KERN HEALTH SYSTEMS

REGULAR MEETING OF THE QI/UM COMMITTEE

Thursday, May 25, 2017
at
7:00 A.M.

at
9700 Stockdale Highway
1st Floor Conference Room
Bakersfield, CA 93311

The public is invited

For more information, call (661) 664-5000

AGENDA

QUALITY IMPROVEMENT (QI) / UTILIZATION MANAGEMENT (UM) COMMITTEE

KERN HEALTH SYSTEMS
1st Floor-Conference Room
9700 Stockdale Highway
Bakersfield, California 93311

Regular Meeting
Thursday, May 25th, 2017

7:00 A.M.

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COMMITTEE MEMBERS: Jennifer Ansolabehere, P.H.N; Satya Ayra, M.D.; Felicia Crawford, RN; Bruce Taylor, DO; Maridette Schloe MS, LSSBB;Danielle C Colayco, PharmD, MS

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

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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])

3) Announcements:
- Form 700
- Introduction-Special Guests, Allen Kennedy from Quality Team and Dr. Chan Park from GMA Healthcare

4) Closed Session:

CA-5) QI/UM Committee Summary of Proceedings March 2nd, 2017 – RECEIVE AND FILE

CA-6) Physician Advisory Committee (PAC) Summaries of Proceedings – RECEIVE AND FILE
- February 2017
- March 2017

CA-7) Pharmacy 2017 TAR Log Statistics 1st Quarter – RECEIVE AND FILE
- January 2017
- February 2017
- March 2017

CA-8) Focus Review Report 1st Quarter 2017 – RECEIVE AND FILE
- Critical Elements Monitoring Ending March 31st, 2016
- IHEBA Monitoring Ending March 31st, 2016
- IHA Monitoring Ending March 31st, 2016
- KRC Monitoring Ending March 31st, 2016
- CCS Monitoring Ending March 31st, 2016
- Perinatal Care Monitoring Ending March 31st, 2016

CA-9) Site Review Summary Report 1st Quarter 2017 – RECEIVE AND FILE

CA-10) SHA Monitoring Report 1st Quarter 2017 – RECEIVE AND FILE

CA-11) VSP Medical Data Collection Summary Reports – RECEIVE AND FILE
- January 2016-December 2016

- February 2016-January 2017
- March 2016-February 2017
- April 2016- March, 2017

CA-12) VSP QI Work Plan Evaluation 2016 – RECEIVE AND FILE
CA-13) VSP QI Program Description 2016 – RECEIVE AND FILE
CA-14) Kaiser UM DME Authorization Denial Reports – RECEIVE AND FILE

- 4th Quarter 2016

CA-15) Kaiser KHS Health Plan Dental Reports– RECEIVE AND FILE

- 1st Quarter 2017

CA-16) Kaiser Grievance Reports – RECEIVE AND FILE

- 1st Quarter 2017

CA-17) Kaiser KHS SPD Reports – RECEIVE AND FILE

- 4th Quarter 2016
- 1st Quarter 2017

CA-18) Kaiser KHS CBA Reports – RECEIVE AND FILE

- 4th Quarter 2016
- 1st Quarter 2017

Member Services

CA-19) 2017 Q1 Call Center Report – RECEIVE AND FILE

- Kern Health Systems/Kaiser
- 2017 Health Dialog Health Information Line Summary
- 2017 Health Coach Call Listening Report Q1

CA-20) Comparative Tabulated Grievance Reports – RECEIVE AND FILE

- 4th Quarter 2016

CA-21) 2016 Grievance Summary Reports – RECEIVE AND FILE

- 4th Quarter 2016

Provider Relations

CA-22) 1st Q 2017 Re-credentialing Report – RECEIVE AND FILE
CA-23) Board Approved New Contracts – RECEIVE AND FILE

- January 2017
- February 2017

CA-24 Board Approved Providers Reports – RECEIVE AND FILE

- March1, 2017
- April 1, 2017

CA-25) 1st Q 2017 After-Hours Calls Survey Results – RECEIVE AND FILE
CA-26) 1st Q 2017 Appointment Availability Survey Results – RECEIVE AND FILE

Disease Management

CA-27) Disease Management Reports – RECEIVE AND FILE

- 4th Quarter 2016
- 1st Quarter 2017

Health Education Reports

28) Health Education Activities Reports

- 1st Quarter 2017 - APPROVE
- 4th Quarter 2016 - RECEIVE AND FILE

QI Department Reports

29) 2016 QI Program Evaluation Executive Summary – APPROVE

30) 2016 QI Program Evaluation – RECEIVE AND FILE
31) 2017 QI Program Description – RECEIVE AND FILE
32) 2017 QI Work Plan – RECEIVE AND FILE
33) Policy and Procedure 2.22-P – RECEIVE AND FILE
    - 2.22-P Attachment D Ancillary Services
    - 2.22-P Attachment E CBAS
34) Policies and Procedures 217-235– RECEIVE AND FILE
    - 2.17-P Access - Treatment of a Minor 2017-01
    - 2.29-P Emergency Protocol and Disaster Plan 2017-01
    - 2.30-I Health Education 2017-01
    - 2.35-P Disease Management 2017-01

UM Department Reports

35) 2017 1st Q Combined UM Reporting – APPROVE
36) 2017 UM Program Description – RECEIVE AND FILE
37) 2016 UM Program Evaluation – RECEIVE AND FILE
38) Policies and Procedures– RECEIVE AND FILE
    - 3.33-P Admission-Discharge Notification 2017-01
    - 3.36-P Asthma Treatment and Management 2017-01
    - 3.37-P Specialty Nutrition Consultation 2017-01

Next regular meeting: August 24, 2017

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, 9700 Stockdale Highway, 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.

CONSENT ITEMS

SUMMARY OF PROCEEDINGS

QUALITY IMPROVEMENT (QI) / UTILIZATION MANAGEMENT (UM) COMMITTEE

KERN HEALTH SYSTEMS
1st Floor-Conference Room
9700 Stockdale Highway
Bakersfield, California 93311

Regular Meeting
Thursday, March 2, 2017
7:00 A.M.

All agenda item supporting documentation is available for public review at Kern Health Systems in the Administration Department, 9700 Stockdale Highway, Bakersfield, 93311 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.

Members Present: Satya Arya, M.D.; Felicia Crawford, RN; Maridette Schloe MS, LSSBB; Dr. Irwin Harris, M.D., Associate Medical Director

Members Absent: Jennifer Ansolabehere; Danielle C Colayco, PharmD, MS P.H.N; Bruce Taylor, DO

Meeting called to order by Dr. Irwin Harris, M.D. @ 7:24 A.M.

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.

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COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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3) Announcements:
- Form 700
- **Felicia Crawford announced that Hoffmann Hospice opened the first Hospice Home here in Kern County.**

4) Closed Session: **N/A**

CA-5) QI/UM Committee Summary of Proceedings December 1st, 2016 – RECEIVED AND FILED

CA-6) Physician Advisory Committee (PAC) Summaries of Proceedings – RECEIVED AND FILED
- October 5, 2016
- November 2, 2016
- December 7, 2016

CA-7) Pharmacy 2016 TAR Log Statistics 4th Quarter – RECEIVED AND FILED
- October 2016
- November 2016
- December 2016

CA-8) Focus Review Report 4th Quarter 2016 – RECEIVED AND FILED
- Critical Elements Monitoring Ending December 31st, 2016
- IHEBA Monitoring Ending December 31st, 2016
- IHA Monitoring Ending December 31st, 2016
- KRC Monitoring Ending December 31st, 2016
- CCS Monitoring Ending December 31st, 2016
- Perinatal Care Monitoring Ending December 31st, 2016

CA-9) Site Review Summary Report 4th Quarter 2016 – RECEIVED AND FILED

CA-10) Asthma & Diabetes Care Monitoring Report 4th Quarter 2016 – RECEIVED AND FILED
CA-11) VSP Medical Data Collection Summary Reports 2016 – RECEIVED AND FILED

- November 2015-October 2016
- December 2015-November 2016
- January 2016-December 2016

CA-12) Kaiser UM DME Authorization Denial Reports – RECEIVED AND FILED

- 3rd Quarter 2016

CA-13) Kaiser 2016 Grievance Reports – RECEIVED AND FILED

- 3rd Quarter 2016
- 4th Quarter 2016

CA-14) Kaiser 2016 Pending and Unresolved Grievance Reports – RECEIVED AND FILED

- 3rd Quarter 2016
- 4th Quarter 2016

CA-15) Kaiser KHS Call Center Reports– RECEIVED AND FILED

- 3rd Quarter 2016
- 4th Quarter 2016

CA-16) Kaiser 2016 KHS Health Plan Dental Reports– RECEIVED AND FILED

- 3rd Quarter 2016
- 4th Quarter 2016

Member Services
CA-17) 2016 Q4 Call Center Report – RECEIVED AND FILED
Provider Relations
CA-18) 4th Q 2016 Re-credentialing Report – RECEIVED AND FILED
CA-19) Board Approved New Contracts – RECEIVED AND FILED

- October 13, 2016
- November 10, 2016
- December 15, 2016

CA-20 Board Approved Providers Reports – RECEIVED AND FILED

- December 1, 2017
- January 1, 2017

CA-21) 4th Q 2016 After-Hours Calls Survey Results – RECEIVED AND FILED
QI Department Reports
CA-22) Policy and Procedure 20.50-I – RECEIVED AND FILED

- 20.50-I Medi-Cal Quality and Performance 2016-07
- 20.50-I Attachment A 2016-09
- 20.50-I Attachment B 2016-08

CA-23) Policy and Procedures CP 230-231– RECEIVED AND FILED

- CP 230-Facility Site Review-Survey 2016-10
- CP 230 Attachment A FSR Tool (Updated 2014)
- CP 230 Attachment B Medical Record Survey Tool 2014
- CP 231 Facility Site Review - Medical Record Review 2016-10

CA-24) Policy and Procedures CP 232-235 – RECEIVED AND FILED

- CP 232 Facility Site Review - Scoring of Facility and Record Review

- CP 233 Facility Site Review - Corrective Action Plans 2016-10
- CP 234 Facility Site Review - Inter Rater Reliability 2016-10
- CP 235 Facility Site Review - Site Evaluation

UM Department Reports

25) 4th Q 2016 Combined UM Reporting – APPROVED
Arya-Crawford: All Ayes

Meeting adjourned by Dr. Irwin Harris, M.D. @ 8:02 A.M.
to Thursday, May 25, 2017

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE MEETING

KERN HEALTH SYSTEMS
9700 Stockdale Highway
1st Floor Board Room
Bakersfield, California 93311

Wednesday, February 1, 2017
7:00 A.M.

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COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D., Angela Egbikuadje, PD.MS, Ph.D; Miguel Lascano, M.D., Raju Patel, M.D., Jacqueline Paul-Gordon, M.D.

Members Absent: David Hair, M.D., Ashok Parmar, M.D.

Meeting called to order at 7:12 A.M. by Dr. Irwin Harris, M.D.

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CA-3) Minutes for KHS Physician Advisory Committee meeting on December 7, 2016 – APPROVED
Amin-Lascano: All Ayes

ADJOURNED TO CLOSED SESSION @ 7:18 A.M.

CLOSED SESSION

4) Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) – **BY A VOTE OF 5-0, THE COMMITTEE APPROVED PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING AND RECREDENTIALING.**

COMMITTEE RECONVENED TO OPEN SESSION @ 7:39 A.M.

5) Health Plan Update – By: Doug Hayward, Chief Executive Officer

6) Provider Practices Overview – Presentation by: Dr. Irwin Harris, Associate Medical Director – EDUCATIONAL
ITEM HELD UNTIL NEXT MEETING

7) Vascular procedure criteria for Peripheral Varicose Veins (to be voted on March 2017 meeting) – DISCUSSION
Decision was made by PAC to invite a vascular specialist to speak on the request by Dr. Harris to update KHS vascular criteria.

8) Ambulatory Hysterectomy Procedures – DISCUSSION

Dr. Lascano commented to committee regarding this issue. He explained Inpatient hospitalization is occasionally needed for Vaginal Hysterectomies for pain and bleeding. KHS' current criteria has been in place, and has been the accepted practice at the Health Plan. He mentioned the need for a personal reviewer at the hospital level to review each case and determine proper status (Outpatient or Inpatient.)
It was agreed in the discussion that KHS's current criteria was sufficient but the plan should allow exceptions for pain control, excessive bleeding, or complicated/extensive procedures, and at that time, the plan would allow a 23 hour observation period.

MEETING ADJOURNED BY DR. IRWIN HARRIS, M.D. @ 8:14 A.M. TO WEDNESDAY, MARCH 1, 2017 AT 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE MEETING

KERN HEALTH SYSTEMS
9700 Stockdale Highway
1st Floor Board Room
Bakersfield, California 93311

Wednesday, March 1, 2017
7:00 A.M.

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COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D., Angela Egbikuadje, PD.MS, Ph.D; David Hair, M.D., Miguel Lascano, M.D., Ashok Parmar, M.D., Raju Patel, M.D., Jacqueline Paul-Gordon, M.D.

Members Absent: None

Meeting called to order at 7:02 A.M. by Dr. Irwin Harris. M.D.

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CA-3) Minutes for KHS Physician Advisory Committee meeting on February 1, 2017 – APPROVED
Patel-Amin: All Ayes

ADJOURNED TO CLOSED SESSION @ 7:03 A.M.

CLOSED SESSION

4) Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) – **BY A VOTE OF 7-0, THE COMMITTEE APPROVED PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING AND RECREDENTIALING.**

Special review by committee of letter received from Dr. Oriente Esposo, M.D. Motion made (Amin) to recommend approval of initial credentialing for 1-year. Motion failed due to a lack of second.

Recommendation made (Harris) to postpone application pending reinstatement of clinical privileges at Bakersfield Memorial Hospital in which practitioner states will be reinstated April 1, 2017. *Motion made (Amin), to postpone action on Oriente Esposo MD's application, seconded (Patel) and carried.*

COMMITTEE RECONVENED TO OPEN SESSION @ 7:31 A.M.

5) Review of Proposed Vascular Criteria – Guest: Dr. Hao D. Bui, M.D. - DISCUSSION **ITEM HELD UNTIL NEXT MEETING**

6) Review Policy 2.30-I Health Education – RECEIVED AND FILED

7) Review Policy 2.35-P Disease Management – RECEIVED AND FILED

8) Review Policy 3.37-P Specialty Nutrition Consultation – RECEIVED AND FILED

9) Review Diabetic Exam Reminder Effectiveness Report for 2016 – RECEIVED AND FILED

MEETING ADJOURNED BY DR. IRWIN HARRIS, M.D. @ 8:03 A.M. TO WEDNESDAY, APRIL 5, 2017 AT 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
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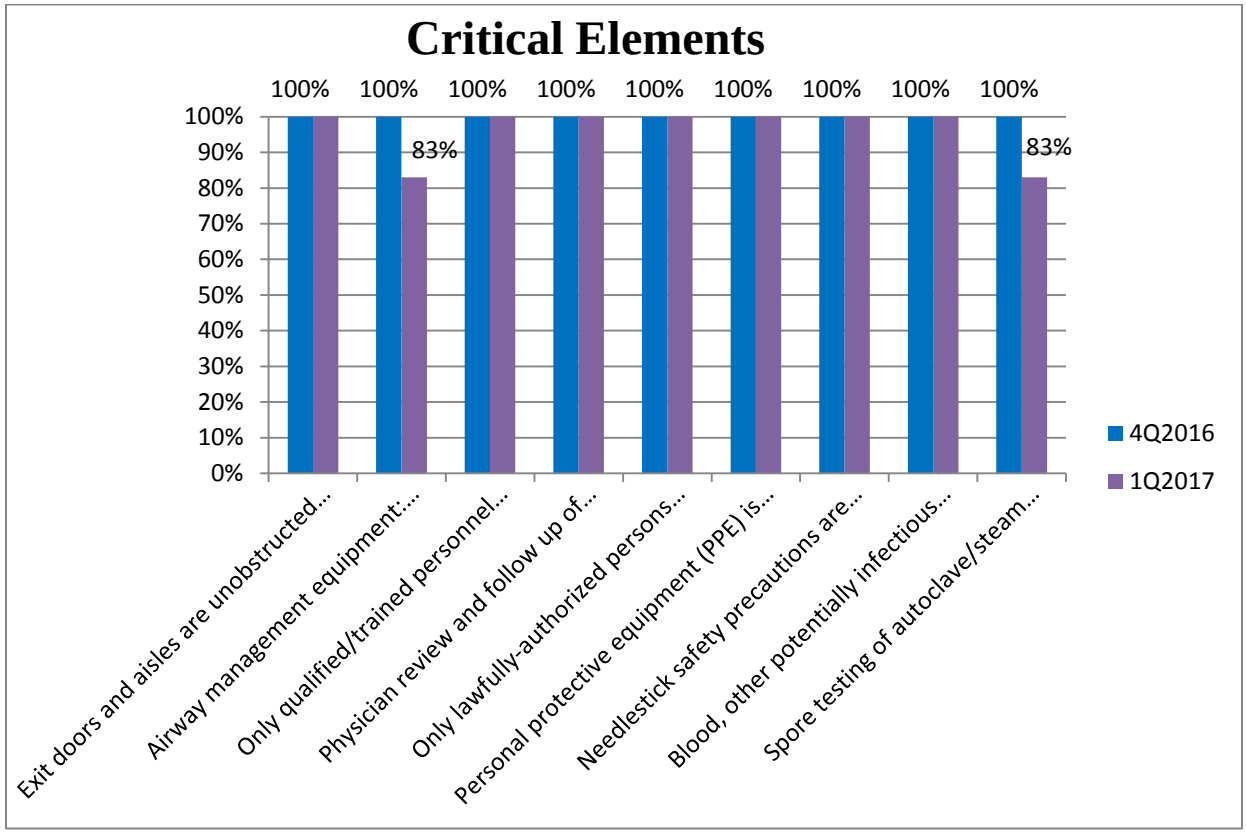
Quarter/Year of Audit	**2017**
Month Audited	**January**
Total TAR's for the month	**2567**
APPROVED TAR'S	
Timeliness - Reviewed & Returned in 1 busines day	**40/40**
Date Stamped	**40/40**
Fax copy attached	**40/40**
Decision marked	**40/40**
DENIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**60/60**
Initally Denied - Signed by Medical Director and/or Pharmacist	**60/60**
Letter sent within time frame	**60/60**
Date Stamped	**60/60**
Fax copy attached	**60/60**
Decision marked	**60/60**
Correct form letter, per current policies used	**60/60**
MODIFIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**0**
Date Stamped	**0**
Fax copy attached	**0**
Decision marked	**0**
Correct form letter, per current policies used	**0**
DUPLICATE TAR'S	
Timeliness - Reviewd & Returned in 1 business day	**17/17**
Date Stamped	**17/17**
Fax copy attached	**17/17**

Quarter/Year of Audit	**2017**
Month Audited	**February**
Total TAR's for the month	**2491**
APPROVED TAR'S	
Timeliness - Reviewed & Returned in 1 busines day	**50/50**
Date Stamped	**50/50**
Fax copy attached	**50/50**
Decision marked	**50/50**
DENIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**58/58**
Initally Denied - Signed by Medical Director and/or Pharmacist	**58/58**
Letter sent within time frame	**58/58**
Date Stamped	**58/58**
Fax copy attached	**58/58**
Decision marked	**58/58**
Correct form letter, per current policies used	**58/58**
MODIFIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**0**
Date Stamped	**0**
Fax copy attached	**0**
Decision marked	**0**
Correct form letter, per current policies used	**0**
DUPLICATE TAR'S	
Timeliness - Reviewd & Returned in 1 business day	**4/4**
Date Stamped	**4/4**
Fax copy attached	**4/4**

Quarter/Year of Audit	**2017**
Month Audited	**March**
Total TAR's for the month	**2904**
	100%
APPROVED TAR'S	
Timeliness - Reviewed & Returned in 1 busines day	**55/55**
Date Stamped	**55/55**
Fax copy attached	**55/55**
Decision marked	**55/55**
DENIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**68/68**
Initally Denied - Signed by Medical Director and/or Pharmacist	**68/68**
Letter sent within time frame	**68/68**
Date Stamped	**68/68**
Fax copy attached	**68/68**
Decision marked	**68/68**
Correct form letter, per current policies used	**68/68**
MODIFIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**0**
Date Stamped	**0**
Fax copy attached	**0**
Decision marked	**0**
Correct form letter, per current policies used	**0**
DUPLICATE TAR'S	
Timeliness - Reviewd & Returned in 1 business day	**12/12**
Date Stamped	**12/12**
Fax copy attached	**12/12**

Critical Elements Reviews: Seven (7) providers were evaluated in the 1st Quarter 2017.

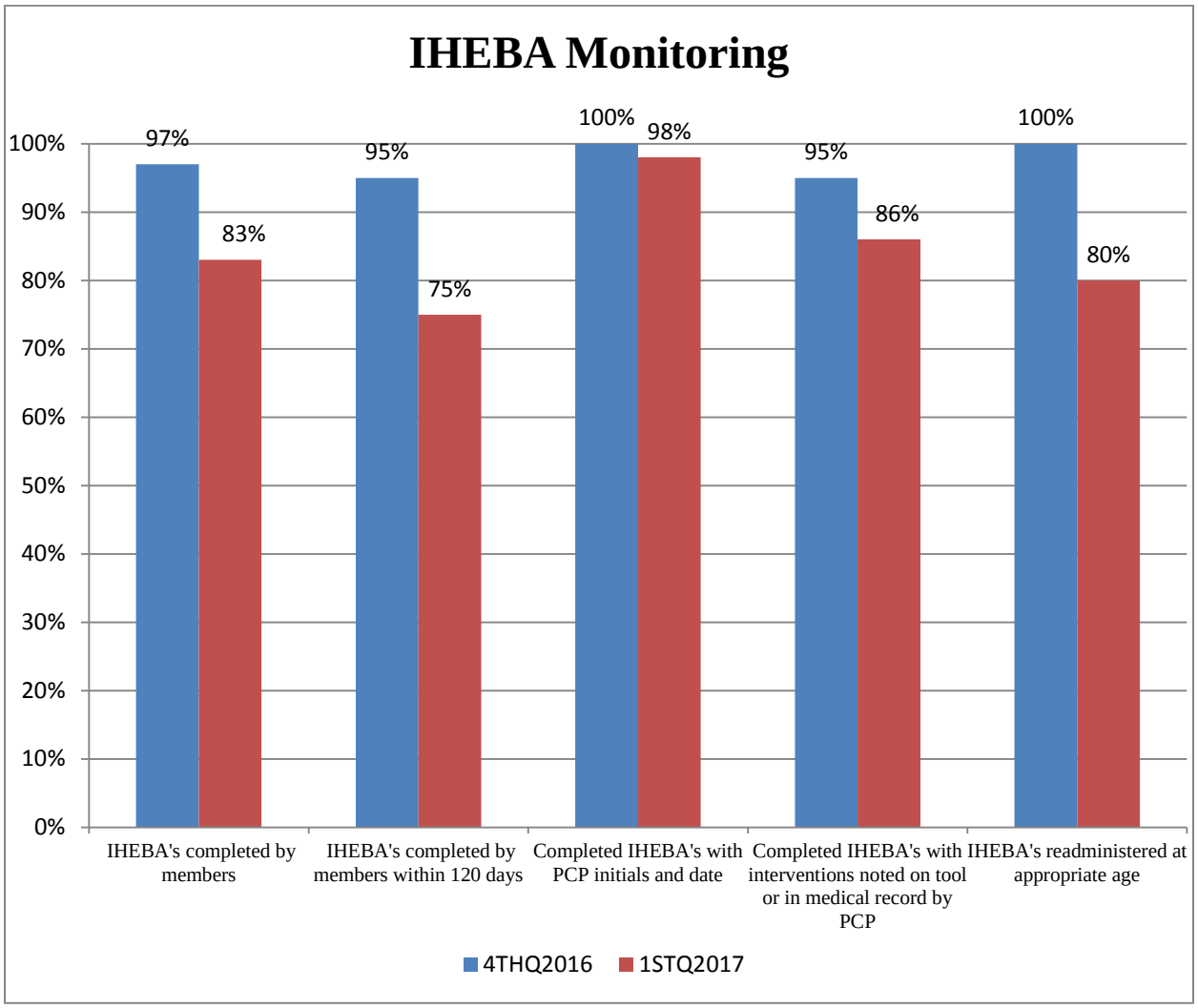
SUMMARY: KHS is responsible for systematic monitoring of all PCP sites between each regularly scheduled full scope site review surveys which includes the nine (9) critical elements. Other performance assessments may include previous deficiencies, patient satisfaction, grievance, and utilization management data. The PCP and/or site contact are notified of all critical element deficiencies found during a full scope site survey, focused survey or monitoring visit. PCP and/or site contact are required to correct 100% of the survey deficiencies regardless of the survey score.



All seven providers evaluated in the 1st Quarter scored 100% in 7 out of 9 areas. The areas of deficiency noted were 1) Airway management equipment: Oxygen delivery system, oral airway or mask, ambu bag, appropriate to practice and populations served and 2) spore testing of autoclave/steam sterilizer with documented results at least monthly. Correction Action Plans (CAPs) were implemented with the providers showing deficiencies and follow-up visits will be conducted.

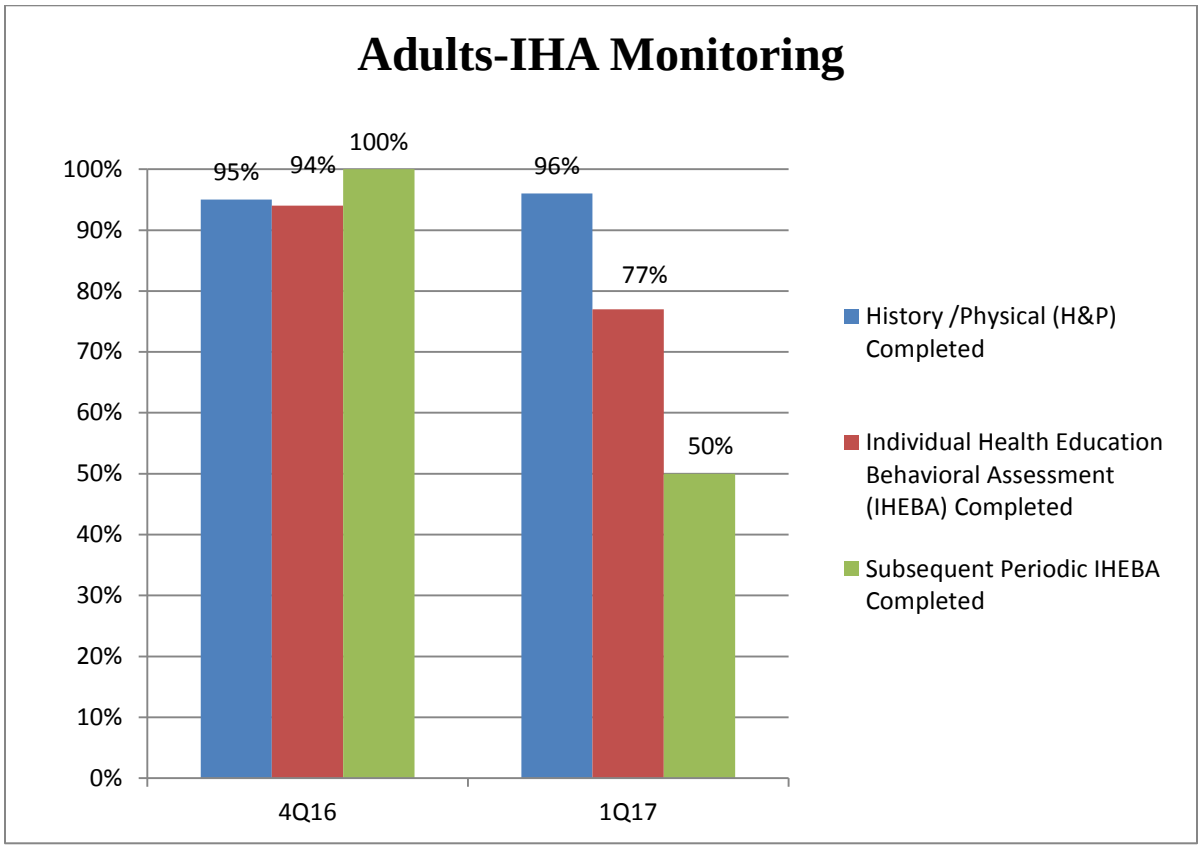
IHEBA Reviews: In the 1st Quarter 2017, Seven (7) providers and 67 Charts were reviewed. The average compliance rate for all five categories in 1st Quarter 2017 was 84%.

SUMMARY: The initial Individual Health Education Behavioral Assessment (IHEBA), commonly referred to as the Staying Healthy Assessment, shall be performed during the Initial Health Assessment (IHA); thereafter, the PCP must re-administer the IHEBA at the appropriate age intervals.



Initial Health Assessment Reviews: In the 1st Quarter 2017, seven (7) providers were reviewed. There were nineteen (15) Adult records and twenty (23) Pediatric records reviewed.

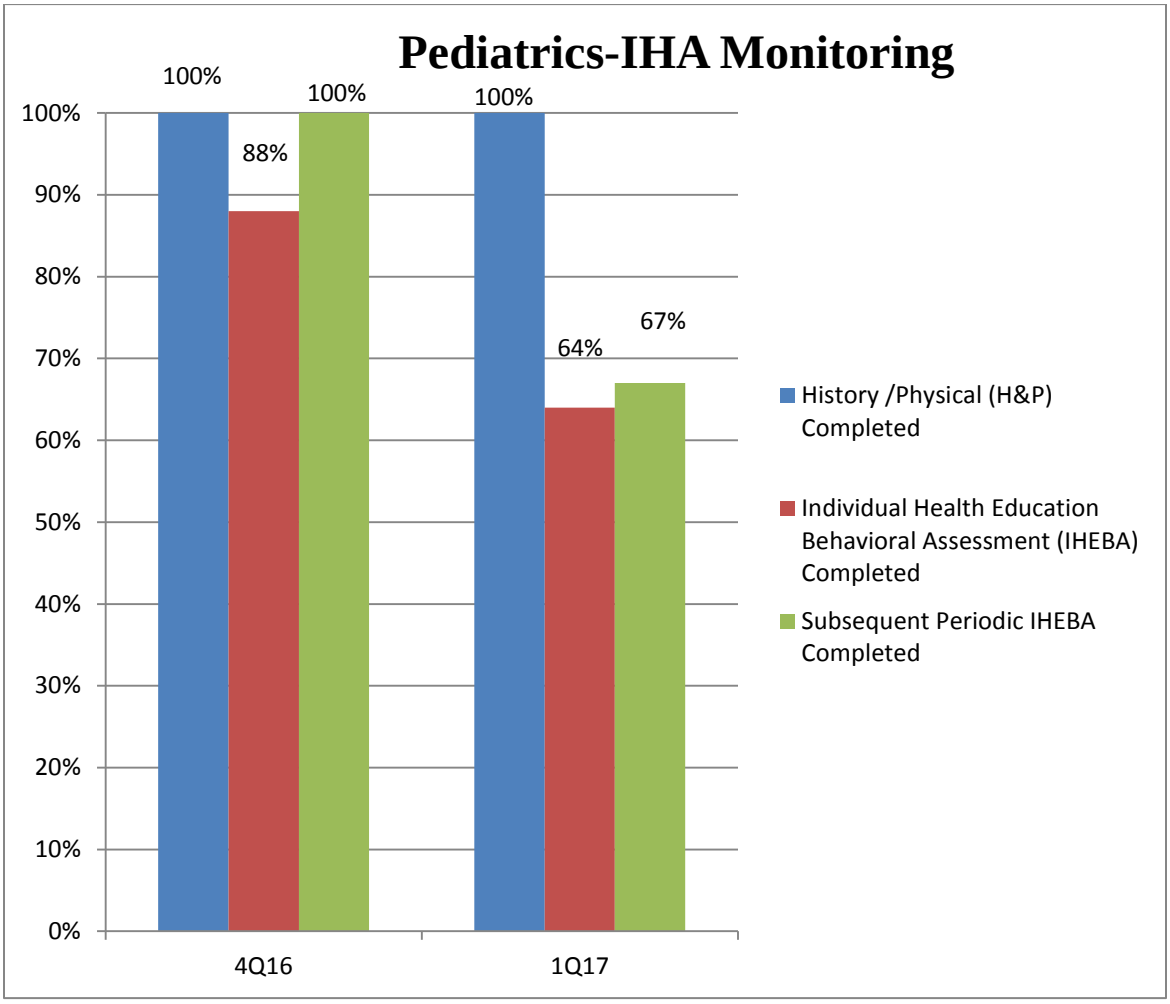
SUMMARY: An Initial Health Assessment (IHA) must be provided to each member within 120 days of enrollment. As PCP's receive their assigned panels, the Practitioner's office should contact members to schedule an IHA to be performed within the 120 day time limit. If the practitioner/staff is unable to contact the member, he/she should contact KHS Member Services Department for assistance. Contact attempts and results are documented by both the PCP and Member Services staff.



The number of H&Ps completed in the IHA Adult charts reviewed was high for both 4Q16 and 1Q17 with an average of 96%. However, the number of initial IHEBAS completed and subsequent Periodic IHEBAs completd both decreased in 1Q17. The Initial IHEBAs completed had a score 77% and Subsequent IHEBAs completed had a score of 50%.

Both adult and pediatric providers perform H&Ps during the initial health assessment. The initial IHEBA/Staying Health Assessment should be performed during the IHA. Performance in Pediatric IHEBA use remains higher than in the adult population for all elements. Corrective Action Plans were implemented and follow-up visits will be conducted.

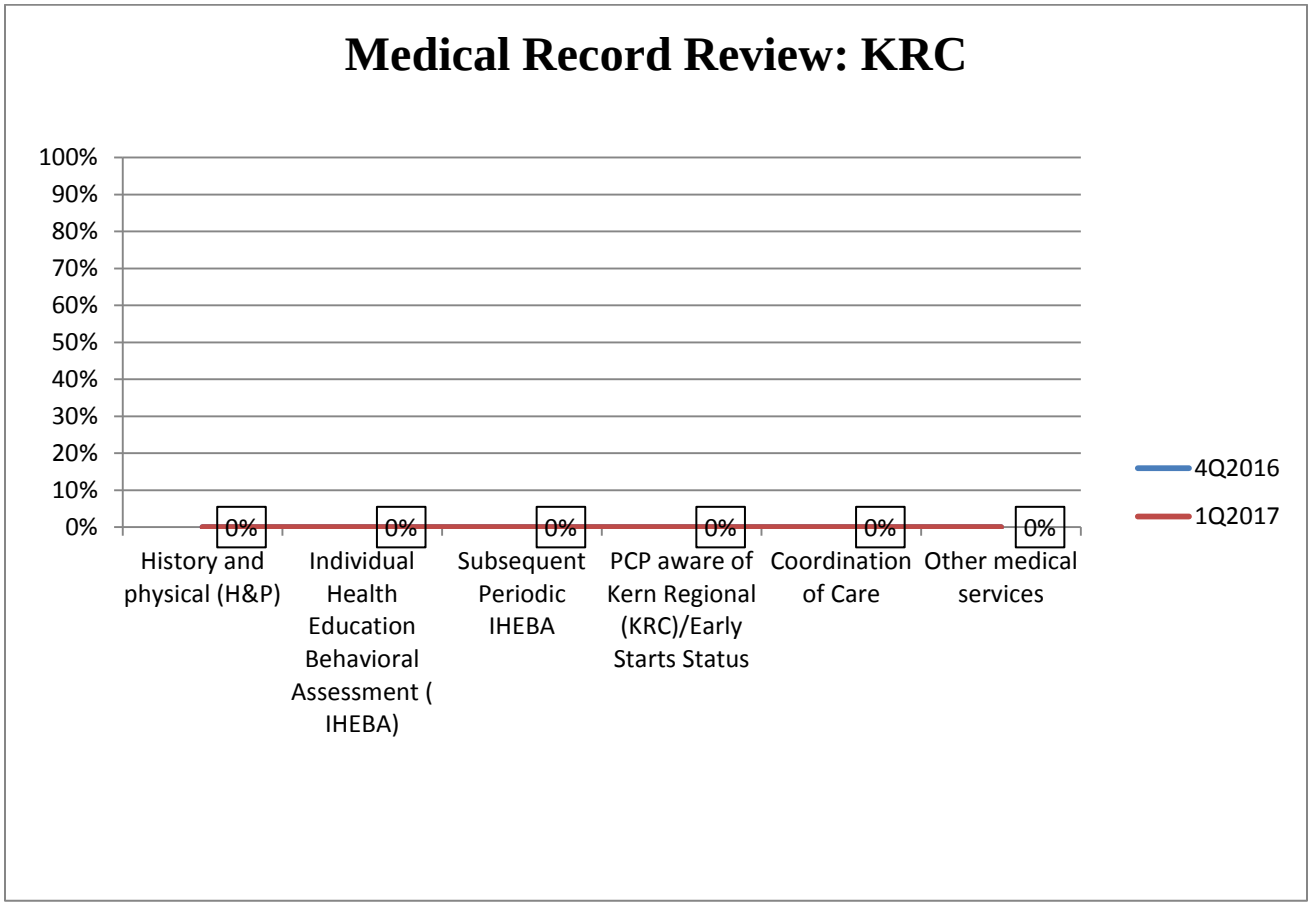
The number of History/Physicals (H&P) completed in the pediatric charts was 100% in both 4Q16 and 1Q17. However, the scores for the Initial IHEBAs completed and Subsequent Periodic IHEBAS both decreased from 4Q16. The 1st quarter findings in the pediatric charts reviewed reflect an Initial IHEBA completion rate of 64% and a Subsequent Periodic IHEBA completion rate of 67%. Corrective Action Plans have been implemented and follow-up visits will be conducted.



KRC Reviews: No data to report in the 1st Quarter of 2017.

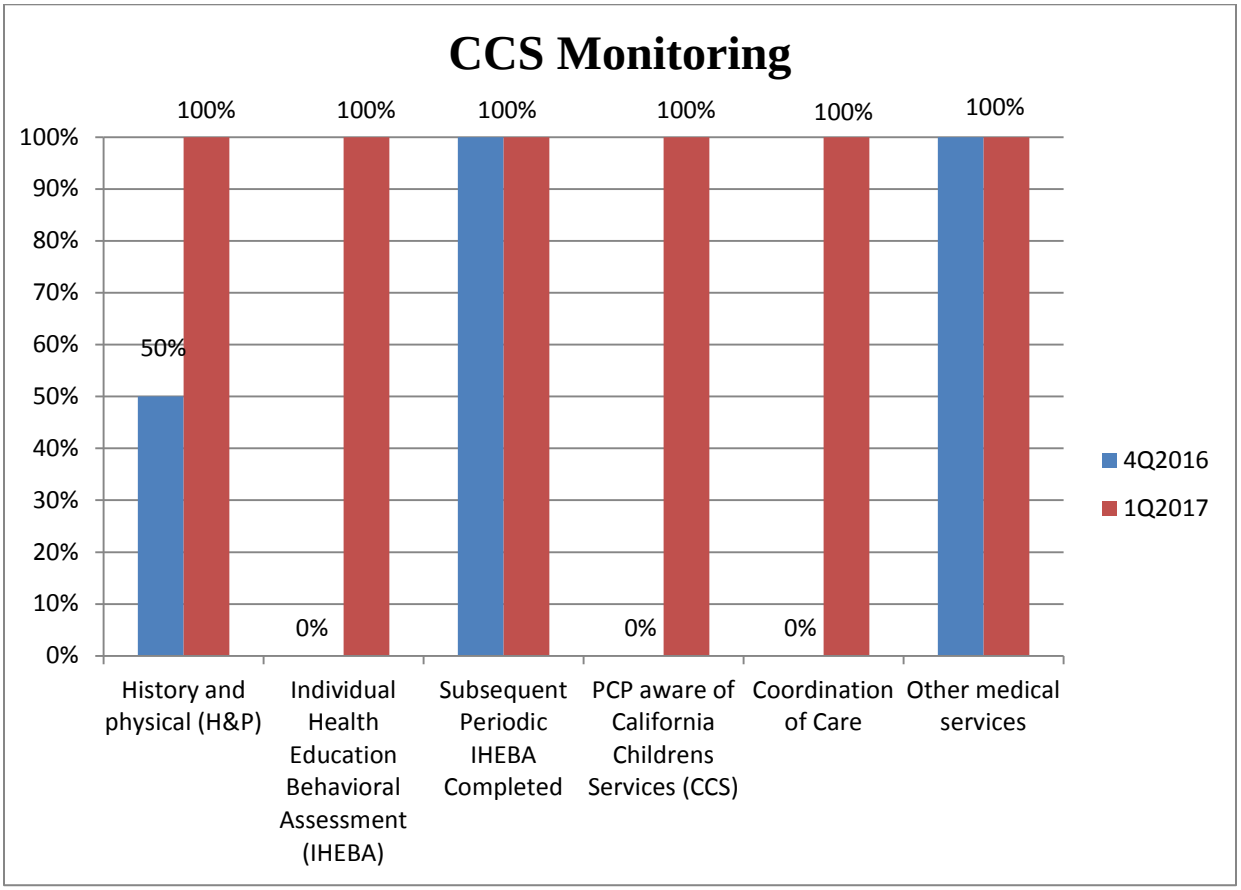
SUMMARY: KHS ensures the provision of primary care interventions and other medically necessary covered services unrelated to the KRC and/or Early Starts eligible condition through medical record review evidenced by appropriate primary care and other necessary intervention. Corrective Action Plans were implemented and these sites are in compliance at this time.

Historically, opportunities for improvement exist in documenting coordination of care and other medical services.



CCS Reviews: In the 1stQ 2017, seven (7) providers and one (1) CCS chart were reviewed.

SUMMARY: KHS ensures the provision of primary care interventions and other medically necessary covered services unrelated to the CCS eligible condition through medical record review evidenced by appropriate primary care and other necessary intervention. KHS collaborates with CCS, the CCS Specialist, and the PCP as necessary to ensure continuity of the member's care.



In 1st quarter 2017 CCS monitoring all providers surveyed scored 100% in all areas:

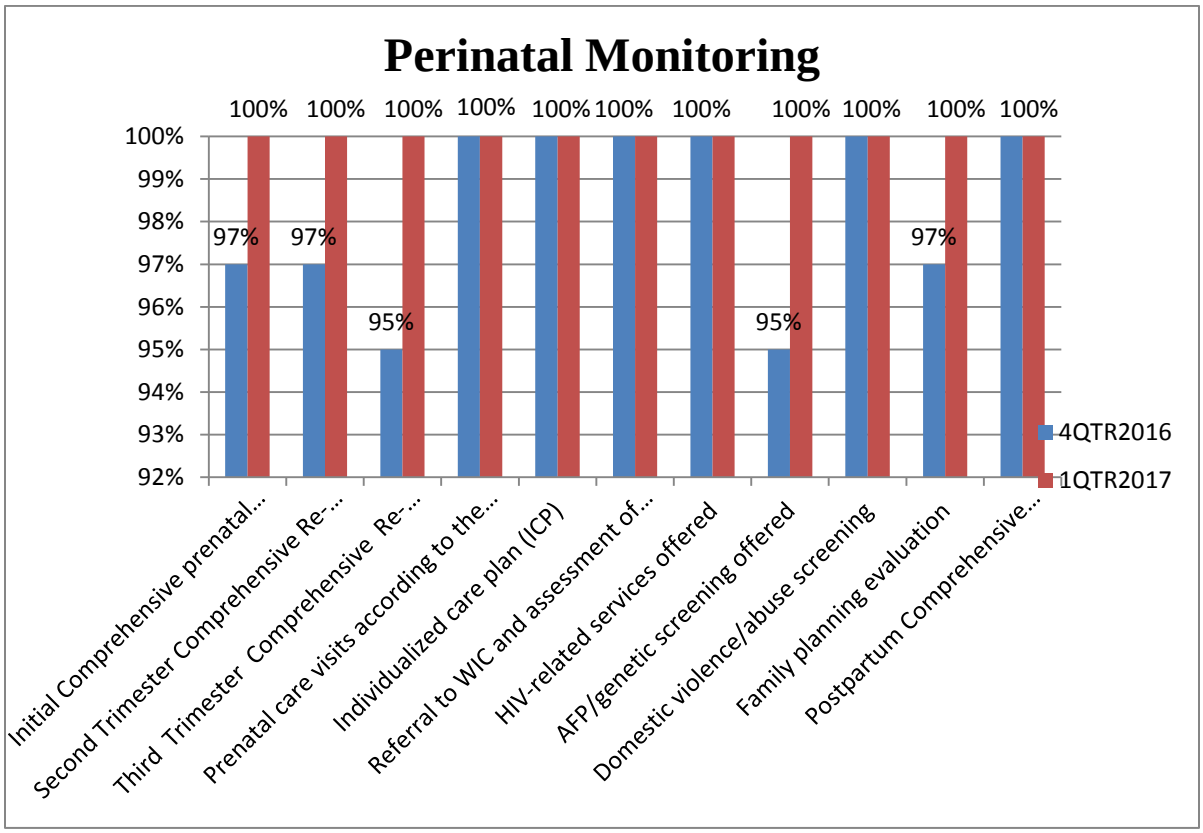
- History and physical (H&P)
- Individual Health Educational Behavioral Assessment (IHEBA)
- Subsequent Periodic IHEBAs completed
- PCP aware of CCS
- Coordination of Care
- Other medical services needed

Perinatal Reviews: In the 1Qtr 2017 three (3) providers were evaluated and twelve (12) charts were reviewed.

SUMMARY: KHS will encourage optimum maternity care as appropriate for all pregnant members. Maternity care includes prenatal care, delivery, postpartum care, education, high risk interventions, and genetic counseling, screening, and referral. All pregnancy providers shall utilize a multi-disciplinary approach to perinatal care. All pregnant KHS members will receive case coordination of Obstetric and Comprehensive Perinatal Services to the degree warranted by the State Department of Healthcare Services (DHCS) combined standardized risk assessment tools. Maternity care will be provided in accordance with the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG).

OB patients are routinely monitored through the QI Department's medical record reviews. Timeliness of prenatal and postpartum care is monitored for HEDIS. When appropriate, the QI nurse implements a CAP for the KHS provider and notifies Provider Relations for follow-up. The QI department collects data (shown above) on these members and reports the aggregate findings to the QI/UM Committee on a regular basis in order to determine necessary interventions. There is a variance from quarter to quarter depending on the number of providers reviewed.

All providers reviewed were fully compliant and scored 100% in all areas.

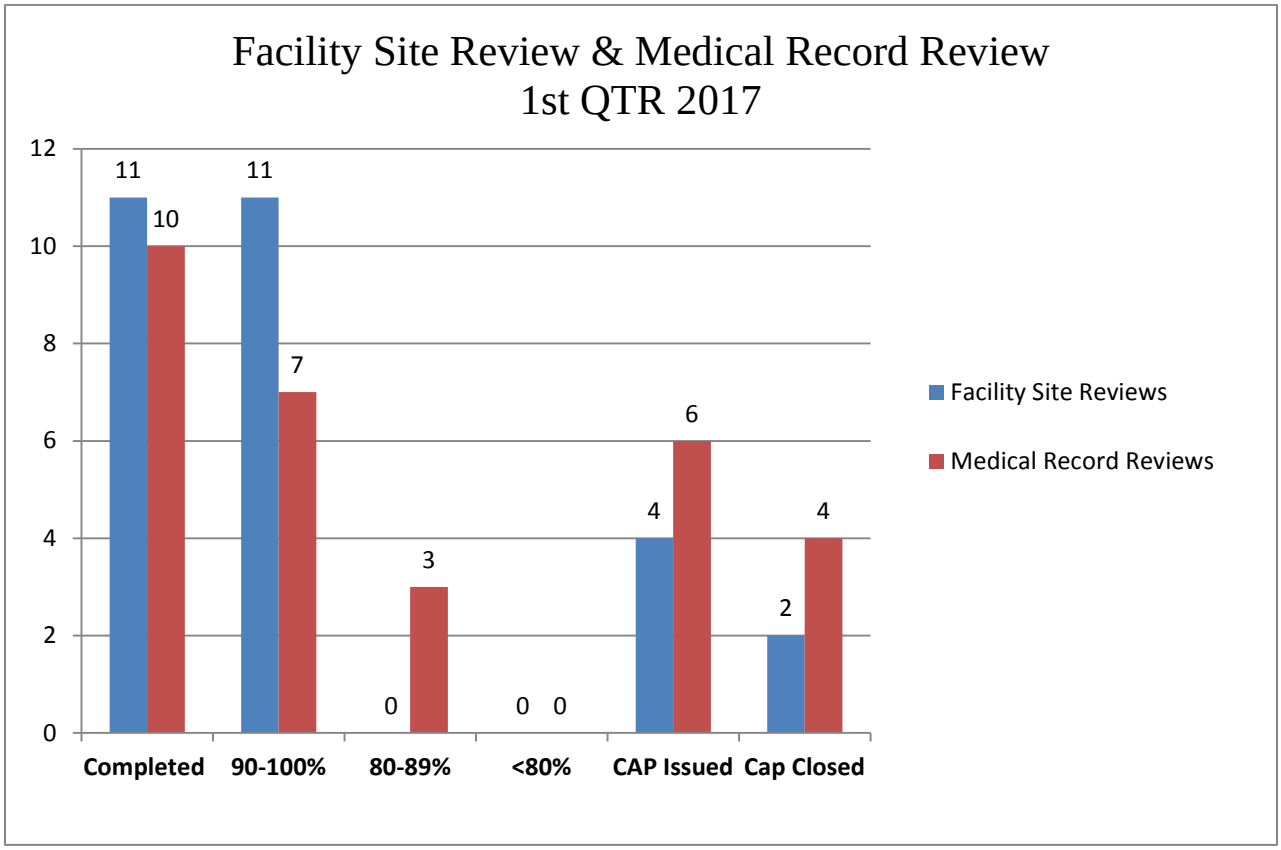


KERN HEALTH SYSTEMS
SITE REVIEW SUMMARY REPORT

Disciplinary Involvement: Quality Improvement and Provider Relations
Data Retrieval Method: Chart Review, Observation, Interview/Survey, Physical Inspection
Department: Quality Improvement
Monitoring Period: January 1, 2017- March 31, 2017

A total of eleven (11) Office Site Reviews were completed in the 1st Quarter. Out of the eleven (11) completed, four (4) were Initial Reviews and seven (7) were Periodic Reviews. One (1) out of the eleven (11) performed were by Health Net, and none were Urgent Care Only.

A total of ten (10) Medical Record Reviews were completed in the 1st Quarter. Three (3) out of ten (10) were Initial Medical Record Reviews and seven (7) were Periodic Medical Record Reviews. There were (4) Facility Site Review Caps issued and six (6) Medical Record Review Caps issued. Four (4) Medical Record Review caps were closed, and two (2) Full Site Review Caps were closed.



Description of Process: Kern Health System Policy 2.22 Facility Site Review requires that KHS personnel perform a facility site review on all contracted primary care (including OB/GYN, IPA's clinics, and hospital ambulatory care clinics) providers for the purpose of establishing facility compliance with the guidelines set forth by the Department of Health Services, Department of Managed Health Care, and the Managed Risk Medical Insurance Board.

According to MMCD Policy Letter 02-02: Plans shall ensure that providers are credentialed according to MMCD contractual and policy requirements. A site review shall be completed as part of the initial Credentialing process if a new provider at a site that has not previously been reviewed is added to a contractor's provider network.

A site review need not to be repeated, as part of the initial Credentialing process if a new provider is added to a provider site that has a current passing site survey score. A site review survey need not to be repeated as part of the re-credentialing process if the site has a current passing site survey score. A passing Site Review Survey shall be considered "current" if it is dated within the last 3 years, and need not to be repeated until the due date of the next scheduled site review survey or when determined necessary through monitoring activities by the plan

Scoring and Corrective Action Plans

QI/UM Committee approved Policy #CP232 and #CP233 as the Scoring and Corrective Action Plan Policies for all Provider Site Reviews

Facility sites that receive an Exempted Pass (90% or above, without deficiencies in critical elements) will not be required to complete a corrective action plan (CAP), unless required by the plan or local plan collaborative. All sites that receive a Conditional Pass (80-89%, or 90% or above with deficiencies in critical elements) will be required to establish a CAP that addresses each of the noted deficiencies. The compliance level categories for both the facility site review and medical record review are the same as listed below:

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

Facility sites that receive an Exempted Pass (90% or above) for medical record review will not be required to complete a CAP for medical record review. On-site CAP follow up visits are intended to verify that processes are in place to remedy deficiencies.

Nine critical survey elements related to the potential for adverse effect on patient health or safety have a scored "weight" of two points. All other survey elements are weighted at one point. All critical element deficiencies found during a full scope site survey, focused survey, or monitoring

visit shall be corrected by the provider within 10 business days of the survey date. Sites found deficient in any critical element during a Full Score Site Survey shall be required to correct 100% of the survey deficiencies, regardless of survey score. Critical elements include the following nine criteria:

1. Exit doors and aisles are unobstructed and egress (escape) accessible.
2. Airway management equipment, appropriate to practice and populations served, are present on site.
3. Only qualified/trained personnel retrieve, prepare or administer medications.
4. Office practice procedures are utilized on-site that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results.
5. Only lawfully-authorized persons dispense drugs to patients.
6. Personal protective equipment (PPE) is readily available for staff use.
7. Needlestick safety precautions are practiced on-site.
8. Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers for collections, processing, storage, transport or shipping.
9. Spore testing of autoclave/steam sterilizer is completed (at least monthly, with documented results).

Top Facility Site Review Defiencies

- Individual Health Education Behavioral Assessment (IHEBA)
- Documentation of education/training for non-licensed medical personnel in maintained on site
- Sterilized packages are labeled with sterilization date and load identification information

Top Medical Record Review Defiencies

- There is no documentation on checking of emergency equipment/supplies for expiration and operating status at least monthly.
- Errors are corrected according to legal medical documentation standards
- Member's assigned primary care physician (PCP) is identified
- Primary language and linguistic service needs of non-or-limited –English proficient (LEP) or hearing –impaired persons are prominently noted
- Adult Immunizations
- Chlamydia screening
- Cervical Cancer Screening

Providers are responsible for coming into compliance with the full site review criteria. KHS felt it would be in the best interest of our members to work with the providers to get them into compliance with the requirements at the time of our follow-up review and/or re-credentialing. If it is found that a site remains out of compliance and/or has a failing score, disciplinary action may be imposed.

KERN HEALTH SYSTEMS
STAYING HEALTH ASSESSMENTS MONITORING

SUMMARY: In addition to a disease management program, KHS attempts to identify opportunities to improve the health of the members who have been identified with health needs. During the course of P4P and HEDIS audits QI nurses identified those patients with positive Staying Healthy Assessments in their medical record. These positive SHAs are shared with Health Education to evaluate clinical follow-up and to assist them in developing their curriculum. The QI department collects data (shown below) on these members and reports the aggregate findings to the QI/UM Committee on a regular basis. There is a variance from quarter to quarter depending on the providers reviewed.

Staying Healthy Assessment Monitoring

During routine audits of medical records, QI RNs validate that a Staying Healthy Assessment was completed yearly. Each SHA with a positive response is forwarded to Health Education for use in developing their curriculum. During 1st Quarter 2017, there were 28 positive SHAs sent to Health Education

Medical Data Collection Summary Report

Period Covered: January, 2016 through December, 2016
Prepared For: KERN HEALTH SYSTEMS - (12049397)

Overview

This report shows an aggregate view of your members who have received an eye exam during the reporting period. It also shows the number and percentage of your members that have one or more of the health conditions listed below, as reported by VSP doctors. VSP focuses on the six conditions listed below because they represent some of the most frequent and costly health conditions for which early detection and treatment can reduce or prevent vision loss as well as potentially avoid more costly treatment. VSP can work with your health plan or disease management company by providing them with patient-specific information upon request.

Summary of Findings

The left section below shows how many of your members received an eye exam during the reporting period as well as how many of them had each of the conditions listed (as reported by VSP doctors). The percentages represent the number of people with the respective conditions divided by the total number that received an eye exam. The right section below shows the estimated number of cases in your member population. We use health and demographic statistics provided by the Centers for Disease Control and the US Census. Also, because prevalence rates vary by age, we incorporate patient age data from your VSP eye exam claims for the reporting period.

The estimates for diabetes and hypertension are expected to be higher than the reported rates because approximately 30% of people with diabetes and 50% of people with hypertension are unaware of their condition and would not report it to their VSP doctor. The percentages represent the estimated number of people with the conditions divided by your total membership. Note that diabetes and hypertension are self-reported while the other conditions are reported based on the VSP doctor's findings. This report does not indicate if cases are newly diagnosed or existing.

Reported Cases

	Members	
Received Eye Exam:	17,880	
Diabetes?:	717	4.0%
Diabetic Retinopathy:	77	.4%
Glaucoma:	18	.1%
Hypertension:	707	4.0%
High Cholesterol	221	1.2%
Macular Degeneration:	17	.1%

Estimated Number of Cases

Total Members:	234,225	
Diabetes?:	5,387	2.3%
Diabetic Retinopathy:	446	.2%
Glaucoma:	893	.4%
Hypertension:	23,408	10.0%
High Cholesterol	35,479	15.1%
Macular Degeneration:	277	.1%

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

Medical Data Collection Summary Report

Period Covered: February, 2016 through January, 2017
Prepared For: KERN HEALTH SYSTEMS - (12049397)

Overview

This report shows an aggregate view of your members who have received an eye exam during the reporting period. It also shows the number and percentage of your members that have one or more of the health conditions listed below, as reported by VSP doctors. VSP focuses on the six conditions listed below because they represent some of the most frequent and costly health conditions for which early detection and treatment can reduce or prevent vision loss as well as potentially avoid more costly treatment. VSP can work with your health plan or disease management company by providing them with patient-specific information upon request.

Summary of Findings

The left section below shows how many of your members received an eye exam during the reporting period as well as how many of them had each of the conditions listed (as reported by VSP doctors). The percentages represent the number of people with the respective conditions divided by the total number that received an eye exam. The right section below shows the estimated number of cases in your member population. We use health and demographic statistics provided by the Centers for Disease Control and the US Census. Also, because prevalence rates vary by age, we incorporate patient age data from your VSP eye exam claims for the reporting period.

The estimates for diabetes and hypertension are expected to be higher than the reported rates because approximately 30% of people with diabetes and 50% of people with hypertension are unaware of their condition and would not report it to their VSP doctor. The percentages represent the estimated number of people with the conditions divided by your total membership. Note that diabetes and hypertension are self-reported while the other conditions are reported based on the VSP doctor's findings. This report does not indicate if cases are newly diagnosed or existing.

Reported Cases

	Members	
Received Eye Exam:	18,519	
Diabetes?:	771	4.2%
Diabetic Retinopathy:	77	.4%
Glaucoma:	21	.1%
Hypertension:	731	3.9%
High Cholesterol	231	1.2%
Macular Degeneration:	19	.1%

Estimated Number of Cases

Total Members:	234,491	
Diabetes?:	5,412	2.3%
Diabetic Retinopathy:	448	.2%
Glaucoma:	897	.4%
Hypertension:	23,504	10.0%
High Cholesterol	35,538	15.2%
Macular Degeneration:	279	.1%

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

Medical Data Collection Summary Report

Period Covered: March, 2016 through February, 2017
Prepared For: KERN HEALTH SYSTEMS - (12049397)

Overview

This report shows an aggregate view of your members who have received an eye exam during the reporting period. It also shows the number and percentage of your members that have one or more of the health conditions listed below, as reported by VSP doctors. VSP focuses on the six conditions listed below because they represent some of the most frequent and costly health conditions for which early detection and treatment can reduce or prevent vision loss as well as potentially avoid more costly treatment. VSP can work with your health plan or disease management company by providing them with patient-specific information upon request.

Summary of Findings

The left section below shows how many of your members received an eye exam during the reporting period as well as how many of them had each of the conditions listed (as reported by VSP doctors). The percentages represent the number of people with the respective conditions divided by the total number that received an eye exam. The right section below shows the estimated number of cases in your member population. We use health and demographic statistics provided by the Centers for Disease Control and the US Census. Also, because prevalence rates vary by age, we incorporate patient age data from your VSP eye exam claims for the reporting period.

The estimates for diabetes and hypertension are expected to be higher than the reported rates because approximately 30% of people with diabetes and 50% of people with hypertension are unaware of their condition and would not report it to their VSP doctor. The percentages represent the estimated number of people with the conditions divided by your total membership. Note that diabetes and hypertension are self-reported while the other conditions are reported based on the VSP doctor's findings. This report does not indicate if cases are newly diagnosed or existing.

Reported Cases

	Members	
Received Eye Exam:	18,832	
Diabetes?:	775	4.1%
Diabetic Retinopathy:	77	.4%
Glaucoma:	23	.1%
Hypertension:	740	3.9%
High Cholesterol	235	1.2%
Macular Degeneration:	18	.1%

Estimated Number of Cases

Total Members:	234,963	
Diabetes?:	5,410	2.3%
Diabetic Retinopathy:	450	.2%
Glaucoma:	898	.4%
Hypertension:	23,509	10.0%
High Cholesterol	35,589	15.1%
Macular Degeneration:	279	.1%

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

Medical Data Collection Summary Report

Period Covered: April, 2016 through March, 2017
Prepared For: KERN HEALTH SYSTEMS - (12049397)

Overview

This report shows an aggregate view of your members who have received an eye exam during the reporting period. It also shows the number and percentage of your members that have one or more of the health conditions listed below, as reported by VSP doctors. VSP focuses on the six conditions listed below because they represent some of the most frequent and costly health conditions for which early detection and treatment can reduce or prevent vision loss as well as potentially avoid more costly treatment. VSP can work with your health plan or disease management company by providing them with patient-specific information upon request.

Summary of Findings

The left section below shows how many of your members received an eye exam during the reporting period as well as how many of them had each of the conditions listed (as reported by VSP doctors). The percentages represent the number of people with the respective conditions divided by the total number that received an eye exam. The right section below shows the estimated number of cases in your member population. We use health and demographic statistics provided by the Centers for Disease Control and the US Census. Also, because prevalence rates vary by age, we incorporate patient age data from your VSP eye exam claims for the reporting period.

The estimates for diabetes and hypertension are expected to be higher than the reported rates because approximately 30% of people with diabetes and 50% of people with hypertension are unaware of their condition and would not report it to their VSP doctor. The percentages represent the estimated number of people with the conditions divided by your total membership. Note that diabetes and hypertension are self-reported while the other conditions are reported based on the VSP doctor's findings. This report does not indicate if cases are newly diagnosed or existing.

Reported Cases

	Members	
Received Eye Exam:	19,172	
Diabetes?:	791	4.1%
Diabetic Retinopathy:	77	.4%
Glaucoma:	26	.1%
Hypertension:	730	3.8%
High Cholesterol	241	1.3%
Macular Degeneration:	21	.1%

Estimated Number of Cases

Total Members:	240,661	
Diabetes?:	5,537	2.3%
Diabetic Retinopathy:	462	.2%
Glaucoma:	919	.4%
Hypertension:	24,072	10.0%
High Cholesterol	36,441	15.1%
Macular Degeneration:	287	.1%

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

2016 Quality Improvement Work Plan Evaluation

Overview The following are Quality Improvement Goals and Monitoring for 2016 with year-end evaluation of each goal.

GOAL	RESULTS
Clinical Practice Guidelines: **Diabetes** Achieve a 50% rate of PCP communication for patients with diabetes who receive eye exams on chart review Achieve 90% dilation (or valid clinical rationale for no dilation) for patients with diabetes who receive eye exams **Glaucoma** Achieve 100% rate of adherence to CPG for patients with glaucoma who receive eye exams on chart review	The rate of doctors following the clinical practice guidelines for diabetes averaged 53% for 2016. Additionally, the rate of dilation or valid rationale documented for no dilation averaged 84%. The high was Q2 in which we achieved a dilation rate of 91%. The PCP communication rate averaged 53% in 2016, which exceeds our goal by 3%. Potential barriers to PCP communication remain a lack of established relationship between ODs and PCPs; PCP is an institution (Kaiser); Letter previously sent; Patient under care of Ophthalmologist; Patient does not know PCP Potential Barriers to dilation or valid rational remains technology advances and increased use of of retinal imaging technology in lieu of dilation. The year began and ended with the rate of doctors following the clinical practice guidelines for glaucoma at 100%. Average for the year was 85%. Potential Barriers: Limited sample size
Complaints & Grievances (C&G) **Trending**	The total number of providers on the C&G trend report in 2016 was 1,664. The rate of the VSP network providers on the report was 1.3% for the year. The two most common complaint categories remain charges and billing medical.
Quality of Care • Process and resolve all PQC cases within required timeframes • Ensure auditors consistently apply quality care standards 100% of the time.	The QA Department received a total of 1,676 Potential Quality of Care complaints from our Customer Care Division. After review, only 148 of the complaints (9%) were opened for investigation. Of the 148 cases investigated 1 was identified as having a borderline quality of care issue. The remaining 147 were found to have no quality of care issues.

GOAL	RESULTS
Quality Assurance Achieve 90% or greater overall pass rate on Quality Assurance Reviews Complete 100% of reviews within department service standards Ensure O.D. Auditors consistently apply QA review standards for doctor patient record reviews 100% of the time	The average pass rate for 2016 was 94%, which exceeds our goal of 90%. Our goal was exceeded every quarter, with the lowest pass rate of 91.7% recorded in Q4.
Accessibility (urban/suburban/ rural) Nationally maintain a 95% or higher accessibility in all classifications	Staff completed a quarterly access and availability study and presented the report to the QM Committee. Results demonstrate VSP meets and exceeds all accessibility goals nationally and in California. All goals were met within standards with no interventions needed. No barriers for this goal
Credential/recredential Complete 100% of doctors with clean applications within standards	100% of doctors with clean applications were credentialed and recredentialed within standards. Potential Barriers: Doctors failing to return application or requested information; vendor failing to deliver provider profiles according to service level agreement
Cultural Competency and Linguistics Achieve 95% accuracy of CA doctors reporting of language capabilities	California Provider Language Reporting survey indicates 90% accuracy which is 5% below the goal of 95%. Appropriate education and follow-up was provided to practices out of compliance. Potential Barriers: System and resource requirements, Client requirements, Doctor and staff engagement
Technology Monitor and evaluate the impact of new and emerging technology as it relates to the delivery of quality eye care	In 2016 the committee evaluated several technologies including tele-retinal imaging, VMAX refractive technology, Vizzario and Level.

Policy: Quality Management & Improvement Program Description	Policy Number: 4010
Policy Owner: Product and Network Strategy, Quality Management	
Applicability: VSP Staff and Providers	
Approved/Authorized By: Quality Management Committee	

OVERVIEW

VSP has a comprehensive Quality Management (QM) and Quality Improvement (QI) Program that presents a framework for ensuring quality eye care for members accessing VSP's doctors. The QM/QI Program Description defines the goals, scope, structure, function and other components for the QM/QI Program at VSP.

SCOPE

PURPOSE

VSP's QM/QI Program ensures quality vision and eye health care to members accessing VSP's doctors. The program is designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services. We strive to continuously pursue opportunities for improvement and problem resolution.

POLICY

It is the policy of the organization to ensure:

- Compliance with VSP approved policies and procedures for the QM/QI process
- Adherence to guidelines, standards and criteria set by government, accrediting agencies, and other regulatory agencies as appropriate
- The QM/QI Program accommodates the contractual requirements and benefit design of each client/health plan

GOALS

The goals of the QM/QI program include, but are not limited to, the following:

- To develop, implement and coordinate all activities that are designed to improve the processes by which care and services are delivered
- To provide tools, resources and training for staff involved in quality of care processes with clinician oversight and guidance
- To identify inappropriate practice patterns and opportunities to improve patient care
- To evaluate the effectiveness of implemented changes in order to continuously improve the quality of care and service provided by VSP and doctors to VSP customers (members, clients, and health plans)
- To ensure that there are documented mechanisms to evaluate the effects of the QM/QI Programs utilizing member and doctor satisfaction data

- To ensure that QM/QI policies and procedures are reviewed, revised and approved, as needed, by the QM Committee
- To utilize efficient and appropriate communication channels to deliver QM information to appropriate individuals
- To facilitate documentation, reporting and follow-up of Credentialing and QM/QI activities in order to facilitate excellence in vision care services and outcomes

LOCAL REVIEW AND COMMENT

Local doctor and member feedback is obtained through the following methods:
- VSP appoints State Professional Representatives to provide local, and/or state specific input
- Doctor and member satisfaction survey process
- Complaint and grievances
- Appeal processes

DELEGATION OF PRIMARY SOURCE VERIFICATION ACTIVITIES

VSP delegates the administrative activities of credentialing to Aperture, Inc., an NCQA certified Credentialing Verifications Organization (CVO). The activities include retrieval of the CAQH application and VSP specific data and all primary source verification. VSP retains all decisions regarding network participation of the doctor.
*QM/QI functions are not delegated to outside entities.

ORGANIZATIONAL STRUCTURE AND RESPONSIBILITY

OVERVIEW

The QM and Credentialing Committees provide direction and oversight that support the efforts of the QM and Credentialing functions.

BOARD OF DIRECTORS

The Board of Directors is responsible for overseeing the QM/QI Program and to review and approve the Program Description (Policy 4010) on an annual basis. The Board delegates the responsibility for development and implementation of the Program to the QM Committee.

SENIOR DIRECTOR OF PRODUCT AND NETWORK STRATEGY

The Senior Director of Product and Network Strategy is responsible for overseeing the development and implementation of the QM/QI program to support eyecare services.

