



# Kern Behavioral Health and Recovery Services

## **Quality Improvement Work Plan FY 2025-2026**

HOPE, HEALING, RECOVERY

PO Box 1000, Bakersfield, CA 93302 | 661.868.6600 | [www.kernbhrs.org](http://www.kernbhrs.org)

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# MISSION VISION VALUES



# KERN QUALITY ASSESSMENT AND IMPROVEMENT PROGRAM DESCRIPTION

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**Kern Behavioral Health and Recovery Services (KernBHRS)** is committed to delivering high-quality, person-centered, and recovery-oriented behavioral health care that is inclusive, culturally responsive, and integrated with primary health services. Our approach prioritizes the unique needs, voices, and lived experiences of each beneficiary, with a focus on advancing service equity and reducing disparities across all populations we serve.

Our mission is to empower individuals facing mental health and substance use challenges by supporting their journey toward wellness, resilience, and full participation in community life. We recognize that true quality extends beyond compliance encompasses access, effectiveness, safety, equity, and client satisfaction.

KernBHRS continuously strengthens its programs through the Quality Assessment and Improvement Program (QAIP), which aligns with the requirements of the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) agreements with the Department of Health Care Services (DHCS). The Kern BHRS QAIP is a structured framework that encompasses quality improvement and evaluation activities designed to enhance the delivery of high-quality behavioral health services. The QAIP also integrates performance improvement priorities identified by the California External Quality Review Organization (CAEQRO).

Oversight of the QAIP is provided by the KernBHRS Director, a licensed mental health professional under the authority of the Kern County Board of Supervisors. Day-to-day development and implementation are led by the Administrator of the Quality Improvement Division (QID), ensuring that KernBHRS remains accountable, data-driven, and responsive to the evolving needs of our community.

## REPORTING AND IMPROVING

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A vital component of the Quality Assessment and Improvement Program (QAIP) is the annual implementation of the Quality Improvement (QI) Work Plan. This plan serves as a strategic framework for advancing KernBHRS's commitment to high-quality, equitable, and person-centered behavioral health care. It reflects a continuous quality improvement cycle that is responsive to the evolving needs of our diverse beneficiary population.

The QI Work Plan outlines KernBHRS's quality priorities for the current fiscal year and includes:

- Monitoring activities, such as the review of beneficiary grievances, appeals (including expedited and fair hearings), provider appeals, and clinical record reviews. These activities ensure transparency, accountability, and compliance with regulatory standards.
- Evidence of impact, demonstrating how QI activities—including Performance Improvement Projects (PIPs)—have led to measurable improvements in clinical care, service delivery, and beneficiary outcomes.

- Descriptions of completed and ongoing QI initiatives, including:
  - Monitoring and resolution of previously identified issues
  - Defined objectives, scope, and timelines for each QI activity
  - Targeted improvements in service delivery, access, and program design
  - Monitoring of key performance indicators and benchmarks
- Mechanisms to assess service accessibility, including goals for:
  - Responsiveness of the 24-hour toll-free telephone line
  - Timeliness of routine and urgent appointments
  - Access to after-hours care
- Cultural and linguistic competence, with evidence of compliance and an annual update to the Cultural Competence Plan included as an appendix to the QI Work Plan.

The QI Work Plan is structured around the fiscal year and includes clearly defined goals, objectives, and responsible parties. Its effectiveness is evaluated annually through the KernBHRS Annual Report and Work Plan Evaluation process. This evaluation helps prioritize improvement areas for the upcoming year. Each goal and objective is assessed using a standardized template that guides authors through reflective questions on implementation and outcomes. Goals are rated as Met, Partially Met, or Not Met.

The Quality Improvement Committee (QIC) oversees the implementation of the QI Work Plan. The QIC meets quarterly to review progress on each goal and receives additional reports on:

- Timeliness of services for both the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS)
- Performance Improvement Projects
- Corporate compliance investigations
- Other quality-related initiatives

Three QIC subcommittees meet more frequently to conduct deeper reviews of Work Plan objectives and performance measures. These subcommittees support in-depth analysis, discussion, and targeted intervention planning.

In addition to Work Plan goals, KernBHRS incorporates other performance measures and compliance standards into its QAIP. These are monitored through the QIC subcommittees. When trends in underperformance or noncompliance are identified, targeted quality improvement interventions are initiated. Data is used to assess the impact of these interventions and inform QIC decision-making. While Work Plan goals may change annually, QAIP performance measures and compliance standards are updated only when deemed necessary by the QIC. The following section outlines key performance indicators and regulatory compliance metrics that are integral to the KernBHRS Quality Assessment and Performance Improvement framework.

## KEY PERFORMANCE INDICATORS

Key Performance Indicators (KPIs) are quantifiable measures used to evaluate the effectiveness, efficiency, and impact of KernBHRS programs and services. These indicators provide objective data that help identify trends, monitor progress toward strategic goals, and highlight areas requiring improvement. KPIs are selected based on regulatory requirements, clinical priorities, and organizational values such as equity, access, and client-centered care.

