome data, as ~~applicable~~appropriate.
e. Develop and implement ~~a~~ monitoring ~~system~~systems to track, compile, and evaluate patterns and variations in care.
f. Continually monitor and evaluate utilization practice patterns of staff ~~and~~, contracted practitioners, and vendors and identify variations in care.
g. Review state regulatory oversight of Long-Term Care (LTC) and Community-Based Adult Services (CBAS) facilities and ~~develop and maintain a process to identify and work~~coordinate with Quality and Credentialing teams to address identified quality ~~issues.~~ concerns.
h. 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~~support care coordination and service delivery.
i. Facilitate and ensure continuity of care for members within and outside of the KHS provider network.
j. Develop and implement performance measures to ~~assure~~ensure regulatory ~~turn-around~~ turnaround time ~~frames~~requirements are met.

J. QI Support Committees

1. Community Advisory Committee (CAC)

The Community Advisory Committee (CAC) provides a link between the community and Kern Family Health Care (KFHC) members to support the delivery of quality services and care that are accessible to all members. The CAC provides input, oversight, and recommendations regarding KFHC policies and member-facing activities as a delegated advisory body to the Board of Directors.

Functions

The functions of the CAC include the following:

1. Review proposed changes to policies or procedures that affect KFHC members.
2. Provide updates and feedback regarding state policies or issues that may impact KFHC members.
3. Provide input on matters that impact members, including member-facing materials and communications such as marketing materials, the KFHC website (including the Provider Directory and Doctor Search tools), the Evidence of Coverage, brochures, flyers, health education materials, radio, television, and billboard advertisements, and member incentive ideas or items.
4. Share member and community experiences that may help KFHC improve how care and services are delivered.
5. Advise KFHC on educational and operational issues affecting members who speak a primary language other than English.
6. Provide recommendations regarding cultural and linguistic considerations to improve accessibility and member experience.

~~1.~~2. Delegation Oversight Committee

The purpose of the ~~Kern Health Systems (~~KHS~~)~~ Delegation Oversight Committee (DOC) is to ensure adequate oversight of performance and adherence to regulatory contracts, requirements, and KHS standards related to subcontractors to which KHS delegates ~~any~~ plan-required ~~function(s).~~functions. This ~~includes~~ oversight ~~of~~includes the ~~entire spectrum, from~~full delegation lifecycle, including pre-delegation ~~auditing, monthly~~audits, quarterly Joint Operating Meetings, routine oversight of delegate reporting and~~/or~~ audits, and annual audits conducted by KHS department leads and staff.

The Compliance Department ~~is~~serves as the leader, facilitator, and coordinator of formal audits of delegated entities as outlined in the annual compliance ~~and~~ monitoring~~/~~ and auditing work plans.

KHS may ~~choose to~~ delegate Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Credentialing, Compliance, Claims, and other ~~departments~~departmental activities and responsibilities to qualified entities~~,~~ where ~~regulatorily allowed.~~permitted by regulatory requirements. The DOC is responsible ~~to oversee~~for overseeing the ongoing assessment of delegated entity performance ~~results~~ to ensure ~~contract~~adherence to contractual and regulatory ~~requirement adherence, as well as achieving business~~requirements and to support achievement of organizational goals and ~~outcomes to deliver~~ delivery of high-quality outcomes for ~~our~~ members.

Duties and Responsibilities

1. Evaluate prospective delegated ~~vendor's~~vendors' ability to perform ~~the~~ proposed delegated activities ~~prior to delegation~~ through ~~a~~ pre-delegation ~~audit~~audits conducted by the relevant business areas.

2. Ensure KHS departments ~~which delegate~~delegating functions establish performance and reporting ~~deliverables for departmental business needs~~requirements designed to assess the effectiveness of health care delivery to members and compliance with regulatory requirements.

3. Review business owners' updates on monitoring and oversight activities and subcontractor performance~~, recommending action~~ and ~~providing~~provide recommendations or feedback ~~where necessary.~~ as appropriate.

4. Assist departments ~~with~~in establishing effective ~~departmental~~ auditing tools designed to measure and report delegated entity performance ~~to~~and ensure compliance with regulatory requirements.

5. Review results of ~~all~~ annual audits of delegated entities, ~~as~~ coordinated by the Compliance Department in accordance with the annual compliance~~,~~ monitoring and auditing work plans.

6. In ~~conjunction~~collaboration with the Delegation Oversight Department, ensure KHS business owners perform all necessary oversight of ~~the~~delegated functions ~~delegated~~ as ~~set forth~~specified in ~~the~~ written delegation ~~agreement on behalf of KHS~~agreements.

7. Review and evaluate delegated ~~entity's~~entity performance, including business owner updates ~~on~~regarding monitoring and oversight activities presented to the DOC.

8. ~~Assist with identifying~~Identify opportunities for performance improvement and ~~/or recommending~~recommend corrective action plans ~~as needed~~ when ~~a deficiency has been~~deficiencies are identified.

9. Review audit findings, recommended changes to contracts and policies, and requested initiatives or project updates ~~by the delegate entity~~submitted by delegated entities.

10. Make recommendations to the Chief Compliance and Fraud Prevention Officer, Compliance Committee, Contract Business Owners, Governance and Compliance Committee, and/or Board of Directors regarding the compliance status of ~~the~~ delegated ~~entity as it relates~~entities in relation to ~~compliance with~~ regulatory requirements, performance expectations, and~~/or~~ other ~~documented requirements.~~ contractual obligations.

11. Escalate ~~outstanding~~unresolved issues from the DOC to the Compliance Committee and/or ~~Kern Health Systems~~the KHS Board of Directors~~, as needed.~~ when appropriate.

12. Recommend and ~~provide oversight of~~oversee corrective action plans (CAPs) to address deficiencies from initiation through ~~CAP~~ closure.

13. ~~Propose~~Recommend sanctions ~~up to and~~, including ~~the~~ revocation ~~and/~~or termination of delegation, if ~~the~~ delegated ~~entity's~~entity performance is inadequate and corrective action plans are not successful.

~~2.~~3. Physician Advisory Committee (PAC)

~~The functions of~~ The Physician Advisory Committee (PAC) ~~encompass~~performs multiple ~~activities to include,~~functions, including serving as the KHS Credentialing and Peer Review Committee~~,~~; overseeing ~~and determining~~ the review and approval of medical technologies and clinical criteria sets~~,~~; addressing and managing the review of sentinel ~~conditions~~events or adverse events identified ~~for~~as quality concerns~~,~~; and ~~evaluates~~evaluating the credentials of all current and prospective practitioners and providers ~~to be added to~~seeking participation in the KHS network~~,~~. Credentialing decisions are based ~~upon~~on requirements ~~by~~ established by the Department of Health Care Services (DHCS~~,~~), Department of Managed Health Care (DMHC~~,~~), Centers for Medicare and Medicaid Services (CMS~~, or~~), National Committee for Quality Assurance (NCQA) accreditation standards, and other applicable ~~law.~~ laws and regulations.

The PAC ~~is actively involved~~also participates in the ~~establishment~~development and oversight of policies related to the KHS Code of Conduct, protection of Protected Health Information (PHI~~)~~), and prevention of Fraud, Waste, and Abuse (FWA). The PAC is comprised of a broad spectrum of ~~KHS~~ participating KHS physician representatives from primary and specialty care.

PAC~~:~~ Credentialing and Peer Review

~~The~~Committee minutes are confidential~~,~~ and ~~information is~~ protected under California ~~Business and Professions~~ Evidence Code Section 1157. In accordance with state law, minutes containing confidential peer review information ~~will~~may be redacted.

The responsibilities of the Credentialing~~/~~ and Peer Review Committee ~~are to develop, monitor, and maintain~~include developing, monitoring, and maintaining credentialing standards~~, oversight of~~ ; overseeing the credentialing program~~,~~ and delegated credentialing ~~oversight, conducting~~activities; and incorporating performance monitoring results from quality improvement activities and member complaints ~~in the~~into recredentialing ~~decision making process~~decisions for the KHS network of participating practitioners and health delivery organizations.

The PAC ~~Committee~~ establishes and maintains credentialing~~/re-credentialing~~ and recredentialing policies and procedures that are consistent with ~~National Committee for Quality Assurance (~~NCQA~~)~~ standards~~, as well as~~ and applicable state and federal laws and regulations. ~~The~~ Credentialing ~~Committee may~~decisions are not ~~base credentialing decisions~~ based on an applicant's race, ethnic~~/~~ or national identity, gender, age, sexual orientation, patient type, or ~~patient's~~the type of insurance coverage ~~in which~~held by the ~~practitioner specializes~~practitioner's patients.

Activities~~:~~

a. Maintain a well-credentialed network of providers and practitioners based on recognized and mandated credentialing standards.
b. Promote continuous improvement in the quality of ~~the~~ care and ~~service~~services provided by ~~the~~ KHS network providers.
c. Investigate patient, member, or practitioner complaints or concerns ~~about~~regarding the quality of clinical care or ~~service provided~~services and ~~to~~ make recommendations for corrective actions~~,~~ ~~if~~ when appropriate.
d. Provide guidance on the overall direction of the credentialing program.
e. Review ~~at least annually~~ the Credentialing ~~Committee~~ Program Description at least annually to ~~assure that~~ensure the program ~~is~~remains comprehensive~~,~~ and effective in meeting ~~the goals and standards of~~ KHS credentialing~~/~~ and recredentialing ~~procedures and supports the Continuous Quality Improvement process~~standards and supporting continuous quality improvement.
f. Evaluate quality concerns related to medical care and ~~make determinations as to~~determine whether ~~there is~~ sufficient evidence exists that ~~the involved~~a practitioner failed to provide care ~~within~~consistent with generally accepted standards.
g. ~~Monitoring~~Monitor the reporting of provider preventable conditions.

PAC ~~-~~Medical Technologies and Clinical Criteria Sets

a. ~~The PAC uses~~Apply principles of evidence-based medicine ~~in its evaluation of~~when evaluating clinical guidelines ~~oversight~~ and monitoring ~~of~~ the quality and cost-effectiveness of medical care provided to KHS members.
b. ~~Performs reviews of~~ Review medical technologies for use by medical and behavioral ~~staff~~health practitioners in the utilization review process.
c. ~~Outlines the~~Establish medical necessity criteria for coverage ~~for a~~of specific ~~technology, service~~technologies, services, or ~~device and as~~devices, incorporating applicable ~~incorporates~~ federal and state ~~regulations~~regulatory requirements.
d. ~~Ensures~~Ensure KHS does not exert economic pressure ~~to cause~~on 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.
e. Assess standards of health care as applied to members and providers, assist ~~with~~in the development of performance indicators for studies, and review clinical guidelines ~~that are promulgated~~distributed to contracting providers~~;~~.

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

The PAC ~~is instrumental in participating~~participates in ~~the establishment~~establishing and ~~maintenance of~~maintaining the following:

1. Confidentiality policies and procedures ~~for protection of~~to protect 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~~Protected Health Information (PHI) is disclosed only in accordance with federal, state, and other applicable regulatory requirements.

   ~~information (PHI) is only released in accordance with federal, state, and all other regulatory agencies.~~

3. ~~Providing oversight in~~ Oversight of strategies to prevent and reduce ~~FWA in~~ fraud, waste, and abuse within the provider ~~networks~~network.

~~3.~~4. Compliance Committee

~~Kern Health Systems (~~KHS~~)~~ is committed to preserving the ~~preservation and~~ integrity of its mission through ~~the enforcement of~~adherence to contractual, legal, ethical, and regulatory standards and guidelines. All KHS employees are expected to ~~adhere to these governing~~comply with applicable laws, regulations, and ethical standards. Management is responsible for ensuring ~~such~~ compliance with these requirements; therefore, compliance is an integral ~~part~~component of ~~good~~effective organizational governance.

~~The establishment of~~ The KHS Compliance Committee ~~(Committee) through this Charter evidence KHS' commitment to the highest~~ oversees and provides guidance related to integrity and ethical standards~~, thereby supporting~~ and supports KHS compliance with contractual obligations~~,~~ and all applicable laws~~,~~ and regulations. The Compliance Committee ~~is~~functions as an oversight committee.

Responsibilities

1. ~~The Compliance Committee's responsibilities include, but are not limited to:~~

   ~~a.~~ Determine ~~the~~ appropriate ~~strategy~~strategies and~~/or approach~~ approaches to promote compliance; ~~to~~ prevent, detect, and correct potential violations; and ~~to~~ advise the Chief Compliance and Fraud Prevention Officer, the Compliance ~~Officer~~Department, and operational departments accordingly.

~~b~~2. Review and approve training related to the Compliance ~~and~~Program, Code of Conduct, Fraud, Waste, ~~or~~and Abuse ~~issues~~(FWA), and privacy requirements, and ensure that training and education activities are effective and completed appropriately ~~completed;~~.

~~c~~3. Review Fraud, Waste ~~or~~, and Abuse reports, including member- and provider-reported cases~~;~~, through the Fraud, Waste, and Abuse Subcommittee.

~~d~~4. Review reported ~~HIP AA~~HIPAA incidents, including prevention and education~~;~~ activities.

~~e~~5. Review ~~Timely Access Reporting;~~

~~f. Review DHCS Attestation~~regulatory reporting deliverables~~;~~.

~~g~~6. Review delegated entities to ensure ~~their~~ performance ~~on~~of delegated functions ~~meet~~meets KHS standards~~;~~ through the Delegation Oversight Subcommittee.

~~h~~7. Review internal and external ~~audits~~audit reports and auditing tools, including ~~reporting~~ outcomes and remediation efforts. Address ~~when~~situations where there is risk of program ~~non-compliance and/~~noncompliance or potential ~~FWA~~fraud, waste, and abuse, and ensure corrective action plans (CAPs) are implemented and monitored for effectiveness~~;~~.

~~i~~8. Review ~~overall~~the effectiveness of ~~the~~ internal controls designed to ensure compliance with applicable regulations in daily operations~~;~~.

~~j~~9. Review reports from the Compliance ~~Officer~~Department and other operational departments, as identified, on at least a quarterly basis~~, concerning~~ regarding the overall Compliance Program~~;~~ and adherence to regulatory requirements.

~~k~~10. Review reports received from regulators regarding monitoring of KHS compliance activities.

11. Monitor the Quality Improvement, Appeals, and Grievance processes, including identifying opportunities to improve quality and service through trend ~~management;~~analysis.

~~l. Validate~~12. Ensure that KHS ~~has~~maintains appropriate and current compliance policies and procedures~~;~~.

~~m~~13. Review the ~~Office of Compliance's~~ process for soliciting, evaluating, and responding to reports and disclosures ~~within~~received through the Compliance Program.

~~n~~14. Oversee ~~the~~ implementation of applicable federal and state programs, including contractual, legal, and regulatory requirements~~, as they relate~~ related to compliance risk, and coordinate with the Compliance Department and the Chief Compliance and Fraud Prevention Officer to ensure the ~~adequacy of the~~ Compliance Program is sufficient to manage ~~the~~organizational compliance ~~oversite of programs; and~~oversight.

~~o. Respond~~15. Review and ~~manage Ad Hoc issues.~~

~~2. In accordance with KHS Policy 4-40-P Corrective Action Plans, the Compliance Committee will monitor the issuance of Corrective Action Plans (CAPs) by the KHS Physician Advisory Committee (PAC). The Compliance Committee will also review tracking and trending concerns and make recommendations when deemed necessary.~~

~~3. In collaboration with the PAC, the Compliance Committee, shall evaluate the effectiveness of each CAP and make recommendations regarding ongoing monitoring activates to ensure continued~~address ad hoc compliance issues as needed.

~~4.~~5. Health Equity Advisory Board

The Health Equity Advisory Board serves as a regional advisory body supporting Quality Improvement (QI) and Health Equity initiatives in Kern County. The board recruits racially, ethnically, and culturally diverse ~~(~~individuals, including ~~those~~representatives from LGBTQI+ communities~~) people.~~ from various stakeholder groups across the county. ~~These~~

Members may include, but are not limited to, general consumers ~~from~~representing racial and ethnic groups ~~that make up KHS's members,~~reflected in KHS membership, the Kern County Health Officer or a designated representative, representatives from County Behavioral Health and County Human Services ~~representatives~~, community-based organizations, community advocates, regional centers, Women, Infants, and Children (WIC) agencies, local education agencies, and traditional and safety net providers.

Advisory Board members focus on issues ~~of~~related to health equity, access, quality, diversity, ~~equity,~~ and inclusion ~~in~~within KHS ~~procedures~~programs and performance metrics to improve health equity. ~~They may:~~ outcomes.

Activities

The Health Equity Advisory Board may:

- Participate in ~~establishing~~advising on public policy ~~which is defined as acts performed by KHS or its employees and staff to assure~~ activities related to KHS programs and services that support the comfort, dignity ~~and convenience of patients who rely on KHS' facilities to provide health~~, and accessibility of care ~~services to them~~for members, their families, and the ~~public~~broader community.
- Review and ~~make~~provide recommendations ~~on~~regarding marketing and member-facing materials.
- Review and ~~make~~provide recommendations ~~on~~regarding the member complaints and grievance process.
- Review and ~~make~~provide recommendations ~~on~~regarding member and provider satisfaction surveys.
- Review and ~~make~~provide recommendations on activities related to Quality Improvement, educational initiatives, operational issues, and cultural competency ~~issues~~concerns affecting Limited English Proficiency (LEP) members.

- Review and ~~make~~provide recommendations ~~on~~regarding staff ~~&~~and provider training related to health equity ~~related training~~.
- Review and ~~make~~provide recommendations ~~on~~regarding contracted vendors and community-based organizations (CBOs~~.~~).

~~5.~~6. Health Equity and Learning (HEAL)

The mission of the Provider Health Equity and Learning (HEAL) Committee is to foster a collaborative environment among healthcare providers ~~in Kern Health Systems, dedicated to advancing~~within KHS that advances health equity. The purpose of the committee is to:

1. Solicit Feedback: ~~Act~~Serve as a platform for providers to share challenges ~~faced~~experienced in ~~the field~~practice and ~~gather~~provide feedback ~~to address~~on issues related to health equity ~~to help~~. This feedback helps inform the development of ~~KHS's~~KHS training ~~offerings,~~ programs, initiatives, and support for ~~Provider Network~~the provider network.
2. Resource Sharing: Facilitate the exchange of resources, funding opportunities, best practices, and innovative approaches to improve healthcare service delivery with a focus on health equity.
3. Training and Development: Identify, develop, and promote opportunities for training and professional development ~~to~~that enhance ~~providers'~~providers' knowledge and skills in delivering equitable healthcare.
4. Practice Expansion: Explore and discuss opportunities ~~for expanding~~to expand access ~~and/or~~to services ~~that align with~~ and support initiatives that advance health equity ~~initiatives~~.

Composition

The HEAL Committee reports to the Health Equity ~~Steering and~~ Transformation Steering Committee~~.~~ (HETSC).

Membership

1. Membership in the Provider HEAL Committee is open to ~~all~~ healthcare practices within ~~Kern Health Systems~~the KHS provider network that express ~~an~~ interest in promoting health equity.
2. ~~Membership~~Participation is voluntary and may include healthcare professionals, administrators, and other relevant stakeholders.
3. Members are expected to actively contribute to the mission and objectives of the committee.

Meetings

1. The committee ~~shall meet regularly,~~meets at least quarterly, either in person or virtually.

2. Additional ad -hoc meetings may be ~~called~~convened as necessary to address specific issues or opportunities.

~~6.~~7. Regional Advisory Committee (RAC)

The Regional Advisory Committee (RAC) ~~is a~~meets quarterly ~~meeting held in one city in each of the~~across Kern County's five regions ~~of Kern County. Every quarter a~~to engage members in discussions about their health and to gather direct community feedback. Each session focuses on a priority topic and is ~~selected~~open to ~~discuss with~~ members and community stakeholders to ~~learn strategies~~share experiences, challenges, and opportunities for improvement ~~and challenges being faced. The.~~

Feedback and insights gathered during RAC meetings are ~~open to everyone in the region and information gained from each region is~~ synthesized at the county level to help inform ~~gaps and best practices occurring throughout the county. These finding~~policy and procedure enhancements, staff and provider training, and targeted outreach and education initiatives.

Findings and recommendations are ~~presented~~elevated to the Health Equity Transformation Steering Committee (HETSC) ~~for review~~ and ~~determination of action steps~~the EQIHEC to ~~address the needs of the county~~support strategic decision making and improve services ~~to~~for Kern Family Health Care members.

IV. Organizational Structure and Resources

A. Clinical Oversight of QIHEP

Under the direction of the Chief Medical Officer (CMO~~,~~), the Medical Directors are responsible for clinical oversight and management of the Quality Improvement Health Equity Program (QIHEP). The program is implemented by the Quality Improvement (QI~~,~~) and Health Equity (HE) departments, with input and collaboration from Quality Performance (QP), Utilization Management (UM~~,~~), Behavioral Health (BH~~,~~), Wellness and Prevention, and Population Health Management (PHM).

Medical Directors oversee clinical aspects of QIHEP activities~~, participating in QIHEP~~ for KHS and its ~~Practitioners, and overseeing~~ participating practitioners, including oversight of credentialing functions~~.~~ and clinical quality initiatives.

Medical Directors must possess a valid ~~Physician's~~Physician and ~~Surgeon's Certificate~~Surgeon license issued by the State of California and ~~certification~~be certified by one ~~(1)~~ of the American ~~Specialty Boards.~~ Board of Medical Specialties (ABMS) member boards.

Principal Accountabilities ~~include:~~

1. ~~Developing~~Develop and ~~implementing~~implement medical ~~policy for~~policies supporting Health Services department activities and ~~QI~~ Quality Improvement functions~~;~~.
2. ~~Reviewing~~Review current medical practices ~~ensuring that~~ to ensure clinical protocols are implemented and that KHS medical personnel ~~of KHS follow~~ adhere to established professional standards and rules of conduct~~;~~.
3. ~~Ensuring that~~Ensure assigned members ~~are provided health care~~receive appropriate healthcare services and medical attention ~~at~~across all service locations~~;~~.
4. ~~Ensuring~~Ensure that medical care ~~rendered~~delivered by participating practitioners meets applicable professional standards for acceptable medical ~~care~~practice.

B. Quality Improvement Department (QI)

Quality Improvement Director

Under the direction of the Chief Medical Officer (CMO) and the Quality Improvement ~~(QI)~~ Medical Director, the Director of Quality Improvement ~~leads~~is responsible for the development, implementation, and oversight of Quality Improvement (QI) initiatives ~~to enhance~~that improve health outcomes and address health disparities ~~within~~among the ~~Kern Health Systems (~~KHS~~)~~ membership. The Director ensures alignment with the KHS ~~Quality Management Plan~~QIHEP, Medi-Cal contractual requirements, and National Committee for Quality Assurance (NCQA) accreditation standards, while ~~fostering~~promoting a culture of continuous improvement across the organization.

Key responsibilities ~~include~~:

- QI Program Development: ~~Designs~~Develops and implements ~~programs that align with KHS's Health Equity and Quality Improvement goals~~quality improvement initiatives aligned with KHS quality and health equity priorities, regulatory standards, and contractual obligations.
- Performance Monitoring & Reporting: Oversees data collection, medical record ~~reviews~~review activities, and ~~analysis of key~~ performance monitoring to evaluate key quality indicators ~~to~~and inform ~~decision-making~~improvement strategies.
- Provider & Community Collaboration: Engages ~~with~~ contracted providers and ~~external~~community partners to ~~drive QI~~support quality improvement initiatives, address disparities, and improve member health outcomes.
- Regulatory Compliance & Accreditation: Ensures compliance with Medi-Cal ~~QI~~quality requirements~~, oversees credentialing,~~ and ~~leads efforts~~supports organizational readiness for regulatory reviews and accreditation ~~preparedness~~activities.

- Interdepartmental Coordination: Facilitates collaboration across KHS departments and external ~~agencies~~partners to integrate ~~QI~~quality improvement activities into ~~organizational~~operational workflows.
- Leadership & Workforce Development: Provides leadership, mentorship, and guidance to QI staff~~, ensuring~~ while supporting professional ~~growth~~development and alignment with ~~KHS's~~KHS quality and health equity objectives.

The Director of QI plays a ~~pivotal~~central role in ~~advancing health equity by~~ identifying disparities, implementing targeted interventions, and ~~continuously~~ improving healthcare quality across the KHS provider network.

NCQA Manager

~~The NCQA Manager,~~ Under the direction of the Director of Quality Improvement, ~~ensures KHS maintains~~the NCQA Manager oversees activities that support the organization's NCQA accreditation and ~~compliance~~ensures alignment with state ~~regulations~~regulatory requirements related to the Quality Improvement Program. This role ~~provides oversight for the successful completion of~~ leads organizational efforts related to initial ~~and renewal~~ accreditation ~~efforts~~ and reaccreditation activities and ~~ensures~~supports ongoing ~~alignment of KHS departments~~compliance with NCQA standards~~, State certification,~~ and contractual quality requirements.

Key responsibilities ~~include:~~

- Accreditation & Regulatory Compliance: Leads the development, coordination, and implementation~~, and coordination~~ of policies~~, procedures,~~ and ~~workflows~~processes required to meet NCQA~~,~~ standards and Medi-Cal~~, and Medicare D-SNP model of care~~ quality requirements.
- Quality Program ~~Support: Integrates~~Integration: Ensures NCQA standards and ~~State regulations~~regulatory requirements are incorporated into ~~QI~~organizational quality improvement processes~~, ensuring compliance across all KHS business areas~~.
- Policy ~~&~~and Process Development: Oversees ~~the~~ development and revision of accreditation~~ and compliance~~-related policies~~, incorporating feedback from~~ and procedures and coordinates updates based on regulatory ~~agencies~~guidance.
- Cross~~-Departmental~~ Department Collaboration: Works with KHS leadership and ~~staff~~ operational departments to embed quality improvement ~~initiatives~~activities into organizational ~~operations, supporting a culture of continuous improvement and health equity~~processes.

The NCQA Manager ~~plays a critical role in maintaining KHS's~~supports the organization's commitment to ~~quality~~regulatory compliance, accreditation~~, and regulatory compliance, ensuring that all initiatives support health equity~~ readiness, and ~~member-centered care.~~continuous quality improvement.

NCQA Accreditation Specialist

Under the direction of the NCQA Manager, the NCQA Accreditation Specialist supports ~~the~~ planning, ~~execution~~coordination, and maintenance of NCQA Health Plan Accreditation and Health Equity Accreditation activities at ~~Kern Health Systems (~~KHS~~).~~. This role ~~ensures~~assists with accreditation readiness ~~by coordinating efforts across departments, following established guidelines,~~ and ~~maintaining a comprehensive~~coordinates cross-departmental activities required to maintain compliance with NCQA ~~accreditation work plan~~standards.

Key responsibilities ~~include:~~

- Accreditation Readiness ~~&~~and Compliance: ~~Assists in managing the NCQA~~ Supports accreditation ~~process, ensuring adherence to~~ preparation activities and ensures documentation and processes align with NCQA standards~~, quality studies, and interventions that support~~ and regulatory ~~compliance and health equity goals~~requirements.
- Process Coordination ~~&~~and Monitoring: ~~Leads interdepartmental coordination to support~~ Coordinates cross departmental activities related to accreditation ~~requirements, track progress, and facilitate corrective action~~work plans and monitors progress toward compliance milestones.
- Quality ~~&~~and Performance ~~Enhancement: Works to ensure outstanding~~Support: Supports quality improvement initiatives that contribute to improved clinical performance and ~~a positive~~ member experience~~, contributing to KHS's commitment to continuous quality improvement and equitable care~~.