OPTOMETRY DIRECTOR

The Optometry Director, a licensed optometrist and participating VSP provider, is responsible for providing direction and oversight to staff on all aspects of QM and Credentialing activities. This includes:

- Establishing standards of care used as a basis for benefit plan design and non-covered services
- Reviewing quality of care and service issues
- Adverse outcomes
- Satisfaction survey results
- Medical record reviews
- Clinical Practice Guidelines/Algorithms
- Clinical oversight of the Associate Optometry Director(s)

In addition, the Optometry Director is substantially involved with the QM and Credentialing Programs. The Optometry Director reports directly to the Director of Network Development

ASSOCIATE OPTOMETRY DIRECTOR

The Associate Optometry Director, a licensed optometrist, may be responsible for all or part of the Optometry Director's responsibilities in the absence of or as delegated by the Optometry Director. The Associate Optometry Director reports to the Director of Network Development with clinical oversight from the Optometry Director.

MEDICAL DIRECTOR

The Medical Director, a board certified ophthalmologist and participating VSP provider, is responsible for providing direction and oversight to staff on all aspects of QM and Credentialing activities. This includes:

- Establishing standards of care used as a basis for benefit plan design and non-covered services
- Reviewing quality of care/service issues
- Adverse outcomes
- Satisfaction survey results
- Medical record reviews
- Clinical Practice Guidelines/Algorithms
- Clinical oversight of the Associate Medical Director(s)

In addition, the Medical Director is substantially involved with the QM and Credentialing Programs. The Medical Director reports directly to the Director of Network Development.

ASSOCIATE MEDICAL DIRECTOR

The Associate Medical Director, board certified ophthalmologist, may be responsible for all or part of the Medical Director's responsibilities in the absence of or as delegated by the Medical Director. The Associate Medical Director reports to the Director of Network Development with clinical oversight from the Medical Director.

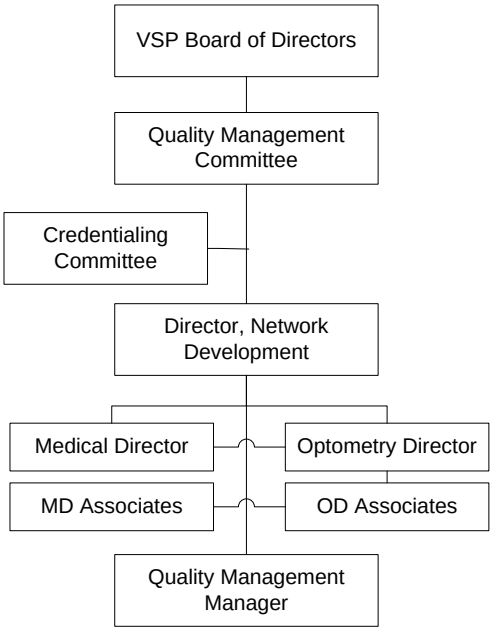
MANAGER, QUALITY MANAGEMENT

The Quality Management Manager is responsible for the development, coordination, oversight and integration of QM/QI activities, and is substantially involved in program functions.

AVAILABILITY

The Medical and Optometry Directors and the Associate Medical and Optometry Directors are practitioners in clinical practice. They meet regularly to review QM and Credentialing issues and to participate in their various committees. During the interim, these professionals are available via phone, e-mail, voicemail and fax to respond to issues as they arise.

THE ORGANIZATION CHART BELOW EXHIBITS THE COMMITTEE AND OVERSIGHT STRUCTURE



COMMITTEES

COMMITTEE TITLES

VSP has two main committees that meet at the Corporate Headquarters in Rancho Cordova, CA.

- QM Committee
- Credentialing Committee

CREDENTIALING COMMITTEE REPORTING AND ACCOUNTABILITY

The QM Committee oversees all QM/QI and Credentialing Program activities and reports to the Board of Directors, via the Board Liaison, at least annually, or more often if needed.

MEMBERSHIP

The Director of Network Development designates the Committee membership. The Board Chairperson reviews Optometry and Medical Director replacement candidates prior to final approval. The terms are for 2 years, unless otherwise directed.

The QM and Credentialing Committees are multidisciplinary committees that include representation from a range of participating providers in its network. The Committees meet at least four times throughout the year either in person or via conference call. Membership in the Committees includes the Optometry Director, Associate Optometry Director(s), Medical Director, Associate Medical Director(s), Director, Network Development, Manager, Quality Management and staff as appropriate.

CHAIR RESPONSIBILITY

The Medical Director and Optometry Director rotate the responsibility for chairing the Committees on a monthly basis. The chair responsibilities include ensuring the appropriate members participate in decision making, voting rights are performed by the appropriate peers, minutes accurately reflect discussions and decisions, and all agenda items are covered

RESPONSIBILITIES

The QM Committee is responsible for establishing processes and recommending policies and procedures for QM and Credentialing. This includes reviewing the scope, objectives, organization and effectiveness of the Programs at least annually.

The Committee is responsible for the selection of routine monitoring of topics and studies relevant to the demographic and geographic characteristics of membership. It is the responsibility of the QM Committee to assure the information and findings of QM/QI activities are used to detect trends, patterns of performance or potential problems, and to develop and implement improvement action plans. It assures the appropriate individuals, departments and doctors receive the necessary information identified for problems or opportunities to improve care or service

VOTING RIGHTS

Voting rights are performed by Optometry and Medical Directors and Associate Directors. A quorum is defined as two clinicians of each specialty. Issues that arise prior to scheduled meetings, which require immediate attention, are reviewed by the Optometry Director/Medical Director and/or designated persons and/or subcommittee and will report back to the QM Committee.

MINUTES

The committee meetings utilize a consistent format for minutes that meets accrediting standards. Documents or handouts presented at the meeting are labeled and included as attachments to the minutes. Contracted health plan staff may review meeting minutes with advance notice to VSP; however, documents may not be reproduced in any manner. Committee minutes are confidential and kept in a secured manner that is maintained according to California Evidence Code Section 1157.

The Board receives the results via the Board Liaison no less than annually, or more often if needed.

QUALITY IMPROVEMENT PROCESS

OVERVIEW

The QI process includes documented policies and procedures utilized in monitoring, reviewing and improving care and services provided to VSP members by VSP doctors. VSP may use applicable provider data for quality improvement activities.
Note: Refer to specific Department Policies for additional information.

POLICY

The QM/QI policy review occurs annually and is revised as needed. Procedural revisions and revisions with clinical impact are reviewed and approved by the QM Committee. The Board of Directors performs subsequent review and approval of changes with clinical impacts. VSP's clients and regulatory agencies receive material revisions to the policy or procedures, as required.

PATIENT SAFETY

Patient safety is reviewed and addressed. Interventions are identified and implemented. Patient safety activities include, but are not limited to:

- Potential Quality of Care Complaints/Grievances
- Credentialing/Recredentialing
- QA Doctor Reviews
- Clinical Practice Guidelines / algorithms
- Member Surveys

Note: The above-mentioned activities are detailed in department procedures

QI WORK PLAN

QM/QI plans activities each year as documented in the QI Work Plan and approved by the QM Committee annually. Quarterly updates to the work plan reflect progress on QM/QI activities and are evaluated annually. The QM Committee reviews the QI Workplan Evaluation annually before forwarding to the Board of Directors.

IMPROVEMENT ACTIVITIES

Development, implementation and review activities include, but are not limited to the following:
Potential Quality of Care Complaints and Grievances [1]
- Doctor Trends
- Complaint type trends
- Credentialing/Recredentialing and Professional Review
- Doctor Improvement Action Plan

Member, Client and VSP Doctor Satisfaction
- QA Report/Evaluations
- QA Doctor Reviews [2]
- Company Satisfaction Survey Results

Risk Management
- Clinical Practice Guidelines and Algorithms

- Assessment of New Technology

Benefit Utilization
- Identification of outlier practice patterns that may identify under or over utilization

Cultural and Linguistics Program
- Report on compliance with Policy C-0007 for serving a culturally and linguistically diverse membership

DISSEMINATION OF QI INFORMATION

Information regarding the QM/QI program is available to members upon request and disseminated to doctors via the Provider Reference Manual.

REPORTING

The Board Liaison reports Committee meeting minutes to the Board, no less than annually. The Board receives ad-hoc reports, as necessary, for serious and/or unusual QI performance issues.

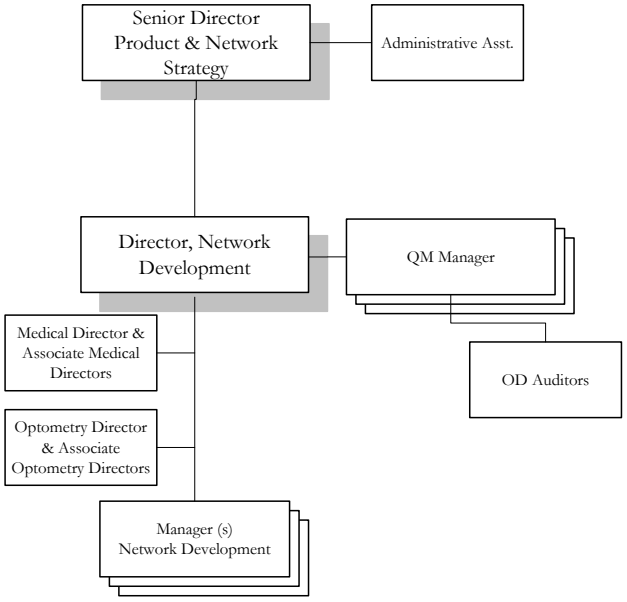
CONFIDENTIALITY

VSP maintains QI studies, committee minutes and survey results according to the VSP Corporate Confidentiality policy found at vsp.com. This policy is consistent with all federal and state laws, regulations and meets accrediting body requirements for both member and doctor.

QUALITY IMPROVEMENT PERSONNEL

The personnel within the departments listed below are responsible for QI activities:

Product and Network Strategy



REFERENCES

ISSUE DATE	REVIEW DATE	ACTION	SECTION(s) REVISED
2002		Policy approved	
	11/01/2014	Annual review and approval	
	09/01/2015	Changes in reporting and organizational structure	Organizational Structure and Accountability; Committees
	10/2015	Quality Management Committee Annual review and approval	
	11/30/2015	Added C&L objective to Improvement Activities	Improvement Activities
	08/24/2016	Updates to reflect reporting structure changes	Throughout the document
	09/14/2016	Annual policy review and approval	
	03/21/2017	Update Board Liaison language	Throughout the document

[1] See Complaints and Grievances policy 1002
[2] See Quality Management Doctor Reviews policy 3010

Kaiser Foundation Health Plan
Southern California Region
4th Quarter UM DME Report 2016

Kern Family Health

Q4 2016	ALL PLAN MEDI-CAL	Kern Family Health
ENROLLMENT	276221.33	4628.67
ACUTE DAYS/1000 MEMB	258.66	316.64
ACUTE DISCHARGES/1000 MEMB	69.55	77.01
ACUTE ALOS	3.74	4.37
ACUTE READMISSION RATE	0.11	0.00
SNF DAYS/1000 MEMB	15.17	9.12
SNF DISCHARGES/1000 MEMB	0.91	1.82
SNF ALOS	18.56	5.00
INPT PSYCH DAYS/1000 MEMB	6.00	7.34
INPT PSYCH DISCHARGES/1000 MEMB	1.12	2.58
INPT PSYCH ALOS	5.67	3.18
OUTPATIENT VISITS/MEMB	6.67	8.84
ER VISITS/1000 MEMB	482.80	167.92
UM DENIALS		3
UM AUTHORIZATIONS		280
TOTAL		283
UM DENIAL RATE**		0.4%
UM APPEALS		0
DME DENIALS		0
DME AUTHORIZATIONS		341
TOTAL		341
DME DENIAL RATE**		0.0%
DME APPEALS		0

**UM Denials/UM Referrals or Requests subject to Prior Authorization

***Appeals includes member appeals, complaint, and grievances

KP Kern HP Dental Q1 2017
Screenshot from Excel Report

1	1. Non-DD Adults Dental General Anesthesia Reporting							
2	C	D	E	F	G	H	I	J
3	County	Reporting Period	Number of Requests for Non-DD Adults	Number of Approvals for Non-DD Adults	Number of Denials for Non-DD Adults Due to Requested Documentation Not Submitted	Number of Denials for Non-DD Adults Due to Not Meeting Medical Necessity Criteria	Number of Denials for Non-DD Adults Due to Other Reasons	Other Denial Reasons for Non-DD Adults
4	Kern	Q1 2017	14	9	0	2	3	2 - Deny Out of Network Non SPD 1 - Non Contracted Provder
5	Kern	Q1 2017	0	0	0	0	0	

1	2. DD Adults Dental General Anesthesia Reporting								
2	A	B	C	D	E	F	G	H	I
3	Plan Code	Plan Name	County	Reporting Period	Number of Requests for DD Adults	Number of Approvals for DD Adults	Number of Denials for DD Adults Due to Requested Documentation Not Submitted	Number of Denials for DD Adults Due to Not Meeting Medical Necessity Criteria	Number of Denials for DD Adults Due to Other Reasons
4	303	KERN HEALTH SYSTEMS	Kern	Q1 2017	0	0	0	0	0
5	303	KAISER FOUNDATION HEALTH PLAN	Kern	Q1 2017	0	0	0	0	0

1	3. Non-DD Children Dental General Anesthesia Reporting							
2	C	D	E	F	G	H	I	J
3	County	Reporting Period	Number of Requests for Non-DD Children	Number of Approvals for Non-DD Children	Number of Denials for Non-DD Children Due to Requested Documentation	Number of Denials for Non-DD Children Due to Not Meeting Medical Necessity Criteria	Number of Denials for Non-DD Children Due to Other Reasons	Other Denial Reasons for Non-DD Children
4	Kern	Q1 2017	213	208	0	4	1	Non Contracted Provider
5	Kern	Q1 2017	5	5	0	0	0	

1	3. Non-DD Children Dental General Anesthesia Reporting							
2	C	D	E	F	G	H	I	J
3	County	Reporting Period	Number of Requests for Non-DD Children	Number of Approvals for Non-DD Children	Number of Denials for Non-DD Children Due to Requested Documentation	Number of Denials for Non-DD Children Due to Not Meeting Medical Necessity Criteria	Number of Denials for Non-DD Children Due to Other Reasons	Other Denial Reasons for Non-DD Children
4	Kern	Q1 2017	213	208	0	4	1	Non Contracted Provider
5	Kern	Q1 2017	5	5	0	0	0	

Kern Family Health Care Report, 2017Q1
Overall Grievance Volumes, Northern and Southern California Regions

Category	Total All Grievance Types	Coverage Disputes	Disputes Involving Medical Necessity	Quality of Care	Access to Care (including appts.)	Quality of Service	Other
Medi-Cal	*25*	3	1	0	1	20	0
	25	*3*	*1*	*0*	*1*	*20*	*0*

*:
1. Excludes CSI and Self Funding
2. Excludes Withdrawns And Soft Deletes
3. Excludes Level Categories Praise(7), Inquiry(8) and Effectuation (9)

KAISER KHS-SPD Q4 2016 Report
Excel Screen Shot

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	1. SPD Continuity of Care Reporting													
2	A	B	C	D	E	F	G	H	I	J	K	L	M	N
3	Plan Code	Plan Name	County	Reporting Quarter	# of SPD requested Continuity of Care Do not fill	# of approvals	# of in process	# of denials Do not fill in	# of denials based on no link between SPD &	# of denials based on of quality of care issues	# of denials because provider did not accept rate	# of denials because provider refused to work with managed care	# of denials based on other reasons (add note in column N)	Explanation of other reasons
4	303	KERN HEALTH SYSTEMS	Kern	Q4 2016	0	0	0	0	0	0	0	0	0	0

	A	B	C	D	E	F	G	H	I	J
1	2. SPD Grievances & Appeals Summary Reporting									
2	A	B	C	D	E	F	G	H	I	J
3	Plan Code	Plan Name	County	Reporting Quarter	# of SPD physical accessibility related grievances	# of SPD access to primary care related grievances	# of SPD access to specialists related grievances	# of SPD out-of-network related grievances	# of SPD other types of grievances	Overall total of SPD grievances Do not fill in
4	303	KERN HEALTH SYSTEMS	Kern	Q4 2016	0	0	0	2	2	4

KAISER KHS SPD Q1 2017
Excel Screen Shot

	B	C	D	E	F	G	H	I	J	K	L	M	N
1	1. SPD Continuity of Care Reporting												
2	B	C	D	E	F	G	H	I	J	K	L	M	N
3	Plan Name	County	Reporting Quarter	# of SPD requested Continuity of Care Do not fill	# of approvals	# of in process	# of denials Do not fill in	# of denials based on no link between SPD &	# of denials based on of quality of care issues	# of denials because provider did not accept rate	# of denials because provider refused to work with managed care	# of denials based on other reasons (add note in column N)	Explanation of other reasons
4	KERN HEALTH SYSTEMS	Kern	Q1 2017	0	0	0	0	0	0	0	0	0	0

	A	B	C	D	E	F	G	H	I	J
1	2. SPD Grievances & Appeals Summary Reporting									
2	A	B	C	D	E	F	G	H	I	J
3	Plan Code	Plan Name	County	Reporting Quarter	# of SPD physical accessibility related grievances	# of SPD access to primary care related grievances	# of SPD access to specialists related grievances	# of SPD out-of-network related grievances	# of SPD other types of grievances	Overall total of SPD grievances Do not fill in
4	303	KERN HEALTH SYSTEMS	Kern	Q1 2017	0	0	0	1	1	2

Kaiser KHS CBAS Q4 2016
Excel Screen Shot

1. CBAS Services and Assessment Reporting

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
												CBAS Outcome					
Plan Code	Plan Name	County	Reporting Quarter	No. of Requests for CBAS	No. of Members Assessed for CBAS	No. of Members Ineligible to Receive CBAS	No. of Members Received ECM services	No. of Members Provided CBAS	No. of Members Provided Unbundled Services	No. of CBAS Providers	Average # Days Between Request & Notice of Eligibility	Discharged: Death	Discharged: Long-Term Nursing Facility Placement	Discharged: Other Services	Patient Moved Out of Plan	Patient Chose to Leave CBAS	Patient Transferred to Different CBAS Center
303	RN HEALTH SYSTEMS	Kern	Q4 2016	0	0	0	0	0	0	0	0	0	0	0	0	0	0

2. CBAS Grievance Reporting

A	B	C	D	E	F	G	H
Plan Code	Plan Name	County	Reporting Quarter	# of Grievances Regarding CBAS Providers	# of Grievances Regarding Contractor Assessment or Reassessment	# of Grievances Regarding Excessive Travel Times to Access CBAS	# of Other CBAS Grievances
303	KERN HEALTH SYSTEMS	Kern	Q4 2016	0	0	0	0

3. CBAS Appeals Reporting

A	B	C	D	E	F	G	H	I	J	K
				(E+F+G)=(H+I+J+K)			(E+F+G)=(H+I+J+K)			
Plan Code	Plan Name	County	Reporting Quarter	# of CBAS Appeals Approved	# of CBAS Appeals Denied	# of CBAS Appeals Withdrawn	# of Appeals Related to Denials or Limited Services	# of Appeals Related to Denial to See Requested Provider	# of Appeals Regarding Excessive Travel Times to Access CBAS	# of Other CBAS Appeals
303	KERN HEALTH SYSTEMS	Kern	Q4 2016	0	0	0	0	0	0	0

4. CBAS Call Center Complaints Reporting

A	B	C	D	E	F
Plan Code	Plan Name	County	Reporting Quarter	Member Calls	Provider Calls
303	KERN HEALTH SYSTEMS	Kern	Q4 2016	0	0

Kaiser KHS CBAS Q1 2017
Excel Screen Shot

1. CBAS Services and Assessment Reporting																	
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
												CBAS Outcome					
Plan Code	Plan Name	County	Reporting Quarter	No. of Requests for CBAS	No. of Members Assessed for CBAS	No. of Members Ineligible to Receive CBAS	No. of Members Received ECM services	No. of Members Provided CBAS	No. of Members Provided Unbundled Services	No. of CBAS Providers	Average # Days Between Request & Notice of Eligibility	Discharged: Death	Discharged: Long-Term Nursing Facility Placement	Discharged: Other Services	Patient Moved Out of Plan	Patient Chose to Leave CBAS	Patient Transferred to Different CBAS Center
303	KERN HEALTH SYSTEMS	Kern	Q12017	0	0	0	0	0	0	0	0	0	0	0	0	0	0

2. CBAS Grievance Reporting							
A	B	C	D	E	F	G	H
Plan Code	Plan Name	County	Reporting Quarter	# of Grievances Regarding CBAS Providers	# of Grievances Regarding Contractor Assessment or Reassessment	# of Grievances Regarding Excessive Travel Times to Access CBAS	# of Other CBAS Grievances
303	ERN HEALTH SYSTEMS	Kern	Q1 2017	0	0	0	0

3. CBAS Appeals Reporting										
A	B	C	D	E	F	G	H	I	J	K
				(E+F+G)=(H+I+J+K)			(E+F+G)=(H+I+J+K)			
Plan Code	Plan Name	County	Reporting Quarter	# of CBAS Appeals Approved	# of CBAS Appeals Denied	# of CBAS Appeals Withdrawn	# of Appeals Related to Denials or Limited Services	# of Appeals Related to Denial to See Requested Provider	# of Appeals Regarding Excessive Travel Times to Access CBAS	# of Other CBAS Appeals
303	RN HEALTH SYSTEMS	Kern	Q1 2017	0	0	0	0	0	0	0

4. CBAS Call Center Complaints Reporting					
A	B	C	D	E	F
Plan Code	Plan Name	County	Reporting Quarter	Member Calls	Provider Calls
303	ERN HEALTH SYSTEMS	Kern	Q1 2017	0	0

A	B	C	D	E	F	G	H	I	J	K
Plan Name	Reporting Quarter	Number of Calls Received Do not fill in	Number of Calls Abandoned	Number of Calls Answered	Average Wait Time (H:MM:SS)	Average Talk Time (H:MM:SS)	Abandonment Rate = D/C Do not fill in	Service Level (0-100)	Member Only Calls (Y/N)	Medi-Cal Only Calls (Y/N)
KERN HEALTH SYSTEMS	Q1 2017	55796	839	54957	0:00:26	0:07:15	1.5%	84%	Y	Y
KAISER FOUNDATION HEALTH PLAN	Q1 2017	865	3	862	0:02:50	0:05:33	0.3%	65%	N	Y
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Total population health. One person at a time.

Coaching Operations

Health Information Line Summary

February 2017

Contents

I. Scope of Services

Health Dialog Services Corporation is a leading provider of population health management solutions. The company works with third-party payers, employers and providers, to improve the health and wellness of their patients, customers and employees while reducing costs and improving performance in key quality measures, such as NCQA's HEDIS and CMS' Stars ratings. Health Dialog's unique capabilities include data analytics, a multi-media coaching platform, and a 24/7 nurse line.

Through its Health Information Line, Health Dialog provides support across the continuum of services, including:

- Answering questions related to a broad range of health topics, including medications, chronic conditions, and acute ailments.
- Assisting members in applying self-care prior to a visit with their health care provider(s).
- Symptom support and emergent support for common, everyday problems, such as fever, pain, injury, and infection. Health Coaches assist members in determining whether to seek care, and how to obtain care at a level that is appropriate for their condition.

The goals of the Health Information Line are to:

- Establish a connection with the member to begin the coaching interaction:
    - Explore the reason for the inbound call.
- Coach the member:
    - Meet each member where he/she is based on the clinical reason for the call and the individual's current circumstances.
    - Identify coaching opportunities based on the clinical reason for the call and the individual's current circumstances.
    - Guide the member where he/she needs to be for optimal care.
- Protect each member's privacy and confidential health information.

Health Dialog Health Coaches are specially trained healthcare professionals including, but not limited to, registered nurses, dietitians, respiratory therapists, and pharmacists. Members can call a Health Coach at no charge, anytime, 24 hours a day, seven days a week, 365 days a year. Health Dialog provides a TTY/TDD and Relay Service that is also available 24/7. Health Coaches provide decision support using medical information, and healthcare information, but do not diagnose, provide treatment recommendations, screening, or counseling. A Health Coach is not a substitute for a physician. Health Coaches do not provide advice or direct care, but rather education and provide recommendations.

Health Dialog's Health Information Line offers 24/7 access to an online messaging portal. Designated Health Coaches review member-initiated web-based messages and respond within a 24-hour time period via secure messaging. Health Dialog uses reasonable and appropriate safeguards to ensure the confidentiality, integrity, and availability of any health information transmitted electronically, and to protect against any reasonably anticipated threats to the security of such information. Secure messages do not include PHI in the header or the body of the message for security reasons.

II. Health Coaching Process

The Health Coach model is founded on the idea that health care choices should depend on individuals making informed healthcare decisions based on the best clinical evidence and their own values and preferences. The primary goal of Health Coaching is to transfer knowledge and skills in an effort to support and motivate members to become more educated and self-reliant healthcare consumers.

Members may present to a Health Coach on the Health Information Line for a varying level of health or wellness issues:

- A healthy member who is concerned with prevention or a health topic (seeking information).
- A member considering changing his/her lifestyle (behavior change).
- A member who has symptoms and is unsure how to respond (symptom support).
- A member in a decision-making window about treatment options (decision support).
- A member with a diagnosis who is trying to manage the condition by interpreting the treatment plan and adjusting it to his/her lifestyle.
- A member in an urgent situation or crisis who needs directive support (emergency support).

Health Coach Focus

The Health Coach provides personalized coaching which explores and addresses barriers and then strategizes with the member on a collaborative plan.

Health Information Line:

- Provides the safest level of care based on a thorough clinical assessment of symptoms.
- Empowers members to make informed decisions regarding a course of action related to issue.
- Transfers knowledge and skills that may be used in the future.
- Strengthens the member/provider relationship and communication.
- Integrates with client and community programs by referring to services and resources.

Members may present with questions concerning prevention or may be curious about a new development they may have seen in the news. A Health Coach will provide the member with unbiased, evidence-based information they are seeking and explore opportunities to assist members with other healthcare needs or concerns.

A follow-up call may be considered when:

- Coaching a member in an emergent situation.
- During periods of time when client/provider is not available and member may need ongoing support.
- Online materials/resources may be offered to the member.
- Coaching a member experiencing a symptom that indicates a provider intervention.

III. Support for Non-English Speaking Members

Health Dialog Health Coaches provide unbiased, evidence-based information during the coaching process with particular respect for unique support needs such as cultural, ethnic, religious, lifestyle, and healthcare beliefs of the individual. Cultural sensitivity and awareness of unique support needs also extends to those members whose physical status lends to differences such as learning style, visual, auditory, and speech impairments where the standard coaching process may need to be altered to meet the members' needs.

Health Dialog personnel are able to assist all eligible members who call Health Dialog regardless of culture or primary language. Health Dialog employees can access the Certified Languages International for any eligible member who speaks a non-English language. All Health Dialog personnel have access to the Certified Languages International translation service when assisting members.

This service provides over the phone interpretation for over 200 languages, 24 hours a day, seven days a week. Health Dialog has an internal Spanish Line for all clients' Spanish-speaking members to access Monday through Friday from 9:00 am – 11:00 pm EST, 8:00 am – 10:00 pm CST.

IV. Quality Improvement

Health Dialog is committed to achieving and surpassing industry standards for service excellence throughout its clinical and program operations. A continuous quality improvement and process improvement model is supplemented by rigorous quality assurance and quality control reviews.

Health Coaching Effectiveness Overview

Call monitoring

Health Dialog's Quality Management Program incorporates various quality indicators related to listening to Health Coach Calls for monitoring purposes. These indicators are designed and implemented to ensure uniformity in coaching, excellent customer service skills, and inter-rater reliability. Call listening may be done at any time for any coach, both random and planned. Health Dialog's Quality Department, Educators and Managers establish a listening schedule for each Health Coach based on previous call listening scores, tenure as a Health Coach, and stage of skill development. The goal is to review an average of at least two calls per Health Coach per month. Health Coaches achieving a bench marked level of excellence on call listening are monitored on a quarterly basis. Reviewed calls are discussed individually with the Health Coach to review successes and discuss improvement opportunities.

In addition, to support self-learning, a Health Coach may be scheduled to conduct self-call listening as needed. Analysis, comparison against established goals, and identification of improvement opportunities occur at various levels including by individual Health Coach, Health Coach Team or Community and across all Coaching Centers.

Health Dialog Health Coaches document all calls for quality assurance purposes to track the history of all health coaching interactions and to allow for integrated, comprehensive, longitudinal capture of a wide variety of member-level data. Examples of quality indicators include review of feedback from members and client-specific performance targets determined per client contract.

Operational performance

Health Dialog uses the following performance standards to monitor and improve the quality of services delivered:

- Speed of answer
- Abandonment rate
- Block rate
- Response time for secure messaging
- Member satisfaction

In addition Health Dialog's Health Coach Managers review call volume through Health Dialog's Cisco and Comstice telephony technology. When the volume is high, Health Coach Managers are alerted, and are able to redeploy assigned outbound call resources to cover unexpected inbound call activity.

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Total population health. One person at a time.







COACHING OPERATIONS

HEALTH COACH CALL LISTENING REPORT: Q1 2017

Quality Improvement – Call Listening Overview

Health Dialog's Quality Monitoring Program incorporates various quality indicators related to listening to coaching calls to ensure progress to desired call quality. These indicators are designed and implemented to ensure uniformity in coaching, excellent customer service, and inter-rater reliability.

Health Dialog's Quality Monitoring Program offers an objective and robust approach, to more fully measure skills and drive continuous improvement.

All evaluated calls are recorded in the call evaluation application and selected calls are discussed with each Health Coach to review successes and identify improvement strategies. Comparative analysis against established goals and identification of improvement opportunities occur at various levels including:

- *Individual Coach staff*
- *Health Coach community*
- *Client population*
- *Across all Coaching Centers*

Health Dialog includes in its Quality Monitoring Program a call listening and scoring approach that incorporates five distinct sections and within each section the varied skills are assessed. Each metric is scored with the opportunity for the call listener to provide pros and grows to indicate "how well" each skill was performed while promoting effective coaching practices and strategies for improvement.

The team identifies all Health Coaches 'above average' over the prior three months.

- *Once a coach achieves the level of 'above average' or higher on quality monitoring over the prior three months, with no individual unsatisfactory call, the Health Coach will move to quality monitoring of two calls monitored/quarter.*
- *If any coach on quarterly monitoring subsequently receives an unsatisfactory call score or average drops below the level of above average, the coach will revert to two calls monitored/month, to be continued until meets quarterly status with no unsatisfactory call scores.*

Call metrics include the following:

1) **Opening**
    a. *Verify member identity*

b. *State all appropriate disclaimers*
c. *Offer eFulfillment as primary option*

2) Communication

a. *Used standard greeting supported by a warm, friendly tone of voice*
b. *Allowed the member to speak without interruption*
c. *Mirrored and clarified to ensure understanding*
d. *Did not cause the member to repeat themselves unnecessarily*
e. *Made verbal acknowledgements to indicate listening*
f. *Eliminated periods of unexplained silence*
g. *Used an effective tone of voice throughout the call*
h. *Made empathetic statements when appropriate*
i. *Adjusted communication style to accommodate the member*

Maintained control of the call

j. *Did NOT take the member "behind the curtain"*
k. *Maintained professional approach*

3) Assessment/Collaboration

a. *Accurately identified the reason for the call*
b. *Used effective and efficient questioning*
c. *Accurately identified all necessary education opportunities*
d. *Coached on identified opportunities*
e. *Effectively collaborated with member*

4) Knowledge Transfer and Documentation

a. *Gave accurate clinical information*
b. *Gave complete clinical information*
c. *Suggested appropriate client resources*
d. *Sent fulfillment appropriately*
e. *Completely and accurately documented the interaction*

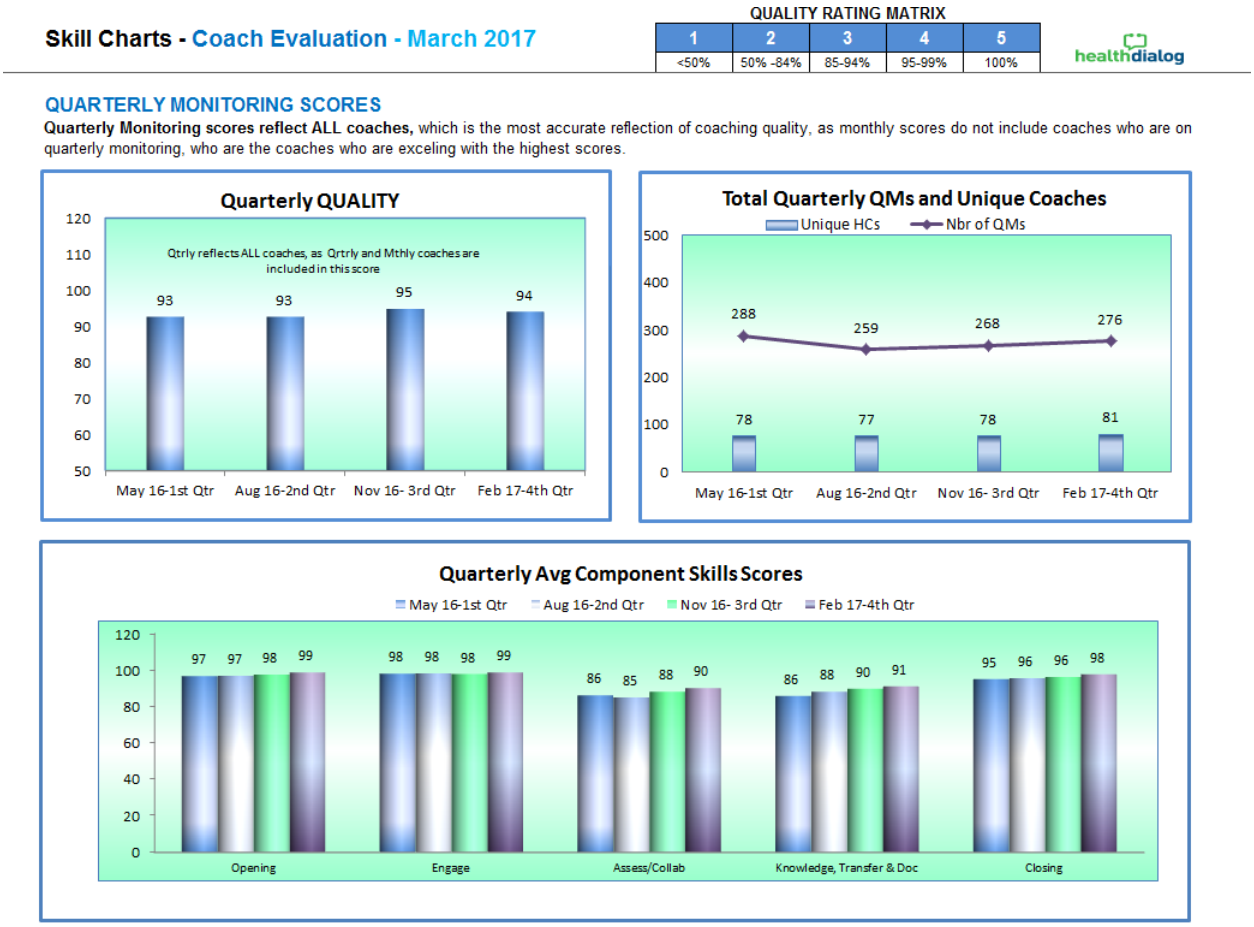
5) Closing

a. *Effectively summarized main points of the call and/or next steps*

b. Scheduled follow-up call when appropriate

c. Used an appropriate closing

Call Quality



Note - Charts updated to reflect Rite Aid Financial Year quarters (previously reflected calendar quarters)

Q1 Action Items

The monthly audit process of 'focused' (as opposed to the 'random' selection of calls for the Quality reviews) call listening and record review of multiple calls/records drilled down to the individual coach, to identify any gaps in documentation and coaching processes with follow up with the individual Health Coach for education/behavior change was continued forQ1.

- *This process includes:*
  - *Particular attention and support provided to the coaches as relates to documentation required for client reporting*
  - *Identification of any process/documentation refinements needed*

- *In Q1 the coach focused Clinical Data Report, drilled down to the individual coach, and focused on clinical, campaign and/or client priorities has been launched with the coaching team giving each manager an opportunity to review the data across their coaching interactions, identifying the clinical coaching completed and pertinent documentation entered.*

- *Over the course of this first quarter, we have continued to monitor, identify opportunities for improvement and make the adjustments with additional training:*
    - *Ongoing reminder resources updated in the coaching application*
    - *Support and clarification given via Email and team meetings*
    - *Focused online 'eLearning' sessions developed and implemented*
- *In collaboration with the Learning and Development team, in Q1, we launched the redesigned team meeting, Monthly Dialog , including;*
    - *eLearning segments addressing professional development focused on the training topics identified from the Health Coach Needs Assessment survey.*

In addition to the interventions and improvements noted above, the following activities occurred to continue skill building and process reinforcement for other categories' scores to remain at high-levels:

- *Quality emails outlining the areas identified above and how the skill is being measured.*
- *Quality tips/demonstrations as a part of the team meetings on areas needing improvement with specifics on how this is being scored.*
- *Monthly team meetings include Quality Team as presenters, using live demonstrations, challenging coaching scenarios, clinical updates/communication tips.*
- *Team managers review the skill gaps individually with each Health Coach.*

Ongoing action items:

- *As needs for particular Health Coach skill development or support for growth have been identified by the Quality Team, mini trainings have been developed and delivered via the monthly team meetings as well as scheduled half-hour to one-hour trainings, supported by individual access to online 'eLearning' trainings.*
- *Results are reviewed with coaching leadership and the education accreditation team for needs assessment, goal identification and staff support focus, with a primary goal to support continuous improvement.*
- *Community Leaders conduct 1:1 coaching sessions with Health Coaches monthly to*

review successes and opportunities in each call listening category.

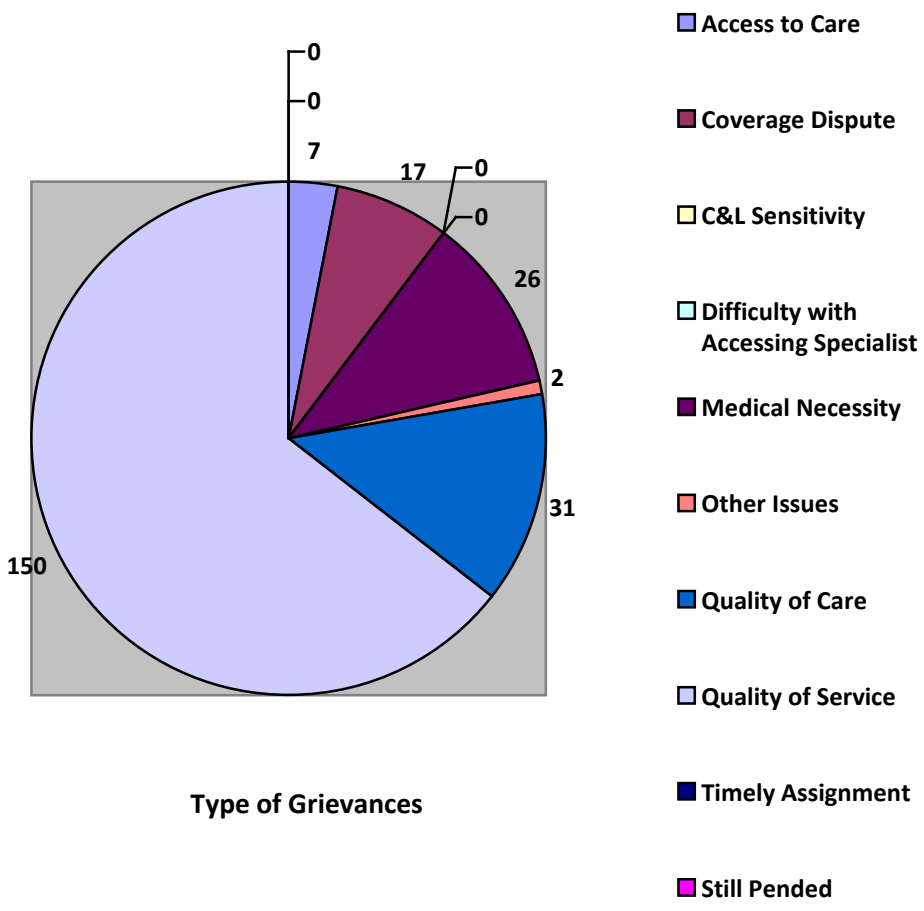
- *Continued refining optimal planning of call listening (random and planned) to assess a Health Coach's progress.*
- *Learning and Development Team participates in leadership/staff feedback sessions as requested to assist with delivery and interpretation of needs and outcomes.*
- *Planned staff training and communication, Intranet information, educational opportunities and community meetings are all in place to offer additional interactive learning opportunities.*
- *Continue to identify and provide focused Health Coach training and support to improve core skills and overall service delivery.*
- *A part of this process has involved email updates as well as time taken during the staff monthly meetings to reinforce 'best practices'.*

2015-2016 COMPARATIVE TABULATED GRIEVANCES

	1st Quarter 2016	1st Quarter 2015	2nd Quarter 2016	2nd Quarter 2015	3rd Quarter 2016	3rd Quarter 2015	4th Quarter 2016	4th Quarter 2015	YTD 2016	YTD 2015
Kern Family Health Care Grievances										
Access to Care (PCP)	8	2	10	5	5	3	7	10	30	20
Access to Care (Specialist)	4	3	5	2	5	1	0	4	14	10
Long Wait Time for Scheduled Appt.	5	0	6	1	5	2	0	4	16	7
Dissatisfied with the Care Received	58	43	82	43	58	81	31	51	229	218
Courtesy and Attitude of Provider	76	66	86	82	117	87	89	66	368	301
Courtesy and Attitude of Staff	35	16	40	38	43	42	18	34	136	130
Courtesy and Attitude of Provider and Staff	30	15	36	32	26	36	43	37	135	120
Referral Not Submitted in a Timely Manner	0	0	0	0	0	0	0	0	0	0
Provider Office Dirty	0	0	0	0	0	0	0	0	0	0
Questioning Denial of a TAR	30	30	23	12	21	19	19	20	93	81
Questioning Denial of a Referral	36	41	39	33	29	27	24	18	128	119
Unhappy with KFHC - P&P (Referral or TAR Process, KFHC Formulary, etc.)	5	0	2	15	0	1	0	0	7	16
24 Hour Nurse On-Call Dissatisfaction	2	0	1	0	0	0	0	1	3	1
Cultural and Lingustic Dissatisfaction	1	1	0	1	1	2	0	1	2	5
Unhappy with Service Received by KFHC Staff Member	2	7	3	11	0	18	0	5	5	41
Other Issue	7	5	15	12	3	9	2	7	27	33
Total Grievances	**299**	**229**	**348**	**287**	**313**	**328**	**233**	**258**	**1193**	**1102**
MCAL (NonSPD) Grievances	**181**	**99**	**164**	**130**	**136**	**228**	**112**	**232**	**593**	**689**
SPD Grievances	**25**	**72**	**80**	**91**	**71**	**97**	**44**	**26**	**220**	**286**
Expansion Grievances	**94**	**58**	**105**	**66**	**107**	**100**	**77**	**80**	**77**	**0**
Cases Found in Favor of the Plan	250	202	285	251	254	267	182	210	971	930
Cases Found in Favor of the Enrollee	49	27	63	36	59	61	51	48	222	172
Pending at the time of report	1	0	1	0	1	0	0	0	3	**0**
Kaiser Permanente Grievances										
Access to Care (PCP)	2	1	1	2	1	0	1	0	0	**3**
Access to Care (Specialist)	0	0	1	0		0	0	0	0	**0**
Long Wait Time for Scheduled Appt.	0	3	0	0		3	2	0	1	**6**
Dissatisfied with the Care Received	3	1	2	2	5	2	2	4	6	**9**
Courtesy and Attitude of Provider	0	0	4	0	3	0	0	0	0	**0**
Courtesy and Attitude of Staff	0	0	2	0	1	0	0	0	0	**0**
Courtesy and Attitude of Provider and Staff	0	12	0	6		5	3	0	7	**23**
Questioning Denial of a TAR	1	0	1	1	1	0	1	0	1	**1**
Questioning Denial of a Referral	1	5	1	2	1	6	1	3	5	**16**
Other Issue	9	3	3	2	1	2	6	1	6	**8**
Total Grievances	**16**	**25**	**15**	**15**	13	**18**	16	8	26	**66**
State Fair Hearings										
Coverage Dispute	3	3	0	1	2	0	1	3	6	7
Medical Necessity	4	4	1	3	4	1	0	3	9	11
Quality of Care	0	0	0	0	0	0	0	1	0	1
Access to Care	0	0	0	0	0	0	0	0	0	0
Quality of Service	0	0	0	1	1	0	0	0	1	1
Other Issues	0	1	0	0	0	0	0	1	0	2
Total	**7**	**8**	**1**	**5**	**7**	**1**	**1**	**0**	**16**	**14**
Cases Found in Favor of the Plan	**2**	**2**	**1**	**5**	**3**	**1**	**1**	**3**	**7**	**11**
Cases Found in Favor of the Enrollee	1	0	0	0	1	0	**0**	0		0
Waiting on Decision or Case not Heard Yet	4	6	2	0	3	0	0	5		11
DMHC Complaints										
Coverage Dispute	0	1	2	2	0	0	0	0	2	3
Medical Necessity	1	2	1	1	0	0	2	1	4	4
Quality of Care	0	0	0	0	0	0	1	0	1	0
Access to Care	0	0	0	0	0	0	0	0	0	0
Quality of Service	0	0	0	0	0	0	0	0	0	0
Other Issues	1	0	0	2	0	1	0	0	1	3
Total	**2**	**3**	**3**	**5**	**0**	**1**	**3**	**0**	**8**	**9**
DMHC Complaints Found in Favor of the Plan	1	1	2	5	0	1	**2**	1	5	8
DMHC Complaints Found in Favor of the Enrollee	1	2	1	0	0	0	1	0	3	2
Decisions Pending at the time of report	0	0	0	0	0	0	0	0	0	0
Independent Medical Reviews										
Delay of Services	0	0	0	1	0	0	0	0	0	1
Modification of Services	0	0	0	1	0	0	0	0	0	1
Denial of Services	3	3	6	1	1	0	2	0	12	4
Total	**3**	**3**	**6**	**3**	**1**	**0**	**2**	**0**	12	6
IMR Cases Found in Favor of the Plan	1	2	3	2	0	0	**1**	0	5	4
IMR Cases Found in Favor of the Enrollee	2	1	3	1	0	0	1	0	6	2
Decisions Pending at the time of report	0	0	0	0	1	0	0	0	1	0
Enrollment Counts vs Grievances Received Per Quarter - Total Enrollment										
Total Enrollment	222,155	192,241	234,266	204,017	238,753	212,733	241,607	216,581		
Grievances per 1,000 Members	1.35	1.19	1.49	1.41	1.32	1.54	0.96	1.19		
Percentage of Grievances	0.135%	0.119%	0.149%	0.141%	0.132%	0.154%	0.096%	0.119%		
Enrollment Counts vs Grievances Received Per Quarter - MCAL (Non SPD) Members										
Total Enrollment	203,985	179,321	220,712	191,061	225,166	203,873	227,973	203,429		
Grievances per 1,000 Members	0.89	0.88	0.74	0.68	0.60	1.61	0.83	1.14		
Percentage of Grievances	0.089%	0.088%	0.074%	0.068%	0.060%	0.161%	0.083%	0.114%		
Enrollment Counts vs Grievances Received Per Quarter - SPD Members										
Total Enrollment	13,453	12,920	13,554	12,956	13,587	13,061	13,634	13,152		
Grievances per 1,000 Members	1.86	5.57	5.90	7.02	5.15	7.42	3.22	1.97		
Percentage of Grievances	0.19%	0.56%	0.59%	0.70%	0.52%	0.74%	0.32%	0.18%		
Enrollment Counts vs Grievances Received Per Quarter - Expansion Members										
Total Enrollment	50,935	32,492	53,316	39,093	54,848	38,310	55,730	47,300		
Grievances per 1,000 Members	1.85	1.79	1.97	1.69	1.95	2.61	1.39	1.69		
Percentage of Grievances	0.19%	0.18%	0.20%	0.17%	0.20%	0.26%	0.14%	0.17%		
Enrollment Counts vs Grievances Received Per Quarter - Kaiser Members										
Total Enrollment	5,542	3,838	6,193	4,606	6,890	4,784	7,103	5,122		
Grievances per 1,000 Members	2.89	6.51	2.42	3.26	1.89	3.76	3.66	1.56		
Percentage of Grievances	0.29%	0.65%	0.24%	0.33%	0.19%	0.38%	0.37%	0.16%		

4th Quarter 2016 Grievance Summary

Issue	Number	In Favor of Health Plan	In Favor of Enrollee
Access to care	7	4	3
Coverage dispute	17	17	0
Cultural and Linguistic Sensitivity	0	0	0
Difficulty with accessing specialists	0	0	0
Medical necessity	26	26	0
Other issues	2	1	1
Quality of care	31	23	8
Quality of service	150	111	39
Timely assignment to provider	0	0	0
Still under review	0	0	0



Type of Grievances

Grievances per 1,000 Members = 0.96

During the fourth quarter of 2016, there were two hundred and thirty three grievances received. Fifty one cases were closed in favor of the Enrollee and one hundred and eighty two were closed in favor of the Plan. Two hundred and twenty nine grievances were closed within thirty days of receipt. There were four grievances not closed within thirty days and had to be pended for

further review. Forty four cases were received from SPD (Seniors and Persons with Disabilities) members. One hundred and seven were received from Medi-Cal Expansion members.

Access to Care

There were seven grievances pertaining to access to care. Four cases closed in favor of the Plan. Three cases closed in favor of the Enrollee. The following is a summary of these issues.

Six members complained about the lack of available appointments with their Primary Care Provider (PCP). Three cases closed in favor of the Plan after the responses indicated the offices provided appropriate access to care based on the Access to Care Standards for PCP appointments. Three cases closed in favor of the Enrollee after the responses indicated the offices did not provide appropriate access to care based on the Access to Care Standards for PCP appointments.

One member complained about the wait time to be seen for a Primary Care Provider (PCP) appointment. The case closed in favor of the Plan after the responses indicated the member was seen within the appropriate wait time for an appointment or the member was there for a walk-in, which are not held to Access to Care wait time protocol.

Coverage Dispute

There were seventeen grievances pertaining to a Coverage Dispute issue. All of the cases closed in favor of the Plan. The following is a summary of these issues:

Fifteen members complained about the denial of a TAR for non-formulary or restricted medications. These cases were found in favor of the Plan. Upon review it was determined that the TARs were appropriately denied as not a covered benefit under the KFHC Drug Formulary.

Two members complained about the denial of a referral authorization request. These cases were closed in favor of the Plan and the decisions were upheld after it was determined that the requests were appropriately denied as the requested services were not a covered benefit or the requested providers were not contracted under KFHC.

Cultural and Linguistic Sensitivity

There were no grievances pertaining to Cultural and Linguistic Sensitivity.

Difficulty with Accessing a Specialist

There were no grievances pertaining to Difficulty Accessing a Specialist.

Medical Necessity

4th Quarter 2016 Grievance Summary

There were twenty six grievances pertaining to Medical Necessity. All of the cases were closed in favor of the Plan.

Twenty two members complained about the denial or modification of a referral authorization request. All of the cases were closed in favor of the Plan as it was determined that there was no supporting documentation submitted with the referral authorization requests to support the criteria for medical necessity of the requested specialist or DME item and the denials were upheld.

Four members complained about the denial of a TAR for a medication. All of the cases closed in favor of the Plan and the denial was upheld after it was determined that there was no supporting documentation submitted with the request that indicated a medical necessity for the requested medication or the step therapy guidelines were not met.

Other Issues

There were two grievances pertaining to Other Issues. One of the cases closed in favor of the Plan. One of the cases closed in favor of the Enrollee. The following is a summary of these issues:

One member complained that he had to go in to his provider's office to obtain refills of his medication and he felt that he should be given more fills of his medications. This case closed in favor of the Plan after it was determined the office asked that member come in for routine appointments due to his medical issues and to follow up on his care.

One member complained that a provider took too long to diagnosis him, which caused him to be off of work longer. This case closed in favor of the Enrollee after it was discovered appropriate care was provided; however, there may have been a miscommunication causing a delay.

Quality of Care

There were thirty one grievances involving Quality of Care issues. Twenty three cases were closed in favor of the Plan. Eight cases were closed in favor of the Enrollee. The following is a summary of these issues:

Eighteen members complained about the quality of care received from a Primary Care Provider (PCP). Twelve cases were closed in favor of the Plan after it was determined that the provider or their staff provided the member with the appropriate care. Six cases were closed in favor of the Enrollee after review of all medical documents and written responses received indicated that appropriate care may not have been provided.

Eight members complained about the quality of care received from a specialty provider. All of these cases were closed in favor of the Plan after review of all medical documents and written responses received indicated that appropriate care was provided.

Four members complained about the quality of care received from the provider or staff with a hospital or urgent care. Three of the cases were closed in favor of the Plan after

review of medical records and written responses received indicated that the members were provided appropriate care. One of the cases closed in favor of the Enrollee after it was determined that the provider or their staff may not have provided the member with the appropriate care.

One member complained about the quality of care received from a pharmacy. This case closed in favor of the Enrollee after it was determined that the provider or their staff may not have provided the member with the appropriate care.

All cases were forwarded to the Quality Improvement (Q.I.) Department for review to determine if further investigation was necessary.

Quality of Service

There were one hundred and fifty grievances pertaining to Quality of Service. One hundred and eleven were closed in favor of the Plan and thirty nine cases were closed in favor of the Enrollee. The following is a summary of these issues:

Eighty nine members complained about the service they received from a provider. Seventy two were closed in favor of the Plan after the written responses were reviewed and it was determined that the service the members received from their providers was appropriate. Seventeen cases were closed in favor of the Enrollee after the written responses were reviewed and showed that the members may not have received the appropriate service from their provider. These cases were sent to PR for Tracking and Trending.

Nineteen members complained about the service they received from a provider and their staff members. Ten cases were closed in favor of the Plan after the written responses were reviewed and it was determined that the service the members received was appropriate. Nine of the cases were closed in favor of the Enrollee after review of the written responses indicated that the members may not have received the appropriate service from the providers and their staff. These cases were sent to PR for Tracking and Trending.

Forty two members complained about the service received from the staff at a health care facility, pharmacy, or provider's office. Twenty nine cases were closed in favor of the Plan after review of the responses indicated that the members received appropriate service at the time of their visits. Thirteen cases were closed in favor of the Enrollee after review of the written response indicated that the members may not have received the appropriate service from the staff at the health care facility, pharmacy or provider's office. These cases were sent to PR for Tracking and Trending.

Timely Assignment to Provider

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

Kaiser Permanente Grievances

4th Quarter 2016 Grievance Summary

During the fourth quarter of 2016, there were twenty six grievances received by KFHC members assigned to Kaiser Permanente. Twenty two cases were closed in favor of the Enrollee and four cases were closed in favor of the Plan.

Access to Care

There was one grievance pertaining to access to care. This case closed in favor of the Enrollee. The following is a summary of this issue.

> One member complained about the excessive wait time to be seen for an appointment. The case closed in favor of the Enrollee.

Coverage Dispute

There was one grievance pertaining to Coverage Dispute issues. This case closed in favor of the Plan. The following is a summary of this issue:

> One member complained that a request for a non-Plan contracted 2nd opinion was not approved. This case found in favor of the Plan as the request is not a covered benefit.

Difficulty Accessing a Specialist

> There were no grievances pertaining to Difficulty Accessing a Specialist.

Medical Necessity

There were five grievances pertaining to Medical Necessity. The following is a summary of these issues:

> Four members complained about services they requested not being approved. Two cases were closed in favor of the Enrollee and services were authorized. Two cases were closed in favor of the Plan as the services requested were not medically necessary.
>
> One member complained about a medication not being approved. This case was closed in favor of the Plan as the medication was found to be not medically necessary.

Quality of Care

There were six grievances pertaining to Quality of Care. Five cases closed in favor of the Enrollees and one case closed in favor of the Plan. The following is a summary of these issues:

> Four members complained about the care they received from their providers or non-clinical staff. Three cases were closed in favor of the Enrollees and one case closed in favor of the Plan.
>
> Two members complained about the facilities being inadequate, not related to an access issue. Both cases closed in favor of the Enrollees.

4th Quarter 2016 Grievance Summary

Quality of Service

There were seven grievances pertaining to Quality of Service. All cases were closed in favor of the Enrollees. The following is a summary of these issues:

Seven members complained about the service they received from their providers or non-clinical staff. All cases were closed in favor of the Enrollees.

Other Issues

There were six grievances pertaining to Other Issues. Four cases were closed in favor of the Enrollees and two were closed in favor of the Plan. The following is a summary of these issues:

Two members complained about operations or policy issues, both cases were closed in favor of the Enrollees.

Two members complained about issues not otherwise specified in the reporting. One case was closed in favor of the Enrollee and the other closed in favor of the Plan.

One member complained about a billing issue. This case was closed in favor of the Plan.

One member complained about a systems or technology issue. This case was closed in favor of the Enrollee.

KERN HEALTH SYSTEMS
1st Quarter 2017
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Report Date: April 3, 2017

Department: Provider Relations

Monitoring Period: January 1, 2017 through March 31, 2017

Population:

Providers	Credentialed	Recredentialed
MD's	34	42
DO's	2	4
AU's	0	0
DC's	0	0
AC's	1	0
PA's	13	5
NP's	18	6
CRNA's	5	1
DPM's	0	1
OD's	4	0
ND's	0	0
BCBA's	5	0
Mental Health	1	0
Ocularist	0	0
Ancillary	10	24
OT	0	0
TOTAL	**93**	**83**

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Acupuncture	1	0	1	0
Allergy & Immunology	0	0	0	0
Anesthesiology / CRNA	8	3	11	0
Audiology	0	0	0	0
Autism / Behavioral Analyst	5	0	5	0
Cardiology	4	2	6	0
Chiropractor	0	0	0	0
Colon & Rectal Surgery	0	0	0	0
Critical Care	0	0	0	0
Dermatology	0	0	0	0
Emergency Medicine	3	0	3	0
Endocrinology	2	1	3	0
Family Practice	17	8	25	0
Gastroenterology	0	1	1	0
General Practice	6	2	8	0
General Surgery	1	1	2	0
Genetics	0	0	0	0
Gynecology	0	0	0	0
Gynecology/Oncology	0	0	0	0
Hematology/Oncology	2	3	5	0
Hospitalist	0	0	0	0
Infectious Disease	0	1	1	0
Internal Medicine	9	8	17	0

KERN HEALTH SYSTEMS
1st Quarter 2017
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Mental Health	1	0	1	0
Mid Wife	0	0	0	0
Naturopathic Medicine	0	0	0	
Neonatology	0	0	0	0
Nephrology	2	2	4	0
Neurological Surgery	1	2	3	0
Neurology	0	2	2	0
Obstetrics & Gynecology	1	5	6	0
Ocularist	0	0	0	0
Occupational Therapy	0	0	0	0
Ophthalmology	0	0	0	0
Optometry	4	0	4	0
Orthopedic Surgery / Hand Surg	0	0	0	0
Otolaryngology	0	0	0	0
Pain Management	3	0	3	0
Pathology	0	2	2	0
Pediatrics	2	8	10	0
Physical Medicine & Rehab	3	0	3	0
Plastic Sugery	1	4	5	0
Podiatry	0	1	1	0
Psychiatry	1	0	1	0
Pulmonary	0	0	0	0
Radiation Oncology	1	0	1	0
Radiology	7	2	9	0
Rheumatology	1	1	2	0
Sleep Medicine	0	0	0	0
Thoracic Surgery	0	0	0	0
Vascular Medicine	0	1	1	0
Vascular Surgery	0	0	0	0
Urology	0	1	1	0
TOTAL	**86**	**61**	**147**	**0**
ANCILLARY				
Ambulance	0	0	0	0
Cardiac Sonography	0	0	0	0
Comm. Based Adult Services	1	0	1	0
Dialysis Center	0	0	0	0
DME	1	1	2	0
Hearing Aid Dispenser	0	0	0	0
Home Health	0	0	0	0
Home Infusion/Compounding	0	0	0	0
Hospice	0	0	0	0
Hospital	0	2	2	0
Laboratory	0	2	2	0
MRI	0	0	0	0
Ocular Prosthetics	0	0	0	0
Pharmacy	5	11	16	0
Pharmacy/DME	0	1	1	0
Physical / Speech Therapy	1	3	4	0

KERN HEALTH SYSTEMS
1st Quarter 2017
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

ANCILLARY				
Prosthetics & Orthotics	0	0	0	0
Radiology	0	1	1	0
Skilled Nursing	0	0	0	0
Sleep Lab	0	1	1	0
Surgery Center	0	2	2	0
Transportation	1	0	1	0
Urgent Care	1	0	1	0
TOTAL	**10**	**24**	**34**	**0**

Defer = 0 **Denied = 0**

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
JANUARY 2017

Name	DBA	Specialty	Address	Comments	Contract Effective Date

JAN BOD was cancelled

All Jan termed contracts will be reported at the Feb BOD.