Key Performance Indicator	Benchmark/Purpose	MHP or DMC-ODS
7 - Day Inpatient Discharge to Outpatient Appointment	All (100%) clients discharged from the hospital will receive a face-to-face outpatient mental health service within seven (7) calendar days.	MHP
Client Satisfaction Consumer Perception Survey	Achieve a cumulative minimum satisfaction rating of 85% or greater on the Consumer Perception Survey.	MHP
Client Satisfaction Treatment Perception Survey	Achieve a cumulative minimum satisfaction rating of 85% or greater on the Treatment Perception Survey.	DMC-ODS
Initial Request to First Rendered Service	80% of routine mental health services will be provided within 14 calendar days (10 business days) of initial request for service.	MHP
Initial Request to First Offered Service	80% of routine mental health services will be offered within 14 calendar days (10 business days) of initial request for service.	MHP
Non-Urgent First Offered Follow-up Appointments	80% of follow-up services will be offered within 14 calendar days of the initial service rendered.	MHP, DMC-ODS
Non-Urgent First Rendered Follow-up Appointments	80% of follow-up services will be provided within 14 calendar days of the initial service rendered.	MHP, DMC-ODS
Inpatient Hospital Recidivism Rate	Less than or equal to 14%. This report tracks the number of clients who return to inpatient within 30 days of discharge.	MHP
No Show Rate - Other Clinicians	No-show rates for other clinical appointments (non-psychiatric) will not exceed 15%.	MHP
No Show Rate - Psychiatric Appointments	No-show rates for psychiatric appointments will not exceed 18%.	MHP
No Show/Cancellation Rate	No-show rates for outpatient appointments will not exceed 60%. No-show rates for NTP and Residential service appointments will not exceed 30%.	DMC-ODS
Penetration Rate	Penetration rates of 4.2 percent or higher in each service area.	MHP
Penetration Rate	The percentage of clients entering the DMC-ODS system stratified by: Age, Race & Gender.	DMC-ODS
Request for Psychiatric Service First Kept	80% of first psychiatric services must be scheduled within 21 days (15 business days) of initial request.	MHP
Request for Psychiatric Service First Offered	80% of first psychiatric services must be done within 21 calendar days (15 business days) of initial request.	MHP
Residential Discharge to Lower Level of Care	At least 85% of clients discharged from residential treatment will have a lower level follow up service within 7 days.	DMC-ODS

<b>Key Performance Indicator</b>	<b>Benchmark/Purpose</b>	<b>MHP or DMC-ODS</b>
Residential Recidivism Rate	Less than or equal to 20%. This report tracks the number of clients who return to residential services within 30 days of discharge.	DMC-ODS
Timeliness of Initial Request to First Service	80% routine SUD services will be conducted within 14 calendar days (10 business days) of initial request for service.  NTP: 80% of SUD services will be conducted within 5 days (3 business days).	DMC-ODS
Timeliness of Initial Request to First Offered- Urgent Service	80% of initial requests for an urgent appointment will be scheduled within 48 hours of initial request.	MHP, DMC-ODS
Timeliness of Initial Request to First Offered Service	80% of routine SUD services will be conducted within 14 calendar days (10 business days) of initial request for service.  NTP: 80% of SUD services will be conducted within 5 days (3 business days) of initial request for service.	DMC-ODS
Withdrawal Management Recidivism Rate	Less than or equal to 2%. This report tracks the number of clients who return to withdrawal management within 30 days of discharge.	DMC-ODS
HEDIS: Follow-up After Emergency Department (ED) visit for Mental Illness (FUM) 7 and 30 Day	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 53.82%; HPL: 73.12%	MHP
HEDIS: Follow-up After Hospitalization for Mental Illness (FUH) 7 and 30 day	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 59.85%; HPL: 75.56%	MHP
HEDIS: Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 60.22%; HPL: 74.14%	MHP
HEDIS: Adherence to Antipsychotic Medication for Individuals with Schizophrenia (SAA)	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 62.56%; HPL: 74.83%	MHP
HEDIS: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL TBD	MHP

Key Performance Indicator	Benchmark/Purpose	MHP or DMC-ODS
HEDIS: Follow-up After Emergency Department (ED) visit for Substance Use (FUA) 7 and 30 Day	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 36.18%; HPL: 49.40%	DMC-ODS
HEDIS: Pharmacotherapy for Opioid Use Disorder (POD)	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 25.28%; HPL: 36.71%	DMC-ODS
HEDIS: Use of Pharmacotherapy for Opioid Use Disorder (OUD)	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 60.20%; HPL: N/A	DMC-ODS
HEDIS: Initiation and Engagement of Substance Use Disorder Treatment (IET-I) (Initiation)	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 44.51%; HPL: 54.92%	DMC-ODS
HEDIS: Initiation and Engagement of Substance Use Disorder Treatment (IET-E) (Engagement)	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 14.39%; HPL: 26.72%	DMC-ODS
HEDIS: Follow-up After High Intensity Care for Substance Use Disorder (FUI) 7 and 30 day	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL TBD	DMC-ODS