The NCQA Accreditation Specialist ~~plays an essential role in sustaining NCQA compliance, ensuring high-quality care delivery, and reinforcing KHS's mission to~~supports the organization's efforts to maintain accreditation readiness and advance ~~health equity~~equitable and ~~member well-being~~ high quality care.

Quality Improvement Manager, RN

Under the direction of the Director of Quality Improvement, the Quality Improvement Manager ensures ~~state,~~ regulatory, ~~and~~ contractual, and accreditation compliance for the ~~Quality Improvement (~~QI~~)~~ Program.

Key responsibilities ~~include:~~

- Regulatory ~~&~~ and Audit Oversight: Manages delegation audits~~,~~ and external quality reviews~~, ensuring~~ to ensure compliance with Medi-Cal ~~and~~ contractual and regulatory requirements.
- Quality Improvement Initiatives: Leads Performance Improvement ~~Plans,~~ Projects (PIPs), improvement plans, and other targeted quality initiatives ~~aimed at enhancing~~ designed to improve clinical outcomes and care delivery ~~and patient outcomes~~.

- Operational Leadership: ~~Applies~~Provides clinical ~~expertise~~ and ~~analytical skills to oversee the day-to-day operations of the~~operational oversight for QI ~~team, driving~~ activities and supports implementation of data~~-informed~~ driven improvement strategies ~~to improve performance and member health equity~~.

The ~~Quality~~QI Manager plays ~~a critical~~an important role in advancing quality improvement ~~efforts, ensuring compliance,~~activities and supporting ~~KHS's mission to enhance~~ equitable ~~and,~~ high ~~-~~quality care delivery.

Quality Improvement Supervisor, RN

The Quality Improvement ~~(QI)~~ Supervisor, RN oversees the daily operations ~~and activities~~ of clinical and non ~~-~~clinical staff within the ~~QI~~Quality Improvement Department~~, ensuring the effective management~~. Responsibilities include oversight of clinical grievances, Potential Quality Issues (PQIs), Performance Improvement Projects (PIPs), and other ~~key quality initiatives. This role involves providing leadership, guidance, and oversight to maintain compliance with regulatory requirements and drive continuous improvement. The QI Supervisor collaborates closely with the QI Manager to optimize workflows, enhance efficiency, and support the successful execution of quality improvement~~quality initiatives.

The QI Supervisor provides leadership, guidance, and oversight to ensure compliance with regulatory requirements and supports implementation of quality improvement activities. The Supervisor collaborates closely with the QI Manager to optimize workflows, improve operational efficiency, and support department performance goals.

Quality Improvement Nurse, RN

The ~~QI~~Quality Improvement Nurse ~~assists in~~supports clinical activities related to monitoring, ~~assessing~~evaluating, and improving ~~performance in~~ healthcare delivery for KHS members in both ambulatory and inpatient ~~health care delivery or health care related services to Kern Health Systems (KHS) membership.~~settings. The QI Nurse assists ~~in the~~with implementation of the ~~KHS~~ QI Program ~~Plan by doing~~through the following activities:

- Communicates with contracted providers regarding quality studies and audit findings~~,~~
- ~~Delivers~~Provides provider ~~or~~and member education ~~in support of~~related to quality ~~health care,~~improvement initiatives
- Conducts medical record reviews ~~and,~~ audits, and HEDIS or HEDIS ~~-~~like chart reviews~~,~~
- ~~Performs clinical investigation of~~Investigates potential quality of care ~~issues~~concerns and member grievances and ~~writes an effective~~prepares clinical ~~summary of the investigation~~summaries for ~~referral to a medical director,~~Medical Director review
- ~~Develop~~Assists with development and ~~ensure completion~~monitoring of provider corrective action plans related to quality ~~-~~of ~~-~~care ~~issues~~concerns or regulatory ~~or accreditation non-compliance,~~noncompliance

- ~~Develop and complete~~ Participates in performance improvement projects ~~aimed at improving member compliance with specific~~designed to improve preventive ~~health measures.~~care and clinical outcomes

Quality Improvement Coordinator

Reporting to the Quality Improvement Manager, the Quality Improvement ~~(QI)~~ Coordinator ~~plays a key role in~~ supports data collection, ~~record maintenance~~documentation management, and regulatory compliance ~~support~~activities for the QI Program. ~~This position is integral to~~

Key responsibilities

- Data Collection and Reporting: Supports Managed Care Accountability Set (MCAS) ~~initiatives, intervention development, and provider site review~~reporting, data tracking, and documentation of QI activities.

~~Key responsibilities include:~~

- ~~Data Collection & Reporting: Supports MCAS methodology, assists in data entry, report preparation, and ensures accurate documentation for QI activities.~~
- Regulatory ~~&~~and Compliance Support: Assists ~~in~~with medical record requests, ~~record~~documentation preparation, and ~~QI~~quality interventions~~, ensuring readiness for~~ in support of regulatory reviews and audits ~~and compliance with State and contractual requirements~~.
- Provider Site Review ~~Assistance~~Support: Provides administrative ~~support~~coordination for facility site reviews and ~~collaborates~~supports collaboration with internal departments and external ~~agencies to facilitate QI~~partners involved in quality improvement initiatives.

The QI Coordinator ~~plays a vital role in supporting quality improvement efforts, ensuring regulatory compliance, and assisting in~~supports the ~~execution~~operational activities of the QI Program and contributes to implementation of data ~~-~~driven quality improvement and health equity ~~interventions within the QI Program~~initiatives.

C. Quality Performance Department (QP)

Senior Director of Contracting and Quality Performance

Under the direction of the Chief Operating Officer (COO) and Chief Medical Officer (CMO), the Senior Director of Contracting and Quality Performance ~~(QP) is responsible for~~oversees provider contracting, quality performance programs, and practice transformation initiatives at ~~Kern Health Systems (~~KHS~~).~~. This ~~role~~position ensures ~~the integrity of~~ provider agreements, value-based care initiatives, and quality improvement ~~(QI) programs, aligning~~activities align with regulatory~~, legal~~ requirements, contractual obligations, and organizational strategic ~~business objectives~~goals.

Key responsibilities ~~include:~~

- Provider Contracting ~~&~~and Compliance: Develops and negotiates provider contracts~~, ensuring~~ and ensures compliance with regulatory requirements, contractual obligations, and organizational risk ~~mitigation, and alignment with KHS's business needs~~management standards.
- Quality ~~&~~and Performance Management: Oversees Pay-for-Performance (P4P) ~~programs~~initiatives, Managed Care Accountability Set (MCAS) reporting, and provider ~~QI initiatives to enhance~~ quality improvement activities to improve clinical performance and provider engagement ~~and healthcare quality~~.
- Practice Transformation ~~&~~and Value-Based Care: Supports providers in transitioning to value-based care models~~, leveraging health IT and~~ through data analytics ~~to improve care delivery and health equity,~~ performance reporting, and practice transformation initiatives.
- Provider Network ~~Efficiency &~~Performance and Financial ~~Performance~~Oversight: Leads process ~~improvements~~improvement initiatives, rate development ~~for provider contracts~~, and oversight of provider incentive and special ~~provider~~ funding ~~distributions~~programs.
- Credentialing ~~&~~and Compliance ~~Oversight~~Coordination: Ensures facility site review processes, credentialing standards, and provider compliance with contractual and ~~legal~~regulatory requirements.

The Senior Director ~~of Contracting and QP~~ plays a ~~critical~~key role in ~~driving~~strengthening provider network ~~integrity, optimizing quality~~ performance, ~~and advancing health equity, ensuring that contracted providers deliver~~improving quality outcomes, and supporting equitable access to high-quality~~, culturally competent, and accessible~~ care for KHS members.

Director of Quality Performance

Under the direction of the Senior Director of ~~Contract~~Contracting and Quality Performance, the Director of Quality Performance ~~is responsible for oversight,~~ oversees the implementation~~,~~ and management of ~~new~~ quality ~~improvement~~performance initiatives ~~specific to~~for the KHS provider network and membership. This includes ~~being responsible for~~ oversight of HEDIS and Medi-Cal Managed Care Accountability Set (MCAS ~~functions)~~ activities and ~~collaborating and supporting~~collaboration with providers to improve ~~health outcomes related to those~~ performance on quality measures.

The Director ~~is~~ also ~~responsible for~~oversees quality ~~improvement~~ initiatives related to Performance Improvement Projects (PIPs~~) and),~~ Facility Site Reviews (FSRs~~). The Director will communicate),~~ and ~~coordinate~~provider engagement activities. Responsibilities include coordinating with ~~contract~~contracted providers ~~regarding~~on 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.~~ initiatives, and quality reporting activities.

~~The Director of Quality Performance is responsible for HEDIS/MCAS and performance and site review 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~~Key Responsibilities

- Develop and maintain collaborative relationships ~~(internally and externally) vital to the success of programs~~with internal departments and external provider partners.
- ~~Assisting network providers and their staff with~~ Support provider practice transformation ~~plans~~efforts to ~~shift into~~improve value-based care~~, improving quality and~~ performance, encounter data ~~submissions~~submission, and quality outcomes.
- ~~Helps practices to identify areas of need and helps with efficiency measures to improve availability, through sharing of~~ Provide providers with performance feedback through scorecards, ~~delivering gaps~~gap-in-care ~~information and~~ reports, risk reports, ~~sharing of~~and satisfaction results ~~as applicable, and delivering other critical operational and efficiency reports~~.
- ~~Monitors and ensures that key~~Monitor quality improvement activities ~~are completed on time~~and ensure timely completion of required reports and ~~accurately to present results to key departmental management~~analyses.
- ~~Evaluates project/~~Evaluate program ~~activities~~performance and ~~results to~~ identify opportunities for improvement.
- ~~Responsible~~Provide leadership and oversight for Quality Performance staff and departmental processes.
- ~~Work collaboratively with Senior Director and Provider Network team to~~ Develop physician ~~practice~~ performance profiling ~~on~~related to HEDIS~~/~~, MCAS~~/STAR~~, and other quality metrics~~, identify opportunities for improvement, and support/manage change implementation~~.
- ~~Establishes and maintains~~ Maintain tracking ~~and monitoring~~ systems for ~~health care~~ quality improvement ~~activities according to~~initiatives and regulatory reporting requirements~~,~~.
- Monitor HEDIS and MCAS performance and identify barriers and improvement opportunities.
- Ensure staff maintain current knowledge of DHCS and DMHC regulatory requirements and quality measure specifications.
- Participate in development and revision of departmental policies and procedures~~, and contractual agreements~~.
- ~~Track~~Coordinate quality performance activities with Utilization Management, Quality Improvement, Pharmacy, and ~~monitor the~~ Population Health Management departments.

- Support provider education related to HEDIS~~/~~, MCAS ~~improvement~~, and quality program goals.
- Ensure compliance with applicable regulatory reporting and quality monitoring requirements.

Quality Performance Manager

The Quality Performance Manager oversees daily operations~~.~~ of MCAS and HEDIS activities, quality improvement projects, and departmental productivity. The Manager supervises MCAS and HEDIS staff and works closely with the Director of Quality Performance to ensure compliance with regulatory and contractual quality requirements.

~~Identify opportunities and potential barriers~~Key responsibilities

- ~~Maintain expertise~~ in MCAS, HEDIS~~/MCAS~~
- ~~Research and documents current health care standards for use in performance improvement study design and methodologies~~ , and 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~~measurement specifications.

  - ~~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~~Lead planning and implementation of ~~methods~~initiatives designed 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~~.
- Serve as a key contributor to the annual HEDIS audit process.

- Develop programs that promote member engagement, improve health outcomes, and enhance member satisfaction.
- Support development of departmental policies, procedures, and program documentation.
- Provide staff training related to quality improvement processes and regulatory requirements.
- Collaborate with senior leadership to support communication with the provider network and other stakeholders.

Quality Performance Supervisor

The Quality Performance Supervisor oversees the daily operations of the KHS facility site review team. The Supervisor maintains certification as a DHCS Master Trainer for site reviews and has experience in quality improvement or healthcare operations.

Under the direction of the Director, the Supervisor plans, coordinates, and monitors quality special programs, including:

- DHCS facility site review requirements
- Department strategic goals~~.~~ and special quality programs related to provider site reviews and education

Quality Performance Nurse, RN

~~The QP nurses possess~~ Quality Performance Nurses maintain a valid California Registered ~~Nursing~~Nurse license and ~~three years registered nurse~~possess clinical experience in ~~an~~ acute ~~health~~ care ~~setting preferably in emergency, critical and/or general medical-surgical care. The QP nurses assist in the~~ or related healthcare settings. These nurses support implementation of the ~~QI~~ Quality Improvement Program and Work Plan through ~~the~~ongoing quality monitoring ~~process. Staffing will consist of an adequate number of QI nurses with the required qualifications to complete the full spectrum of~~activities.

Primary responsibilities ~~for the QI Program development and implementation. Additionally, the QI nurses teach contracting~~include supporting MCAS performance activities and the KHS facility site review program. QP Nurses also educate contracted providers on DHCS ~~MMCD~~Managed Care Division standards and KHS policies and procedures to ~~assist them in maintaining~~support regulatory compliance. ~~The primary function of the QP nurse is implementation and support of MCAS performance and KHS' site review program.~~

~~**MCAS/HEDIS Supervisor**~~

~~The QP MCAS/HEDIS Supervisor is responsible for oversight and daily operations of KHS' MCAS/HEDIS performance. The Supervisor 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 Supervisor 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.).~~

Quality Performance Operations Analyst

The ~~QP~~Quality Performance Operations Analyst ~~is responsible for~~supports reporting ~~needs~~and data management activities related to MCAS and facility site review ~~reporting needs.~~programs. The Analyst serves as ~~the Subject Matter Expert (SME)~~a subject matter expert for MCAS and HEDIS ~~aspects~~components of ~~KHS'~~the KHS Quality Program. Under the direction of the ~~Supervisor and~~ Director~~, this position provider oversight, management,~~ and Supervisor, the Analyst oversees validation and submission of data ~~and reports submissions~~required for the annual DHCS MCAS~~/~~ and HEDIS ~~audit~~audits. This ~~includes serving~~role also serves as ~~the~~a liaison between the ~~QP~~Quality Performance Department, vendors, and internal ~~KHS~~ departments~~,~~ such as ~~IT.~~ Information Technology.

Quality Performance Coordinator

~~The QP~~Quality Performance Coordinators ~~are responsible for functions~~support operational activities related to data collection, data entry, report preparation, ~~maintenance, collaboration, and regulatory compliance support for the department. The coordinator serves as the liaison between the health plan and provider network for~~ and documentation management for quality performance initiatives.

Under the direction of the Director or Supervisor, Coordinators assist with medical record retrieval, scheduling, ~~and various departmental initiatives and interventions. Under the direction of the QP Director and/or Supervisor, the Coordinators perform Quality related duties, including but not limited to~~provider outreach, and regulatory reporting activities. Coordinators also support MCAS data collection, ~~sorting, chasing, and analyzing medical records.~~ medical record review activities, and other departmental quality improvement initiatives.

D. Health Equity Department

Chief Health Equity Officer (CHEO)

The Chief Health Equity Officer ~~oversees~~(CHEO) is responsible for the strategic leadership, development, implementation, ~~review and~~ and oversight of health equity initiatives across KHS. The CHEO oversees the development, implementation, evaluation, and revision of health equity policies ~~and,~~ procedures~~;~~, and programs that support the QIHEP.

The CHEO maintains the QIHEP Program Description and Work Plan~~;~~, coordinates implementation activities~~;~~, and ensures appropriate reporting to the EQIHEC. The CHEO ~~also~~ serves as the primary liaison between ~~Kern Health Systems~~KHS and ~~any~~ regulatory agencies on health equity ~~issues and~~ programs~~.~~ and initiatives.

The CHEO ~~sits on~~serves as a member of the EQIHEC and provides a health equity perspective for ~~all~~ non-clinical areas~~;~~ of the ~~CHEO seat~~organization. This position may not be delegated. ~~The CHEO oversees the development, evaluation, and/or revision of the QIHEP description.~~ The CHEO also ~~oversees how~~ensures that health equity ~~is embedded~~principles are integrated into ~~the KHS culture for all non-clinical aspects (i.e.,~~organizational practices, including member engagement, marketing, member ~~engagement, member~~ services, community ~~supports, etc.);~~partnerships, and community support programs.

Health Equity Manager

The Health Equity Manager is responsible for the ~~daily~~day-to-day management and operational implementation of the QIHEP ~~including~~. This position oversees development and ~~management~~implementation of ~~projects and activities~~health equity initiatives, programs, and interventions designed to ~~expand and advance~~improve the delivery and quality of ~~health equity measures, cultural competency~~culturally and linguistically appropriate services~~;~~ for KHS members.

The Health Equity Manager supervises staff within the Health Equity Office (HEO) and supports operational ~~effectiveness through~~activities including project management, process improvement initiatives, contract ~~execution~~implementation, and performance monitoring~~. The Health Equity Manager supervises all staff directly working in the Health Equity Office (HEO).~~ related to health equity activities.

Senior Health Equity Analyst

The Senior Health Equity Analyst ~~will provide reports;~~provides data analytics, reporting, project management~~,~~ ~~process improvement~~ support, and ~~data integrity based on~~operational analysis for the Health Equity Office. This position supports the collection, ~~association, compliance review~~validation, analysis, and interpretation of data ~~and operational processes. The~~ related to health equity initiatives and organizational performance.

The Senior Health Equity Analyst ~~is responsible for developing a complete understanding of the stated and actual~~works to identify disparities, operational gaps, and improvement opportunities through structured analysis of program data and stakeholder needs ~~of Health Equity Office stakeholders (internal and external), not simply their expressed desires, through a methodical analytical process, identify and report gaps, and help develop solutions to~~

address revealed findings. The Senior Health Equity . The Analyst assists the HEO in defining the technicalanalytical and reporting needs of KHS'srequirements for QIHEP and initiatives and activities of the Health Equity Transformation Steering Committee (HETSC initiatives and). The position may also facilitate or govern analytical discussions between various groupsand data interpretation activities across internal departments and external partners.

Health Equity Project Coordinator

The Health Equity Project Coordinator coordinatessupports the coordination and organizes projects for the Health Equity Office. Supports the successful implementation of projects within timelines for associated department assignments and tasks. initiatives managed by the Health Equity Office. This position also coordinates the functions assists with project planning, scheduling, and tracking of the health equity initiatives to ensure activities are completed within established timelines.

The Health Equity Project Coordinator also provides administrative and operational support for the EQIHEC and allassociated subcommittees, including coordination of meeting logistics, documentation, and reporting activities.

E. Appeals and Grievances

Member GrievancesGrievance and Appeals System

KHS maintains a Member Grievance and AppealAppeals system that complies with theapplicable federal and state regulatory requirements set forth in the, including 42 Code of Federal Regulations (CFR) Sections 438.228 and 438.400 – 438.424, Title 28 California Code of Regulations (CCR) Sections 1300.68 and 1300.68.01, and Title 22 CCR Section 53858.

KHS useutilizes all applicable notice templates included in theDHCS All Plan Letter (APL) 21-011 and ensures that members receive timely written acknowledgement and a acknowledgment of grievances and appeals, as well as written notice of resolution to the member as quickly as possiblewithin required regulatory timeframes.

Grievances withthat involve a Potential Quality Issue (PQI) identified are referred to the Quality Improvement (QI department as a PQI referral) Department for further investigation and actionfollow-up. All potential quality of care issuesconcerns are reviewed by the KHS Chief Medical Officer (CMO) or their designee to determine the severity level and appropriate follow-up actions needed. .

All PQI cases are tracked and the data provided to the CMO or designee incorporated into provider monitoring activities and may be reviewed during the provider credentialing/re-credentialing and recredentialing process. OtherAdditional actions may include tracking and trending a providerproviders for additionalrepeated PQIs and/or request(s) for a requesting corrective action plan (CAP) for issues orplans (CAPs) when quality concerns are identified during review.. When appropriate, the CMO or their designee may present select cases to the Physician

Advisory Committee (PAC) for further review and ~~direction as needed~~recommendations.

KHS regularly analyzes grievance and appeals data to identify~~, investigate, report and act upon~~ trends ~~impacting health care~~related to healthcare access, quality of care, and service delivery. Findings from grievance and appeal analyses are used to ~~the members~~inform quality improvement activities and corrective actions when necessary.

Grievance Satisfaction Data

~~-~~KHS also reviews member ~~grievances~~grievance trends and satisfaction ~~study~~survey results ~~as methods for identifying~~to identify potential patient safety issues and opportunities to improve member experience and quality of care.

F. Credentialing

The Credentialing Department operates under the direction of the Deputy Director of Contracting and Quality Performance, who reports to the Chief Operating Officer (COO) and is responsible for Provider Operations~~, including~~. Responsibilities include oversight of credentialing staff activities and ~~re-~~credentialing ~~functions, oversight~~ processes for directly contracted practitioners, providers, and delegated Independent Practice Associations (IPAs~~, and resolving credentialing-related Provider issues.~~).

The Chief Medical Officer (CMO), or the Medical Director designee, maintains overall clinical oversight of the credentialing program. The CMO participates in the development and review of the credentialing program, credentialing processes, and credentialing policies and procedures. The CMO or designee reviews and approves practitioner and provider credentialing and recredentialing files and reports credentialing actions to the Board of Directors.

Provider Operations~~, which~~ includes Provider Contracting, Provider Network Management, Provider Relations, and Provider Training ~~&~~and Development~~, is committed to having~~. These functions support the development and maintenance of a culturally competent and linguistically accessible provider network ~~comprised~~that reflects the diversity of ~~diverse providers who are knowledgeable~~the KHS membership and is responsive to members' cultural practices and beliefs.

~~This includes a commitment to identifying, assessing, and addressing behavioral health inequities to eliminate disparities and ensure access to healthcare for all members.~~ Provider Operations ~~contributions to organizational QIHE~~also contributes to the QIHEP by supporting initiatives ~~includes the management of providers' profile and~~ that identify, assess, and address disparities in healthcare access and delivery. This includes analysis of provider demographic and profile data ~~analyses to that of the KHS members'~~to help ensure alignment between the provider network and the cultural and ~~linguistical~~linguistic needs~~.~~ of KHS members.

G. Member Services

KHS implements and maintains written policies and procedures that ~~set forth the Member's~~define member rights and responsibilities ~~and shall communicate its~~. These policies are communicated to ~~its~~KHS members, providers, and~~,~~ prospective members upon request~~, potential members.~~. KHS ensures that members are ~~also assured~~informed of their rights, including the right to confidentiality~~;~~ of personal health information, the right to establish advance directives, and ~~rights~~the right to ~~linguistic~~receive language assistance services and culturally appropriate communications. Member Services supports the QIHEP by assisting members with access to care, responding to member inquiries, and facilitating communication between members, providers, and KHS departments.

H. Pharmacy Department

The Pharmacy Department supports the QIHEP through medication safety monitoring, provider outreach, and collaboration with interdisciplinary teams to promote safe and effective medication use for KHS members.

Medication Safety Monitoring~~: Pharmacy will expand on the current monitoring of~~

KHS conducts ongoing monitoring of medication utilization to promote safe prescribing practices and reduce the risk of adverse drug events. The Pharmacy Department reviews pharmacy claims and prescribing patterns to identify potentially inappropriate medication use and opportunities for intervention.

Safety monitoring activities include:

- Monitoring opioid prescribing patterns, including high-dose opioid therapy, concurrent opioid and central nervous system depressant use (such as benzodiazepines or muscle relaxants), and members receiving opioids~~/controlled substances as defined by~~ without naloxone. These activities align with federal opioid safety initiatives, including provisions of the SUPPORT Act. ~~Though previously managed via prospective Pharmacy Benefit Manager (PBM) rules, KHS will retrospectively~~
- Conducting retrospective review ~~claims for possible action in regard to the Beer's list for~~of medications identified on the Beers Criteria for potentially inappropriate medication use among geriatric members. ~~KHS will also monitor~~
- Monitoring and responding to 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~~U.S. Food and Drug Administration (FDA) or pharmaceutical manufacturers.

When potential medication safety concerns are identified, KHS sends notification letters to the ~~physician on record to evaluate the~~prescribing provider requesting evaluation of the medication regimen for clinical appropriateness ~~of~~

~~the regimen for that member~~.

Provider Collaboration and Interdisciplinary Review

The Director of Pharmacy, or designee, participates in interdisciplinary ~~teams weekly to discuss drug~~care review meetings to evaluate medication regimens ~~of~~for select members~~. KHS also sends letters~~ and identify opportunities for improved medication management. KHS also provides targeted communication to providers regarding ~~drug~~ member medication profiles ~~of members that have been identified~~when potential issues such as ~~having~~therapeutic duplication, drug ~~duplications,~~ interactions, ~~and/~~or missing therapies~~.~~ are identified.

Quality Performance and Gap Closure

The Pharmacy ~~is~~Department supports quality performance initiatives by developing ~~a series of report suites~~and maintaining reporting tools 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~~may be non-compliant ~~for that measure, and we will be working~~ with ~~other depts~~quality measures related to ~~best close the gap. The approach will incorporate brining in the local~~medication adherence or pharmacy-related HEDIS and Medi-Cal Managed Care Accountability Set (MCAS) measures. These reports are used to support collaboration with internal departments and community pharmacies to ~~help with~~conduct outreach to ~~the~~ members and providers, improve medication adherence, and close identified care gaps.

I. Population Health Department (PHM)

The ~~Kern Health System (~~KHS~~)~~ Population Health Management (PHM) ~~Service will support~~ Department supports whole-person care by integrating and ~~aggregating historical~~analyzing administrative, medical, behavioral health, dental, social service, and program ~~information~~data from ~~disparate~~multiple sources. This integrated approach ~~will drive~~enables risk ~~-~~stratification, population segmentation, tiering, screening and assessment ~~and screening~~ processes, data analytics, and performance reporting. ~~By transforming raw~~

Through the transformation of data into actionable insights, PHM ~~will identify~~identifies opportunities for continuous quality improvement~~, reduce bias~~ and ~~error in~~supports informed decision ~~-~~making. These efforts allow KHS ~~will~~to connect ~~its~~ members ~~to~~with the ~~right~~appropriate services and supports at the right time and ~~place depending~~in the appropriate care setting based on their needs and preferences.

~~In addition to data integration, PHM will facilitate meaningful~~PHM also facilitates engagement with network providers, public health agencies, schools, and community-based organizations (CBOs) to ~~enhance~~strengthen data sharing across the healthcare delivery ~~systems~~system. These partnerships ~~will promote~~support care coordination and help identify and ~~mitigate~~address social determinants of health (SDOH) that contribute to health disparities~~.~~

~~Through these collaborative efforts, KHS aims to connect all members to primary care, preventive and wellness services, and disease management programs while ensuring members at risk for complex health issues are linked to specialized services~~.

~~PHM will also gather, share;~~Through these collaborative efforts, KHS works to ensure members are connected to primary care providers, preventive and ~~assess timely~~ wellness services, disease management programs, and ~~accurate~~ other appropriate healthcare services. Members identified as having complex health needs are connected to specialized services and care management programs.

PHM collects, analyzes, and shares timely member data to identify ~~efficient and effective~~ opportunities for intervention~~. This will be achieved through data-driven risk stratification,~~ and improvement. These activities include predictive analytics, identification of care gaps, ~~and~~ standardized ~~assessment~~assessments, and risk stratification processes. ~~These tools will allow~~This approach allows KHS to proactively identify members with rising health risks and ~~provide personalized~~implement targeted interventions to improve health outcomes and reduce ~~health~~ disparities.