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
FEBRUARY 9, 2017

Name	DBA	Specialty	Address	Comments	Contract Effective Date
Priority Urgent Care	Same	Urgent Care	4821 Panama Lane #A-C Bakersfield, CA 93313		2/1/2017
Wal-Mart Stores Inc.	Same	Pharmacy	All Kern County Locations	Retro effective date 1/15/2017.	1/15/2017
Rio Bravo Oncolgy Inc	Same	Radiation Oncology	4500 Morning Drive Ste 101 Bakersfield CA 93306	Retro effective date 1/1/2017.	1/1/2017
California Institute of Behavior Analysis Inc	Leafwing Center	ABA	13440 Ventura Ave Ste 200 Sherman Oaks CA 91423		2/1/2017
Bowcor Inc	Special Explorer Center	ABA	401 19th Street Bakersfield CA 93301		2/1/2017
Mosaic Counseling Center	Same	Behavioral Health	1430 Truxun Avenue Bakersfield CA 93301	Retro effective date 2/1/2017.	2/1/2017
Heartwatch Solutions Inc	Heartwatch Solutions Inc	Cardiac Monitoring (Implanted cardiac devices)	9400 Empire State Drive Bakersfield CA 93311	Retro effective date 1/1/2017.	1/1/2017
Adventist Health Medical Center Tehachapi	Adventist Health Medical Center Tehachapi (RHC)	PCP Services	Cal City/Tehachapi/Mojave	Retro effective date 1/1/2017.	1/1/2017
Ridgecrest Medical Transportation	Same	Transportation	1110 West Ridgecrest Blvd. Ridgecrest CA 93555	Retro effective date 2/1/2017.	2/1/2017
Eugene Lin, AC	Chinese Acupuncture of Bakersfield	Acupuncture	1805 27th Street, Bakersfield Ca 93301	Retro effective date 2/1/2017.	2/1/2017
Southern California Orthoedic Institute	SCOI (David Wahba, MD)	Pain Medicine	2400 Bahamas Drive Ste 200 Bakersfield CA 93309	Retro effective date 1/1/2017.	1/1/2017

Kern Health Systems

Board Approved New Providers effective March 1, 2017

NAME	DBA/ADDRESS	Specialty	Provider #	Pay To #	Effective
Arreaza, Hector MD	Clinica Sierra Vista 815 Dr. Martin Luther King Blvd Bakersfield CA 93307	Family Medicine	PRV037064	PRV000002	3/1/2017
Barasch, Eugene MD	Donald E. Cornforth Md Inc 1401 Garces Hwy Delano CA 93215	Radiology, Diagnostic	PRV037069	PRV005447	3/1/2017
Basak, Tina MD	Kern Radiology Medical Group 2301 Bahamas Drive Bakersfield CA 93309	Radiology, Diagnostic	PRV035284	PRV001406 PRV001405 PRV001406 PRV005565	3/1/2017
Blankenship, Clayton NP-C	Centric Health - Priority Care Clinic 3012 Sillect Avenue Ste C Bakersfield CA 93308	Family Medicine	PRV037415	PRV000503	3/1/2017
Chamberlain, William PA-C	Centric Health - Priority Care Clinic 3012 Sillect Avenue Ste C Bakersfield CA 93308	Family Medicine	PRV037416	PRV000503	3/1/2017
Chandy, Valsamma NP-C	Delano Prompt Care Clinic 1201 Jefferson Street Delano CA 93215	General Practice	PRV000975	PRV005653	3/1/2017
Chiquillo Sosa, Rafael MD	Clinica Sierra Vista 301 Brundage Lane Bakersfield CA 93304	Family Medicine	PRV038096	PRV000002	3/1/2017
Cobos, Everado MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	Hematology/Oncology	PRV036725	PRV035424 PRV035423 PRV035553 PRV035425	3/1/2017
Do, Megan DO	Kern County Hospital Authority dba: Kern Medical 1700 Mt Vernon Avenue Bakersfield CA 93307	Cardiovascular Disease	PRV036743	PRV035424 PRV035423 PRV035553 PRV035425	3/1/2017
Fitzpatrick, Megan MD	Kern Radiology Medical Group 2301 Bahamas Drive Bakersfield CA 93309	Diagnostic Radiology	PRV035421	PRV001406 PRV001405 PRV001406 PRV005565	3/1/2017

Kern Health Systems

Board Approved New Providers effective March 1, 2017

Gardiner, Christopher PA-C	Omni Family Health 525 Roberts Lane Bakersfield CA 93308	General Practice	PRV029513	PRV000019	3/1/2017
Hinojosa, Veronica BCBA	Center for Autism & Related Disorders LLC 5300 Lennox Avenue Ste 100 Bakersfield CA 93309	Behavioral Analyst	PRV037063	PRV029341	3/1/2017
Hill, Jasmine NP	William Bichai MD Inc 3900 San Dimas Street Bakersfield CA 93301	Internal Medicine	PRV012696	PRV029341	3/1/2017
Kang, Thomas MD	Accelerated Urgent Care 9500 Stockdale Hwy Ste 100 Bakersfield CA 93311	Family Medicine	PRV036729	PRV032603 PRV033690	3/1/2017
Lin, Yong-Shun (Eugene) AC	Yong-Shun Lin, AC AKA: Eugene Y.S. Lin, AC 1805 17th Street Bakersfield CA 93301	Acupuncture	PRV036707	PRV036707	2/1/2017
Lubbers, John BCBA-D	California Institute of Behavior Analysis Inc dba: LeafWing Center 13440 Ventura Blvd Ste 200 Sherman Oaks CA 914723	Behavioral Analyst	PRV038631	PRV038630	2/1/2017
Luna, Rosa PA-C	Clinica La Victoria 3940 San Dimas Street Bakersfield CA 93301	General Practice	PRV011030	PRV000408 PRV032448 PRV034778	3/1/2017
Magana, Heliodoro PA-C	LAGS Spine & Sportscare Medical Centers 3550 Q Street Ste 201 Bakersfield CA 93301	Pain Management	PRV030975	PRV000403	3/1/2017
Morales, Melba LCSW	Omni Family Health 4600 Panama Lane Ste 102B Bakersfield CA 93313	Clinical Social Worker	PRV034887	PRV000019	3/1/2017
Nichols-Ray, Janice NP-C	West Side Family Health Care 100 E North Street Taft CA 93268	General Practice	PRV001981	PRV000306	3/1/2017
North Chester Community Health Center Pharmacy	Omni - N. Chester Comm. HC Pharmacy 210 N. Chester Avenue Bakersfield CA 93308	Pharmacy	PRV039004	PRV039004	2/1/2017

Kern Health Systems

Board Approved New Providers effective March 1, 2017

Palacios, Fernando MD	Clinica Sierra Vista 8787 Hall Road Lamont CA 93241	Family Medicine	PRV037410	PRV000002	3/1/2017
Pokkamthanam, Suneena PA-C	The Heart Center 5020 Commerce Drive Bakersfield CA 93309	Cardiovascular Disease	PRV038236	PRV000310	3/1/2017
Ridgecrest Medical Transportat	Ridgecrest Medical Transportation 1110 W Ridgecrest Blvd Ridgecrest CA 93555	Non-Emergent Medical Transportation	PRV038589	PRV038589	2/1/2017
Russin, Jonathan MD	Kern County Hospital Authority dba: Kern Medical 1700 Mt Vernon Avenue Bakersfield CA 93306	Neurological Surgery	PRV008219	PRV035424 PRV035423 PRV035553 PRV035425	3/1/2017
Sanchez, Hector NP-C	LAGS Spine & Sportscare Medical Centers 3550 Q Street Ste 201 Bakersfield CA 93301	Pain Management	PRV038850	PRV000403	3/1/2017
Smith, Jessica BCBA	Center for Autism & Related Disorders LLC 5300 Lennox Avenue Ste 100 Bakersfield CA 93309	Behavioral Analyst	PRV037062	PRV032083	3/1/2017
Smith, Pamela NP-C	GMA Healthcre Providers 3838 San Dimas Street Ste B-231 Bakersfield CA 93301	General Surgery	PRV002799	PRV000386	3/1/2017
Tamjidi, Seyed MD	Delano Regional Medical Center 1401 Garces Hwy Delano CA 93215	OB/GYN	PRV006754	PRV000190	3/1/2017
Williams, Preston PA-C	Accelerated Urgent Care 9500 Stockdale Hwy Ste 100 Bakersfield CA 93311	General Practice	PRV036827	PRV032603 PRV033690	3/1/2017
Williams, Trevor PA-C	Centric Health - Priority Care Clinic 3012 Sillect Avenue Ste C Bakersfield CA 93308	Internal Medicine	PRV038720	PRV000503	3/1/2017

Kern Health Systems

Board Approved Providers Effective April 1, 2017

NAME	DBA/ADDRESS	Specialty	Provider #	Pay To #	Effective
Ali, Slamat MD	Nephrology Medical Group of Bakersfield, Inc 5401 White Lane Bakersfield CA 93301	Internal Medicine / Nephrology	PRV037408	PRV000400	4/1/2017
Anugom, Felista NP-C	LAGS Spine & Sportscare Medical Centers 3550 Q Street Ste 201 Bakersfield CA 93301	Physical Med/Rehab	PRV039380	PRV000403	4/1/2017
Arnold, Jeanne NP-C	Comprehensive Medical Group 1230 Jefferson Street Delano CA 93215	Family Medicine	PRV037521	PRV000258	4/1/2017
Ayala, David CRNA	Regional Anesthesia Associates Inc 1700 Mt Vernon Avenue Bakersfield CA 93306	Certified Nurse Anesthetist	PRV037240	PRV037540	4/1/2017
Bell, DeVaughn NP	Clinica Sierra Vista 301 Brundage Lane Bakersfield CA 93304	Family Medicine	PRV037411	PRV000002	4/1/2017
Cartwright, Kenneth MD	Coffee Surgery Center Aka: All Kids Dental 2525 Eye Street Ste 100 Bakersfield CA 93301	Anesthesiology	PRV038281	PRV000369	4/1/2017
Chateau D'Bakersfield	National Mentor Healthcare dba: Chateau D'Bakersfield 824 18th Street Bakersfield CA 93301	CBAS / Adult Day Health Care	PRV038986	PRV038986	3/1/2017
Chaychi, Leila MD	Telehealthdocs Medical Group 2215 Truxtun Avenue Bakersfield CA 93301	Endocrinology	PRV037517	PRV036952	4/1/2017
Cheung, Mark OD	Advanced Center for Eyecare 1721 Westwind Drive Suite B Bakersfield CA 93314	Optometry (See Note)	PRV035907	PRV000314	4/1/2017
CVS Pharmacy (Multiple Locations)	Garfield Beach CVS LLC dba: CVS Pharmacy 1 CVS Drive PO Box 1075 Woonsocket RI 02895 *Additional locations being added: #16160 - 3401 Mall View Road - 93306 #17602 - 11000 Stockdale Hwy - 93311 #17552 - 2901 Ming Ave - 93304 #16723 - 9100 Rosedale Hwy - 93312	Pharmacy	PRV039383 MALL VIEW PRV039383 STOCKDALE PRV039385 MING AVE PRV039386 ROSEDALE	PRV039383 MALL VIEW PRV039383 STOCKDALE PRV039385 MING AVE PRV039386 ROSEDALE	4/1/2017

Kern Health Systems
Board Approved Providers Effective April 1, 2017

Deits, Richard MD	The Heart Center (V. Kumar MD) 5020 Commerce Drive Bakersfield CA 933019	Cardiolgy	PRV038051	PRV000310	4/1/2017
Gearhart, Diane NP	Clinica Sierra Vista 2400 Wible Road Ste 14 Bakersfield CA 93304	Family Medicine / Pediatrics	PRV037409	PRV000002	4/1/2017
Graziano, Sabrina OD	BeSpectacled Eye Care Optometric Corp. 5603 Auburn Street Ste A Bakersfield CA 93306	Optometry (See Comments)	PRV038806	PRV039299	3/1/2017
Hacker, Mark PA-C	Clinica Sierra Vista 815 Dr Martin Luther King Blvd Bakersfield CA 93307	Family Medicine	PRV037522	PRV000002	4/1/2017
Hasan, Mohamed MD	Delano Prompt Care Clinic 1201 Jefferson Delano CA 93215	Pediatrics (Specialist)	PRV030943	PRV005653	4/1/2017
Hernandez, Priscila BCBA	Center for Autism & Related Disorders LLC 5300 Lennox Avenue Ste 100 Bakersfield CA 93309	Behavioral Analyst	PRV037061	PRV032083	4/1/2017
Juve, John CRNA	Regional Anesthesia Associates Inc 1700 Mt Vernon Avenue Bakersfield CA 93306	Certified Nurse Anesthetist	PRV000726	PRV037540	4/1/2017
Lavalle, Peter MD	LAGS Spine & Sportscare Medical Centers 3550 Q Street Ste 201 Bakersfield CA 93301	Psychiatry	PRV039372	PRV000403	4/1/2017
Madrilejo, Nelson MD	Centennial Medical Group 1801 16th Street Ste A Bakersfield CA 93301	Endocrinology	PRV009006	PRV032371	3/1/2017
Miura, Hiroko CRNA	Valley Anesthesia Associates 2615 Eye Street (SJCH) Bakersfield CA 93301	Certified Nurse Anesthetist	PRV003800	PRV000376	4/1/2017
Motarjem, Pejman MD	Kern Radiology Medical Group 2301 Bahamas Drive Bakersfield CA 93309	Radiology, Diagnostic	PRV036770	PRV005565 PRV001406 PRV001405 PRV029441	4/1/2017
Ng, Eileen OD	Advanced Center for Eyecare 1721 Westwind Drive Suite B Bakersfield CA 93314	Optometry (See Note)	PRV036058	PRV000314	4/1/2017
Oji, Oji MD	Regional Anesthesia Associates Inc 1700 Mt Vernon Avenue Bakersfield CA 93306	Anesthesiology	PRV037706	PRV037540	4/1/2017
Okonkwo, Christiana NP-C	LAGS Spine & Sportscare Medical Centers 3550 Q Street Ste 201 Bakersfield CA 93301	Physical Medicine/Rehab	PRV039373	PRV000403	4/1/2017

Kern Health Systems
Board Approved Providers Effective April 1, 2017

Patton, Wendell MD	Grossman Medical Group Inc 420 34th Street Bakersfield CA 93301	Plastic/Hand Surgery	PRV037407	PRV000405	4/1/2017
Presores, Glenn NP-C	Omni Family Health 210 North Chester Avenue Bakersfield CA 93308	Internal Medicine / Pediatrics	PRV037554	PRV000019	4/1/2017
Redlich, Robert MD	Renaissance Imaging Medical Group 1600 West Avenue J Lancaster CA 93534	Diagnostic Radiology	PRV039382	PRV000324	4/1/2017
Robles, Rolando MD	Omni Family Health 210 N Chester Avenue Bakersfield CA 93308	Family Medicine	PRV038097	PRV000019	4/1/2017
Schroeder, Alicia NP-C	Omni Family Health 161 N Mill Street Tehachapi CA 93561	Family Medicine	PRV036726	PRV000019	4/1/2017
Torres, Joe NP-C	Delano Prompt Care Clinic 1201 Jefferson Delano CA 93215	Internal Medicine (Specialist)	PRV036731	PRV005653 DELANO PRV005640 WASCO	4/1/2017
Vo, Quang MD	Telehealthdocs Medical Group 2215 Truxtun Avenue Bakersfield CA 93301	Rheumatology	PRV037516	PRV036952	4/1/2017
Wang, Kevin OD	Advanced Center for Eyecare 1721 Westwind Drive Suite B Bakersfield CA 93314	Optometry (See Note)	PRV038193	PRV000314	4/1/2017
White, Barbara CRNA	Regional Anesthesia Associates Inc 1700 Mt Vernon Avenue Bakersfield CA 93306	Certified Nurse Anesthetist	PRV034497	PRV037540	4/1/2017
Williams, John CRNA	Regional Anesthesia Associates Inc 1700 Mt Vernon Avenue Bakersfield CA 93306	Certified Nurse Anesthetist	PRV037813	PRV037540	4/1/2017
Williford, Jason PA-C	LAGS Spine & Sportscare Medical Centers 3550 Q Street Ste 201 Bakersfield CA 93301	Physical Med/Rehab & Pain Medicine	PRV039381	PRV000403	4/1/2017
JN Cooper Physical Therapy, Inc	JN Cooper Physical Therapy, Inc 142 E Tulare Avenue Shafter CA 93263	Physical Therapy	PRV031625	PRV031625	4/1/2017

KERN HEALTH SYSTEMS

AFTER HOURS CALLS RESULTS

2017 - Quarter 1

Provider Relations Department

AFTER HOURS CALLS SURVEY

Q1, 2017

KERN HEALTH SYSTEMS

Introduction

As required by 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:

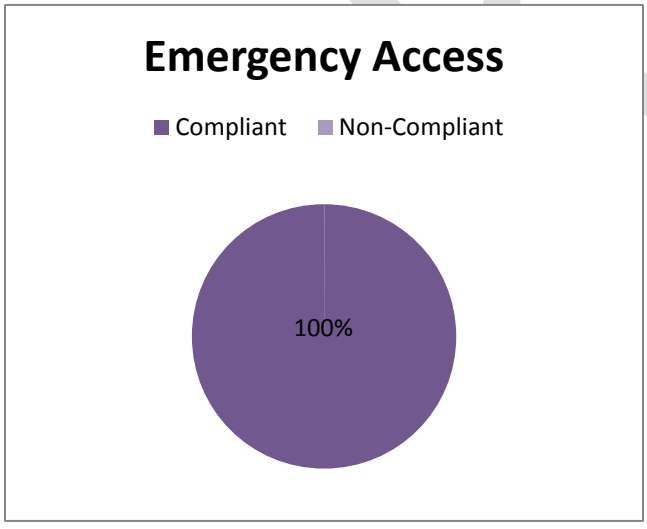
1.) Provider's answering machine or answering service must instruct the member to call 911 if the purpose of the call is a medical emergency.

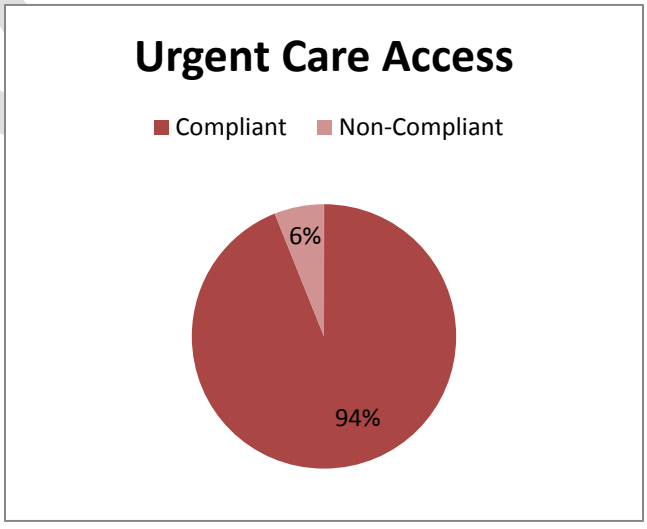
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

Survey was conducted by Health Dialog. Results are to be reported to the KHS QI/UM Committees and to Executive Staff.

Results

115 provider offices were contacted during Q1. Of those offices, 115 were compliant with the Emergency Access Standards and 108 were compliant with the Urgent Care Access Standards.





AFTER HOURS CALLS SURVEY

Q1, 2017

Trending

As this is the first time KHS has used the new vendor, Health Dialog, trending will be provided with Q2 results.

Follow –Up / Outreach / Training

Thank you letters will be sent to the providers who are in compliance with KHS standards and policies.

Notices and copies of the policy will be mailed to the providers who were found to be out of compliance this quarter. Provider Relations Representatives will also follow up with a visit or phone call to answer any questions.

Out of Compliance Providers:

Ashmead Ali, MD (Urgent Care Access Standards)

Clinica La Victoria – San Dimas (Urgent Care Access Standards)

Clinica La Victoria – White Lane (Urgent Care Access Standards)

Clinica La Victoria – Delano (Urgent Care Access Standards)

Harjeet Singh, MD (Urgent Care Access Standards)

Northeast Walk-In Clinic (Urgent Care Access Standards)

Ridgecrest Regional Hospital RHC (Urgent Care Access Standards)

KERN HEALTH SYSTEMS

APPOINTMENT AVAILABILITY SURVEY RESULTS

2017 - Quarter 1

Provider Relations Department

APPOINTMENT AVAILABILITY SURVEY

Q1, 2017

Introduction

As required by the Department of Health Care Services (DHCS) and Title 28 CCR Section 1300.67.2.2, Kern Health Systems (KHS) uses an appointment availability survey to assess compliance with access standards for Kern Family Health Care (KFHC) Members.

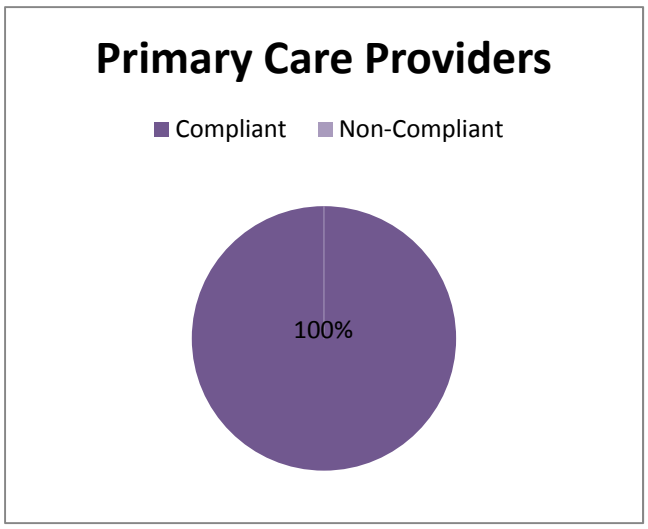
KHS policy and Department regulation require that members must be offered appointments within the following timeframes:

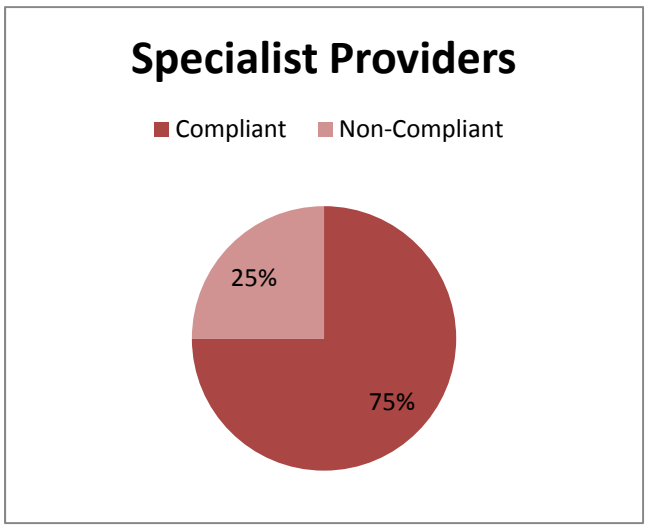
1) Non-urgent primary care appointments – within ten (10) business days of request.
2) Appointment with a specialist – within 15 business days of request;

The survey was conducted internally by KHS staff and utilized the DHCS survey methodology, basing appointment results on the third available appointment offered. Results are to be reported to the KHS QI/UM Committees and to Executive Staff.

Results

A random sample of 15 provider offices and 15 specialist offices were contacted during Q1. Of the 15 primary care providers surveyed, all 15 were compliant with the non-urgent primary care appointment within 10 business day standard. Of the 15 specialist providers surveyed, 10 were compliant with the specialist appointment within 15 business day standard, 4 were non-compliant with the standard, and 1 did not answer or have adequate messaging, which KHS considers non-compliant.





APPOINTMENT AVAILABILITY SURVEY

Q1, 2017

Follow –Up / Outreach / Training

Notices of non-compliance with applicable policy language were delivered to the 4 non-compliant providers via a Provider Relations Representative office visit; phone call out reach was made to the provider office who did not answer. Providers who were found to be out of compliance this quarter will be included in future appointment availability surveys for further monitoring.

Out of Compliance Providers:

Leonard Perez, MD - Kern Women's Health Group (Specialist Appointment within 15 days)

Dilsner Dhoot, MD - California Retina Consultants (Specialist Appointment within 15 days)

Arvind Shad, MD - San Joaquin Valley Pulmonary Medical Group (Specialist Appointment within 15 days)

Bryon Mui, MD – Bryon Mui, MD, A Medical Corporation (Specialist Appointment within 15 days)

Jennifer Lee, DPM - The Heart Center (Specialist Appointment within 15 days)*
**Provider office did not answer.*

KERN HEALTH SYSTEMS
DISEASE MANAGEMENT DEPARTMENT QUARTERLY REPORT

Report Date: January 17, 2017

Reporting Period: October 1, 2016 – December 31, 2016

DISEASE MANAGEMENT DEPARTMENT OVERVIEW:

Disease Management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant variables in achievement of desirable outcomes. Disease Management supports the physician or practitioner/member relationship and plan of care; emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines, and member empowerment strategies, and; evaluates clinical, humanistic, and economic outcomes.

The Disease Management Department performs assessments, coordinates care, monitors and evaluates medical services for members with an emphasis on quality of care, continuity of services, and cost-effectiveness. The three program areas of the Disease Management Department are Diabetes and Hypertension, Asthma and High Risk Pregnancies.

Disease Management Department Staffing:

Position	Quantity
Disease Management RN	2
Disease Management SSC's	4

Case Manager RN Caseload:

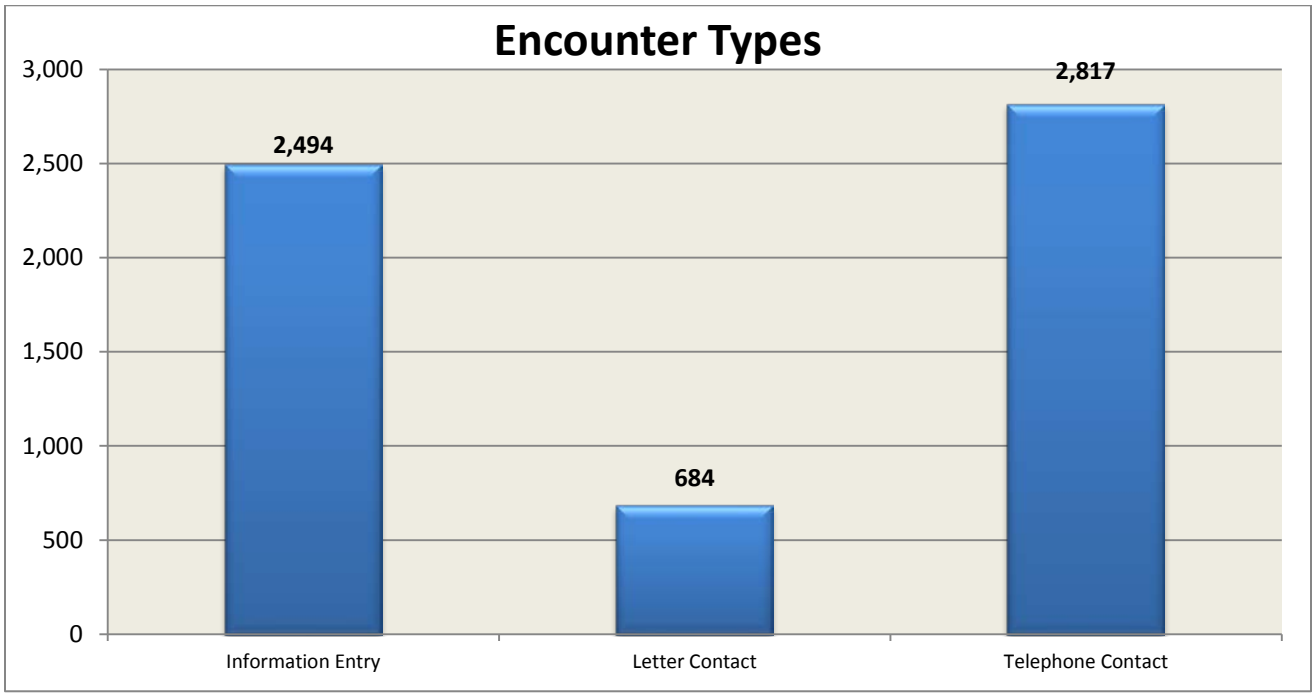
Staff	Caseload
RN 1	150
RN 2	133
RN 3	0
RN 4	0
TOTAL	**283**

DM Program Caseload:

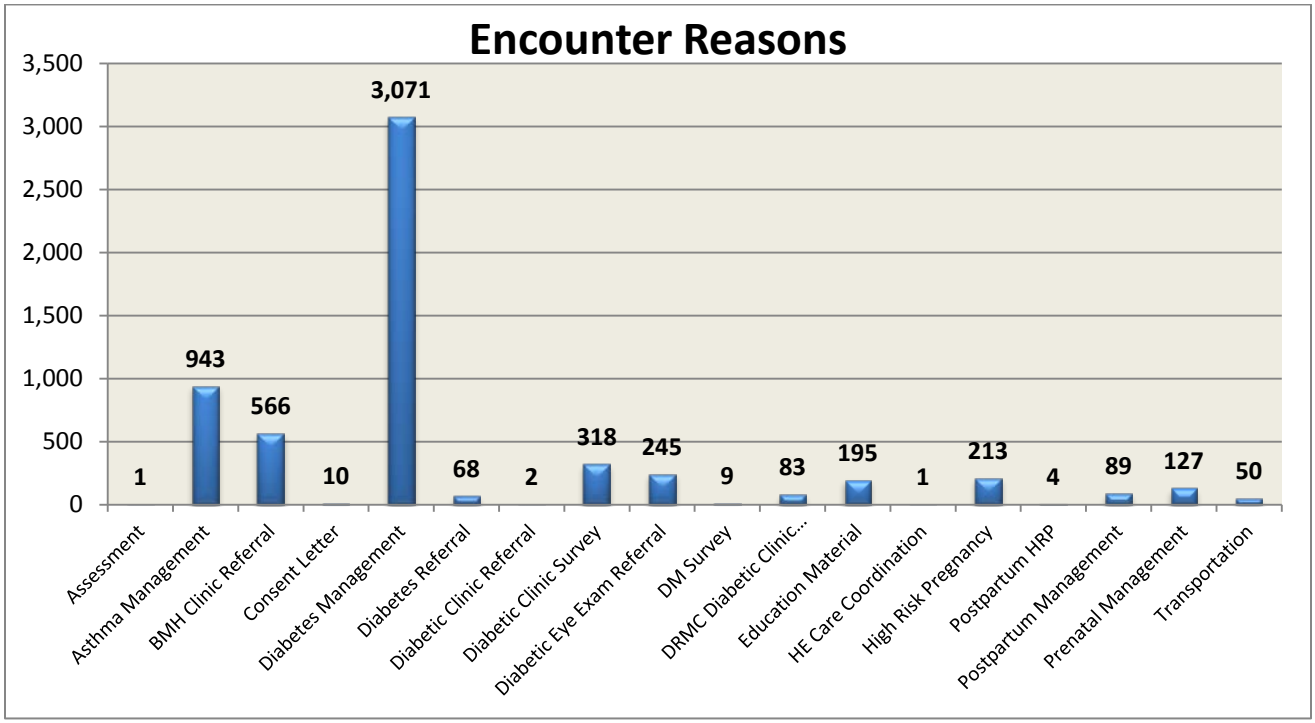
DM Program	Caseload
Asthma	96
Diabetes and Hypertension	167
High Risk Pregnancy	20
TOTAL	**283**

Encounters:

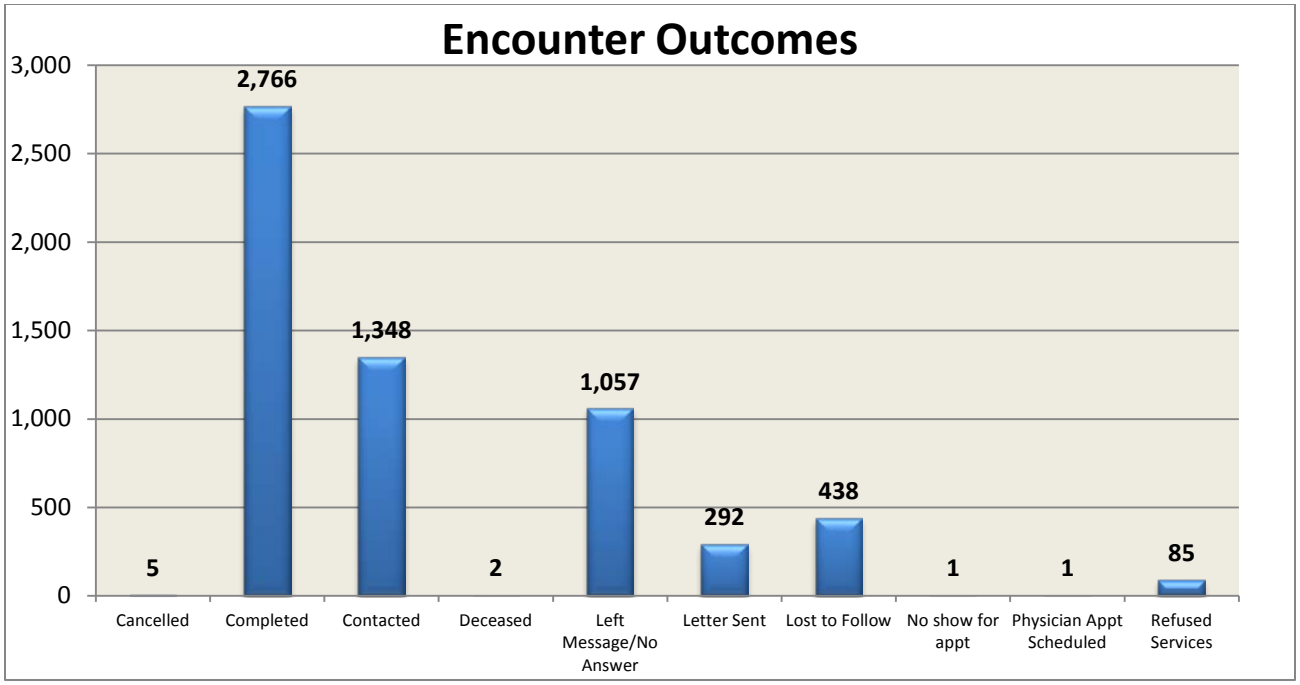
There were a total of 5,995 encounters submitted during this quarter for 1,790 KFHC members and the majority of the encounter types were listed as a Telephone Contact at 47%.



The majority of the encounter reasons at 51% was listed as Diabetes Management.

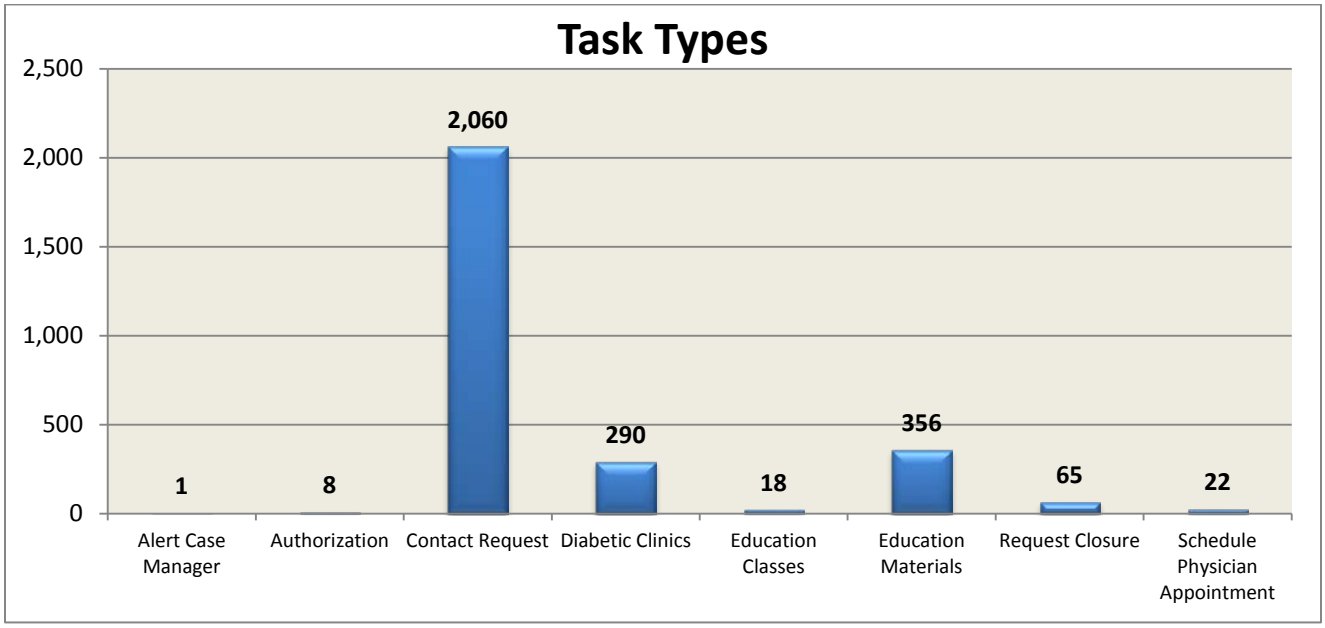


The majority of the encounter outcomes at 46% are listed as completed.

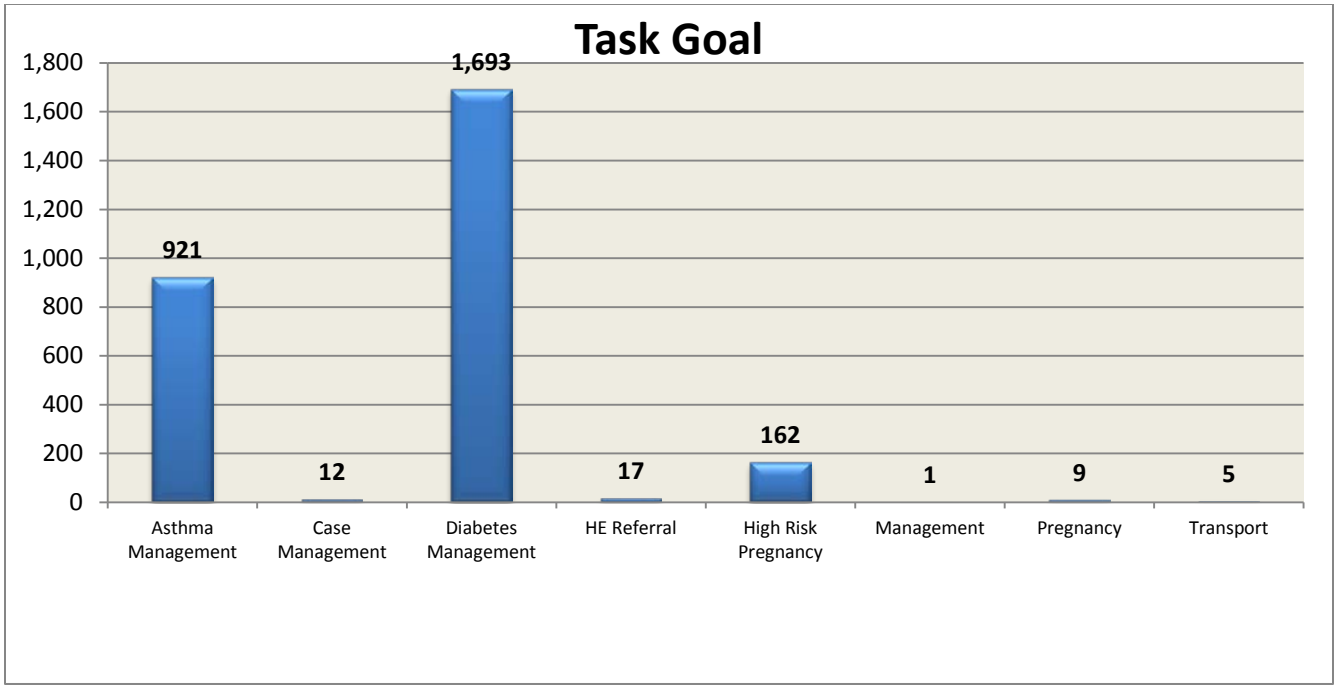


Tasks:

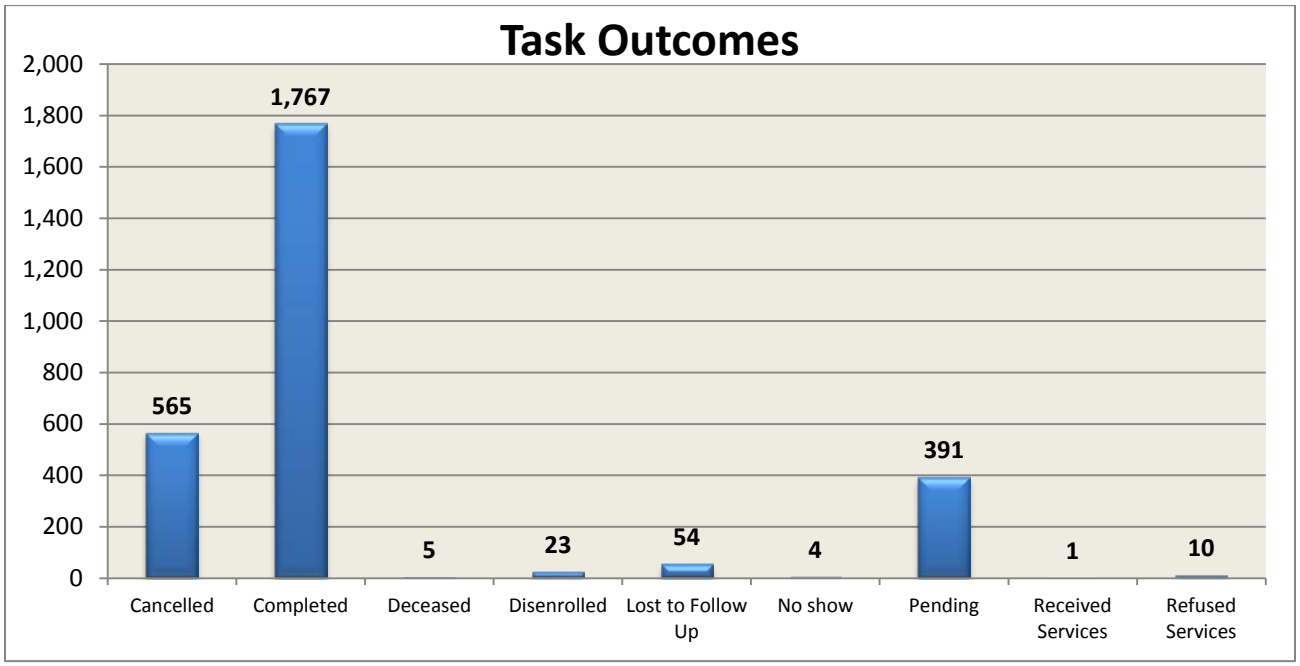
There were a total of 2,820 tasks assigned to the Disease Management department during the quarter for 1,343 KFHC members. The majority of Task Types were Contact Request at 73%.



The majority of task goals at 60% was listed as Diabetes Management.

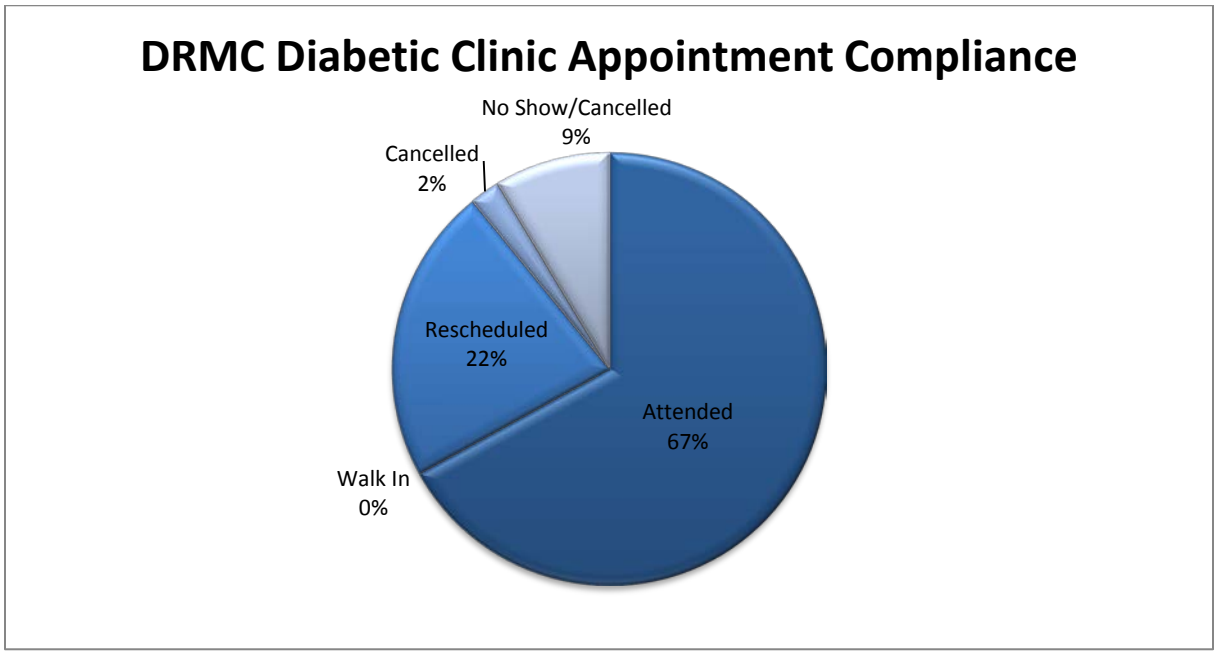


The majority of the task outcomes at 63% are completed.



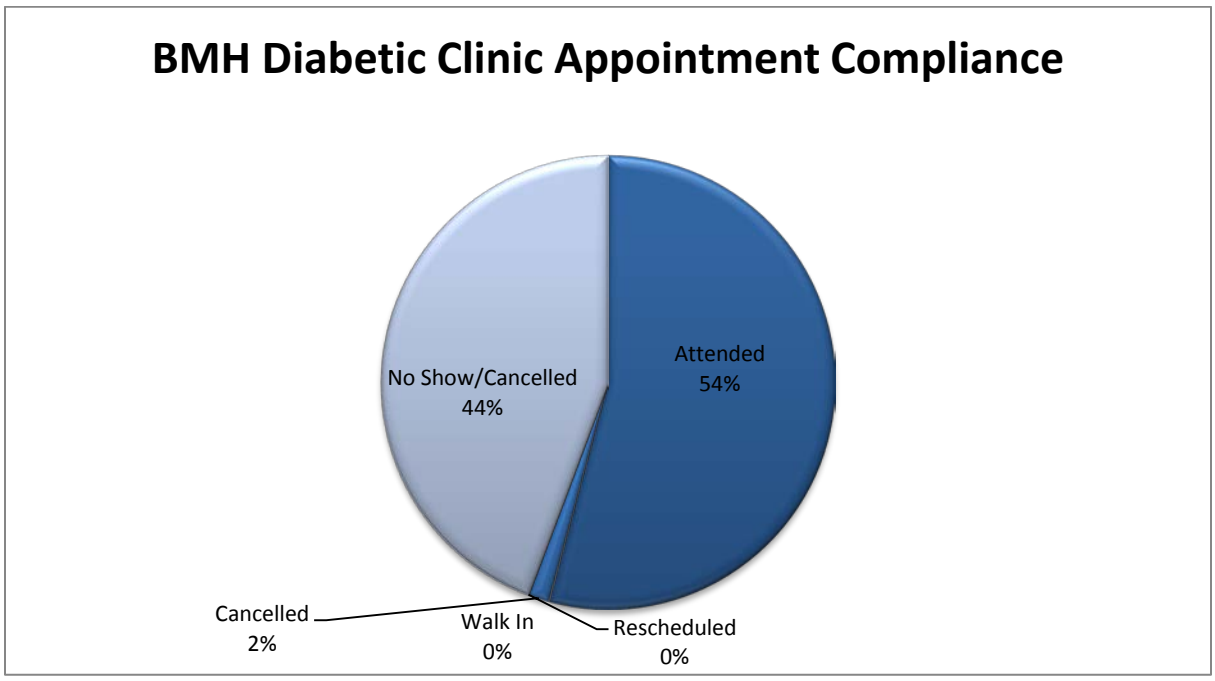
Delano Regional Medical Center (DRMC) Diabetic Clinic

Appointment compliance at the DRMC Diabetic Clinic revealed 67% of members attended their scheduled appointment.



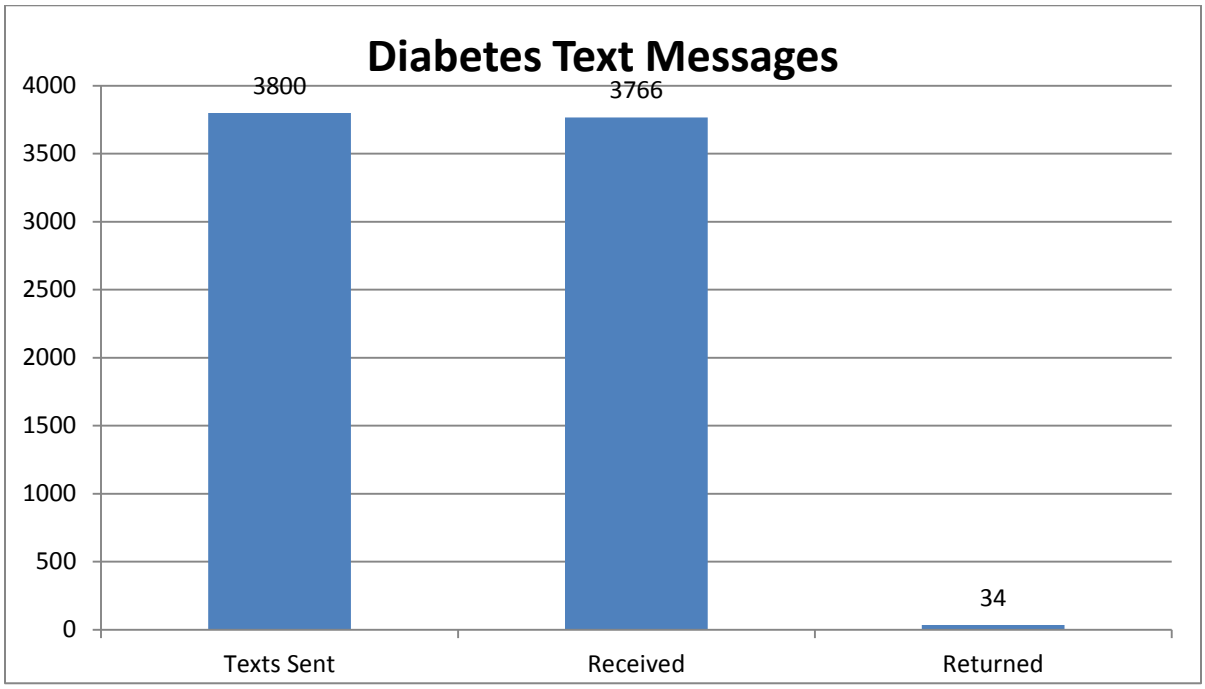
Bakersfield Memorial Hospital (BMH) Diabetic Clinic

Appointment compliance at the BMH Diabetic Clinic revealed 54% of members attended their scheduled appointment.



Diabetes Text Messaging Program

Twelve diabetes related text messages, totaling 3,800, were sent to members during this quarter. 99% of those messages were successfully received by the members.



Propeller Asthma Management Pilot

KHS' Disease Management Department and Dignity Health have partnered with Propeller Health to pilot a digital asthma management program for 20 KHS members with asthma. Through the use of medication sensors, mobile applications and an online dashboard, KHS is able to track the frequency of the controller and rescue asthma inhalers used by each participating member, receive email notifications when a member is identified as in poor control of his/her asthma and identify the geographic location of where the member used their medication (smartphone enrolled members only). Members do not need internet access or a smartphone to participate. By the end of this quarter, 15 members are actively engaged in this pilot and are sending data to the online patient health dashboard hosted by Propeller Health.

Automated Reminder Calls

KHS sends automated reminder calls to members in need of completing specific health actions. During this quarter, there were no automated reminder calls sent with regards to diabetes related screenings.

KERN HEALTH SYSTEMS
DISEASE MANAGEMENT DEPARTMENT QUARTERLY REPORT

Report Date: April 12, 2017

Reporting Period: January 1, 2017 – March 31, 2017

DISEASE MANAGEMENT DEPARTMENT OVERVIEW:

Disease Management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant variables in achievement of desirable outcomes. Disease Management supports the physician or practitioner/member relationship and plan of care; emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines, and member empowerment strategies, and; evaluates clinical, humanistic, and economic outcomes.

The Disease Management Department performs assessments, coordinates care, monitors and evaluates medical services for members with an emphasis on quality of care, continuity of services, and cost-effectiveness. The three program areas of the Disease Management Department are Diabetes and Hypertension, Asthma and High Risk Pregnancies.

Disease Management Department Staffing:

Position	Quantity
Disease Management RN	4
Disease Management SSC's	4

Case Manager RN Caseload:

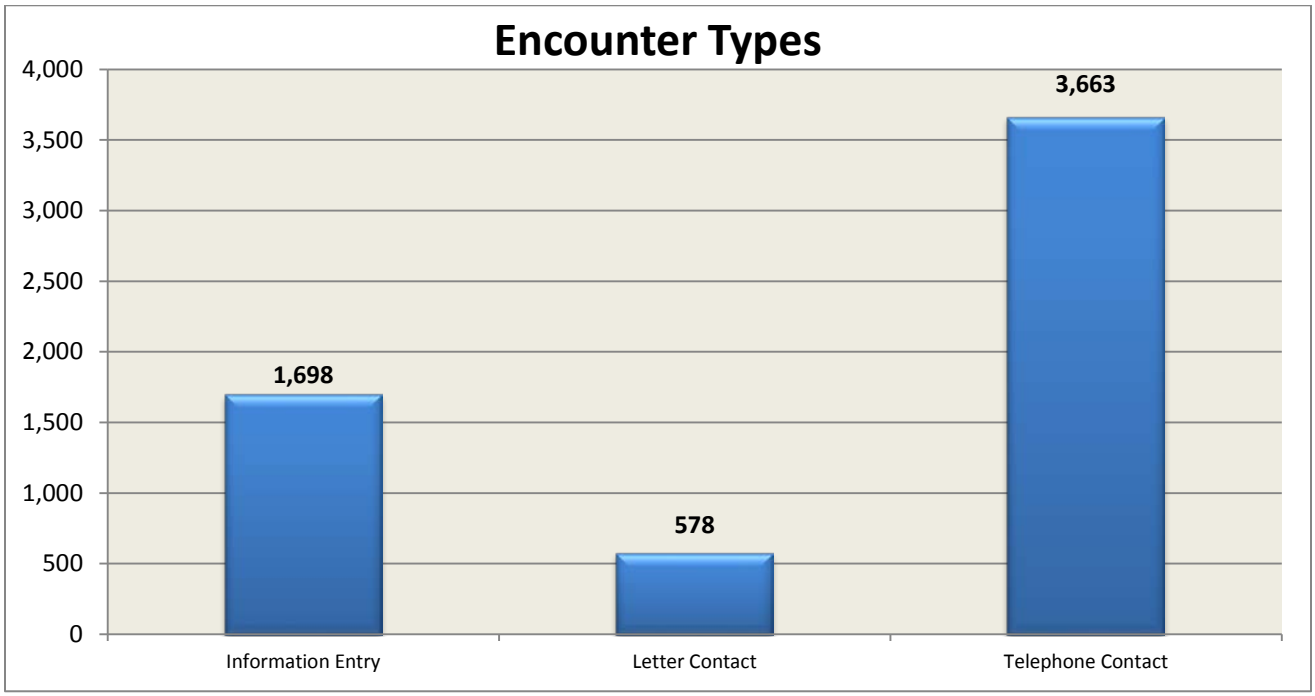
Staff	Caseload
RN 1	160
RN 2	135
RN 3	50
RN 4	12
TOTAL	**357**

DM Program Caseload:

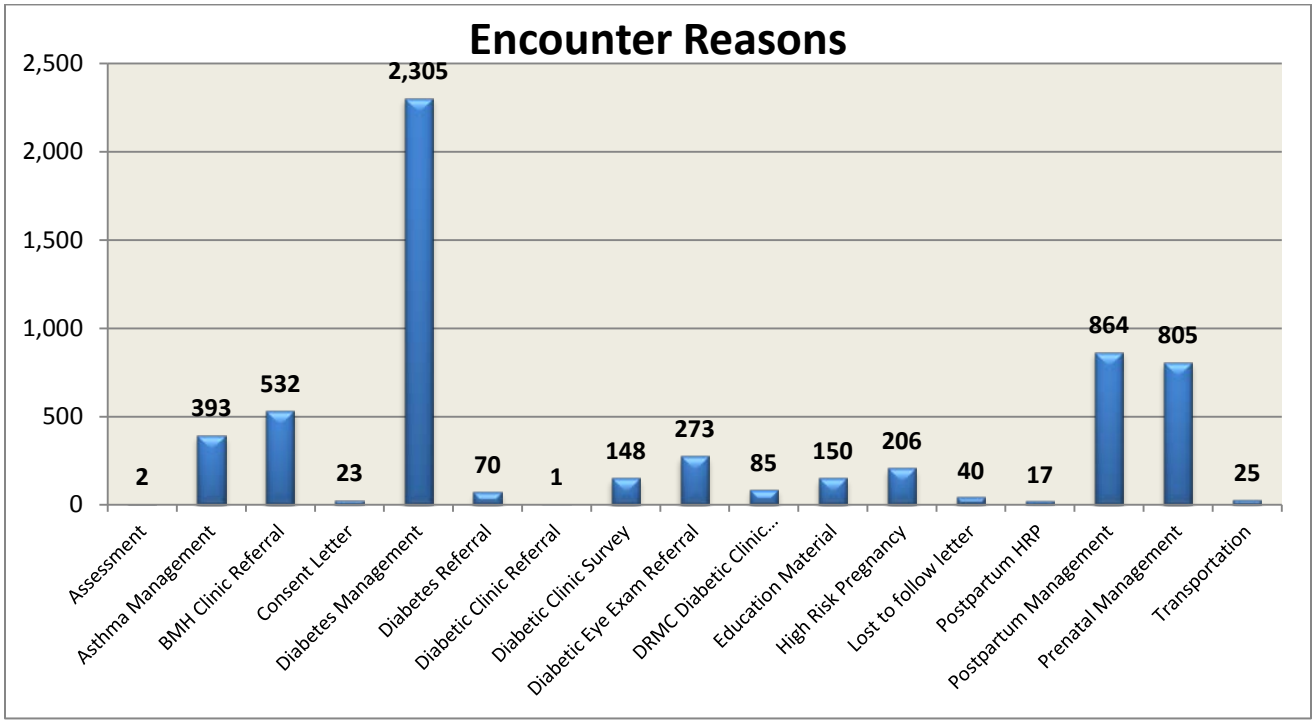
DM Program	Caseload
Asthma	94
Diabetes and Hypertension	232
High Risk Pregnancy	31
TOTAL	**357**

Encounters:

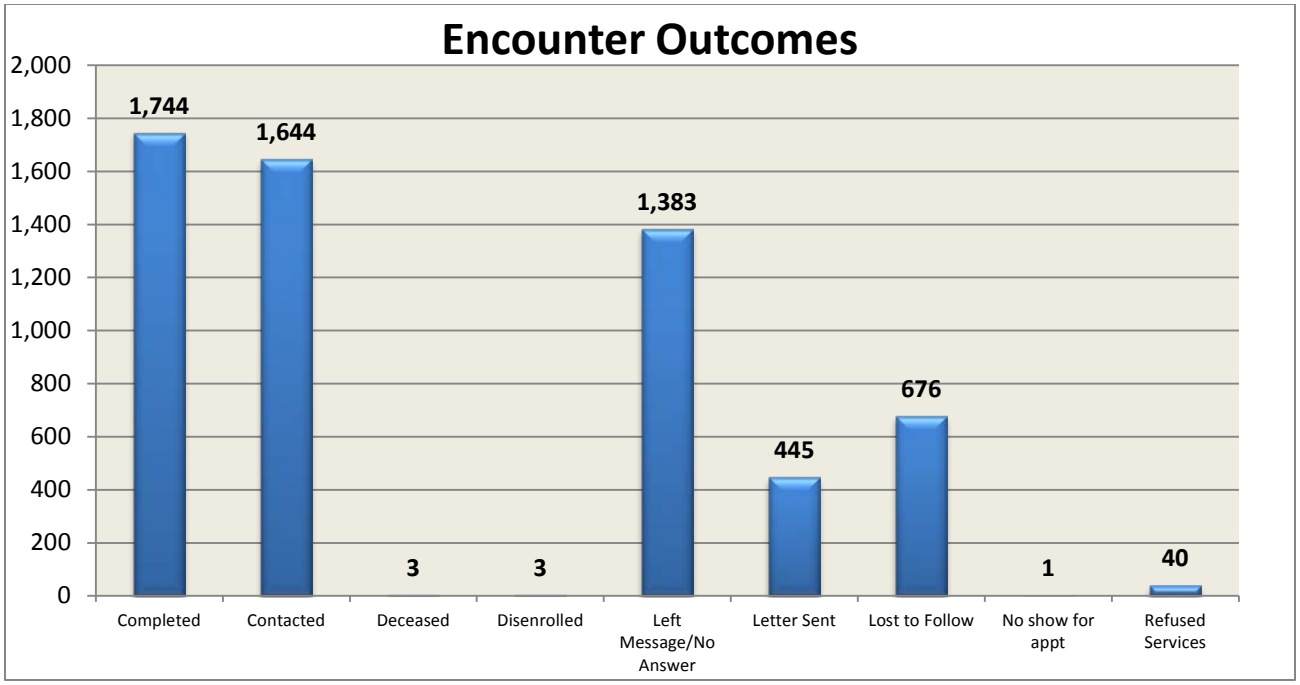
There were a total of 5,939 encounters submitted during this quarter for 1,989 KFHC members and the majority of the encounter types were listed as a Telephone Contact at 62%.



The majority of the encounter reasons at 39% was listed as Diabetes Management.

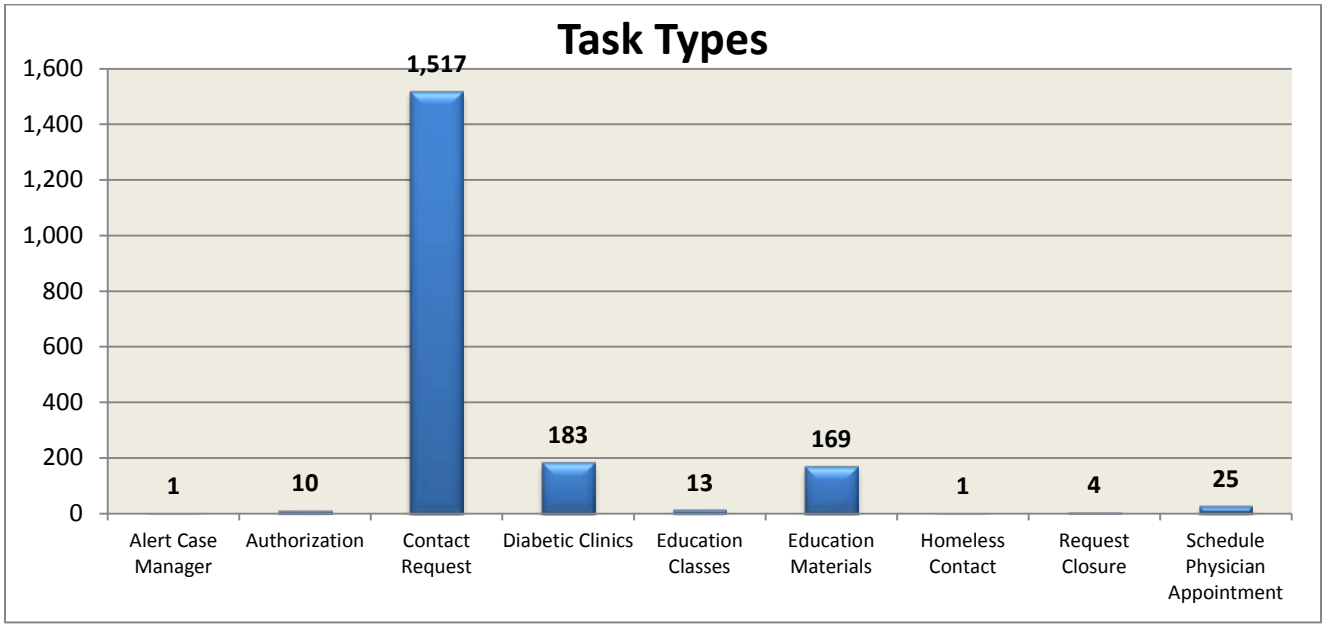


The majority of the encounter outcomes at 29% are listed as completed.

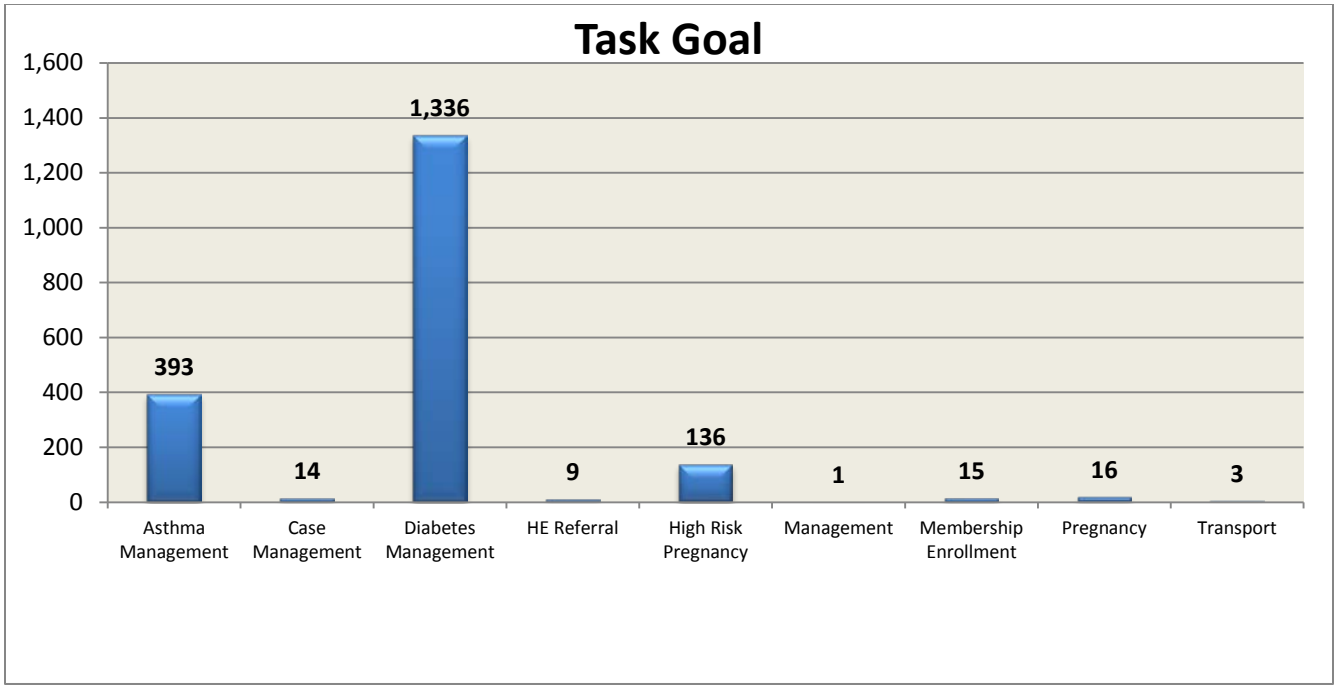


Tasks:

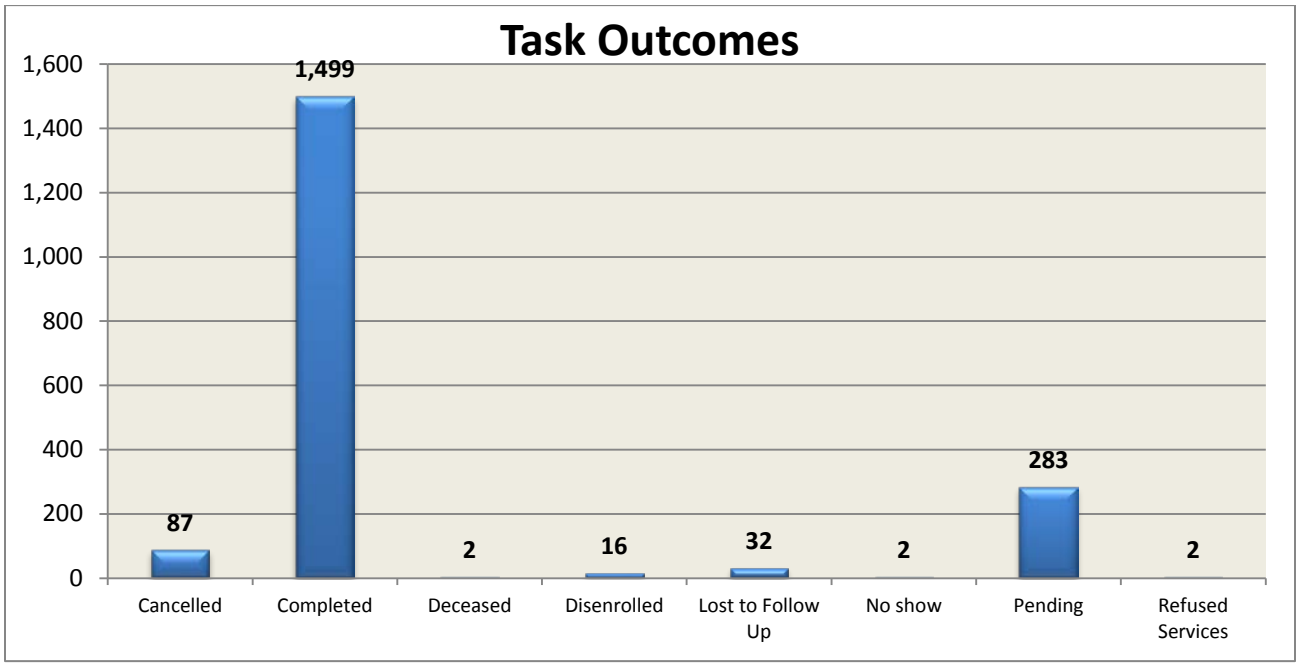
There were a total of 1,923 tasks assigned to the Disease Management department during the quarter for 896 KFHC members. The majority of Task Types were Contact Request at 79%.



The majority of task goals at 69% was listed as Diabetes Management.

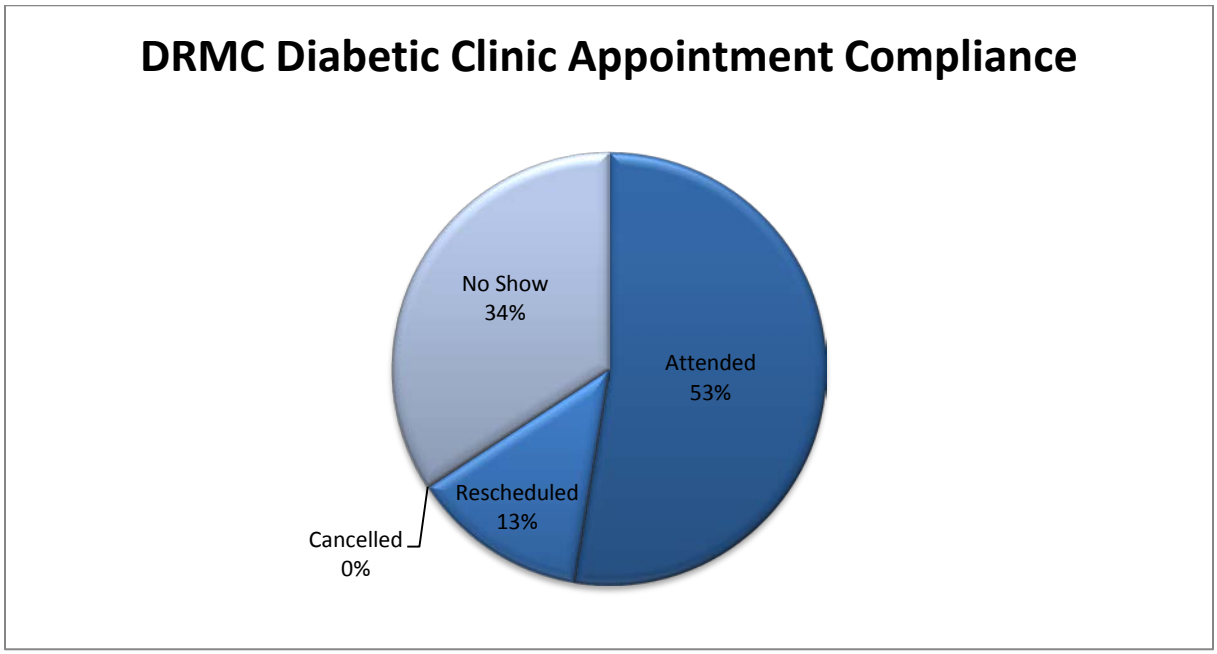


The majority of the task outcomes at 78% are completed.



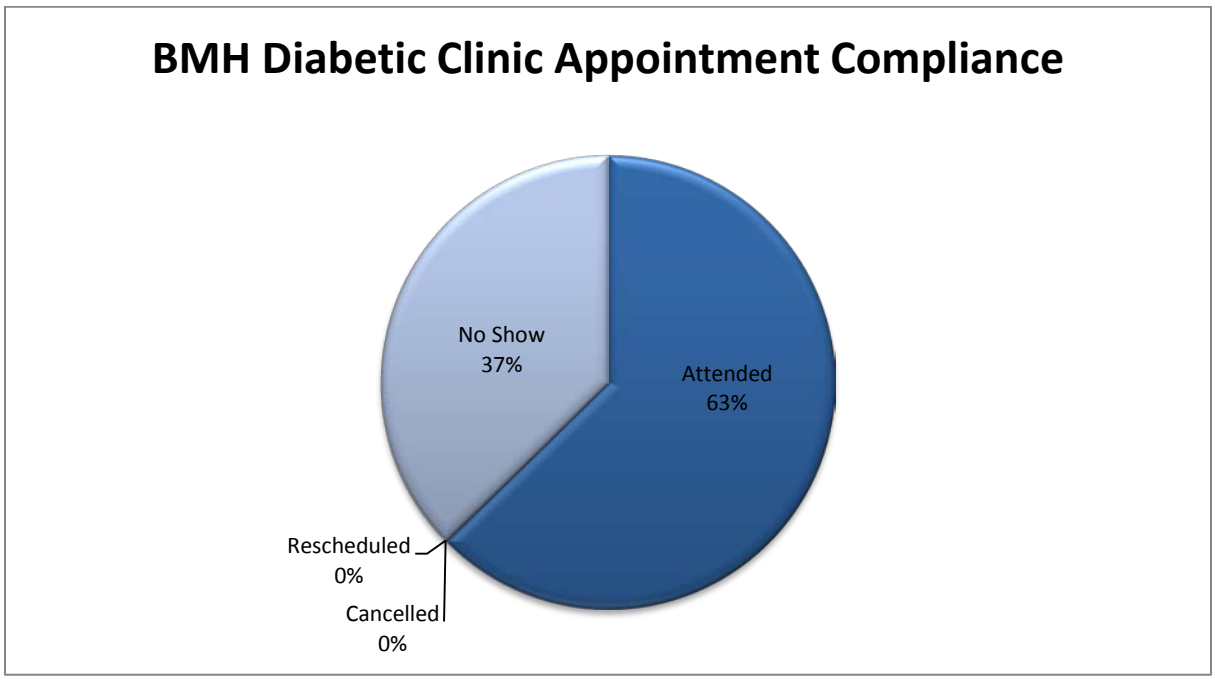
Delano Regional Medical Center (DRMC) Diabetic Clinic

Appointment compliance at the DRMC Diabetic Clinic revealed 53% of members attended their scheduled appointment.



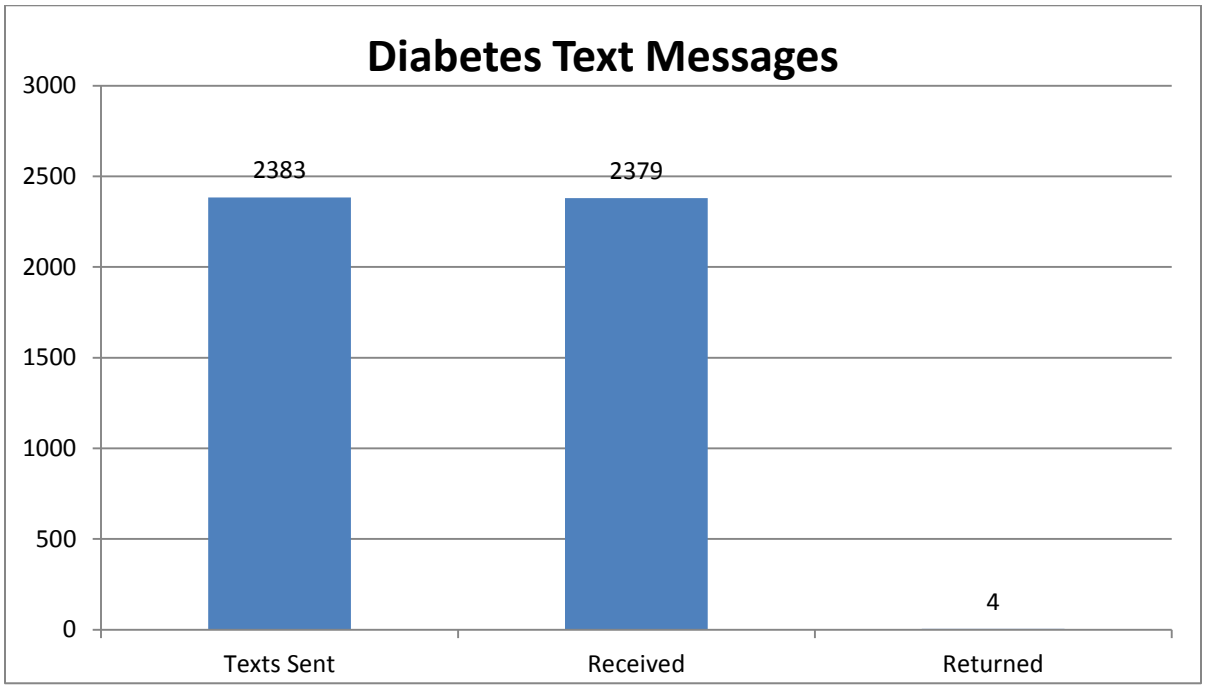
Bakersfield Memorial Hospital (BMH) Diabetic Clinic

Appointment compliance at the BMH Diabetic Clinic revealed 63% of members attended their scheduled appointment.