## REGULATORY COMPLIANCE STANDARDS

The list below outlines key regulatory compliance standards that are actively monitored through the Regulatory Compliance Committee. While not exhaustive, these standards represent critical areas of oversight within the broader KernBHRS compliance framework. KernBHRS maintains a comprehensive system of checks and balances to ensure adherence to all applicable laws, regulations, and contractual obligations. This includes structured processes such as contract monitoring, site visits, quality assurance reviews, documentation audits, and utilization management activities—all of which contribute to a culture of accountability and continuous improvement

TOPIC	COMPLIANCE STANDARD	Application
Change of Provider	100% of MHP change of Provider Requests are addressed.	MH
Corporate Compliance Training	100% of the staff will complete the Corporate Compliance training each year	MH, SUD
Documentation Compliance	95% of MHP documents within the electronic health record will be written according to all DHCS guidance and Clinical guidelines.	MH
Documentation Compliance	SUD teams will achieve a score of 95% or better on their semester progress note reviews.	SUD
Documentation Timeliness	75% of "Routine Services", will be documented in the EHR within 3 business days of the provided service	MH, SUD
Documentation Timeliness	100% of "Crisis Services" will be documented in the EHR within 24 hours of provided service	MH, SUD
Grievance and Appeals	98% of grievance and appeals will be processed according to DHCS policy.	MH, SUD
HIPAA Training	100% of staff will complete the annual HIPAA training each year	MH, SUD
No Show Indicator	100% of the time when using scheduler, and a client does not show up for a scheduled appointment, staff will change the indicator to reflect "No Show."	MH, SUD
NOABD	95% of all MH NOABDs will be provided to a beneficiary upon an adverse determination	MH
NOABD	90% of all SUD NOABDs will be provided to a beneficiary upon an adverse determination	SUD
Privacy and Security Training	100% of the staff will complete the Privacy and Security training each year.	MH, SUD
Privacy Breach Investigation	100% of all Potential Breaches will be reported to CCO within 24 hours of discovery of the event	MH, SUD
Records Request	100% of Client request for records will be processed within 15 days.	MH, SUD
Service Verification	95% of all mental health and substance use services captured in the electronic health record will be an honest and accurate account of a service.	MH, SUD

## ORGANIZATION OF QUALITY IMPROVEMENT COMMITTEE (QIC)

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The Quality Improvement Committee (QIC) plays a central role in evaluating and enhancing the quality of KernBHRS's service delivery system. Its primary aim is to improve care processes and ensure services effectively meet the needs of beneficiaries. The QIC provides oversight, guidance, and accountability for quality improvement activities across the organization. Its responsibilities include:

- Providing oversight and active involvement in Quality Improvement (QI) activities, including Performance Improvement Projects (PIPs)
- Recommending policy decisions that support system-wide quality goals
- Reviewing and evaluating the outcomes of QI initiatives
- Initiating and supporting necessary quality improvement actions
- Ensuring timely follow-up and resolution of QI processes
- Documenting decisions and actions through formal meeting minutes
- Monitoring key performance standards to assess system performance and identify areas for improvement
- Through these functions, the QIC ensures that KernBHRS maintains a culture of continuous improvement, regulatory compliance, and client-centered service delivery.

The Quality Improvement Committee (QIC)—also referred to as the **Executive QIC**—provides oversight of three key subcommittees: the System-wide Quality Improvement Committee, the Key Performance Indicator Committee, and the Regulatory Compliance Committee. These subcommittees are essential to the effective oversight and evaluation of compliance efforts and performance outcomes across KernBHRS.

Given the breadth and complexity of content reviewed by the Executive QIC, the subcommittees play a critical role in supporting focused monitoring, deeper analysis, and more actionable quality improvement. Together, the Executive QIC and its subcommittees are responsible for the following activities:

- Collecting and analyzing data to assess progress toward established goals and priority improvement areas
- Identifying opportunities for improvement and determining which to pursue based on impact and feasibility
- Coordinating with relevant internal and external committees to ensure effective communication and alignment
- Gathering input from providers, beneficiaries, and family members to identify barriers to clinical care and administrative services
- Designing and implementing targeted interventions to improve performance
- Measuring the effectiveness of interventions and integrating successful strategies into system operations
- Reviewing beneficiary grievances, appeals (including expedited and fair hearings), provider appeals, and clinical record reviews

This structure ensures that quality improvement efforts are data-driven, inclusive, and aligned with KernBHRS's mission to deliver equitable, person-centered behavioral health services.

The Quality Improvement Committee (QIC) and its subcommittees actively engage providers, beneficiaries, family members, community stakeholders, and direct service staff in the planning, design, and implementation of the Quality Assessment and Performance Improvement (QAPI) program. The use of multiple subcommittees reporting to the Executive QIC enables more focused oversight, broader stakeholder input, and more effective tracking of performance and compliance efforts.