~~KHS will~~ PHM activities also support ~~the unique needs~~ identification and management of members ~~population, including~~ with diverse health and social needs~~ (e.g.,~~, including behavioral health, developmental health, physical health, and oral health~~);~~ needs. This includes members requiring Long-Term Services and Supports (LTSS~~) needs~~), as well as ~~health risks, rising risks, and~~members experiencing health-related social needs ~~due to~~associated with social determinants of health (SDOH~~) in~~).

Findings from the Population Needs Assessment~~. KHS is~~ (PNA) inform PHM strategies and interventions designed to address identified gaps in care and improve the overall health of the KHS membership. Through these efforts, KHS remains committed to ~~ongoing initiatives to deliver~~delivering comprehensive, coordinated, and equitable care across its service areas.

J. Human Resources Department

The KHS Human Resources Department ~~is dedicated to promoting~~supports the organization's commitment to diversity, equity, and ~~inclusivity~~inclusion within the workforce. ~~Comprised of~~The department includes Talent Acquisition, Employee Relations, Benefits and Wellness Programming, and Learning and Professional Development~~, the department is committed to implementing~~. Human Resources implements equitable and accessible recruiting, hiring, onboarding, professional development, and succession planning practices ~~to ensure and sustain a diverse workforce. To enhance cultural and linguistic competency within the organization, the HR department prioritizes creating a culture of trust, empathy, and humility, guiding employees towards a deeper understanding of cultural and linguistic diversity in their daily work. The department will also work towards developing policies and leadership practices that continuously support diversity, equity, and inclusion in compliance with regulations, supportive of~~

~~organizational values, and in pursuit of industry best practices. This will help the organization remain trusted and highly responsive to the needs of employees and the communities it serves~~designed to support and sustain a diverse workforce.

To strengthen cultural and linguistic competency across the organization, the Human Resources Department promotes a culture of trust, empathy, and cultural humility. Through training, policy development, and leadership engagement, the department supports employees in developing a deeper understanding of cultural and linguistic diversity in their daily work. Human Resources also works to ensure policies and leadership practices support diversity, equity, and inclusion while remaining compliant with regulatory requirements, aligned with organizational values, and reflective of industry best practices. These efforts help ensure KHS remains responsive to the needs of employees, members, and the communities it serves.

1. Hiring Initiatives

As described in the KHS Diversity, Equity, and Inclusion (DEI) Program Charter, KHS is ~~dedicated~~committed to building a workforce that is diverse, qualified, and engaged, and ~~one~~ that reflects the diversity of the communities ~~KHS serves in~~served throughout Kern County. KHS strives to ~~create~~maintain a workplace environment that is safe, inclusive, and strengths-based, providing ~~abundant~~ opportunities for employees of all backgrounds, cultures, and linguistic abilities to ~~belong~~contribute and ~~flourish.~~ succeed.

Human Resources and hiring managers are responsible for ensuring that recruiting, hiring, and succession planning practices ~~are inclusive~~promote inclusion and reflect the demographic needs of the communities served.

~~Commitment to~~ Health equity considerations in hiring~~, recruiting,~~ and ~~succession planning includes~~ recruitment include:

- Posting job opportunities ~~in~~using inclusive language across a broad network of recruitment platforms and diversity ~~job sites and~~-focused job boards ~~to help attract a more diverse workforce, including groups of underrepresented individuals. KHS also incorporates~~.
- Incorporating inclusive language into job descriptions~~, conducts~~ and position announcements.
- Conducting panel interviews ~~with members reflective of the community's~~that reflect community diversity~~, and uses~~.
- Utilizing standardized assessment tools~~.~~ to support equitable hiring practices.

These practices help ensure KHS ~~aims to create~~maintains a ~~diverse and inclusive~~ workforce ~~that can provide better~~capable of delivering culturally responsive services to ~~all communities~~its diverse membership.

2. KHS Bilingual Workforce

~~Departments who~~ Several KHS departments employ staff members ~~to~~who provide linguistic services to ~~the membership include~~members, including Behavioral Health, Wellness ~~&~~and Prevention, Marketing, Member Engagement, Member Services, Utilization Management, Population Health Management, Enhanced Care Management, Community Support Services, Quality Improvement, and Pharmacy. ~~All bilingual staff must pass a verbal bilingual assessment before being hired or during employment. Certificates of linguistic proficiency are monitored and maintained by the Cultural and Linguistic Team. For KHS staff who have received certification of bilingual proficiency, a copy of the certificate is kept in their personnel file with Human Resources.~~

All bilingual staff must pass a verbal bilingual proficiency assessment either prior to hire or during employment. Certificates of linguistic proficiency are maintained and monitored by the Cultural and Linguistic Services team. Copies of bilingual certification documentation are maintained in the employee's personnel file by Human Resources.

KHS defines qualified ~~bi-lingual~~bilingual staff as individuals who:

- ~~Proficient~~Demonstrate proficiency in speaking and understanding a language other than English.
- ~~Having a fundamental~~Possess working knowledge ~~in a language other than English that includes the use and application of~~ of specialized vocabulary, terminology ~~and phraseology~~, and concepts required to communicate effectively in healthcare settings.
- ~~Having the ability~~Are able to communicate directly ~~effectively~~, accurately, and impartially with members who have limited English proficiency~~.~~ (LEP).

~~KHS~~ Member Services ~~Bi-lingual Representative staff will only~~bilingual representatives provide oral interpretation services ~~and are prohibited from providing~~only. These staff are not permitted to provide written translation services, including editing~~, and~~ or proofreading translated documents, ~~and~~or to perform sight translation ~~services~~.

K. Provider Network Management (PNM)

The Provider Network Management (PNM) Department is responsible for ~~growing~~recruitment, management, and ~~overseeing~~monitoring of the ~~Plan's~~KHS provider network ~~of providers and is comprised of: Contracting, Credentialing,~~. The department includes Provider Relations, Provider Network Analytics, Provider Engagement, Grants and Special Programs, and ~~Analytics and Regulatory Reporting.~~ the Homeless Management Information System (HMIS).

The Senior Director of Provider Network ~~heads~~leads the PNM Department. The Deputy Director of Provider Network oversees Provider Relations, Provider Network Analytics, and Provider Engagement, and reports to the Senior Director. The Deputy Director of ~~Provider Contracts~~Grants and Special Programs oversees Grants and Special Programs and HMIS operations and also 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.~~

Provider Relations

The Provider Relations ~~Representative~~ Team ~~is comprised~~consists of a Provider Relations ~~Supervisor and seven~~Manager, two Provider Relations Supervisors, and eight Provider Relations Representatives. ~~The~~ Provider Relations Representatives ~~are~~serve as the ~~direct link~~primary liaison between ~~the Plan and the Provider. The Provider Representatives are responsible for provider~~ KHS and network providers. Responsibilities include provider onboarding, maintaining provider relationships, and addressing provider inquiries and operational issues. The team supports effective communication between KHS and contracted providers and assists providers in navigating plan policies, procedures, and operational requirements.

Provider Network Analytics

The Provider Network Analytics Team includes the Provider Network Analytics Program Manager and two Provider Network Analysts. This team is responsible for monitoring network accessibility and supporting regulatory reporting requirements, including Department of Managed Health Care (DMHC) Timely Access reporting, DMHC Annual Network Review, and Department of Health Care Services (DHCS) Annual Network Certification. The team also collaborates with the KHS Credentialing Department to maintain the accuracy of the provider directory.

Provider Engagement

The Provider Engagement Team consists of the Provider Engagement Manager, two Provider Network Specialists, and one Provider Network Coordinator. The team supports provider recruitment activities, maintains relationships with Enhanced Care Management (ECM) and Community Supports (CS) providers, and coordinates provider education and ~~conduct~~engagement initiatives. Responsibilities include development of provider training materials, coordination of provider outreach ~~to noncontracted providers for potential recruitment~~activities, and administration of the Provider Satisfaction Survey.

~~The Grants Team is comprised of a~~ **Grants** ~~Manager~~ **and** ~~a~~**Special Programs**

The Grants ~~Specialist. The Grants Team is responsible for developing~~Team develops and administers grant programs ~~and identifying and reaching out to~~ designed to support innovative initiatives that improve access to care and strengthen community-based services. The team identifies providers who may qualify for ~~certain grants from the Plan. The Grants team is responsible for creation~~grant funding and ~~tracking of appropriate grant's milestones and goals. The KHS~~manages grant program ~~works to financially aid~~milestones, monitoring, and reporting activities. These grant initiatives help support provider capacity and encourage innovative programs that benefit the communities served by KHS.

Homeless Management Information System (HMIS)

The HMIS Team consists of the Homeless Services Manager and a Provider Network Representative for Special Projects. As the HMIS Administrator, the team oversees configuration, data quality, and daily operations of the Homeless Management Information System to ensure compliance with U.S. Department of Housing and Urban Development (HUD) standards and Continuum of Care (CoC) policies. The team provides training, technical assistance, and ongoing support to participating agencies to promote accurate, consistent, and timely data entry. HMIS data are analyzed to support performance monitoring, reporting, and strategic planning efforts ~~to bring beneficial services~~that strengthen the community's response to ~~our community~~homelessness.

~~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).~~

Network Accessibility Monitoring

Provider network accessibility is primarily monitored ~~via~~through 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.~~ and provider count analysis

These reports ~~track and monitor the Plan's~~ evaluate compliance with regulatory ~~compliance~~ standards including:

- Primary Care Provider ~~to standards such as: PCP to member and Physician to~~ member ratios~~,~~
- Physician-to-member ratios
- Appointment availability~~,~~ standards
- Provider response times
- ~~, Provider~~ After-hours provider availability
- ~~, and~~ In-office wait times

~~.~~ The ~~PNM~~Provider Network Analytics Team also 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~~ primary care providers, specialists, non-physician mental health providers, specialty obstetric/gynecology providers, and hospitals to ensure compliance with regulatory access standards. If regulatory standards ~~If any~~ are not met for a specific provider type ~~/~~ or geographic region ~~is not meeting regulatory standards, it is,~~ the ~~responsibility the PNM~~Provider Network Analytics Team ~~to~~may request an Alternative Access Standard and coordinate with recruitment teams to identify ~~potential~~ providers for ~~recruitment/~~contracting ~~activities.~~ and network expansion. The ~~PNM~~Provider Network Analytics Team also reviews access grievance data to ~~determine if any~~identify trends involving specific providers, provider~~, group~~ groups, or ~~specialty is experiencing the same~~specialties that may indicate ongoing access ~~issue~~issues.

Governance and Reporting

The Provider Network Department hosts the Network Adequacy Committee (NAC) on a ~~continuous~~quarterly basis. ~~The Provider Relations Department provides routine~~During these meetings, access monitoring reports ~~of access study data for review and recommended action by~~ and network adequacy data are reviewed by executive leadership and senior directors. Committee findings and recommendations are reported to the EQIHEC to support oversight of network access, availability, and quality improvement activities.

L. Utilization Management Department (UM)

Please refer to the Utilization Management Program (UMP) Description for detailed information regarding Utilization Management ~~activities and related~~ (UM) activities. The UMP is a formal document supported by clinical, operational,

and administrative policies and procedures ~~(P&Ps) delineating how UM functions are performed. The UMP and P&Ps are written to adhere to federal and state regulatory requirements to include CA Health & Safety Code, Title 22, Welfare & Institutions Code, CMS Code of Federal Regulations, the CA Department of Health Care Services 22-20202 KHS Contractual Provisions, and current NCQA Standards and Guidelines. The UM documents are developed through the involvement of actively involved KHS providers in accordance with H&S Code sections 1363.5 and 1367.01 and 28 CCR sections 1300.70(b)(2)(H) and (c). The UM Director is a standing member of the EQIHE Committee~~that define how UM functions are implemented and monitored.

The UMP and associated policies and procedures are developed and maintained to ensure compliance with applicable federal and state regulatory requirements, including the California Health and Safety Code, Title 22 of the California Code of Regulations, the California Welfare and Institutions Code, the Centers for Medicare and Medicaid Services (CMS) Code of Federal Regulations, the Department of Health Care Services (DHCS) Medi-Cal Managed Care Contract provisions, and current National Committee for Quality Assurance (NCQA) Standards and Guidelines. UM activities support appropriate utilization of healthcare services and coordination of care for KHS members in alignment with regulatory requirements and organizational quality improvement objectives.

M. Behavioral Health Department (BH)

~~The~~ KHS ~~responsibility~~is responsible for administering and managing behavioral health (BH) and substance use ~~care is dependent on the Medi-Cal member's severity of impairment. For~~ disorder (SUD) services for its members in accordance with Medi-Cal managed care requirements.

Mental Health Services

KHS provides behavioral health~~; KHS~~ services ~~are typically~~ for ~~treatment of~~members with mild to moderate ~~impairment~~behavioral health conditions, also referred to as non-specialty mental health~~. Kern County Medi-Cal Behavioral Organization manages severe mental health impairment referred to as~~ services. Members requiring Specialty Mental Health Services, including those with severe mental health conditions, are referred to and managed by the Kern County Medi-Cal Behavioral Health Plan, administered by the Kern Behavioral Health and Recovery Services Department.

~~For substance use disorders~~

Substance Use Disorder Services

KHS provides Screening, Brief Intervention, and ~~counseling~~Referral to Treatment (SBIRT) services ~~and refers~~to identify members at risk for substance use disorders. Members requiring treatment for ~~misuse of~~ alcohol~~. Active treatment for Medi-Cal members with~~ or substance ~~use disorder (SUD) services must be rendered by a SUD~~ misuse

are referred to certified Drug Medi-Cal ~~certified program~~Organized Delivery System (DMC-ODS) providers for appropriate treatment services.

Behavioral Health Treatment for Children

KHS covers Behavioral Health Treatment (BHT~~), including Applied Behavior Analysis (ABA) therapy,~~) services for Medi-Cal beneficiaries under the age of 21. Covered services include Applied Behavior Analysis (ABA) and other evidence-based behavioral interventions designed to support children with developmental or behavioral conditions. Through these services, the Behavioral Health Department works to ensure that behavioral health and substance use disorder services are accessible, appropriate to the member's level of need, and coordinated with county behavioral health programs and community resources. These efforts support continuity of care, quality service delivery, and improved health outcomes for KHS members.

N. Wellness and Prevention Department~~-~~

~~N.~~A. ~~-~~Please refer to the Cultural and ~~linguistics~~ Linguistic Services Program Description and the Health Education Program Description for detailed information regarding Cultural and Linguistic (C&L) and Health Education (HE)

~~Please refer to the Program Descriptions for Cultural and Linguistics and Health Education for C&L and Health Education~~ activities and related wellness and prevention ~~activities.~~

initiatives. The Wellness ~~&~~and Prevention Department is responsible for providing comprehensive, culturally~~,~~ and linguistically appropriate wellness and prevention services ~~with the intent of promoting health~~designed to promote healthy behaviors, ~~improving~~improve health outcomes, ~~reducing~~reduce risk for disease, and ~~empowering~~empower members to ~~be active participants~~actively participate in their health care. The ~~W&P~~ department also ensures members have access to quality language assistance services to effectively communicate with their health care providers. The Wellness and Prevention Department is ~~headed~~led by the Senior Director of Wellness ~~&~~and Prevention and ~~is composed~~consists of ~~four~~three teams~~:~~.

Cultural ~~&~~and Linguistic Services ~~- comprised~~

The Cultural and Linguistic Services team consists of a Manager, Cultural ~~&~~and Linguistic Specialists, and a Cultural ~~& Linguistics~~and Linguistic Coordinator ~~to provide comprehensive,~~. This team ensures that KHS members have access to culturally~~,~~ and linguistically appropriate ~~competent~~ services ~~to plan members with improved~~that improve access to care and health outcomes.

~~These~~ Services include, but are not limited to ~~linguistic:~~

- Language interpretation services
- ~~,~~Translation of written member ~~information~~ materials~~,~~
- Cultural competency training and education for staff, providers, and contracted vendors~~,~~
- Monitoring and ~~assessing, monitoring,~~evaluation of cultural and ~~evaluating the Cultural & linguistics~~linguistic services provided by ~~the Plan,~~KHS, network providers, and contracted vendors~~.~~
  - ~~Community Health & Wellness – comprised of a Manager, Health Education Specialist and Lifestyle Coach to establish community-based health and wellness initiatives that promote health, prevent illness, and improve health literacy to vulnerable communities in Kern County.~~

These activities help ensure that services are accessible to members with limited English proficiency and that communication barriers are minimized.

Member Wellness and Prevention

The Member Wellness ~~&~~and Prevention ~~(MWP) – comprised~~team consists of a Manager, Supervisor, Health Educators, ~~Health Education~~Program Specialists~~ and,~~ Lifestyle Coaches~~ to provide~~, and Health Education Assistants. This team develops and implements health education, wellness, and prevention programs ~~, services, interventions~~ using evidence-based ~~programs~~ approaches. Services are delivered directly to ~~our~~ members or through partnerships with ~~partner~~community organizations~~. Services are delivered through~~ and may include:

- One-on-one ~~on~~ coaching
- ~~,~~Group classes~~, written material~~ and workshops
- Written health education materials such as ~~member~~ newsletters~~,~~ and brochures~~, and other health education material. Partner~~
- Community outreach activities

The team collaborates with providers to enhance provider~~/patient interaction~~ member communication and increase ~~knowledge~~awareness of ~~member~~members' health education needs. ~~The MWP has~~Member Wellness and Prevention is also responsible for oversight of ~~the~~ readability and suitability standards ~~and member incentive programs.~~ for member materials, management of member incentive programs, and development of community-based health and wellness initiatives that promote health literacy and disease prevention among vulnerable populations in Kern County.

Wellness ~~&~~and Prevention Partnerships~~ – comprised of a~~

The Wellness and Prevention Partnerships team consists of a Manager, Program Manager, ~~Program Manager~~ and Program Liaisons~~ to establish and foster relationships and promote~~. This team establishes and maintains

partnerships with community organizations and providers to expand access to preventive services. Community partners include organizations such as local public health departments and Women, Infants, and Children (WIC) programs.

Responsibilities include:

- Promoting preventive service benefits among providers and community partners ~~and providers, such as the local public health department and Women Infants and Children programs, in order to~~
- Supporting outreach activities that expand access ~~and reach of health and~~to wellness and prevention programs ~~and services to members.~~
- Administering Community Health Worker services and Asthma Preventive Services programs
- Supporting initiatives related to the Population Needs Assessment (PNA)

Regulatory Compliance

KHS is committed to delivering culturally and linguistically appropriate ~~heath~~health care services. ~~Services will comply~~Cultural and linguistic services are provided in compliance with applicable federal and state regulations, including Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act ~~of 2010~~, 42 CFR ~~section~~ §438.10, ~~Exhibit A, Attachment III, Section 5.2.10 (Access Rights), and APL~~Medi-Cal Managed Care Contract requirements issued by the Department of Health Care Services (DHCS), and DHCS All Plan Letter 21-004.

The Senior Director of Wellness and Prevention ~~is~~serves as a standing member of the EQIHEC to ensure the integration of wellness, prevention, and cultural and linguistic initiatives within the Quality Improvement Health Equity Program.

O. Enhanced Care Management Department (ECM)

Please refer to the Enhanced Care Management Program Description for detailed information regarding Enhanced Care Management activities and ~~related ECM activities~~program operations.

P. Community Support Services (CSS) Department

Please refer to the Community Support Services Program Description for ~~CSS~~detailed information regarding Community Support Services activities and related ~~CSS activities~~program operations.

Q. Business Intelligence (BI)

~~Functions include:~~

~~Establish~~The Business Intelligence (BI) department supports the Quality Improvement Health Equity Program by providing advanced analytics, reporting, and data governance to inform organizational decision making and performance monitoring. BI establishes advanced health analytics capabilities to ensure ~~that~~ leadership has ~~full purview~~comprehensive visibility into ~~the~~ population ~~to improve~~ health trends, enabling improvements in the individual experience of care~~; improve the health of the~~ , overall population ~~while reducing per capital~~ health outcomes, and the cost of care.

- ~~The department is responsible~~ for ~~populations.~~
- ~~Create, manage~~creating, managing, and continuously ~~improve~~improving corporate Key Performance Indicators (~~KPI's~~)

KPIs) that support organizational goals and regulatory requirements. BI also works to reduce operational silos ~~and proactively manage and improve overall operations~~by providing integrated data insights that support proactive management and continuous operational improvement across departments.

- ~~Provide~~BI provides and ~~validate standard~~validates standardized metrics and ~~information around~~ reporting related to process ~~improved~~improvement initiatives to ensure that project goals, objectives, ~~or~~and return on ~~investments (ROI)~~investment are achieved.

~~Establish~~ In addition, the department establishes data governance ~~over various~~practices across organizational systems to ensure that reliable, accurate data can be ~~consumed~~used for analytics and reporting purposes.

- ~~Manage all operational and regulatory reporting inventory for the organization.~~

The department manages the organization's inventory of operational and regulatory reports and supports reporting requirements across multiple departments. BI also participates in the annual HEDIS audit process and supports routine HEDIS reporting needs, including maintenance of reporting dashboards, production of routine reports, and implementation of annual HEDIS technical specifications.

R. Information System & Data Management

KHS utilizes information provided through the Information Technology (IT), Operations, and Provider Network Management departments~~. KHS MIS~~ to support program oversight, operational management, and regulatory reporting. The KHS Management Information System (MIS) has the capability to capture, edit, and utilize various data elements for both internal management ~~use~~purposes and to meet ~~the~~ data quality and timeliness requirements.

These capabilities include ~~DHCS'~~the collection and submission of encounter data, network provider data, program data, and ~~template data submissions and processes.~~required reporting templates to the Department of Health Care Services (DHCS). The MIS also ~~has the ability to meet~~supports Population Health Management data integration requirements and ~~is able~~has the capacity to provide ~~the~~ requested data to DHCS and the Centers for Medicare and Medicaid Services ~~upon request~~(CMS) as required.

~~KHS's~~The KHS Information Technology ~~(IT)~~ Division, ~~comprising of~~which includes Data Analytics, Information Security, Technical Support Services, and Operational Systems, follows ~~the~~ culturally and linguistically appropriate business practices as ~~outlined~~established by KHS leadership and Human Resources. ~~IT provides~~ The IT Division supports the implementation of new technologies~~,~~ and ~~enhancing~~ enhancement of existing systems~~,~~ to ensure that ~~all KHS~~ staff ~~can~~are able to perform their work in ~~a~~ an accessible and culturally competent environment. This includes~~, but is not limited to, offering~~ providing technologies and tools ~~compliant~~that comply with Americans with Disabilities Act (ADA) standards, assistive technologies, and website ~~compliance.~~accessibility requirements.

The Data Analytics ~~shall support~~function supports the organization's ~~QIHE~~Quality Improvement Health Equity operational initiatives by collecting, storing, and analyzing demographic data and profiles ~~of~~for both KHS members and providers~~,~~. These activities include conducting statistical analyses~~,~~ and ~~aid in~~supporting the development and ~~facilitation~~administration of assessments and surveys used to inform quality improvement and health equity initiatives.

KHS ~~(~~MIS~~)~~ has the capacity to enable interoperability for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks to support coordinated care and data sharing across the health care delivery system.

~~KHS~~The MIS supports ~~at~~ a ~~minimum:~~

- ~~All~~wide range of operational and program data necessary for the administration and oversight of the Quality Improvement Health Equity Program. These include Medi-Cal eligibility data~~.~~
- ~~Information on~~; enrollment information for members ~~enrolled with Kern Health Systems.~~
- ~~served by KHS;~~ provider claims status and payment data~~.~~
- ~~;~~ health care ~~services~~service delivery encounter data~~.~~
- ~~;~~ network provider ~~data.~~
- ~~Program~~information; program and reporting data~~.~~
- ~~Template data.~~

- ~~;~~ screening and assessment data~~.~~
- ~~Referrals including~~; referrals and tracking of referred services to ~~follow up with Members to ensure~~confirm that services were rendered~~.~~
- ~~;~~ electronic health ~~records.~~
- ~~Prior auth~~record data; prior authorization requests and specialty referral ~~system.~~
- ~~Care Management~~tracking; care management and care coordination information; financial data~~.~~
- ~~Care Coordination data.~~
- ~~Financial information.~~
- ~~;~~ social drivers of health ~~data.~~

information; and grievance and appeal ~~information~~data used to monitor member experience and access to care.

S. Marketing

The Marketing Department operates under the direction of the Senior Director of Marketing, who reports to the ~~Chief Health Equity Officer.~~CHEO. The ~~Marketing~~ department is responsible for conducting ~~appropriate~~ product and market research to support the development and implementation of marketing strategies and member communication plans ~~for~~across all KHS products ~~including Member~~. These activities include the development and dissemination of member-facing materials ~~(e.g., Member Newsletters,~~such as member newsletters, the Evidence of Coverage, website~~, etc.). The Quality Improvement and Health Equity Departments work closely with the Marketing and Wellness & Prevention Departments to ensure that Member materials are implemented in a timely manner~~ content, and other communication resources.

The Marketing Department collaborates closely with the Quality Performance, Health Equity, and Wellness and Prevention Departments to ensure that member communications are developed and distributed in a timely manner and align with organizational goals related to quality, health equity, and member engagement. These coordinated efforts support clear communication with members and promote access to information regarding available benefits, services, and health programs.

V. Role of Participating Providers

A. 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 Performance** – KHS requires contracted providers to comply with DHCS' Managed Care Accountability Set (MCAS) and participate in quality-based initiatives aimed at improving, access, quality, and health equity for our members. Routine meetings are conducted with a subset of participating providers to ensure monitoring, communication, and supporting of achieving MPLs and maintaining high quality care.

B. 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 ~~QIHE Program~~QIHEP activities, standards, and review system.
Provider contracts include provisions for the following:

a. An agreement to participate in the KHS ~~QIHE Program~~QIHEP 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 ~~QIHE Program~~QIHEP 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 ~~QIHE Program~~QIHEP, 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 ~~QIHE Program~~QIHEP 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 ~~QIHE Program~~QIHEP, including access to applicable records and information.

C. Conflict of Interest

Network practitioners serving on any QI and Health Equity program-related committee, who are or were involved in the care of a member under review by the committee, are not allowed to participate in discussions and determinations regarding the case. Committee members cannot review cases involving family members, providers, or suppliers with whom they have a financial or contractual affiliation or other similar conflict of interest issues. All required employees and committee participants sign a Conflict-of-Interest statement on an annual basis. Fiscal and clinical interests are separated. KHS and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage, services, or care. There are no financial incentives for UM decision-makers that could encourage decisions that result in under-utilization.

Confidentiality Statement

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.

VI. Program Documents

A. Work Plan

The annual QIHEP Work Plan is designed to target specific QIHEP activities, projects, and tasks to be completed during the upcoming year, ~~and~~as well as the monitoring and investigation of previously identified issues. A focal activity for the Work Plan is the annual evaluation of the ~~QIHE Program~~QIHEP, including accomplishments and

impact on members. Evaluation and planning of the ~~QIHE Program is done~~QIHEP are conducted 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 and Health Equity Departments on an annual basis and is presented to the 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~~may occur ~~by~~through specific mailings or KHS Provider Bulletins to contracting providers.
- The activities in the ~~QIHE~~QIHEP Work Plan are annually evaluated for effectiveness.
- ~~QIHE~~QIHEP Work Plan responsibilities are assigned to appropriate individuals.