Diabetes Text Messaging Program

Thirteen diabetes related text messages, totaling 2,383 were sent to members during this quarter. 99.8% of those messages were successfully received by the members.



Propeller Asthma Management Pilot

KHS' Disease Management Department and Dignity Health have partnered with Propeller Health to pilot a digital asthma management program for 20 KHS members with asthma. Through the use of medication sensors, mobile applications and an online dashboard, KHS is able to track the frequency of the controller and rescue asthma inhalers used by each participating member, receive email notifications when a member is identified as in poor control of his/her asthma and identify the geographic location of where the member used their medication (smartphone enrolled members only). Members do not need internet access or a smartphone to participate. By the end of this quarter, 15 members are actively engaged in this pilot and are sending data to the online patient health dashboard hosted by Propeller Health.

Automated Reminder Calls

KHS sends automated reminder calls to members in need of completing specific health actions. During this quarter, there were no automated reminder calls sent with regards to diabetes related screenings.

ACTION ITEMS

KERN HEALTH SYSTEMS HEALTH EDUCATION ACTIVITIES REPORT
FIRST QUARTER 2017

Report Date: April 10, 2017

OVERVIEW

Kern Health Systems' Health Education department provides comprehensive, culturally and linguistically competent services to plan members with the intent of promoting healthy behaviors, improving health outcomes, reducing risk for disease and empowering plan members to be active participants in their health care.

- Member Wellness and Chronic Condition Based Incentives launched in March 2017
- School Wellness Grant and Stipend Programs in Q3 2017
- Summer Member Newsletter hits member homes in June 2017
- Propeller Asthma Pilot ends in May 2017
- PM160 forms discontinued in July 2017
- Video Remote Interpreting Services Pilot starts in Q3/Q4 2017
- Expanded class locations outside of the Bakersfield area

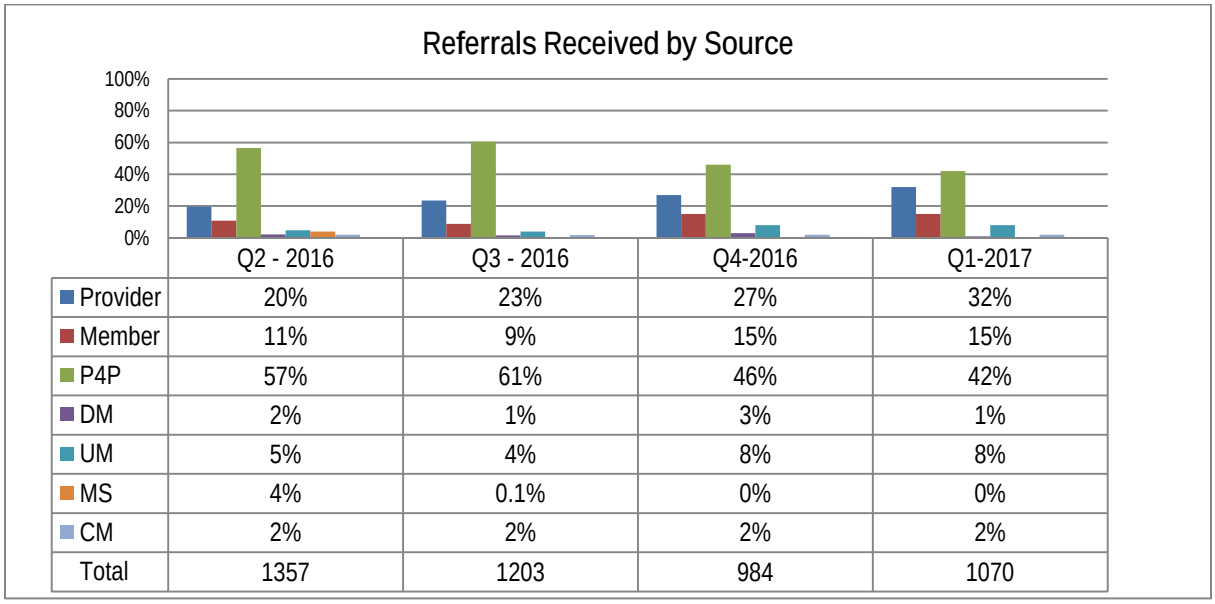
The following pages reflect statistical measurements for the Health Education department detailing the ongoing activity for 1st quarter 2017.

Respectfully submitted,
Isabel Silva, MPH, CHES

KERN HEALTH SYSTEMS HEALTH EDUCATION ACTIVITIES REPORT
FIRST QUARTER 2017

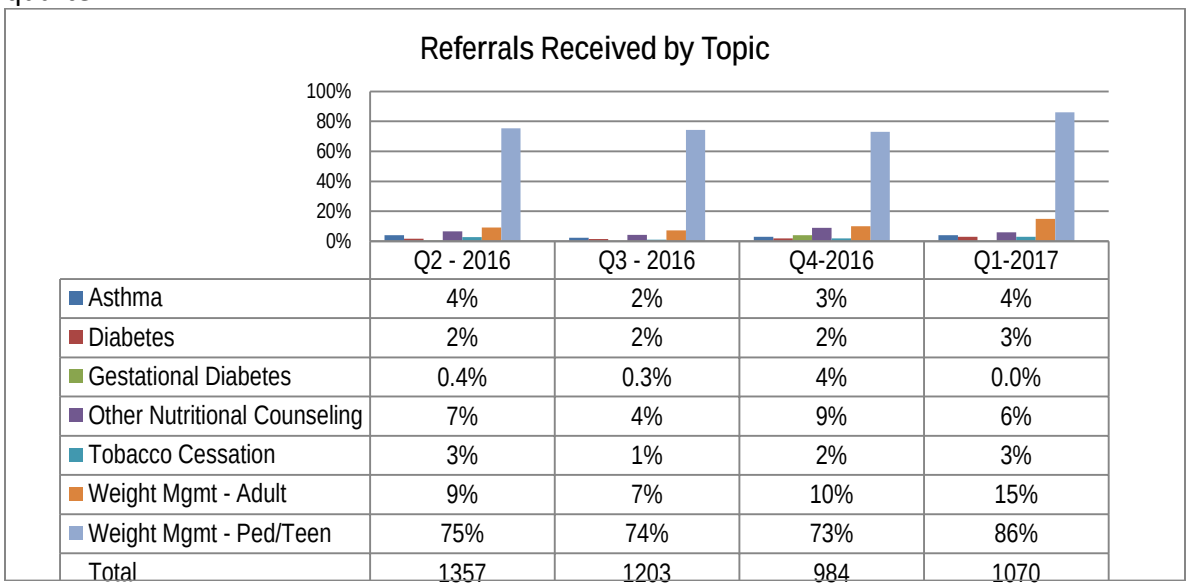
REFERRALS FOR HEALTH EDUCATION SERVICES

The Health Education Department (HE) receives referrals from various sources. Internal referrals are received from the Kern Health Systems (KHS) Utilization Management Department (UM), the Member Services Department (MS), the Disease Management Department (DM), Case Management (CM), and the Provider Pay for Performance Program. Externally, KHS providers submit referrals for health education services according to the member's diagnosis. Kern Family Health Care (KFHC) members can also self-refer for health education services.



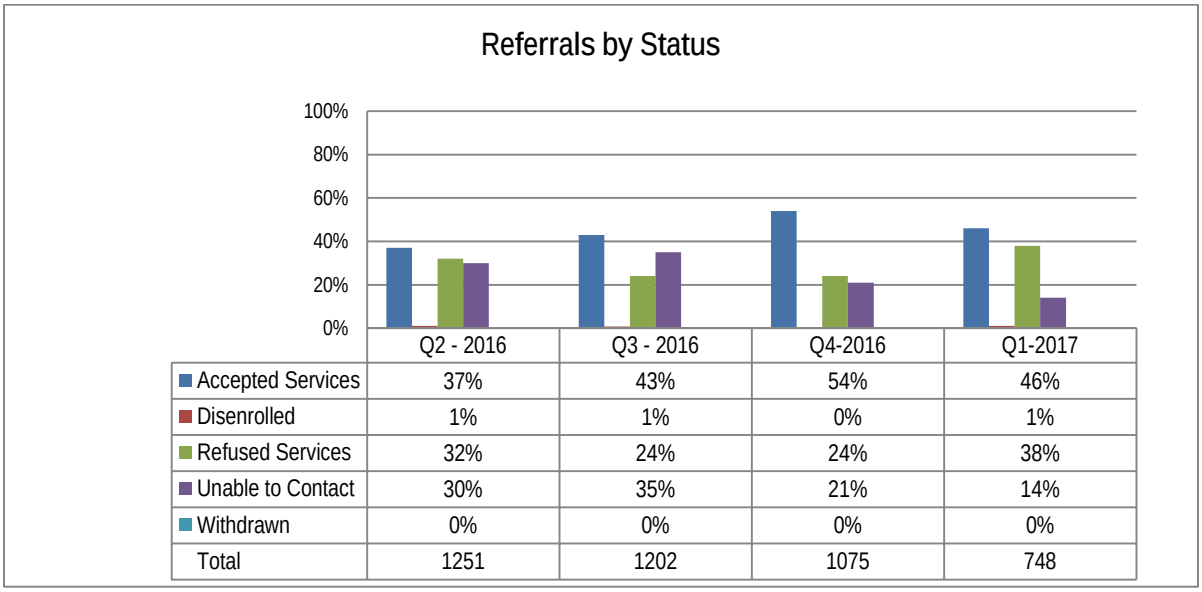
	Q2 - 2016	Q3 - 2016	Q4-2016	Q1-2017
Provider	20%	23%	27%	32%
Member	11%	9%	15%	15%
P4P	57%	61%	46%	42%
DM	2%	1%	3%	1%
UM	5%	4%	8%	8%
MS	4%	0.1%	0%	0%
CM	2%	2%	2%	2%
Total	1357	1203	984	1070

During this quarter, there was a 9% increase in referrals received in comparison to the previous quarter.



	Q2 - 2016	Q3 - 2016	Q4-2016	Q1-2017
Asthma	4%	2%	3%	4%
Diabetes	2%	2%	2%	3%
Gestational Diabetes	0.4%	0.3%	4%	0.0%
Other Nutritional Counseling	7%	4%	9%	6%
Tobacco Cessation	3%	1%	2%	3%
Weight Mgmt - Adult	9%	7%	10%	15%
Weight Mgmt - Ped/Teen	75%	74%	73%	86%
Total	1357	1203	984	1070

The HE department receives referrals for various health conditions. Weight management education continues to be the most requested service for members. It accounted for 86% of all referrals received in the 1st Quarter of 2017.



	Q2 - 2016	Q3 - 2016	Q4-2016	Q1-2017
Accepted Services	37%	43%	54%	46%
Disenrolled	1%	1%	0%	1%
Refused Services	32%	24%	24%	38%
Unable to Contact	30%	35%	21%	14%
Withdrawn	0%	0%	0%	0%
Total	1251	1202	1075	748

The rate of members who accepted to receive health education services decreased from 54% in the 4th quarter in 2016 to 46% in the 1st quarter in 2017.

Member reasons for refusal of health education services were also collected. During this quarter, the top 5 reasons for referral refusal were due to the following:

1. The member prefers to be mailed educational material.
2. The member not interested in the services.
3. The member received previous education.
4. The member/parent doesn't feel that he/she or his/her child needs the services.
5. Member is unable to receive services due to work/school schedule.

HEALTH EDUCATION SERVICE PROVIDERS

The HE department offers various types of services through KHS or through community partnerships. Health Education services include the following topics:

- Asthma
- Breastfeeding
- Diabetes
- Gestational Diabetes
- Heart Health

- Nutrition Counseling
- Tobacco Cessation
- Stroke Prevention
- Weight Management for Overweight/Obesity

Kern Family Health Care (KFHC):

- Healthy Eating and Active Lifestyle Workshop
    - Workshops are held every month in English and Spanish. Group discussions include, but are not limited to healthy cooking demo workshops, portion control, calorie counting, food label reading, meal planning, and physical activity.

- Breastfeeding Education
    - The workshop location varies and is held upon request. Workshops are provided by a certified lactation educator. Discussions include but are not limited to hunger cues and feeding, proper positioning and latching, pumping and storing milk, and community resources.

- Breathe Well Asthma Workshop
    - Classes are held every month in English or Spanish. Class discussions include, but are not limited to asthma physiology, triggers, medication use, action plans, warning signs, and non-toxic cleaning.

Bakersfield Memorial Hospital (BMH):

- Diabetes Management Classes (English only)
    - Class discussions include, but are not limited to, medications, portion control, meal planning, food label reading, and carbohydrate counting.

- Heart Healthy Classes
    - Class discussions include, but are not limited to, healthy eating and meal planning, how to use food labels in making food choices, what to eat and avoid, cooking ideas, healthy snacks, and eating out and eating healthy.

- Small Steps to a Healthier Weight (English only):
    - This series of 6 monthly classes' helps you lose weight and improve your overall health. Monthly topics include: hydration, whole unprocessed foods, fiber, healthy fats and portion control.

- Individual Nutrition Counseling
    - Appointments are held monthly and services are provided by a registered dietitian. Diagnoses include, but are not limited to gestational diabetes, failure to thrive, hypertension, diabetes, and obesity.

- Kids Weight Management Classes (English and Spanish)

  Classes are schedule based on Member's needs and availability of their schedule. Class discussions include, but are not limited to, medications, portion control, meal planning, food label reading, and carbohydrate counting.

Community Wellness Program (CWP):

- Individual Asthma, Diabetes, Nutrition or Stroke Prevention Education
  - Education is given in the privacy of the member's home, a mutually agreed location, community site, or CWP's office at 2634 G Street, Bakersfield, CA 93301.
  - Discussion topics include, but are not limited to asthma control and medication use, weight management, diabetes management, meal planning, food label reading, and physical activity.

- Freedom from Smoking Program
  - This smoking cessation class series educates members on ways to building a new lifestyle to overcome their tobacco addiction and tips on never going back to smoking.

Clinica Sierra Vista (CSV) WIC:

- Diabetes Management Classes
  - Classes are held monthly in English and Spanish. Class discussions include, but are not limited to medications, portion control, meal planning, food label reading, and carbohydrate counting.

- Heart Healthy Classes
  - Classes are held monthly in English and Spanish. Class discussions include, but are not limited to healthy eating and meal planning, how to use food labels in making food choices, what to eat and avoid, cooking ideas, healthy snacks, and eating out and eating healthy.

California Smokers' Helpline (CSH):

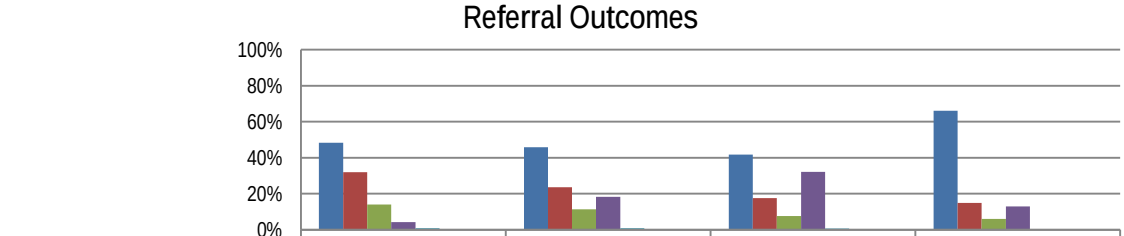
- Telephone Smoking Cessation Counseling
  - Members are connected by phone to a CSH representative or referred to CSH through their online referral system. CSH offers free telephone counseling, self-help materials, a text messaging program, and online help in six languages to help people quit smoking.

UC Cooperative Extension:

- Eat Smart, Be Active Class Series

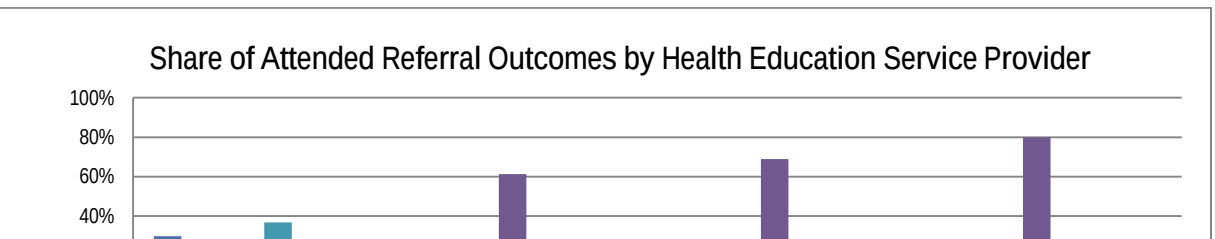
- Classes are offered once a week for eight weeks in English and Spanish. Classes provide nutrition information, cooking demonstrations, food to taste activities, physical activity, how to saving money, and keeping food safe to eat.

REFERRAL OUTCOMES



	Q2 - 2016	Q3 - 2016	Q4 - 2016	Q1 - 2017
Attend	48%	46%	42%	66%
No Show	32%	24%	18%	15%
Refused	14%	11%	8%	6%
Unable to contact member	4%	18%	32%	13%
Disenrolled	1%	1%	1%	0%
Withdrawn	0%	0%	0.17%	0%
Total referrals	412	535	598	346

During this quarter, the rate of members who attended or received health education services out of all members who accepted services increased from a 45% to a 63%.

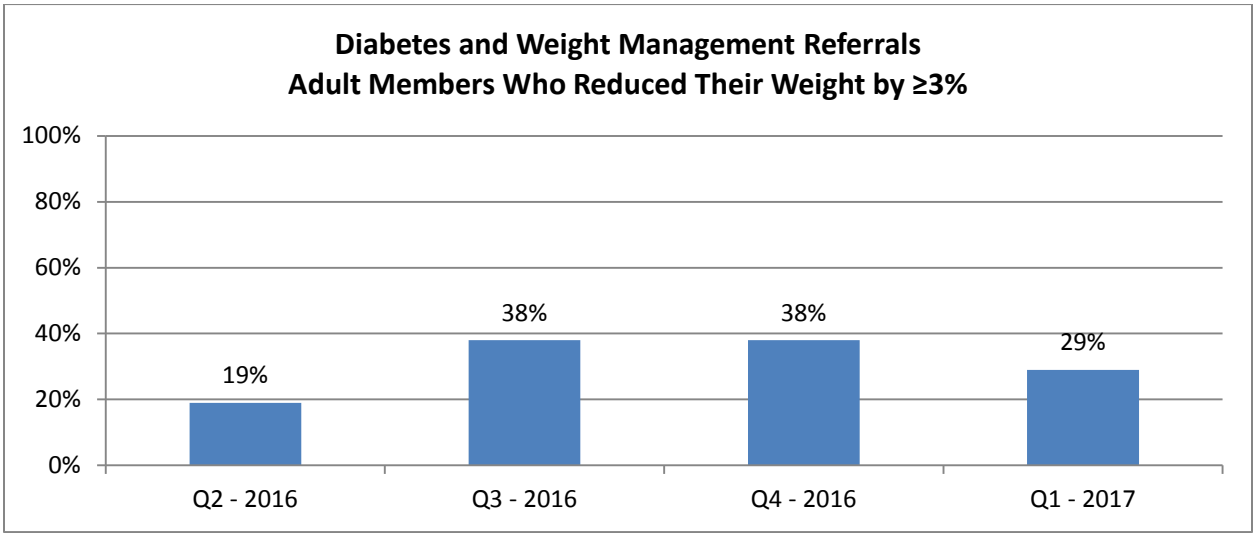


	Q2 - 2016	Q3 - 2016	Q4 - 2016	Q1 - 2017
BMH	30%	25%	21%	17%
CSH	0%	0%	0%	1%
CSV WIC	5%	1%	0%	1%
CWP	28%	61%	69%	80%
KFHC	37%	9%	7%	1%
DRMC	1.0%	3%	3%	0%
UCCE	0%	1%	0%	0%
Total	199	245	250	346

CWP classes accounted for the largest share of referral outcomes where a member attended a class or appointment. CWP's share of attended outcomes increased from 69% to a 80%.

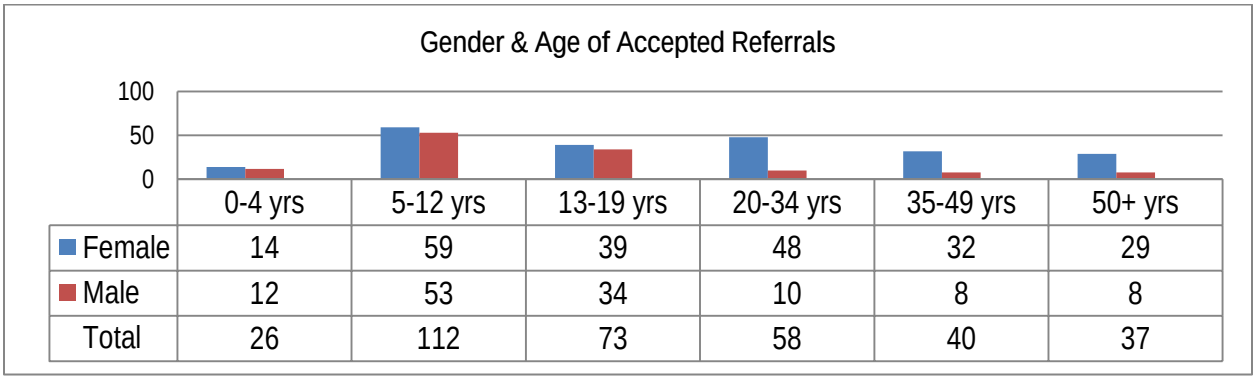
Effectiveness of Health Education Services

To evaluate the effectiveness of the diabetes and weight management health education services provided to members, a 3-month follow up call was conducted on members who received services during the prior quarter. Findings revealed that the rate of members reporting a weight reduction of 3% or greater decreased from a 38% to a 29%.



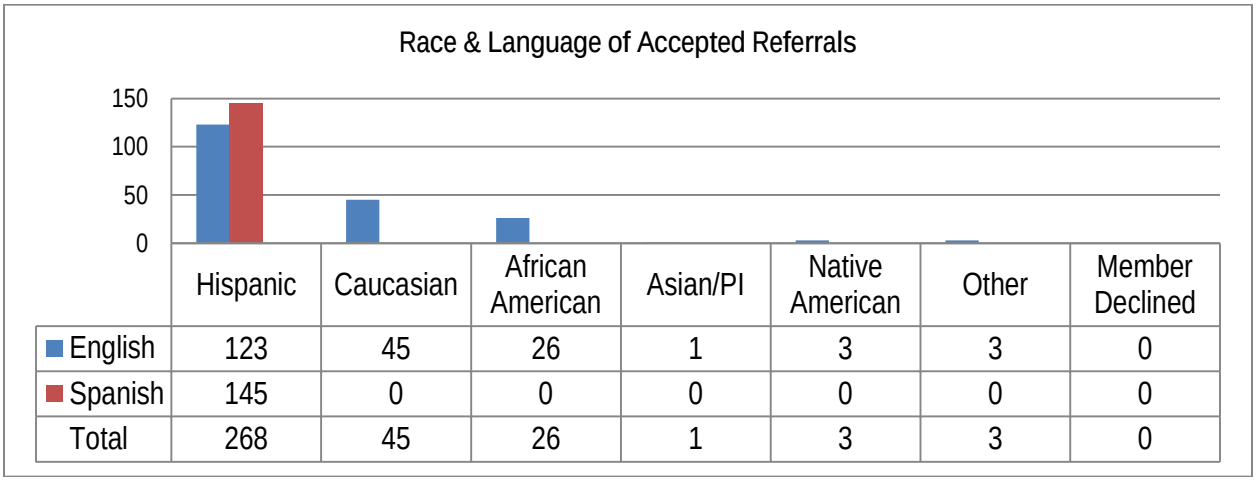
Demographics of Members Served

KHS' provides services to a culturally and linguistically diverse member population. KHS' language threshold is English and Spanish and all services and materials are available in these languages. For non-threshold languages, telephonic interpreters are available through Language Line and American Sign Language (ASL) interpreters are available through Life Signs.



	0-4 yrs	5-12 yrs	13-19 yrs	20-34 yrs	35-49 yrs	50+ yrs
Female	14	59	39	48	32	29
Male	12	53	34	10	8	8
Total	26	112	73	58	40	37

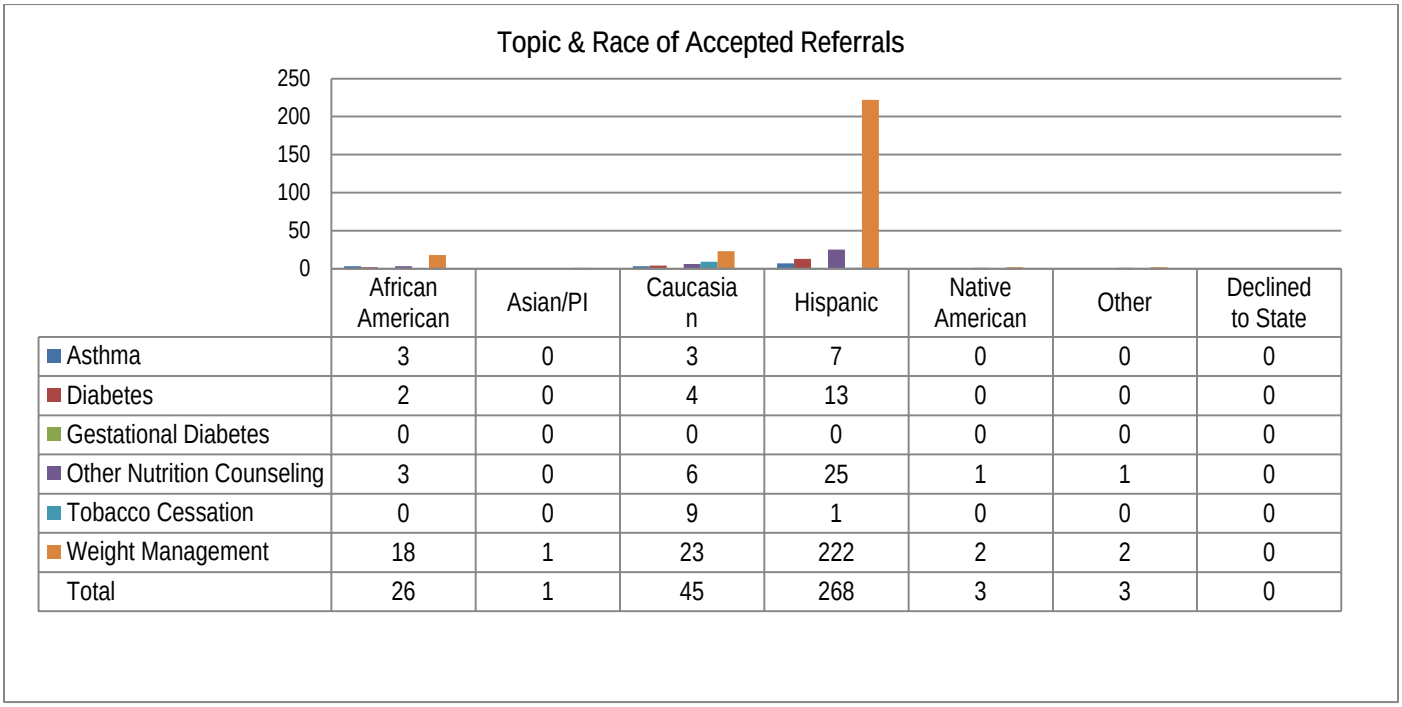
Out of the members who accepted to receive health education services, the largest gender-age groups were male ages 5-12 years and female ages 5-12 years.



	Hispanic	Caucasian	African American	Asian/PI	Native American	Other	Member Declined
English	123	45	26	1	3	3	0
Spanish	145	0	0	0	0	0	0
Total	268	45	26	1	3	3	0

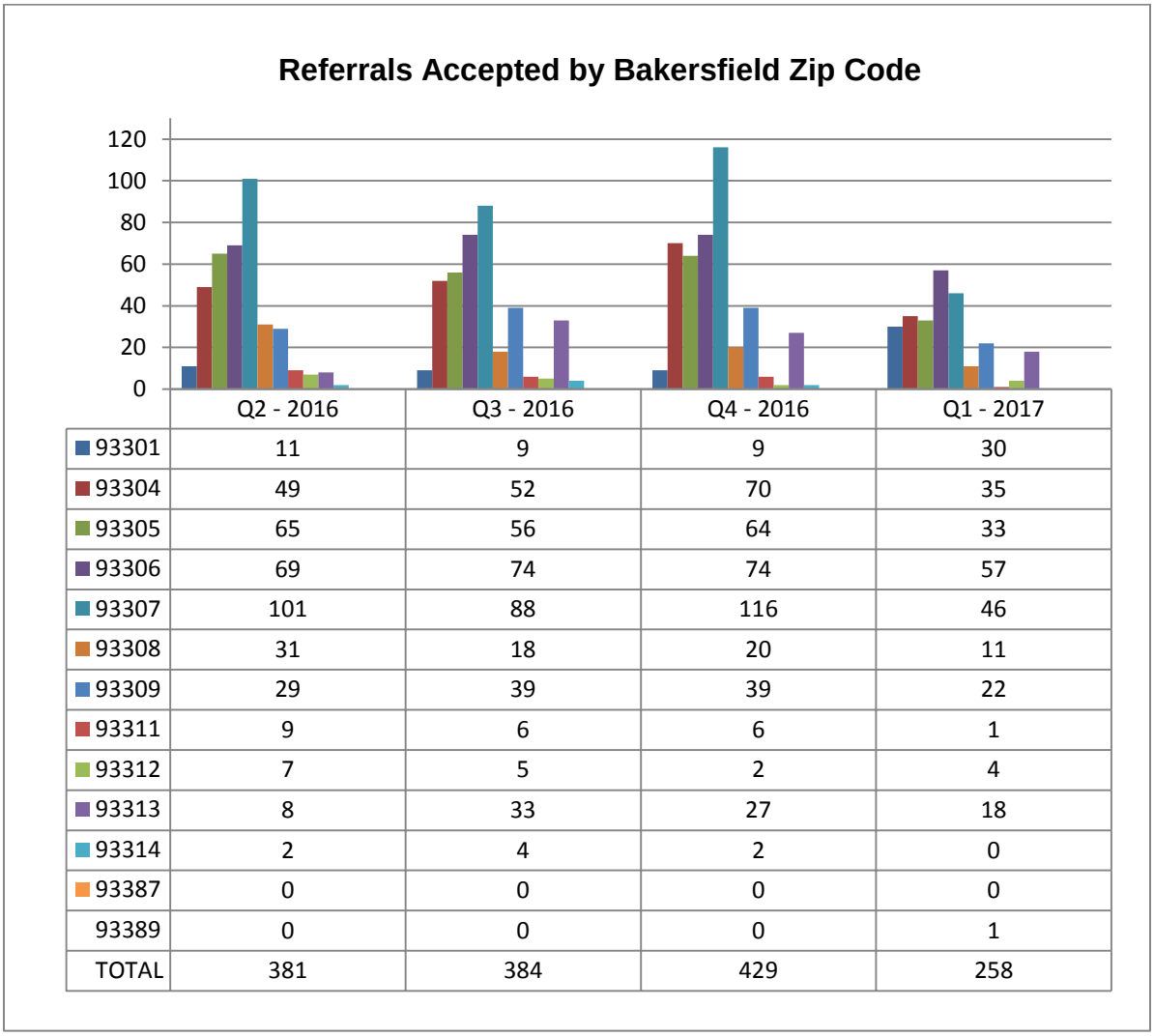
A breakdown of member classifications by race and language preferences revealed that 47% of members who accepted services are Hispanic and preferred to speak Spanish.

Referrals accepted by language and race were assessed during this quarter. Findings revealed that 42% of members who accepted services were Spanish speaking and referred for weight management education to manage obesity.



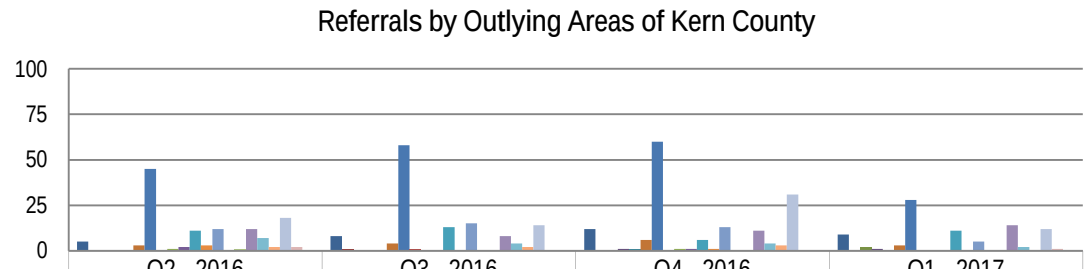
	African American	Asian/PI	Caucasian	Hispanic	Native American	Other	Declined to State
Asthma	3	0	3	7	0	0	0
Diabetes	2	0	4	13	0	0	0
Gestational Diabetes	0	0	0	0	0	0	0
Other Nutrition Counseling	3	0	6	25	1	1	0
Tobacco Cessation	0	0	9	1	0	0	0
Weight Management	18	1	23	222	2	2	0
Total	26	1	45	268	3	3	0

Additionally, 64% of the members who accepted services were of the Hispanic race and referred for weight management education to manage obesity.



	Q2 - 2016	Q3 - 2016	Q4 - 2016	Q1 - 2017
93301	11	9	9	30
93304	49	52	70	35
93305	65	56	64	33
93306	69	74	74	57
93307	101	88	116	46
93308	31	18	20	11
93309	29	39	39	22
93311	9	6	6	1
93312	7	5	2	4
93313	8	33	27	18
93314	2	4	2	0
93387	0	0	0	0
93389	0	0	0	1
TOTAL	381	384	429	258

KHS serves members in the Kern County area with the exception of Ridgecrest. During this quarter, 75% of the members who accepted services reside in Bakersfield and the highest concentration of members were in the 93307 area.

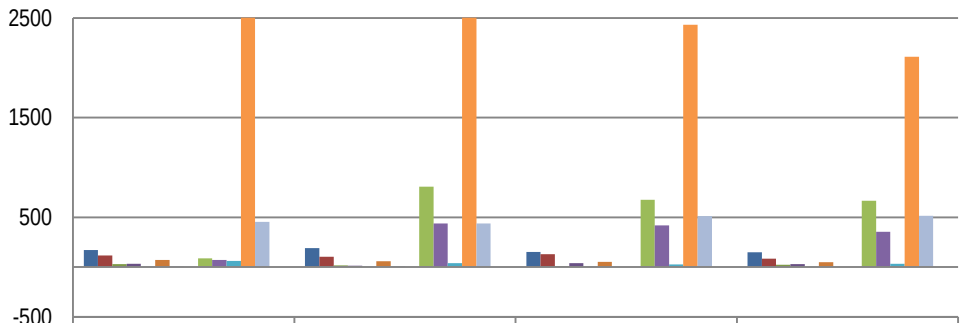


	Q2 - 2016	Q3 - 2016	Q4 - 2016	Q1 - 2017
Arvin	5	8	12	9
Bodfish	0	1	0	0
Boron	0	0	0	2
Buttonwillow	0	0	1	1
Caliente	0	0	1	0
California City	3	4	6	3
Delano	45	58	60	28
Edwards	0	1	0	0
Frazier Park	1	0	1	0
Lake Isabella	2	0	1	0
Lamont	11	13	6	11
Lost Hills	3	0	1	0
McFarland	12	15	13	5
Mojave	0	0	0	0
Rosamond	1	0	0	0
Shafter	12	8	11	14
Taft	7	4	4	2
Tehachapi	2	2	3	0
Wasco	18	14	31	12
Weldon	2	0	0	1
TOTAL	124	128	151	88

Additionally, 25% of the members who accepted services reside in the outlying areas of Kern County and the highest concentration of members in the outlying areas were in Delano.

Health Education Mailings

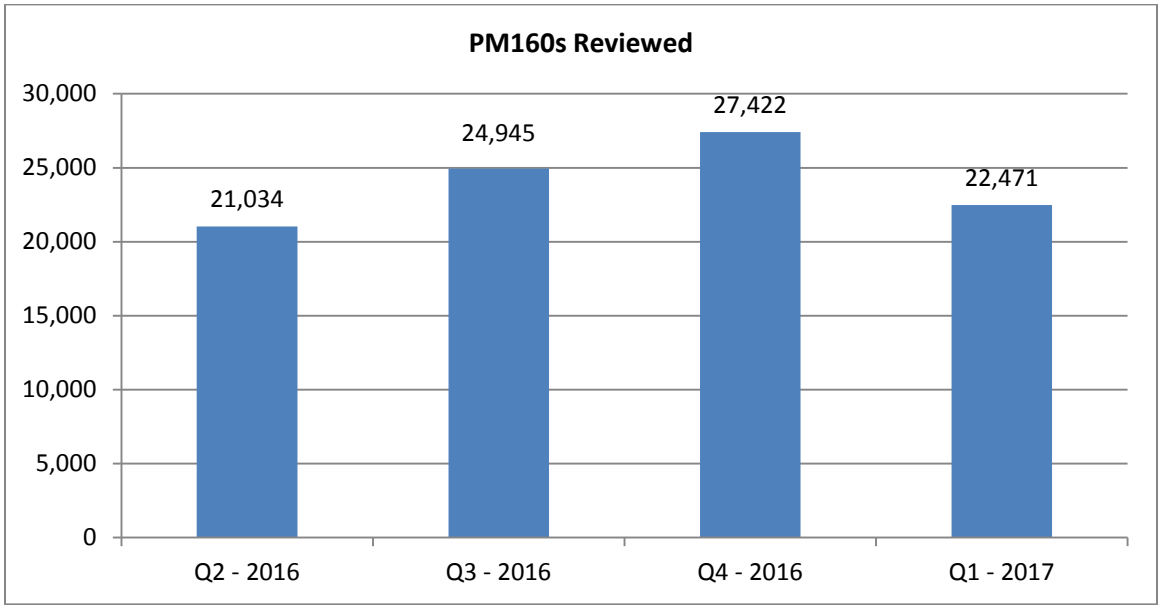
In addition to referrals, the HE department mails out a variety of educational material in an effort to assist members with gaining knowledge on their specific diagnosis or health concern. During this quarter, the HE department mailed 4,010 educational packets to members on the following health topics:



	Q2 - 2016	Q3 - 2016	Q4 - 2016	Q1 - 2017
Anemia	172	191	151	147
Asthma	116	104	129	84
High Cholesterol	30	16	11	24
Diabetes	34	14	40	31
Gestational Diabetes	1	2	2	0
High Blood Pressure	72	60	52	48
Nutrition	3	8	0	0
COPD	0	0	0	0
Postpartum Care	87	807	676	666
Prenatal Care	70	436	417	354
Smoking Cessation	62	39	27	32
Weight Management	2509	2714	2433	2111
Postpartum Incentive	453	437	511	513
Total	3609	4828	4449	4010

PM160 PROCESSING

KHS Primary Care Providers (PCP) are required to document pediatric preventive care services on a PM160 and submit these forms to KHS. On a daily basis, the HE department reviews these forms to evaluate for possible health education interventions.



INTERPRETER REQUESTS

Telephonic Interpreter Requests

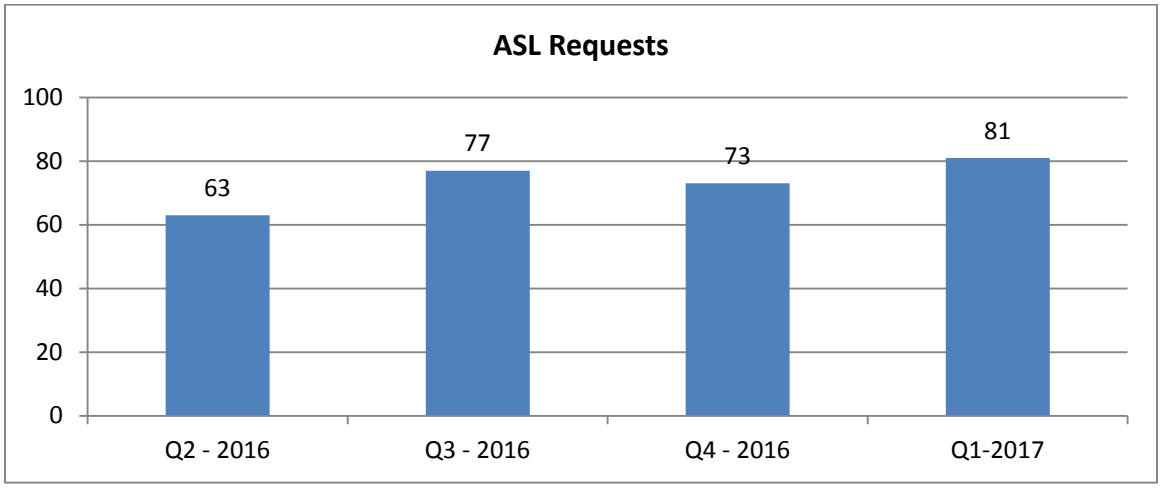
During this quarter, there were 570 requests for telephonic interpreting services through KHS' interpreting vendor, Language Line Solutions. The majority of these requests were for a Punjabi interpreter.

	Q2-2016	Q3-2016	Q4-2016	Q1 - 2017
Amharic	0	0	4	2
Arabic	34	30	37	61
Bengali	0	1	1	0
Burmese	0	0	1	0
Cambodian	3	5	4	2
Cantonese	2	2	1	1
Farsi	0	0	0	1
Gujarati	1	1	0	0
Hindi	7	0	1	4
Ilocano	4	2	3	2
Japanese	0	0	1	0
Karen	0	1	0	1
Korean	7	2	6	3
Laotian	0	0	0	4
Mandarin	7	14	7	0
Marshallese	0	0	0	0
Mongolian	0	1	0	0

Polish	21	7	1	0
Punjabi	105	107	115	61
Russian	0	0	2	0
Spanish	12	16	75	387
Tagalog	17	14	20	16
Telugu	0	0	0	1
Vietnamese	6	14	17	20
Visayan	0	0	1	0
Tamil	1	0	0	0
Thai	2	0	0	0
Turkish	0	1	0	0
Urdu	0	0	0	1
Total	**229**	**218**	**297**	**570**

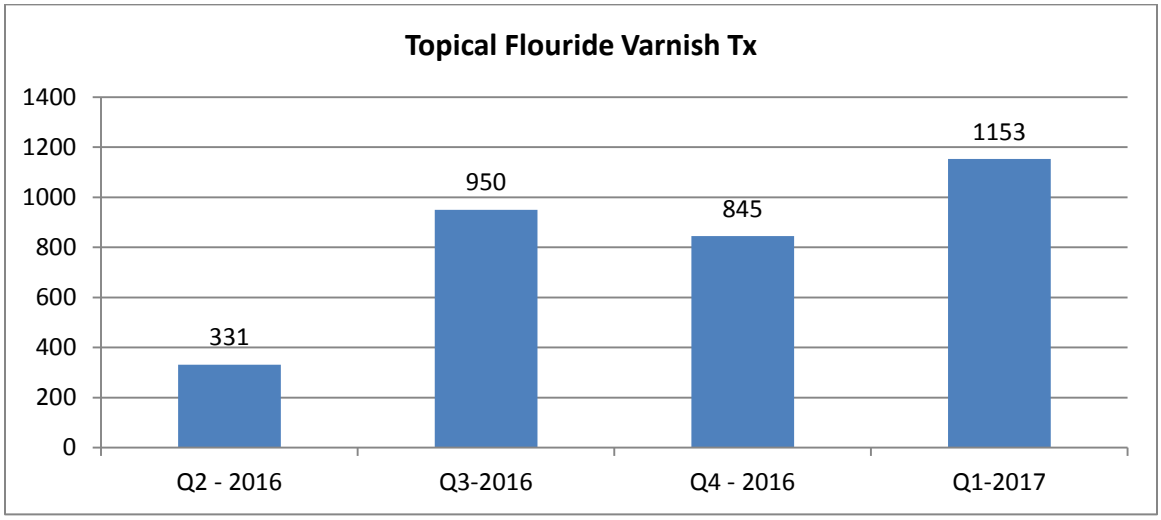
American Sign Language (ASL) Requests

During this quarter, there were a total of 81 requests received for an American Sign Language interpreter, which was an 11% increase in comparison to the previous quarter.



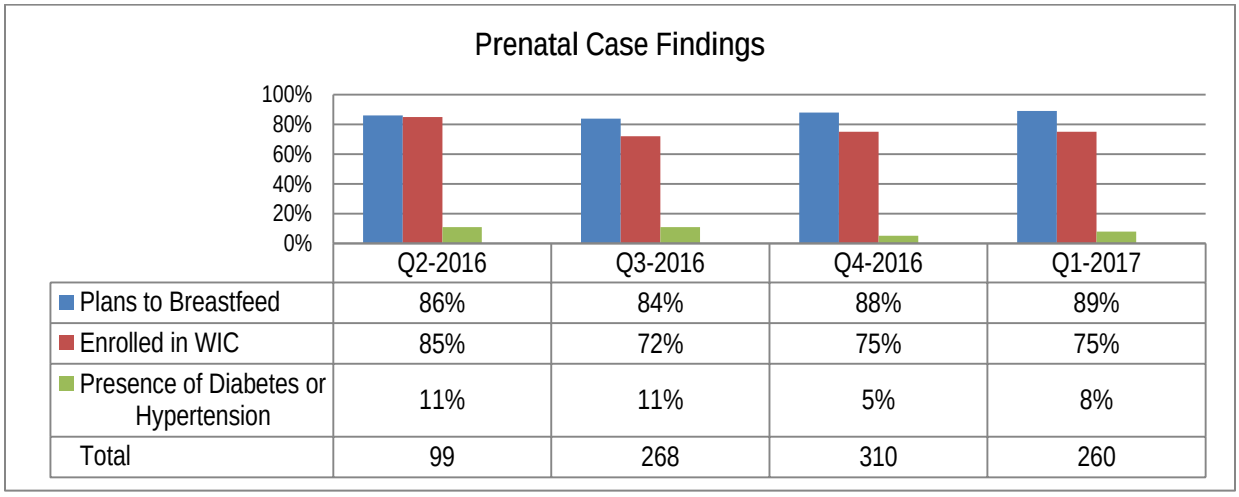
TOPICAL FLUORIDE VARNISH TREATMENTS

Fluoride varnish treatments are effective in preventing tooth decay and more practical and safer to use with young children. KHS covers up to three topical fluoride varnish treatments in a 12-month period for all members younger than 6 years.



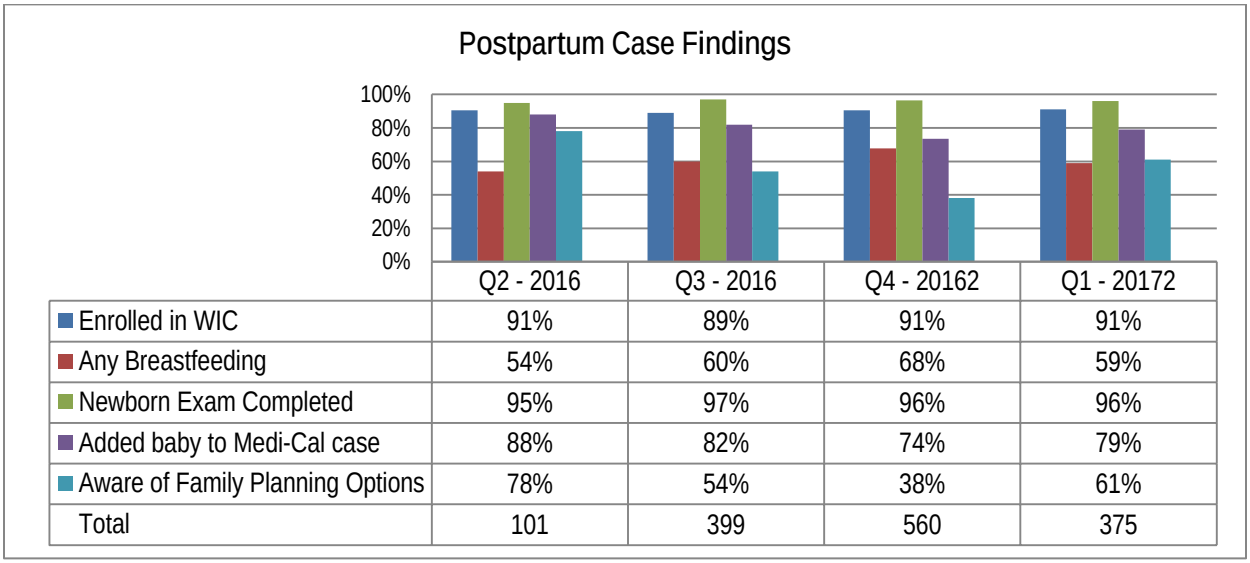
OB CASE MANAGEMENT PROJECT

The HE department performs outreach education calls to all members identified as being pregnant or postpartum.



	Q2-2016	Q3-2016	Q4-2016	Q1-2017
Plans to Breastfeed	86%	84%	88%	89%
Enrolled in WIC	85%	72%	75%	75%
Presence of Diabetes or Hypertension	11%	11%	5%	8%
Total	99	268	310	260

During this quarter, the HE department successfully contacted 260 pregnant members. Members who are not successfully contacted by phone and are at least 18 years of age or older are mailed a letter asking them to contact KHS' HE department as soon as possible.



	Q2 - 2016	Q3 - 2016	Q4 - 20162	Q1 - 20172
Enrolled in WIC	91%	89%	91%	91%
Any Breastfeeding	54%	60%	68%	59%
Newborn Exam Completed	95%	97%	96%	96%
Added baby to Medi-Cal case	88%	82%	74%	79%
Aware of Family Planning Options	78%	54%	38%	61%
Total	101	399	560	375

The HE department successfully contacted 375 postpartum members during this quarter. The rate of members who reported any breastfeeding decreased from 68% to 59%.

KERN HEALTH SYSTEMS HEALTH EDUCATION ACTIVITIES REPORT
FOURTH QUARTER 2016

Report Date: April 17, 2017

Reporting Period: October 1, 2016 to December 31, 2016

EXECUTIVE SUMMARY

Health Education Referrals

- 984 referrals were received for health education services, which is an 18% decrease compared to the previous quarter.
- The majority of referrals continue to be for the management of pediatric/teen obesity.
- Members who accepted to receive services increased from 43% to 54%.
- The rate of members who attended their health education service appointment remained at 45%.
- Referrals to CWP decreased from 62% to 57%.
- The rate of adult members who received diabetes or weight management education and reported losing at least 3% of their body weight during the 3rd quarter 3-month follow-up calls remained the same at 38%.

OB Case Management Project

- 319 pregnant and 560 postpartum members successfully contacted.
- Prenatal findings revealed:
    - 6% of members reported they had diabetes or hypertension.
    - 27% of members had not yet enrolled in WIC.
- Postpartum findings revealed:
    - The rate of members who had added their newborn to their Medi-Cal case decreased from 82% to 74%.
    - The rate of members that had discussed their family planning/birth control options with their OB provider decreased 54% to 38%.
    - The rate of any breastfeeding increased from 60% to 68%.
- 511 postpartum exam incentives were mailed to members which is a 5% increase from the prior quarter.

Automated Calls and Text Messages

- Member outreach automated health reminder calls were sent to 62,228 members on the importance of cervical cancer screening, well child visit, immunizations or prenatal and postpartum care. Call outcomes revealed 51% of the calls were successfully delivered.

Health Education Social Media Posts

- KFHC posted 23 Facebook posts and 23 Twitter posts with content written or developed by the KFHC HE Department. Topics included a variety of top health issues among our members.

Fluoride Varnish

- KHS received 845 claims for topical fluoride varnish treatments in Q4 2016, which is an 11% decrease in comparison to the previous quarter.

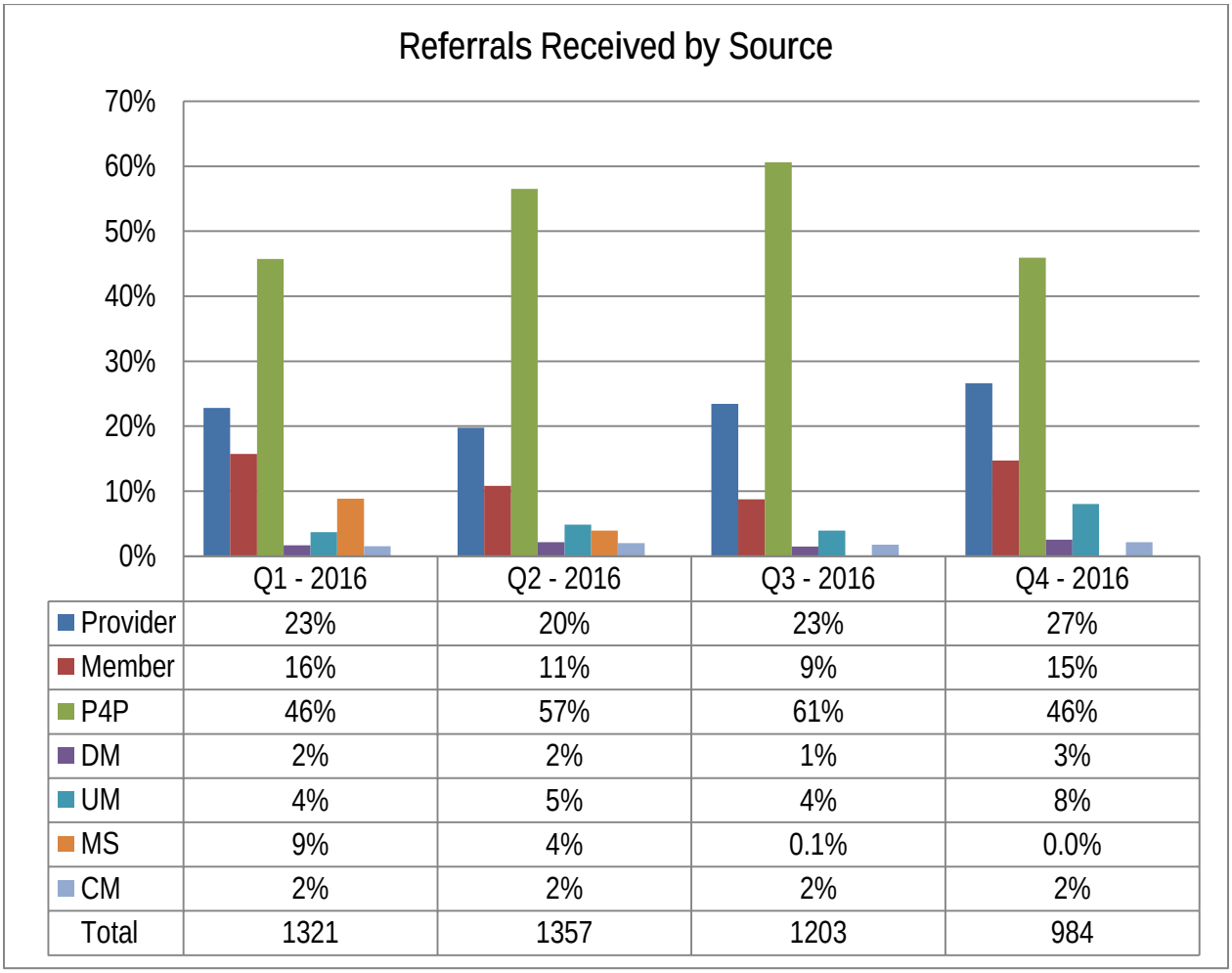
Interpreting Services

- Review of member access to cultural and linguistic services revealed 73 requests for an American Sign Language Interpreter and 297 requests for telephonic interpreting services. Punjabi continues to be the most commonly requested language for telephonic interpreter requests.

Respectfully submitted,
Isabel Silva, MPH, CHES

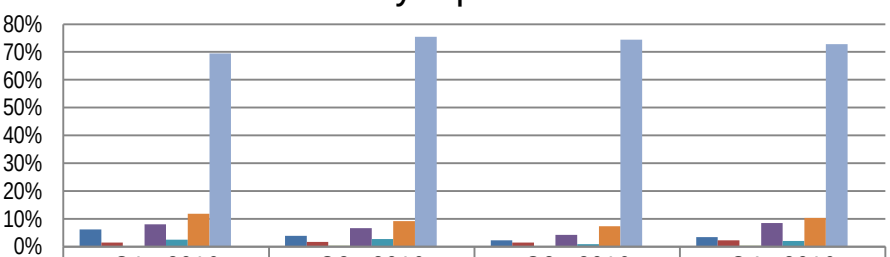
REFERRALS FOR HEALTH EDUCATION SERVICES

The Health Education Department (HE) receives referrals from various sources. Internal referrals are received from the Kern Health Systems (KHS) Utilization Management Department (UM) through outpatient referrals, the Member Services Department (MS) through the New Member Entry Calls, the Disease Management Department (DM), Case Management (CM), and the Provider Pay for Performance Program. Externally, KHS providers and community-based organizations submit referrals for health education services according to the member's diagnosis. Kern Family Health Care (KFHC) members can also self-refer for health education services for their own diagnosis or health concerns.



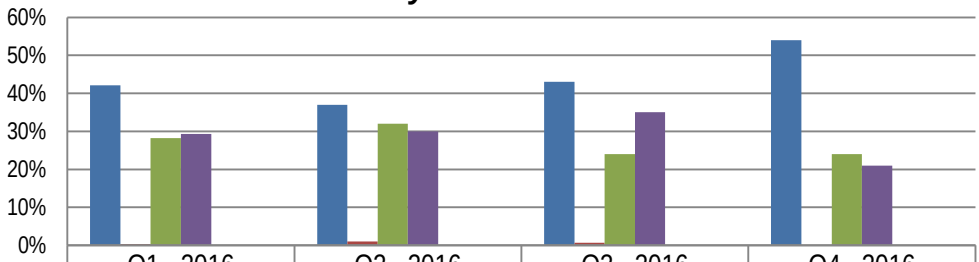
	Q1 - 2016	Q2 - 2016	Q3 - 2016	Q4 - 2016
Provider	23%	20%	23%	27%
Member	16%	11%	9%	15%
P4P	46%	57%	61%	46%
DM	2%	2%	1%	3%
UM	4%	5%	4%	8%
MS	9%	4%	0.1%	0.0%
CM	2%	2%	2%	2%
Total	1321	1357	1203	984

During this quarter, there was an 18% decrease in referrals received in comparison to the previous quarter.



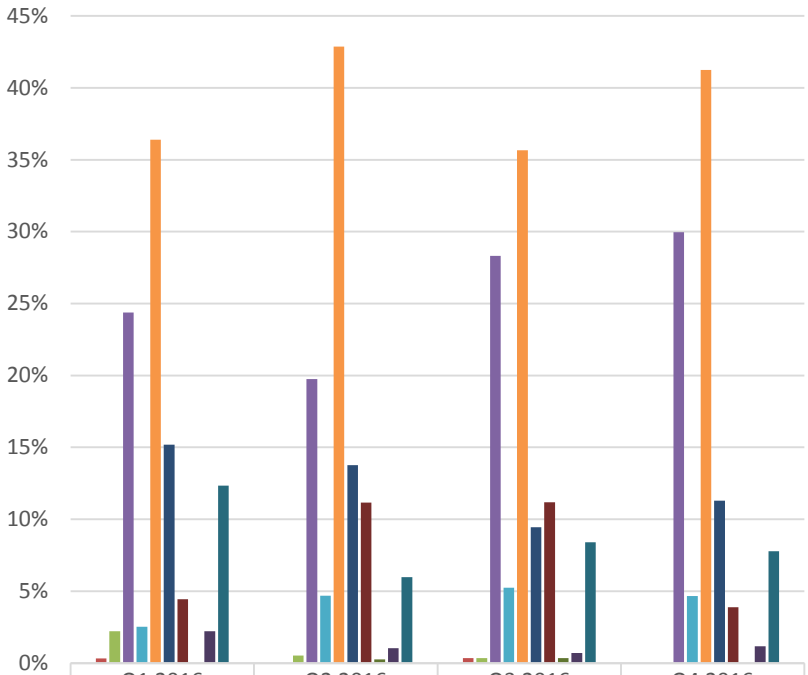
	Q1 - 2016	Q2 - 2016	Q3 - 2016	Q4 - 2016
Asthma	6%	4%	2%	3%
Diabetes	2%	2%	2%	2%
Gestational Diabetes	0.2%	0.4%	0.3%	0.4%
Other Nutritional Counseling	8%	7%	4%	9%
Tobacco Cessation	3%	3%	1%	2%
Weight Mgmt - Adult	12%	9%	7%	10%
Weight Mgmt - Ped/Teen	69%	75%	74%	73%
Total	1321	1357	1203	984

The HE department receives referrals for various health conditions. Weight management education continues to be the most requested service for members. It accounted for 83% of all referrals received in the 4th Quarter of 2016.



	Q1 - 2016	Q2 - 2016	Q3 - 2016	Q4 - 2016
Accepted Services	42%	37%	43%	54%
Disenrolled	0%	1%	1%	0%
Refused Services	28%	32%	24%	24%
Unable to Contact	29%	30%	35%	21%
Withdrawn	0%	0%	0%	0%
Total	1134	1251	1202	1075

The rate of members who accepted to receive health education services increased from 43% in the 3rd quarter to 54% in the 4th quarter.



	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Member cancelled & rescheduled 3 times. New PCP referral required.	0%	0%	0%	0%
Member changed to private/other insurance.	0.32%	0%	0.35%	0%
Member is already scheduled for services.	2%	0.52%	0.35%	0%
Member is not interested in the service.	24%	20%	28%	30%
Member is unable to receive services due to personal issues.	3%	5%	5%	5%
Member prefers to be mailed educational material.	36%	43%	36%	41%
Member received previous education.	15%	14%	9%	11%
Member unable to receive due to work/school schedule.	4%	11%	11%	4%
Member unaware provider submitted referral.	0%	0.26%	0.35%	0%
Member would like to first schedule an appointment with provider.	2%	1%	0.70%	1%
Member/Parent doesn't feel that they/their child needs the service.	12%	6%	8%	8%
Total	316	385	286	257

Members who were not successfully contacted are mailed a letter requesting that they contact KHS' HE department as soon as possible. Of the members who were mailed a letter, 52 members contacted the HE department.

Member reasons for refusal of health education services were also collected. During this quarter, the top 5 reasons for referral refusal were due to the following:

1. The member prefers to be mailed educational material.
2. The member not interested in the services.
3. The member received previous education.
4. The member/parent doesn't feel that he/she or his/her child needs the services.
5. Member is unable to receive services due to personal issues.

HEALTH EDUCATION SERVICE PROVIDERS

The HE department offers various types of services through KHS or through community partnerships. Health Education services include the following topics:

- Asthma
- Breastfeeding
- Diabetes
- Gestational Diabetes
- Heart Health
- Nutrition Counseling
- Tobacco Cessation
- Stroke Prevention
- Weight Management for Overweight/Obesity

Kern Family Health Care (KFHC):

- Adult Weight Management Education for overweight/obese members

- Pediatric/Teen Weight Management Education for overweight/obese members
    - Class locations may vary. During this quarter, classes were held at:
        - **Bessie Owens Primary School**
          815 Potomac Ave
          Bakersfield, CA 93307
        - **El Camino Real School**
          911 El Camino Real
          Arvin, CA 93203
        - **Greenfield Family Resource Center**

5400 Monitor Street
Bakersfield, CA 93307

- **Longfellow Elementary School**
  1900 Stockton St.
  Bakersfield, CA 93305
- **Stella Hills Elementary School**
  3800 Jewett Avenue
  Bakersfield, CA 93301

- Workshops are held every month in English and Spanish. Group discussions include, but are not limited to healthy cooking demo workshops, portion control, calorie counting, food label reading, meal planning, and physical activity.

➢ Individual Counseling
- Appointments are held at Kern Family Health Care, 9700 Stockdale Highway, Bakersfield, CA 93311.
- Appointments are held when requested and services are provided by a health educator. Diagnoses include, but are not limited to gestational diabetes, diabetes, asthma, and obesity.

➢ Breastfeeding Education
- The workshop location varies and is held upon request. Workshops are provided by a certified lactation educator. Discussions include but are not limited to hunger cues and feeding, proper positioning and latching, pumping and storing milk, and community resources.

➢ Asthma Education
- Class locations may vary. During this quarter, classes were held at:
  - **Evergreen Elementary School**
    2600 Rose Marie Drive
    Bakersfield, CA 93304
  - **Kern Family Health Care**
    Truxtun Board Room
    5701 Truxtun Ave, Suite 201
    Bakersfield, CA 93309
  - **Owens Primary Elementary School**
    815 Potomac Ave
    Bakersfield, CA 93307
  - **Stella Hills Elementary**
    3800 Jewett Ave
    Bakersfield, CA 93301

- Classes are held every month in English or Spanish. Class discussions include, but are not limited to asthma physiology, triggers, medication use, action plans, warning signs, and non-toxic cleaning.

Bakersfield Memorial Hospital (BMH):

Classes and individual nutrition counseling are offered at 3838 San Dimas St. Suite B-131, Bakersfield, CA 93301.

- Diabetes Management Classes (English only)
  - Classes are on the 3rd Wednesday of every month between 3-5 p.m. Class discussions include, but are not limited to, medications, portion control, meal planning, food label reading, and carbohydrate counting.

- Heart Healthy Classes
  - Classes are on the 3rd Tuesday of every month between3:30-5:00p.m. Class discussions include, but are not limited to, healthy eating and meal planning, how to use food labels in making food choices, what to eat and avoid, cooking ideas, healthy snacks, and eating out and eating healthy.

- Small Steps to a Healthier Weight (English only):
  - This series of 6 monthly classes' helps you lose weight and improve your overall health. Monthly topics include: hydration, whole unprocessed foods, fiber, healthy fats and portion control.

- Individual Nutrition Counseling
  - Appointments are held monthly and services are provided by a registered dietitian. Diagnoses include, but are not limited to gestational diabetes, failure to thrive, hypertension, diabetes, and obesity.

- Kids Weight Management Classes (English and Spanish)
  Classes are schedule based on Member's needs and availability of their schedule. Class discussions include, but are not limited to, medications, portion control, meal planning, food label reading, and carbohydrate counting.

Community Wellness Program (CWP):

- Individual Asthma, Diabetes, Nutrition or Stroke Prevention Education

- CWP contacts the member within 7 business days to schedule an appointment. Education is given in the privacy of the member's home, a mutually agreed location, community site, or CWP's office at 2634 G Street, Bakersfield, CA 93301.
- Discussion topics include, but are not limited to asthma control and medication use, weight management, diabetes management, meal planning, food label reading, and physical activity.

➢ Freedom from Smoking Program
- Classes are held at 2634 G Street, Bakersfield, CA 93301.
- This smoking cessation class series educates members on ways to building a new lifestyle to overcome their tobacco addiction and tips on never going back to smoking.

Clinica Sierra Vista (CSV) WIC:

➢ Diabetes Management Classes
- Classes are held at:
  - **Central Bakersfield Community Health Center**
    301 Brundage Lane
    Bakersfield, CA 93304
  - **Delano Community Health Center**
    1508 Garces Highway, Suite 1
    Delano, CA 93215
  - **East Bakersfield Community Health Center**
    1125 E. California Avenue
    Bakersfield, CA 93307
- Classes are held monthly in English and Spanish. Class discussions include, but are not limited to medications, portion control, meal planning, food label reading, and carbohydrate counting.

➢ Heart Healthy Classes
- Classes are held at:
  - **Central Bakersfield Community Health Center**
    301 Brundage Lane
    Bakersfield, CA 93304
  - **Delano Community Health Center**
    1508 Garces Highway, Suite 1
    Delano, CA 93215
  - **East Bakersfield Community Health Center**
    1125 E. California Avenue
    Bakersfield, CA 93307

- Classes are held monthly in English and Spanish. Class discussions include, but are not limited to healthy eating and meal planning, how to use food labels in making food choices, what to eat and avoid, cooking ideas, healthy snacks, and eating out and eating healthy.