Subcommittee membership is tailored to the focus of each group and is described in detail later in this document. Notably, the System-wide Quality Improvement Committee (SQIC) is open to the public and includes a diverse range of stakeholders. Each meeting includes time for public comment, reinforcing KernBHRS's commitment to transparency and community engagement.

The QIC subcommittees are responsible for:

- Collecting and analyzing data to assess progress toward established goals and priority areas for improvement
- Identifying and prioritizing opportunities for system enhancement
- Coordinating with internal and external committees to ensure effective information exchange
- Gathering input from beneficiaries and families to identify barriers to care and service delivery
- Recommending and supporting the implementation of targeted interventions
- Measuring the effectiveness of interventions and integrating successful strategies into system operations
- Recommending policy changes and reporting significant findings to the Executive QIC
- Reviewing beneficiary grievances, appeals (including expedited and fair hearings), provider appeals, and clinical records

The Quality Improvement Division (QID) supports the QIC by leading measurement, monitoring, and reporting activities. While QID plays a central role, performance monitoring occurs at multiple levels throughout the system. All QID activities align with current behavioral health industry standards and are designed to improve access, quality of care, and service outcomes.

QID's monitoring responsibilities include, but are not limited to:

- Beneficiary and system outcomes
- Utilization management and review
- Provider capacity and credentialing
- Documentation compliance and service verification
- Medication monitoring and network adequacy
- Client and family perception surveys
- Oversight of the problem resolution process

- Corporate compliance and privacy functions
- QID also leads system-wide improvement initiatives using evidence-based methodologies such as Lean Six Sigma and Plan-Do-Study-Act (PDSA) cycles, ensuring that quality improvement efforts are both strategic and sustainable.

The QIC has several other system committees that are tasked with the oversight of specific areas and/or system functions. These committees are not sub-committees of the QIC. However, they provided the QIC regular updates on their improvement activities. These committees include:

- Length of Stay Committee
- Morbidity and Mortality Committee
- Internal Psychiatric Strategy meeting
- Cultural Competency Resource Committee
- Full-Service Partnership Committee

The Cultural Competence Plan works synchronously with our Quality Improvement Plan. The goal of the plan is to improve services for all diverse groups. In addition to the state and federal cultural competence requirements, we also integrate requirements specific to our funding, substance use delivery system, and mental health plan.

# KernBHRS QI Program



# EXECUTIVE QUALITY IMPROVEMENT COMMITTEE (QIC)

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## PARTICIPANTS

- A. Director
- B. Deputy Directors
- C. System of Care Administrators
- D. Resource Operations Manager  
(Infrastructure & Technology)
- E. Finance Director
- F. Senior Human Resources Manager
- G. Public Information Officer
- H. Members of the Quality Improvement  
Division

## SCOPE/ AREAS OF RESPONSIBILITY (MHP AND DMC-ODS)

- A. Delegation of data and analysis of data to measure work plan goals.
- B. Determine policy decisions
- C. Monitor and evaluate result of PIP's
- D. Institute needed quality improvement actions
- E. Ensure follow up of quality improvement processes
- F. Prioritize areas of improvement; identify opportunities for improvement
- G. Ensure appropriate exchange of information
- H. Oversee the design and implementation of interventions to improve performance
- I. Ensure Incorporation of successful interventions into operations
- J. Develop and oversee the implementation of the Annual Work Plan
- K. Conduct an annual evaluation of the Work Plan goals
- L. Conduct an annual evaluation of the QAPI program
- M. Share relevant information with stakeholders and staff
- N. Document minutes including any decisions and actions
- O. Oversee implementation of practice guidelines

# SYSTEM-WIDE QUALITY IMPROVEMENT COMMITTEE (SQIC)

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## **PARTICIPANTS**

- A. Behavioral Health Board member(s)  
(CHAIR)
- B. Direct service staff
- C. Ethnic Services Manager
- D. QID staff person(s)
- E. Representative from each contract provider
- F. Consumer Family Learning Center (CFLC)
- G. Clients
- H. Family Members
- I. Community Stakeholders
- J. Members of the public

## **SCOPE/ AREAS OF RESPONSIBILITY (MHP AND DMC-ODS)**

- A. Provide feedback to guide system improvement
- B. Make recommendations to Executive QIC
- C. Progress toward Work Plan goals
- D. Identify system improvement opportunities
- E. Incorporate perspectives and feedback from direct service staff, clients, family members, stakeholders, and contract providers.
- F. Hold open meetings advertised to the public

# KEY PERFORMANCE INDICATOR COMMITTEE (KPIC)

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## PARTICIPANTS

- A. Director
- B. Deputy Directors
- C. System of Care Administrators
- D. Contract Providers
- E. QID Staff
- F. Finance Director
- G. Direct Services staff