Components of the QIHEP Work Plan:

- Quality and Safety of Clinical Care
- Quality of Service
- Member ~~&~~and Provider Satisfaction
- Addressing Cultural, Ethnic, Racial, and Linguistic Needs of Members

B. Work Plan Evaluation

An annual evaluation of the QIHEP shall be prepared based on the activities presented to the EQIHEC during the calendar year. The EQIHEC reviews and approves the QIHEP evaluation. The QIHEP evaluation shall also be reviewed by the Board of Directors (BOD~~.~~). The Chief Health Equity Officer, with support from the Chief Medical Officer and/or Directors of Quality, will develop an evaluation of the QIHEP based on activities that were presented to the EQIHEC and BOD during the calendar year. ~~The EQIHEC reviews and approves the QIHEP evaluation.~~
The QIHEP evaluation includes the following:

- A description of completed and ongoing quality improvement activities.
- Trended performance data from indicators to assess quality of care and service.
- An analysis of demonstrated improvements in care and service.
- A thorough evaluation of the program structure and effectiveness of the QIHEP, including progress toward influencing safe clinical practices throughout the network.

- Monitoring efforts of medical groups and other subcontractors to ensure that delegated functions meet cultural, linguistic, and sensitivity standards.
- Evaluation of patterns~~/~~ and trends for member grievances and discrimination complaints related to cultural~~/~~, linguistic, and sensitivity issues.
- A thorough evaluation of progress on non-clinical goals (~~i.e.,~~for example, Human Resources, Marketing, Member Engagement, Community Engagement~~, etc.)~~).

KHS will also utilize the following methods to conduct ongoing monitoring and evaluation of its cultural competency and SPD awareness programs ~~and~~, as well as annual sensitivity, diversity, cultural competency, and health equity training for all staff, providers, subcontractors, and downstream subcontractors at key points of contact:

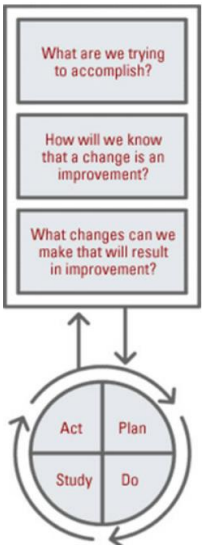
- Disenrollment data~~,~~
- MCAS/HEDIS results by race~~/~~, ethnicity, language, and other demographic factors~~,~~
- Complaint and grievance reports~~,~~
- Member satisfaction survey results by race~~/~~, ethnicity, language, and other demographic factors~~,~~
- Population Needs ~~Assessments~~Assessment findings ~~results~~ by race~~/~~, ethnicity, language, and other demographic factors~~,~~
- Performance Improvement Projects (PIPs~~),~~)
- Health Education Activities Reports~~,~~
- Training attendance reports, attestations of training completion, and/or completion of post-training quizzes~~,~~

VII. Quality Improvement Processes

A. KHS Quality Improvement (QI) Initiatives

1. Plan-Do-Study-Act Cycle

The QIHEP quality activities and studies are developed using the Plan-Do-Study-Act (PDSA) model. The PDSA is an iterative, four-stage problem-solving model used for improving a process or carrying out change.



In accordance with the California Department of Health Care Services (DHCS) ~~2025~~2024 contract, KHS will conduct quality studies, quality review activities, results, and assessments and submit the outcomes in reports to ~~the~~ DHCS ~~in~~at the reporting unit level and within the time frames ~~as~~ directed by DHCS.

2. Data Collection Methodology

~~KHS employs a structured data collection methodology designed to measure and improve healthcare quality and health equity outcomes. Data collection methods are determined based on the type of measure and available data sources, ensuring accuracy and reliability. Data validation is integral to this process, reinforcing the credibility of findings and supporting data-driven decision-making. Data is continuously collected, aggregated, and analyzed to monitor performance, identify disparities, and uncover opportunities for improvement. When performance gaps are identified, KHS implements targeted interventions with measurable goals. The effectiveness of these interventions is assessed through ongoing data analysis, ensuring that improvements are sustainable over time. If data indicates a need for a different approach, KHS re-evaluates strategies and adjusts action plans accordingly.~~

KHS collects and analyzes data from multiple internal and external sources to monitor the quality, safety, accessibility, and effectiveness of healthcare services provided to members. Data collection activities support the identification of trends, disparities, opportunities for improvement, and evaluation of quality improvement initiatives. Quality monitoring activities rely on multiple data sources including MCAS/HEDIS performance measures, member grievances and appeals, PQI investigations, facility site reviews, utilization data, member

satisfaction surveys, and External Quality Review reports. Data is obtained from administrative claims, encounter data, medical record reviews, member and provider surveys, regulatory reporting systems, and internal operational reports. These data sources are used to evaluate performance against established benchmarks, contractual requirements, and organizational goals.

Collected data are aggregated, validated, and analyzed by the Quality Improvement, Quality Performance, Business Intelligence, and other relevant departments to ensure accuracy and completeness. Results are reviewed by the EQIHEC and applicable subcommittees to identify trends, monitor progress toward quality improvement objectives, and determine appropriate interventions when opportunities for improvement are identified. Data collection activities also support monitoring of health disparities and identification of opportunities to improve equitable access to care and outcomes across the KHS membership.

3. Measurement Process

KHS systematically monitors and evaluates quality improvement initiatives to assess their effectiveness and compliance with internal policies and external regulatory requirements. Performance is reviewed at least quarterly, with benchmarks and standards derived from:

- Nationally recognized clinical guidelines
- Peer-reviewed research
- Regulatory and contractual requirements
- Internal trend analyses
- State and federal quality measures

KHS uses these metrics to assess accessibility, availability, and equity in healthcare services, ensuring that interventions align with best practices and community needs.

4. Evaluation Process

A comprehensive evaluation framework guides KHS in assessing the effectiveness of Quality Improvement (QI) initiatives. Both quantitative and qualitative methodologies are employed:

- Quantitative Analysis: Benchmark comparisons, trend assessments, and statistical testing are used to evaluate the impact of QI initiatives.
- Qualitative Analysis: Root cause and barrier analyses are conducted collaboratively with key stakeholders to understand systemic challenges and identify sustainable solutions.

Cross-departmental collaboration ensures that evaluation findings inform future quality initiatives, driving continuous improvement in health outcomes.

5. Communication and Feedback

KHS fosters a culture of transparency and engagement through proactive communication with internal teams and external partners, including providers and stakeholders. Key communication channels include:

- Internal Education ~~&~~and Engagement: Staff meetings, committee updates, and training sessions on QI initiatives.
- Provider Communication: Newsletters, targeted mailings, ~~KHS's~~the KHS provider portal, and direct outreach via quality visits.
- Performance Feedback: Providers receive actionable insights, including:
    1. Member-specific service and intervention lists
    2. Clinical guideline recommendations
    3. Performance data from HEDIS, CAHPS, and other quality measures
    4. Recognition for quality improvement achievements
    5. Compliance feedback based on audits, grievances, and utilization trends.

These communications reinforce accountability and foster a collaborative approach to quality improvement.

6. Improvement Processes

Performance indicators are used to identify quality concerns and disparities in care delivery. When deficiencies are detected, KHS initiates corrective actions, which may include:

- Provider-level remediation plans (Corrective Action Plans - CAPs)
- Enhanced provider education and technical assistance
- Temporary restrictions on new member assignments for non-compliant providers
- Delegation oversight adjustments
- Contract terminations for persistent non-compliance~~.~~

By integrating rigorous oversight, continuous evaluation, and data-driven decision-making, KHS ensures that quality improvement efforts translate into meaningful and sustainable healthcare enhancements for Medi-Cal members.

VIII. Quality Improvement Work Plan

A. Quality of Clinical Care

1. MCAS Measures

KHS is contractually required to submit data and measurement outcomes for specific health care measures identified by the Department of Health Care Services (DHCS). The measures are a combination of ~~ones~~those selected by DHCS from the ~~library of~~ Healthcare Effectiveness Data and Information Set (HEDIS) library and the Core Measures set from the Centers for Medicare and Medicaid Services (CMS). An audit is performed by DHCS's EQRO and the licensed auditor for Department of Managed Health Care (DMHC) HEQMS requirements 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 at the 50th percentile or better for measurement year (MY) 2025. Results for the 2025 measures will be calculated and submitted in report year (RY) 2026. Please reference the table on page ~~23~~22 for the list of MCAS measures.

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~~notification 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 the Department of Health Care Services (DHCS~~)~~), as outlined in their contract.

2. Performance Improvement Projects (PIPs)

KHS is mandated to participate in two (2) PIPs. These PIPs span ~~over~~ an approximate 36-month time frame and are each ~~broken out~~divided 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~~three years from 2023 through 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~~specifically the W30 measure for the 0~~-~~15 ~~months~~month African American population.

Non-Clinical PIP~~:~~

The non-clinical PIP ~~is specific to~~focuses on the FUA and FUM measures ~~with a heavy reliance~~and relies heavily on support from the Behavioral Health Department for ~~support~~ implementation of interventions. ~~QP~~The Quality Performance Department will ~~be partnering~~partner with the Behavioral Health Department, ~~UM, PHM, and any~~Utilization Management, Population Health Management, and other necessary stakeholders.

B. Safety of Clinical Care

1. Patient Safety Program

KHS recognizes that patient safety is a key component of delivering quality health care and focuses on promoting best practices ~~that are~~ aimed at improving patient safety. KHS engages members and providers to promote safety practices. KHS also focuses on reducing the risk of adverse events that can occur while providing medical care in different delivery settings. Some of the safety initiatives include:

1. Appropriate Medication Utilization
2. Review of Inpatient Admissions
    a. Readmissions
    b. Length of Stay
    c. Inappropriate Discharges
    d. Unexpected Mortalities
3. Provider Preventable Conditions (PPCs)
4. Potential Quality Issues (PQIs)
5. Initial Health Assessment Monitoring
6. Over-utilization and Under-utilization
7. Performance with healthcare outcomes and clinical processes
8. Adherence to clinical and preventive health guidelines
9. Effectiveness of chronic conditions, population health and care management programs

2. Potential Quality Issues (PQIs)

The QI Department reviews all Potential Quality Issues (PQIs) and adverse events involving practitioners and providers. Areas of review include primary and specialty care, hospitals, long-term care (LTC) facilities, skilled nursing facilities (SNF), and transportation providers. All identified PQIs are referred to the QI Department for investigation and evaluation, ensuring that timely and appropriate actions are taken to address potential concerns. The Medical Director oversees the process, ensuring alignment with recognized standards of care, evaluating all cases, and referring matters to the EQIHEC and/or Physician Advisory Committee for further assessment, as necessary.

3. Facility Site Review, Medical Record and Physical Accessibility Reviews

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 QP 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~~reviews include an assessment for patient safety issues and sentinel events.
- Bloodborne pathogens and regulated wastes are handled according to established laws.

In collaboration with other Kern County health plans for site reviews, KHS coordinates~~,~~ reviews as described in APL 22-017, *Site Reviews: Facility Site Review and Medical Record Review*, and the applicable Memorandum of Understanding (MOU~~)~~).

4. Credentialing and Recredentialing

KHS maintains a comprehensive pre-contractual and post-contractual assessment and monitoring system to ensure that contracting providers have the capacity and capability to perform required functions. The pre-contractual assessment requires providers seeking to contract with KHS to complete a detailed document covering key areas such as health care delivery systems—, including clinical safety, access and waiting times, referral

tracking, medical records, and health education—, as well as credentialing information.

Post-contractual monitoring includes ongoing evaluation to ensure continued compliance with contractual requirements, quality standards, and regulatory guidelines. Specific policies outline the standards, tools, and processes used to support these activities, ensuring accountability and quality in provider credentialing and recredentialing.

C. Quality of Service

1. Grievance and Appeals

KHS monitors performance areas affecting member experience. KHS has established categories and quantifiable standards to evaluate grievances received byfrom members. All grievances are categorized ininto several different categories, including but not limited to the following: continuity of care, geographic access, language access, provider availability, timely access, discrimination, care coordination, and quality of care.

The organization's goal is to resolve all grievances within thirty (30) days of receipt. KHS grievancesgrievance and appeals data isare presented on a quarterly basis to the EQIHEC and PAC, as needed. KHSKHS's goal is to maintain the overall complaint rate below thresholds as established by regulatory agencies such as DHCS, DMHC, and CMS.

2. Access to Care

The Plan maintains ongoing monitoring efforts to ensure its network is able to provide appropriate access to health care services, in line with regulatory standards and member needs. The Plan's Provider Network Management department utilizes appointment availability surveys, capacity/ and adequacy analysisanalyses, grievance reviews, provider/ and member mapping, and other tools to conduct Plan monitoring:. These efforts are presented to the Plan's Network Adequacy Committee (NAC) and EQIHEC on a quarterly basis. Areas monitored include, but are not limited to:, appointment availability, access to after-hours -care, time, and distance (geographic) accessibility, provider type availability, and network capacity.

D. Member and Provider Satisfaction

Member Satisfaction

KHS conducts a comprehensive CAHPS survey and analysis annually to assess member satisfaction with the services and care received. CAHPS is a set of standardized surveys that ask health care consumers to report on and evaluate their care experience. The survey focuses on key areas likesuch as getting care needed care; getting

appointments ~~to~~with PCPs and Specialty Care Providers (SCPs); satisfaction with KHS and its practitioners; and other key areas of ~~the~~ plan operations.

CAHPS surveys serve as a means to provide usable information about the quality of care received by ~~the~~ members. KHS uses this tool as one of its key instruments to identify opportunities for improvement. As part of the annual evaluation, KHS reviews ~~the~~ CAHPS results to identify relative strengths and weaknesses in performance, ~~determines~~determine where improvement is needed, and ~~tracks~~track progress with interventions over time.

Provider Satisfaction

KHS monitors performance areas affecting provider satisfaction annually and submits the results to DHCS and CMS. This study assesses the satisfaction experienced by KHS's network of PCPs, SCPs, and behavioral health providers. Information obtained from these surveys ~~allow plans~~ allows the Plan to measure how well ~~they are~~it is meeting ~~their~~ providers' expectations and needs.

This study examines ~~the satisfaction of the~~ provider network satisfaction in the following areas: overall satisfaction~~, all~~; comparisons with other plans~~, finance~~; financial issues~~,~~; utilization and quality management; network~~,~~ coordination of care~~,~~; pharmacy~~, Health Plan Call Center Service Staff,~~ services; health plan call center service staff; and provider relations. Based on the data collected, KHS reports the findings to the QIW and EQIHEC. ~~The~~These committees review the findings and make recommendations ~~on~~regarding potential opportunities for ~~improvements~~improvement.

E. Addressing Cultural, Ethnic, Racial and Linguistic Needs of Members

Integrated KHS Resources and Documents Utilized to Support the ~~**QIHE Program**~~QIHEP:

Population Needs Assessment

The Wellness ~~&~~and Prevention Department conducts a Population Needs Assessment of ~~KHS'~~KHS members to determine health education and cultural~~/~~ and linguistic needs. The Population Needs Assessment ~~will be~~is updated ~~every year~~annually for the duration of the contract with the Department of Health Care Services (DHCS~~.~~). The contents of the Population Needs Assessment ~~will~~ define the goals and objectives, data sources and methodology, member demographics, member health status, disease prevalence and gap analysis, health education ~~and~~needs, cultural and linguistic service needs, and key recommendations, planned actions, and conclusions~~. (APL 19~~ (APL 19-011). KHS uses the Population Needs Assessment (PNA) to inform its QIHEP priorities and to share pertinent information regarding ~~the~~ PNA findings and ~~the~~ identified targeted strategies with its providers.

CLAS

KHS assesses, identifies, documents, and reports members' demographic and linguistic needs annually. The goals of the Culturally and Linguistically Appropriate Services (CLAS) program align with KHS' mission to support the well-being of members through a commitment to accessible, high-quality health services and community-focused local care.

The CLAS program aims to help KHS identify inequities, address social determinants of health, and work toward removing systemic barriers that generate bias and discrimination in health care. KHS' CLAS objective is to advance health equity to improve the quality of health care and reduce health care disparities by assessing, respecting, and responding to the needs of the Plan's diverse multicultural members.

Population Health Model of Care

The KHS Population Health Management (PHM) Model of Care (MOC) ~~is to provide~~provides a strategic ~~road map~~roadmap defining the approach ~~towards~~toward the provision of ~~healthcare~~health care and ~~preventative~~preventive services ~~and~~. It focuses on collaborative partnerships with providers to assist in delivering high-quality care to all members in a timely and efficient manner while reducing costs.

The PHM ~~MOC~~Model of Care is designed to better coordinate ~~member's~~members' care and utilize various data sources to ~~draw~~generate insights on how to address each member's individual needs and make hospitals and clinics more accessible and effective.

PHM is a proactive, data-driven strategy focused on improving the health of a given population ~~by~~through a defined network of financially linked providers, achieved in partnership with the community (Health Catalyst, 2020). The Primary Care Physician (PCP) forms the backbone of PHM. The PCP ~~is~~serves as the ~~signal caller~~central coordinator who identifies problems early through various clinical and socio-behavioral screenings and refers patients to specialists~~.~~ when appropriate. At the same time, KHS provides support to the PCP to ensure the patient receives high-quality, comprehensive health care in a timely manner. The Director of PHM is a standing member of the Health Equity Transformation Steering Committee.

~~Diversity, Equity, and Inclusion and~~ Health Equity Education and Training

KHS does not delegate health equity activities. Providers are required to actively participate in and comply with health equity activities. To support this expectation, KHS provides annual training to employees, contracted staff, providers, ~~sub-contractors~~subcontractors, and downstream subcontractors at key points of contact on sensitivity, diversity, cultural competency, effective communication, health equity, and inclusion ~~relating~~as they relate to members.

Training ~~will promote~~promotes access to and delivery of services in a culturally competent manner ~~to~~for all members and potential members regardless of ~~their~~ sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56. ~~Training will consider structural and institutional racism, heath inequities and its impact on members, staff, providers, subcontractors, and downstream subcontractors. Trainings will include, but not be limited to topics such as:~~

Training also considers structural and institutional racism, health inequities, and their impact on members, staff, providers, subcontractors, and downstream subcontractors. Trainings include, but are not limited to, the following topics:

- Beliefs about illness and health for identified cultural groups within ~~KHS'~~KHS membership and Kern County~~,~~
- The need for gender-affirming care~~,~~
- Methods for interacting with providers and navigating the health care ~~structure,~~system
- Traditional home remedies that may impact provider-recommended treatment plans~~,~~
- Skills and practices ~~regarding~~related to culture-~~related~~specific health care issues ~~of~~among the membership~~,~~
- How cultural competency relates to quality of care and access to care~~,~~
- Appropriate use and provision of interpreters~~,~~
- Translation ~~process of~~processes for written ~~informing~~informational documents~~,~~
- Health literacy~~,~~
- ~~PNA~~Population Needs Assessment findings and identified targeted strategies~~,~~
- Culturally and linguistically appropriate community resources~~,~~
- Required completion of continuing medical education on cultural competency and implicit bias~~.~~

IX. External Audits/Regulatory Audits and Delegation Oversight

A. Auditing and Monitoring Activities

Enforcement~~/~~ and Compliance

~~.~~The Director of Quality Improvement is responsible for the monitoring and oversight of the ~~QIHE Program~~QIHEP, including ~~enforcement of~~ ensuring compliance with KHS standards, regulatory requirements, and ~~required~~program activities. Compliance monitoring activities ~~can be found in sections of~~ are described within the policies ~~related to~~

~~the~~associated with each specific monitoring ~~activity. The general~~ function. When deficiencies are identified, the process for obtaining compliance ~~when deficiencies are noted, and~~ , including the development and implementation of Corrective Action Plans (CAPs ~~are requested,~~), is ~~delineated~~outlined in applicable policies~~.~~ and procedures. Compliance activities ~~not under~~that fall outside the oversight of ~~QI~~the Quality Improvement Department are the responsibility of the Compliance Department.

Medical Reviews and Audits by Regulatory Agencies

~~–~~The KHS Director of Compliance ~~&~~and Regulatory Affairs, in collaboration with the Chief Health Services Officer (CHSO) and the Director of Quality Improvement, manages ~~KHS~~ medical reviews and ~~medical~~regulatory audits conducted by ~~regulatory~~external oversight agencies. Recommendations, findings, or sanctions ~~received from~~ issued by regulatory agencies ~~for~~related to medical matters are addressed through the ~~QIHE Program. CAPs for medical matters~~QIHEP. Corrective Action Plans associated with medical review findings are presented to, approved by, and monitored ~~by~~through the EQIHEC.

B. Delegation

~~KHS delegates quality improvement activities as follows:~~

~~1. VSP – delegation of QI processes with oversight through the EQIHEC.~~

KHS does not delegate Quality Improvement or Performance-related functions, as defined in the 2024 DHCS Medi-Cal Managed Care Contract. Should delegation of quality-related activities occur in the future, KHS will maintain oversight through a formal delegation oversight process including pre-delegation assessment, performance monitoring, and corrective action as required. Relevant contractual definitions include the following:

- Downstream Subcontractor means an individual or entity that has a Downstream Subcontractor Agreement with a Subcontractor or another Downstream Subcontractor. A Network Provider is not considered a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
- Downstream Fully Delegated Subcontractor means a Downstream Subcontractor that contractually assumes all duties and obligations of the Contractor under the Contract, through the Subcontractor, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan may operate as a Downstream Fully Delegated Subcontractor.
- Fully Delegated Subcontractor means a Subcontractor that contractually assumes all duties and obligations of the Contractor under the Contract, except for those contractual duties and obligations where delegation

is legally or contractually prohibited. A managed care plan may operate as a Fully Delegated Subcontractor.

- Subcontractor means an individual or entity that has a Subcontractor Agreement with the Contractor that relates directly or indirectly to the performance of the Contractor's obligations under the Contract. A Network Provider is not considered a Subcontractor solely because it enters into a Network Provider Agreement.

X. Conflict of Interest

All members of the ~~Equity, Quality Improvement, and Health Equity Committee (~~EQIHEC~~)~~ and its subcommittees are required to review and sign a Conflict of Interest Statement~~,~~ affirming their commitment to ethical decision-making. Committee members must disclose any potential conflicts of interest and recuse themselves from discussions and voting on matters where they have a direct or indirect interest. Individuals personally involved in the care or service provided to a patient, or in an event or finding undergoing quality evaluation, may not vote or render a decision regarding the appropriateness of such care. By signing the Conflict of Interest Statement, members agree to abide by its terms, ensuring transparency and integrity in the committee's decision-making process.

XI. Confidentiality

All members, participating staff, and guests of the EQIHEC ~~Committee~~ and its 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~~of 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~~provisions 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~~member confidentiality ~~of members~~ to their practitioners. KHS monitors contracting providers for compliance with KHS confidentiality standards during provider facility and medical ~~records~~record reviews and through the grievance

process. The EQIHEC ~~Committee~~ reviews practices regarding the collection, use, and disclosure of medical information.

XII. 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.

~~Committee to provide relevant input and suggestions for topics and issues presented.~~

Health Insurance Portability and Accountability Act (HIPAA)

KHS complies with all applicable HIPAA requirements supported by HIPAA compliance policies. All HIPAA-related policies are accessible to all KHS contracted providers and KHS staff. HIPAA information is posted on the KHS website. Ongoing mandatory education is required annually for all staff.

XIII. Communication of Quality and Health Equity Activities

Results of performance improvement activities are communicated to the appropriate department~~,~~ and/or multidisciplinary committee as determined by the nature of the activity. The EQIHEC subcommittees report their summarized information to the EQIHEC quarterly to facilitate communication along the continuum of care. The EQIHEC reports activities to the Governing Board, through the CMO or designee, on a quarterly basis. EQIHEC participants are responsible for communicating pertinent, non-confidential ~~QIHE~~QIHEP issues to all members of KHS staff. Communication of ~~QIHE~~QIHEP trends to KHS contracted entities, members, practitioners, and providers ~~is~~occurs through the following:

- Practitioner participation in the EQIHEC and its subcommittees

- Health Network Forums, Medical Director ~~meeting~~meetings, and other ongoing ad ~~-~~hoc meetings
- Practitioner and member newsletters regarding relevant ~~QIHE program~~QIHEP topics
- The QIHEP program description, available to providers and members on the KHS website. This includes QIHEP goals, processes, and outcomes as they relate to member care and service~~.~~
- Annual practitioner education through provider relations and the Provider Manual

XIV. Annual Evaluation

~~**Annual Evaluation of the KHS Quality Improvement Health Equity Program**~~

On an annual basis, KHS evaluates the effectiveness and progress of the ~~QIHE~~QIHEP Program Description and Work Plan~~,~~ and updates the program as needed. The CMO, with assistance from the Quality Improvement Medical Director, Director of QI, Pharmacy Director, Director of Wellness & Prevention, Director of Marketing, Director of Member Services, Senior Director of Contracting & QP, and Director of QP, documents a yearly summary of all completed and ongoing ~~QIHE Program~~QIHEP 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 ~~QIHE Program~~QIHEP 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 ~~QIHE Program~~QIHEP. 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 ~~QIHE~~QIHEP Program ~~summary~~Description and Work Plan are presented to the Board of Directors for assessment of covered health care rendered to members, comments, activities proposed for the upcoming year, and approval of changes ~~in~~to the ~~QIHE Program~~QIHEP. The Board of Directors is responsible for the direction of the ~~QIHE Program~~QIHEP and actively evaluates the annual plan to determine areas for improvement. Board of ~~Director~~Directors 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 ~~QIHE~~QIHEP activities and progress toward meeting ~~QIHE~~QIHEP goals is available to members and contracting providers upon request by contacting KHS Member Services.