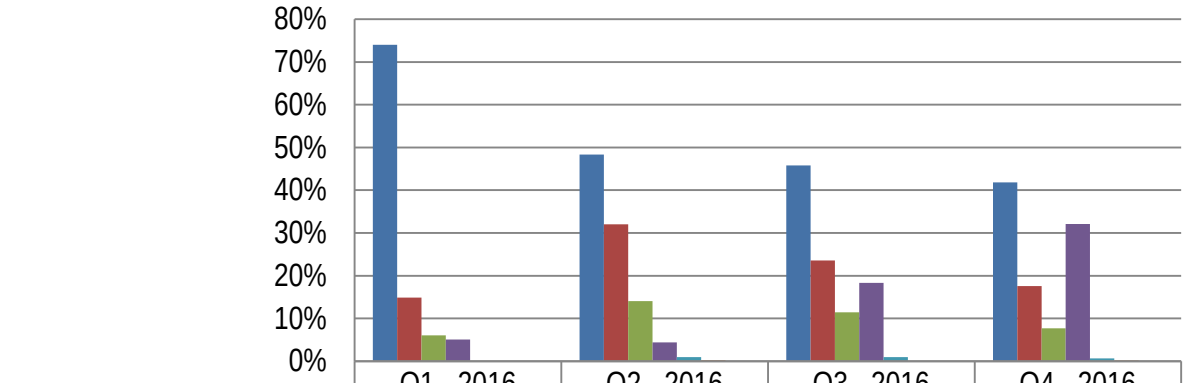
California Smokers' Helpline (CSH):

- Telephone Smoking Cessation Counseling
  - Members are instructed to call:
    - 800-662-8887 (English)
    - 800-456-6386 (Spanish)
  - Members can also be connected by phone to a CSH representative or referred to CSH through their online referral system. CSH offers free telephone counseling, self-help materials, a text messaging program, and online help in six languages to help people quit smoking. A certificate of completion that allows members to fill a prescription for the nicotine patch is mailed to them.

UC Cooperative Extension:

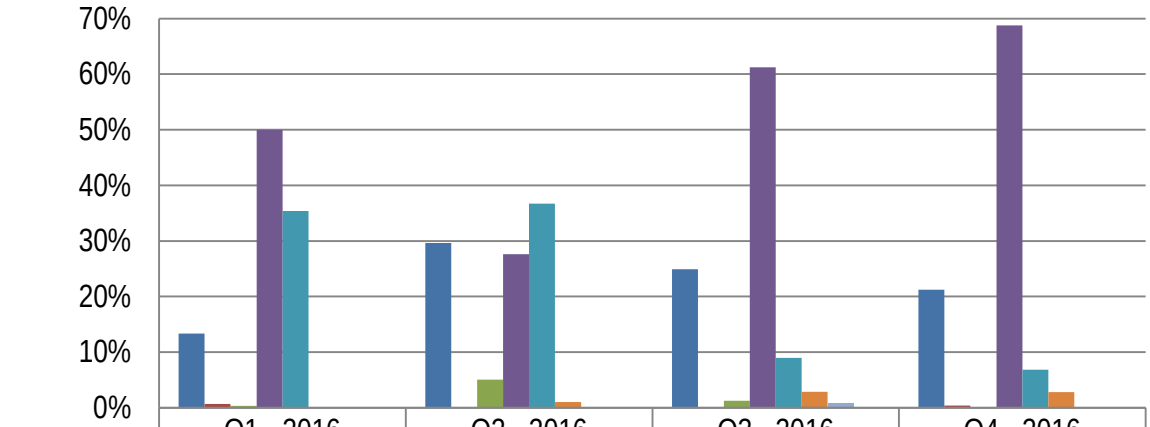
- Eat Smart, Be Active Class Series
  - Class locations vary and are offered once a week for eight weeks in English and Spanish. Classes provide nutrition information, cooking demonstrations, food to taste activities, physical activity, how to saving money, and keeping food safe to eat.

REFERRAL OUTCOMES



	Q1 - 2016	Q2 - 2016	Q3 - 2016	Q4 - 2016
Attend	74%	48%	46%	42%
No Show	15%	32%	24%	18%
Refused	6%	14%	11%	8%
Unable to contact member	5%	4%	18%	32%
Disenrolled	0%	1%	1%	1%
Withdrawn	0%	0.24%	0%	0.17%
Total referrals	416	412	535	598

During this quarter, the rate of members who attended or received health education services out of all members who accepted services remained the same at 45%.

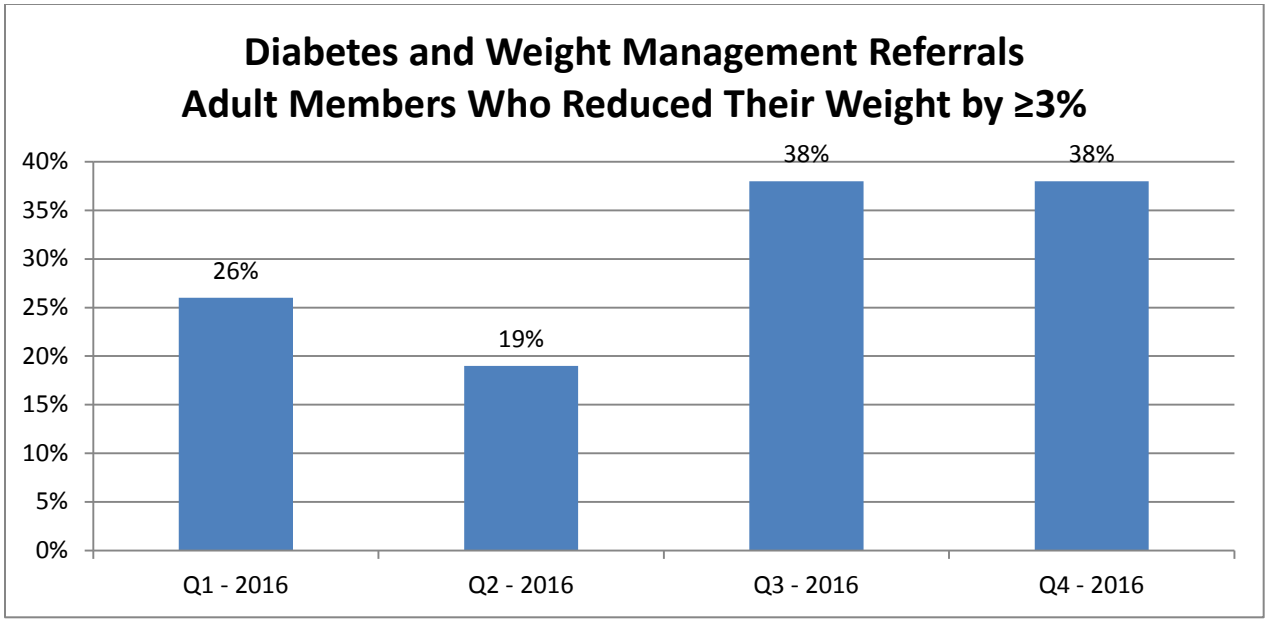


	Q1 - 2016	Q2 - 2016	Q3 - 2016	Q4 - 2016
BMH	13%	30%	25%	21%
CSH	1%	0%	0%	0%
CSV WIC	0.32%	5%	1%	0%
CWP	50%	28%	61%	69%
KFHC	35%	37%	9%	7%
DRMC	0%	1.0%	3%	3%
UCCE	0%	0%	1%	0%
Total	308	199	245	250

CWP classes accounted for the largest share of referral outcomes where a member attended a class or appointment. CWP's share of attended outcomes decreased from 62% to 57%.

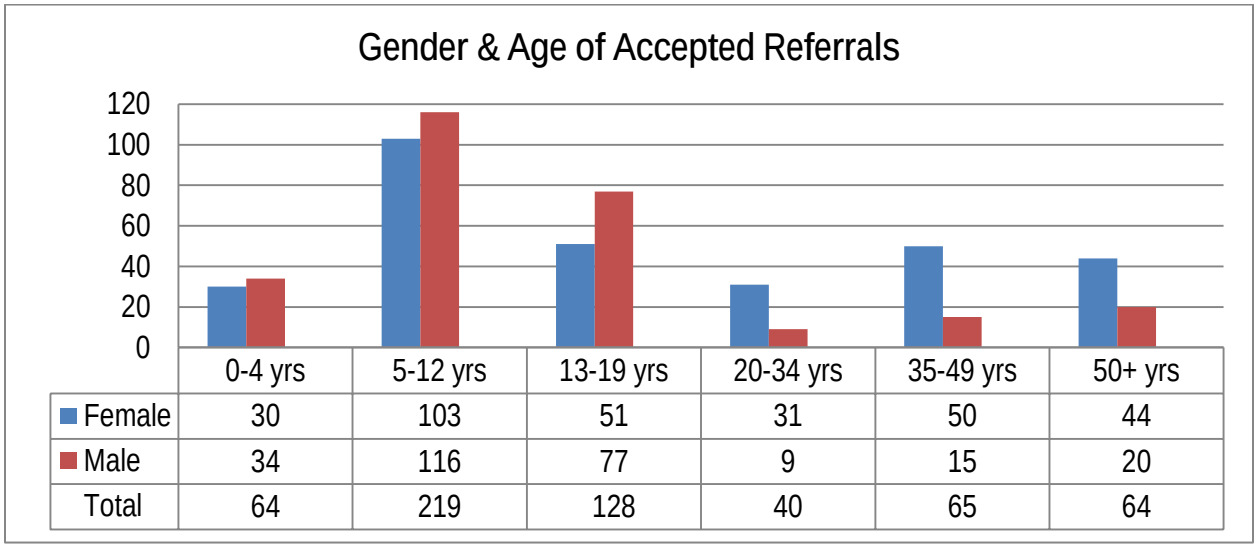
Effectiveness of Health Education Services

To evaluate the effectiveness of the diabetes and weight management health education services provided to members, a 3-month follow up call was conducted on members who received services during the prior quarter. Findings revealed that the rate of members reporting a weight reduction of 3% or greater remained the same at 38%.



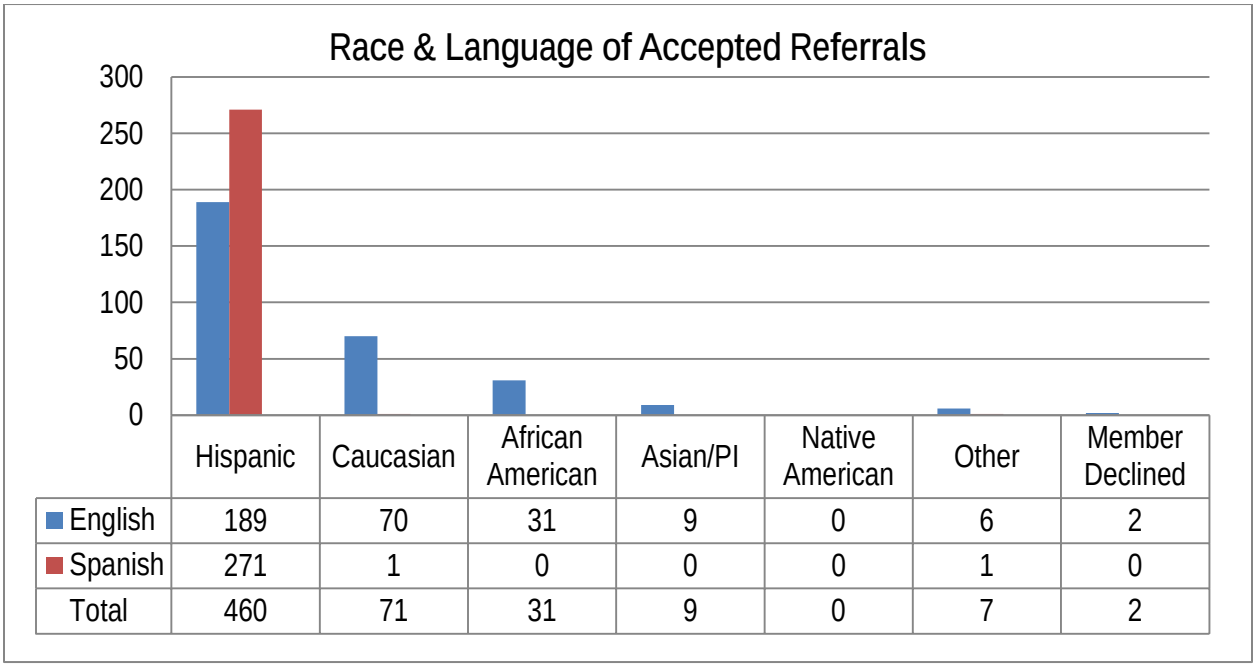
Demographics of Members Served

KHS' HE department provides services to a culturally and linguistically diverse member population. KHS' language threshold is English and Spanish and all services and materials are available in these languages. For non-threshold languages, telephonic interpreters are available through Language Line and American Sign Language (ASL) interpreters are available through Life Signs.



	0-4 yrs	5-12 yrs	13-19 yrs	20-34 yrs	35-49 yrs	50+ yrs
Female	30	103	51	31	50	44
Male	34	116	77	9	15	20
Total	64	219	128	40	65	64

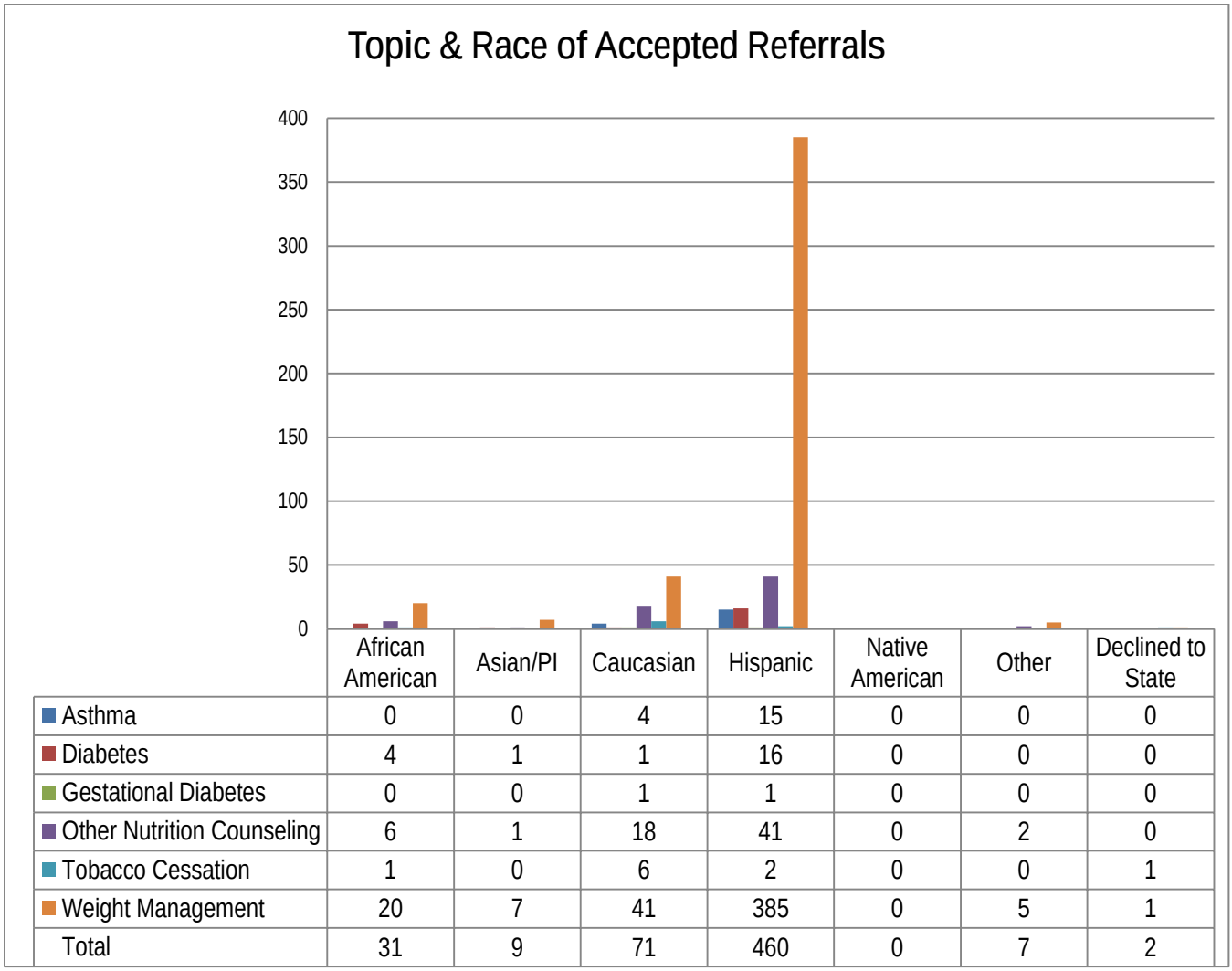
Out of the members who accepted to receive health education services, the largest gender-age groups were male ages 5-12 years and female ages 5-12 years.



	Hispanic	Caucasian	African American	Asian/PI	Native American	Other	Member Declined
English	189	70	31	9	0	6	2
Spanish	271	1	0	0	0	1	0
Total	460	71	31	9	0	7	2

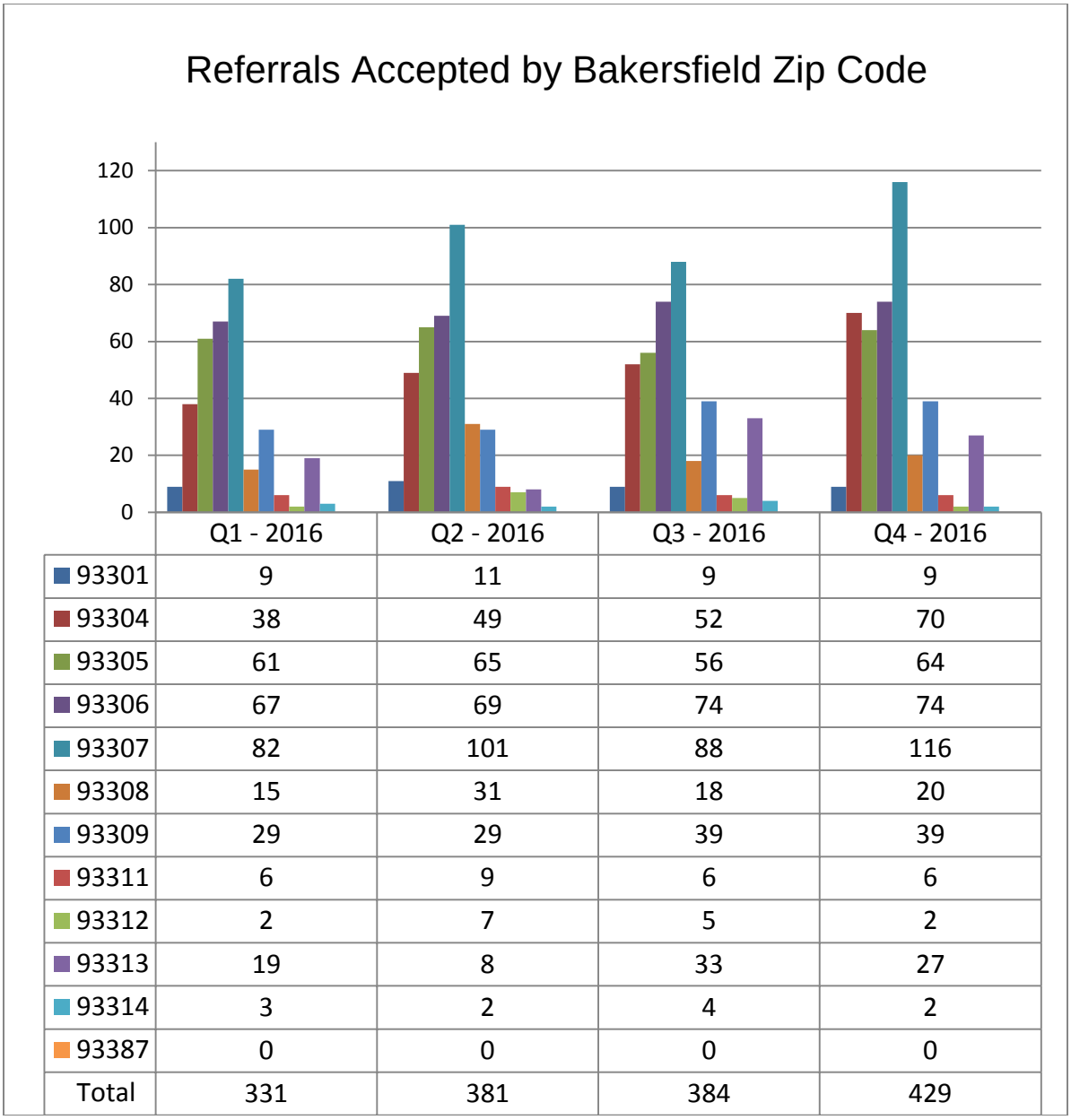
A breakdown of member classifications by race and language preferences revealed that 47% of members who accepted services are Hispanic and preferred to speak Spanish.

Referrals accepted by language and race were assessed during this quarter. Findings revealed that 41% of members who accepted services were Spanish speaking and referred for weight management education to manage obesity.



	African American	Asian/PI	Caucasian	Hispanic	Native American	Other	Declined to State
Asthma	0	0	4	15	0	0	0
Diabetes	4	1	1	16	0	0	0
Gestational Diabetes	0	0	1	1	0	0	0
Other Nutrition Counseling	6	1	18	41	0	2	0
Tobacco Cessation	1	0	6	2	0	0	1
Weight Management	20	7	41	385	0	5	1
Total	31	9	71	460	0	7	2

Additionally, 66% of the members who accepted services were of the Hispanic race and referred for weight management education to manage obesity.

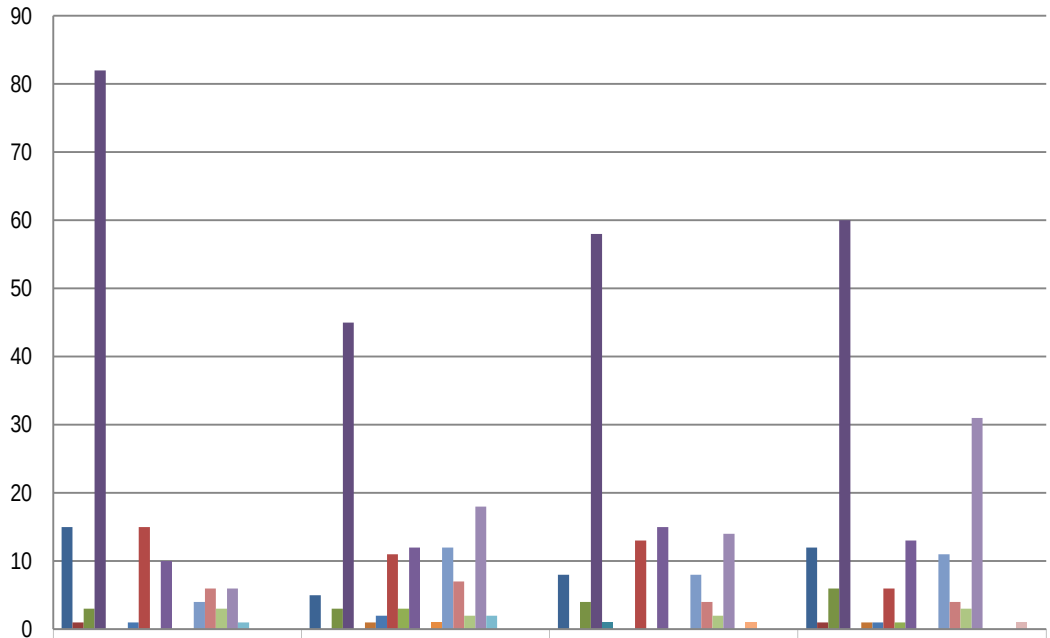


	Q1 - 2016	Q2 - 2016	Q3 - 2016	Q4 - 2016
93301	9	11	9	9
93304	38	49	52	70
93305	61	65	56	64
93306	67	69	74	74
93307	82	101	88	116
93308	15	31	18	20
93309	29	29	39	39
93311	6	9	6	6
93312	2	7	5	2
93313	19	8	33	27
93314	3	2	4	2
93387	0	0	0	0
Total	331	381	384	429

KHS serves members in the Kern County area with the exception of Ridgecrest. During this quarter, 73% of the members who accepted services reside in Bakersfield and the highest concentration of members were in the 93307 area.

KERN HEALTH SYSTEMS HEALTH EDUCATION ACTIVITIES REPORT
FOURTH QUARTER 2016

Referrals by Outlying Areas of Kern County

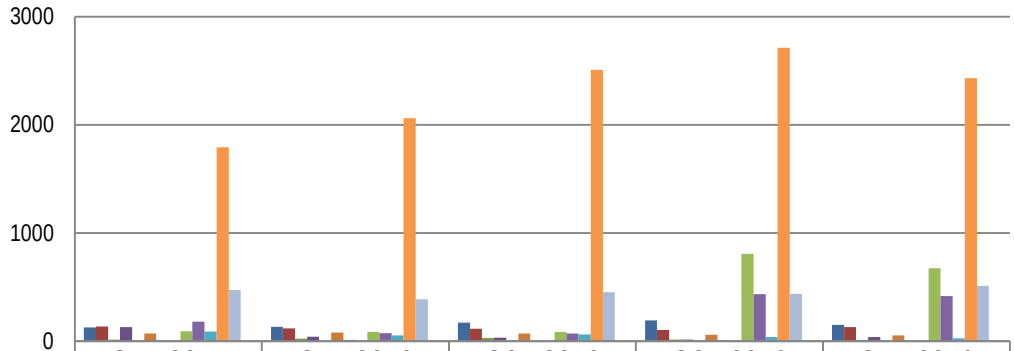


	Q1 - 2016	Q2 - 2016	Q3 - 2016	Q4 - 2016
Arvin	15	5	8	12
Buttonwillow	1	0	0	1
California City	3	3	4	6
Delano	82	45	58	60
Edwards	0	0	1	0
Frazier Park	0	1	0	1
Lake Isabella	1	2	0	1
Lamont	15	11	13	6
Lost Hills	0	3	0	1
McFarland	10	12	15	13
Mojave	0	0	0	0
Rosamond	0	1	0	0
Shafter	4	12	8	11
Taft	6	7	4	4
Tehachapi	3	2	2	3
Wasco	6	18	14	31
Weldon	1	2	0	0
Bodfish	0	0	1	0
Boron	0	0	0	0
Caliente	0	0	0	1
Total	147	124	128	151

Additionally, 26% of the members who accepted services reside in the outlying areas of Kern County and the highest concentration of members in the outlying areas were in Delano.

Health Education Mailings

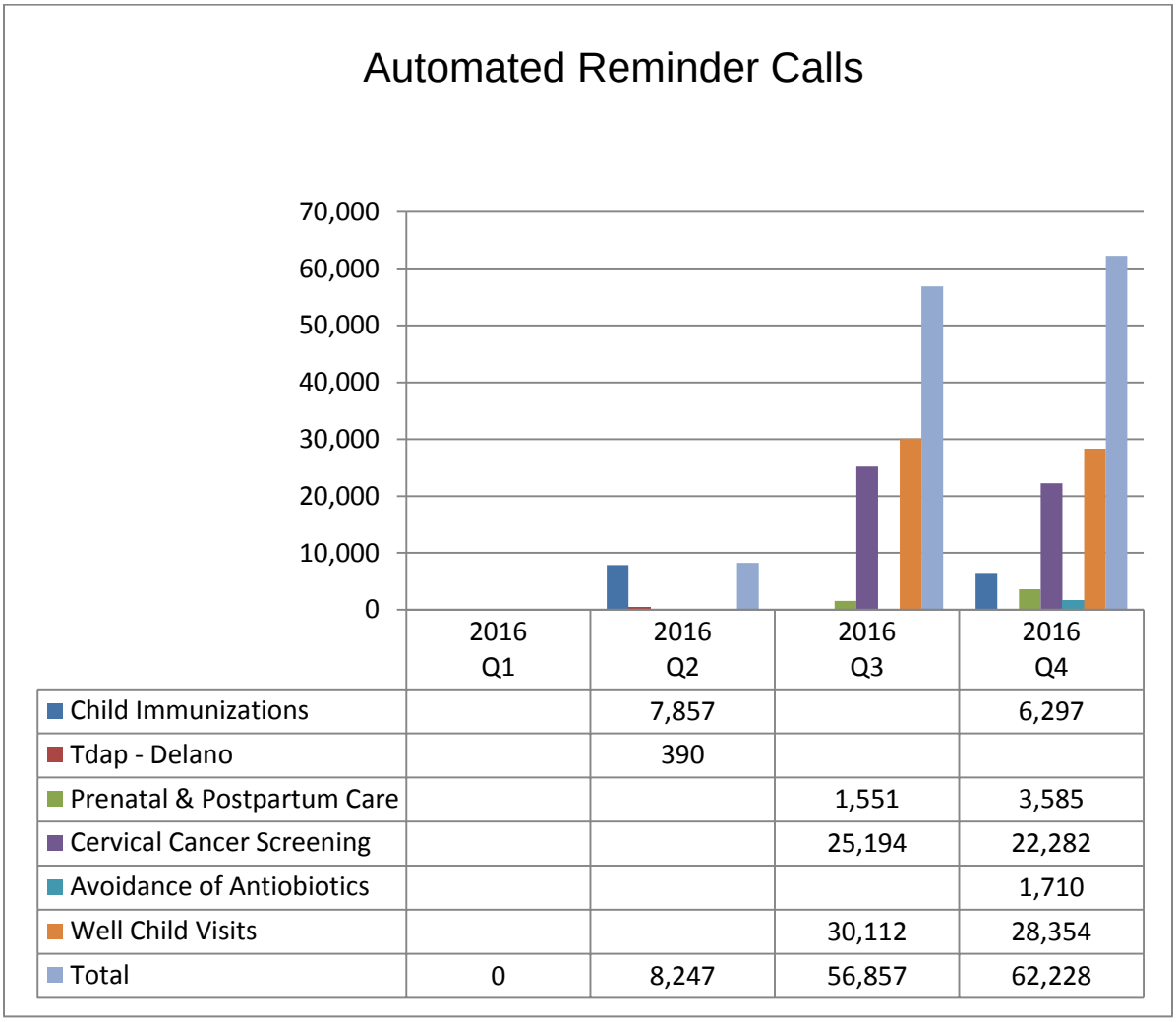
In addition to referrals, the HE department mails out a variety of educational material in an effort to assist members with gaining knowledge on their specific diagnosis or health concern. During this quarter, the HE department mailed 4449 educational packets to members on the following health topics:



	Q4 - 2015	Q1 - 2016	Q2 - 2016	Q3 - 2016	Q4 - 2016
Anemia	126	133	172	191	151
Asthma	136	119	116	104	129
High Cholesterol	16	24	30	16	11
Diabetes	129	43	34	14	40
Gestational Diabetes	3	0	1	2	2
High Blood Pressure	72	80	72	60	52
Nutrition	1	11	3	8	0
COPD	1	0	0	0	0
Postpartum Care	92	85	87	807	676
Prenatal Care	180	74	70	436	417
Smoking Cessation	88	53	62	39	27
Weight Management	1,792	2061	2509	2714	2433
Postpartum Incentive	473	389	453	437	511
Total	3109	3072	3609	4828	4449

AUTOMATED REMINDER CALLS

KFHC's HE Department sends automated reminder calls and text message notifications on different health topics to help members manage chronic health conditions and stay healthy. During this quarter, KFHC sent automated reminder calls to 62,228 members on the importance of cervical cancer screenings, prenatal/postpartum care, or childhood wellness exams and immunizations. Call outcomes revealed 51% of the calls were successfully delivered in the 4th quarter of 2016.



	2016 Q1	2016 Q2	2016 Q3	2016 Q4
Child Immunizations		7,857		6,297
Tdap - Delano		390		
Prenatal & Postpartum Care			1,551	3,585
Cervical Cancer Screening			25,194	22,282
Avoidance of Antiobiotics				1,710
Well Child Visits			30,112	28,354
Total	0	8,247	56,857	62,228

HEALTH EDUCATION SOCIAL MEDIA POSTS

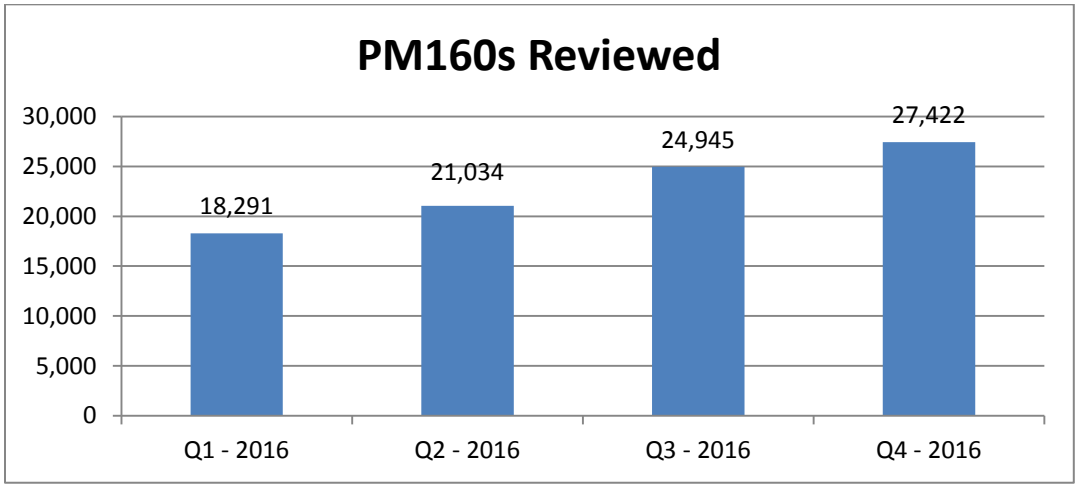
KFHC's HE Department coordinates health education information posts on KFHC's social media pages with KFHC's Marketing Department. KFHC posted a total of 23 Facebook posts and 23

Twitter posts with health education information written or developed by the KFHC HE Department. Topics of KFHC HE posts on social media included:

- Healthy eating, healthy recipe, and physical activity
- Safety
- Cold, flu, and STD prevention
- Maternal and child health
- Diabetes and other chronic disease awareness and prevention
- Mental health awareness

PM160 PROCESSING

KHS Primary Care Providers (PCP) are required to document pediatric preventive care services on a PM160 and submit these forms to KHS. On a daily basis, the HE department reviews these forms to evaluate for possible health education interventions.



INTERPRETER REQUESTS

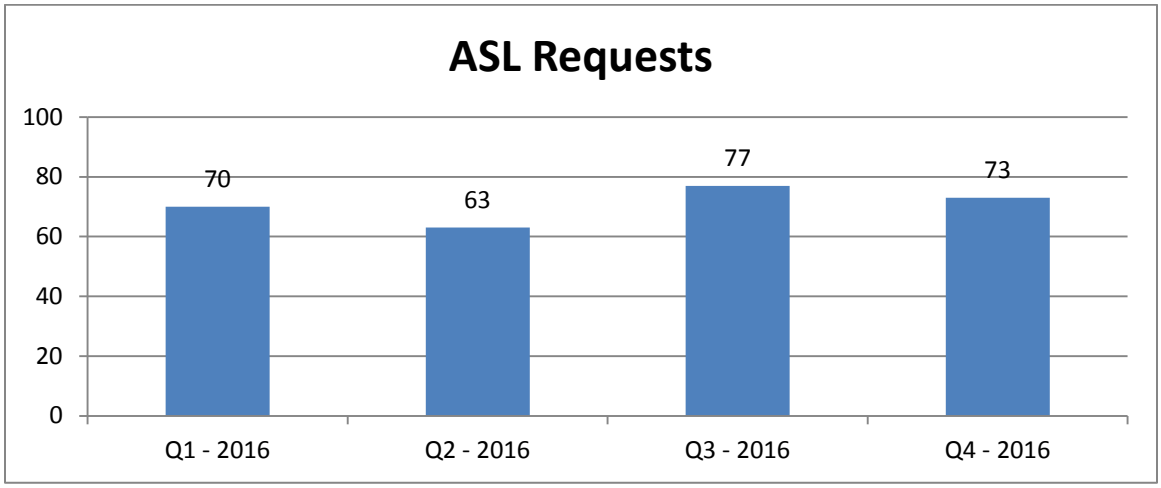
Telephonic Interpreter Requests

During this quarter, there were 297 requests for telephonic interpreting services through KHS' interpreting vendor, Language Line Solutions. The majority of these requests were for a Punjabi interpreter.

	Q1 - 2016	Q2-2016	Q3-2016	Q4-2016
Amharic	0	0	0	4
Arabic	27	34	30	37
Bengali	0	0	1	1
Burmese	0	0	0	1
Cambodian	0	3	5	4
Cantonese	2	2	2	1
Farsi	3	0	0	0
Gujarati	0	1	1	0
Hindi	0	7	0	1
Ilocano	0	4	2	3
Japanese	0	0	0	1
Karen	0	0	1	0
Korean	4	7	2	6
Laotian	1	0	0	0
Mandarin	0	7	14	7
Marshallese	0	0	0	0
Mongolian	0	0	1	0
Polish	9	21	7	1
Punjabi	51	105	107	115
Russian	1	0	0	2
Spanish	7	12	16	75
Tagalog	22	17	14	20
Vietnamese	15	6	14	17
Visayan	1	0	0	1
Tamil	0	1	0	0
Thai	0	2	0	0
Turkish	0	0	1	0
Total	**143**	**229**	**218**	**297**

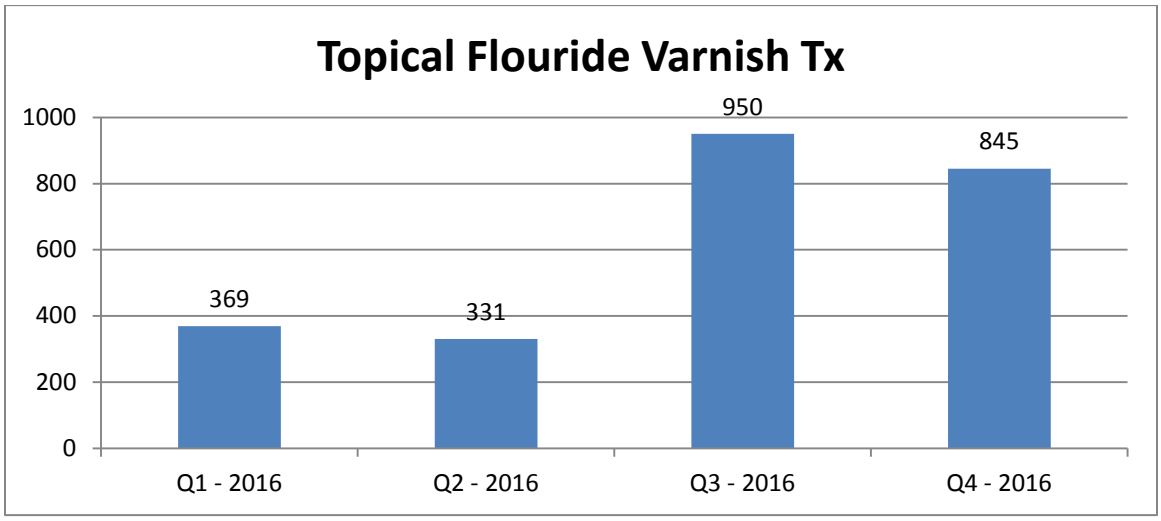
American Sign Language (ASL) Requests

During this quarter, there were a total of 73 requests received for an American Sign Language interpreter, which was a 5% decrease in comparison to the previous quarter.



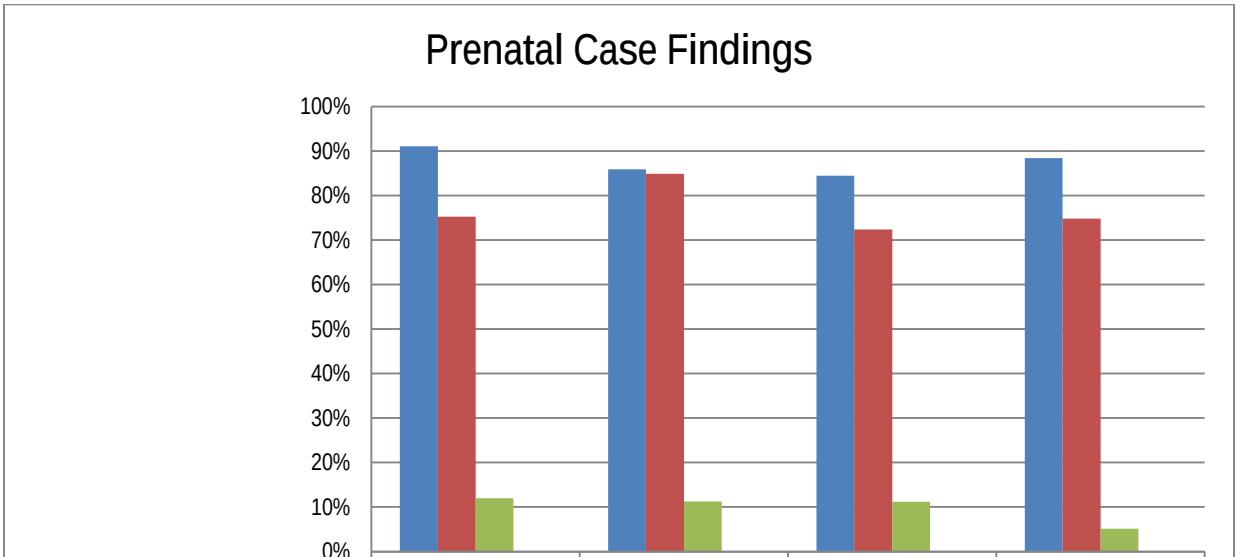
TOPICAL FLUORIDE VARNISH TREATMENTS

Fluoride varnish treatments are effective in preventing tooth decay and more practical and safer to use with young children. KHS covers up to three topical fluoride varnish treatments in a 12-month period for all members younger than 6 years.



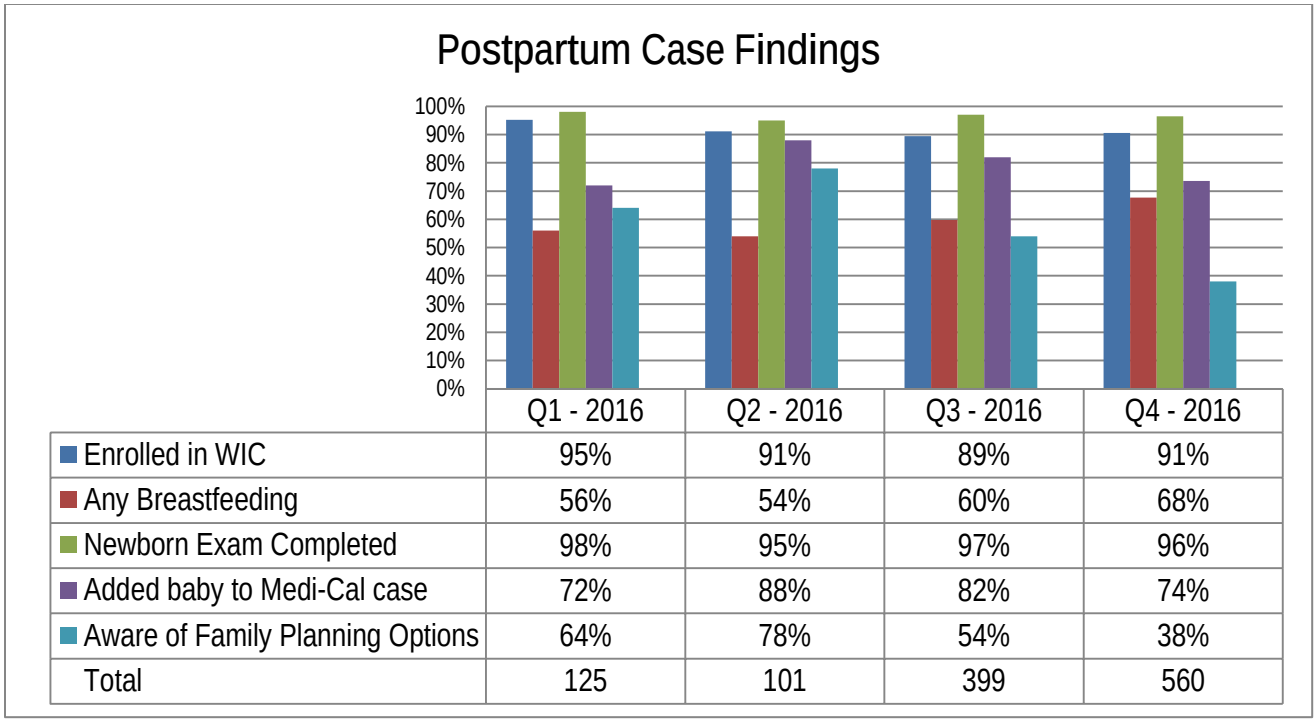
OB CASE MANAGEMENT PROJECT

The HE department performs outreach education calls to all members identified as being pregnant or postpartum.



	Q1 - 2016	Q2 - 2016	Q3 - 2016	Q4 - 2016
Plans to Breastfeed	91%	86%	84%	88%
Enrolled in WIC	75%	85%	72%	75%
Presence of Diabetes or Hypertension	12%	11%	11%	5%
Total	101	99	268	310

During this quarter, the HE department successfully contacted 319 pregnant members. Members who are not successfully contacted by phone and are at least 18 years of age or older are mailed a letter asking them to contact KHS' HE department as soon as possible.

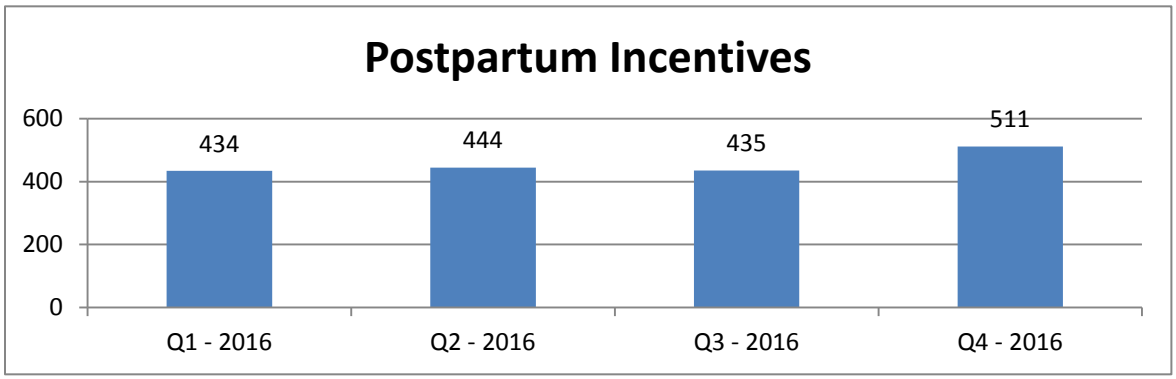


	Q1 - 2016	Q2 - 2016	Q3 - 2016	Q4 - 2016
Enrolled in WIC	95%	91%	89%	91%
Any Breastfeeding	56%	54%	60%	68%
Newborn Exam Completed	98%	95%	97%	96%
Added baby to Medi-Cal case	72%	88%	82%	74%
Aware of Family Planning Options	64%	78%	54%	38%
Total	125	101	399	560

The HE department successfully contacted 560 postpartum members during this quarter. The rate of members who reported any breastfeeding increased from 60% to 68%, which is an all-time high according to data from previous Health Education Activities Reports.

Incentive Projects

In an effort to promote postpartum health, KHS provides a baby "onesie" with a SIDS prevention message to members who complete postpartum exams within 3-8 weeks after delivery. The number of postpartum exam incentive incentives mailed out to members in the 4th quarter increased by 17% in comparison to the previous quarter.



KERN HEALTH SYSTEMS

2016 QUALITY IMPROVEMENT(QI) PROGRAM

EXECUTIVE SUMMARY

Reporting Period: October 1, 2015- September 30, 2016

1. QI ACTIVITIES

According to the Medi-Cal Managed Care Division (MMCD) All Plan Letter, all Medi-Cal managed care health plans are contractually required to report an annual performance measurements results, participate in a consumer satisfaction survey and conduct ongoing quality performance projects (PIPs).

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS):

HEDIS 2016 is the latest edition of the Healthcare Effectiveness Data and Information Set, a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS has been developed and maintained by the National Committee for Quality Assurance (NCQA), a private not-for-profit organization dedicated to improving health care quality, since the early 1990s.

All Medi-Cal managed care health plans must submit annual report scores for the required External Accountability Set (EAS) performance measures. The Department of Health Care Services (DHCS) currently requires all contracted health plans to report selected HEDIS measures to comply with the EAS reporting requirement.

The previous calendar year is the standard measurement year for HEDIS data. Therefore, the HEDIS 2016 results shown in this report are based on 2015 data, with a few exceptions which are noted in the descriptions of the measures.

HEDIS 2016 Results: MCAL

- Measures that exceeded the Minimum Performance Level (MPL)
  - Timeliness of Prenatal Care (PPC)- 79.08%
  - Postpartum Care (PPC)- 54.45%
  - Childhood Immunization Status-Combo #3 (CIS) - 66.13%
  - Immunizations for Adolescents Combo #1(IMA) - 78.10%
  - Controlling High Blood Pressure (CBP) – 50.85%
  - Use of Imaging Studies for Low Back Pain (LBP) - 76.04%
  - HbA1c Testing (CDC) - 84.31%

- HbA1c Control (<8.0%) (CDC) - 40.88%
- HbA1c Poor Control (>9.0%) (CDC) - 47.99%
- Diabetic Retinal Eye Exam (CDC) - 49.82%
- Medical Attention for Nephropathy* (CDC) - 50.51%
- Blood Pressure Control* (<140/90 mm HG) (CDC) - 61.86%
- BMI Percentile (WCC) – 69.59%
- Counseling for Nutrition (WCC) – 66.67%
- Counseling for Physical Activity (WCC) - 57.91%
- Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life – 67.15%
- Medical Management for People with Asthma
  - Medication compliance 50% Total – 49.71%
  - Medication Compliance 75% Total – 25.43%
- Annual Monitoring for Patients on Persistent Medications (MPM)
  - ACE Inhibitors or ARBs- 89.26%
  - Digoxin - 46.27%
  - Diuretics - 88.72%

➢ Measures that were below the MPL:

- Children and Adolescents' Access to Primary Care Practitioners (CAP)
  - 12-24 months - %
  - 25 months-6 years - 82.43%
  - 7-11 years - 82.70%
  - 12-19 years - 81.16%
-
- Cervical Cancer Screenings (CCS) - 52.07%
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis – 21.22%

MMCD All Plan Letter states that for each measure that does not meet the established MPL or is reported as "No Report"(NR), the health plan must submit an Improvement Plan (IP) within 60 days of being notified by DHCS of the measures for which IPs are required. The CAP measures are excluded from Improvement Plans

CONSUMER STATISFACTION SURVEYS (CAHPS):

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for both adults and children was administered by the EQRO in 2016. DHCS will provided the "sample frame" member information for contracted health plans to the EQRO.

PERFORMANCE IMPROVEMENT PROJECTS (PIPs):

MMCD All Plan Letter states that full-scope health plans are required to conduct and/or participate in two (2) PIPs. Kern Health Systems chose Childhood Immunizations and Management of Members with Asthma as our two topics

- Childhood Immunizations PIP
  - Goal: By June 30, 2017, we will increase the 12-month rolling average for Drs. S's practice by 5 percentage points when compared to the June 2015 12-month rolling average rate of 21.23% (21.23% to 26.23%).
  - Measurement Period: 12-month rolling average as of June 2015
  - Baseline Rate: = 21.23%. The rolling average was calculated by summing the associated numerators between July 2014 and June 2015 and dividing by the sum of the associated denominators between July 2014 and June 2015.
  - Data Collection Methodology: Rates will be calculated based on Trending Report outlined in Module 2 and review of members' charts to obtain rolling 12 month average.
  - Auditor's Validation: KHS submitted modules 1 and 2 to the EQRO in January 2016. HSAG accepted modules 1 and 2.
- Management of Members with Asthma PIP
  - Goal
  - By June 30, 2017, we will increase the 12-month rolling average for Drs. Senar's practice by 5 percentage points when compared to the June 2015 12-month rolling average rate of 21.23% (21.23% to 26.23%).
  - Measurement Period: 12-month rolling average as of June 2015
  - Baseline Rate: = 21.23%. The rolling average was calculated by summing the associated numerators between July 2014 and June 2015 and dividing by the sum of the associated denominators between July 2014 and June 2015.
  - Data Collection Methodology: Rates will be calculated based on Trending Report outlined in Module 2 and review of members' charts to obtain rolling 12 month average.
  - Auditor's Validation: KHS submitted modules 1 and 2 to the EQRO in January 2016. HSAG accepted modules 1 and 2.

2. FACILITY SITE REVIEWS AND COLLABORATION

Kern Health Systems (KHS) personnel performs a facility site review on all contracted primary care (including OB/GYNs and Pediatric) providers. Personnel performing the site review are trained by a Medi-Cal Managed Care Division (MMCD) nurse on the required criteria for site compliance. All contracting plans within a county have equal responsibility for the coordination and consolidation of provider site reviews. Site review responsibilities are shared equally by all plans within the county.

The purpose of conducting site reviews is to ensure that all contracted PCP sites used by plans for delivery of services to plan members have sufficient capacity to: 1) provide appropriate primary health care services; 2) carry out processes that support continuity and coordination of care; 3) maintain patient safety standards and practices; and 4) operate in compliance with all applicable federal, state, and local laws and regulations.

- Facility Site Review (FSR)
  - During the reporting period, there were 47 facilities that received a FSR.
    - *Scoring*
      - 47 facilities scored between 90-100%
      - No site facilities scored between 80-89%
      - No site facilities scored under 80%
    - *Corrective Action Plans (CAPs)*
      - Eight of the 47 sites reviewed were issued a CAP.
        - All sites have come into compliance and the CAPs have all been closed.

- Medical Record Review (MRR)
  - During the reporting period, there were 41 medical record reviews were performed
    - *Scoring*
      - 0 40 facilities scored between 90-100%
      - One facility scored between 80-89%
      - No sites scored under 80%
    - *Corrective Action Plans (CAPs)*
      - 14 of the 41 sites reviewed t were issued CAPs.
      - . All of the sites reviewed have come into compliance and the CAPs have been closed..

3. MONITORING AND FOCUS REVIEWS

All PCP sites are monitored between each regularly scheduled full scope site review survey. Methods may include site visits, but also include methodologies other than site visits. Monitoring sites between audits shall include the use of both internal systems and external sources of information. Evaluation of the nine critical elements shall be monitored on all sites between full scope site surveys.

The focused review is a "targeted" audit of one or more specific site or medical record review survey areas, and is not substituted for the full scope survey. Focused reviews are used to monitor providers between full scope site review surveys, to investigate problems identified through monitoring activities, or to follow up on corrective actions.

- Critical Elements Monitoring
- Diabetes Care Monitoring
- Asthma Care Monitoring
- Prenatal Care Monitoring

- Initial Health Assessment (IHA)
- IHEBA aka Staying Healthy Assessment
- California Children's Service (CCS)
- KRC Monitoring
- Referral Process Monitoring

QI Program Evaluation
2016

Reporting Period: October 1, 2015- September 30, 2016

1. QI ACTIVITIES

According to the Medi-Cal Managed Care Division (MMCD) APL 15-024 all Medi-Cal managed care health plans are contractually required to report an annual performance measurements results, participate in a consumer satisfaction survey and conduct ongoing quality improvement projects (PIPs).

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS):

HEDIS 2016 is the latest edition of the Healthcare Effectiveness Data and Information Set, a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS has been developed and maintained by the National Committee for Quality Assurance (NCQA), a private not-for-profit organization dedicated to improving health care quality, since the early 1990s.

All Medi-Cal managed care health plans must submit annual report scores for the required External Accountability Set (EAS) performance measures. The Department of Health Care Services (DHCS) currently requires all contracted health plans to report selected HEDIS measures to comply with the EAS reporting requirement.

The previous calendar year is the standard measurement year for HEDIS data. Therefore, the HEDIS 2016 results shown in this report are based on 2015 data, with a few exceptions which are noted in the descriptions of the measures. HEDIS 2016 results can be found in Appendix A. APL 15-024 also states that for each measure that does not meet the established MPL or is reported as "No Report" (NR), the health plan must submit an Improvement Plan (IP) within 60 days of being notified by DHCS of the measures for which IPs are required. KHS submitted IPs for the AAB and CCS measures for HEDIS 2016 and submitted PIPs for the CIS-Combo 3 and the MMA measures. All were accepted by DHCS

CONSUMER STATISFACTION SURVEYS (CAHPS):

Per MMCD APL 15-024 the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for both adults and children was administered by the EQRO in 2016. DHCS provided the "sample frame" member information for contracted health plans to the EQRO. No CAHPS surveys will be required for the next 3 years.

QUALITY IMPROVEMENT PROJECTS (PIPs):

KHS's QIPS were Diabetes Care and All-Cause Readmissions. Executive Leadership ensured resources were allocated to these topics. QIPs were retired per APL 14-024 and replaced with PIPs. KHS's PIPs are Immunizations for Children Two Years of Age based on HEDIS measure use CIS-Combo3 and The Use of Controller Medication in Persons with Asthma based on the MMA measure. These PIPs follow the PDSA format formalized into five modules. KHS has submitted Modules 1-3 and are now in Module 4 which is Intervention Testing.

All-Cause Readmission: KHS completes retrospective review of all cases by QI and CM. The Transition of Care Program is ongoing including Medication Reconciliation and a Post-Discharge clinic for discharge patients who are unable to be seen by their PCPs within 3 or 4 days. Health Homes will be piloted in 2017

Diabetes Care: Health Education expanded their text messaging program further in 2016. The Delano Diabetes clinic was spread to an additional site affiliated with Bakersfield Memorial Hospital.

2. FACILITY SITE REVIEWS AND COLLABORATION

Kern Health Systems (KHS) personnel perform a facility site review on all contracted primary care providers. This includes Internal Medicine, General and Family Practice, OB/GYN and Pediatricians in free-standing offices, IPAs or Clinics. OB/GYN not acting as PCPs and Urgent Care Clinics are considered high volume providers and receive site reviews as well.

Personnel performing the site review are trained by a Medi-Cal Managed Care Division (MMCD) nurse on the required criteria for site compliance. All contracting plans within a county have equal responsibility for the coordination and consolidation of provider site reviews. Site review responsibilities are shared equally by all plans within the county. KHS has a MOU with Health Net and both plans shares site review information.

The purpose of conducting site reviews is to ensure that all contracted PCP sites used by plans for delivery of services to plan members have sufficient capacity to: 1) provide appropriate primary health care services; 2) carry out processes that support continuity and coordination of care; 3) maintain patient safety standards and practices; and 4) operate in compliance with all applicable federal, state, and local laws and regulations.

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The focused review is a "targeted" audit of one or more specific site or medical record review survey areas, and is not substituted for the full scope survey. Focused reviews are used to monitor providers between full scope site review surveys, to investigate problems identified through monitoring activities, or to follow up on corrective actions. The nine critical elements are always reviewed. Additional areas of monitoring may include but are not limited to:

- Diabetes Care Monitoring
- Asthma Care Monitoring
- Prenatal Care Monitoring
- Initial Health Assessment (IHA)
- IHEBA aka Staying Healthy Assessment
- California Children's Service (CCS)
- KRC Monitoring
- Referral Process Monitoring
- SBIRT
- Tobacco use
- Other preventive care services

QI PROGRAM OVERVIEW

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
Oversight of all delegated QI functions for the following services: • Kaiser • VSP	Met	8/25/2016	QI and UM evaluations, programs and workplans for Kaiser and VSP are expected to be placed on the agenda of the August 2016 QI/UM committee	Complete for 2016
QI Policies and Procedures	Met	Ongoing	1. QI Policies and Procedures are updated annually as well as reviewed periodically in order to comply with any new regulatory requirements.	Complete for 2016

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			2. Each policy and procedure is reviewed against the DHCS contract and regulatory requirements and revised as needed to ensure compliance. 3. Revisions to current QI policies and procedures have been taken to the QI/UM committee 4. Delegated credentialing tools provided and policy review done with Provider Relations Department and UM	
Audits				
P4P	Met	9/30/2016	P4P – The ongoing P4P audit was performed to evaluate the use of Provider portal to capture IHA, Prenatal and BMI percentile/Weight counselling. Providers who had scored 100% in 4 sequential audits were omitted from the denominator and will be assessed yearly. A random sample of the remaining providers' were audited and results were shared with the CMO and Director of PR	Complete for 2016
ER prescription audit	Met	9/30/2016	AIS Rx – QI performed quarterly audits for AIS to evaluate if a sufficient amount of medications were given to members who accessed ER and were given a prescription to fill on discharge. Results were given to AIS	Complete for 2016
Site review timeliness audit	Met	9/30/2016	Site Review Timeliness – A quarterly retrospective audit was performed to ensure that Site and Medical Record reviews were done on time. All site reviews and follow-up in this time period were timely.	Complete for 2016
Clinical Guidelines	Met	9/30/2016	The PAC reviewed and completed the following Clinical Guidelines and related policies:	Complete for 2016

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			1. Stress Testing 2. Crash Cart Guidelines 3. General Exam Guidelines 4. Medical Records and Other Protected Health Information 5. Mammography Guidelines	
Diabetes Care	Met	9/30/2016	21 charts were reviewed during focused reviews to evaluate diabetes care. Performance was discussed with provider and/or office staff. Due to low denominators, QI is discontinuing this audit and focusing on positive Staying Healthy Assessments (SHAs) in collaboration with Health Education.	Complete for 2016 and discontinued
Asthma Care	Met	9/30/2016	33 charts were reviewed during focused reviews to evaluate asthma care. Performance was discussed with provider and/or office staff. Due to low denominators, QI is discontinuing this audit and focusing on positive Staying Healthy Assessments (SHAs) in collaboration with Health Education.	Complete for 2016 and discontinued
30 day readmission	Met	Ongoing	The QI department continues to look for opportunities for improvement in members who are readmitted within 30 days of discharge. This organization-wide focus has brought the following changes: • Social Workers have been added to the CM Department to better serve the member • Transition of Care program is ongoing, identifying members at risk of readmission and linking them to appropriate services including medication reconciliation and a Discharge Clinic	Complete for 2016

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
Notifications (Death, General)	Met	Ongoing	The QI department continues to look for opportunities for improvement through the Notification process. Concurrent and retrospective reviews have identified internal opportunities for improvement. All notifications are tracked and trended information is shared with the Associate Medical Director during the re-credentialing process	Complete for 2016
Grievances	Met	Ongoing	The QI department continues to look for opportunities for improvement through the Grievance process. Retrospective reviews have identified external opportunities for improvement. All notifications are tracked and trended information is shared with the Associate Medical Director during the re-credentialing process	Complete for 2016
Resources				
• Director of Quality Improvement	Not Met	TBD	This position remained vacant all year and is no longer posted	unknown
• QI supervisor	Met	9/30/2016	The department's QI supervisor provides oversight of all QI activities, reporting to the Administrative Director Health Services and the CMO	Complete for 2016
• QI RN II	Met	9/30/2016	The department currently has three RN II positions. Each position is filled by a senior RN in the department. The positions are: • Master Trainer • HEDIS RN • Clinical Liaison	Complete for 2016
• QI RN I	Met	9/30/2016	The QI department is at full staff. QI RN I = 3 FTEs	Complete for 2016
• QI Coordinator	New	9/30/2016	This position was budgeted for 2015 to insource	Complete for 2016

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			HEDIS Medical Record retrieval and has been very successful	
• QI Assistant	New	9/30/2016	This is the second position budgeted for 2015 to insource HEDIS Medical Record retrieval. This position also is responsible for the Member Incentive.	Complete for 2016
• Business Analyst	Met	9/30/2016	This position is responsible for providing an advanced role in the analysis of health care information as it relates to multiple disciplines for Health Services. This Business Analyst reports directly to the CMO.	Complete for 2016
Senior Support Clerk	Met	9/30/2016	QI has two (2) SSCs who support the clerical needs of the department for site reviews and medical record reviews.	Complete for 2015
QI Projects				
QI Workflows	Not Met	9/30/2016	No projects related to QI workflow were completed in 2015/16	N/A
QI site automation	Not Met	9/30/2015	No projects related to QI site reviews were completed in 2015/16:	N/A
Modifier 25 education	Met	9/30/2016	Data analysis of performance in the pediatric HEDIS measures showed that many young members only saw their PCP for injury or illness. In order to capture immunizations and more extensive assessments, educational material was developed to help providers and offices convert applicable sick visit to well visits with modifier 25. This would allow provider payment for immunization and other preventive care done during a sick visit. The provider portal was adapted to show each unmet	Ongoing through the remainder of 2016

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			HEDIS/P4P measure on the eligibility screen which the office staff can print and flag for the provider	
Member Incentive	Met	12/31/2015	To motivate young members and their families to see their PCP for well-visits, a member incentive was trialed in November 2014. This 'Wellness Rewards Program' offered 2 movie tickets for each child who had a well-visit through the end of 2014. The head of household's name was put in a monthly raffle for the chance to win one of ten $25.00 gift certificates. The trial was a success and the incentive has now become an ongoing event. The 2015 member incentive, targeting members ages 12 months to 19 years of age was started 7/1/2015. 20,995 letters were mailed to households of 29,393 pediatric members notifying them of the opportunity to receive two movie tickets and be involved in a monthly raffle for one of ten $25.00 gift certificates. 660 letters, consisting of 923 members in came back undeliverable. The 2016 member incentive was begun in July 2016 with the modification of the monthly raffle prize being reduced to $10.00 but choosing twenty five winners. The Wellness Rewards Program was introduced to providers through provider bulletins, staff meetings and QI site visits. Pediatric providers were encouraged to call their eligible members and reference the program to encourage members to	2015 member incentive complete. 2016 member incentive ongoing through the remainder of 2016

<table>
<tr><th>Goal</th><th>Metrics</th><th>Target Completion</th><th>Action Steps and Monitoring</th><th>Results</th></tr>
<tr><td></td><td></td><td></td><td>come in for their IHA, immunizations and well visits.</td><td></td></tr>
<tr><td colspan="5">Committees</td></tr>
<tr><td>Quality Improvement/Utilization Management Committee (QI/UMC)</td><td>Met</td><td>Quarterly - ongoing</td><td>1. Reports to the Board of Directors and retains oversight of the QI Program with direction from the Medical Director.
2. The QI/UMC promulgates the quality improvement process to participating groups and physicians, practitioner/providers, subcommittees, and internal KHS functional areas with oversight by the Chief Medical Officer.
3. Committee also performs oversight of UM activities conducted by KHS to maintain high quality health care and effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services.
4. Nine (9) of the eleven (11) positions are filled; four (4) QI/UMC meetings were held in the reporting period with attendance as follows:
<table>
<tr><th>Position</th><th>Attended</th><th>Representative</th></tr>
<tr><td>CMO/Medical Director</td><td>1/4</td><td>Dr Gowda/Dr Harris</td></tr>
<tr><td>#1 Family Practitioner</td><td>4</td><td>Bruce Taylor</td></tr>
<tr><td>#2 Pediatrician</td><td>1</td><td>Nilesh Shah</td></tr>
<tr><td>Specialist #1 OB/GYN</td><td>3</td><td>R Sharma – now vacant</td></tr>
<tr><td>Specialist #2 ENT</td><td>4</td><td>Dr. Arya</td></tr>
<tr><td>Home Health</td><td>4</td><td>Felicia Crawford</td></tr>
<tr><td>Mid-Level Practitioner</td><td>4</td><td>Bill Redman/ Danielle Colayco</td></tr>
<tr><td>Public Health</td><td>4</td><td>Jennifer Ansolabehere, P.H.N.</td></tr>
<tr><td>Ancillary #1</td><td>4</td><td>Maridette from Omni</td></tr>
<tr><td>Ancillary #2</td><td>4</td><td>Maria DeLima, rural.</td></tr>
<tr><td>Hospital Representative</td><td>vacant</td><td></td></tr>
</table></td><td>Complete for 2016</td></tr>
</table>

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
	Met	9/30/2016	1. Practitioner attendance and participation in the QI/UM Committee or subcommittees is required. 2. The participating practitioners represent a broad spectrum of specialties and participate in clinical QI and UM activities, guideline development, peer review committees and clinically related task forces. 3. The extent of participation must be relevant to the QI activities undertaken by KHS.	Complete for 2016
	Met	9/30/2016	1. Practitioner participation and attendance for this reporting period continue to result in improved communication. 2. Participating practitioners who are involved in the QI Program also serve as a communications conduit to the practitioner community. 3. These practitioners help educate participating practitioners and providers about the principles of QI and UM, it's specific quality activities and the results of these activities	Complete for 2016
Physician Advisory Committee (PAC)	Met	9/30/2016	1. Serves as advisor to the Board of Directors on health care issues, peer review, provider discipline, and credentialing/recredentialing decisions. 2. This committee meets on a monthly basis and is responsible for reviewing practitioner/provider grievances and/or appeals, practitioner/provider quality issues, and other peer review matters as directed by the KHS	Complete for 2016

<table>
<tr><th>Goal</th><th>Metrics</th><th>Target Completion</th><th>Action Steps and Monitoring</th><th>Results</th></tr>
<tr><td></td><td></td><td></td><td>Medical Director.
3. The PAC has a total of eight (8) voting committee positions.</td><td></td></tr>
<tr><td></td><td>Met</td><td>9/30/2016</td><td>Eleven (11) PAC meetings were held during the reporting period with attendance as follows:
<table><tr><th>Attendee</th><th>Meetings Attended</th></tr><tr><td>Dr Gowda/Dr Harris</td><td>11</td></tr><tr><td>Hasmukh Amin, M.D.</td><td>7</td></tr><tr><td>Angela Egbikuadje, PD.MS, Ph.D</td><td>0</td></tr><tr><td>David Hair, M.D.</td><td>11</td></tr><tr><td>Miguel Lascano, M.D.</td><td>6</td></tr><tr><td>Ashok Parmar, M.D.</td><td>11</td></tr><tr><td>Raju Patel, M.D.</td><td>11</td></tr><tr><td>Jacqueline Paul-Gordon, M.D.</td><td>10</td></tr></table></td><td>Complete for 2016</td></tr>
<tr><td></td><td>Met</td><td>9/30/2016</td><td>The PAC reviewed and completed the following Clinical Guidelines and related policies:
1 Stress Testing
2 Crash Cart Guidelines
3 General Exam Guidelines
4 Medical Records and Other Protected Health Information
5 Mammography Guidelines</td><td>Complete for 2016</td></tr>
<tr><td>Pharmacy and Therapeutics Committee (P&T)</td><td>Met</td><td>9/30/2016</td><td>1. Serves to objectively appraise, evaluate and select pharmaceutical products for formulary addition or deletion.
2. This is an ongoing process to ensure the optimal use of therapeutic agents.
3. P&T meet quarterly to review products to evaluate efficacy, safety, ease of use and cost.
4. Medications are evaluated on their clinical use</td><td>Complete for 2016</td></tr>
</table>

<table>
<tr><th>Goal</th><th>Metrics</th><th>Target Completion</th><th>Action Steps and Monitoring</th><th>Results</th></tr>
<tr><td></td><td></td><td></td><td>and develop policies for managing drug use and administration.</td><td></td></tr>
<tr><td></td><td>Met</td><td>9/30/2016</td><td>Three (3) P&T meetings were held during the reporting period with attendance as follows:
<table>
<tr><th>Attendee</th><th>Meetings Attended</th></tr>
<tr><td>Alison Bell, Pharm. D</td><td>2</td></tr>
<tr><td>Dilbaugh Gehlawat, M.D.</td><td>3</td></tr>
<tr><td>Paul J. Herndon, Pharm. D</td><td>3</td></tr>
<tr><td>Kimberly Hoffmann, Pharm. D</td><td>3</td></tr>
<tr><td>Jeremiah (Jay) Josen, Pharm. D</td><td>3</td></tr>
<tr><td>Sam Ratnayake, M.D.</td><td>0</td></tr>
<tr><td>Sarabjeet Singh, M.D.</td><td>2</td></tr>
<tr><td>Vasanthi Srinivas, M.D</td><td>2</td></tr>
</table></td><td>Complete for 2016</td></tr>
<tr><td>Public Policy/Community Advisory Committee (PP/CAC)</td><td>Met</td><td>9/30/2016</td><td>1. PAC provides a mechanism or structured input from KHS members and community representatives regarding how KHS operations impact the delivery of care.
2. The PP/CAC is supported by the Board of Directors to provide input in the development of public policy activities for KHS.
3. The committee meets every four months and provides recommendations and reports findings to the Board of Directors.</td><td>Complete for 2016</td></tr>
<tr><td></td><td>Met</td><td>9/30/2016</td><td>PP/CAC has twelve (12) committee positions. Seven (7) of the twelve (12) positions were filled; Four (4) PP/CAC meetings were held in the reporting period with attendance as follows:</td><td>Complete for 2016</td></tr>
</table>

<table>
<tr><th>Goal</th><th>Metrics</th><th>Target Completion</th><th>Action Steps and Monitoring</th><th>Results</th></tr>
<tr><td></td><td></td><td></td><td>
<table>
<tr><th>Attendee</th><th>Meetings Attended</th></tr>
<tr><td>Dr Gowda</td><td>1</td></tr>
<tr><td>Basulto, Beatriz</td><td>3</td></tr>
<tr><td>Hernandez-Colin, Santa Cecilia</td><td>1</td></tr>
<tr><td>Albert, Jenny</td><td>0</td></tr>
<tr><td>Hefner, Janet</td><td>4</td></tr>
<tr><td>Wood-Slayton, Jennifer</td><td>2</td></tr>
<tr><td>Vega, Juan</td><td>3</td></tr>
<tr><td>Townsend, Pam</td><td>3</td></tr>
</table>
</td><td></td></tr>
<tr><td colspan="5">Regulatory Compliance</td></tr>
<tr><td>DHCS audit</td><td>Met</td><td>8/29-9/9/2015</td><td>DHCS performed a general audit. There were no findings related to QI</td><td>Complete for 2016</td></tr>
<tr><td>HEDIS 2016</td><td>Met</td><td>6/30/2016</td><td>On 6/15/2016, all elements of HEDIS 2015 were complete and approved by HSAG and NCQA accepted our submission. We did not meet the AAB or CCS measures and Improvement Plans were submitted to DHCS</td><td>Complete for 2016</td></tr>
<tr><td>AAB IP</td><td>ongoing</td><td>12/31/2016</td><td>In HEDIS 2016, KHS did not meet the MPL for the AAB measures. Interventions to raise the rates included:
Evaluation of data showed Urgent Care Centers being the highest volume prescribers for antibiotics for members with bronchitis
AAB posters explaining why antibiotics are not helpful when someone has bronchitis were placed in UCC waiting areas
Peer to peer education where our Associate Medical Director met with providers
Member outreach with call, pre-test,</td><td>Ongoing through 2016</td></tr>
</table>

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			mailing of AAB magnet and post-test	
CCS IP	ongoing	12/31/2016	In HEDIS 2016, KHS did not meet the MPL for the CCS measures. Interventions to raise the rates included: CCS • Worked with high volume provider to have: o Patient navigators contact those with unmet needs o Open a clinic that provides women's preventive care services o Provide data to provider for them to evaluate their performance • Sent proactive letters to those without cervical cancer screening in the past two years.	Ongoing through 2016
QIPs	Met	6/30/2016	APL 15-024 retired the QIPs. In its place HPs are required to complete Performance Improvement Projects (PIPs). The Diabetes and All-Cause Readmission projects have ended. KHS chose Childhood Immunizations and Management of Mediations for Asthma as our two PIPs to begin in 2016	Complete and closed
PIPs				
CIS-Combo 3	Met	7/31/2017	The CIS-Combo 3 PIP was submitted to DHCS on 7/1/2015 and was approved. We have submitted Modules 1-3 to HSAG.	Ongoing
MMA	Met	7/31/2017	DHCS approve MMA as our second PIP. We have submitted Modules 1-3 to HSAG.	Ongoing
Site Reviews				

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
• Initial	Met	9/30/2016	29 Initial site reviews were completed with PERS (Attachment C). All subsequent medical record reviews were complete. All CAPS and required follow-up visits were completed and closed.	Completed for 2016
• Full	Met	9/30/2016	47 Full Site and Medical Record reviews were completed. PERS (Attachment C) were reviewed and completed if needed. All CAPS and required follow-up visits were completed and closed.	Completed for 2016
• Focused	Met	9/30/2015	37 Focused (Periodic) reviews were completed. All CAPS and required follow-up visits were completed and closed.	Completed for 2016
• Pending F/U	Met	9/30/2016	There are no pending follow-up visits. All CAPS and required follow-up visits were completed and closed.	Completed for 2016

KERN HEALTH SYSTEMS

2017

Quality Improvement Program Description

I. Mission: In a commitment to the community of Kern County and the members of Kern Health Systems (KHS), the Quality Improvement/Utilization Management Committee (QI/UMC) is dedicated to improving the health status of members, while maintaining the medically appropriate and efficient use of available resources. The QI/UMC oversees all covered health care services delivered to members by systematic methods that develop, implement, assess and improve the integrated health delivery systems of KHS. All contracting providers of the Plan will participate in the Quality Improvement (QI) activities. The Plan's goal is to attain satisfied, healthy members and numerous collegial partners in the health care community.