## SCOPE/ AREAS OF RESPONSIBILITY (MHP AND DMC-ODS)

- A. Key Performance Indicators
- B. Network Adequacy
- C. Performance Improvement Projects
- D. Culturally appropriate services review
- E. Access to Services
- F. Provider Relations
- G. Service Utilization
- H. Service Capacity
- I. Penetration
- J. Client Perception
- K. Timeliness of Services
- L. Review effectiveness of service measures
- M. Ensure validity and reliability of measures
- N. Clinical Outcomes
- O. Data Governance

# REGULATORY COMPLIANCE COMMITTEE (RCC)

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## **PARTICIPANTS**

- A. Privacy/Compliance Office (CHAIR) and staff
- B. Resource Operation Manager (Infrastructure & Technology)
- C. QID Administrator or designated staff system of care
- D. System of Care Administrators
- E. Human Resources representative
- F. Patient's Rights Supervisor
- G. QID Staff
- H. Appointed Supervisors

## **SCOPE/ AREAS OF RESPONSIBILITY (MHP AND DMC-ODS)**

- A. Regulatory compliance monitoring results
- B. Service Verification
- C. Compliance investigations
- D. Security breaches
- E. HIPPA violations
- F. Relevant trainings
- G. Program Integrity
- H. Risk Management
- I. Exclusions Reporting
- J. Confidentiality/Privacy
- K. Staff Education and Training
- L. Credentialing
- M. Quality Monitoring Results
- N. Documentation Compliance Reviews
- O. Timeliness of documentation compliance reviews
- P. Information Notice implementation efforts
- Q. Beneficiary Protection reports

## PERFORMANCE IMPROVEMENT PROJECTS

A Performance Improvement Project (PIP) is a process that involves setting goals, implementing systemic changes, measuring outcomes, and making subsequent appropriate improvements. Kern BHRS is mandated to conduct four PIPs, one Clinical and one Non-Clinical for both the Mental Health Plan (MHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS).

The purpose of a PIP is to assess and improve processes and outcomes of treatment provided by KernBHRS. PIPs are presented at the Quality Improvement Committee, and two of the QIC subcommittees, the Key Performance Indicator Committee, and the System Quality Improvement Committee. The goal of a PIP is to drive measurable, sustained improvements in the quality of care and outcomes for individuals served by the behavioral health plans.

Each PIP and current Problem Statement is listed in the table below.

PIP Title/Topic	AIM/Problem Statement	Measure Definition
<b>DMC-ODS Clinical:</b> Pharmacotherapy for Opioid Use Disorder (POD)	By December 31, 2027, KernBHRS will use targeted interventions to increase the percentage, by 5% points each year, of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members ages 16 and older with a diagnosis of OUD.	The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.
<b>DMC-ODS Non-Clinical:</b> Increasing SUD Peer Support Service Delivery	By December 31, 2027, Kern Behavioral Health and Recovery Services (KernBHRS) System of Care will use targeted interventions to increase the number of unique clients, ages 18+, who received at least one SUD Peer Support Service by at least 5% points.	The percentage of unique SUD members who received at least one peer support service by a certified Peer Support Specialist during the measurement period.
<b>MH Clinical:</b> Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	Will the targeted interventions provided to adult members, ages 18 and older, with a schizophrenia or schizoaffective diagnosis, who were dispensed and remained on an antipsychotic medication for at least 80% of the treatment period, increase by 5% points each measurement year?	The percentage of adults, 18 years of age and older, who have schizophrenia or schizoaffective disorder diagnosis, and was dispensed and remained on an antipsychotic medication for at least 80% of the treatment period.
<b>MH Non-Clinical:</b> Increasing Mental Health Peer Support Service Delivery	By December 31, 2027, Kern Behavioral Health and Recovery Services (KernBHRS) will use targeted interventions to increase the number of unique members, ages 18+, who received at least one specialty mental health Peer Support Service by at least 5% points.	The percentage of unique MH members, who received at least one peer support service by a certified Peer Support Specialist during the measurement period.

## UTILIZATION MANAGEMENT

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Kern BHRS behavioral health plans operate a Utilization Management Program that is under the oversight of the QIC. The utilization management program is designed to ensure Medi-Cal beneficiaries have access to the services they need when they need them. The program includes processes for making utilization decisions and monitoring those decisions. It also includes mechanisms for detecting under and over utilization of services. The Utilization Management Program is outlined in a variety of Kern BHRS policies and procedures including an umbrella policy that describes the overarching Utilization Management Program. The Utilization Management Program includes an array of standards and reports monitored through the various QIC committees. Elements of the Utilization Management program are monitored through the Work Plan, the Regulatory Compliance Committee, and the Key Performance Indicator Committee. The UM program evaluates medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries prospectively and retrospectively.

Kern Behavioral Health and Recovery Services (KernBHRS) operates a comprehensive Utilization Management (UM) Program as an essential component of its Quality Assessment and Performance Improvement (QAPI) framework.