~~2025~~2026 **Quality - Health Equity Program Description**

Kern Health Systems

Effective Date: January 1, ~~2025~~2026

_____ Date _____

Chief Executive Officer

Emily Duran

_____ Date _____

Chief Medical Officer

_____ Date _____

Chief Health Equity Officer

_____ Date _____

Chief Operations Officer

_____ Date _____

Medical Director of Quality Improvement

_____ Date _____

Director of Quality Improvement

_____ Date _____

Senior Director of Contracting & Quality Performance

_____ Date _____

Director of Quality Performance

_____ Date _____

Senior Director of Wellness and Prevention

_____ Date _____

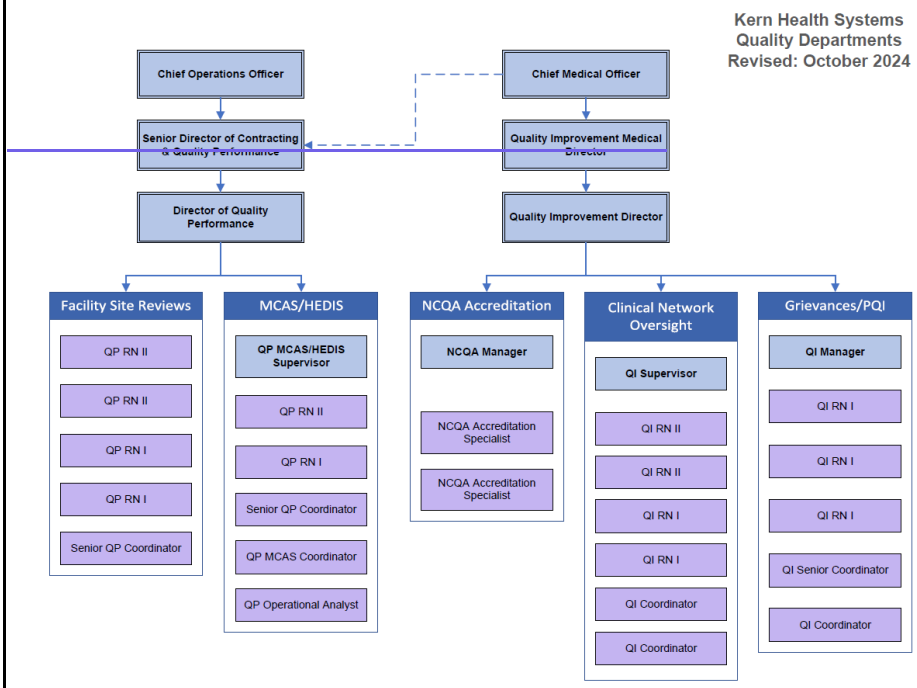
Director of Population Health Management

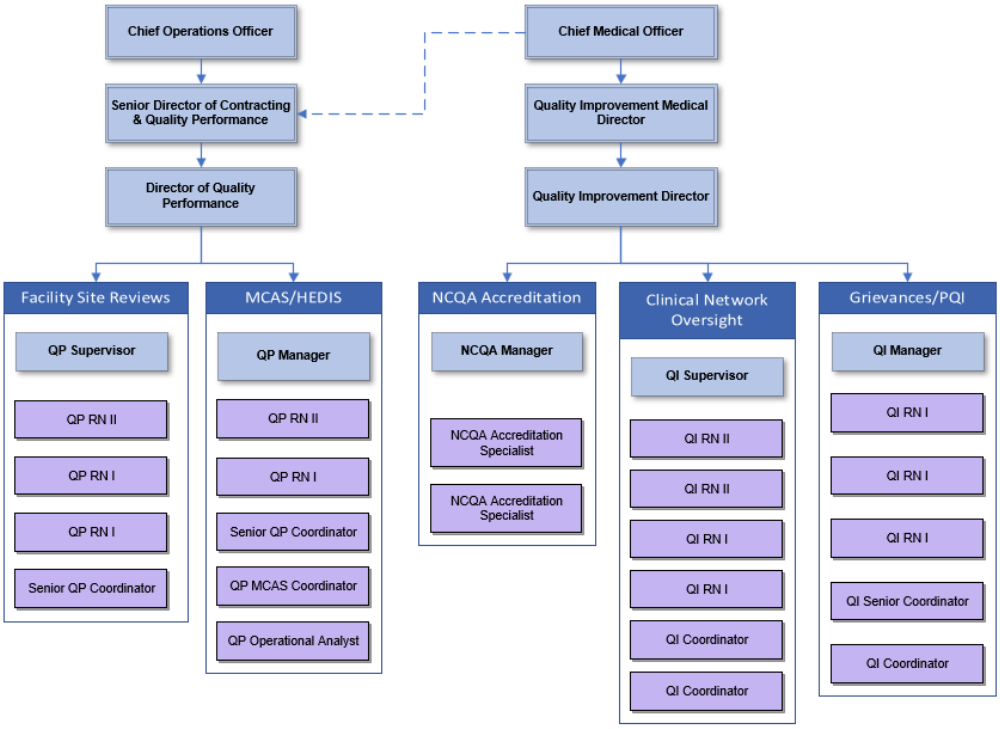
XV. Appendix

Appendix A: Population Needs Assessment ~~October 2024~~September 2025

https://www.kernfamilyhealthcare.com/about-us/community-reports/

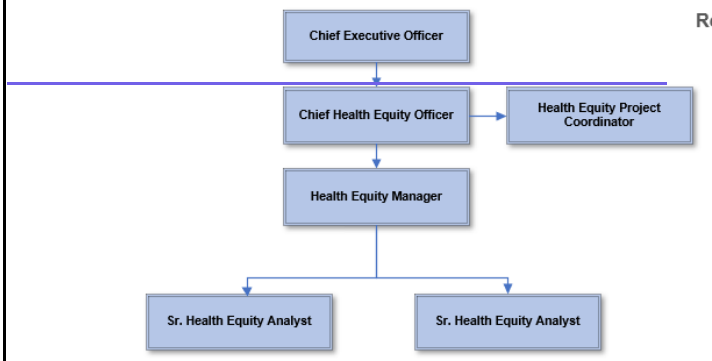
Appendix B: Quality Departments Organization Structure

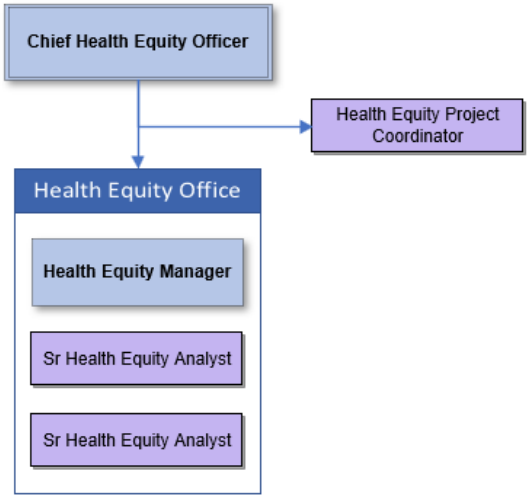



Chief Operations Officer
Chief Medical Officer
Senior Director of Contracting & Quality Performance
Quality Improvement Medical Director
Director of Quality Performance
Quality Improvement Director
Facility Site Reviews
QP Supervisor
QP RN II
QP RN I
QP RN I
Senior QP Coordinator
MCAS/HEDIS
QP Manager
QP RN II
QP RN I
Senior QP Coordinator
QP MCAS Coordinator
QP Operational Analyst
NCQA Accreditation
NCQA Manager
NCQA Accreditation Specialist
NCQA Accreditation Specialist
Clinical Network Oversight
QI Supervisor
QI RN II
QI RN II
QI RN I
QI RN I
QI Coordinator
QI Coordinator
Grievances/PQI
QI Manager
QI RN I
QI RN I
QI RN I
QI Senior Coordinator
QI Coordinator

Appendix C: Health Equity Office Organization Structure

Kern Health Systems
Health Equity Office
Revised: December 2024





Kern Health Systems Annual Quality Improvement Health Equity Work Plan - 2026

Source	Key Performance Measure	Objective/Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Staff
I. Quality Program Structure							
NCQA 1D	QIHE Governance	Conduct quarterly EQIHEC Meetings	No issues identified	Meet quorum of voting members at every meeting		12/31/2026	Quality Improvement Director & Health Equity Manager
NCQA 1C	Annual QI Evaluation of 2025	Summary of completed and ongoing QI activities, trending of results and overall evaluation of effectiveness	No issues identified	Annual approval by the EQIHEC and the BOD		3/31/2026	Quality Improvement Director
NCQA 1A	2026 Quality Improvement Health Equity Program Description	QIHE Program description of committee accountability, functional areas and responsibilities, reporting relationship, resources and analytical support	No issues identified	Annual approval by the EQIHEC and the BOD	Annual review and update	3/31/2026	Quality Improvement Director & Health Equity Manager
NCQA 1B	2026 Annual Quality Improvement Health Equity Work Plan	Yearly planned objectives and activities	No issues identified	Annual approval by the EQIHEC and the BOD		3/31/2026	Quality Improvement Director
DHCS	Policies and Procedures	Annual review of KHS Quality Improvement P&Ps	No issues identified	100% of policies reviewed and updated as needed		12/31/2026	Quality Improvement Director
NCQA	NCQA Health Plan Accreditation	Maintain Health Plan Accreditation	Provider Directory online vs printed did not match	Maintain Full Health Plan Accreditation	Quarterly Mock Audits Update P&Ps to current standards	12/31/2026	Quality Improvement Director
NCQA	NCQA Health Outcomes Accreditation	Maintain Health Outcomes Accreditation	No issues identified	Maintain Full Health Outcomes Accreditation	Update P&Ps to current standards	12/31/2026	Health Equity Manager
II. Quality of Clinical Care							
DHCS	MCAS Measures	21 MCAS measures mandated by DHCS to meet the minimum performance levels (MPLs)		Meet minimum performance levels (MPLs)		8/31/2026	Quality Performance Director
DHCS	Clinical PIP: Focus on Health Equity, specific to the W30 0-15 months African American Population	2023-2026 performance improvement project (PIP) overseen by HSAG focused on increasing the number of children ages 0 - 15 months old with completing an annual well care visit.	Did not meet MPL for multiple measures in Children's Domain of Care	Use MY2023 W30 (0-15months) baseline data to develop PIP interventions and get Annual Approval by HSAG.		12/31/2026	Quality Performance Director
DHCS	Non-Clinical PIP: Specific to FUA and FUM measures	2023-2026 performance improvement project (PIP) overseen by HSAG focused on improving Behavioral Health measures throug provider notivications with in 7-days of the ER visit.	Did not meet MPL for FUA and FUM measures	Use MY2023 baseline data to develop interventions that includes a process for notifying PCPs of ED visits for eligible population. Annual Approval by HSAG		12/31/2026	Quality Performance Director
IHI/DHCS	Health Equity Sprint Collaborative	Completion of well-care visits for African-American babies and children for W30 and WCV MCAS measures	Did not meet MPL for WCV or W30	Utilize MY2023 data to develop strategic provider partnerships to improve compliance for targeted population	2 provider partnerships and 1 CBO partnership in support of well-care visits	4/1/2026	Quality Performance Director
III. Safety of Clinical Care							
	Patient Safety Program/Clinical Network Oversight	Conduct Audits of select measures (IHA, Lead Screening, telehealth, EPSDT, etc.)	No issues identified	Conduct monitoring of provider performance	Conduct monitoring of provider performance at least semi-annually	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Quality Improvement Director
DHCS	Potential Quality of Care Issue (PQI)	Monitoring of PQI volume month over month	No issues identified	Median <30/month Level 1 and above	Continue quarterly monitoring & report findings to QIW	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Quality Improvement Director
DHCS	Potential Quality of Care Issue (PQI)	PQI Rates by Provider	No issues identified	Network <1.00 PQI/1000 interactions	Continue quarterly monitoring & report findings to QIW	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Quality Improvement Director

Kern Health Systems Annual Quality Improvement Health Equity Work Plan - 2026

Source	Key Performance Measure	Objective/Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Staff
DHCS	Potential Quality of Care Issue (PQI)	PQI Rates by ethnicity, english as a second language, sexual orientation, gender identity	No issues identified	Baseline monitoring	Continue quarterly monitoring & report findings to QIW	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Quality Improvement Director
DHCS	Potential Quality of Care Issue (PQI)	Timeliness of resolution	No issues identified	Within 120 calendar days or per policy	Continue quarterly monitoring & report findings to QIW	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Quality Improvement Director
DHCS	Facility Site Review	Conduct on site reviews at the time of initial credentialing or contracting, and every three years thereafter, as a requirement for participation in the California state Medi-Cal Managed Care (MMCD) Program	Issues were identified in Critical Elements while conducting FSR.	Complete FSR and medical record audit of 100% of practitioners due for credentialing or recredentialing	CSR will schedule and complete reviews timely.	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Quality Performance Director
DHCS	Physical Accessibility Review Survey (PARS)	Conduct PARS audit with FSR	No issues identified	Complete the PARS audit of 100% of practitioners due for credentialing or recredentialing	QP Senior coorninator will schedule and complete all PARS due 2026	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Quality Performance Director
DHCS	Medical Record Review	Conduct medical record review of practitioners due for facility site reviews	Previously identified issues from MRR: 1. Hepatitis B Virus screenings not documented 2. Member Risk Assessments not documented 3. HIV infection screening not documented	Achieve medical record review score of 85% for each practitioner	CSR will schedule and complete reviews timely.	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Quality Performance Director
	Drug Utilization Review	Physician Administered Drugs (PAD)	No issues identified	72 hrs for urgent, 5 days for routine	Continue quarterly monitoring & report findings to DUR	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Pharmacy Director
NCQA	Credentialing/Recredentialing	Credential/recredential practitioners timely	No issues identified	100% timely credentialing/recredentialing of practitioners	Review of trends for Grievances and PQIs, QOC look back review 3 years	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Credentialing Manager
IV. Quality of Service							
DHCS	Grievance & Appeals	Timeliness of acknowledgement letters	Issues identified and action plan in place	90% Within 5 calendar days	Continue quarterly monitoring & report findings to QIW	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Member Services Director
DHCS	Grievance & Appeals	Timeliness of resolution	Issues identified and action plan in place	90% within 30 calendar days and 72 hours for expedites	Continue quarterly monitoring & report findings to QIW	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Member Services Director
DHCS	Access to Care - PCP	Urgent Care within 48 hours	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Provider Network Management Director
DHCS	Access to Care - PCP	Routine Care - 10 business days	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Provider Network Management Director
DHCS	Access to Care - SCP	Urgent Care within 48 hours	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Provider Network Management Director
DHCS	Access to Care - SCP	Routine Care - 15 business days	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Provider Network Management Director

Kern Health Systems Annual Quality Improvement Health Equity Work Plan - 2026

Source	Key Performance Measure	Objective/Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Staff
DHCS	Telephone Access to Member Services	Speed of Answer	No issues identified	< 30 seconds	Continue quarterly monitoring & report findings to QIW	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Member Services Director
DHCS	Telephone Access to Member Services	Call abandonment rate	No issues identified	< 5%	Continue quarterly monitoring & report findings to QIW	3/31/2026 6/30/2026 9/30/2026 12/31/2026	Member Services Director
V. Member Experience							
	CAHPS Survey	Adult and Child Medicad Survey	Rating of Specialist scored 65.1% in the Adult Survey	Improve Rating of Specialist to equal regional peers 66.9%	Improve Rating of Specialist to equal regional peers 66.9%	12/31/2026	Member Engagement Manager
VI. Provider Engagement							
	Provider Satisfaction Survey	Would Recommend	No issues identified	Maintain 98th Percentile	Report survey results to QIW annually	9/30/2026	Provider Network Management Director
	Provider Satisfaction Survey	Utilization and Quality Management	No issues identified	Maintain 97th Percentile	Report survey results to QIW annually	9/30/2026	Provider Network Management Director
	Provider Satisfaction Survey	Degree to which the plan covers and encourages preventive care and wellness	No issues identified	Maintain 96th Percentile	Report survey results to QIW annually	9/30/2026	Provider Network Management Director
	Provider Education	Host at least one educational conference for Providers	No issues identified	Host one educational conference for Providers	Medical Management of Obesity for Primary Care Providers Conference	11/30/2026	Quality Improvement Medical Director

To: Executive Quality Improvement Health Equity Committee (EQIHEC)

From: Kailey Collier, Director of Quality Performance

Date: March 17, 2026

Re: Quality Performance (QP) Report Q4 2025

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 fourth quarter of 2025.

Discussion Items:
See page 2 of this document.

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

Requested Action:
Review for approval.

KERN HEALTH SYSTEMS

Quality Performance Department
Executive Summary
4th Quarter 2025

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

6 Initial Facility Site Reviews and 3 Initial Medical Record Reviews were completed in Q4 2025. 9 Periodic FSRs and 9 periodic MRRs were also completed. 100% of Facility Site Reviews passed and 96% YTD of Medical Record Reviews passed. 2 of 54 sites failed the first review, however Corrective Action Plans were completed and closed. QP also conducts mid-cycle interim reviews of facilities to monitor facility compliance. The QP department also conducts Physical Accessibility Review Surveys (PARS) and 6 were completed in Q4 2025.

II. Quality Improvement Projects (pages 11-12)

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

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

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

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

The QP team continued 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. 15 of 18 measures improved compared to last year. Based on administrative data, we are meeting MPL for 5 measures. We are within 5% MPL for 3 additional measures. These rates are reflective of year-to-date administrative data only. We anticipate changes as we move through the MY2025 MCAS annual audit.

KERN HEALTH SYSTEMS

QUALITY PERFORMANCE DEPARTMENT

QUARTERLY EQIHEC COMMIITTEE REPORT

Q4 2025

KERN HEALTH SYSTEMS
Quality Performance Department Quarterly EQIHEC Committee Report
Q4 2025

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

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

II. Quality Improvement Projects

A. Performance Improvement Projects (PIPs)

B. Red Tier & Strike Team

V. Managed Care Accountability Set (MCAS) Updates

VI. Policy and Procedures

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

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

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

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

Critical Elements:

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

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

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

Scoring and Corrective Action Plans

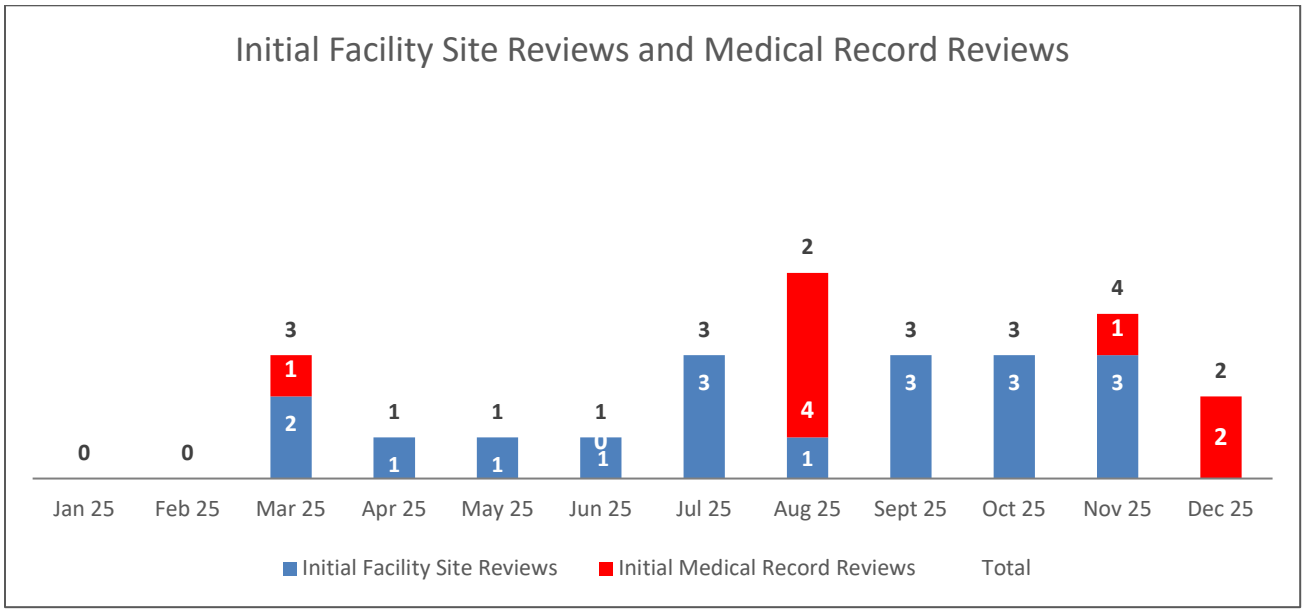
Provider sites that receive an FSR or MRR score with an Exempted Pass (90% or above, without deficiencies in critical elements) are not required to complete a corrective action plan (CAP). All sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements) are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

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

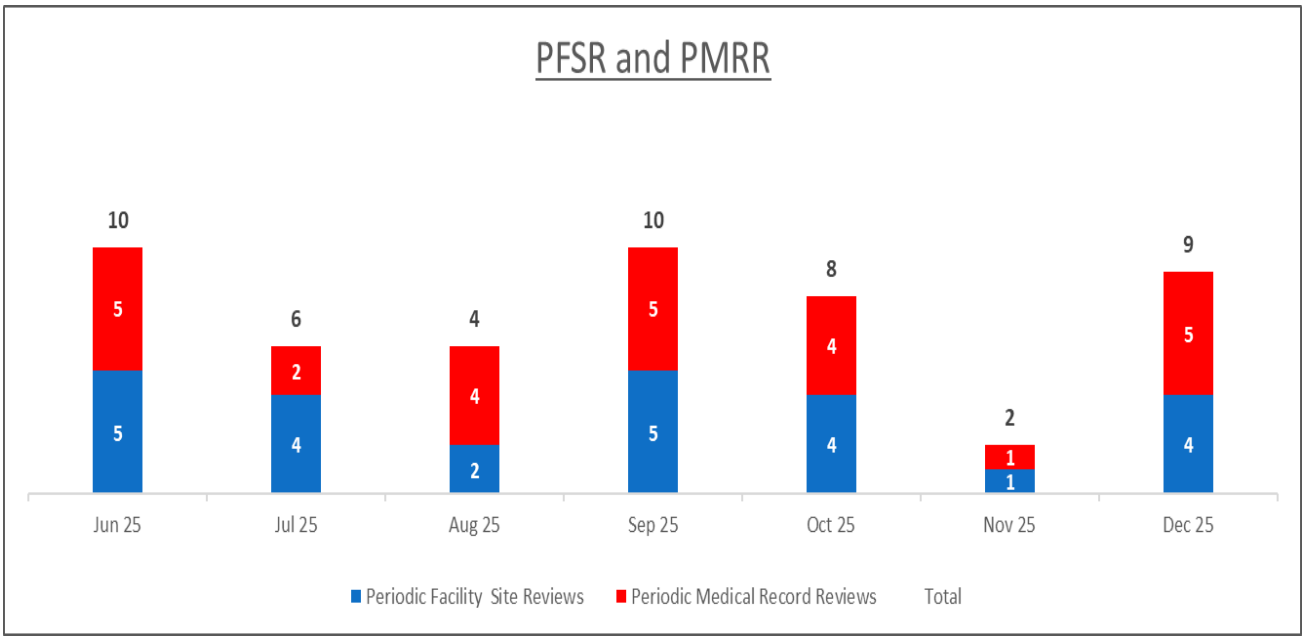
Corrective Action Plans (CAPs)

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

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

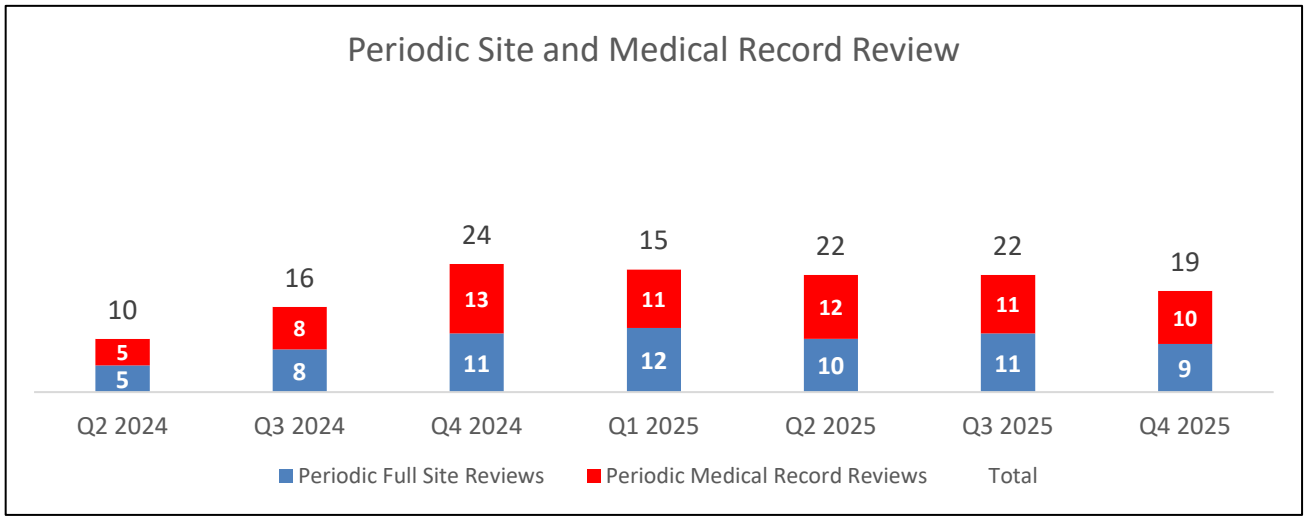


The number of Initial Facility Site and Medical Record Reviews is determined by the number of new providers requesting to join KHS' provider network. There were 6 IFSRs and 3 IMRR completed in Q4 of 2025.



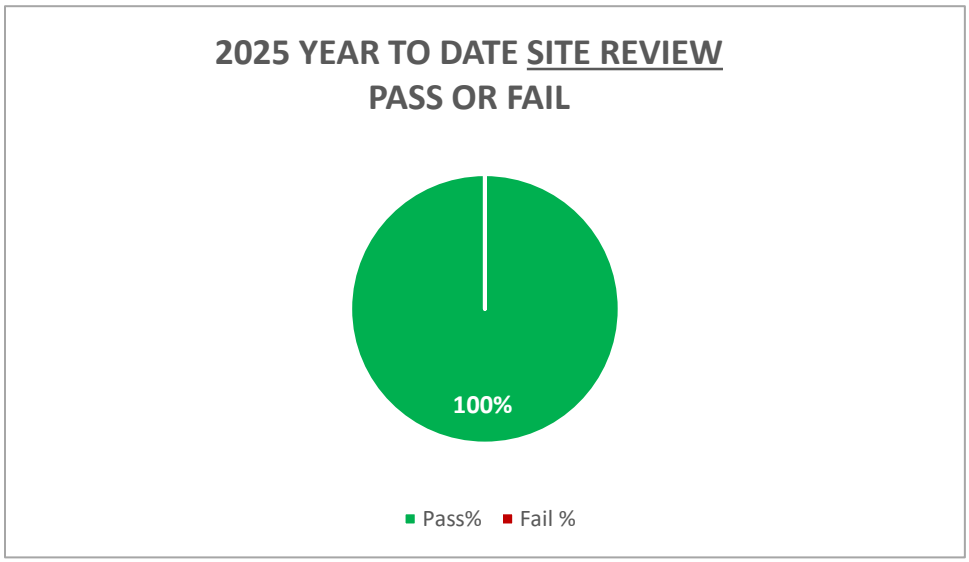
B. Periodic Full Site and Medical Record Reviews

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

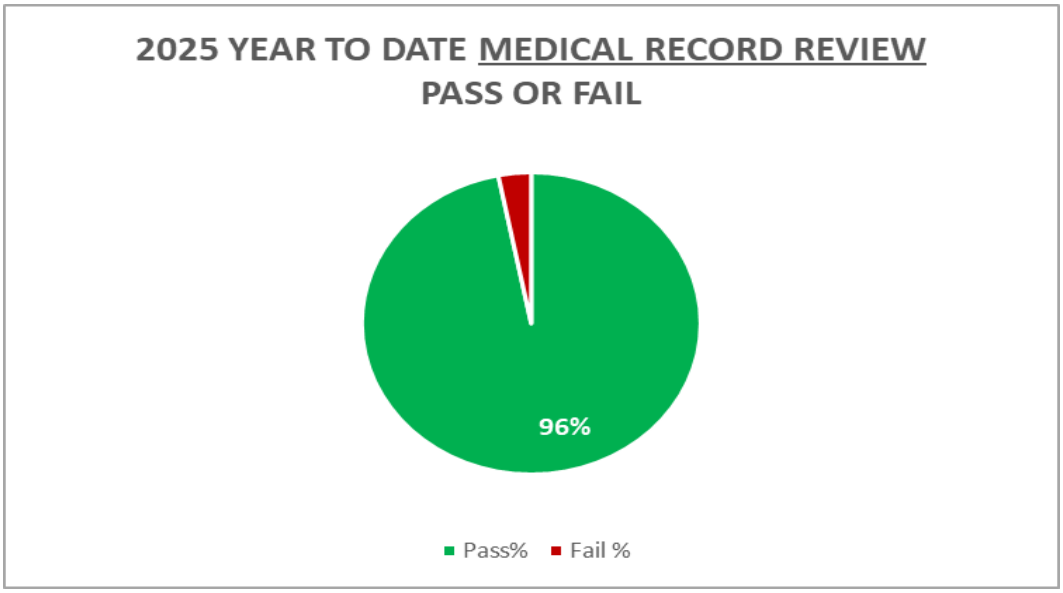


The above chart shows the number of Periodic Full Site Reviews and Medical Record Reviews that were due and completed for each quarter to date.

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



Based on DHCS' standard 80% or higher is considered as passed. Scoring 80% - 89% is considered a "conditional pass" and requires a CAP only for the elements that were non-compliant. A score below 80% is considered a Fail and requires a CAP for the entire site or medical record review.
For 2025, 100% of the Initial and Periodic site reviews performed passed. There were 61 site reviews completed.