II. Purpose: Kern Health Systems (KHS), d.b.a. Kern Family Health Care (KFHC), is the Local Initiative for the arrangement of medical care as well as mild to moderate behavioral health care for Medi-Cal enrollees in Kern County. Severe mental health care is carved out under KHS' Medi-Cal plan and arranged and covered, instead, by the Kern County Mental Health Department pursuant to a contract between the County and the State. The Kern County Board of Supervisors established KHS in 1993. The Board of Supervisors appoints a Board of Directors, who serve as the governing body for KHS.

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

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

1. The development and implementation of a structure for the assessment, measurement and problem resolution of the health and vision needs of the members.
2. To provide the process and structure for quality improvement by contracting providers.
3. To provide oversight and direction for processes affecting the delivery of covered health care to members, either directly or indirectly.
4. To ensure that members have access to covered health care in accordance with state legal standards.
5. To monitor and improve the quality and safety of clinical care for covered services for members.

III. Goals and Objectives: KHS has developed and implemented a plan of activities to encompass a progressive health care delivery system working in cooperation with contracting providers, members and regulatory agencies. An evaluation of program objectives and progress is performed by the QI/UMC on an annual basis with modifications as directed by the KHS Board of Directors. Specific objectives of the QI Program include:

1. Improving the health status of the members by identifying potential areas for improvement in the health care delivery plan.

2. Developing, distributing and promoting guidelines for care including preventive health care and disease management through education of members and contracting providers.

3. Developing and promoting health care practice guidelines, including maintenance of standards, credentialing and recredentialing, pharmaceutical and behavioral health care usage of providers.

4. Establishing and promoting open communication between KHS and contracting providers in matters of quality improvement and maintaining communication avenues between KHS, members, and contracting providers in an effort to seek solutions to problems that will lead to improved health care delivery systems.

5. Providing monitoring and oversight of delegated activities.

6. Performing tracking activities and trend analysis on a wide variety of information, including over and under utilization data, grievances, accessibility of health care services, pharmacy data, facility and medical record review results to identify patterns that may indicate the need for quality improvement.

7. Promoting an awareness and commitment in the health care community toward quality improvement in health care, safety and service. Continuously identifying opportunities for improvement in care processes, organizations or structures that can improve safety and delivery of health care to members. Providing appropriate evaluation of professional services and medical decision making and to identify opportunities for professional performance improvement.
8. Reviewing member concerns regarding quality of care issues that are identified from grievances or from the Public Policy/Community Advisory Committee (PP/CAC).

9. Identifying and meeting external regulatory requirements for licensure and accreditation.

10. Continuously monitoring internal processes in an effort to improve and enhance services to members and contracting providers.

11. Performing an annual assessment and evaluation (updating as necessary) of the effectiveness of the QI Program and its activities to determine how well resources have been deployed in the previous year to improve the quality and

safety of clinical care and the quality of service provided to members, and presenting results to the QI/UMC and Board of Directors.

IV. Scope: The KHS QI Program applies to all programs, services, facilities, and individuals that have direct or indirect influence over the delivery of health care to members. This may range from choice of contracting provider to the provision and institutionalization of the commitment to environments that improve clinical quality of care (including behavioral health), promote safe clinical practices and enhance service to members throughout the organization. The scope of the QI Program includes the following elements:

1. The QI Program is designed to monitor, oversee and implement improvements that influence the delivery, outcome and safety of the health care of members, whether direct or indirect. KHS will not unlawfully discriminate against members based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. KHS will arrange covered services in a culturally and linguistically appropriate manner. The QI Program reflects the population served. The majority of issues remain centered on family units consisting of young women and children, or children alone. The main ethnicity of our members is reported as Hispanic.

2. The QI Program monitors the quality and safety of covered health care administered to members through contracting providers. This includes all contracting physicians, hospitals, vision care providers, behavioral health care practitioners, pharmacists and other applicable personnel providing health care to members in inpatient, ambulatory, and home care settings.

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

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

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

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

Quality Improvement Application: the KHS QI program is applied to all procedures, care, services, facilities and individuals with direct or indirect influence over the delivery of health care to members.

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

V. Authority: Lines of authority originate with the Board of Directors and extend to contracting providers. Further details can be found in the KHS organizational chart.

1. **The KHS Board of Directors:** The Board of Directors serves as the governing body for KHS. The Board of Directors assigns the responsibility to lead, direct and monitor the activities of the QI and Utilization Management (UM) programs to the QI/UMC. The QI/UMC is responsible for the ongoing development, implementation and evaluation of the QI and UM programs. All the activities described in this document are conducted under the auspices of the QI/UMC. The KHS Board of Directors are directly involved with the QI process in the following ways:

    a. Approve and support the QI Program direction, evaluate effectiveness and resource allocation. Support takes the form of establishing policies needed to implement the program.
    b. Receive and review periodic summary reports on quality of care and service, and make decisions regarding corrective action when appropriate for their level of intervention.
    c. Receive, review, and make final decisions on issues involving provider credentialing and recredentialing recommendations from the Physician Advisory Committee (PAC).
    d. Receive input from the PP/CAC.
    e. Receive reports representing actions taken and improvements made by the QI/UMC, at a minimum on a quarterly basis.
    f. Evaluate and approve the annual QI Program Description.
    g. Evaluate and approve the annual QI Program Work Plan, providing feedback as appropriate.
    h. Evaluate and approve the annual QI Program Evaluation.
    i. Monitor the following activities delegated to the KHS Chief Medical Officer (CMO):

        1) Oversight of the QI Program
        2) Chairperson of the QI/UMC
        3) Chairperson of associated subcommittees
        4) Supervision of Health Services staff
        5) Oversight and coordination of continuity of care activities for members
        6) Proactive incorporation of quality outcomes into operational policies and procedures
        7) Oversight of all committee reporting activities so as to link information

    The Board of Directors delegates responsibility for monitoring the quality of health care delivered to members to the CMO and the QI/UMC with

administrative processes and direction for the overall QI Program initiated through the CMO.

2. **Chief Medical Officer:** The CMO reports to the Chief Executive Officer (CEO) and the KHS Board of Directors and, as Chairperson of the QI/UMC and Subcommittees, provides direction for internal and external QI Program functions, and supervision of the KHS staff including:

   a. Application of the QI Program, by KHS staff and contracting providers
   b. Participation in provider quality activities, as necessary
   c. Monitoring and oversight of provider QI and UM programs, activities and processes
   d. Oversight of KHS delegated credentialing and recredentialing activities
   e. Retrospective review of KHS credentialed providers for potential or suspected deficiencies related to quality of care
   f. Final authority and oversight of KHS non-delegated credentialing and recredentialing activities
   g. Monitoring and oversight of any delegated UM activities
   h. Supervision of Health Services staff involved in the QI Program, including: Administrative Director of Health Services, QI Supervisor, Health Education and Disease Management Manager, Case Management Supervisor, UM Health Services Manager, Pharmacy Director, and other related staff
   i. Supervision of all Quality Improvement Activities performed by the QI Department
   j. Monitoring that covered medical care provided meets industry and community standards for acceptable medical care
   k. Actively participating in the functioning of the plan grievance procedures
   l. Resolving grievances related to medical quality of care

   KHS may have designee performing the functions of the CMO when the CMO position is not filled.

3. The Medical Director and/or **Associate Medical Director(s): The Medical Director and/or Associate Medical Director(s)** support the CMO with projects as assigned and serves the role of CMO in the CMO's absence or when the CMO position is not filled. The Medical Director and/or Associate Medical Director(s) reports to the CEO and CMO.

4. **QI/UM Committee (QI/UMC):** The QI/UMC reports to the Board of Directors and retains oversight of the QI Program with direction from the CMO. The QI/UMC develops and enforces the quality improvement process with respect to contracting providers, subcommittees and internal KHS functional areas with oversight by the CMO. This committee also 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.

5. **Subcommittees:** The following subcommittees, chaired by the CMO, or designee, report to the QI/UMC:

a. **Physician Advisory Committee (PAC):** This committee is composed of contracting PCPs and Specialists and is charged with addressing provider issues.

Performs peer review, addresses quality of care issues and recommends provider discipline and Corrective Action Plans.

Performs credentialing functions for providers who either directly contract with KHS or for those submitted for approval of participation with KHS, including monitoring processes, development of pharmacologic guidelines and other related functions.

Develops clinical practice guidelines for acute, chronic, behavioral health or preventive clinical activities with recommendations for dissemination, promotion and subsequent monitoring. Performs review of new technologies and new applications of existing technologies for consideration as KHS benefits.

6. Other Committees: The following committees, although independent from the QI/UMC, submit regular reports to the QI/UMC:

a. Pharmacy and Therapeutics (P&T) Committee: performs ongoing review and modification of the KHS formulary and related processes, oversight of contracting pharmacies, including monitoring processes, development of pharmacologic guidelines and other related functions.

b. Public Policy/Community Advisory Committee (PP/CAC): The PP/CAC reviews and comments on operational issues that could impact member quality of care, including access, cultural and linguistic services and Member Services.

VI. Committee and Subcommittee Responsibilities: Described below are the basic responsibilities of each Committee and Subcommittee. Further details can be found in individual committee policies.

1. **QI/UM Committee (QI/UMC):**

a. **Role** – The QI/UMC directs the continuous monitoring of all aspects of covered health care (including Utilization Management) administered to members, with oversight by the CMO or designee. Committee findings and recommendations for policy decisions are reported through the CMO to the Board of Directors on a quarterly basis or more often if indicated.

i. **Objectives** – The QI/UMC provides review, oversight and evaluation of delegated and non-delegated QI activities, including: accessibility of health care services and care rendered, continuity and coordination of care, utilization management, credentialing and recredentialing, facility and medical record compliance with established standards, member satisfaction, quality and safety of services provided, safety of clinical care and adequacy of treatment. Grievance information, peer review

and utilization data are used to identify and track problems, and implement corrective actions. The QI/UMC monitors member/provider interaction at all levels, throughout the entire range of care, from the member's initial enrollment to final outcome.

Objectives include review, evaluation and monitoring of UM activities, including: quality and timeliness of UM decisions, referrals and pre-authorizations, concurrent and retrospective review; approvals, modifications, and denials, evaluating potential under and over utilization, and the provision of emergency services.

ii. **Program Descriptions**– The QI/UMC is responsible for the annual review, update and approval of the QI and UM Program Descriptions, including policies, procedures and activities. The Committee provides direction for development of the annual Work Plans and makes recommendations for improvements to the Board of Directors, as needed.

iii. **Studies** – The review and approval of proposed studies is the responsibility of the QI/UMC, with subsequent review of audit results, corrective action and reassessment. A yearly comprehensive plan of studies to be performed is developed by the CMO, Administrative Director Health Services, Supervisor QI, Manager, Health Education and Disease Management and the QI/UMC, including studies that address the health care and demographics of members.

b. **Function -** The following elements define the functions of the QI/UMC in monitoring and oversight for quality of care administered to members:

i. Identify methods to increase the quality of health care and service for members
ii. Design and accomplish QI Program objectives, goals and strategies
iii. Recommend policy direction
iv. Review and evaluate results of QI activities at least annually and revise as necessary
v. Institute needed actions and ensure follow-up
vi. Develop and assign responsibility for achieving goals
vii. Monitor quality improvement
viii. Monitor clinical safety
ix. Prioritize quality problems
x. Oversee the identification of trends and patterns of care
xi. Monitor grievances and appeals for quality issues
xii. Develop and monitor Corrective Action Plan (CAP) performance
xiii. Report progress in attaining goals to the Board of Directors
xiv. Assess the direction of health education resources

xv. Ensure incorporation of findings based on member and provider input/issues into KHS policies and procedures
xvi. Provide oversight for the KHS UM Program
xvii. Provide oversight for KHS credentialing
xviii. Provide oversight of the Health Education Department
xix. Assist in the development of clinical practice and preventive care health guidelines

The following elements define the functions of the QI/UMC in monitoring and oversight of utilization management in covered health care administered to members:

i. Annually review the UM Program Descriptions, new and/or revisions to existing policies, and medical criteria to be utilized in the evaluation of appropriate clinical and behavioral health care service. The UM Program is approved annually by the QI/UMC.
ii. Develop special studies based on data obtained from UM reports to review areas of concern and to identify utilization and/or quality problems that affect outcomes of care.
iii. Review over and under utilization practices retrospectively utilizing any or all of the following data: bed-day utilization, physician referral patterns, member and provider satisfaction surveys, readmission reports, length of stay and referral and treatment authorizations. Action plans are developed including standards, timelines, interventions and evaluations.
iv. Ensure that UM decision-making is based only on appropriateness of care and service.
v. Evaluate results of member and provider satisfaction surveys that relate to satisfaction with the UM process and report results to the QI/UMC. Identified sources of dissatisfaction require CAPs and are monitored through the QI/UMC.
vi. Evaluate the effectiveness of the UM Program using data on member and provider satisfaction;
vii. Identify potential quality issues and report them to the QI Department for investigation
viii. Oversee the implementation of new technologies and new applications of existing technologies approved by the QI/UMC for inclusion of KHS benefits.
ix. Facilitate and oversee education on UM for providers.
x. Annually review and approve the KHS Health Education program, new and/or revisions to existing policies, and criteria to be utilized in the provision of Health Education services for members.
xi. Identify potential quality issues with subsequent reporting to the QI/UMC.

c. **Structure –** the QI/UMC provides oversight for the QI and UM Programs and is composed of:

i. 1 KHS Chief Medical Officer or designee (Chairperson)

ii. 2 Participating Primary Care Physician
iii. 2 Participating Specialty Physicians
iv. 1 Participating Home Health Representative
v. 1 Participating Mid-Level Practitioner
vi. 1 Kern County Public Health Officer or Rep.
vii. 2 Other Participating Ancillary Representatives
viii. 1 Participating Hospital Representative
ix. 1 Administrative Director Health Services,
x. 1 Supervisor QI,
xi. 1 Manager Health Education and Disease Management
xii. Staff (Committee staff support)

The QI/UMC is responsible for periodic assessment and review of subcommittee activities and recommendations for changes, with subsequent reporting to the Board of Directors at least quarterly.

d. **Meetings -** The QI/UMC meets at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. Issues needing immediate assistance that arise prior to the next scheduled meeting are reviewed by the CMO and reported back to the QI/UMC, when applicable.

2. Physician Advisory Committee (PAC):

a. **Role –** The PAC serves as advisor to the Board of Directors on health care issues, peer review, provider discipline and credentialing/ recredentialing decisions. This committee is responsible for reviewing provider grievances and/or appeals, provider quality issues, and other peer review matters as directed by the KHS Chief Medical Officer or designee.

The QI/UMC has delegated credentialing and recredentialing functions for KHS to the PAC. The PAC is responsible for reviewing individual providers for denial or approval of participation with KHS.

The PAC is charged with the assessment of standards of health care as applied to members and providers; assist with development of indicators for studies; and regularly review guidelines that are promulgated to contracting providers and members. This committee consists of a variety of practitioners in order to represent the appropriate level of knowledge to adequately assess and adopt healthcare standards. The committee obtains an external independent review and opinion when necessary to assist with a decision regarding preventive care guidelines, disease management or coverage of a new technology as a covered benefit for members.

The PAC reviews and comments upon pertinent KHS standards and guidelines with updates, as needed. The PAC evaluates improvements in practice patterns of contracting providers and the development of local care standards. Development of educational programs includes input

from the PAC. The PAC reviews and comments on other issues as requested by the Board of Directors.

b. **Function –** the functions of the PAC are as follows:

i. Serve as the committee for clinical quality review of contracting providers.
ii. Evaluate, assess and make decisions regarding contracting provider issues, grievances and clinical quality of care issues referred by the KHS CMO or designee and develop and recommend actions plans as required.
iii. Review provider qualifications, including adverse findings and recommend to the Board of Directors approval or denial of participation with KHS on initial credentialing and every three years in conjunction with recredentialing. Report Board action regarding credentialing/recredentialing to the QI/UMC at least quarterly.
iv. Review contracting providers referred by the KHS CMO or designee due to grievance and/or complaint trend review, other quality indicators or other information related to contracting provider quality of care or qualifications.
v. Review, analyze and recommend any changes to the KHS Credentialing and Recredentialing program policies and procedures on an annual basis or as deemed necessary.
vi. Monitor any delegated credentialing/recredentialing process, facility review and outcomes for all providers.
vii. Develop, review and distribute preventive care guidelines for members, including infants, children, adults, elderly and perinatal patients.
viii. Base preventive care and disease management guidelines on scientific evidence or appropriately established authority.
ix. Develop, review and distribute disease management and behavioral health guidelines for selected diagnosis and treatments administered to members.
x. Periodically review and update preventive care and clinical practice guidelines as presented by the CMO.
xi. Review and assess new medical technologies and new applications of existing technologies for potential addition as covered benefits for members.
xii. Assess standards of health care as applied to members and providers, assist with development of indicators for studies and review guidelines that are promulgated to contracting providers.
xiii. Assess industry and technology trends with updates to KHS standards as indicated.

c. **Structure** – the PAC is structured to provide oversight of quality of care concerns, delegated credentialing activities and the overall credentialing program to monitor compliance with KHS requirements. Contracting providers with medically related grievances that cannot be resolved at the administrative level may address problems to the PAC.

Recommendations and activities of the PAC are reported to the QI/UMC and Board of Directors on a regular basis. The committee is composed of:

i. KHS Chief Medical Officer (Chairperson)
ii. General/Family Practitioner
iii. General Internist
iv. Pediatrician
v. Obstetrician/Gynecologist
vi. Invasive Specialist
vii. Non-invasive Specialist
viii. Practitioner at Large

The PAC consists of a variety of practitioners to represent a broad level of knowledge to adequately assess and adopt healthcare standards.

d. **Meetings –** The PAC meets at least quarterly or more frequently if necessary.

3. Pharmacy and Therapeutics Committee (P&T):

a. **Role –** the P&T Committee monitors the KHS Formulary, oversees medication prescribing practices by contracting providers, assesses usage patterns by members and assists with study design and clinical guidelines development.

b. **Function –** the functions of the P&T Committee are as follows:

i. Objectively appraise, evaluate and select pharmaceutical products for formulary addition or deletion. 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;
ii. Evaluate the clinical use of medications and develop policies for managing drug use and administration;
iii. Monitor for quality issues regarding appropriate drug use for KHS and members. This includes Drug Utilization Review (DUR) and Drug Use Evaluation (DUE) programs;
iv. Provide recommendations regarding protocols and procedures for the use of non-formulary medications;
v. Provide recommendations regarding educational materials and programs about drug products and their use to contracting providers;
vi. 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;
vii. Monitor and assess contracting pharmacy activities as needed through review of audits and pharmacy profiling.

c. **Structure –** The QI/UMC has delegated the responsibility of oversight of pharmaceutical activities related to members to the P&T Committee. The committee reports all activities to the QI/UMC quarterly or more frequently depending on the severity of the issue. The committee is composed of:

i. 1 KHS Chief Medical Officer (Chairperson)
ii. 1 KHS Director of Pharmacy (Alternate Chairperson)
iii. 1 KHS Board Member
iv. 1 Retail/Independent Pharmacist
v. 1 Retail/Chain Pharmacist
vi. 1 Specialty Practice Pharmacist
vii. 1 General Practice Medical Doctor
viii. 1 Pediatrician
ix. 1 Internist
x. 1 OB/GYN

d. **Meetings –** The P&T Committee meets quarterly with additional meetings as necessary.

4. Public Policy/Community Advisory Committee (PP/CAC):

a. **Role –** the PP/CAC provides a mechanism for structured input from members regarding how KHS operations impact the delivery of their care. The role of the PP/CAC is to implement and maintain community linkages.

b. **Function –** the functions of the PP/CAC are as follows:

i. Culturally appropriate service or program design.
ii. Priorities for health education and outreach program
iii. Member satisfaction survey results
iv. Findings of health education and cultural and linguistic Group Needs Assessment.
v. Plan marketing materials and campaigns.
vi. Communication of needs for provider network development and assessment.
vii. Community resources and information.
viii. Periodically review the KHS grievance processes;
ix. Review changes in policy or procedure that affects public policy;
x. Advise on educational and operational issues affecting members who speak a primary language other than English;
xi. Advise on cultural and linguistic issues.

c. **Structure** – The PP/CAC is delegated by the Board of Directors to provide input in the development of public policy activities for KHS. The committee makes recommendations and reports findings to the Board of Directors. Appointed members include:

i. 1 Ex-officio Non-Voting Member: KHS Director of Marketing and Member Services (Chairperson)

ii. 5 subscribers/members
iii. 2 Community Representatives
iv. 2 Participating Health Care Practitioner
v. 1 Kern County Health Officer or Representative
vi. 1 Director, Kern County Department of Human Services or Representative

d. **Meetings -** The PP/CAC meets at least quarterly with additional meetings as necessary.

5. Grievance Review Team (GRT)

a. **Role** – The GRT provides input towards satisfactory resolution of member grievances and determines any necessary follow-up with Provider Relations, Quality Improvement, Pharmacy and/or Utilization Management.

b. **Function** - functions of the GRT are as follows:

i. Ensure that KHS policies and procedures are applied in a fair and equitable manner.
ii. Hear grievances in a timely manner and recommend action to resolve the grievance as appropriate within the required time-frame.
iii. Review and evaluate KHS practices and procedures that consistently produce dissatisfaction, and recommend, when appropriate, modification to such practices and procedures.

c. **Structure** – Appointed members include:
i. 1 KHS Chief Medical Officer (Chairperson) or designee
ii. 1 KHS Director of Marketing and Member Services
iii. 1 KHS Director of Provider Relations
iv. 1 KHS Chief Operations Officer
v. 1 KHS Grievance Coordinator (Staff)
vi. 1 KHS Director of Compliance and Regulatory Affairs
vii. 1 KHS Supervisor Quality Improvement or designee
viii. 1 KHS Administrative Director of Health Services or designee
ix. 1 KHS Pharmacy Director

d. **Meetings** - The GRT meets on a weekly basis.

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

1. **Chief Executive Officer (CEO)** – appointed by the Board of Directors, the CEO has the overall responsibility for KHS management and viability. Responsibilities include: KHS direction, organization and operation; developing strategies for each department including the QI Program; Human Resources direction and position appointments; fiscal efficiency; public relations; governmental and community liaison, and contract approval. The CEO directly supervises the Chief Financial Officer (CFO), Chief MedicalOfficer, Compliance Department, and the Director of Marketing and Member Services. The PAC

reports to the CEO and contributes information regarding provider issues. The CEO interacts with the Chief Medical Officer regarding ongoing QI Program activities, progress towards goals, and identified health care problems or quality issues requiring corrective action.

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

   The CMO reports to the CEO and communicates directly with the Board of Directors as necessary. The CMO supervises the following Medical Services departments and related staff: Quality Improvement, Utilization Management, Pharmacy, Health Education and Disease Management. The CMO also supervises all QI activities performed by the Quality Improvement Department. The CMO devotes the majority of his time to quality improvement activities. The duties of the position include: providing direction for all medical aspects of KHS, preparation, implementation and oversight of the QI Program, medical services management, resolution of medical disputes and grievances; and medical oversight on provider selection, provider coordination, and peer review. Principal accountabilities include: 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).

   The CMO is responsible for providing direction to the QI/UMC and associated committees including PAC and P&T Committee. As Chairperson of the QI/UM Committee and associated committees, the CMO provides assistance with study development and coordination of the QI Program in all areas to provide continued delivery of quality health care for members. The CMO assists the Director of Provider Relations with provider network development and works with the CFO to ensure that financial considerations do not influence the quality of health care administered to members.

   The CMO is also responsible for oversight of the development and ongoing revision of the Provider Policy and Procedure Manual related to health care services. The CMO executes, maintains, and updates a yearly QI Program for KHS and an annual summary of the QI Program activities to be presented to the Board of Directors. Resolution of medical disputes and grievances is also the responsibility of the CMO. The CMO and staff work with the appropriate departments to develop culturally and linguistically appropriate member and provider materials that identify benefits, services, and quality expectations of KHS. The CMO provides continuous assessment of monitoring activities,

direction for member, provider education, and coordination of information across all levels of the QI Program and among KHS functional areas and staff.

3. **Administrative Director of Health Services (the "Director")** - The Director must possess a valid Registered Nurse (RN) license issued by the State of California, five years of experience in an acute health care facility and 15 years of experience in U.M./Q.I. in the managed care ambulatory setting, and a minimum of 10 years management experience. The Director has knowledge of managed care systems in a Knox-Keene licensed health plan, applicable standards and laws pertaining to quality improvement programs for the DHCS, NCQA and HEDIS data collection and analysis, study design methods, and appropriate quality tools and applications. The Administrative Director dedicates 100% of his/her time to the Health Services section and reports to the CMO . The Administrative Director assists the CMO in developing, coordinating and maintaining the QI Program and its related activities to oversee the quality process and monitor for health care improvement. Activities include the ongoing assessment of contracting provider compliance with KHS requirements and standards, including: medical record assessments, accessibility and availability studies, monitoring provider trends and report submissions, and oversight of facility inspections. The Administrative Director monitors the review and resolution of medically related grievances with the CMO, and evaluates the effectiveness of QI systems.

   The Director is responsible for the oversight and direction of the KHS Quality Improvement staff.

   a. **QI Program Staffing** – the Director oversees a QI Program staff consisting of the following:

      i. QI Supervisor – The QI supervisor prosessed a valid Californina Registered Nursing license and ten years QI experience in varied healthcare settings including healthplan, acute care and outpatient services. The QI Supervisors manages the day to day opperations of the department and leads quality and process improvement related initiatives.

         The QI Supervisor is responsible for initiating, developing, implementing and reporting on quality studies. Principal accountabilities include: designing data collection tools and/or other tools as necessary for study activity, implementing studies as directed in coordination with other KHS functional areas, providing oversight of study processes or activities to ensure appropriate collection of data or information, preparing report formats for results of studies as appropriate to improve KHS processes and delivery of care, managing the QI staff to ensure high productivity and high quality output, and working with other KHS staff involved in research or study processes.

      ii. QI Registered Nurses – The QI nurses possess a valid California Registered Nursing license and five years registered nurse

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

iii. QI Coordinator – The QI Coordinator is a graduate from a licensed Medical Assistant training institution with 3 – 5 years experience in a provider office setting. The QI Coordinator manages the HEDIS process including but not limited to producing and validating the chase list, producing fax lists, collecting data and reporting essential elements of the HEDIS process.

iv. QI Assistant - The QI Assistant is a graduate from a licensed Medical Assistant training institution with 2 years experience in a provider office setting. The QI Assistant assists in validating the chase list, produces fax lists, performs follow-up calls to verify receipt, collects data and reports essential elements of the HEDIS process.

v. QI Senior Support Clerk – The QI Senior Support Clerk has a high school diploma or equivalent; two years experience in the field of medical care, a typing skill of 45 net wpm, and at least one year data entry experience. Assists in the promotion of QI activities related to monitoring, assessing and improving performance in health care delivery of covered services to members.

vi. QI Business Systems Analyst – graduated from an accredited college or university with a Bachelor's degree in Business Administration and two years of paid experience in report generation, analysis and result documentation. Experience may be substituted for education on a year for year basis. Experience preferred in health care industry, desirable in the MediCare or MediCaid environment. Experience in Business Objects Reporting and HEDIS reporting.Assists in running queries and reports using business supplied reporting tools. Analysis of reporting results and data mining of query information is a critical component of this position. Assist in business process improvement and streamlining workflows.
For other Health Services staff, please see the UM, CM HE or DM Program Plans

VIII. Program Information – KHS utilizes information provided through the Management Information Systems (MIS), Operations and Provider Relations departments.

Information includes claims and UM data, encounter and enrollment data, and grievance and appeal information. The KHS QI Department identifies data sources, develops studies and provides statistical analysis of results.

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

1. The Work Plan is developed by the Supervisor QI, on an annual basis and is presented to the QI/UMC and Board of Directors for review and approval. Timelines and responsible parties are designated in the Work Plan.
2. 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.
3. After review and approval of quality study results including action plans initiated by the QI/UMC, KHS disseminates the study results to applicable providers. This can occur by specific mailings or KHS' Provider bulletins to contracting providers.
4. The activities in the QI Work Plan are annually evaluated for effectiveness.
5. QI Work Plan responsibilities are assigned to appropriate individuals.

X. QI Activities – Covered health care provided to members is evaluated through a variety of activities designed to identify areas for corrective action and assess improvement.

1. **Quality Studies** – Studies are conducted across the spectrum of health care as described below.

   a. **Primary Care Physician (PCP) and Specialist Access Studies** – KHS performs physician access studies on a quarterly basis. Further details on KHS access studies can be found in KHS Policy 4.30, Accessibility Standards.

      i. **PCP and Specialist Appointment Availability** – KHS conducts ongoing telephone appointment availability study on contracting PCPs and specialists to compare the availability of urgent, non-emergent acute, routine non-urgent, routine physical, well-child, and new prenatal visits with the KHS standard for each type of visit This program is used to monitor access to care and quality of member service. Calls are made to contracting providers to assess their level of member service, competence and access of care compliance. Results of the access studies are shared with contracting providers, QI/UMC, Board of Directors and DHCS.

      ii. **PCP After-Hours Access** – KHS contracts with an after-hours triage service to facilitate after-hours member access to care. The Administrative Director Health Services reviews monthly reports

for timeliness, triage response and availability of contracting providers. Results of the access studies are shared with contracting providers, QI/UMC, Board of Directors and DHCS.

2. **HEDIS**– KHS performs annual HEDIS submission in accordance with NCQA specifications. The measures performed each year are determined by accountability sets prescribed by the DHCS, NCQA and Managed Risk Medical Insurance Board (MRMIB), and by specific needs identified by the KHS Medical Director. The HEDIS process is audited by California's EQRO.

For 2017, the accountability sets are:

Measure	**DHCS**
Timeliness of Prenatal Care	X
Post Partum Care	X
Well-Child Visits: 3-6 years	X
Childhood Immunizations (combo 3)	X
Cervical Cancer Screening	X
Comprehensive Diabetes Care	X
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	X
Ambulatory Care Utilization	X
Children's and Adolescents' Access to PCPs	X
Weight Assessment & Counseling For Nutrition & Physical Activity For Children & Adolescents (WCC-N and WCC-PA)	X
Annual Monitoring for Patients on Persistent Medications	X
Use of Imaging Studies for Low Back Pain	X
Controlling High Blood Pressure	X

Further details on KHS HEDIS studies can be found in the HEDIS technical specifications published by NCQA and in KHS internal policies. KHS's 2016 rates can be found in Appendix A.

For 2017, DHCS and MMDC have instructed plans to perform one non-HEDIS quality reporting measures. NQF Measure #134, Screening for Clinical Depression and Follow-Up Plan is an admin only measure. These requirements are communicated to health plans before HEDIS data collection, and may vary year-to-year.

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 is reported as a "No Report" (NR) due to an audit failure, an Improvement Plan (IP) is contractually required to be submitted within 60 days of being notified by DHCS of the measures for which IPs are required. The CAP measures are excluded from Improvement Plans

3. **Quality Improvement Projects (QIPs)** – The QIPs, contractually required by the DHCS ended in July 2015 with the new EQRO contract.

4. **Performance Improvement Projects (PIPs)** – KHS is mandated to participate in two (2) PIPs. The first one was approved by DHCS and HSAG and will mirror the CIS-Combo 3 HEDIS measure. The second PIP is improving the care of members with Asthma.

5. In 2016, the CAHPS **Member Satisfaction Survey** – was performed according to NCQA's HEDIS® methodology. The HEDIS® specifications require health plans to utilize the Consumer Assessment of Health Plans (CAHPS®) Survey, and to administer the survey through a third party, NCQA-certified data collection vendor. HSAG will not administer the survey in 2017.

   Survey results are shared with DHCS, NCQA, the KHS Board of Directors and QI/UMC. Each of the members sampled receive both English and Spanish versions of the survey. There are nine measures in both the Adult Member Satisfaction Survey:

   - Health Plan Rating
   - Health Care Received Rating
   - Specialist Rating
   - Personal Doctor/Nurse rating
   - Customer Service
   - Courteous and Helpful Office Staff
   - How Well Doctors Communicate
   - Getting Care Quickly
   - Getting Needed Care

   The survey includes questions to determine member satisfaction with access to care and quality of care. The survey will include CAHPS questions for the member survey to assess member perception and satisfaction of accessing timely health care under KHS.The survey will also include a question to assess member perception and satisfaction of accessing 24-hour telephone triage service under KHS. KHS informs contracting providers of the survey results.

   CAPs are issued in accordance with *KHS Policy and Procedure #10.10–P: Corrective Action Plans.* All access compliance activities are reported to the Director of Provider Relations who prepares an activity report and presents all information to the CEO, Chief Medical Officer, Chief Operations Officer and Quality Improvement/Utilization Management (QI/UM) Committee.

   The Director of Marketing and Member Services reports at least monthly to the CEO, Chief Medical Officer and Chief Operations Officer. At least quarterly, reports are furnished to the QI/UM Committee.

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

7. **Corrective Actions** –A Corrective Action Plan (CAP) is designed to eliminate deficiencies, implement appropriate actions, and enhance future outcomes.

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

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

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

10. **Health Education** – KHS actively works to improve the health of members. Those with chronic conditions are identified through pharmacy data, referral information, high-risk OB report submission and other reporting measures. Members are notified of the KHS health education programs for diabetes through targeted mailings and Member Services phone calls.

11. **Disease Management Program** - KHS has developed and implemented a Disease Management Program to enhance the delivery of health care to members who would benefit from a systematic and ongoing approach to disease management. This is achieved through systematic identification and stratification of members eligible for the program, and then the coordination and delivery of appropriate health care services to these members, including health education, clinical management and coordination with practitioners.

    Each disease management program contains well-formulated activities that address the continuum of care. The effectiveness of activities is evaluated using

quantitative measures and appropriate data. Contracting providers are involved in disease management development. KHS has developed and implemented disease management system to address asthma and diabetes.

12. **Targeted Case Management –** KHS Utilization Management is responsible for coordinating the member's health care with the targeted case management provider and to determine the medical necessity of diagnostic and treatment services recommended by the targeted case management provider that are covered services.

    The goal of the Case Management Department is to help members maintain optimum health and/or improved functional capability, educate members regarding their health and reinforce the PCP prescribed treatment plan. These efforts are anticipated to decrease costs and improve quality through focusing on the delivery of care at the appropriate time and in the appropriate setting.

    Complex Case Management is the systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management. Basic Case Management means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered basic case management services.

    Members in the Complex Case Management Group and members assigned to the Case Management Team will be assigned a Nurse Case Manager and respective support staff. The team will focus on comprehensive coordination of services based on patient-specific needs to improve increase the quality and impact of the health care and supportive services the member is receiving.

13. **Trended Adverse Event/Sentinel Events** Utilization Management is responsible for coordinating and conducting prospective, concurrent and retrospective utilization review for medical necessity, appropriateness of hospital admission, level of care/continuum of care, and continued in patient stay, as appropriate.

    The QI Department reviews all hospital re-admissions that occurred within 30 days of the first hospital discharge to assist in identification and follow-up of potential quality of care issues.

    Any incidents that warrant possible further investigation are forwarded from the Utilization Management Department, Member Services Department, or any other KHS Department, to the QI Department for a Quality Review. These include member deaths, delay in service or treatment or other opportunities for improvement.

    Greivances that are closed in favor of the member or closed with a quality of care issue identified are forwarded to the QI department for further review and action. At minimum, all cases are tracked and the data provided to the CMO or designee

during the provider credentialing/re-credentialing process. Other actions may include request(s) for a plan of correction for issues or concerns identified during review.

a. **Member Safety** – KHS continuously monitors patient safety for members and develops appropriate interventions as follows:

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

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

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

   iii. **Coordination of Care Studies** – KHS performs Coordination of Care Studies to reduce the number of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days.

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

   v. **Interventions** – KHS initiates interventions appropriate to the identified issue. Such interventions are based on evaluation of processes and could include: distribution of safety literature to members, education of contracting providers, streamlining of processes, development of guidelines, and/or promotion of safe practices for members and providers.

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

XI. KHS Providers: KHS contracts with physicians and other types of health care providers. Provider Relations 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.

XII. Annual Evaluation of the KHS Quality Improvement Program: On an annual basis, KHS evaluates the effectiveness and progress of the QI Program and Work Plan and updates the program as needed. The Chief Medical Officer, with assistance from the Supervisor of QI, Administrative Director of Health Services, Pharmacy Director, Manager Health Educator, Director of Marketing and Member Services and Director of Provider Relations, documents a yearly summary of all completed and ongoing QI Program activities with documentation of evidence of improved health care or deficiencies, status of studies initiated, or completed, timelines, methodologies used, and follow-up mechanisms.

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

The yearly QI Program summary and Work Plan are presented to the Board of Directors for assessment of covered health care rendered to members, comments, activities proposed for the coming year, and approval of changes in the QI Program. The Board of Directors is responsible for the direction of the QI Program and actively evaluates the annual plan to determine areas for improvement. Board of Director comments, actions and responsible parties assigned to changes are documented in the minutes. The status of delegated follow-up activities is presented in subsequent Board meetings. A summary of QI activities and progress toward meeting QI goals is available to members and contracting providers upon request by contacting KHS Member Services.

XIII. 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.

XIV. Confidentiality: All members, participating staff and guests of the QI/UMC and

subcommittees are required to sign the Committee Attendance Record, including a statement regarding confidentiality and conflict of interest. All KHS employees are required to sign a confidentiality agreement upon hiring. 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.

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

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

XVII. Provider Participation:

1. **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.
2. **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.

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

1. Provider contracts include provisions for the following:
    a. An agreement to participate in the KHS QI Program including cooperation with monitoring processes, the grievance resolution system, and evaluations necessary to determine compliance with KHS standards.
    b. An agreement to provide access to facilities, equipment, books, and records as necessary for audits or inspection to ascertain compliance with KHS requirements.
    c. Cooperation with the KHS QI Program including access to applicable records and information.

d. Provisions for open communication between contracting providers and members regarding their medical condition regardless of cost or benefits.

2. Physician contracts include provisions for the following:

   a. An agreement to participate in the KHS QI Program including cooperation with monitoring processes, the grievance resolution system, utilization review, and evaluations necessary to determine compliance with KHS standards.

   b. An agreement to provide access to facilities and records as necessary for audits or inspections to ascertain compliance with KHS requirements.

   c. Cooperation with the KHS QI Program, including access to applicable records and information.

3. Hospital contracts include provisions for the following:

   a. An agreement to participate in the KHS QI Program, including cooperation with monitoring processes, the grievance resolution system, utilization review, and evaluations necessary to determine compliance with KHS standards.

   b. Development of an ongoing QI Program to address the quality of care provided by the hospital including CAPs for identified quality issues.

   c. An agreement to provide access of facilities, equipment, books, and records as necessary for audits or inspection to ascertain compliance with KHS requirements.

   d. Cooperation with the KHS QI Program, including access to applicable records and information.

XIX. On-Site Medical Records: member medical records are not kept on site. Paper supporting documents for UM, Grievance and quality review processes are shredded following use.

XX. **Delegation:** KHS delegates quality improvement activities as follows:

1. In collaboration with other Kern County Health Plans – delegation for Site Reviews as describe PL 14-004 and the applicable MOU.
2. Kaiser Permenante – delegation of QI and UM processes with oversight through the QI/UM committee
3. VSP – delegation of QI and UM processes with oversight through the QI/UM committee

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

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

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

2. Credentialing information.

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

1. **Provider Relations Department –** provider credentialing and recredentialing, using site visits to monitor safe practices and facilities.

2. **Member Services Department –** by analyzing and taking actions on complaint and satisfaction data and information that relates to clinical safety.

3. **UM Department –** in collaboration with the Member Services Department, by implementing systems that include follow-up to ensure care is received in a timely manner.

XXIII. Enforcement/Compliance: The Supervisor of QI, , under the direction of the Chief Medical Officer and Administrative Director Health Services, is responsible for monitoring and oversight of the QI Program, including enforcement of compliance with KHS standards and required activities. Compliance activities can be found in sections of policies related to the specific monitoring activity. The general process for obtaining compliance when deficiencies are noted, and CAPs are requested, is delineated in policies.

XXIV. Medical Reviews and Audits by Regulatory Agencies - KHS' Director of Compliance & Regulatory Affairs, in collaboration with the Administrative Director of Health Services, manages KHS medical reviews and medical audits by regulatory agencies. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QI Program. CAPs for medical matters are approved and monitored by the QI/UMC.

_____

KHS Board of Directors (Chair) Date

_____

Chief Executive Officer Date

_____

Chairman QI/UMC Date

Appendix A

HEDIS 2016
Hybrid Measures

Measure		2016 Rate
CCS	Cervical Cancer Screening	51.82
CIS-3	CIS – Combo 3	66.67
CDC-E	Eye Exam (Retinal) Performed	49.64
CDC-HT	HbA1c Testing	84.31
CDC-H9 *	HbA1c Poor Control (>9.0%)	49.45
CDC-H8	HbA1c Control (<8.0%)	39.42
CDC-N	Medical Attn. for Nephropathy	90.51
CDC-BP	Blood Pressure Control <140/90	62.04
CBP	Controlling High Blood Pressure	50.85
IMA-1	Immunizations for Adolescents	78.10
PPC-Pre	Timeliness of Prenatal Care	79.08
PPC-Pst	Postpartum Care	56.45
WCC-BMI	BMI percentile	69.34
WCC-N	Counseling for Nutrition	66.67
WCC-PA	Counseling for Phys Activity	57.66
W-34	Well-Child Visits	67.15

***** A lower rate indicates better performance therefore the number of required numerators must decrease by the number shown.

Administrative Measures

Measure		2016 Rate
AAB**	Avoidance of Antibiotic Treatment	21.22
CAP-1224	12-24 Months	92.64
CAP-256	25 Months – 6 Years	82.43
CAP-711	7-11 Years	82.70
CAP-1219	12-19 Years	81.16
LBP	Use of Imaging for Low Back Pain	76.04
MPM-ACE	ACE inhibitors or ARBs	89.26
MPM-Dig	Digoxin	46.27
MPM-Diu	Diuretics	88.72
MMA	Medication Compliance 50% Total	49.71
MMA	Medication Compliance 75% Total	25.43

****** Rate for this measure is derived by an inverse calculation. The number of required numerators must decrease by the number shown.

Note: For measures shaded in gray, DHCS is not holding MCPs accountable to meet the MPLs for HEDIS 2016 (measurement year 2015).

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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNT ABILITY	STATUS
I. QUALITY MANAGEMENT AND IMPROVEMENTS				
A. Annual Review/Approval of QI Program Documents				
1. Approval QI Evaluation	Approval of 2016 QI Program Evaluation	5/19/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	QI/UMC Agenda May 2017
2. Review/Update and Approval of QI Program Description	Approval of 2017 QI Program Description	5/19/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	QI/UMC Agenda May 2017
3. Review/Update and Approval of QI Work Plan	Approval of 2017 QI Work Plan	5/19/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	QI/UMC Agenda May 2017
B. Analysis of Member Demographics and Morbidities Data	Previous year end data and ongoing risk stratification for CM and DM targetted interventions	ongoing	Chief Information Officer, Administrative Director Health Services, Director Health Education, Cultural and Linquistic Services	Ongoing 2017
C. Clinical - Focused Studies				
1. State Required				
a. IP - AAB	regulatory requirement due to HEDIS scores below MPL	12/31/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ending 12/31/2016
b. IP - CCS	regulatory requirement due to HEDIS scores below MPL	12/31/2016	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	
c. CIS PIP	18 month quality improvement project led by HSAG	6/30/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing through July 2017
d. MMA PIP	18 month quality improvement project led by HSAG	6/30/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing through July 2017
2. Health Plan Required	TBD based on opportunities for improvement	Ongoing 2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2017
D. 2017 HEDIS Monitoring (Medi-cal) / Quality Measurements				
1. The Roadmap	Report to State EQRO Auditor - HSAG	1/29/2017	QI/Claims/PR/MIS	Submitted
2. Childhood Immunization Status	Report annually to QI/UM Committee/Board of Directors (BOD)/DHCS	8/27/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
3. Well Child Visits 3rd, 4th, 5th, and 6th years of life	Report annually to QI/UM Committee/BOD/DHCS	8/27/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
4. Prenatal and Postpartum Care	Report annually to QI/UM Committee/BOD/DHCS	8/27/2017	Director of QI, Health Education and Disease Management / MIS	In Progress
5. Comprehensive Diabetes Care	Report annually to QI/UM Committee/BOD/DHCS	8/27/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
6. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Report annually to QI/UM Committee/BOD/DHCS	8/27/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
7. Annual Monitoring for Patients on Persistent Medications	Report annually to QI/UM Committee/BOD/DHCS	8/27/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
8. Cervical Cancer Screening	Report annually to QI/UM Committee/BOD/DHCS	8/27/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
9. Children's and Adolescent's Access to PCPs	Report annually to QI/UM Committee/BOD/DHCS	8/27/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
10. Ambulatory Care	Report annually to QI/UM Committee/BOD/DHCS	8/27/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress

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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNT ABILITY	STATUS
11. Immunizations in Adolescents	Report annually to QI/UM Committee/BOD/DHCS	8/27/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
12. Use of Imaging Studies for Low Back Pain	Report annually to QI/UM Committee/BOD/DHCS	8/27/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
13. Controlling High Blood Pressure	Report annually to QI/UM Committee/BOD/DHCS	8/27/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
14. Asthma Medication Ratio	Report annually to QI/UM Committee/BOD/DHCS	8/27/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
15. Weight Assessment & Counseling for Nutrition & Physical Activity for Children and Adolescents	Report annually to QI/UM Committee/BOD/DHCS	8/27/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
16. All Cause Readmissions	Report annually to QI/UM Committee/BOD/DHCS	8/27/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
F. Other On-going Monitoring				
1. 30 day re-admissions	In annual report 2017 QI Plan Evaluation to QI/UMC & BOD	Annually	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2017
2. Unanticipated Deaths 3. Focused Reviews	In annual report in 2017 QI Plan Evaluation to QI/UMC & BOD	Annually	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	2017
a. Referral Process	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2017
b. IHEBA - Staying Healthy Assessment	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2017
c. Initial Health Assessment (IHA)	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2017
d. Kern Regional Center/Early Start Program	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2017
e. California Children's Service (CCS)	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2017
f. Critical elements	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2017
g. Diabetes Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ending 12/31/2017
h. Asthma Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ending 12/31/2017
i. Maternity Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2017
G. Safety of Clinical Care				
1. Autoclave	Credentialing/Recredentialing/As necessary	Facility Site Rev/Focus Review	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2017
2. Bio-hazardous wate	Credentialing/Recredentialing/As necessary	Facility Site Rev/Focus Review	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2017
3. Infection Control	Credentialing/Recredentialing/As necessary	Facility Site Rev/Focus Review	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2017

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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNT ABILITY	STATUS
4. Facility Site Review (FSR) DHS Database	FSR database of completed site reviews	Jan / July 2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2017
5. Focused Reviews - Critical Elements	Physician Site Monitoring / Quarterly Reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2017
I. Availability				
1. Primary Care Practitioners				
a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Quarterly	Director of Provider Relations, Director AIS	In Progress
b. Geographic Standard - *Health Education Cultural and Linguistics Needs Assessment*	Measure and Report to DHS every three years	2/1/2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Director Health Education, Cultural and Linquistic Services	Next Needs Assessment due 2021
2. Speciality Practitioners				
a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Quarterly	Director of Provider Relations, Director AIS	Ongoing 2017
b. Geographic Standard - N/A	Measure and Report	N/A	N/A	N/A
J. Access				
1. Primary Care Appointments				
a. Preventive Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Quarterly	Director AIS/Director PR	Ongoing 2017
b. Routine Primary Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Quarterly	Director AIS/Director PR	Ongoing 2017
c. Urgent Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Quarterly	Director AIS/Director PR	Ongoing 2017
e. After-hours Care Standard	Measure/Report to QI/UM Committee Quarterly	Quarterly	Director AIS/Director PR	Ongoing 2017
2. Telephone access to Member Services				
a. Abandonment rate	Measure/Report to QI/UM Committee Quarterly	Quarterly	Director AIS/Director PR	Ongoing 2017
b. Speed of answer	Measure/Report to QI/UM Committee Quarterly	Quarterly	Director AIS/Director PR	Ongoing 2017
3. Mental Health Appointment	Annual MOU Meetings/Grievances	As necessary	Utilization Management/Grievance Review Team	Ongoing 207
a. Life-threatening Emegency Standard (immediate care)	Report as necessary to QI/UM Committee	As necessary	Director AIS/Director PR	Ongoing 2017
b. Non-life-threatening Emergency Standard	Report as necessary to QI/UM Committee	As necessary	Director AIS/Director PR	Ongoing 2017
c. Urgent needs Standard	Report as necessary to QI/UM Committee	As necessary	Director AIS/Director PR	Ongoing 2017
d. Routine office visit Standard (visit within 10 working days)	Report as necessary to QI/UM Committee	As necessary	Director AIS/Director PR	Ongoing 2017
e. Telephone access to screening and triage Standard	Report as necessary to QI/UM Committee	As necessary	Director AIS/Director PR	Ongoing 2017
1) Caller reaches non-recorded voice				
2) Abandonment rate				
K. Encounters, Complaints, Grievances and Appeals Data Analysis	Report aggregate data quarterly to QI/UM Committee	Quarterly	Director of Member Services	Ongoing 2017
L. CAHPS Survey	State administered N/A	2017	State Administered/CIO/Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	TBD
1. Results reported to QI/UMC	Report to QI/UMC when applicable	Tentatively 2017	State Administered/CIO/Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	TBD
2. Results reported to practitioners and providers	Report in Provider Newsletter/Bulletin when applicable	Tentatively 2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI, Director of Provider Relations	TBD

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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNT ABILITY	STATUS
M. Disease Management System				
1. Asthma	Measure and Report to QI/UM Committee	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ending 12/31/2017
2. Diabetes	Measure and Report to QI/UM Committee	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ending 12/31/2017
3. Staying Healthy Assessments (IHEBA)	Measure and Report to QI/UM Committee	Quarterly	Chief Medical Officer (CMO), Administrative Director Health Services, Director Health Education, Cultural and Linquistic Services, Supervisor QI	Beginning 1/1/2017
4. Prenatal	Measure and Report to QI/UM Committee	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing
N. Clinical Practice Guidelines	Report to QI/UM Committee	Annually	CMO	As appropriate
1. Annual Measurement of Performance of at least 2 aspects of 3 Clinical Pactice Guidelines	To be determined	Annually	Chief Medical Officer (CMO) / Administrative Director Health Services/ Manager UM	As appropriate
a. To be determined	Measure, analyze and report	Annually	Chief Medical Officer (CMO) / Administrative Director Health Services/ Manager UM	As appropriate
b. To be determined	Measure, analyze and report	Annually	Chief Medical Officer (CMO) / Administrative Director Health Services/ Manager UM	As appropriate
c. Mental Health Guidelines	Annual MOU Meetings	Annually	Chief Medical Officer (CMO) / Administrative Director Health Services/ Manager UM	As appropriate
2. Develop New Guidelines	Develop, approve and implement	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	2017 Guidelines:
a. To be determined	Reported to QI/UM Committee from PAC	To be determined	Medical Director or designee	As appropriate
O. Continuity of Care Monitoring	Monitored through Grievances, FSR/Peer Review, HEDIS	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	As appropriate
1. Primary Care Practitioner (PCP)	Monitored through Grievances, FSR/Peer Review, HEDIS	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing
2. PCP & Mental Health	Monitored through Grievances, Peer Review, HEDIS	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services	Ongoing
3. Specialist	Monitored through Grievances, Peer Review, HEDIS	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services	Ongoing
P. Cultural and Linguistic Services Report (HFP)	To meet needs of limited English proficient applicants and subscribers - to address types of services	Annually	Director Disease Management, Cultural and Linquistic Services	4Q 2017
R. Delegation of QI Activities	QI/UM delegation to Kaiser and VSP includes ongoing reporting of Grievances, QI Program, Evaluation and Workplan	2Q 2017	Director of Provider Relations	2Q 2017
S. Annual Review of QI Policies and Procedures	Submit to QI/UMC and DHCS	Annually and as necessary	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI/Director AIS	Ongoing
T. QI/UM Committee				
1. Reports and agenda items	Gathered from pertinent departments	Quarterly or more often if nec	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing

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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNT ABILITY	STATUS
2. Minutes	Attached to next meetings agenda and sent to BoD	Quarterly or more often if nec	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing
3. Form 700	Send to all committee members	Initial / Yearly December	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing
4. PO's and Check Requests	Fill out for each member attending meeting	Feb /May Aug/Nov	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI / Accounting	Ongoing
II. UTILIZATION MANAGEMENT - See UM WorkPlan				
A. Annual Review/Approval of UM Program Documents	Program Description 2017	2/26/2017	Director of Health Services	QI/UMC May 2017 Agenda
	Evaluation 2016	2/27/2017		QI/UMC May 2017 Agenda
III. CREDENTIALING AND RECREDENTIALING				
A. Initial Credentialing Site Visit & Medical Record	Upon Credentialing/Quarterly FSR Summary	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing
B. Organization Providers Quality Assessment	Data Reviews are received from QI/UM/AIS/MS for any opportunities form improvement identified. QI Department	At least quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing
1. Hospitals	Tracking girevances, Notifications, Deaths and QI issues	Ongoing	Director of Provider Relations	Ongoing
2. SNF's	Tracking girevances, Notifications, Deaths and QI issues	Ongoing	Director of Provider Relations	Ongoing
3. Home Health Agencies	Tracking girevances, Notifications, Deaths and QI issues	Ongoing	Director of Provider Relations	Ongoing
4. Free-Standing Surgery Centers	Tracking girevances, Notifications, Deaths and QI issues	Ongoing	Director of Provider Relations	Ongoing
5. Impatient MH/SA Facilities	Tracking girevances, Notifications, Deaths and QI issues	Ongoing	Director of Provider Relations	Ongoing
6. Residential MH/SA Facilities	Tracking girevances, Notifications, Deaths and QI issues	Ongoing	Director of Provider Relations	Ongoing
7. Ambulatory MH/SA Facilities	Tracking girevances, Notifications, Deaths and QI issues	Ongoing	Director of Provider Relations	Ongoing
C. Ongoing Monitoring of Sanctions and Complaints	Ongoing; time sensitive; sanctions; grievance process	Ongoing	Director of Provider Relations/AIS	Ongoing
D. Credentialing / Recredentialing File Audit	Ongoing KHS/AIS random audits	Ongoing	Director of Provider Relations	Ongoing
E. Delegated Credentialing	Delegation will be for hospital based practitioners if hospital is JCI accredited	Annually / as necessary	Director of Provider Relations	Ongoing
F. Annual Review of Credentialing/Recredentialing Policies and Proc	Ongoing	Annually / as necessary	Director of Provider Relations	Ongoing
IV. MEMBER RIGHTS AND RESPONSIBILITIES				
A. Statement of Members' Rights and Responsibilities	Review, annually / revise as necessary	Annually / as necessary	Director of Member Services	Ongoing
B. Distribution of Rights Statement to Members & Practitioners	As necessary	Annually / as necessary	Director of Member Services	2017
C. Complaints and Appeals	Aggregate/analyze/report to QI/UM Committee Quarterly	Quarterly	Director of Member Services	In progress
D. Grievance Report (HFP)	Report number and types of benefit grievances for previous calendar year - geographic region, ethnicity, gender and primary language	Quarterly	Director of Member Services	Ongoing
E. Annual Analysis of Privacy and Confidentiality Policies	Review annually / Revise as needed	Ongoing	Director AIS	Ongoing
F. Marketing Information	Focus Groups, Public Policy/Community Advisory Committee	Ongoing	Director of Marketing	Focus groups will be continued in 2017
G. Delegation of Members' Rights and Responsibilities Activities	Non-delegated. Grievance committee	N/A	Grievance Committee	Ongoing

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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNT ABILITY	STATUS
H. Annual Review of Member Rights Policies and Procedures	Non-delegated	N/A	Grievance Committee	Ongoing
V. PREVENTIVE HEALTH SERVICES				
A. Adoption of Preventive Health Guidelines	As necessary	2017	CMO and PAC	Ongoing
B. Annual Distribution of Preventive Health Guidelines to Practitoners	As necessary	2017	Director Provider Relations	Ongoing
C. Annual Analysis of Member Demographics to Identify High Risk Population	Annually and as needed	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services/ Director Health Education, Cultural and Linguistic Services	In progress
D. Health Promotion for Members and Wellness Program	Ongoing through PSA, traditional and social media including FaceBook, twitter, Text Messaging program, Healthy Eating and Active Lifestyle Class, You-tube cooking classes, Member newsletters,	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services/ Director Health Education, Cultural and Linguistic Services	Ongoing
V. PREVENTIVE HEALTH SERVICES				
E. Delegation of Preventive Health Activities	Non-delegated	N/A	QI/UM Committee	N/A
F. Annual Review of Preventive Health Policies and Procedures	Annually / revise as necessary	2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Director Health Education, Cultural and Linguistic Services	Ongoing
VI. MEDICAL RECORDS				
A. Review of Medical Record Documentation Standards	Annually / revise as necessary	2017	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing
B. Distribution of Standards to New Providers	Ongoing / as necessary	Ongoing	Director of Provider Relations	Ongoing
C. Audit of Medical Records Documentation	Refer to Credentialing/Recredentialing	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI / Director of Provider Relations	Ongoing
D. Annual Review of Policies and Procedures	Annually / revise as necessary	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI / Director of AIS	Ongoing

Ancillary Services Physical Accessibility Review Survey

California Department of Health Care Services
Managed Care Quality and Monitoring Division

For purposes of this tool, Ancillary Services refers to Diagnostic and Therapeutic services such as, but not limited to: Radiology, Imaging, Cardiac Testing, Kidney dialysis, Physical Therapy , Occupational therapy , Speech therapy ,Cardiac rehabilitation, Pulmonary testing.

Provider Name: _____ ☐ Radiology ☐ Infusion ☐ Physical Therapy ☐ Other _____	Date of Review: Name of Reviewer:
Address: City:	Health Plan Name:
Phone: FAX:	Contact Person Name:

	Level of Access:
Basic Access: Demonstrates ancillary facility site access for the members with disabilities to parking, building, elevator, restroom, diagnostic and treatment use. To meet Basic Access requirements, all (34) Critical Elements (CE) must be met.	☐ Basic Access
Limited Access: Demonstrates ancillary facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, restroom, diagnostic and treatment use. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.	☐ Limited Access
Medical Equipment: Diagnostic and treatment equipment meet accessibility features for use as indicated the "accessibility indicators". (assistance is available for the equipment used).	☐ Medical Equipment is available ☐ List of Equipment

Below are the symbols that will be used in the provider directories to indicate areas of accessibility at the ancillary site. These should also be used in online directories. In order for an ancillary site to receive a symbol, the appropriate criteria must be met.

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first 5 symbols (P, EB, IB, R, PD).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	**Critical Elements (CE): 3,7,8,11**				
EB = EXTERIOR BUILDING	**(CE): 14,20,21,22,25**				
IB = INTERIOR BUILDING	**(CE): 28,31,42,43,44,45,46,47**				
R =RESTROOM	**(CE): 53, 55,56,59,62,64**				
PD = PATIENT DIAGNOSTIC AND TREATMENT USE	**(CE): 66,67,70,76,78**				
T = MEDICAL EQUIPMENT	**(T): 72,73,74,77,80,81**				

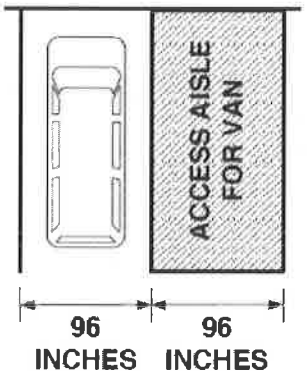
2nd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

3rd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

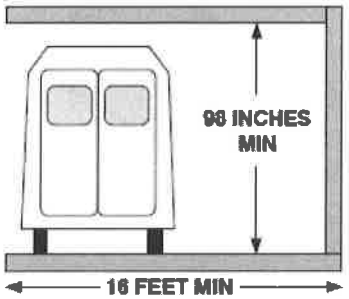
Name: _____ Signature: _____ Date: _____

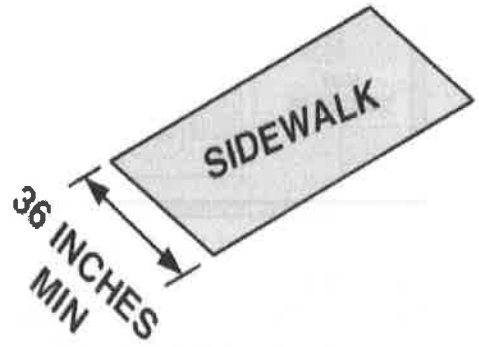
PARKING						
1	Is off-street public parking available?	Self explanatory.				
2	Are accessible parking spaces provided in off-street parking?	Self explanatory.				
3 (CE)	**Are the correct number of accessible parking spaces provided?** **1 to 25 total spaces – 1 required** **26 to 50 – 2 required** **51 to 75 – 3 required** **76 to 100 – 4 required** **101 to 150 – 5 required** **151 to 200 – 6 required** **201 to 300 – 7 required** **301 to 400 – 8 required**	**If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.**				
4	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				

5	Is there an access aisle next to the accessible space(s)?	The access aisle is the space next to the accessible parking space where a person using the accessible space can load and unload from the vehicle.  				
6	Is the parking space(s) and access aisle(s) free of curb ramps that extend into the space and other obstructions?	If a curb ramp extends into the parking space(s) or access aisle, a person using that space and aisle would not have adequate level space to unload and load from the vehicle.				