The UM Program supports KernBHRS's commitment to delivering high-quality, equitable, and cost-effective care by:

- Ensuring medical necessity and service appropriateness through systematic utilization reviews (UR) of clinical documentation, treatment plans, and service authorizations.
- Promoting timely access to care by monitoring appointment availability, service timeliness, and network adequacy.
- Preventing over- and under-utilization of services through data-driven analysis and real-time monitoring of service patterns.
- Aligning with CalAIM documentation reform to streamline workflows and reduce administrative burden while maintaining clinical integrity.
- Detecting and preventing fraud, waste, and abuse through integrated compliance monitoring and audit processes

Oversight of the UM Program is provided by the Quality Improvement Committee (QIC). Executive QIC and the subcommittees receive regular reports regarding utilization management activities. In addition, QID collaborates with clinical teams, providers, and administrative staff to ensure that UM activities are integrated into daily operations and aligned with KernBHRS's mission and strategic goals.

Performance metrics related to utilization—such as service penetration rates, authorization turnaround times, and denial rates—are routinely analyzed to identify trends, disparities, and opportunities for improvement. Findings from UM activities inform system-wide quality improvement initiatives and are incorporated into the annual QI Work Plan and Evaluation.

## 2025-2026 WORK PLAN GOALS

<b>Goal #1 Provider Financial Appeals:</b> 100% of Provider Financial Appeals will be processed and sent final response within 60 calendar days of appeal.	Responsible Party  Training and Compliance Administrator
Objectives 1. Ensure 100% of provider appeals are logged and acknowledged within 5 business days of receipt from Patients' Rights, to initiate timely processing and maintain with the 60 days turnaround requirement. 2. Conduct bi-weekly audits of open provider appeals to ensure each case is progressing toward resolution and identify any that are at risk of exceeding the 60-day limit.	
<b>Goal #2 Psychiatric No Show:</b> 90% Decrease the Psychiatric No-Show rate for KernBHRS to below 18%	Responsible Party  Medical Services Administrator
Objectives: 1. Monitor the already implemented standardized follow-up process for 100% of no-show appointments within 2 business days to identify barriers and reschedule as appropriate. 2. All Clinical Outpatient teams will Review no-show data monthly with their administrator as necessary to identify trends (e.g., location, time, provider) and conduct targeted outreach or adjustments to scheduling practices based on findings	
<b>Goal #3 Contract Processing Cycle Time:</b> The Reduce the average contract processing cycle time by 25% from the current 87 days to approximately 65 days.	Responsible Party  Clinical Plan Services Administrator
Objective: 1. Within 90 days, conduct a full review of the current contract processing workflow with internal and external stakeholders to identify systemic challenges that contribute to the 87-day processing average. 2. Identify, design, and implement two process changes with internal and external stakeholders within the next quarter to streamline the contract review and approval process. 3. Track and report contract cycle time metrics monthly to monitor progress toward the 65-day target and make data-driven adjustments per recommendations as needed	
<b>Goal #4 DMC-ODS Client and Family Satisfaction Rate – TPS:</b> The Substance Use Division and its contract providers will achieve a cumulative minimum satisfaction rating of 85% or greater on the Treatment Perception Survey	Responsible Party  Substance Use Disorder Administrator
Objective: 1. Complete the TPS. 2. Ensure at least 90% of eligible clients and family members are offered the TPS during the designated survey periods by training staff and monitoring distribution compliance. 3. Review TPS results quarterly to identify areas of concern and implement at least one targeted service improvement initiative per quarter based on client and family feedback.	

<p><b>Goal #5 MHP UM Review:</b> 95% of reviewed medical necessity determination on MH assessments will be consistent between assessor and reviewer.</p>	<p>Responsible Party</p>
<p>Objective:</p> <ol style="list-style-type: none"> <li>1. Complete Assessment Reviews for all MH teams to ensure appropriate determination of medical necessity Begin re-credentialing internal and contracted staff as required based on their original credentialing approval date.</li> <li>2. Provide feedback and recommendations to supervisors and administrators if any areas of concerns or improvement are identified during the reviews.</li> <li>3. Provide Assessment training to all new MH clinicians to ensure everyone is using the same process and criteria when determining medical necessity</li> </ol>	<p>QID, Documentation Compliance Supervisor</p>
<p><b>Goal #6 DMC-ODS UM Review:</b> 95% of reviewed medical necessity determination on ASAM assessments will be consistent between assessor and reviewer.</p>	<p>Responsible Party</p>
<p>Objective:</p> <ol style="list-style-type: none"> <li>1. Maintain quarterly audit process to review a random sample of ASAM assessments, track consistency rates, and provide individualized feedback and coaching to staff as needed.</li> <li>2. Share results with providers after quarterly reviews to help improve assessment determinations.</li> </ol>	<p>Substance Use Disorder Administrator</p>
<p><b>Goal #7 Consumer and Family Satisfaction - CPS:</b> The Mental Health Plan and its contract providers will achieve a cumulative minimum satisfaction rating of 85% or greater on the Consumer Perception Survey.</p>	<p>Responsible Party</p>
<p>Objective:</p> <ol style="list-style-type: none"> <li>1. Complete the CPS.</li> <li>2. Work with DHS to support efforts to provide alternative placement options for youth with complex needs.</li> </ol>	<p>QID, Quality Monitoring Supervisor</p>
<p><b>Goal #8 24/7 Access Line:</b> The MHP 24/7 access line logs will contain the names, disposition, date, and time of 100% of test calls</p>	<p>Responsible Party</p>
<p>Objective:</p> <ol style="list-style-type: none"> <li>1. Ensure that all calls are logged with accurate information.</li> <li>2. Ensure that all DHCS access line standards are met by call takers</li> </ol>	<p>Crisis Administrator</p>
<p><b>Goal #9 Fair Hearing:</b> 100% of State Fair Hearings will be conducted within 90 calendar days of the request</p>	<p>Responsible Party</p>
<p>Objective:</p> <ol style="list-style-type: none"> <li>1. Check CDSS Appeals Case Management System website every day.</li> <li>2. Log 100% of Fair Hearing requests within 2 business days of receipt and immediately notify all relevant parties to initiate the scheduling process.</li> <li>3. Ensure all Fair Hearings are scheduled within 30 calendar days of the request date to allow sufficient time for preparation and to meet the 90-day completion requirement.</li> </ol>	<p>QID, Administrative Coordinator</p>