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

For Q4 2025, the top 3 deficiencies identified for Opportunities for improvement in Facility Site Reviews are:

1. Emergency phone number contacts are posted, updated annually and as changes occur.
2. There is no process to document checking of emergency medication, equipment and supplies for expiration and operating status at least monthly.
3. No eye charts (literate and illiterate) and occluder for vision testing.

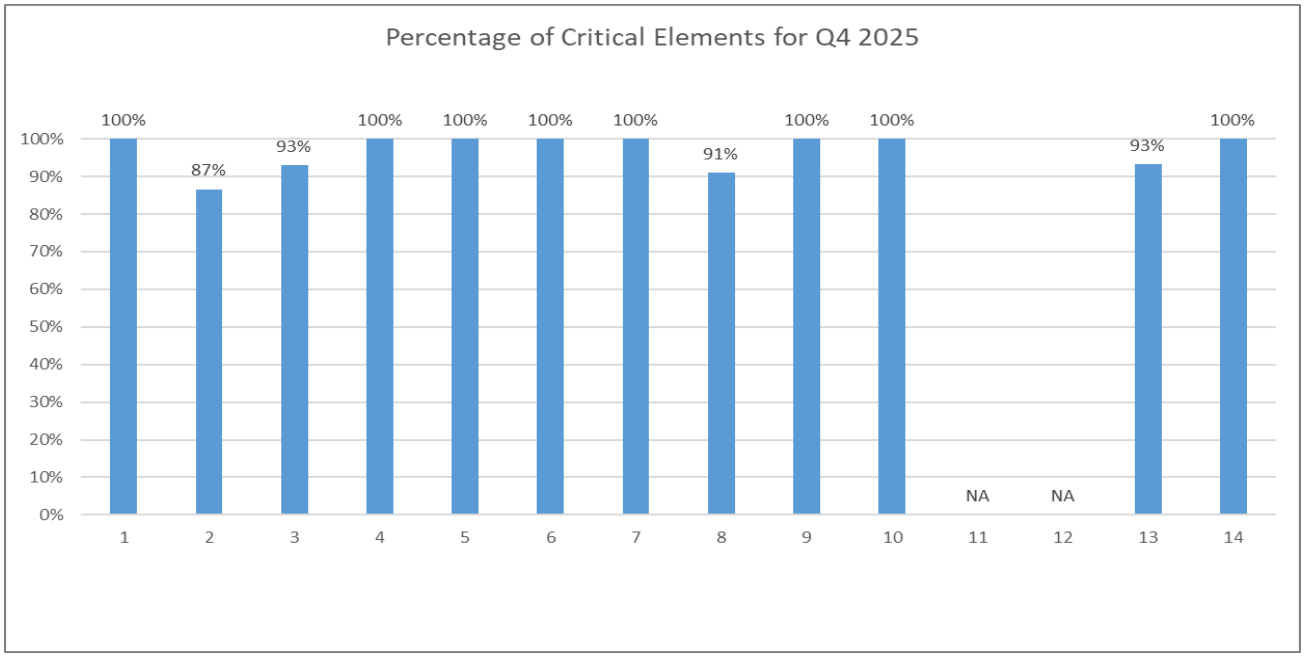
Education was provided regarding these deficiencies. We will continue to monitor for any new trends.

For Q4 2025, the top #3 deficiencies identified for Opportunities for improvement in Medical Record Reviews are:

1. Vaccine Information Statement (VIS) is not documented.
2. Sexually Transmitted Infection (STI) Screening and Counseling.
3. Member Risk Assessment is not being completed in both adult and pediatrics.

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

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



There were 15 FSRs completed for Q4 2025, and 12 sites have passed the critical elements.

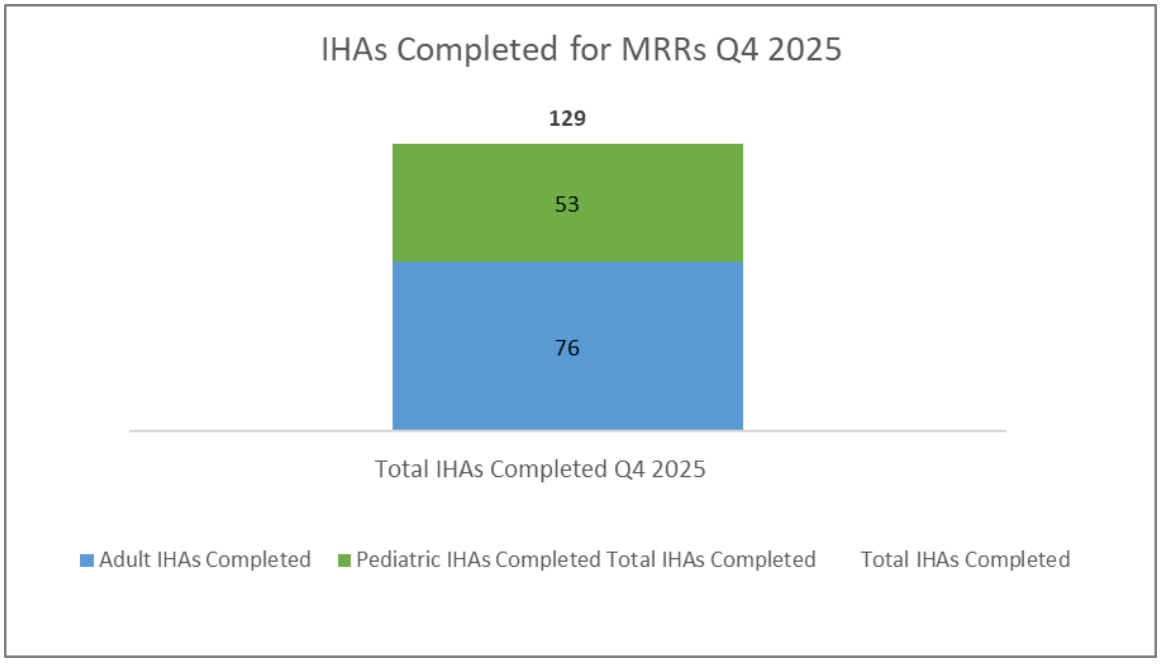
The site review team is working closely with sites by proving ongoing education to ensure compliance.

D. IHA's percentage for MRRs:

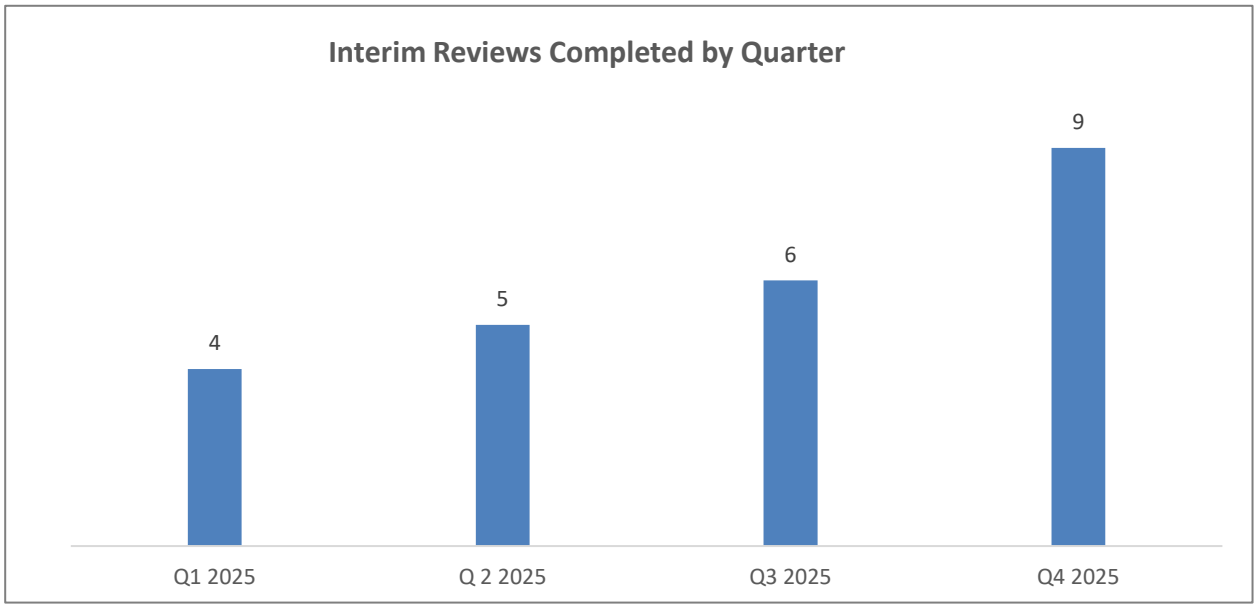
For Q4 2025, based on the medical record reviews, 129 IHA's were completed. 53 total pediatric charts and 76 adult charts. 49 out of the 53 pediatric charts were compliant and 4 were non-compliant. Out of all the 76 Adult charts, 51 adult charts were found to be compliant and 25 were non-compliant. Education was provided for the non-complaint charts.

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

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

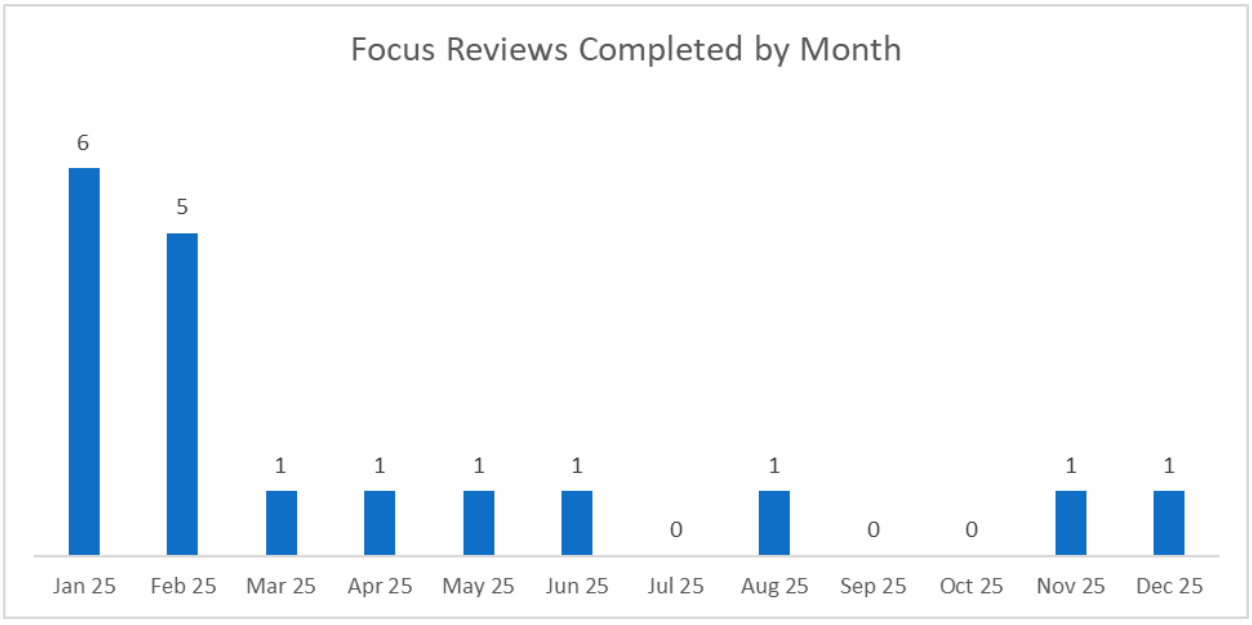


E. Interim Reviews: Interim Reviews are conducted between Initial and first Periodic Full Site Reviews or between two Periodic Full Site Reviews. Typically, they occur about every 18 months. These reviews are intended to be a check-in to ensure the provider is compliant with the 14 critical elements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

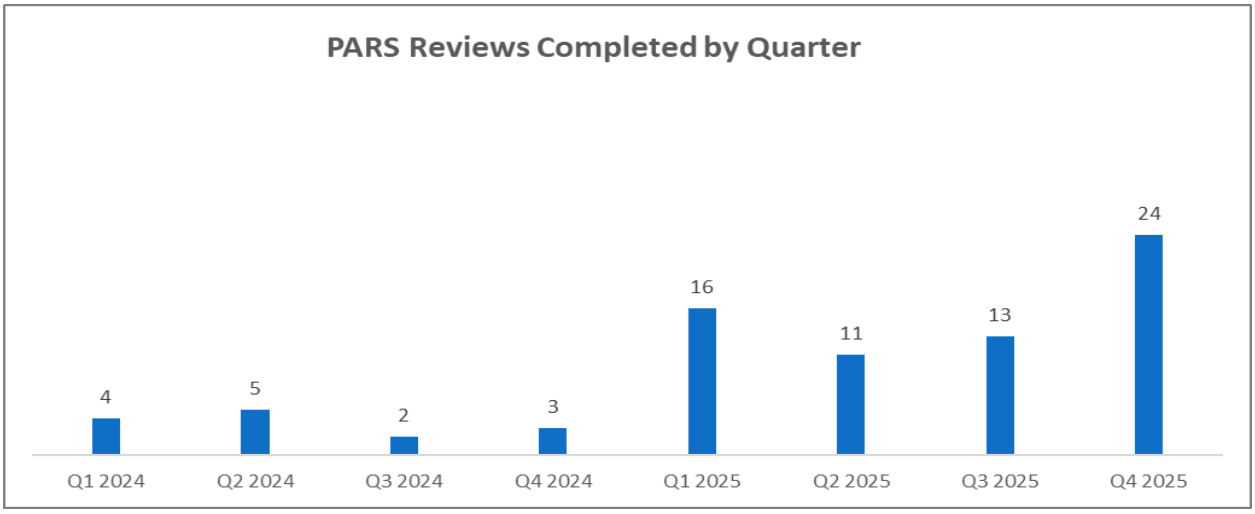


For Q4 2025, there were 9 Interim reviews completed.

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 Q4 2025, we had 2 Focused MRRs completed. 18 Focused MRRs were completed in 2025.



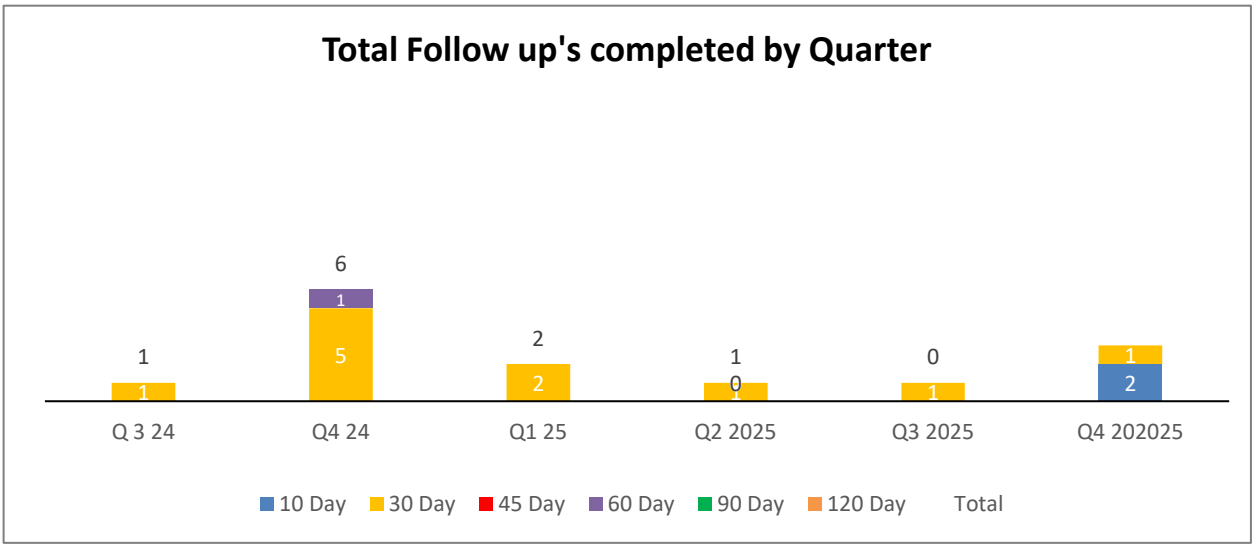
G. Physical Accessibility Review Survey (PARS):



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 Q4 2025, 24 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 Q4 2025, there were two 10 day follow-ups and one 30-day follow-up completed.

II. Quality Improvement Projects:

A. Performance Improvement Projects (PIPs):

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

Clinical PIP:

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

The PIP team Attended 2 Maternal Health Disparities Webinars. Participated in the maternal health disparities webinars and met with PIP team leadership to plan our next steps. We have worked on developing a process map and completed key driver's diagram.

All QI Tools completed, including Process Map, with aid from QP department, Member Services, and Member Outreach Marketing. Continued efforts on how to track data (member services outreach on W30, text reminders of WBVs, Mobile unit WBV events). Work on the clinical PIP progresses, as we summarize efforts made in 2024 onto the new forms provided and include efforts in progress through December of 2025. These include weekend clinics with pilots' pediatric sites to close well visit gaps in care, and educational and supportive items, such as diaper bags for new parents and magnets to track well baby visits.

The PIP successfully passed external validation review by Health Services Advisory Group.
KHS_CA2025-26_PIP-Val_W30_Tool
Methodology Confidence: Moderate (per HSAG validation). Confidence in Directional Improvement: Moderate to High confidence in Statistically Significant Impact: Not yet demonstrated.

Overall Assessment: The PIP is externally validated, methodologically sound, and demonstrates upward trend performance. Sustainability is strongest where interventions are embedded in provider infrastructure or supported across departments. Achieving statistically significant improvement will require sustained intervention execution and potentially greater magnitude of change in MY2025.

<u>Current State:</u>

Measure: Six or more well-child visits by 15 months (W30–6)
Population: Black/African American infants

Period	Rate
Pre-Baseline (MY2022)	20.47%
Baseline (MY2023)	33.33%
Remeasurement 1 (MY2024)	35.21%

- +12.86 percentage point improvement from pre-baseline to baseline.
- +1.88 percentage point improvement from baseline to Remeasurement 1.
- Improvement not statistically significant (p=0.7977).
- Performance remains below historical MPL (55.72%).

Assessment: Positive directional movement; magnitude remains modest.

Barriers:

- Transportation access and fuel cost burden.
- Work and school schedule conflicts.
- Childcare constraints.
- Outdated member contact information.
- Vaccine hesitancy and misinformation.
- Small denominator size limiting statistical power.

These remain multifactorial and require sustained intervention layering.

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 have partnered with the Behavioral Health Department, UM, PHM, and any other necessary stakeholders. PIP work continues as we compile 2024 efforts onto the newly supplied forms and incorporate ongoing work through the December 2025 submission.

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

Methodology accepted based on the 2025-2026 PIP Validation Tool received 09/2025. All critical elements were Met. Overall methodology confidence: High. Confidence for significant improvement: No Confidence due to lack of improvement over baseline in Remeasurement 1.

Current State:

- Baseline (2023): 39.09% (761/1947)
- Remeasurement 1 (2024): 19.65% (706/3592)
- Performance declined due to substantial denominator increase and limitations in ADT data sources. Statistical testing showed significant difference (p=0.0001), but performance decreased.

Barriers:

- ADT data currently received from only one participating ED
- ADT report initially pulled incomplete/incorrect data elements
- Limited provider access and awareness of ADT reports
- Increased denominator volume diluted notification rate

Claims lag may impact timely identification

B. MCAS Initiatives

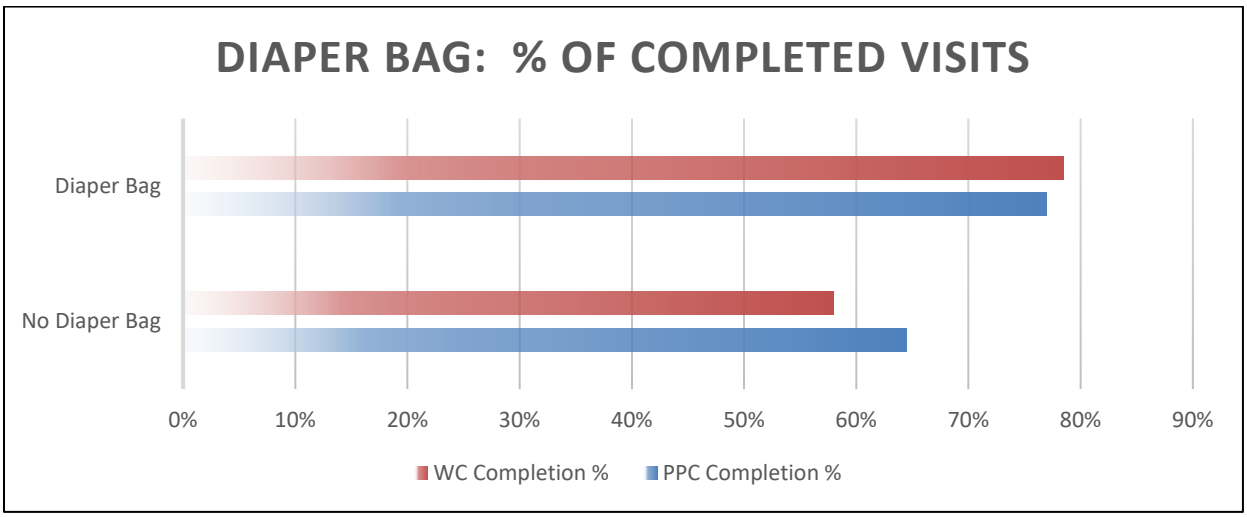
The purpose of this report is to provide an update on interventions put into place to improve the compliance rates of the MCAS measures.

Interventions to improve MCAS performance:

- Provider Touchpoint Updates:
  - Meeting with top 20 providers per membership volume
  - The Big 3 providers and team meet every other month to review MCAS rates, improvements, focus targets and any barriers
  - Scheduled ad hoc provider groups to discuss rates, focus measures and questions.

  - Full set of resources given, including Provider Guide, Coding Card, 2024 MCAS measures list, Member Rewards, and Transportation Benefits
  - Routine communication with providers via email, via teams, and in-person meetings

- Diaper Bag Initiative:
  - Partnered with local hospital to identify mothers who delivered via ADT data
  - Approximately 200 new mothers received diaper bags filled with resources and necessities tailored to moms and babies
  - Included a well-baby visit magnet tracker to support education and awareness of critical visits during the first 30 months of life



- Opportunities to collaborate with community-based organizations continue and scheduling with mobile units around Kern County with CSV, Omni, KM and PVMG
- KHS supported scheduling members for their breast Cancer Screening (BCS) with Stockdale Radiology
- Dr. Duggal effort is continuing to improve patients' health that are dealing with diabetes decreasing A1c's focus on 9-11%
- Adolescent Well Visit Smart Watch have completed 3rd quarter winners and called 30 winners
- New MERP incentive was approved to focus on Flu for CIS-10 Measure that will start in the Fall
- MERP's new incentive with postpartum mother to engage with W30 and establish care with provider at Kern Medical delivered 200 diaper bag 100% completed
- Organized four Saturday clinics with two providers for children needing well child visits, who received POC gift card directly after their visit with a member engagement rep on sit
- Completed final review for Provider Guide and Coding Card for MY2025, with leadership approval and hand off to Marketing team for upload to the KHS external website
- Modifications to the MERP to ensure prioritization and support of necessary barriers includes changes to the following measures as of 10/1/2025:

- Removed:
  - CHL
  - FUA
  - FUM
- Decreased incentive:
  - LSC $25 to $15
  - Prenatal $50 to $30
  - GSD
    - $10 to complete A1c
    - $15 if compliant 8.9<
- Additional incentives: :
  - CIS Flu $25
    - 0-2 years of age, 2 set of vaccines

- Member Engagement Rewards Program (MERP):
  - IHA
  - BCS
  - CCS
  - GDS (HBD)
  - LSC
  - PPC Pre/ Post
  - W30
  - WCV
- InComm: Visa incentives were sent out to our members 10/13, incentive was successful
  - Text Messages Campaign goes out to members encouraging them to schedule their appointments for gaps in care with a focus on:
    - Breast Cancer Screening
    - Blood Lead Screening
    - Initial Health Appointment
    - Chlamydia Screening
    - Cervical Cancer Screening
    - Prenatal & Postpartum Care
    - Well-Care Visits
    - Well-Baby Visits in first 30 Months of Life
  - Robocalls will be sent out to members that do not receive text messages.

III. Managed Care Accountability Set (MCAS) Updates :

For MY2024 MCAS Reporting:

- Meet MPL for 12 out of 18 measures:
    - AMR, BCS-E, CBP, CCS, CHL, CDEV, GSD, IMA-2, LSC, W30, PPC- Pre, PPC- Post, TFLCH
    - Within 5% of MPL for 3 additional measures

- MCAS MY2025 will start kicking off January 2026
- Time spent setting up and training with temp abstractor nurses with EMRs and software to perform abstractions of MCAS audit medical records, as well as answering clinical and process questions as the audit progressed in its first month, and over-reads of the abstractions.