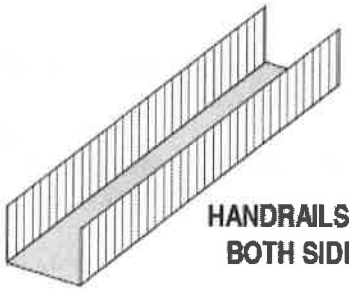
7 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the parking locations?**	**Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.**				
8 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the drop off locations?**	**See above Question # 7.**				

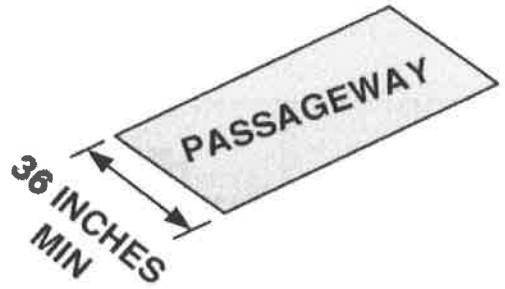
9	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility. 				
10	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				
	Is VAN accessible parking provided?	**1 van space for every 6 standard accessible spaces must be provided, but never less than one. For example, if there are 23 total spaces, at least one accessible space is required and it must be large enough (See Question # 5 for dimensions) to accommodate a van. If there are 201 total parking spaces, at least seven accessible spaces would be required and two of those would have to accommodate vans.**				
12	Is VAN accessible parking signage provided?	Signs must be mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle.				

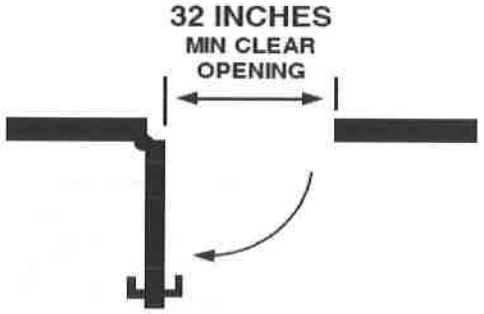
13	If van accessible parking is provided in a parking garage, is there at least 8 feet 2 inches (98 inches total) vertical clearance available for full-sized, lift equipped vans?	If there is no parking garage, check NA. If designated accessible parking is located in a garage, the vertical clearance should be at a minimum 8 feet 2 inches (98 inches). Vertical clearance should be posted.  				

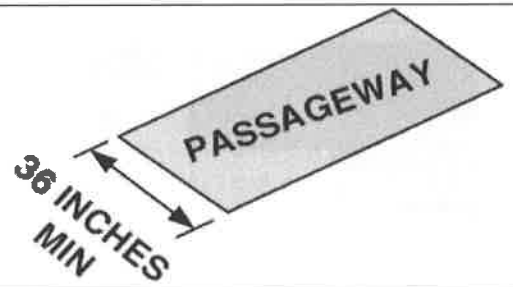
EXTERIOR ROUTE (FROM ACCESSIBLE PARKING, PUBLIC TRANSPORTATION, AND PUBLIC SIDEWALK TO THE ENTRANCE)						
14 (CE)	**For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)**	**Self explanatory.**				
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
15	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following:(Please mark NA for those that do not apply.)					

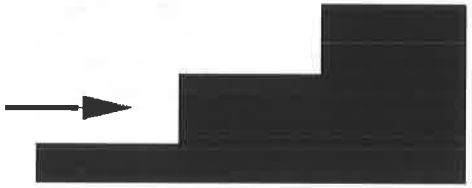
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
16	Is the accessible route to the building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	An example of a stable surface is a floor or ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.	[redacted]			
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
17	Is there an accessible route that does not include stairs or steps?	Self explanatory.				

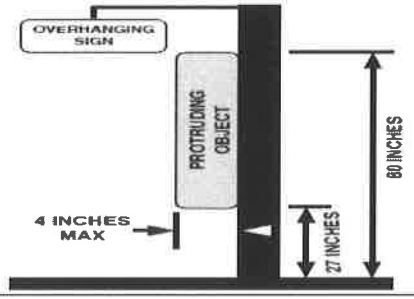
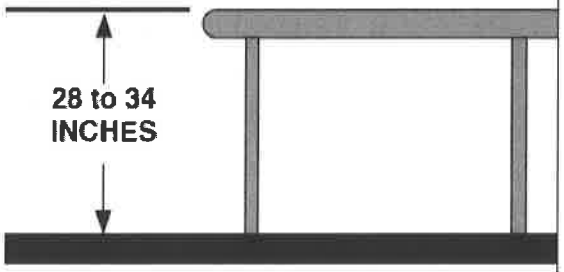
18	Is the route to the entrance from the accessible parking spaces, including transitions at curb ramps, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				
RAMPS:						
19	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				
20 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	**If the ramp is not longer than 6 feet, check NA.**  **HANDRAILS ON BOTH SIDES**				

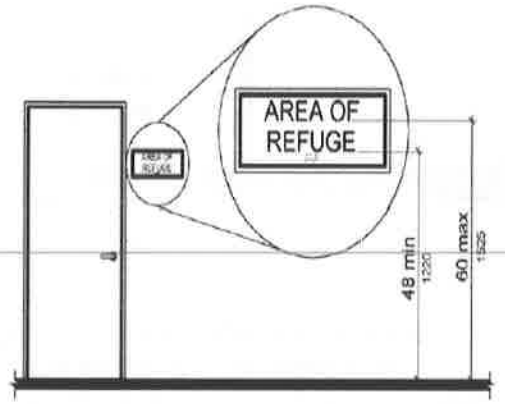
21 (CE)	**Are all ramps at least 36 inches wide?**					

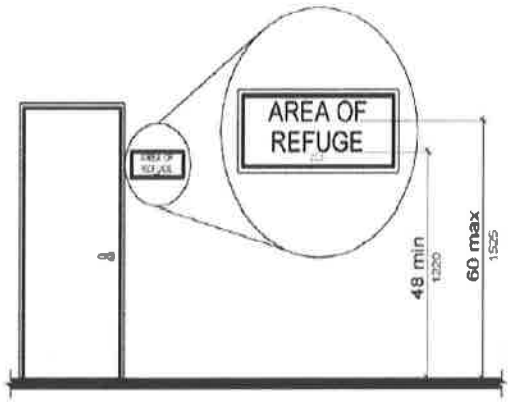
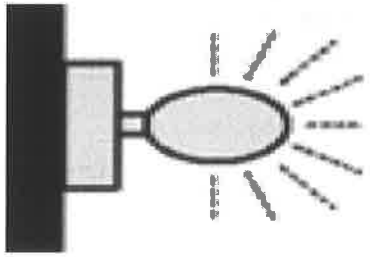
BUILDING ENTRANCE						
22 CE	**Is the main entrance accessible?**	**Self explanatory.**				
23	If a main entrance is not accessible, is there another accessible entrance?	Self explanatory.				
24	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					
25 (CE)	**Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?**	**When measuring double doors, measure the opening with one door open to 90°.** 				

26	Are there automatic doors?	Self explanatory.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH TO THE PARTICIPANT AREAS						
27	Is there an interior route to the patient area?	Some patient areas are accessed directly from the street or drop off rather than being located within a larger building or complex, therefore they do not have interior routes.				
	Are <u>ALL</u> interior paths of travel at least 36 inches wide?					
29	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				

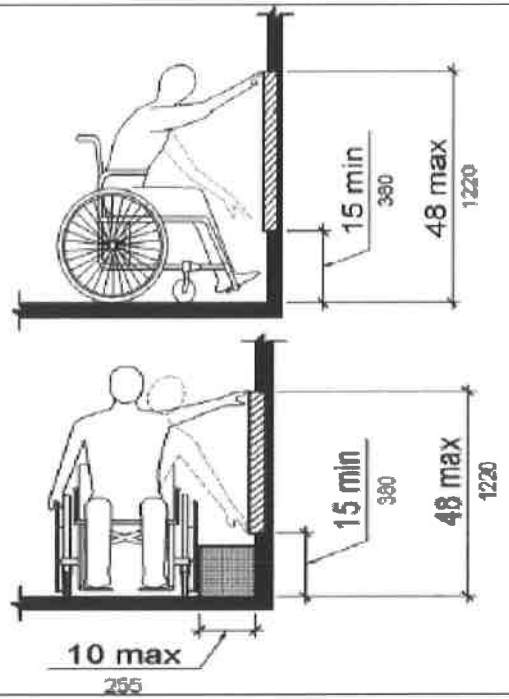
30	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				
31 (CE)	**If there are stairs on the accessible route, are there handrails on each side?**	**If there are no stairs, check NA.**				
32	If there are stairs, are all stair risers closed that are on the accessible route?					
33	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				

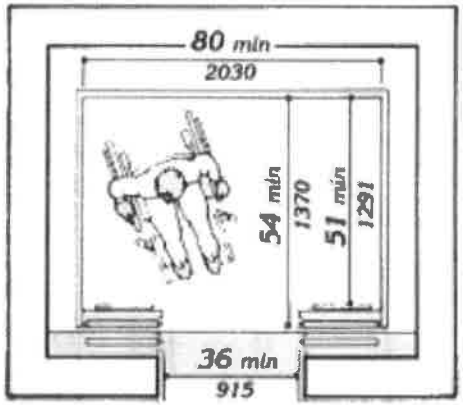
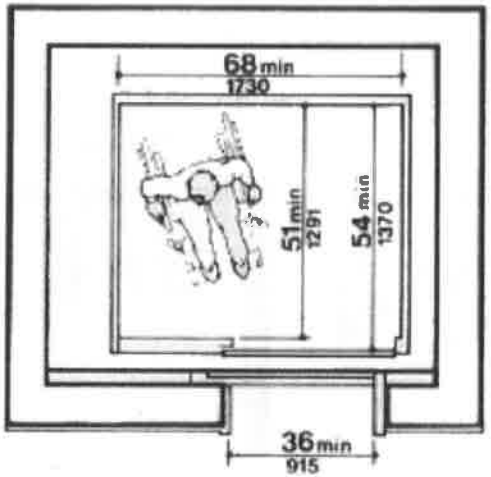
34	Is the path through the facility free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it.  				
35	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
36	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items?	 				

37	Does the office have a method, other than a lowered counter, by which people can sign in/register? (If yes, please note this method in comments.)	A medical office may use reasonable alternative methods to meet this need such as a clip board.				
38	Do signs identifying permanent rooms and spaces include raised letters and Braille?					

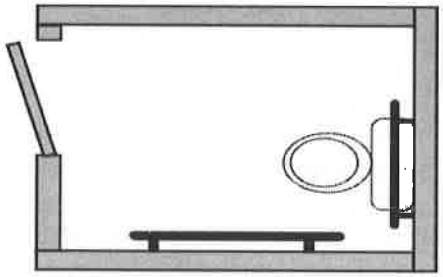
39	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				
40	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and Participant Areas?	If the building does not have a fire alarm system, check NA. 				

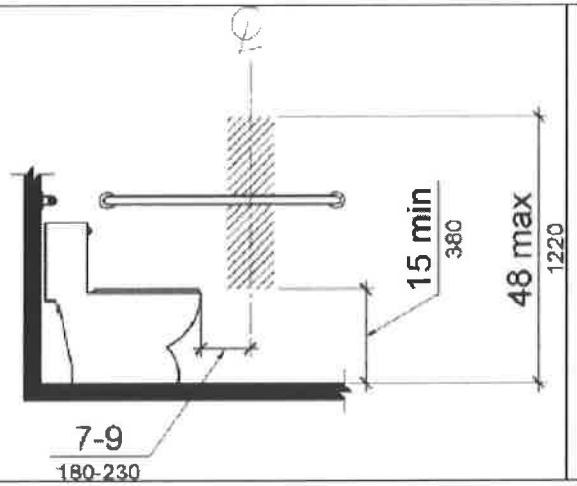
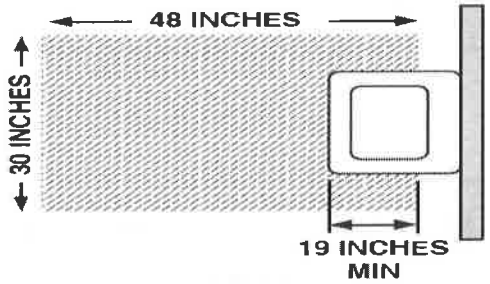
ELEVATORS						
41	Is there an elevator?	Self explanatory.				
42 (CE)	**If needed, is the elevator available for public/patient use during business hours?**	**Self explanatory.**				
43 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	**A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement.** 				
44 (CE)	**Is there a raised letter and Braille sign on each side of each elevator jamb?**	**These signs allow everyone to know which floor they are on before entering or exiting the elevator.**				

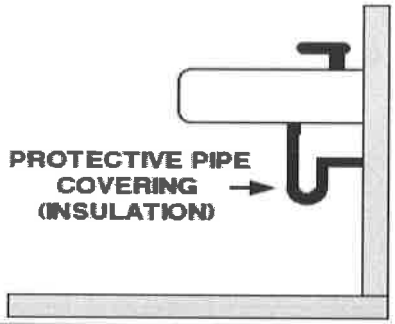
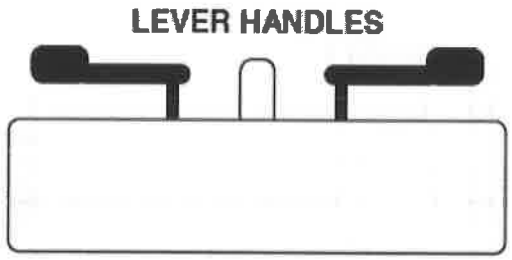
45 (CE)	**Are the hall call buttons for the elevator no higher than 48 inches from the floor?**					

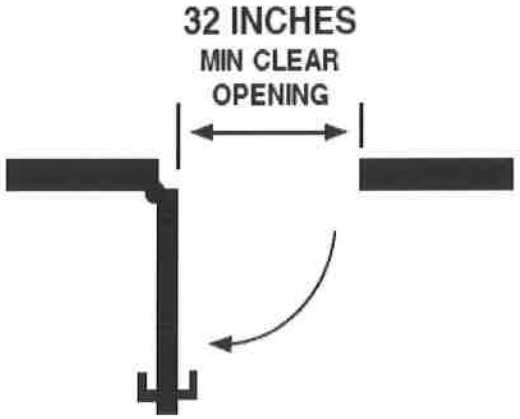
46 (CE)	Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?	The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.  (a)  				
	Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?	Self explanatory.				

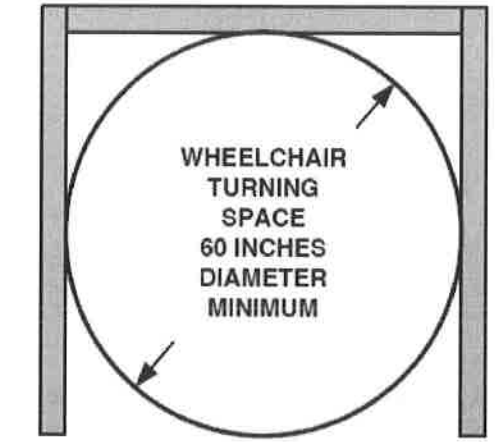
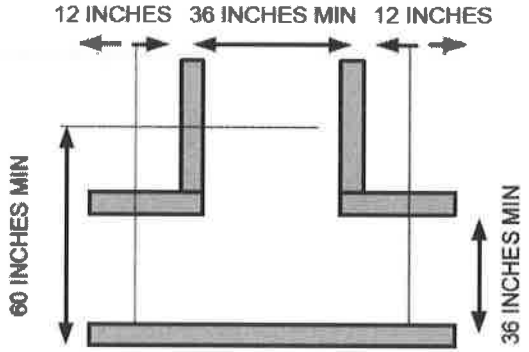
48	Is there an emergency communication system in the elevator?	Self explanatory.				
49	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				
50	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				

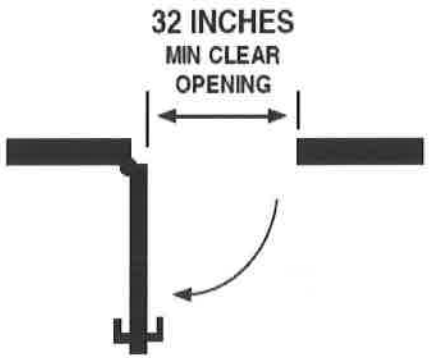
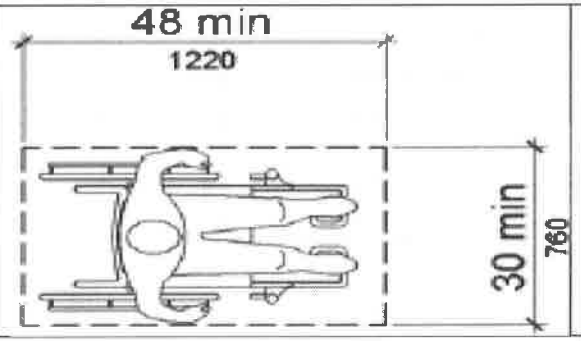
ALL RESTROOMS/TOILET ROOMS (WITH AND WITHOUT STALLS):						
51	Is there an accessible restroom/toilet room?	Self explanatory.				
52	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
53 (CE)	**Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?**	**Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface.** 				
54	Are all objects mounted at least 12 inches above and 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				

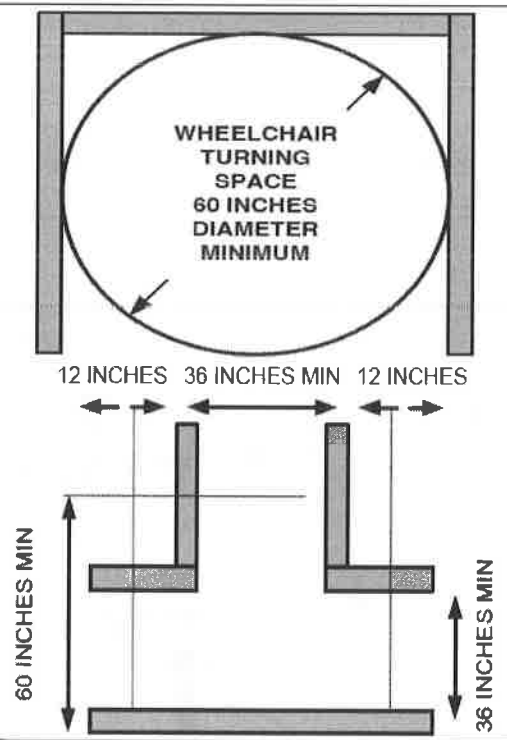
55 (CE)	**Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?**					
56 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?**	**This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath.** 				
57	Is the space in front of the sink free of trashcans and other movable items?	Self explanatory.				

58	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
59 (CE)	**Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)**	**A knob handle would not be accessible.** 				
60	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
61	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				

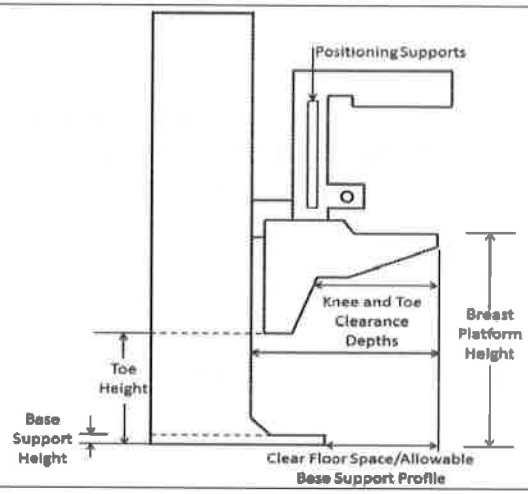
62 (CE)	**Do restroom doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					
63	Is the space inside the restroom clear, without trashcans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

64 (CE)	**Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the restroom to allow a turn around for wheelchair and scooter users?**	 				
65	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				

PATIENT AREAS (DIAGNOSTIC & TREATMENT, ROOMS)						
	Do doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?					
	Is there space next to the equipment for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto following?					
	a. Equipment (such as PT)?					
	b. Diagnostic apparatus?					
	c. Patient activity areas (such as OT, dining)?					
	d. Infusion (chairs, beds for chemo, dialysis)?					

68	Patient Dressing Rooms are accessible (all bullet points need to be present) • Doorways are at least 32 inches • Turning Radius is 60x60 inches • Seating 17-19 inches from the floor • Grab bars	If there are reasonable alternative for dressing room accommodations, this measure is met.				
69	In the diagnostic/treatment area, is there a 60 inch diameter turning circle or a 60 inch x 60 inch "T" shaped space so that a wheelchair or scooter user can make a 180° turn?					
70 (CE)	**If any diagnostic equipment or treatment tables/chairs are used, is there a patient pre-assessment process (i.e. phone, prior to appointment) to verify that the necessary services can be provided?**	Self explanatory.				

71	Does the Diagnostic Table have a weight limit?	Document weight limit : □ MRI _____ □ CT _____ □ Fluoroscopy_____ □ PET _____ □ Bone Density/Dexascan _____ □ Ultrasound _____ □ Nuclear Medicine_____ □ Xray_____ □ _____ □ _____				
72 (T)	**Is there height adjustable equipment (chairs and tables) that lowers between 17 inches and 19 inches from the floor to the top of the cushion?**	Score each appropriate equipment that do or do not lower 17 to 19 inches from the floor to the top of the cushion:				
	a. MRI					
	b. CT					
	c. Fluoroscopy					
	d. PET					
	e. Bone Density/Dexascan					
	f. Ultrasound					
	g. Nuclear Medicine					
	h. Xray					
	i. Physical Therapy Table					
	j. Dialysis Chair					
	k. Other					
	l. Other					
73 (T)	**Mammography machine can accommodate wheelchair users with knee and foot clearance under the breast plate allowing technologist to take quality**	The top of breast platform needs to go to 26 inches above the floor to accommodate an individual seated in a wheelchair.				

	images.					
74 (T)	**A Mammography chair is available for patients who must be seated.** ***Example:*** *persons with balance difficulties, or cannot stand for any length of time.*	The chair's footrests must accommodate and ride over the base support.				
75	Are transfer and positioning supports available?	Examples include: • Positioning supports while on the equipment as pillows, wedges, strapping, transfer supports Please list elements in comments.				
76 (CE)	**Does staff provide patient transfer assistance on and off of equipment (this includes use of lift equipment when needed).**	**Self Explanatory**				

77 (T)	**Is lift equipment available to assist staff with transfers (portable, overhead, or ceiling mounted)?**	**Self Explanatory**				
78 (CE)	**Is staff trained yearly on safe transfer techniques?**	**Self explanatory**				

WEIGHT MEASUREMENT						
79	Are patients normally weighed at this provider site?	Self explanatory				
80 (T)	**Is a weight scale available that can be used by a wheelchair or scooter user, obese patients whose weight exceeds the weight limits for standard scales, and for patients that cannot step onto a standard scale?**	**Accessible scale platform dimensions should be a minimum of 32x 36 inches**				
81 (T)	**If there is no accessible scale, are other methods to weigh the patient in place?**	**Examples of other methods to weigh the patient are: weight scales integrated into examination tables, chairs, stretchers, and lifts, or an accessible scale located in a nearby office, within the same building.**				

References

2010 ADA Standards for Accessible Design
U.S Department of Justice
http://www.ada.gov/2010ADAstandards_index.htm

The revised regulations for Titles II and III of the Americans with Disabilities Act of 1990 (ADA) were published in the Federal Register on September 15, 2010. They provide the scoping and technical requirements for new construction and alterations resulting from the adoption of revised 2010 Standards in the final rules for Title II (28 CFR part 35) and Title III (28 CFR part 36). The 2010 ADA Standards go into effect March 15, 2012, but can be used now instead of the 1991 standards. The FSR Attachment C draws upon access requirements found in both the 1991 Americans with Disabilities Act Accessibility Guidelines and the 2010 ADA Standards. Some diagrams that appear in the FSR Attachment C are reproduced from these sources.

Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are 1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:

2009 California Building Standards Code with California Errata and Amendments
State of California
Department of General Services
Division of the State Architect
Updated April 27, 2010
http://www.documents.dgs.ca.gov/dsa/pubs/access_manual_rev_04-27-10.pdf

Some diagrams are reprinted with permission from the Kentucky Department of Vocational Rehabilitation. These illustrations can also be found in:

"Health Care Usability Profile V3"
© Copyright 2008
Oregon Health & Science University RRTC: Health & Wellness
Authors: Drum, C.E., Davis, C.E., Berardinelli, M., Cline, A., Laing, R., Horner-Johnson, W., & Krahn, G.
Oregon Institute on Disability and Development
Portland, OR 97239
rrtc@ohsu.edu
healthwellness.org

Community Based Adult Services (CBAS) Physical Accessibility Review Survey

California Department of Health Care Services
Managed Care Quality and Monitoring Division

Provider Name: ☐ CBAS ☐ Other	Date of Review: Name of Reviewer:
Address: City:	Health Plan Name:
Phone: FAX:	Contact Person Name:
	Level of Access:
Basic Access: Demonstrates facility site access for the members with disabilities to parking, building, elevator, Participant Areas, and restroom. To meet Basic Access requirements, all (24) Critical Elements (CE) must be met.	☐ Basic Access
Limited Access: Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, participant areas, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.	☐ Limited Access

Below are the symbols that will be used in the provider directories to indicate areas of accessibility at a provider office/site. These should also be used in online directories. In order for a provider office to receive a symbol, the appropriate criteria must be met.

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first six symbols (P, EB, IB, R, PA,). And a provider who has Medical Equipment Access will meet the medical equipment elements for the last symbol (T).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	Critical Elements (CE): 6,7,8				
EB = EXTERIOR BUILDING	(CE): 9,15,16,17,20				
IB = INTERIOR BUILDING	(CE): 23,26,36,37,38,39,40,41				
R=RESTROOM	(CE): 47,49,50,53,56,58				
PA= PARTICIPANT AREAS	(CE): 60,61				

2nd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

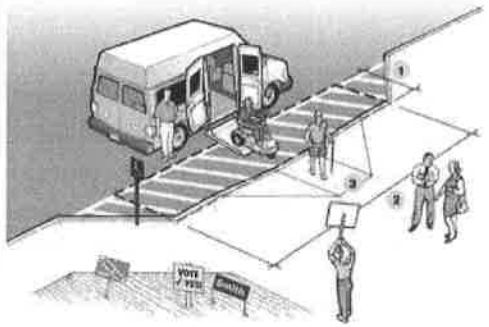
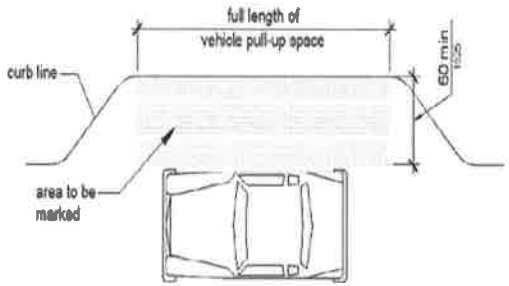
3rd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

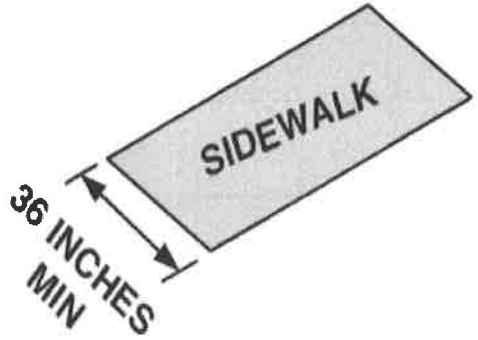
Name: _____ Signature: _____ Date: _____

PARKING						
1	Are accessible parking spaces provided in the designated parking area?	Self explanatory.				
2	Are the correct number of accessible parking spaces provided? 1 to 25 total spaces – 1 required 26 to 50 – 2 required 51 to 75 – 3 required 76 to 100 – 4 required 101 to 150 – 5 required 151 to 200 – 6 required 201 to 300 – 7 required 301 to 400 – 8 required	If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.				
3	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				

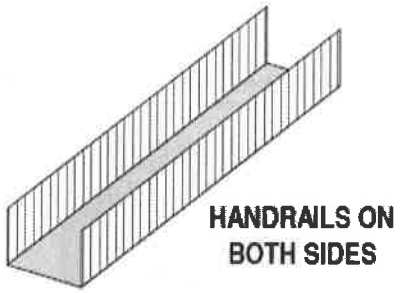
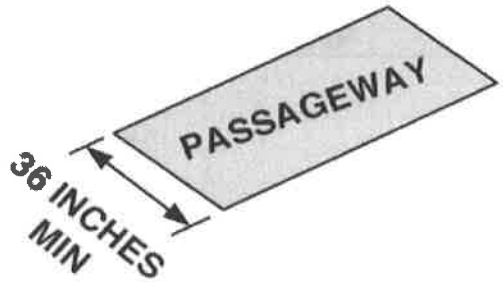
4	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility. 				
5	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				

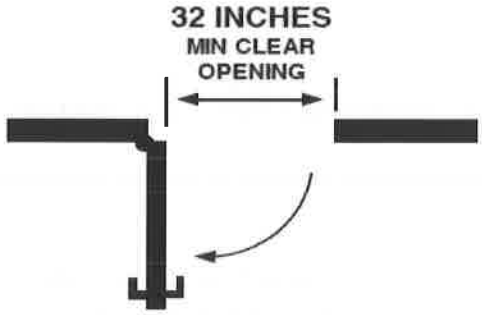
6 (CE)	**Is a passenger loading zone provided with a vehicular pull-up space.**	The vehicular pull-up space dimension is a minimum of 96 inches wide and 20 feet long				

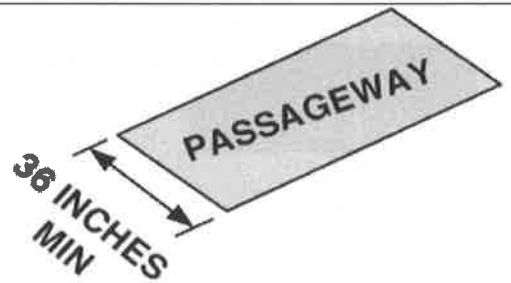
7 (CE)	**Is there an access aisle that adjoins an accessible route and does not overlap the Vehicular way /driveway?**	**Access aisles serving vehicle pull-up *spaces* shall be a minimum of 60 inches wide.**  				
8 (CE)	**Do curbs on the route have curb ramps at the drop off locations?**	**Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.**				

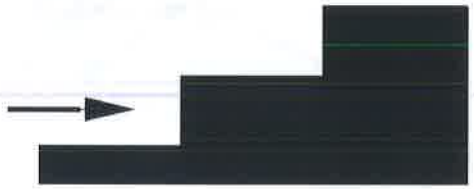
EXTERIOR ROUTE (FROM DROP OFF AND PICK UP LOCATIONS TO THE ENTRANCE)						
9 (CE)	**For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)**	**Self explanatory.**				
	a. Public Transportation					
	b. Public sidewalk?					
	c. Drop off?					
10	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following: (Please mark NA for those that do not apply.)					
	a. Public Transportation					
	b. Public sidewalk?					
	c. Drop off?					
11	Is the accessible route to the	An example of a stable surface is a floor or				

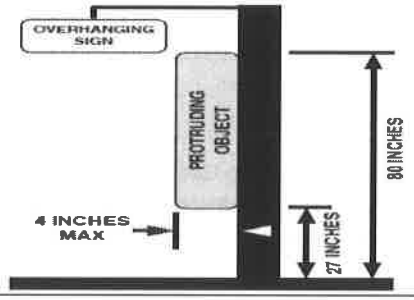
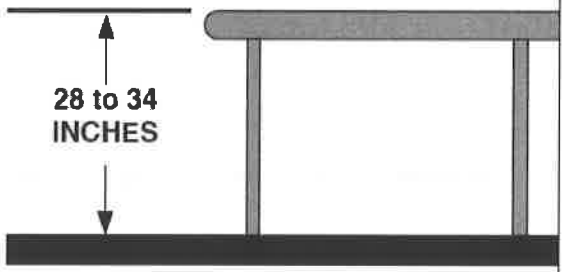
	building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.				
	a. Public Transportation					
	b. Public sidewalk?					
	c. Drop off?					
12	Is there an accessible route that does not include stairs or steps?	Self explanatory.				
13	Is the route to the entrance from drop off, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				

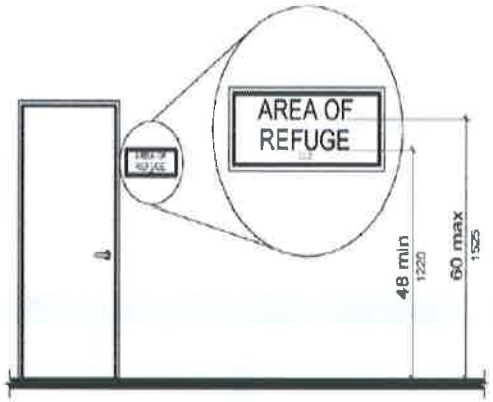
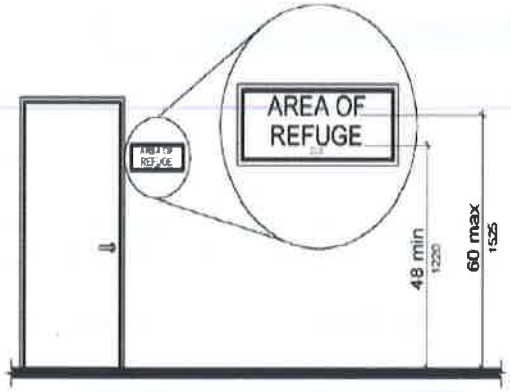
RAMPS:						
14	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				
15 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	**If the ramp is not longer than 6 feet, check N/A.** 				
16 (CE)	**Are all ramps at least 36 inches wide?**					

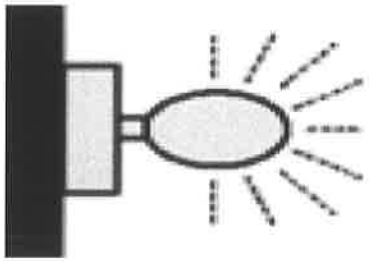
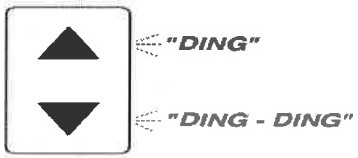
BUILDING ENTRANCE						
	Is the main entrance accessible?	**Self explanatory.**				
18	If a main entrance is not accessible, is there another accessible entrance?	Self explanatory.				
19	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					
	Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?	**When measuring double doors, measure the opening with one door open to 90°.** 				

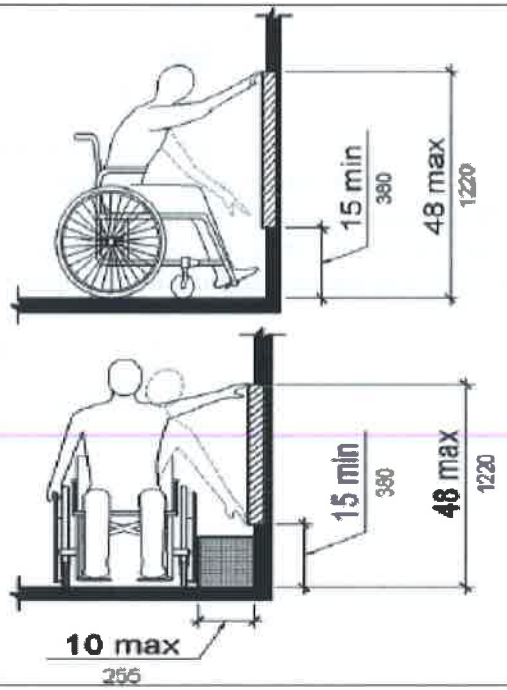
21	Are there automatic doors?	Self explanatory.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH TO THE PARTICIPANT AREAS						
22	Is there an interior route to the participant area?	Some participant areas are accessed directly from the street or drop off rather than being located within a larger building or complex, therefore they do not have interior routes.				
23 (CE)	**Are <u>ALL</u> interior paths of travel at least 36 inches wide?**					
24	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				

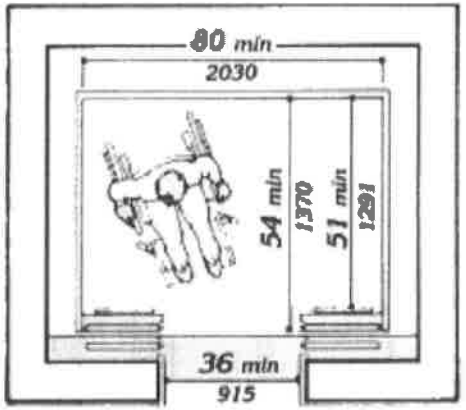
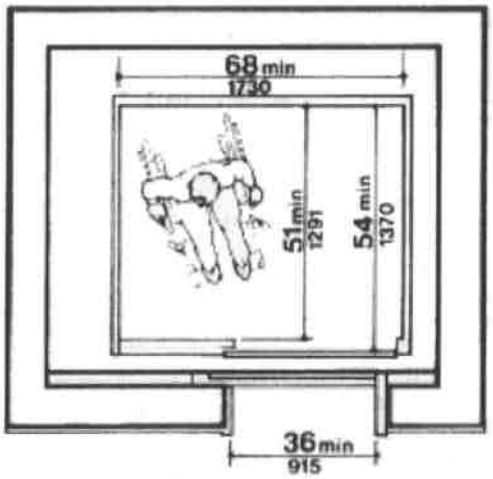
25	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				
26 (CE)	**If there are stairs on the accessible route, are there handrails on each side?**	**If there are no stairs, check N/A.**				
27	If there are stairs, are all stair risers closed that are on the accessible route?					
28	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				

29	Is the path through the facility free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it.  				
30	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
31	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items.	 				

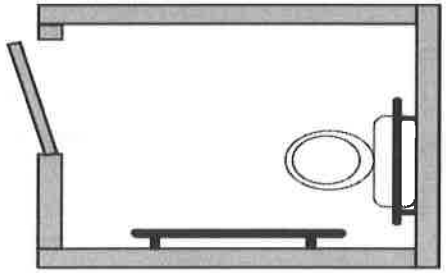
32	Do signs identifying permanent rooms and spaces include raised letters and Braille?					
33	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				

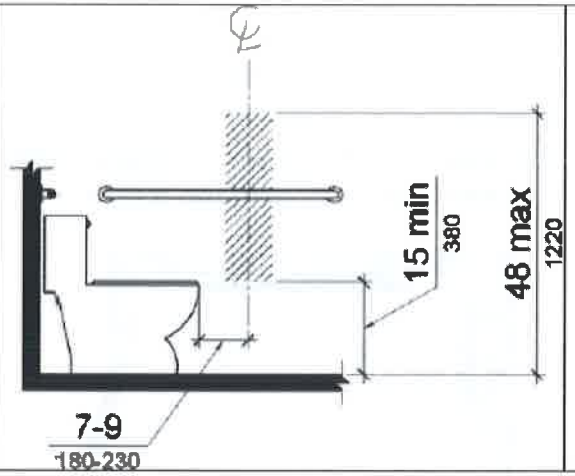
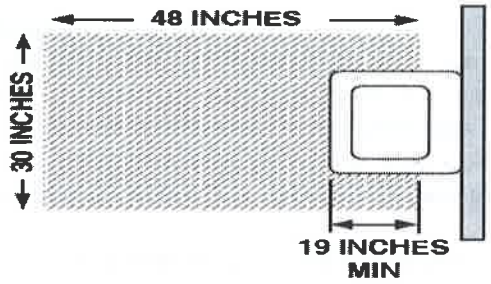
34	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and Participant Areas?	If the building does not have a fire alarm system, check NA. 				
ELEVATORS						
35	Is there an elevator?					
36 (CE)	**If needed, is the elevator available for public/patient use during business hours?**	**Self explanatory.**				
37 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	**A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement.** 				

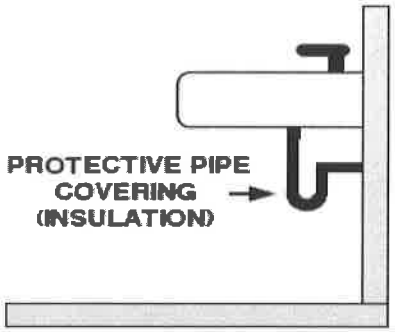
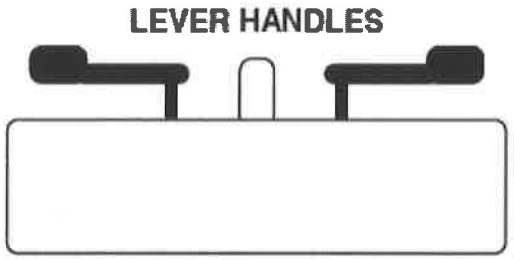
38 (CE)	**Are there raised letter and Braille sign on each side of each elevator jamb?**	**These signs allow everyone to know which floor they are on before entering or exiting the elevator.**				
39 (CE)	**Are the hall call buttons for the elevator no higher than 48 inches from the floor?**					

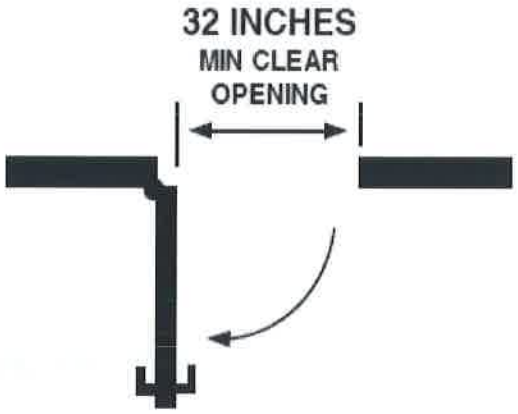
40 (CE)	Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?	The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.  (a)  				
41 (CE)	Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?	Self explanatory.				

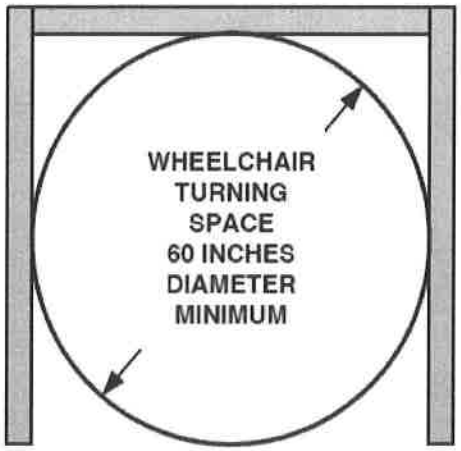
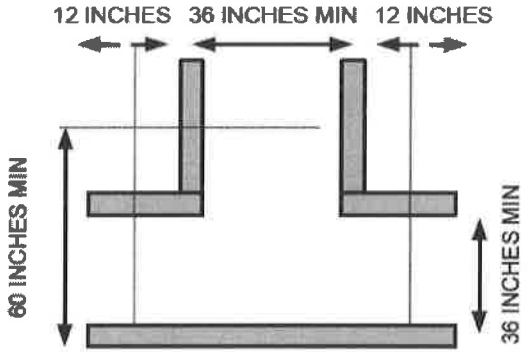
42	Is there an emergency communication system in the elevator?	Self explanatory.				
43	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				
44	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				

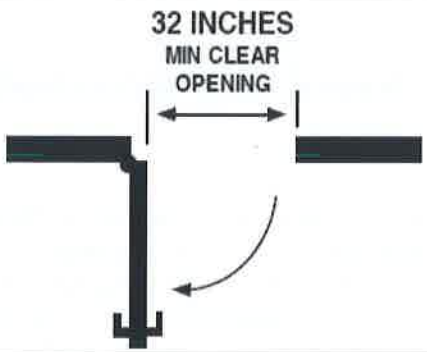
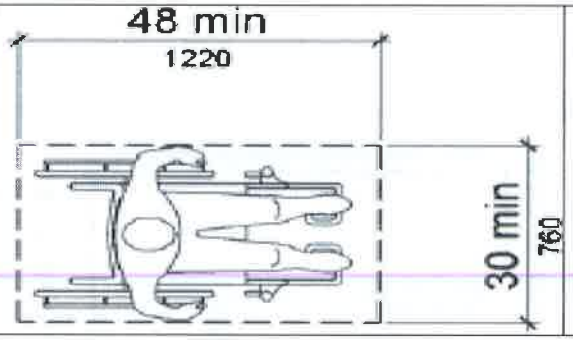
ALL RESTROOMS/TOILET ROOMS (WITH AND WITHOUT STALLS):						
45	Is there an accessible restroom/toilet room?	Self explanatory.				
46	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
47 (CE)	**Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?**	**Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface.** 				
48	Are all objects mounted at least 12 inches above and/or 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				

49 (CE)	**Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?**					
50 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?**	**This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath.** 				
51	Is the space in front of the sink free of trashcans and other movable items?	Self explanatory.				

52	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
53 (CE)	**Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)**	**A knob handle would not be accessible.** 				
54	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
55	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				

56 (CE)	**Do restroom doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					
57	Is the space inside the restroom clear, without trashcans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

58 (CE)	**Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the restroom to allow a turn around for wheelchair and scooter users?**	 				
59	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				
PARTICIPANT AREAS (QUIET ROOM/THERAPY ROOM S-PT/OT, ACTIVITY AREA)						

60 (CE)	**Do doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					
61 (CE)	**There is space in the following areas for a wheelchair or scooter user to approach and park for participation in activities or use of exercise equipment:**					
	a. Quiet room?					
	b. Physical Therapy Room {PT}?					
	c. Occupational Therapy {OT}?					
	d. Activity Area					

62	Is there a bed that is between 17 inches and 19 inches from the floor to the top of the cushion?	Self explanatory				

References

2010 ADA Standards for Accessible Design
U.S Department of Justice
http://www.ada.gov/2010ADAstandards_index.htm

The revised regulations for Titles II and III of the Americans with Disabilities Act of 1990 (ADA) were published in the Federal Register on September 15, 2010. They provide the scoping and technical requirements for new construction and alterations resulting from the adoption of revised 2010 Standards in the final rules for Title II (28 CFR part 35) and Title III (28 CFR part 36). The 2010 ADA Standards go into effect March 15, 2012, but can be used now instead of the 1991 standards. The FSR Attachment C draws upon access requirements found in both the 1991 Americans with Disabilities Act Accessibility Guidelines and the 2010 ADA Standards. Some diagrams that appear in the FSR Attachment C are reproduced from these sources.

Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are 1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:

2009 California Building Standards Code with California Errata and Amendments
State of California
Department of General Services
Division of the State Architect
Updated April 27, 2010
http://www.documents.dgs.ca.gov/dsa/pubs/access_manual_rev_04-27-10.pdf

Some diagrams are reprinted with permission from the Kentucky Department of Vocational Rehabilitation. These illustrations can also be found in:

"Health Care Usability Profile V3"
© Copyright 2008
Oregon Health & Science University RRTC: Health & Wellness
Authors: Drum, C.E., Davis, C.E., Berardinelli, M., Cline, A., Laing, R., Horner-Johnson, W., & Krahn, G.
Oregon Institute on Disability and Development
Portland, OR 97239
rrtc@ohsu.edu
healthwellness.org

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Access – Treatment of a Minor				POLICY #: 2.17-P	
DEPARTMENT: Health Services – Quality Improvement					
Effective Date: 08/1997	Review/Revised Date: 1/26/2017	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A Hayward
Chief Executive Officer

Date 1/24/17

Chief Medical Officer

Date

Deborah Murray
Administrative Director Health Services

Date 1/26/17

POLICY:

Under normal circumstances, treatment of a minor requires the consent of the parent/guardian. Under the following circumstances, minors may be treated without the consent of the parent/guardian:

- The minor becomes ill or injured while attending school and the parent/guardian cannot be reached
- The minor gives consent for those services that qualify as minor consent services
- A qualified relative caregiver gives consent

The details of these exceptions are outlined in this policy.

PROCEDURES:

1.0 TREATMENT DURING SCHOOL HOURS

If a parent or guardian cannot be reached, a physician and the hospital may provide reasonable treatment without the consent of the child's parent(s) or legal guardian for any child enrolled in any school in any district when the child is ill or injured during regular school hours.

2.0 MINOR CONSENT SERVICES

By statutory definition, a person under the age of 18 is incompetent to consent to medical treatment except as otherwise allowed by law. Please read this policy in full to define those exceptions. Minors may access treatment for sensitive services such as sexual assault, drug or alcohol abuse for children 12 years of age or older, pregnancy, family planning, venereal disease for children 12 years of age or older, sexually transmitted diseases designated by the Medical Director for children 12 years of age or older, and mental health care for children 12 years of age or older who are mature enough to participate intelligently and which is needed to prevent the children from seriously harming themselves or others or because the children are the alleged victims of incest or child abuse.[12]

If patient is…	Parental consent required?	Are parents responsible for care?	Is minor consent sufficient?	May MD inform parents of treatment without minor consent?
Under 18, unmarried, no special circumstances	Yes	Yes	No	Yes
Under 18, married or previously married[i]	No	No	Yes	No
Under 18, no special circumstances, emergency and parents not available[ii]	No	Yes	Yes (if capable)	Yes
Emancipated minor (declaration by court, identification card from DMV)[iii]	No	No	Yes	No
Self-sufficient minor (over 15, not living at home, manages own financial affairs)[iv]	No	No	Yes	Yes
Not married, pregnant, under 18, care related to prevention or treatment of pregnancy[v]	No	Yes*	Yes	Probably not +
Not married, pregnant, under 18, care not related to prevention or treatment of pregnancy and no other special circumstances	Yes	Yes	No	Yes
Under 18, on active duty with Armed Forces[vi]	No	No	Yes	No
Under 18, over 12, care for contagious reportable disease or condition[vii]	No	No	Yes	Probably not +
Under 18, over 12, care for rape[viii]	No	Yes*	Yes	Probably +
Under 18, care for sexual	No	Yes*	Yes	Yes, usually +

assault[ix]				
Under 18, over 12, care for alcohol or drug abuse[x]	No	Only if participating in counseling	Yes	Yes, usually +
Under 18, over 12, care for mental health, outpatient only[xi]	No	Only if parents are participating in the counseling	Yes, if capable	Yes, usually +

Members are made aware of minor consent services through the *Member Handbook.*

KHS personnel will not discuss with a minor's parents, the access of sensitive services by the minor as defined above without consent of the minor.

3.0 QUALIFIED RELATIVE CAREGIVER[xii]

An adult relative, with whom a minor is living, who is not the parent, legal guardian, or conservator of the minor may provide consent for medical care for the minor by signing a *Caregiver's Authorization Affidavit.* (See Attachment A). All of the following must apply in order for the consent to be valid:

A. The minor must be living with the adult relative

B. The adult must be a "qualified relative", which is defined in the law as a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix, "grand" or "great," or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.

C. The adult must advise the parents of the proposed medical treatment and have received no objection thereto; or the adult must be unable to contact the parents

D. The adult must complete an affidavit in which he or she attests that the elements outlined above are true and correct.

Once the affidavit is completed in its entirety, KHS practitioners/providers or their personnel must, if possible, make one further attempt to reach the minor's parents prior to care being delivered to the minor.

A copy of the signed affidavit must be placed in the minor's permanent medical record. The affidavit is valid for only one year from the date of the signature. This affidavit does NOT mean that the minor is automatically a dependent for health care coverage purposes.

Adult caregivers should be encouraged to seek legal guardianship of the minor by KHS practitioners/providers and KHS personnel.

4.0 MONITORING

The effectiveness of this policy is monitored through the Facility Site Review process. See *KHS Policy and Procedure #2.22 – Facility Site Review* for details.

ATTACHMENTS:

- Attachment A – *Caregiver's Authorization Affidavit*

REFERENCE:

Revision 2017-01: Reviewed by QI Supervisor. Revisions made to signatory list

[i] **Revision 2013-07:** Policy reviewed by Director of Quality Improvement. No revisions required. Update with management titles and new format. **Revision 2009-04:** Reviewed by Director of Quality Improvement, Health Education & Disease Management. Updated titles. no additional revision needed. Not reviewed by the AIS Compliance Department. **Revision 2002-02:** Annual review. Revised per DHS Comment 09/19/01. Policy #2.18 – Consent for Treatment of Minor by a Relative Other Than a Parent was absorbed into #2.17.

[i] Family Code, Section 7002

[ii] Business and Professional Code, Section 2397

[iii] Family Code, Sections 7002, 7050, 7140

[iv] Family Code, Section 6922

[v] Family Code, Section 6925

[*] It should be recognized that although the minor's parents or guardian are legally responsible for payment even though the law allows the minor to give consent, as a practical matter, other considerations, such as confidentiality of medical information, may prevent the hospital from seeking payment from the minor's parent or guardian.

[+] Law unclear. Depends on circumstances. Careful analysis recommended.

[vi] Family Code, Section 7002

[vii] Family Code, Section 6926

[+] Law unclear. Depends on circumstances. Careful analysis recommended.

[viii] Family Code, Section 6927

[*] It should be recognized that although the minor's parents or guardian are legally responsible for payment even though the law allows the minor to give consent, as a practical matter, other considerations, such as confidentiality of medical information, may prevent the hospital from seeking payment from the minor's parent or guardian.

[+] Law unclear. Depends on circumstances. Careful analysis recommended.

[ix] Family Code, Section 6928

[*] It should be recognized that although the minor's parents or guardian are legally responsible for payment even though the law allows the minor to give consent, as a practical matter, other considerations, such as confidentiality of medical information, may prevent the hospital from seeking payment from the minor's parent or guardian.

[+] Law unclear. Depends on circumstances. Careful analysis recommended.

[x] Family Code, Section 6929

[+] Law unclear. Depends on circumstances. Careful analysis recommended.

[xi] Family Code, Section 6924

[12] CCR Title 22, Section 50063.5

[xii] Family Code Sections 6550-6552 (SB 592). Legal Memorandum from California Association of Hospitals and Health Systems dated October 31, 1994; File Code CAHHS 94-10-61.

Attachment A

CAREGIVER'S AUTHORIZATION AFFIDAVIT

The minor named below lives in my home and I am 18 years of age or older.

1. Name of minor:_____
2. Minor's birthdate:_____
3. My name: (adult giving authorization)_____
4. My home address:_____

   _____
5. I am a grandparent, aunt, uncle or other qualified relative of the minor
6. Check one or both (for example, if one parent was advised and the other cannot be located):

   ❑ I have advised the parent(s) or other person(s) having legal custody of the minor of my intention to authorize medical care, and have received no objection.

   ❑ I am unable to contact the parent(s) or other person(s) having legal custody of the minor at the time, to notify them of my intended authorization.
7. My date of birth:_____
8. My California drivers license identification card number:_____

Warning: *Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both.*

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:_____

Signature:_____

Please Note:

- This declaration does not affect the rights of the minor's parents or legal guardian regarding the care, custody and control of the minor, and does not mean that the caregiver has legal custody of the minor.
- A person who relies on this affidavit has no obligation to make any further inquiry or investigation.
- This affidavit is not valid for more than one year after the date on which it is executed.

To Caregivers:

1. "Qualified relative," for purposes of item 5, means a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix "grand" or "great," or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.

2. The law may require you, if you are not a relative or a currently licensed foster parent, to obtain a foster home license in order to care for a minor. If you have any questions, please contact your local department of social services.
3. If the minor stops living with you, you are required to notify any school, health care provider, or health care service plan to which you have given this affidavit.
4. If you do not have the information requested in item 8 (California driver's license or I.D.), provide another form of identification such as your social security number or Medi-Cal number.

To School Officials:

1. Section 48204 of the Education Code provides that this affidavit constitutes a sufficient basis for a determination of residency of the minor, without the requirement of a guardianship or other custody order, unless the school district determines from actual facts that the minor is not living with the caregiver.
2. The school district may require additional reasonable evidence that the caregiver lives at the address provided in item 4.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Emergency Protocol and Disaster Plan				POLICY #: 2.29-P	
DEPARTMENT: Health Services – Health Education and Disease Management					
Effective Date: 2002-06	Review/Revised Date: 1/13/2017	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 1/13/17

Chief Medical Officer — Date

Chief Operating Officer — Date 1/6/17

Deborah L Murray
Administrative Director of Health Services — Date 1/5/17

POLICY[i]:
During business hours, Kern Health Systems (KHS) network providers shall be prepared to provide emergency services for the management of emergency conditions and/or medical conditions that occur on site until the emergent situation is stabilized and/or treatment is initiated by the local 911 Emergency Medical Service (EMS) system. It is recommended that 911 be contacted in the event of an emergency that exceeds the capabilities of either the facility or personnel and that the office manager or designee provide direction in an emergency or disaster. A site must have a clearly established system for providing basic emergency care on site until the local EMS has taken over care/treatment.

1.0 DEFINITIONS

"Emergency Medical Condition" is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (or unborn child of a pregnant woman) in serious jeopardy

- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

"Emergency Services" means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.

"Minimum Emergency Equipment" is emergency equipment to establish and maintain a patent/open airway and/or manage anaphylactic reaction.

"Accessible Location" is one that is reachable by personnel standing on the floor, or other permanent working area, without the need to locate/retrieve step stool, ladder or other assistive devices.

2.0 EMERGENCY PROTOCOL

The following emergency services/protocols should be implemented in all provider offices:

A. **Emergency equipment and medication,** appropriate to patient population and conditions treated, are available on site and in an accessible location.

B. **Airway management:** minimum airway control equipment includes a wall oxygen delivery system or portable oxygen tank, oropharyngeal airways, nasal cannulas, ambu bags and bag-valve masks. Various sizes of airway devices are on site that is appropriate to patient population within the practice[ii]. Portable oxygen tanks are maintained at least ¾ full.

A method/system is in place for oxygen tank replacement. If oxygen tanks are less than ¾ full at time of site visit, site has a backup method for supplying oxygen if needed ***and*** a schedule plan for tank replacement. Oxygen tank is secure with flow meter and mask/cannula attached. Oxygen tubing need not be connected to oxygen tank, but must be kept in close proximity to tank. Oxygen tanks are checked monthly with results logged.

C. **Anaphylactic reaction management:** minimum equipment includes Epinephrine 1:1000 (injectable), also for pediatric sites Ephnephrine 1:10,000 (injectable), Benadryl 25 mg. (oral), or Benadryl 50 mg/ml (injectable), tuberculin syringes, Betadine solution, and alcohol wipes.

D. **A medical emergency kit** with the above medications is located in an easily accessible place. An inventory list of emergency drugs/supplies is posted on the emergency kit with the expiration dates noted. There is a current medication administration reference (e.g. medication dosage chart) available for readily identifying the correct medication dosages (e.g. adult, pediatric, infant, etc.).

E. **Emergency Crash Cart/Kit:** if there is an emergency "Crash" cart/kit on site, contents are appropriately sealed and within the expiration dates posted on label/seal.

F. **Site personnel have been trained** in procedures/action plan to be carried out on site in case of medical and non-medical emergencies. Site staff is able to describe the following:

1. Site-specific procedures for handling medical emergencies until the individual is under the care of local emergency medical services (EMS)
2. Site-specific procedure for handling non-medical emergencies, such as fires, workplace violence incidents, etc.

Site personnel have been trained and can demonstrate knowledge and correct use of all emergency medical equipment kept on site that they are expected to operate within their scope of work. Documented evidence that emergency equipment is adequately maintained according to the specified manufacturer's guidelines for the equipment, or is serviced annually by a qualified technician may include a log, checklist or other appropriate methods. The documented evidence shows that standard operating procedures have been followed for routine inspection/maintenance, calibration, repair of failure or malfunction, testing and cleaning of all specialized equipment. Appropriate written records include calibration or other written logs, work orders, service receipts, dated inspection sticker, etc.

G. **A posted emergency phone number list** shall include local emergency response services (e.g., fire, police/sheriff, and ambulance), emergency contacts (e.g., responsible managers, supervisors), and appropriate State, County, City and local agencies (e.g., local poison control number). This list shall be dated, and updated annually. The poison control telephone number, 1-800-222-1222, is posted on each telephone.

H. **Current clinic office hours** along with an emergency contact number are posted outside of office entrance.

I. **When a practitioner is not on site** during regular office hours, site staff is able to contact the practitioner at all times by telephone, cell phone, pager, etc. Personnel is knowledgeable about site-specific physician office hour schedule(s), local and/or Plan-specific systems for after-hours urgent and emergent practitioner coverage available 24 hours a day, 7 days per week, and system for providing follow up care. Current resource information is available to site personnel.

3.0 CPR CERTIFICATION

CPR Certification serves to ensure patient safety through appropriate preparation of office personnel. The following staff working in patient care areas are encouraged to maintain current CPR Certification:

A. Physician
B. Non-Physician Medical Practitioners
C. Registered Nurses
D. Licensed Vocational Nurses
E. Medical Assistants

A copy of the CPR Certificate should be maintained in the employee's file. A copy of the certificate should also be maintained on site. Re-certification is necessary every two years.

4.0 ORDINANCES

Sites must meet city, county and state fire safety and prevention ordinances.

FIRE CLEARANCE/OCCUPANCY CERTIFICATION

Provider offices should maintain a current fire clearance certificate. The annual fire clearance/occupancy certification should be posted or filed on-site.

Offices within the city of Bakersfield obtain Fire Clearance from the City Fire Department and Occupancy Certification from the Department of Development Services.

Offices outside of Bakersfield, but within Kern County, receive Fire Clearance from the County Fire Department and Occupancy Certification from the County Building Inspection Department.

5.0 NON-MEDICAL EMERGENCY PROCEDURES

Non-medical emergencies include incidents of fire, natural disaster (e.g. earthquakes), workplace violence, etc. Specific information for handling fire emergencies and evacuation procedures is available on site to staff. Personnel know *where to locate* information on site, and *how to use* information. Evidence of training must be verifiable, and may include informal in-service, new staff orientation, external training courses, education curriculum and participant lists, etc.

6.0 SITE ENVIRONMENT SAFETY[iii]

6.1 Illumination

Lighting should be adequate in patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel.

6.2 Access Aisle

Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) should provide a clear circulation path. Means of egress (escape routes) should be maintained free of all obstructions or impediments to full instant use of the path of travel in case of fire or other emergency. Building escape routes should provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. Cords (including taped cords) or other items should not be placed on or across walkway areas.

The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route, but may be reduced to a minimum or 32 inches at a doorway.

6.3 Exits

Exit doorways should be unobstructed and clearly marked by a readily visible "Exit" sign.

6.4 Evacuation Routes

Clearly marked, easy-to-follow escape routes should be posted in visible areas, such as hallways, exam rooms and patient waiting areas.

6.5 Electrical Safety

Electrical cords should be in good working condition with no exposed wires, frayed or cracked areas. Cords should not be affixed to structures, placed in or across walkways, extended through walls, floors, and ceilings, or under doors or floor coverings. Extension cords should not be used as a substitute for permanent wiring. All electrical outlets should have an intact wall faceplate. Sufficient clearance should be maintained around lights and heating units to prevent combustible ignition.

6.6 Fire Fighting/Protection Equipment

There should be firefighting/protection equipment in an accessible location on site at all times. An accessible location is one that is reachable by personnel standing on the floor, or other permanent working area, without the need to locate/retrieve a step stool, ladder, or other assistive device. At least one of the following types of fire safety equipment should be on site:

A. Smoke detector with intact, working batteries
B. Fire alarm device with code and reporting instructions posted conspicuously at phones and employee entrances
C. Automatic sprinkler system with sufficient clearance (10 inches) between sprinkler heads and stored materials
D. Fire extinguisher in an accessible location that displays readiness indicators and has an attached current dated inspection tag.

REFERENCE:

Revision 2016-12: Minor revisions, updated signatory list and poison control number.
Revision 2010-**08:** Minor revision provided by Director of Quality Improvement, Health Education and Disease Management. **Revision 2005-06: Revision 2002-02:** Revised per DHS comment letter dated 01/30/02 to meet contractual requirements. **Revision 2001-11**: Created per DHS suggestion that provider sample policies be added to the KHS Provider Administration Manual.

[ii] MMCD Policy letter 02-02

[iii] DHS Facility Site Review tool (April 2001)

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Health Education				POLICY #: 2.30-I	
DEPARTMENT: Health Services - Quality Improvement					
Effective Date: 03/2003	Review/Revised Date: 1/13/2017	DMHC		PAC COMMITTEE	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 1/13/17

Chief Operating Officer — Date 1/12/17

Chief Medical Officer — Date

Administrative Director of Health Services — Date 1/11/17

Director of Compliance and Regulatory Affairs — Date 1-6-17

POLICY[1]:
Kern Health Systems (KHS) will provide plan members with appropriate health education services as required by contractual, statutory, and regulatory requirements.

KHS will maintain the organized delivery of health education programs using educational strategies and methods that are appropriate for Members and effective in achieving behavioral change for improved health.[2]

To define KHS's health education system by providing a system for referring, providing, and monitoring of health education services.

PROCEDURES:

1.0 ADMINISTRATIVE OVERSIGHT

The supervision of the health education system will be by a full-time health educator. This individual will possess a master's degree in public or community health (MPH) with specialization in health education.[3]

2.0 QUALITY IMPROVEMENT PLAN

The health education system will be coordinated and integrated with the Quality Improvement Plan.

3.0 HEALTH EDUCATION AND CULTURAL/LINGUISTIC GROUP NEEDS ASSESSMENT

Findings from the Group Needs Assessment and other relevant data will be used to establish health education program priorities. These findings will also be used to establish appropriate levels of intervention for specific issues and target populations. The health education system will be reviewed annually to ensure appropriate allocation of health education resources based upon needs assessment findings, program evaluation results, and utilization data. (See *Policy and Procedure #2.11-I: Group Needs Assessment*)

4.0 PROGRAM DELIVERY

Health education programs will be delivered using educational strategies, methods, and materials that are appropriate for the member population and effective in achieving behavioral change for improved health. Appropriate services may be provided through individual sessions, group classes, support groups, disease management programs and educational materials. All health education programs will be at no charge to KHS members.[4] Programs and services will be provided directly and/or through subcontracts or other formal agreements with providers that have expertise in delivering health education services to the Member population.[5]

Written health education materials are defined as materials designed to assist members to modify personal health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes, including updates on current health conditions, self-serve, and management of health conditions. They do not include informing materials which are vital documents that provide members essential information about access to and usage of KHS services.

4.1 Health Education Materials[6]

Written health education materials will be available in all threshold languages and upon request by members, alternative formats such as Braille, large size print, online, CD or other methods[7]. In addition, all materials will be written at or below a sixth grade reading level using a readability formula that is most appropriate and reliable for the type of material and target audience. KHS may manually calculate the reading level of materials or use software to test readability that is appropriate for the sample size. Acceptable readability formulas include SMOG, Fry Graph, FOG, Flesch Reading Ease, and Dale-Chall. KHS may exclude State-mandated legal language in calculating the reading level of health education material. Medical terminology,

technic... words and multi-syllable words that must be included in the health education materials and cannot be substituted for simpler one or two syllable words may be counted only once when testing for reading level. Requirements for reading level and readability formulas are applicable only for written materials produced in English. All materials will reflect cultural and linguistic sensitivity.

4.2 Review and Approval of Member Education Materials

KHS may approve written member health education materials as long as the following conditions are met:

a. Materials are assessed and approved using the Readability and Suitability Checklist (See Attachment A) and all required elements have been met. KHS may purchase and use material developed by DHCS approved companies without having to complete the Readability and Suitability Checklist. KHS is ultimately still responsible for ensuring that the materials given to members meet the standards and requirements as outlined in regulations, contracts, and policy letters.

b. Materials that do not meet the required font size and/or style but are deemed as the most suitable for KHS members may be approved by KHS' health educator under the following conditions:
    i. KHS' health educator signs an exemption letter on KHS letterhead with a rationale for the selection of the material.
    ii. The exemption is noted under Section B of the Readability and Suitability Checklist.
    iii. The signed exemption letter, completed checklist and approved material will be kept on file provided to DHCS upon request.
    iv. The signed Readability and Suitability Checklist, along with the approved health education materials, must be kept on file in electronic or hard copy format and made available to DHCS for auditing or monitoring purposes upon request.

c. The assessment and approval process must be conducted by a qualified health educator or health education specialist with the equivalent training and background required by DHCS for their health education consultants.

d. Medical content accuracy is reviewed and approved by KHS' Medical Director or other clinically licensed staff, as appropriate.

e. Materials not previously approved by DHCS shall be reviewed and approved within twelve months of the release of MMCD APL 11-018 by a qualified health educator using the Readability and Suitability Checklist. The qualified health educator will determine whether the materials require the additional review of KHS' Medical Director or other clinically licensed staff to verify the medical content accuracy.

g. KHS shall review previously approved materials every three years to determine health and medical information is current and visual images are up to date. Medical content accuracy will be reviewed and approved by KHS' Medical Director or other clinically licensed staff, as appropriate.

Qualified Health Educator. A qualified health educator must have one of the following qualifications:

i. Master of Public Health (MPH) degree with a health education or health

promotion emphasis.

ii. Master's degree in community health with a specialization in health education or health promotion

iii. Awarded a Master Certified Health Education Specialist (MCHES) by the National Commission for Health Educating, Inc.

KHS staff that is assigned health education duties must meet one of the criteria above in order to approve health education materials.

If KHS does not have a qualified health educator on staff, KHS is required to submit health education materials to DHCS for review and approval with all required sections completed on the Readability and Suitability Checklist, (See Attachment A) except Section H. Section H will be completed by the DHCS health education consultant.

4.3 Readability and Suitability Checklist

KHS shall provide adequate health education materials in a manner and format that is easily understood and culturally and linguistically appropriate for members. Health education materials should include plain and simple language to increase member understanding of the important medical or health information included in the material. The attached Readability and Suitability Checklist address the following criteria:

A. Publication description
B. Content and key messages
C. Layout
D. Visuals
E. Cultural appropriateness
F. Language translations
G. Field testing
H. Medical Content
I. Approval signatures

KHS may purchase and use materials developed by DHCS approved companies without having to complete the Readability and Suitability Checklist. KHS is still responsible for verifying these materials meet the standards and requirements outlined in the DHCS contract and All Plan and Policy Letters. A list of approved companies is maintained and distributed by DHCS.

4.4 Field-Testing

Health education materials which are developed, adapted, or obtained from outside sources must be field tested with the exception of the following:

A. Brief updates on cold prevention and the availability of the seasonal flu vaccinations
B. Newsletters (KHS is encouraged to use readability and suitability guidelines in the development of articles)
C. Flyers, handouts or posters about new programs or services available to members, or instructions on how to access and use services
D. Health education materials developed by county/city health departments, California state governmental organizations or the U.S. federal government.