<b>Goal #10 Access to After Hours Service:</b> 90% of service providers will have service available outside the typical service hours (8-5. Mon-Fri).	Responsible Party
Objective: 1. Improve client accessibility to outpatient care providers. 2. Reduce use of emergency and crisis services by increasing availability of outpatient provider. 3. Provide flexible service hours.	QID Administrator
<b>Goal #11 Credentialing:</b> 100% of KernBHRS staff and contract provider staff will complete the credentialing process.	Responsible Party
Objective: 1. Reduce the process time needed per application by improving internal and inter-agency communication, for example to improve responsiveness from internal teams and from contract providers. 2. Implement or update a centralized credentialing tracking system to monitor the status of all staff and contract provider credentialing, with updates and alerts for missing or expiring documentation 3. Conduct monthly audits of credentialing files to verify completeness and compliance and follow up with staff or providers who are out of compliance within 5 business days.	Training and Compliance Administrator
<b>Goal #12 Medication Monitoring:</b> Each provider will achieve a combined rating of 85% or higher on peer review medication monitoring evaluation	Responsible Party
Objective: 1. Complete monthly reviews of prescribers (internal and contracted) utilizing the Medication Monitoring tool, revised to reflect updated standards Monitor logged outreach events to ensure staff are engaging and educating the community on the program. 2. Provide individual provider and Medical Staff group feedback based on quarterly/ monthly findings. 3. Identify system-wide improvements to support improved medication services to clients 4. Contractors that have elected to complete their own reviews internally will submit them to QID for processing	Medical Services Administrator
<b>Goal #13 DMC-ODS Access Line:</b> 95% of all DMC-ODS access test calls will be given a customer service rating of standard or above	Responsible Party
Objective: 1. QID will perform monthly test calls and provide results to SUD Access Line. 2. SUD Access Line supervisors will review results with all staff to encourage ongoing excellent customer service.	Substance Use Disorder Administrator
<b>Goal #14 Treatment Court Referrals:</b> Establish a baseline for number of Treatment Court referrals that access SUD Treatment services.	Responsible Party
Objective: 1. Develop and implement a standardized data collection process within 30 days to track all Treatment Court referrals and their subsequent access to SUD (Substance Use Disorder) treatment services. 2. Train staff to provide additional wrap around support to clients referred by Treatment Court 3. Establish processes for accurate data tracking after clients enter treatment, ensuring needed communication with the courts.	Substance Use Disorder Administrator