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

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

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

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

Measure Met MPL

Measure Met HPL

▲ Measure increased compared to last year same time

▼ Measure decreased compared to last year same time

The chart below displays trending rates for MY2024 and MY2025:

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

MCAS MY2024 & MY2025 Performance Trending Metrics

Measure	Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	2024	70.00%	77.96%	75.70%	74.17%	75.00%	76.02%	74.53%	73.80%	73.41%	73.16.%	72.32% ▼	71.66%
	2025	52.94%	79.80%	78.56%	75.48%	74.80%	75.87%	75.82%	75.13%	75.07%	74.38%	73.75% ▲	73.78%
BCS	2024	44.23%	45.63%	47.44%	48.73%	50.08%	51.42%	52.66%	54.29%	55.56%	56.51%	57.69% ▲	58.61%
	2025	42.71%	43.76%	46.66%	48.52%	49.89%	47.39%	48.54%	50.11%	51.16%	52.21%	53.16% ▼	54.29%
CBP	2024	9.26%	18.53%	25.05%	29.78%	33.20%	39.86%	43.20%	44.26%	45.40%	46.51%	47.43% ▼	48.39%
	2025	10.99%	22.57%	32.06%	38.27%	42.30%	45.56%	48.48%	51.22%	53.43%	54.95%	55.77% ▲	56.56%
CCS	2024	37.99%	36.76%	38.23%	39.55%	40.91%	42.09%	46.05%	47.50%	48.49%	49.70%	50.69% ▼	51.71%
	2025	45.81%	46.30%	47.70%	48.96%	50.43%	500.80%	51.80%	52.94%	53.94%	54.97%	55.75% ▲	56.65%
CDEV	2024	6.26%	9.18%	11.86%	13.90%	15.79%	17.40%	18.80%	19.66%	20.27%	20.64%	20.84% ▲	20.93%
	2025	7.42%	10.97%	14.21%	17.12%	20.09%	21.79%	23.36%	24.43%	25.08%	25.57%	12.76% ▼	12.88%
CHL	2024	22.15%	33.05%	35.23%	37.90%	39.96%	45.63%	48.75%	51.25%	52.92%	54.37%	55.75% ▲	57.05%
	2025	25.79%	34.17%	38.95%	43.18%	46.56%	45.43%	46.65%	48.42%	49.52%	50.45%	51.18% ▼	52.05%
CIS-10	2024	10.01%	11.62%	12.17%	12.53%	12.42%	13.04%	13.14%	18.61%	18.77%	19.03%	19.33% ▼	19.45%
	2025	10.16%	12.47%	13.82%	14.27%	15.05%	17.93%	18.05%	18.15%	18.31%	18.46%	19.51% ▲	19.72%
FUA 30Day follow up	2024	20.00%	16.11%	20.27%	19.10%	18.59%	20.93%	22.50%	23.91%	22.91%	23.16%	23.13% ▼	23.34%
	2025	16.25%	16.43%	19.51%	21.14%	21.36%	21.65%	23.75%	23.90%	24.28%	24.15%	24.45% ▲	25.86%
FUM 30Day follow up	2024	9.09%	25.00%	21.88%	17.86%	15.91%	19.74%	20.82%	20.25%	19.50%	20.53%	21.45% ▼	20.72%
	2025	9.80%	13.91%	17.83%	17.03%	17.26%	30.56%	32.83%	33.39%	33.46%	35.12%	35.64% ▲	35.75%
GSD*	2024	98.79%	92.48%	85.96%	80.56%	75.65%	71.23%	67.63%	66.71%	62.92%	61.58%	59.61% ▼	54.41%
	2025	96.31%	88.14%	74.38%	67.74%	64.57%	61.03%	59.85%	58.81%	57.11%	55.77%	67.71% ▲	66.49%
IMA-2	2024	20.41%	21.78%	23.08%	24.49%	25.82%	27.71%	29.52%	32.00%	32.88%	33.54%	34.06% ▼	34.25%
	2025	23.52%	25.63%	27.62%	28.83%	30.65%	32.07%	33.33%	34.84%	35.59%	36.20%	37.26% ▲	37.35%
LSC	2024	54.60%	57.84%	60.05%	62.04%	63.05%	64.95%	66.60%	67.25%	67.90%	68.60%	68.96% ▼	69.11%
	2025	64.57%	67.38%	69.66%	71.31%	72.55%	73.44%	73.99%	74.42%	74.74%	74.87%	75.12% ▲	75.27%
PPC-Pre	2024	25.10%	26.84%	28.68%	30.70%	33.22%	37.55%	43.83%	46.35%	48.18%	49.63%	49.44% ▼	49.27%
	2025	27.34%	30.00%	60.25%	61.72%	63.46%	64.71%	65.78%	66.53%	63.55%	63.60%	76.61% ▲	77.29%
PPC-Post	2024	47.47%	52.40%	57.47%	59.72%	61.74%	63.15%	67.75%	64.29%	64.65%	71.15%	74.06% ▼	74.66%
	2025	53.97%	59.25%	60.25%	64.83%	65.32%	65.48%	66.72%	67.60%	70.48%	72.42%	76.61% ▲	77.29%
TFL-CH	2024	14.64%	17.16%	20.65%	23.68%	26.00%	29.18%	31.71%	33.47%	35.76%	37.77%	9.36% ▼	39.53%
	2025	16.98%	16.82%	23.76%	23.94%	26.90%	29.40%	33.94%	35.64%	37.61%	39.93%	41.23% ▲	42.74%
W30 (0-15M)	2024	24.72%	29.30%	34.04%	37.92%	41.33%	44.51%	47.26%	49.52%	51.70%	53.09%	53.62% ▲	52.20%
	2025	21.56%	24.94%	28.57%	31.99%	35.59%	38.29%	41.26%	45.27%	47.20%	48.82%	54.19% ▼	49.91%
W30 (15-30M)	2024	51.49%	54.30%	56.86%	59.32%	61.71%	63.56%	64.36%	65.26%	66.12%	66.53%	66.71% ▼	65.87%
	2025	53.86%	57.50%	60.60%	63.10%	65.28%	66.60%	67.69%	68.33%	68.61%	68.68%	68.40% ▲	68.23%
WCV	2024	2.80%	6.13%	10.59%	15.01%	19.77%	24.31%	29.14%	34.53%	38.73%	43.19%	46.72% ▼	49.77%
	2025	2.75%	6.25%	10.67%	15.71%	20.67%	25.71%	27.55%	32.14%	39.29%	43.58%	46.90% ▲	49.93%

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

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

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

- BCS- Breast Cancer Screening
- CHL- Chlamydia Screening in Women Ages 16 – 24
- CDEV- Developmental Screening in the First 3 Years of Life
- GSD- Glycemic Status Assessment for Patients with Diabetes
- W30- (0-15M)- Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.

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

IV. Policy Updates: There were no policy updates in Q4 2025.

Quality Performance

Q4 2025

Kailey Collier, Director of QP

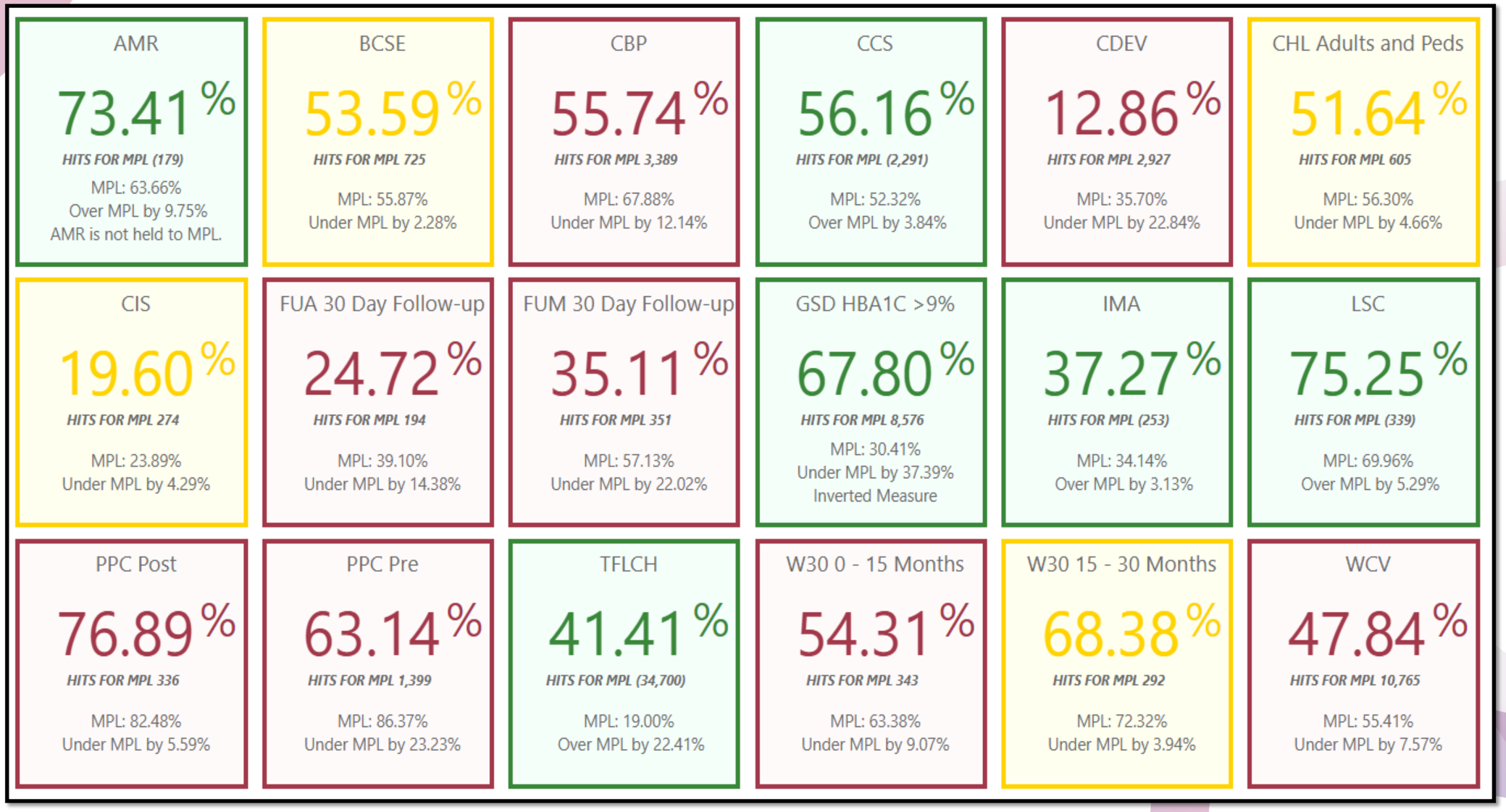
KERN HEALTH SYSTEMS

Q4 2025 YTD Performance

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

**GSD is an inverse measure – not currently compliant based on administrative data.*

There are known measure logic issues being investigated for GSD, CDEV, and WCV.



Q4 2025 Trending Performance

KHS MCAS MY2024 vs. MY2025 Comparison

AMR 73.41% HITS FOR MPL (179) +1.75 % change Dec'24 71.66%	BCSE 53.59% HITS FOR MPL 725 -5.02 % change Dec'24 58.61%	CBP 55.74% HITS FOR MPL 3,389 +7.35 % change Dec'24 48.39%	CCS 56.16% HITS FOR MPL (2,291) +4.45 % change Dec'24 51.71%	CDEV 12.86% HITS FOR MPL 2,927 -8.08 % change Dec'24 20.93%	CHL Adults and Peds 51.64% HITS FOR MPL 605 -5.41 % change Dec'24 57.05%
CIS 19.60% HITS FOR MPL 274 +0.15 % change Dec'24 19.45%	FUA 30 Day Follow-up 24.72% HITS FOR MPL 194 +1.88 % change Dec'24 22.84%	FUM 30 Day Follow-up 35.11% HITS FOR MPL 351 +0.35 % change Dec'24 34.75%	GSD HBA1C >9% 67.80% HITS FOR MPL 8,576 -13.39 % change Dec'24 54.41%	IMA 37.27% HITS FOR MPL (253) +3.02 % change Dec'24 34.25%	LSC 75.25% HITS FOR MPL (339) +6.13 % change Dec'24 69.11%
PPC Post 76.89% HITS FOR MPL 336 +2.23 % change Dec'24 74.66%	PPC Pre 63.14% HITS FOR MPL 1,399 +13.86 % change Dec'24 49.27%	TFLCH 41.41% HITS FOR MPL (34,700) +1.89 % change Dec'24 39.53%	W30 0 - 15 Months 54.31% HITS FOR MPL 343 +2.10 % change Dec'24 52.20%	W30 15 - 30 Months 68.38% HITS FOR MPL 292 +2.51 % change Dec'24 65.87%	WCV 47.84% HITS FOR MPL 10,765 -1.93 % change Dec'24 49.77%

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

**GSD is an inverse measure*
There are known measure logic issues being investigated for GSD, CDEV, and WCV.

2026 Regulatory Submissions

Quality Measures Programs 2026	
DHCS MCAS	21 measures + CAHPS
NCQA HPR	36 measures + CAHPS
DMHC HEQMS	13 measures + CAHPS
DHCS QIP	7 measures + 3 DHCS measures
Stars Part C Part D	45 measures total: 25 measures + CAHPS (8 measures at 2x weight) 12 measures

- The above chart reflects the quantity of measures by regulator
- Although there is significant overlap in measures, there are various factors to consider including:
  - Financial implications
  - Measure weights
  - Accreditation
  - Delegated functions

2026 MCAS updates

- Retirement of CHL and AMR
- Addition of 4 new measures:
  - PDS, PND, DSF (held to MPL)
  - AAF (report only)
- 10 measures reported via ECDS methodology for MY2026
- Anticipate all digital measures by MY2029

KERN HEALTH SYSTEMS

Internal Strategy – Measure Focus

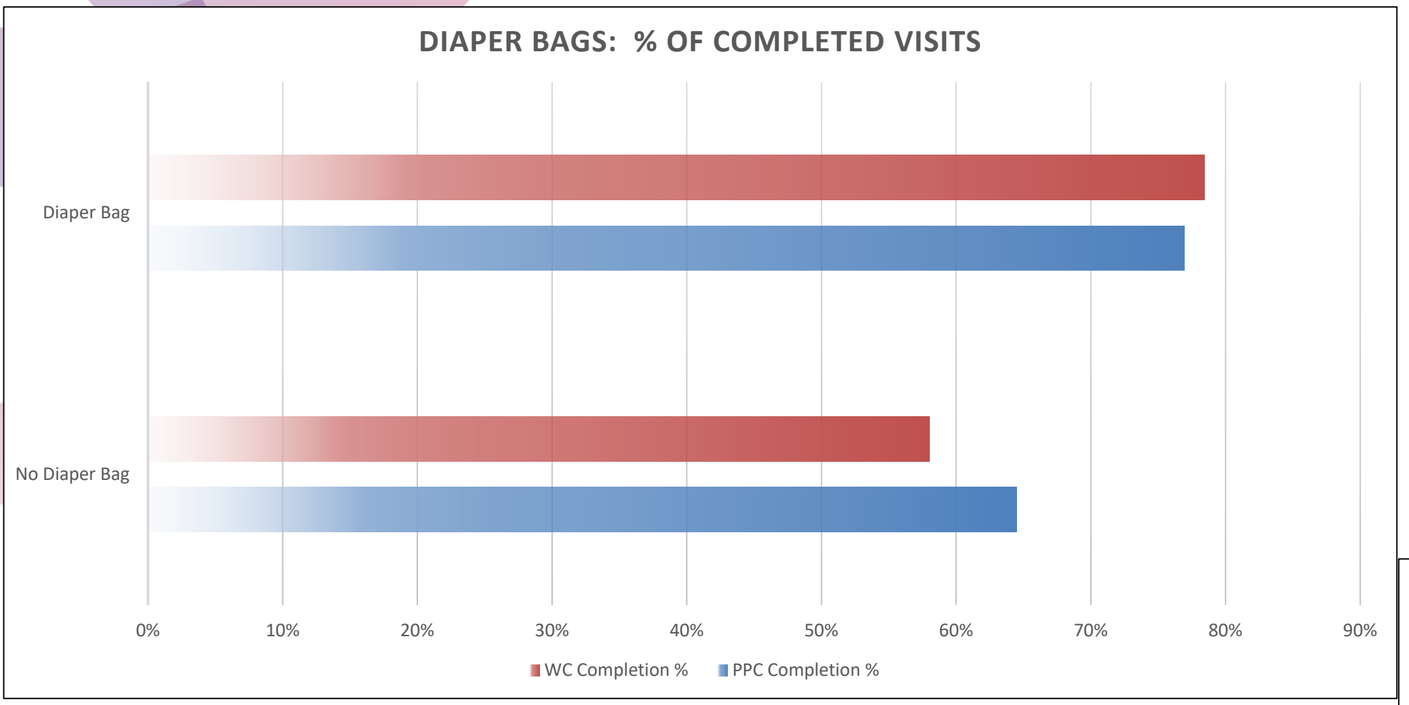


2026 Quality Measures of Focus							
	QWI	Auto Assignment	DHCS MCAS	DMHC HEQ	NCQA HPR	Stars	QIP
CBP	x	x	x	x	x	x	
GSD	x	x	x	x	x	x	
PPC - Pre	x	x	x	x	x		
PPC - Post	x	x	x	x	x		
WCV	x	x	x	x	x		
W30 (0-15)	x	x	x	x	x		
W30 (15-30)	x	x	x	x	x		
CIS-E	x	x	x	x	x		x
IMA-E	x	x	x	x	x		x
COL-E			x	x	x	x	
CCS-E			x		x	x	
FUA		x	x		x		x
FUM		x	x		x		x
CAHPS - Adult	x		x	x	x	x	
CAHPS - Child	x		x	x		x	

2025-2026 Initiatives

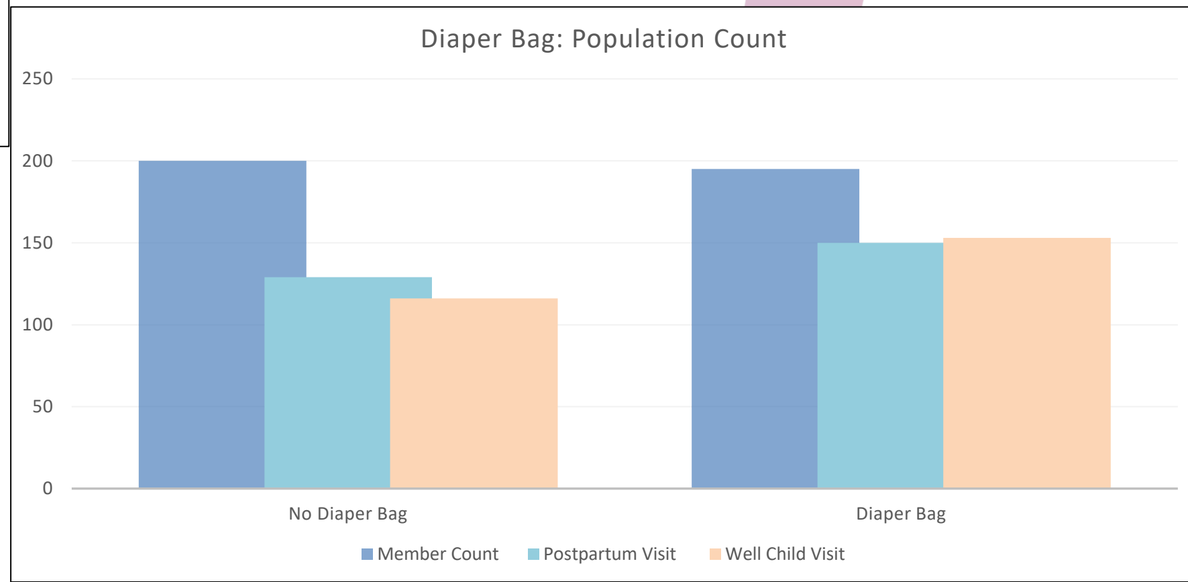
- Diaper Bag Incentives
- Well-Child Visit tracker magnet
- Develop high-performing provider program
- Mobile mammograms targeted to new age group
- Enhance outreach and targeted marketing
- Leverage site review staff for provider education
- MERP updates

Diaper Bag Initiative



- **There was an approximate increase of 20% in WCV and 11.5% for postpartum visits for the population who received a diaper bag compared to the ones who did not receive a diaper bag.**

- **Approximately 200 diaper bags were delivered to postpartum mothers within 1-2 days of delivery at a local hospital**
- **The graphs show gap closure for moms and babies who received a diaper bag compared to a random sample of 200 moms and babies who did not receive a diaper bag**



KERN HEALTH SYSTEMS

THANK YOU!

To: Executive Quality Improvement Health Equity Committee (EQIHEC)

From: Pawan Gill, Health Equity Manager

Date: March 17, 2026

Re: Health Equity Office (HEO)/Health Equity Transformation Steering Committee (HETSC) Update

---

Background:
The Medi-Cal Managed Care Plan Health Equity Office Program is defined by the Quality Improvement Health Equity Program Description and the Quality Improvement Health Equity Program Workplan. The program descriptions for the Health Equity Office and the Quality Improvement Program were combined in 2025 to form the QIHE Program Description & associated Program Evaluation which was presented for review and approval by the Quality Improvement Dept. The 2026 HEO workplan is being presented separately for review, discussion and approval. This will ultimately be combined with the QI Workplan after review and approval and submitted to DHCS as the 2026 QIHE Workplan. This plan was last reviewed in the December EQIHEC meeting. Programs added are the Well Child Visits, Birth Bridge Initiative and Breast Cancer Screening Measure Intervention. The HEO/HETSC presentation provides information on key HEO Activities included in the 2025 QIHE program evaluation.

Discussion Items:
- 2026 HEO Work Plan
- Birth Bridge Initiative
- Annual Evaluation
- Q4 RACs

Fiscal Impact:
None.

Requested Action:
- 2026 HEO Work Plan – Review for Approval to be added to QIHE
- Birth Bridge Program Description – Receive and File
- 2025 HEO Evaluation Summary - Receive and File
- 2025 Q4 RAC Report – Receive & File

2026 Health Equity Office - Workplan

GOAL	OBJECTIVE	RESPONSIBLE PERSON(S)	ACTIVITIES/INTERVENTIONS	MEASURE(S)	TARGET DATE OF COMPLETION	PREVIOUSLY IDENTIFIED ISSUE	DATE COMPLETED	STATUS & DESCRIPTION OF STATUS
MEMBER DOMAIN (45%)								
Focus on member wellness, prevention, reducing health disparity and quality improvement/performance								
Create and maintain a comprehensive report of all organizational wide health equity related programs and interventions to better inform development of key programs and initiatives	Identify, track & report organizational wide, HE related targeted interventions/programs and develop effective tracking mechanism to capture and report health equity related programming	HEO Manager	Create tracking sheet of all targeted interventions including lead dept, focus population, etc.	HETSC reviews organization-wide targeted intervention and discuss engagement strategy for existing pro	12/31/2026	Yes		Presented draft at first quarter HETSC meeting for additional input
Enhance organizational workflows to improve the effectiveness of designed interventions in service of members	Create organization process flow that formalizes HEO engagement in initial design phase of developing targeted interventions or programs	HEO Manager in partnership with COSA & BI	Create template and process for launch of new health equity related intiatives	Completion of template; review at HETSC & EQIHEC	12/31/2026	Yes		Updated target date to Q4; Cosa restructure
Member Needs Assessment	Conduct an annual member needs assessment. Identified gaps in the provider network will be addressed through the recommendations of the Network Adequacy Committee.	Director of Provider Network Management	Run report to assess needs of members. Review with stakeholders. Adjust provider network as necessary.	Percentage increase of providers; # of findings taken to NAC	8/8/2026	Yes		Ongoing
Collection of Providers' Race/Ethnicity Demographic Data	Expand and increase data integrity and reportability related to the the Collection of Provider's Demographic data to enable more effective decision making	Director of Provider Network Management & HEO Manager	Run current report, identify areas of opportunity to validate & update existing data and expand data collection	# of providers with updated demographic collection categories, data sharing capabilities etc	9/30/2026	Yes		Ongoing
Share CLAS Progress with Stakeholders	Share CLAS progress with stakeholders, including obtaining MHC distinction	Sr Director of Wellness & Prevention	Share with Stakeholders		8/31/2026	No		Ongoing
Annual evaluation of the CLAS program	Conduct annual evaluation of the CLAS program	Sr Director of Wellness & Prevention	Share with Stakeholders Identify and address areas for improvement	# of actionable items taken to committee; # of actions taken to address gaps	12/31/2026	No		Ongoing
Improve tracking mechanism of grievances	Enhance current tracking mechanism to capture and easily report types of grievances (particularly discrimination related) and monitor regularly to identify trends	Complaints and Grievances Manager & HEO	Assess current report, add necessary columns and include in HESTC report	Create tracking mechanism with a minmum 2 year look back to establish initial tracking mechanism for grievances with a focus on HE	9/30/2026	No		Adjusted to Q3. Received log from MS; +ing to JIVA
Assessment of member experience with Language Resources	Assess baseline of member experience with language resources	Cultural & Linguistics Manager and HEO	Run Annual Report Share with Stakeholders Identify and address areas for improvement	# of actionable items taken to committee; # of actions taken to address gaps	12/31/2026	No		Ongoing, Q1 data collected.
Intimate Partner Violence - COP	Idetify and address IPV among membership	HEO Manager	Further integrate IPV Initiatives into MCP operations, improvove education screending and response, collect IPV data and support provders	# of actionable items taken; correlated MCAS measures	12/31/2026	Yes		2 year program
Pre/Post Natal Measures - Alaskan/Native American Disparity Program	Conduct focus group in partnership with BHAIP to understand barriers	HEO Manager	Gather qualitative data in the form of focus groups to understand barriers and design culturally tailored intervention	# of fous groups conducted; summary report/presentation and approval of program for 2026 launch	12/31/2026	Yes		Reaching out to BHAIP
Cervical Cancer Screening Measure Intervention- Asian Pacific Islander	Develop culturally tailored Cervical cancer screening education materials and identify community partners to conduct screening events (min 2)	HEO Manager	Create educational materials in partnership with CBO's and W&P and organize 2 screening events	# of partners engaged; #of materials developed; # of events held; screenings conducted	12/31/2026	Yes		Will extend to 2026
Chlamydia Screening Measure Intervention- Hispanic population/rural farming communities	Develop and/or leverage culturally tailored Chlamydia screening education & outreach campaign and organize a minimum of 2 screening events (1 in rural area)	HEO Manager	Develop education & outreach campaign and organize 2 screening events	#of materials distributed; # of events held; screenings conducted	12/31/2026	Yes		Will extend to 2026
Well Child Visit	Caucasian, Native Population, Pacific Islanders, African American	HEO Manager in partnership with QP	Support the increase in WCV screenings, particularly in underperforming demographics, through innovative partnerships with schools, providers and CBOs	#of materials developed or distributed; # of events held; screenings conducted and interventions/PDSA's completed	12/31/2026	Yes		IHI-DHCS Child HE Collaborative 2.0
Birth Bridge Initiative/Doula Expansion Program	Improve maternal and infant health outcomes in Kern County by strengthening the local doula workforce and expanding access to culturally responsive birth support.	HEO Manager	Doula technical support, onboarding and orientation; offer professional development; increase program participation	# of contracted doulas; # of professional development hours, #of assigned members/utitization of benefits; increase in compliance on associated measures	12/31/2026	No		Partnership with QP, PHM, W&P, PNM & BH
Breast Screening Measure Intervention- Hispanic population/rural farming communities	Develop and/or leverage culturally tailored Breast Cancer screening education & outreach campaign and organize a minimum of 2 screening events (1 in rural area)	HEO Manager	Develop education & outreach campaign and organize 2 screening events	#of materials distributed; # of events held; screenings conducted	12/31/2026	No		Will extend to 2026
PROVIDER DOMAIN (15%)								
Provide training, programmatic support and incentives ato provider network to ensure the delivery of quality care to all members								
Multicultural Practices Provider Survey	Assess provider cultural responsiveness. Additional goals and objectives with a timetable for implementation are documented in the C&L	Director of Provider Network Management	Conduct Survey Review results Adjust provider network and/ or address gaps	# of actionable items taken to committee; # of actions taken to address gaps	8/8/2026	No		in Process
Assess KHS Provider Network Language Capabilities	Assesss provider language capabilities to that of the KHS member language needs.	Director of Provider Network Management	needs of members. Review with stakeholders. Add to Provider Directory	By December 31, 2025, KHS will increase language access through translation and/or interpreter services to at least 20 events where specific language needs are determined.	12/31/2026	No		in Process
Provider Training on Language Resources	Offer KHS contracted providers access and availability of language assistance resources	Director of Provider Network Managementor/ Cultural & Linguistics Manager	Run report to assess needs of members. Review with stakeholders.	HEO to review current provider resources available to providers re: language assistance resources - expand current offerings	7/31/2026	No		annually, last completed July 2024.