<p><b>Goal #15 Reduce Overdose Rate:</b> Implement strategies to reduce rate of overdoses in Kern County including outreach to individuals that have had overdoses utilizing shared data from Managed Care Plans and other county departments.</p>	<p>Responsible Party</p>
<p>Objective:</p> <ol style="list-style-type: none"> <li>1. Develop processes to obtain data from Managed Care Plans and the county Public Health department to identify individuals who have experienced an overdose.</li> <li>2. Initiate a targeted outreach program to engage 100% of identified individuals who have experienced a recent overdose, offering linkage to SUD treatment, harm reduction services, and peer support.</li> <li>3. Track and analyze overdose incidents quarterly using EMS, hospital, and law enforcement data to evaluate the effectiveness of outreach efforts and adjust strategies as needed to reduce overdose rates.</li> </ol>	<p>Substance Use Disorder Administrator</p>
<p><b>Goal #16 Enhance Data Exchange:</b> Develop and enhance data exchange initiative with partner agencies and MCP's.</p>	<p>Responsible Party</p>
<p>Objective:</p> <ol style="list-style-type: none"> <li>1. Develop a data governance framework and secure data-sharing infrastructure within 90 days to support compliant and efficient exchange of information with partner agencies and MCPs.</li> <li>2. Collaborate with stakeholders to identify and prioritize key data elements (e.g., client demographics, service utilization, outcomes) to be shared, ensuring alignment with program goals and privacy regulations.</li> <li>3. Launch a data exchange project with two additional MCPs meeting the requirements as specified in the State MCP MOU.</li> </ol>	<p>Resource Operations Manager</p>
<p><b>Goal #17 Position Recruitment:</b> Increase recruitment of clinical and administrative positions.</p>	<p>Responsible Party</p>
<p>Objective:</p> <ol style="list-style-type: none"> <li>1. Enhance outreach and visibility of job opportunities through targeted marketing and community engagement.</li> <li>2. Streamline and optimize the recruitment process SUD QID will run providers' training reports and follow up with providers before their annual review.</li> </ol>	<p>Senior Human Resources Manager</p>
<p><b>Goal #18 High Fidelity Wrap:</b> Implement High Fidelity Wrap Around</p>	<p>Responsible Party</p>
<p>Objective:</p> <ol style="list-style-type: none"> <li>1. Establish a dedicated High Fidelity Wraparound team by identifying and training staff in the HFW model, including facilitators, family support partners, and youth support partners</li> <li>2. Create and adopt standardized policies, procedures, and documentation tools aligned with state and national HFW fidelity standards to guide consistent implementation across all participating agencies.</li> </ol>	<p>Children's Administrator</p>
<p><b>Goal #19 Leverage Fiscal Data:</b> Develop and implement fiscal performance dashboards to monitor and enhance FFP drawdown tracking</p>	<p>Responsible Party</p>
<p>Objective:</p> <ol style="list-style-type: none"> <li>1. Identify and define at least five key fiscal performance indicators related to FFP drawdown.</li> <li>2. Develop and launch interactive fiscal dashboards Meet with Health Plans to increase provider engagement and send referrals to MAT providers.</li> </ol>	<p>Resource Operations Manager</p>

<p><b>Goal #20 Enable Service Capture:</b> Identify and implement three quality improvement initiatives aimed at enhancing FFP drawdown through improved service capture processes.</p>	<p>Responsible Party</p>
<p>Objective:</p> <ol style="list-style-type: none"> <li>1. Complete a baseline audit of service documentation accuracy and completeness across all programs within 60 days to identify common gaps that impact FFP eligibility and drawdown.</li> <li>2. Prioritize the findings based on fiscal impact; systematically develop and deliver targeted training sessions every quarter and resources for supervisory, clinical, and administrative staff on proper service documentation, coding, and billing practices to improve FFP-eligible service capture.</li> <li>3. Develop systems to monitor billable service delivery at the staff and team levels within 90 days. Track trends monthly with a goal of increasing FFP eligibility and drawdown to 20% over the next year.</li> </ol>	<p>Clinical Plan Services Administrator</p>
<p><b>Goal #21 Outpatient Adult Timeliness Accuracy:</b> RAWC Teams will improve the accuracy of timeliness performance data by ensuring that the number of enrolled clients aligns within 10% of the number of assigned timeliness forms.</p>	<p>Responsible Party</p>
<p>Objective:</p> <ol style="list-style-type: none"> <li>1. Conduct monthly reconciliation of enrolled client lists and assigned timeliness forms to identify and correct discrepancies, ensuring alignment within a 10% margin.</li> <li>2. Provide quarterly training to RAWC team members on accurate client enrollment tracking and timeliness form assignment procedures to reduce data entry errors and improve reporting accuracy.</li> <li>3. Develop and implement a real-time dashboard or tracking tool that compares enrolled clients to submitted timeliness forms, with automated alerts for variances exceeding 10%.</li> </ol>	<p>Adult System of Care Administrator</p>
<p><b>Goal #22 Service Integration:</b> Ensure KLD is able to bill for services under the DMC-ODS plan by securing AOD and DMC certification.</p>	<p>Responsible Party</p>
<p>Objective:</p> <ol style="list-style-type: none"> <li>1. Complete all required documentation and facility readiness tasks</li> <li>2. Submit and secure Drug Medi-Cal certification with DHCS.</li> </ol>	<p>Kern Linkage Administrator</p>
<p><b>Goal #23 Financial Information Dissemination:</b> Complete development of team expense reports in Allocap which includes the revenue generated in the programs</p>	<p>Responsible Party</p>
<p>Objective:</p> <ol style="list-style-type: none"> <li>1. Collaborate with fiscal and program leads to finalize the structure and key data elements (e.g., expenses, revenue, cost per service unit) to be included in the Allocap team expense reports within 30 days.</li> <li>2. Work with IT and fiscal teams to ensure accurate integration of program-level revenue data into Allocap, with automated data feeds or manual entry protocols established within 60 days.</li> <li>3. Provide training to all relevant staff on accessing and interpreting the new Allocap reports within 2 weeks of launch and establish a monthly reporting schedule for ongoing financial transparency.</li> </ol>	<p>Finance Director</p>