Collection of Providers' Race/Ethnicity Demographic Data	Assess provider's race/ethnicity demographic profile to that of the member race/ethnicity profile	Director of Provider Network Management/Credentialing Manager	Assess race/ethnicity profiles of providers to members Review reports with stakeholders. Take corrective actions	Initial measurement: Meet with at least 2 districts; Once launched measures will be performance based on specific intervention	8/31/2026	No		Ongoing
EPT Program Administration	Guide, support and administor all 2025 Equity Practice Transformation (EPT) porgram deliverables with our participating practices	HEO Manager	Cyle 2: Year 2 PhmCAT, Data Implementation Plan, Measures report, KPI Assessment Cycle 3: Implementation plan, care team assessment, clinical guidelines and report, outreach & engagement	Deliverables are evaluated by DHCS	12/31/2026	No	Cycle 2; May 1, 2025	Ongoing; 2 clinics pending May deliverables; Cycle 3 due Nov 1st
COMMUNITY DOMAIN (25%)								
Build relationships and invest in communities & community based orgnzations (CBOs)								
HEO Regional Listening Sessions	Gather qualitative data directly from members and the community regarding their experience	HEO Manager	Assess baseline of member experience for medical access, quality and trust	On an annual basis, conduct Regional Listening sessions in each of the 5 designated regions of Kern.	3/31/2026	No	4/2/2025	East - 3/11/25, North - 3/19/25, West 3/21/25, Central 3/25/25, South 4/2/25
Regional Access Committees's	Gather qualitative data directly from members and the community regarding their experience	HEO Manager	Assess baseline of member experience for medical access, quality and trust	By December 31, 2024, a process will be implemented to track the organizational diversity of community partners outreached for each RAC.	12/31/2026	No		Assigned 2024 RAC Outreach Lookback 5/24
Develop Comprehnsive Community Investment Strategy	Assess KHS community investments to ensure equitable and effective use of organizational resources	HEO Manager	Track, analyze and report community investments by activity (sponsorships, contracts, community grants programs), identify areas of improvement & address gap	By December 31, 2024, a process will be implemented to effectively track organizational investments in the community across departments.	12/31/2026	No		Tracking spreadsheet disseminated; working with Business Intelligence (BI) to create dashboard
Develop Comprehensive School Partnership Strategy	Assess KHS school partnership strategy to ensure equitable and effective use of organizational resources and maximize impact	HEO Manager	Streamline and formalize educational partnerships with schools; co-create a strategy with district and multiple KHS depts on health initiatives	Initial measurement: Meet with at least 2 districts; Once launched measures will be performance based on specific intervention	11/30/2026	No		BCSD Meeting Dates 1/28/25, 4/11/25
EMPLOYEE DOMAIN (15%)								
Engage and develop employees with training, culture initiatives, and state-mandated DEIB programs. Ensure employments practices are fair & equitable.								
Assessment of KHS Workforce Demographics	Analyze KHS workforce demographics	Health Equity Manager & HR	workforce activities. Review with stakeholders. Monitor workforce demographics for hiring		9/30/2026	No		Previous lookback completed 7/12/24
JEDI Committee	Development of the KHS DEI Task Force will serve as the stepping stone to mobilize efforts around implementation of DEI practices, policies, engagement, climate pulse checks, and training opportunities.	Health Equity Manager	Solicit workforce participation for task force development Establish task force with regular occuring meeting schedule		At least quarterly	No	1/16/25 3/19/25 5/15/25	Monthly Meetings established
Organizational Climate Assessment	Conduct Annual Organizational Climate Assessment	HR & Health Equity Manager	Develop KHS Organizational Climate Assessment Tool in conjunction with HR Facilitate Organizational response to results	Launch of survey; survey participation	4/30/2026	No	4/1/2025	Employee Engagement - Trust Index Survey launched
Diversity, Equity and Inclusion (DEI) Training	Implement organization- wide Health Equity training	Health Equity Officer	Assess organizational training needs Create DEI Training Curriculum	Launch of training with 100% completion rate	12/31/2026	No	2/25/2025	DEI Cirriclum approval 2/25/25; TGI submitted & delivered; reviewing feedback for changes
Ensure Bilingual KHS Workforce	Maintain a bilingual Member Services Department workforce that is representative of 5% of the population	Director of Human Resources Director of Member Services	Maintain Member Service Staffing Share with Stakeholders Add to Qualified	Stated in goal	4/30/2026	No		Q2 Member Services has 54 of 123 staff certified bilingual employees that are bilingual (44%).
Bi-Lingual Staff Competency Assessment	Conduct Language Proficiency Test for all new bilingual applicants	Director of Human Resources Director of Member Services	Facilitate LPT Assessment Provide LPT assessment scores	% complete	5/31/2026	No		As of 5/12/2025 we have 141 certified bilingual employees which is 21% of our workforce (141/698 EE)
Staff Experience with Language Assistance Resources	Assess baseline of staff experience with language resources	Cultural & Linguistics Manager & Human Resources	Run Annual Report Share with Stakeholders Identify and address		12/31/2026	No		Ongoing, have completed Q1 data

Kern Family Health Care – Health Equity Office

Birth Bridge Initiative: Connecting Families, Doulas & Clinical Care Teams

Program Description

The Kern Family Health Care (KFHC) Birth Bridge Initiative was established to improve maternal and infant health outcomes in Kern County by strengthening the local doula workforce and expanding access to culturally responsive birth support. Recognizing the important role doulas play in improving birth experiences, reducing complications, and supporting healthy pregnancies, the program works to increase awareness, access, and collaboration across the local maternal health ecosystem.

Launched in 2025, the program focuses on increasing the number of trained and active doulas serving Kern Family Health Care members while ensuring doulas are supported in successfully navigating the Medi-Cal doula benefit and KFHC provider network requirements. The Health Equity Office provides guidance and technical assistance to help doulas complete the onboarding process, connect with community partners, and begin serving members effectively.

In addition to workforce development, the program works closely with hospitals, clinics, and community providers to strengthen partnerships with doulas. Through provider education and training opportunities, the program helps healthcare teams better understand the benefits of doula support and how collaborative care models can improve maternal and birth outcomes.

The Birth Bridge Initiative also invests in the professional growth of doulas by offering ongoing training opportunities, peer learning spaces, and resources to help doulas grow their practices and reach more families. These supports are designed to build a sustainable doula workforce that reflects the cultural and linguistic diversity of Kern County.

A key focus of the program is partnering with doulas to conduct targeted outreach and community engagement, particularly in communities experiencing disproportionate maternal health disparities. Through these efforts, the program aims to expand awareness of doula services, connect families to supportive care during pregnancy and postpartum, and ultimately help close gaps in maternal and infant health outcomes.

Through collaboration with doulas, healthcare providers, and community partners, the Birth Bridge Program is helping build a stronger, more equitable maternal health support system for families across Kern County.

KERN HEALTH SYSTEMS

Health Equity Office
HETSC
2025 Evaluation Summary

EQIHEC

March 2026

HEO: From Strategy to Standard Practice

Kern Family Health Care®

2025 Highlights:

- Integrated health equity into core operations using regional strategies and routine quality improvement processes
- Expanded enterprise-wide data and qualitative insights, including SOGI data, member experience, and provider feedback, to guide action.
- Equipped employees and providers with training and tools to deliver equitable, culturally responsive care.
- Established health equity as a sustained organizational capability, not a time-limited program

NCQA Health Equity Accreditation – 100%

- 100% NCQA Health Equity Accreditation Score achieved in mid-2025
- Health Equity Department established in 2023 and reached full accreditation in under 2 years in a completely new program
- Reflects enterprise-wide collaboration, disciplined execution, and sustained commitment to equitable care
- Validates KHS's ability to operationalize health equity and deliver measurable, system-level impact

Established in 2023, accredited with a 100% NCQA score by mid-2025—an exceptional milestone for the organization.

DHCS EPT Program Administration Impact

- $8,037,160 invested in 12 provider practices ($1.78m+ earned through Dec 2025 with potential to earn the remainder if they continue meeting milestones)
- Equity embedded into clinical operations and quality improvement
- Milestones achieved across data standardization and validation, provider and staff training, and population level disparity analysis
- Targeted interventions to close gaps in care and drive sustainable change

Improving outcomes for KFHC members across Kern County with stronger provider partnerships

Qualitative Feedback: The Stories Behind the Stats

- Established structured listening and engagement mechanisms across **Members, Providers, Employees, and Community** to elevate lived experience alongside quantitative data.
- **Key Domains & Channels**
- **Members:** Listening sessions → Regional Access Committees; member interviews; Community Advisory Committee; CBO engagement; SOGI data collection
- **Providers:** HEAL; EPT provider interviews & pilots; IHI–DHCS Health Equity Collaborative; IPV Community of Practice
- **Employees:** Redesigned Employee Engagement Survey; first DEI survey; JEDI Committee
- **Community:** Kern Health Equity Partnership; BIMHI; Prosperity Neighborhood Initiative; Blue Zones; KCSOS Equity Symposium; Sexuality & Gender Identity Healthcare Symposium
- **Impact:**
- Identified access barriers and service gaps not visible in claims or surveys, strengthened trust and bidirectional communication, informed targeted operational, clinical, and community-based interventions
- *Result: Durable feedback loops that translate lived experience into measurable improvements in access, quality, and member experience.*

Doula Benefit Implementation

- Comprehensive Doula Training & Onboarding: Offered an in-depth orientation covering the Medi-Cal doula benefit, how to become a contracted provider with KHS, and guidance on billing and submitting claims. Resulted in contracting 15 Doulas by EOY 25
- Pear Suite Partnership: Contracted with Pear Suite to streamline documentation and claims workflows.
- Hospital Access Support: Launched a lanyard program enabling doulas to bypass hospital visitor lines, reducing delays and ensuring timely support for birthing clients.

These efforts reflect KHS's commitment to addressing maternal health inequities and supporting community-based providers in delivering culturally responsive care

2025 Health Equity & QP Awards

- **Purpose:** Recognize providers advancing health equity, quality performance, and member outcomes.
- **Strategy:** Incentivize innovation, promote best practices, and align equity with MCAS and quality priorities.
- **Impact:** Accelerates equitable outcomes, provider engagement, and system-wide performance improvement.

Thank You

Kern Family Health Care®

Kern Family Health Care®

QUARTER 4

CAL AIM

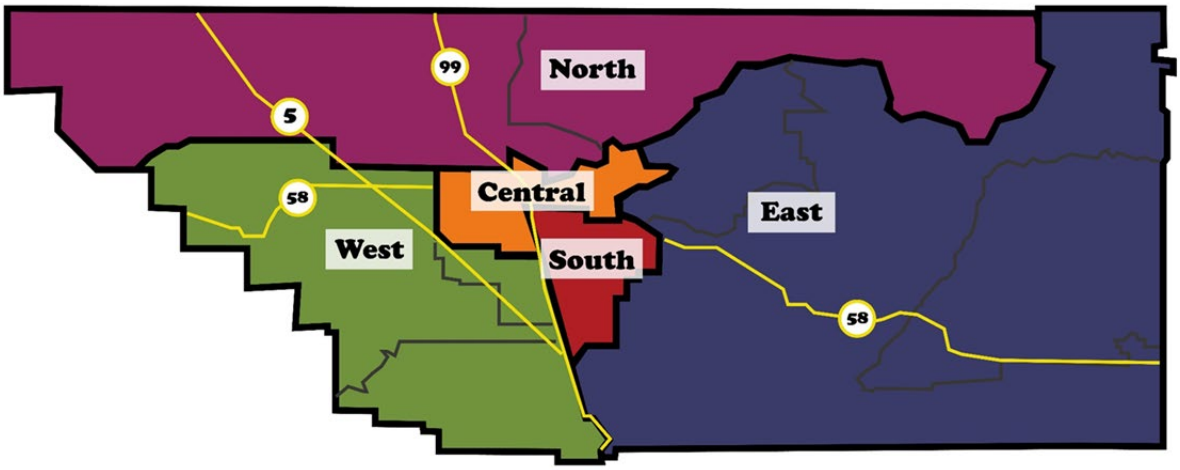
REGIONAL ACCESS COMMITTEES

Quarter 4 Meetings

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

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

- West – Lebec/Tejon – October 7, 2025
- East – Tehachapi – October 14, 2025
- South – Greenfield – October 16, 2025
- North – Shafter – October 16, 2025
- Central – Bakersfield – October 28, 2025



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

- Community Engagement
- Community Support Services
- Cultural and Linguistics
- Enhanced Care Management
- Health Equity
- Member Engagement
- Member Services

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

LEBEC/TEJON

Date: October 7, 2025
Location: El Tejon School
Attendees: 15
- 7 KFHC Members

Predominate Culture: White
Families: 8
Staff: 10

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

Anastasia Lester began the discussion by asking the community if they knew about Cal AIM services prior to the presentation. Only two attendees knew of this service. The attendees emphasized the need for the services to be provided in their region.

> *"We are told all the time that these are countywide services, but then they aren't available here."*

Cal AIM Services in the Region

Ms. Lester then asked the community what Cal AIM services would be most impactful to their region. The attendees stated all would be impactful. The participants specifically said in their community the greatest needs were housing, case management, drug services, recuperative care, and care/post care coordination. The discussion about housing was not only for affordable housing, but housing for those out of drug rehabilitation or young people no longer living at home. The discussion on drug services was to address both youth and adults.

Addressing the Older Community

Ms. Lester asked based on the presentation what issues they foresee being challenges. The attendees emphasized the need to support the older community. The audience felt the most impact to this community would be to address the supports around adaptations in the home (like handrails, ramps, wider hallways), transportation to not only clinics but basic needs (like a grocery store), reducing the amount of time at the clinics (as the community felt it was overwhelming and did not support the health of the older community), and the local ability to get x-rays and cancer services.

Getting the Word Out

Ms. Lester asked the community about getting the word out, since most of the audience were learning about these services for the first time. The attendees stated there were lots of ways to get the word out: the local paper, social media, churches, youth sporting organizations, commodity giveaways, and the local library. There was an emphasis on getting the word out through Parent Square, which is an app used to communicate with parents through their local districts and schools.

> *"Make sure and advertise programs that are actually in our local community, not just everything because we will think everything is here."*

Key Takeaways

- Educate the community on the services available to their community.
- Advertise services in formats that the local community uses.
- Emphasize the importance of services specified by the region.
- Support the older community with services, education, and timeliness.

TEHACHAPI

Date: October 14, 2025
Location: Adventist Health Medical Center
Attendees: 6
- 0 KFHC Members

Predominate Culture: Hispanic
Families: 1
Staff: 8

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

Anastasia Lester began the discussion by asking the community if they knew about Cal AIM services prior to the presentation. No attendees knew of this service.

Community Needs

Ms. Lester asked the attendees, based on the presentations, what were the things that they felt would have the greatest impact on their community. The community felt there was a high need for pharmacy services (since there are no services locally), tailored meals and housing. An attendee asked how the tailored meals work since there are times when the fog and snow would not allow people to get food in parts of the region. Kern Family Health Care staff provided an example of using local companies to store the food, so that it is ready to be delivered locally, so that the weather is not a factor in getting the Member their food. The community also wanted to emphasize the need for general practitioners in their region.

> *"There are a lot of supports needed in our region. We are the forgotten region. Any of the programs talked about are needed."*

Housing Program

When discussing the community needs, there was a large discussion around the needs of housing. The attendees talked about the need for affordable housing in their community as prices have "sky-rocketed," but also the need to keep the community together. One attendee asked about the housing program offered through Cal AIM and if the person would have to leave the community to use this service. Kern Family Health Care staff explained that typically yes, as most of the housing options are in Bakersfield, however, there are times when partnerships and arrangements can be made locally.

> *"Our community wants to stay together, so having to go to Bakersfield is not always an option we are willing to take, especially for services that is supposed to be countywide."*

Outreach

Ms. Lester asked the participants how to educate the community on the services Kern Family Health Care has to offer. The participants stated the following: churches, the local library, commodity giveaways, community events, and the Rec and Park organization, which host a lot of events for the community.

Key Takeaways

- Collaborate with the local community partners to have services accessible locally.
- Educate the community on the services available through the channels they recommend.
- Access to general practitioners
- Access to pharmacy.
- Local access to Cal AIM services.

GREENFIELD

Date: October 16, 2025
Location: Greenfield Family Resource Center
Attendees: 14
- 5 KFHC Members

Predominate Culture: Hispanic
Families: 7
Staff: 8

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

Anastasia Lester began the discussion by asking the community if they knew about Cal AIM services prior to the presentation. Only two attendees knew of this service.

"We have to live, before we can live better."

Needs of the Community

Ms. Lester asked the attendees, based on the presentation, what were the top services that would best service their region. The participants stated that the needs are to address valley fever and diabetes. The other issue that was important to the region was to have provider hours shifted to have availability to when the community is not working, such as weekends or hours after 5pm.

"It would be helpful to have specialists that can help the diseases we have here for our people."

Continuity of Care

One participant spoke about the desire to have a system that would allow providers, especially in clinics, to see all the history and notes from previous appointments. Another participant stated this would be helpful as there are different doctors and each time, they meet a new doctor that must talk about what happened to them all over again and retraumatize themselves. The audience nodded in agreement.

"I don't want to keep telling different doctors the same story over and over again. It makes me feel bad."

Pharmacy

The participants transitioned their discussion to the challenges being faced by the pharmacy. The attendees talked about the need to have providers that communicated better about the medications being prescribed to the patient. Another issue being faced by the region is the timeliness of the referral being sent to the pharmacy and the availability of the medication.

Outreach

Ms. Lester closed the discussion by asking the audience how to get the word out about these services. The suggestions were to promote services at meetings, collaboratives, trusted partner voices. The community also felt it was important to have materials for each service separately in different languages.

Take Aways

- Pharmacy Needs
- Support Services for Diabetes and Valley Fever
- Non-Traditional Provider Hours
- Education of Services
- Continuity of Care

SHAFTER

Date: October 16, 2025
Location: Veterans Park
Attendees: 41
- 25 KFHC Members

Predominate Culture: Hispanic
Families: 40
Staff: 7

Due to the recent concerns around Immigration and Customs Enforcement (ICE) issues, the information was presented and gathered at a booth during the National Night Out. Surveys were taken to gather information and Cal AIM staff were present to provide additional information or answer questions about the programs.

Enhanced Care Management (ECM)/ Community Support Services (CSS) Services

The surveys showed that approximately fifty percent of the participants had heard of the services. Twenty-five percent of the participants have used either ECM or CSS Services. Over two-thirds felt that the Cal AIM services could help their region. And half requested more information.

> *"[Our region] needs of the supports that the program has to offer."*

What Did They Know About Cal AIM

The participants stated that they felt that the services were different based on the person. Many of the responses were that the services were for people with chronic illness. Other people felt the services were basic support for Members in need. Participants also felt that the programs provide information on medical prescriptions and medications. The other thought was that the programs were in place to help Members transition from homelessness.

> *"My daughter received the service and was able to get the therapy that she needs."*

What the Region Wants for Their Health

The survey also asked the participants to provide feedback on the services that would be helpful to support the health of the region. There were five major responses that surfaced to the top. The first was the ability to access providers, both in terms of time to get an appointment and their hours of availability. The next was the need for transportation, the education to know that it is a benefit for Members, and how to access it. The third was how to obtain mental health services and availability for quick appointments. The fourth was to access affordable housing in the local communities. Access to free nutrition and exercise classes rounded out the top five responses.

> *"This service would help because when I don't have availability to get to my appointment, I have to cancel."*

Key Takeaways

- Educating the Community on the Services
- Access to Provider Appointments
- Accessing Mental Health Services and Housing
- Access and Education on Transportation
- Obtaining Free Nutrition and Exercise Classes

BAKERSFIELD

Date: October 28, 2025
Location: Boys and Girls Club – Armstrong Youth Center
Attendees: 11
- 5 KFHC Members

Predominate Culture: Black/Hispanic
Families: 4
Staff: 8

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

Anastasia Lester began the discussion by asking the community if they knew about Cal AIM services prior to the presentation. Only two attendees knew of this service.

Enhanced Care Management (ECM)/ Community Support Services (CSS) Services

Ms. Lester asked the participants about the presentation they had just heard. The attendees asked questions that were specific to their situations, such as environmental support to a woman who needed grab bars in her home. Another attendee asked about transitional rent for her brother who was at a challenging point in his life. Overall, the attendees felt there were great services that would help their region. One participant asked about the referral process and was told about the KHS app. When Ms. Lester asked who knew about the app, only half of the attendees had her of it before. KHS staff explained how to access it.

"The services sound great, but how does the process really work and how long does it take to get them?"

Top Services from the Presentation

Ms. Lester asked the audience to provide the top services they felt would benefit their region from the presentation. The top four responses were mostly focused on the senior and special needs populations: senior housing, accessibility adaptations, environmental adaptations, and wall heater/ swamp cooler. The audience explained that these areas help the most with independence of the person receiving the services.

"My child is severely autistic. I wish I had known about these services earlier, they could really help my family."

Healthy Lifestyle Needs

Ms. Lester concluded the meeting by asking the audience if there were things that ECM/CSS did not provide, which they felt would support a healthy life. The audience felt that getting free experiences, including exercise, for youth and seniors to get out of the house was particularly important. The participants also felt behavioral health services like support groups and grief counseling would create better health. Another response was to assist in getting homes clean at no cost to help with the environmental factors making people sick. The other recommendation from the audience was education and support in buying, making, and understanding healthy food and meals.

Take Aways

- Education in the Services
- Support for Seniors
- Support for Persons with Special Needs
- Linkages to Healthy Activities for All Ages
- Behavioral Health Support

REGIONAL OVERVIEW:

- Unknown Benefit
- Outreach Specific to the Region
- Address Senior Needs
- Enhance Pharmacy Services
- Access to Behavioral Health Services
- Substance Use Supports
- Transportation Education
- Providers Provide Non-Traditional Hours
- Increase in Provider Availability
- Affordable and Accessible Housing
- KHS App Training
- Digital Divide

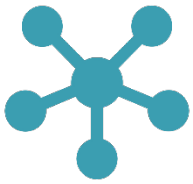
RECOMMENDATIONS:

EDUCATION



- Cal AIM Services
- Transportation
- Behavioral Health
- KHS App Training

SERVICES



- Substance Use
- Pharmacy
- Providers
- Housing
- Seniors

MARKETING



- Use alternative methods to promote services based on Regional Needs
- Locate Local Champions
- Addressing the Digital Divide



- Quarter 1
  - HR-1
- Quarter 2
  - Transportation
- Quarter 3
  - Telehealth
- Quarter 4
  - Behavioral Health

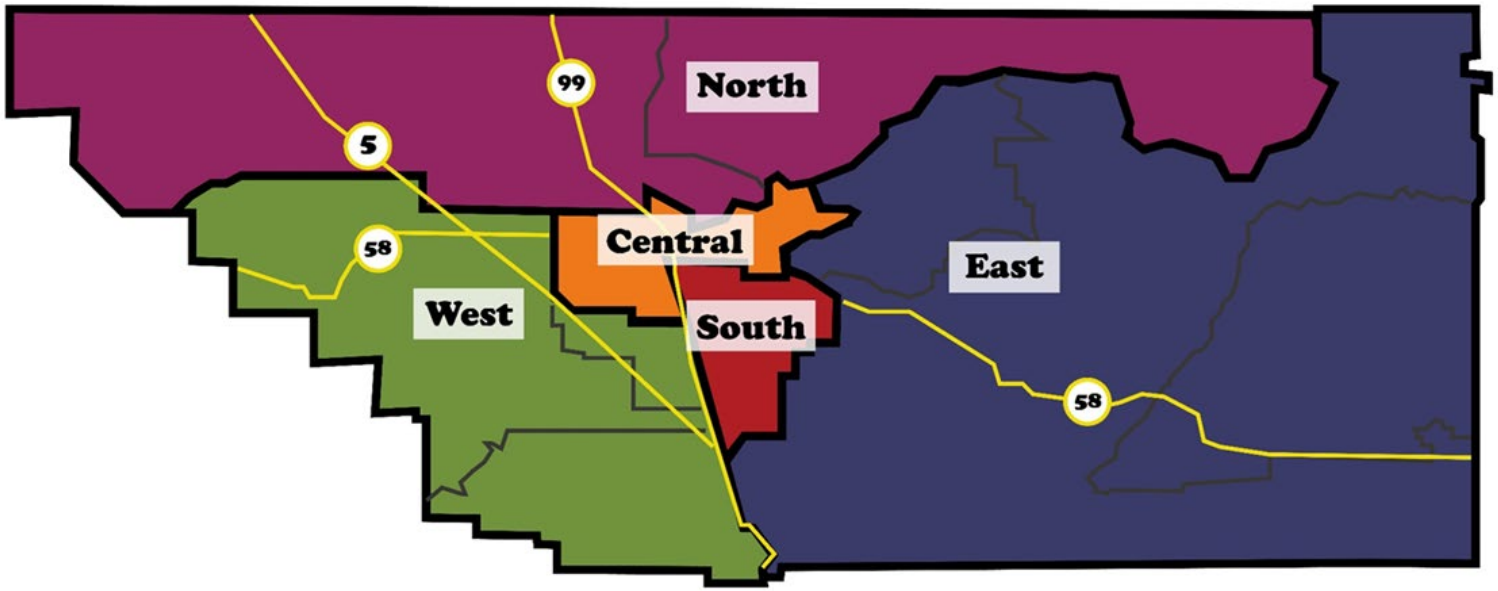


QUARTER 4 RACS - CAL AIM

Presented by Health Equity

FIVE REGIONS

- Central - Bakersfield - BGC
- North - Shafter
- East - Tehachapi
- West - Lebec/Tejon
- South - Greenfield



THE TEAM

- COMMUNITY ENGAGEMENT
- CULTURAL AND LINGUISTICS
- HEALTH EQUITY
- MEMBER ENGAGEMENT
- MEMBER SERVICES
- ENHANCED CARE MANAGEMENT
- COMMUNITY SUPPORT SERVICES
- FRCS/COLLABORATIVES
- COMMUNITY PARTNERS



BAKERSFIELD - CENTRAL REGION

- Attendees: 11
    - 5 KFHC Members
- Predominate Culture: Black/Hispanic
- Families: 4
- Staff: 8

- Education on the Services
- Support for Seniors
- Support for Persons with Special Needs
- Linkages to Healthy Activities for All Ages
- Behavioral Health Support

SHAFTER - NORTH REGION

- Attendees: 41
  - 25 KFHC Members
- Predominate Culture: Hispanic
- Families: 40
- Staff: 7
- **Health Fair Style - due to ICE

- Educate the Community on the Services
- Access to Provider Appointments
- Accessing Mental Health Services and Housing
- Access and Education on Transportation
- Obtaining Free Nutrition and Exercise Classes

TEHACHAPI - EAST REGION

- Attendees: 6
    - 0 KFHC Members
- Predominate Culture: White
- Families: 1
- Staff: 8

*** Severe weather and incorrect address

- Work with the local community partners to have services accessible locally.
- Educate the community on the services available through the channels they recommend.
- Access to general practitioners
- Access to pharmacy.
- Local access to Cal AIM services.

LEBEC/TEJON - WEST REGION

- Attendees: 15
    - 7 KFHC Members
- Predominate Culture: White
- Families: 8
- Staff: 10

- Educate the community on the services available to their community.
- Advertise services in formats that the local community uses.
- Emphasize the importance of services specified by the region.
- Support the older community with services, education, and timeliness.

GREENFIELD - SOUTH REGION

- Attendees: 14 Adults
    - 5 KFHC Adult Members
- Predominate Culture: Hispanic
- Families: 7
- Staff : 8

- Pharmacy Needs
    - Timeliness of referrals and medication availability
- Support Services for Diabetes and Valley Fever
- Non-Traditional Provider Hours
- Education of Services
- Continuity of Care

REGIONAL OVERVIEW - COMMON THEMES FOR ALL RAC MEETINGS

- Unknown Benefit
- Outreach Specific to the Region
- Address Senior Needs
- Enhance Pharmacy Services
- Access to Behavioral Health Services
- Substance Use Supports
- Providers Provide Non-Traditional Hours
- Increase in Provider Availability
- Affordable and Accessible Housing
- Transportation Education
- KHS App Training
- Digital Divide

RECOMMENDATIONS

- Education
  - Cal AIM Services
  - Transportation
  - Behavioral Health
  - KHS App Training
- Marketing
  - Use alternative methods to promote services based on Regional Needs
  - Locate Local Champions
  - Addressing the Digital Divide
- Services
  - Substance Use
  - Pharmacy
  - Providers
  - Housing
  - Seniors



2026 SCHEDULE

Quarter 1 - HR-1

Quarter 2 - Transportation

Quarter 3 - Telehealth

Quarter 4 - Behavioral Health


QUESTIONS