KHS' health educator shall provide oversight for the field testing and select the most appropriate methodology based on the complexity of the material or determine if that health education material does not require field testing. The field testing process and results must be documented on the Readability and Suitability checklist. Materials not field tested must have an explanation documented on the Readability and Suitability checklist explaining the reason. Field testing may include, but is not limited to the following:

a. Review of the material during a Community Advisory Committee Meeting
b. Key informant interviews with members or community informants
c. Focus groups with targeted members to determine relevance and effectiveness of complex educational materials
d. Written member surveys.

KHS may accept field testing results conducted by outside organizations or vendors when using purchased materials or materials obtained from the public domain, if KHS' health educator determines that the field testing was conducted appropriately, and participants represent a population similar to KHS members.

4.5 Translation of Health Education Materials

The process for translating health education materials into will be in accordance with KHS Policy and Procedure 12.02-I: Translation of Written Member Materials.

4.6 Alternative Formats

KHS takes into account the specific needs of Seniors and Persons with Disabilities (SPD). Upon request by the SPD member, family caregiver or provider, KHS provides educational materials in alternative formats such as Braille, large print, audio, or other appropriate methods. Requests for health educational material in alternative formats will be handled by the KHS Health Education department.

4.7 Staff Training

The KHS health educators ensure that appropriate KHS staff have received training on KHS' policy and procedure for ensuring readability and suitability of health education materials. This includes training on how to use the readability calculation formulas and software. Oversight of health education materials review and final approval is provided by KHS' health educators.

4.8 Health Education Outreach

Targeted outreach will be used to promote optimal program use and participation by members. This outreach will include information about health education services in all new member orientation, member handbooks, member newsletter articles and other benefit informing materials. Telephone contacts will be conducted to all newly enrolled members with a diagnosis relevant to current health education services. In addition, PM160s, indicating diagnoses that would benefit from health education interventions, will be used to identify members for referral to health education services.

5.0 PROGRAM SCOPE

The following areas of program intervention will be provided:

5.1 Appropriate Use of Health Care Services

This includes the effective use of the managed health care system; preventive and primary health care services; obstetrical care; health education services; and complementary and alternative care.[8] Members will be educated during the new member orientations.

5.2 Risk-Reduction and Healthy Lifestyles

This will include interventions designed to assist members to modify personal health behaviors, achieve and maintain healthy lifestyles and promote positive health outcomes. Programs will include tobacco use and cessation, alcohol and drug use, injury prevention, prevention of sexually transmitted diseases, HIV and unintended pregnancy, nutrition, weight control, physical activity and parenting.[9]

5.3 Self-Care and Management of Health Conditions

These are interventions designed to assist members to learn and follow self-care regimens and treatment therapies for existing medical conditions, chronic diseases or health conditions, including programs for pregnancy, asthma, diabetes and hypertension.[10]

6.0 POINT OF SERVICE EDUCATION

Members will receive health education services as part of preventive and primary health care visits.[11] To facilitate this process, providers' are required to utilize the "Staying Healthy" assessment form. *(KHS Policy and Procedure #3.05-P: Preventive Medical Care)* Utilizing the Staying Healthy assessment will allow health risk behaviors, health practices and health education needs related to health conditions to be identified. Health education interventions, counseling and referral to health education services should be documented and recorded in the member's medical record[12]. To assist providers in providing effective health education services, the Health Education Department will provide resource information, educational materials and other pertinent program resources to all providers, upon request.[13]

6.1 Communication with the PCP

After the member has completed the health education services, health education staff forwards to the referring PCP, information identifying the class subject, date, and any pertinent notes. The PCP is informed to include this information in the member's medical record for documentation of health education services.

6.2 Monitoring and Reporting

A spreadsheet is maintained for all health education referrals. At the end of each month, staff reviews the status of all referrals that have been processed. No shows are contacted to assess interest in rescheduling. Completed referrals are updated in the health education spreadsheet. The spreadsheet is used to create a monthly, quarterly and annual Health Education Activities report. This report is used to monitor member utilization of health education services as well as provider referrals. The Health Education Activities report is submitted to the Quality Improvement Utilization Management Committee (QI/UM) and the Public Policy Community Advisory Committee (PP/CAC) for review.

7.0 HEALTH EDUCATION REFERRALS

Health education services will be available and accessible upon KHS staff referral, member self-referral or referral by contracting medical providers. Upon receipt of a health education referral, health education staff will contact the member to assess their interest in participating in health education services and their availability. In coordinating the referral, health education staff will also assess the member's linguistic and transportation needs. Transportation and interpreter services are provided accordingly. The best available health education resource is then identified for the member. Health education staff will coordinate the referral between the appropriate resources and the member.

8.0 PROVIDER EDUCATION AND TRAINING

Education and training of contracted medical providers and other allied health care providers will be provided to support delivery of effective health education services for members. Provider education and training will include:

A. Group Needs Assessment Findings
B. Staying Healthy Assessment
C. Techniques to enhance effectiveness of provider/patient interactions
D. Educational tools, modules, materials and staff resources
E. Plan specific resource and referral information and
F. Health Education requirements, standards, guidelines and monitoring.

9.0 PROGRAM STANDARDS, MONITORING AND EVALUATION

KHS will adopt appropriate health education policies and procedures, standards and guidelines and conduct relevant levels of evaluation which will include process, impact and outcome evaluation methodologies, to ensure effectiveness in achieving health education program goal and objectives.[14] KHS will periodically review the health education system to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates effective implementation of the health education requirements.[15] The Health Education Department is responsible for assessing and monitoring the health education programs that are offered to members to meet its health education standards.

The adopted standards/guidelines are supported by professional experts/peers, best practices, and/or published research findings. (See Health Education Guidelines for Medicaid Managed Care: The California Health Education Taskforce of Guidelines for Medicaid Managed Care, Fall 2000.) KHS will monitor the performance of providers who are contracted to deliver health education programs and service to members, and implement strategies to improve provider performance and effectiveness.[16] Monitoring provider performance will be measured by evaluating the number of health education referrals by providers and assessing program services and materials during site reviews. In addition, KHS monitors its Health Education resources by reviewing member grievances and through an annual review of programs participating in the network to identify changes or additions to program offerings. Methods used to communicate relevant health education issues to providers include direct correspondence, provider bulletins, provider forums, provider portal and through provider policy manuals.

9.1 DHCS Oversight

DHCS will monitor KHS for compliance through field and desk monitoring reviews for the readability and suitability checklist and approved health education materials. DHCS will also investigate any complaints about KHS's health education materials.

ATTACHMENTS:

- Attachment A: Readability and Suitability Checklist

REFERENCE:

[1] **Revision 2017-01:** Policy updated by Health Education & Disease Management Manager. **Revision 2013-10**: Included requirements for approving health education materials and added language for materials that may be used if they meet standards and requirements in DHCS Contract and All Plan Letters. **Revision 2012-03:** Revised to comply with MMCD All Plan Letter 11-018. Revision 2010-10: Revised by Director of Quality Improvement, Health Education and Disease Management. **Revision 2006-08:** Revised as requested (06/23/2006). **Revision 2005-09:** Routine review. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004). **Revision 2003-06**: Requested by DHS 03/04/03. **Revision 2002-11**: Created per Health Education request. Reviewed by Health Education for compliance with MMCD Policy Letter 02-04

[2] DHS Contract A-10 7(A)(4)
[3] DHS Contract A-10 7(A)(2)
[4] DHS Contract A-10 7(A)(3)
[5] DHS Contract A-10 7(A)(3)
[6] DHS Contract A-10 7(A)(5)
[7] MMCD Letter 11-018 §5 Alternative formats
[8] DHS Contract A-10 7(A)(6)(a)
[9] DHS Contract A-10 7(A)(6)(b)
[10] DHS Contract A-10 7(A)(6)(c)
[11] DHS Contract A-10 7(A)(7)
[12] DHS Contract A-4 13(D)(8)
[13] DHS Contract A-10 7(A)(7)
[14] DHS Contract A-10 7(A)(8)
[15] DHS Contract A-10 7(A)(9)
[16] DHS Contract A-10 7(A)(8)

Medi-Cal Managed Care Division (MMCD)

Attachment A: Readability and Suitability Checklist

This Checklist Applies to Health Education Materials Only (See Attachment B for definition)

Title of Material:	Main Topic:
Key Message(s):	
Target Audience:	Date Last Reviewed:
Developed By:	Date Developed:

Material Format: ☐ **Flyer** ☐ **Brochure** ☐ **Booklet** ☐ **Poster** ☐ **Other:**

READING LEVEL (6th GRADE READING LEVEL OR LOWER)

Date Assessed: **Reading Level:** **Method Used:**

List medical /technical term(s) that were scored only once:

A. CONTENT ☐ APPROVED

Required: (All required items must be met in order to approve the material.) **Met**

1. Content is accurate and up-to-date ☐
2. Number of concepts/messages is limited to 2-3 per page ☐
3. Sentences are simple ☐
4. Technical terms are defined ☐
5. Material is written in an active voice ☐

Recommended: (Items follow best practice guidelines, but are not required for approval.)

6. Material has a positive tone ☐
7. Material explains how and where to get help or more information ☐

B. LAYOUT ☐ APPROVED

Required: (All required items must be met in order to approve the material.) **Met**

1. Font size is at least 12-point; senior-specific materials are at least 14-point ☐
2. Serif font styles are used for blocks of text ☐
3. All capital letters are used only for headings and when grammatically correct ☐
4. There is an adequate amount of white space (aim for 30%) ☐
5. The layout guides the reader appropriately ☐
6. Headings and subheadings are used to organize and separate ideas ☐
7. Main points are emphasized using bold, italics, boxes or increased font size ☐
8. Bullets or numbers are used for lists ☐
9. There is adequate contrast between the print color and the background color ☐

Recommended: (Items follow best practice guidelines, but are not required for approval.)

10. Left margin is justified (text is aligned on the left) ☐
11. Right margin is unjustified (text is <u>not</u> aligned on the right) ☐

C. VISUALS ☐ APPROVED

Required: (All items in this section must be met in order to approve the material.) **Met**

1. Visuals are relevant to accompanying text ☐
2. Visuals are simple and uncluttered ☐
3. People and activities are representative of the intended audience ☐
4. Phone numbers are bolded if they appear in the text document ☐

Recommended: (Items follow best practice guidelines, but are not required for approval.)

5. Visuals have captions, if needed ☐
6. Graphs and charts only used when absolutely necessary ☐
7. Material is printed on non-glossy paper ☐

D. CULTURAL APPROPRIATENESS ☐ APPROVED

Required: (All required items be met in order to approve the material.) **Met**

1. Visuals are culturally appropriate for the intended audience (material is not offensive, does not reinforce stereotypes, and is inclusive in representation) ☐
2. Content is culturally appropriate for the intended audience (provides culturally meaningful information such as "how to" advice and examples) ☐
3. Topic-specific cultural relevance is reflected where applicable (such as food and exercise habits of the intended audience) ☐
4. Plan-produced materials are available in alternative formats upon request ☐ N/A ☐

E. TRANSLATED/NON-ENGLISH MATERIALS ONLY (Complete this section, if applicable.) ☐ APPROVED

This material is available in the following languages, in addition to English:

☐ Arabic ☐ Armenian ☐ Cantonese ☐ Farsi ☐ Hmong
☐ Khmer ☐ Korean ☐ Mandarin ☐ Russian ☐ Spanish
☐ Tagalog ☐ Vietnamese ☐ Other (specify) _____

Required: (All items in this section must be met in order to approve the material.) **Met**

1. Translation accurately conveys all the information found in the English version ☐
2. Translation is based on meaning (not a literal translation) ☐
3. Word and phrase usage is consistent ☐
4. Material is sensitive to local language (phrases, words, expressions) ☐
5. Translation was reviewed by at least one person in addition to the translator ☐

F. FIELD TESTING (The Plan's health educator will determine field testing methodology and/or whether field testing is needed for this material.) ☐ APPROVED ☐ N/A

Was this material field tested? ☐ Yes ☐ No If no, please explain:

Type of field testing conducted: Total # of participants:_____

☐ Focus Groups: # of Focus Groups: _____ ☐ Individual Member Interviews

☐ Community Advisory Committee (CAC) Review ☐ Other: _____

Brief Summary of Field Testing Results:

G. MEDICAL CONTENT REVIEW (The Plan's health educator will determine whether the material requires clinical review to verify medical accuracy. Check "N/A" if not applicable to material.) ☐ APPROVED ☐ N/A

Required: (All items in this section must be met, unless "N/A" is checked above.)	**Met**
1. Content is medically accurate	☐
2. Content is up-to-date	☐

Primary Medical Content Reviewer:

Reviewed by: ☐ Physician ☐ NP, PA, RN ☐ Pharmacist ☐ Other (describe):

Print Name: Title:

Signature: Date:

Secondary Medical Content Reviewer (optional)

Reviewed by: ☐ Physician ☐ NP, PA, RN ☐ Pharmacist ☐ Other (describe):

Print Name: Title:

Signature: Date:

H. HEALTH EDUCATOR CERTIFICATION & SIGNATURE (Leave blank if submitting to MMCD for approval)

My signature below certifies that this material has been reviewed as stated and, if approved, meets the criteria outlined in MMCD All Plan Letter 11-018. **Materials must be reviewed and re-certified every 3 years.**

Initial Material Review & Certification ☐ APPROVED

If not approved, describe reason(s): ☐ NOT APPROVED

Print Name: Title:

Signature: Date:

Subsequent (3-year) Material Review & Certification ☐ APPROVED

If not approved, describe reason(s): ☐ NO LONGER APPROVED

Print Name: Title:

Signature: Date:

Subsequent (6-year) Material Review & Certification ☐ APPROVED

If not approved, describe reason(s): ☐ NO LONGER APPROVED

Print Name: Title:

Signature: Date:

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Disease Management				POLICY #: 2.35-P	
DEPARTMENT: Health Services – Disease Management					
Effective Date: 10/2006	Review/Revised Date: 1/23/2017	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer

Date 1/23/17

Chief Medical Officer

Date

Deborah L Lewis

Administrative Director of Health Services

Date 1/19/17

POLICY:
Kern Health Systems (KHS) shall maintain a disease management program. KHS shall determine the program's targeted disease conditions and implement a system to identify and encourage members to participate.[i]

PROCEDURES:

1.0 ACCESS

Members may access disease management programs through:

A. Self-referral by calling KHS at 1-800-391-2000
B. KHS Interdepartmental referrals to the KHS Disease Management and/or Health Education Department
C. PCP referral

Members may access medical nutrition therapy as outlined in *KHS Policy and Procedure #3.37-P: Specialty Nutrition Consultation.*

Training and education is provided by KHS contract providers, community resources, the KHS Health Educator, and the KHS Disease Management and Case Management Staff. All member training and education is provided by appropriately licensed or registered health care professionals.[ii]

2.0 AVAILABLE DISEASE MANAGEMENT PROGRAMS

2.1 Diabetes Disease Management Program

KHS provides coverage for diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable the member to properly use covered equipment, supplies, and medications, and additional diabetes outpatient self-management training, education, and medical nutrition therapy upon the direction or prescription of those services by the member's Primary Care Practitioner.[iii] Training shall include instruction that will enable members and their families to gain an understanding of the diabetic disease process and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications.[iv]

2.2 Asthma Disease Management Program[v]

KHS provides coverage for asthma education, including education to enable a member to properly use inhaler spacers, nebulizers (including face masks and tubing), and peak flow meters. Education is consistent with current professional medical practice.

2.3 Prenatal Management Program

KHS provides prenatal management education to assist expectant members achieve a positive pregnancy outcome. Education includes coordinating and supporting timely prenatal care, early identification of high risk factors (diabetes and hypertension), and providing education and support to members and their family during pregnancy and immediately following delivery. Education is consistent with current professional medical practice.

REFERENCE:

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[i] **Revision 2017-01:** New language on prenatal management education provided. Titles updated. **Revision 2013-05:** Revised by Director of Quality Improvement, Health Education and Disease Management. Policy reformatted. **Revision 2006-10:** Revised per DHS Workplan comment 11d (1/18/06). **Revision 2005-11:** Created during DHS Workplan review. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004). Redline shows changes in language taken from policy #3.54 – Diabetes Management (2000-04).

[i] DHS Contract A-11 (3)

[ii] HSC §1367.51(d)

[iii] HSC §1367.51(d)

[iv] HSC §1367.51(e)

[v] HSC §1367.06 (d)

Health Services Quarterly Committee Reporting- Reporting Period January 1, 2017 to March 31, 2017

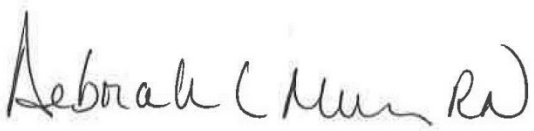
Utilization Management Overview

The 2017 membership enrollment exceeded 248,000 in Q1 2017. Additional benefit coverage and broadening interdisciplinary collaboration to support the membership growth will continue through 2017.

- Non –Emergency Medical Transportation expansion
- Transgender Services
- Health Home Program expansion
- Transition of Care Program expansion
- Kern Medical Diabetic Clinic
- Opioid Coalition
- Palliative Care
- California Children Services Transition Conference
- Disease Management Conditions

The following pages reflect statistical measurements for Utilization Management, Case Management and Disease Management detailing the ongoing compliance activity for the 1st Quarter 2017.

Respectfully submitted,



Deborah Murr RN, BS HCM
Administrative Director of Health Services
Kern Health System

Timeliness of Decision Trending

Summary:

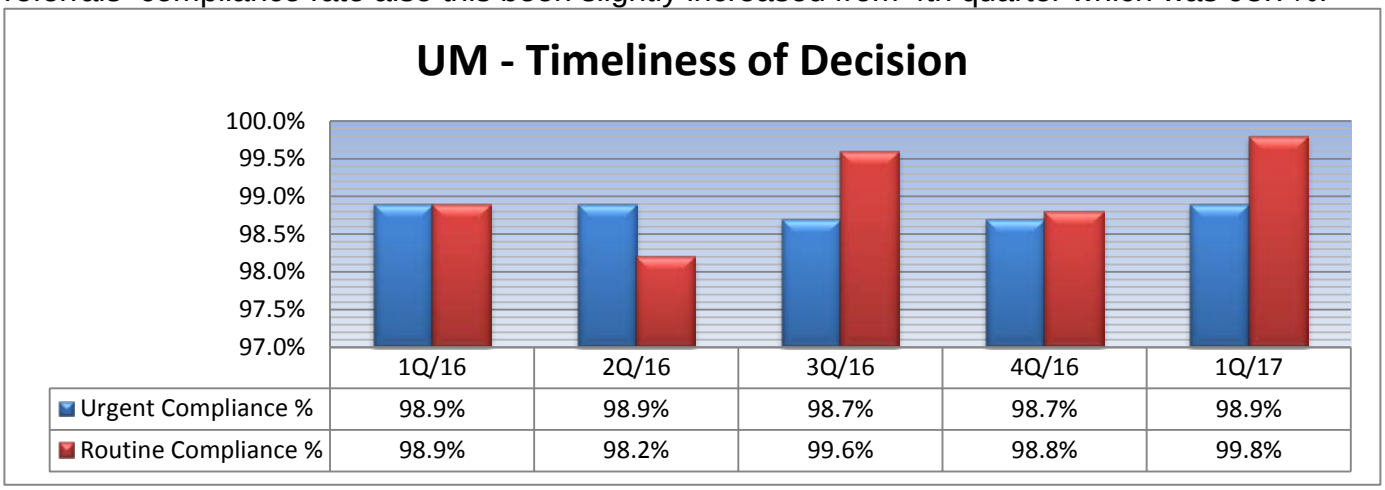
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

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

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

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

There were 24,901 referrals processed in the 1st quarter 2017 of which 2,258 referrals were reviewed for timeliness of decision. In comparison to 4th quarters 2016 processing time, the routine referrals compliance rate has been increased from the 4th quarter which was 98.8%, and urgent referrals compliance rate also this been slightly increased from 4th quarter which was 98.7%.

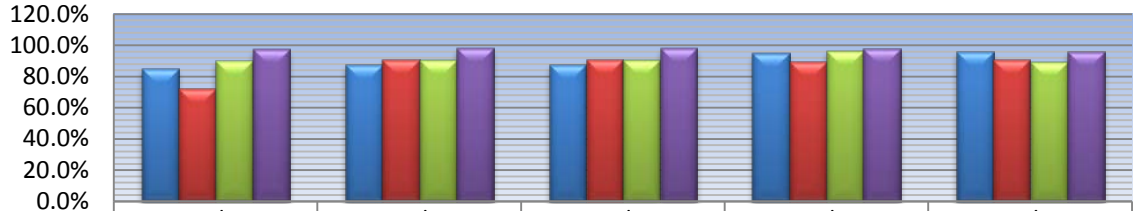


	1Q/16	2Q/16	3Q/16	4Q/16	1Q/17
Urgent Compliance %	98.9%	98.9%	98.7%	98.7%	98.9%
Routine Compliance %	98.9%	98.2%	99.6%	98.8%	99.8%

Audit Criteria:

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

UM - Referral Notification Compliance



	1Q/16	2Q/16	3Q/16	4Q/16	1Q/17
Member Notification	85.4%	87.9%	87.9%	94.7%	96.0%
Provider Notification	72.3%	91.0%	91.0%	89.4%	91.0%
Criteria Included	90.2%	90.0%	90.0%	96.4%	89.0%
MD Signature Included	97.4%	98.0%	98.0%	97.7%	96.0%

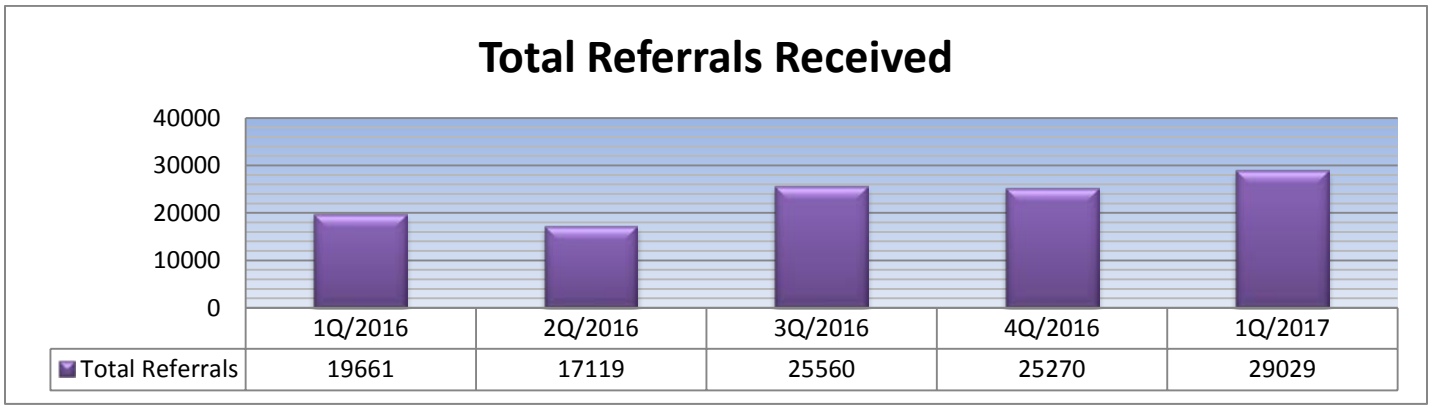
Summary: Overall compliance rate from 4th quarter of 2016 had been decreased which was 94.5%
Action: This compliance audit will be discussed at the UM Staff meeting. Compliance deficiencies have been discussed with individual staff members as appropriate.

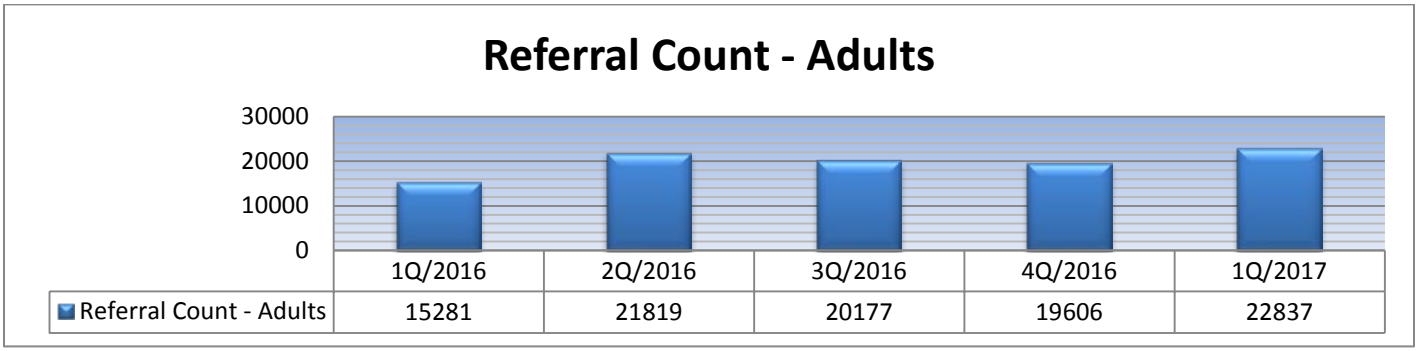
Notice of Action Audit 1st Quarter

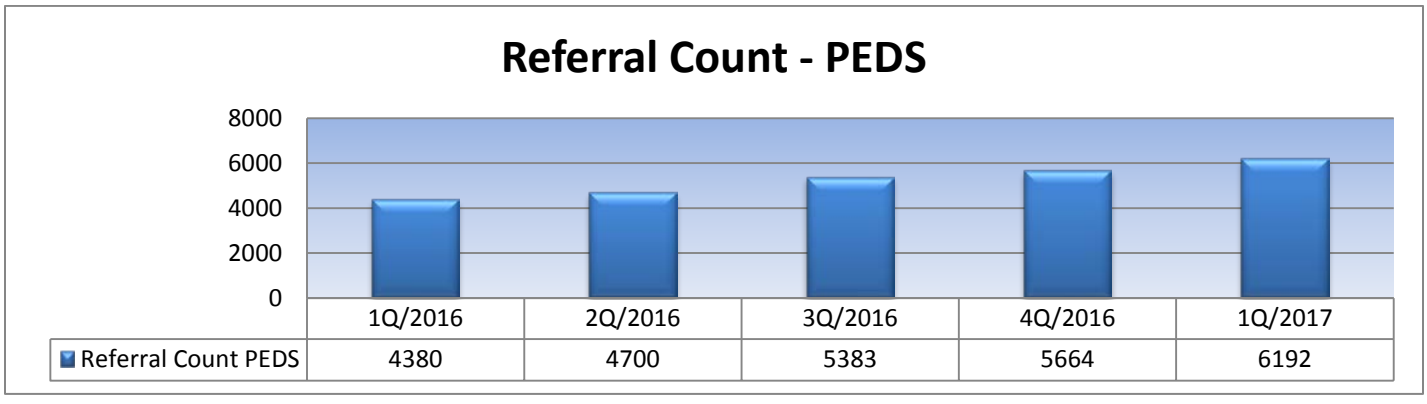
	1st 6 Week Cycle	2nd 6 Week Cycle	3rd 6 Week Cycle	4th 6 Week Cycle	Overall Percentage
Nurse 1	30%	Continue on audit mode	-	-	No longer KHS employee
Nurse 2	27%	20.00%	continue on audit mode		No longer KHS employee

Referral Activity

Outpatient Referral Denial Statistics
The overall denial rate for the 1st quarter is 8%. After elimination of CCS requests, the denial rate is 7% to reflect those denials for medical necessity or other administrative denials.







KHS Monthly Inpatient and LOS Report

Report captures how many members were inpatient during reporting month, excluding CCS denials

Dates of Discharge Between : 1/01/2017-3/31/2017

	20 and Under	Over 20	Totals
Total Inpatient:	1513	6176	7689
Total LOS:	7012	24734	31746
Average LOS:	4.6	4.0	4.1

PAR Facilities	Admits	LOS	Average LOS
Totals :	7021	26936	3.8
Adult Inpatient	4,502	15900	3.5
Adult Observation	719	1002	1.4
Adult Rehab/SNF	369	3479	9.4
Pediatric Inpatient	1424	6511	4.6
Pediatric Rehab/SNF	7	44	6.3

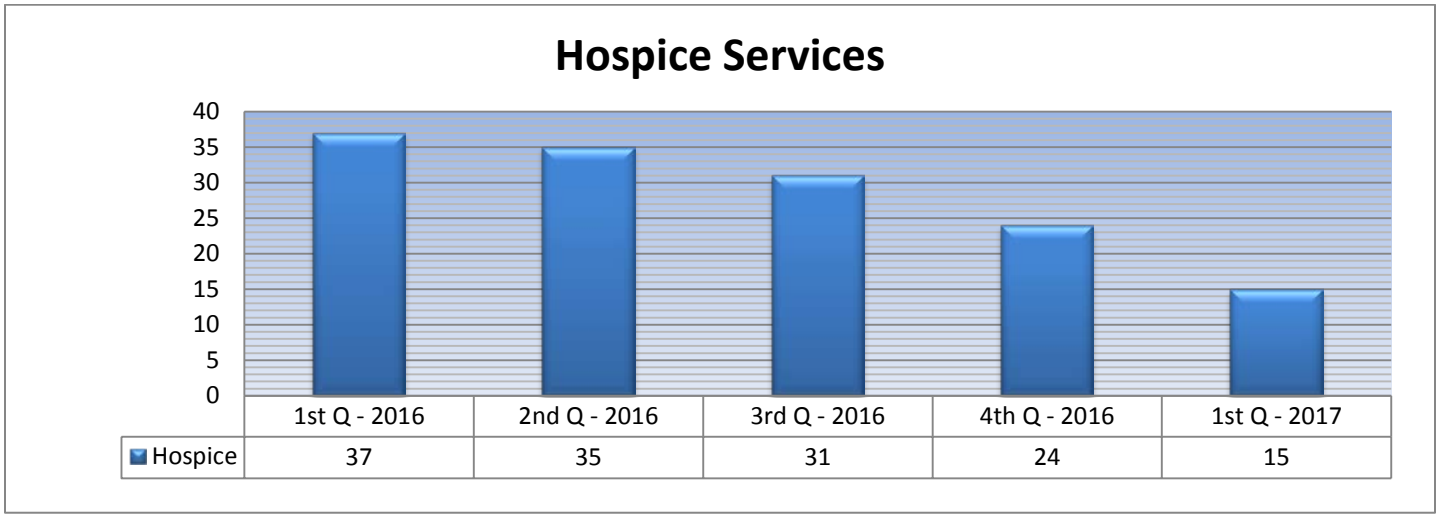
NPAR Facilities	Admits	LOS	Average LOS
Totals :	668	4810	7.2
Adult Inpatient	367	1831	5.0
Adult Observation	28	23	0.8
Adult Rehab/SNF	191	2499	13.1
Pediatric Inpatient	73	384	5.3
Pediatric Rehab/SNF	9	73	8.1

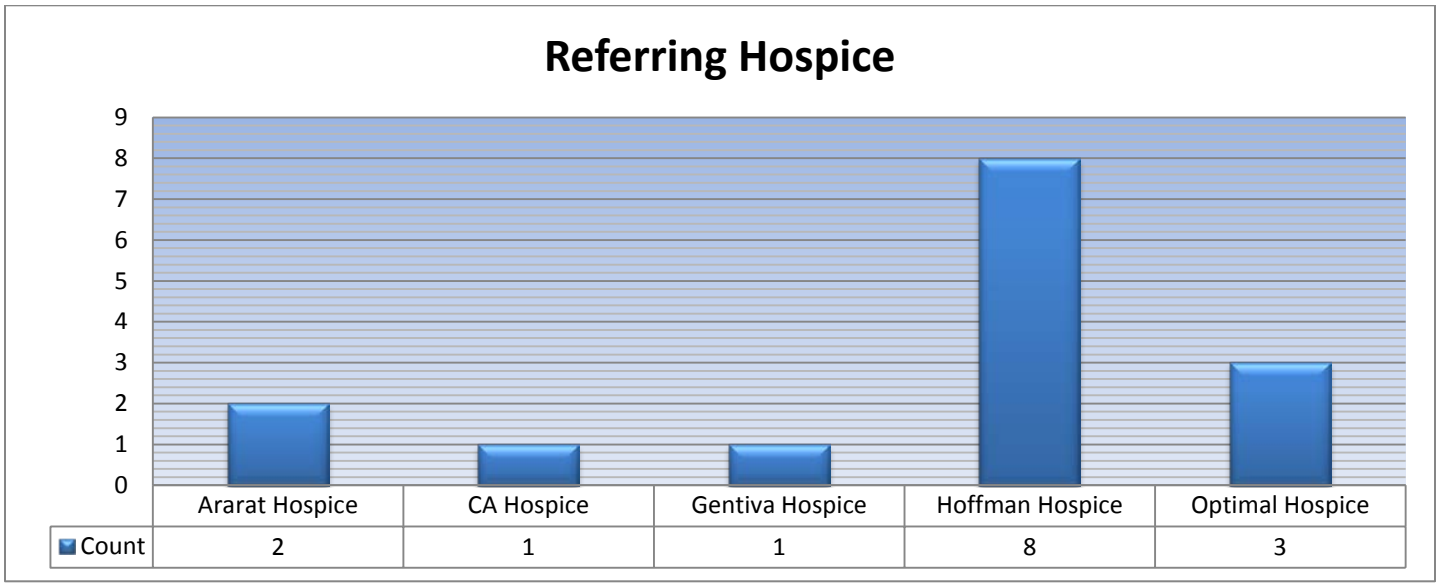
(Greater than 15 Inpatient days - Total LOS)

Activity by Facility	Total Inpatient	Total LOS	Average LOS
BAKERSFIELD MEMORIAL HOSPITAL	1733	5947	3.4
KERN COUNTY MEDICAL AUTHORITY	1225	4782	3.9
SAN JOAQUIN COMMUNITY HOSPITAL	1275	4483	3.5
MERCY HOSPITAL	997	2897	2.9
HEALTHSOUTH BAKERSFIELD REHABI	221	1686	7.6
GOOD SAMARITAN HOSPITAL	504	1056	2.1
VALLEY CHILDREN'S HOSPITAL	152	995	6.5
CHILDRENS HOSPITAL OF LOS ANGE	91	649	7.1
THE REHABILITATION CENTER OF B	45	645	14.3
VALLEY CHILDRENS HOSPITAL	148	638	4.3
EVERGREEN AT ARVIN HEALTHCARE	43	638	14.8
DELANO REGIONAL MEDICAL CENTER	255	557	2.2
UCLA MEDICAL CENTER	91	523	5.7
UNITED CARE FACILITIES	40	449	11.2
KECK HOSPITAL OF USC	60	386	6.4
ANTELOPE VALLEY HOSP	77	366	4.8
CAPRI IN THE DESERT	30	339	11.3
BELLAGIO IN THE DESERT	26	339	13.0
GOLDEN LIVING CENTER - BAKERSF	27	336	12.4
UNITED CARE NETWORK	28	325	11.6
KINDRED HOSPITAL	19	293	15.4
	30	241	8.0
AMALFI IN THE DESERT	17	236	13.9

Activity by Facility	Total Inpatient	Total LOS	Average LOS
BAKERSFIELD HEART HOSPITAL	68	211	3.1
HOFFMANN HOSPICE OF THE VALLEY	28	194	6.9
GENTIVA HOSPICE	10	166	16.6
FRESNO COMMUNITY HOSPITAL AND	24	164	6.8
PACIFICA HOSPITAL OF THE VALLE	8	151	18.9
LIFEHOUSE HEALTH	14	139	9.9
VFP HOMES	10	138	13.8
UCSF MEDICAL CENTER	20	124	6.2
KERN VALLEY HEALTHCARE DISTRIC	52	118	2.3
SORRENTO IN THE DESERT	4	90	22.5
USC NORRIS CANCER	9	85	9.4
HENRY MAYO NEWHALL MEMORIAL HO	22	84	3.8
LIFEHOUSE BAKERSFIELD OPERATIO	5	80	16.0
CEDARS-SINAI MED CENTER	7	66	9.4
MOUNTAIN VIEW CHILD CARE	3	62	20.7
NAPOLI IN THE DESERT	4	60	15.0
HOLLYWOOD PRESBYTERIAN MEDICAL	6	59	9.8
MISSION COMMUNITY	3	56	18.7
LUCILE SALTER PACKARD CHILDREN	7	55	7.9
PALMDALE REGIONAL MEDICAL	10	53	5.3
SANTA MONICA UCLAMC AND ORTHOP	11	52	4.7
PARKVIEW JULIAN CONVALESCENT H	2	48	24.0
STONEBRIDGE MANOR	4	43	10.8
GOLDEN LIVING CENTER - SHAFTER	7	42	6.0
KERN MEDICAL CENTER	19	40	2.1
UCSD MEDICAL CENTER	4	38	9.5
LOMA LINDA UNIVERSITY MEDICAL	6	28	4.7
PALI MOMI MEDICAL CENTER	3	28	9.3
HARBOR - UCLA MED FOUNDATION	2	28	14.0
KECK HOSPITAL OF USC	5	27	5.4
LONG BEACH MEMORIAL MEDICAL C	5	23	4.6
CITRUS VALLEY MEDICAL CENTER I	2	18	9.0
KAWEAH DELTA DIST HO	4	17	4.3
ARROWHEAD REGIONAL MED	4	16	4.0
ROSEWOOD	3	16	5.3
COMMUNITY MEDICAL CENTER	1	16	16.0
BROOKDALE RIVERWALK SNF	1	16	16.0

Hospice Utilization has decreased in the 1st Quarter 2017. KHS staff are reviewing potential diagnoses that may qualify for specific measures or treatments provided under hospice care which may assist in improving the quality of life and decrease hospitalizations during the end stages of a members chronic disease.

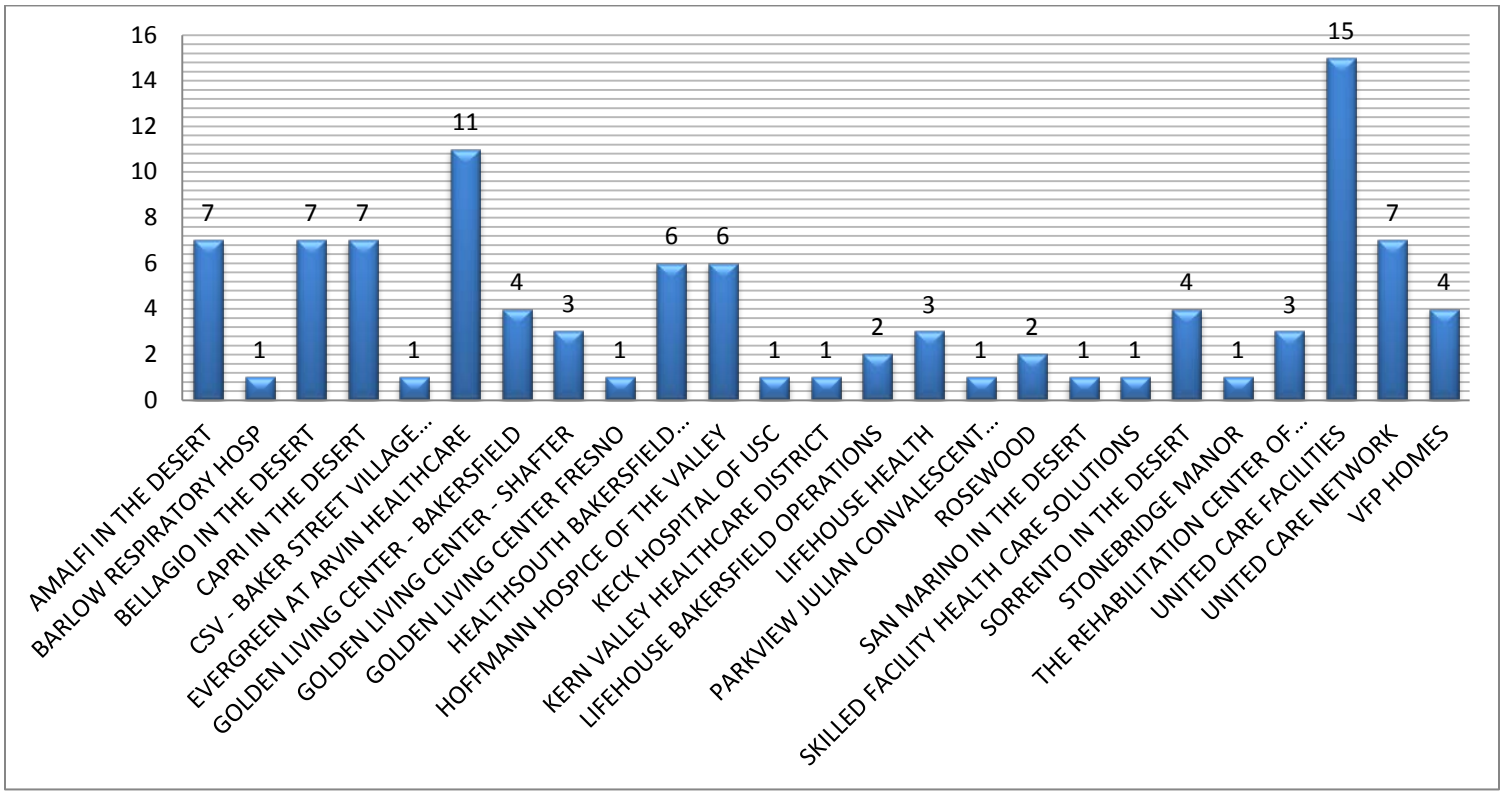




Nursing Facility Services Report

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

Summary: Summary: During the 1st quarter 2017, there were 103 referrals for Nursing Facility Services. The average length of stay was 21 days for these members. During the 1st quarter there were only 3 denials of the 103 referrals.



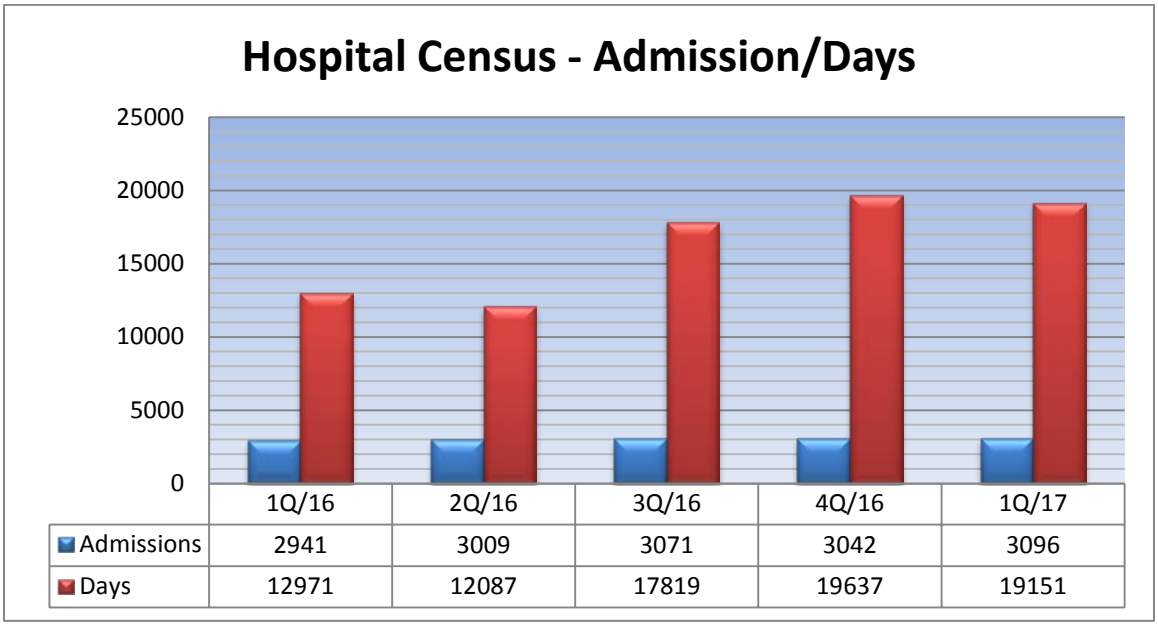
Health Dialog Report

Kern Health Systems (KHS) continues the relationship with Health Dialog, to provide KHS membership with 24-hour advice and nurse triage phone services as indicated in KHS Policy 3.15-I. Health Dialog dispositions are determined by evidence based protocols and the nature of the members concern. There continues to be an upward trend with Emergent care recommendations, which could be a reflection of the member's seeking care later or new member knowledge of benefit availability or health care navigation.

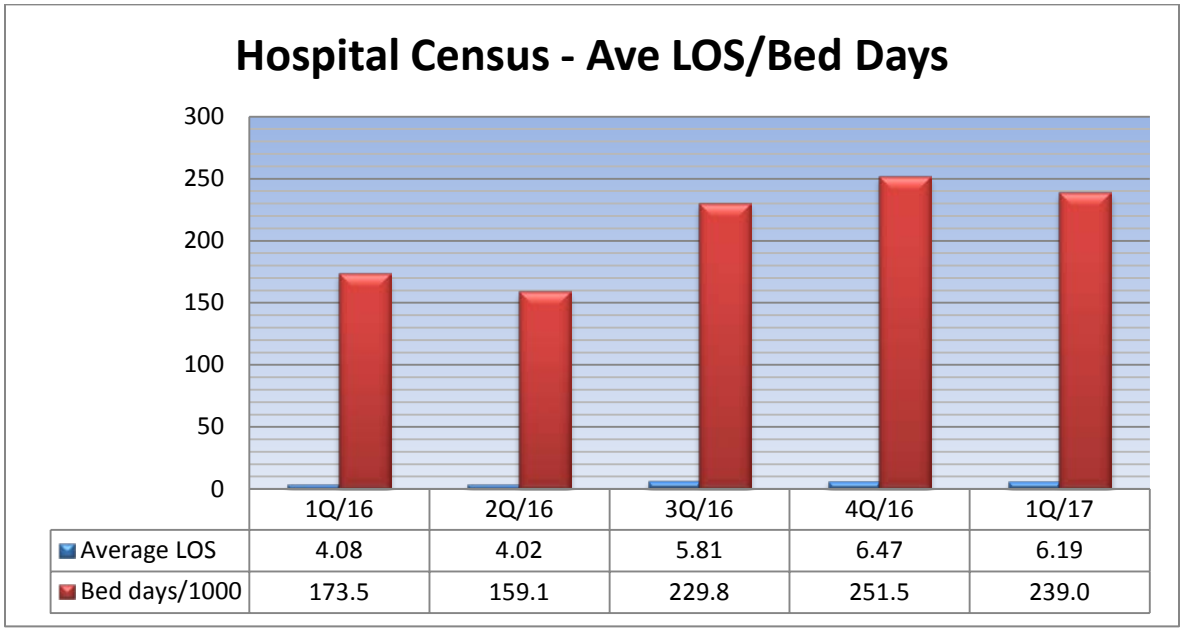
Redirection Rates - Inbound Symptom Check Calls (Rolling Twelve Months)

		Downward Redirection			Upward & Downward Redirection		
Member's Initial Intended Treatment Plan or Setting	Number of Symptom Check Calls	DENOMINATOR	NUMERATOR	PERCENT	DENOMINATOR	NUMERATOR	PERCENT
Call 911	17	10	7	70.0%	10	7	70.0%
Emergency Room	364	120	87	72.5%	184	102	55.4%
Urgent Care	244	54	40	74.1%	82	64	78.0%
Call Provider or Office Visit	218	36	20	55.6%	120	70	58.3%
Home Treatment	266	N/A	N/A	N/A	227	173	76.2%
None	288	N/A	N/A	N/A	N/A	N/A	N/A

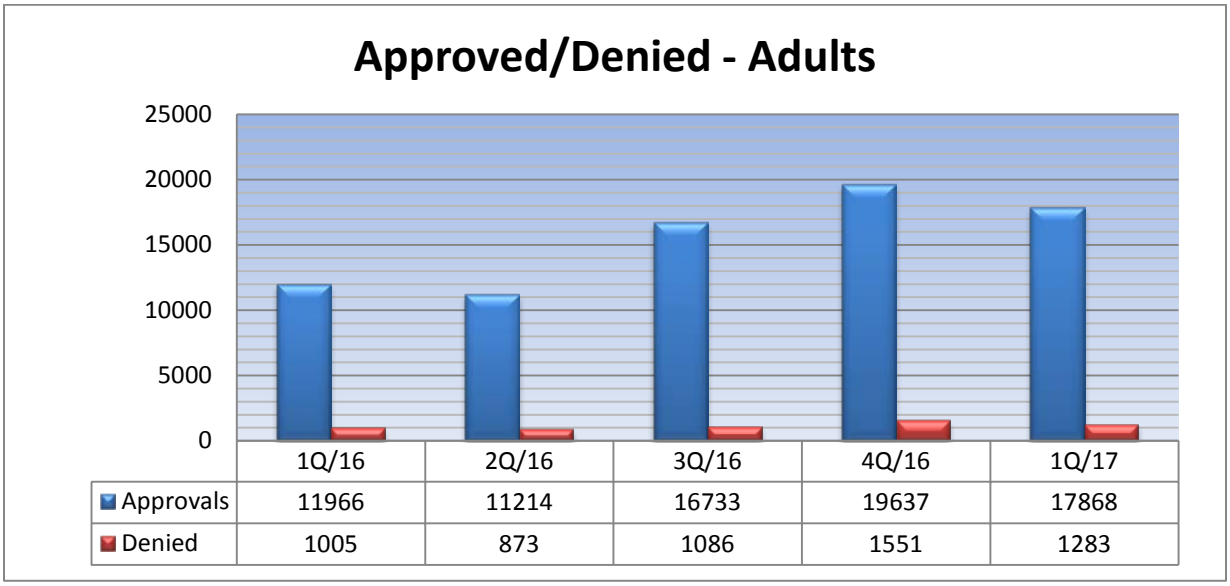
Inpatient 1st Quarter Trending

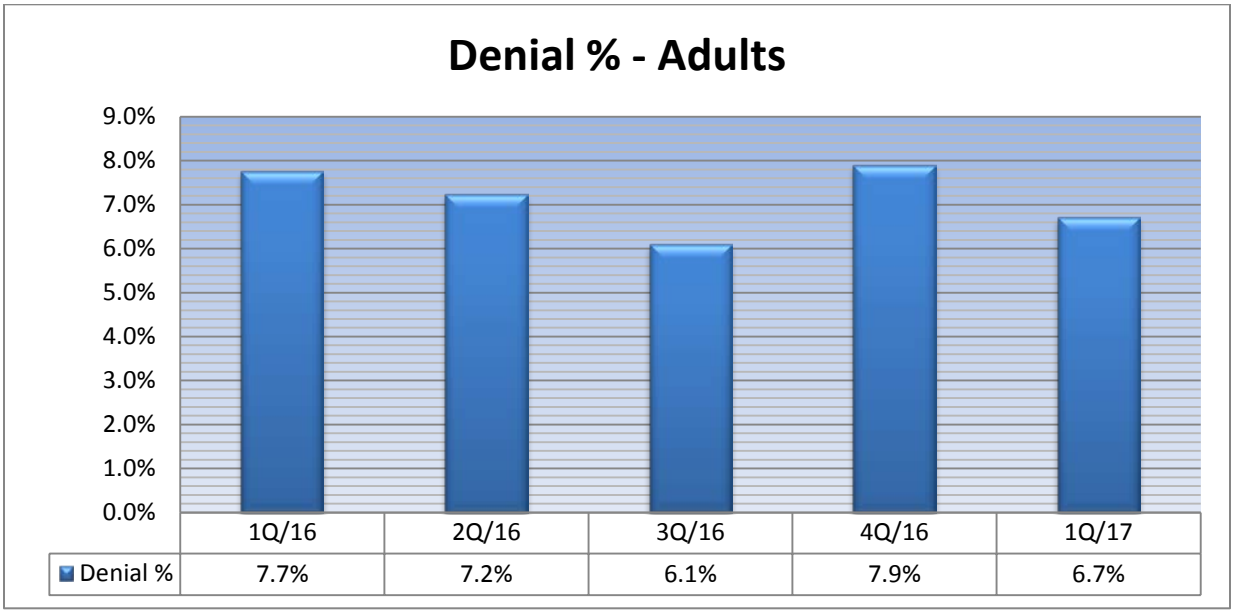


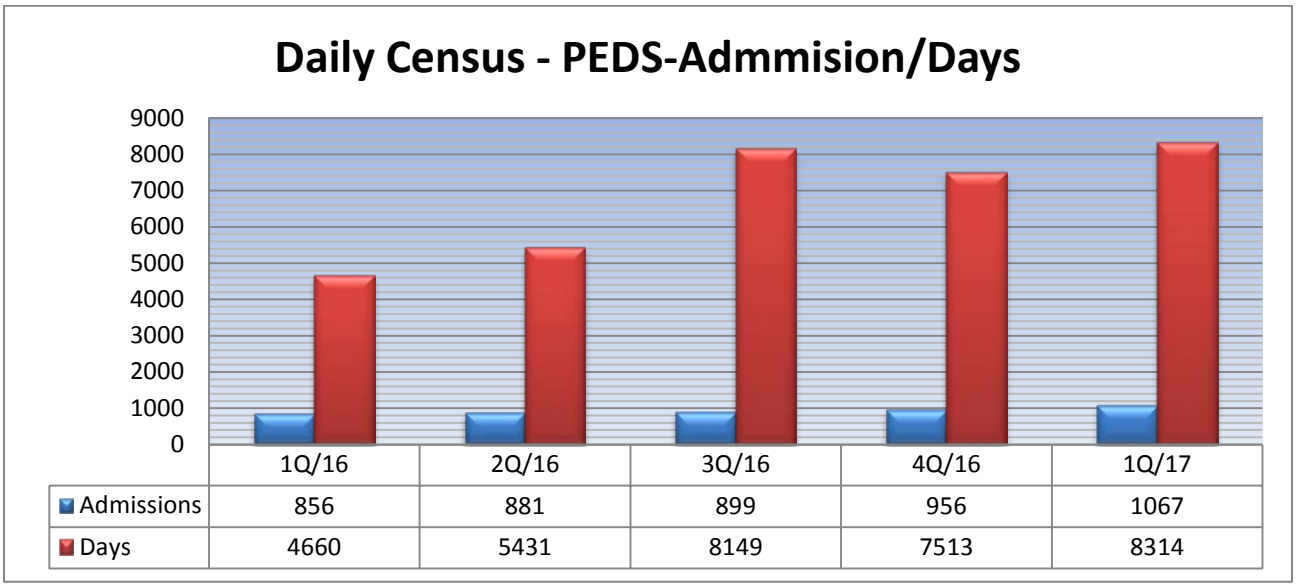
	1Q/16	2Q/16	3Q/16	4Q/16	1Q/17
Admissions	2941	3009	3071	3042	3096
Days	12971	12087	17819	19637	19151



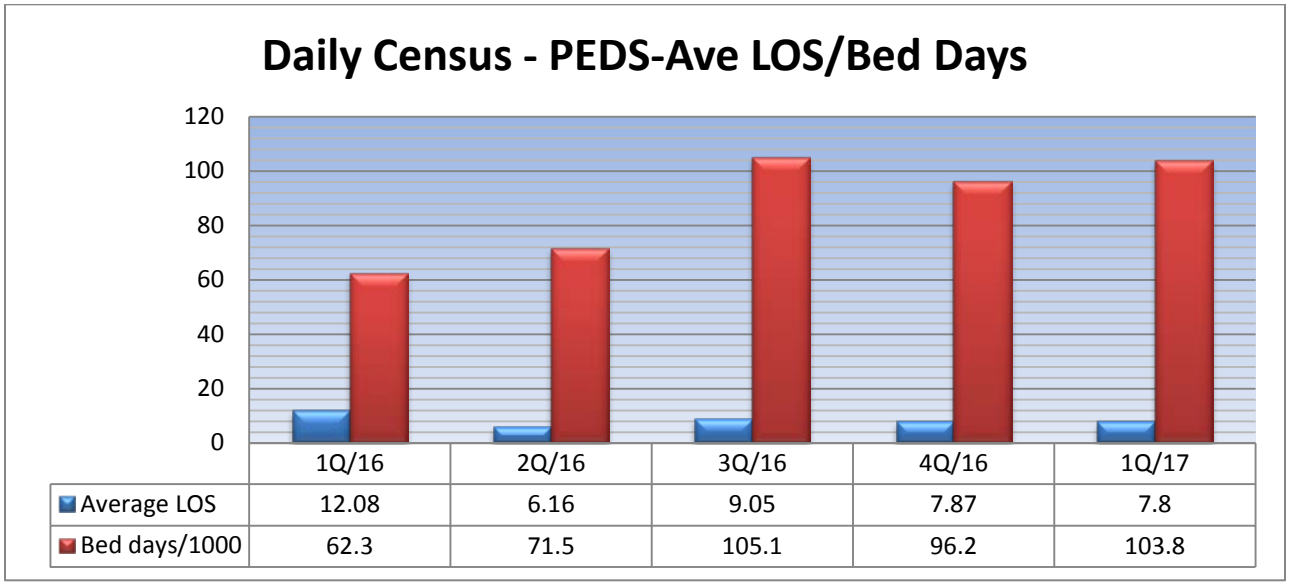
	1Q/16	2Q/16	3Q/16	4Q/16	1Q/17
Average LOS	4.08	4.02	5.81	6.47	6.19
Bed days/1000	173.5	159.1	229.8	251.5	239.0


Approved/Denied - Adults
25000
20000
15000
10000
5000
0
1Q/16
2Q/16
3Q/16
4Q/16
1Q/17
Approvals
11966
11214
16733
19637
17868
Denied
1005
873
1086
1551
1283

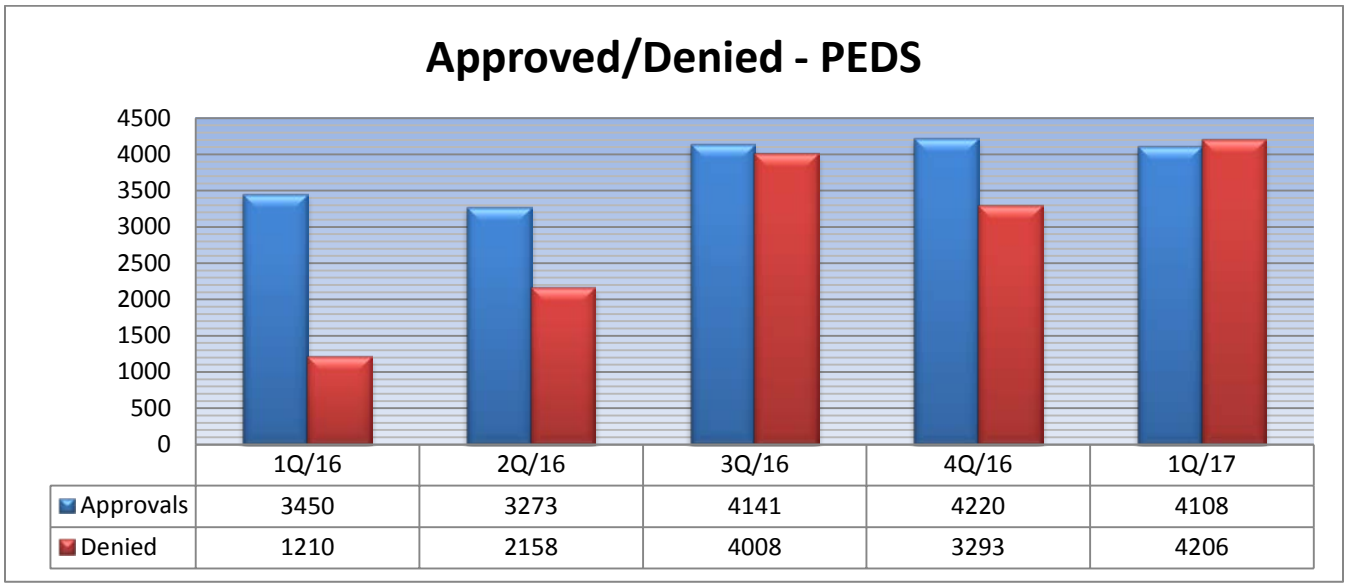

Denial % - Adults
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
1Q/16
2Q/16
3Q/16
4Q/16
1Q/17
Denial %
7.7%
7.2%
6.1%
7.9%
6.7%



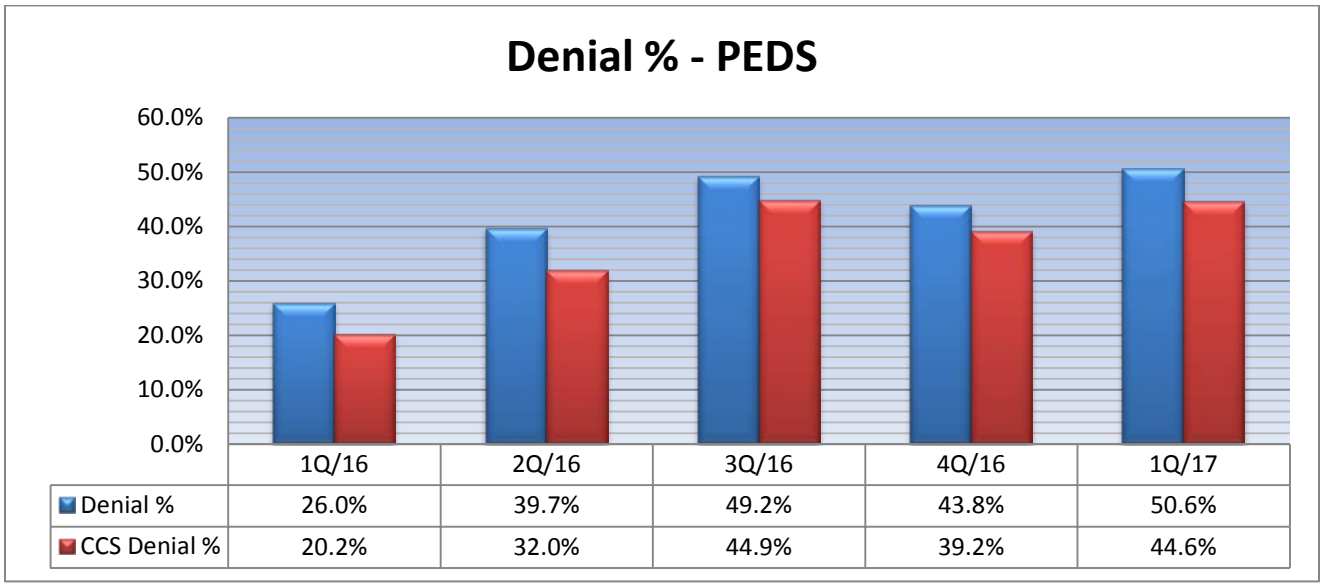
	1Q/16	2Q/16	3Q/16	4Q/16	1Q/17
Admissions	856	881	899	956	1067
Days	4660	5431	8149	7513	8314



	1Q/16	2Q/16	3Q/16	4Q/16	1Q/17
Average LOS	12.08	6.16	9.05	7.87	7.8
Bed days/1000	62.3	71.5	105.1	96.2	103.8

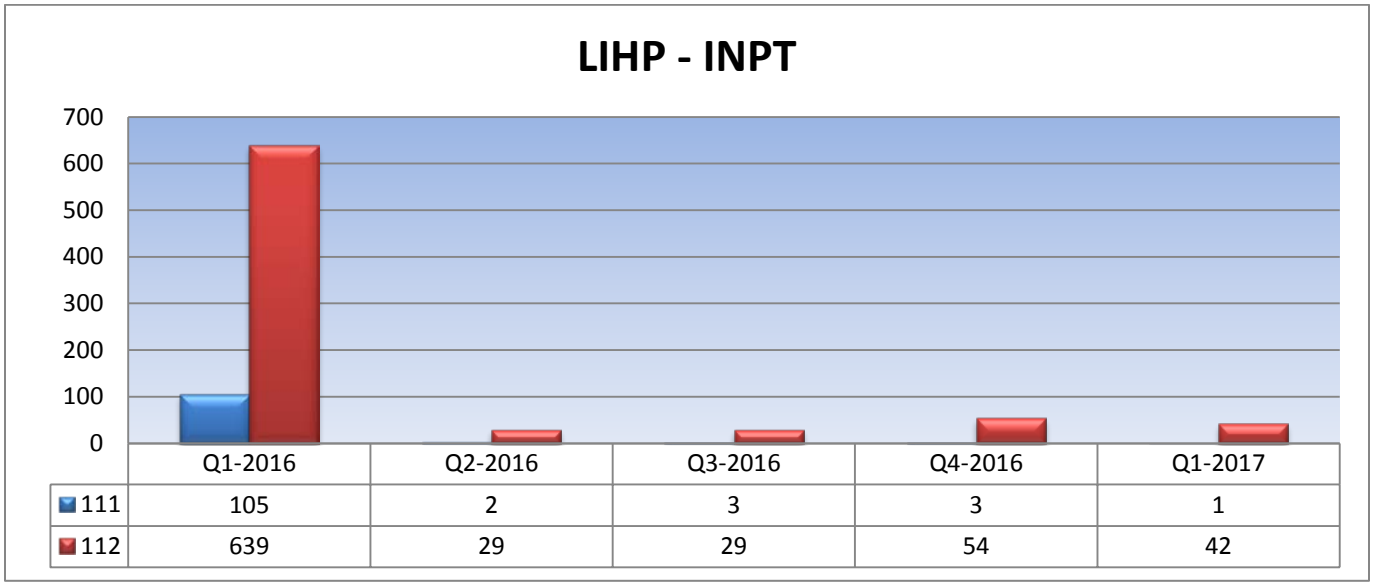


	1Q/16	2Q/16	3Q/16	4Q/16	1Q/17
Approvals	3450	3273	4141	4220	4108
Denied	1210	2158	4008	3293	4206

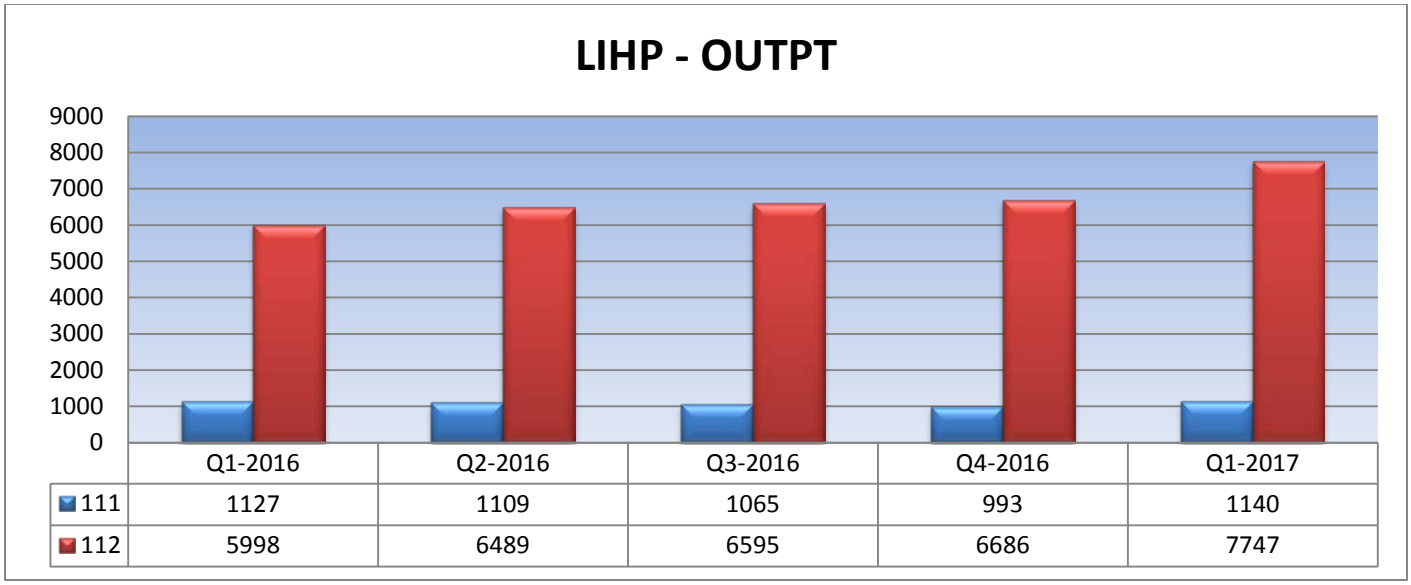


	1Q/16	2Q/16	3Q/16	4Q/16	1Q/17
Denial %	26.0%	39.7%	49.2%	43.8%	50.6%
CCS Denial %	20.2%	32.0%	44.9%	39.2%	44.6%

LIHP – Expansion Member Group 111/112 Trending:



	Q1-2016	Q2-2016	Q3-2016	Q4-2016	Q1-2017
111	105	2	3	3	1
112	639	29	29	54	42



	Q1-2016	Q2-2016	Q3-2016	Q4-2016	Q1-2017
111	1127	1109	1065	993	1140
112	5998	6489	6595	6686	7747

1st Quarter All Continuity of Care

Quarter	Total Continuity of Care	Approvals	Number of SPD(s)
1st 2017	4	3	2

1st Quarter UM Provider Disputes

UM Provider Disputes	
Favor of Provider	1
Favor of Plan	1
Total	2

Autism Reporting

UNIQUE CASES		Mild	Moderate	Severe	Total	Undetermined						
PRE TRANSITION	23	3	7	1	11	12						
POST TRANSITION	357	46	102	22	170	187						
Total - Eligible	380	49	109	23	181	199						
Severity %		27%	60%	13%								
Age 7 or less		16	77	18	111	129						
Age 8 or greater		38	57	5	100	85						
% < 7		14%	69%	16%								
% > 8		38%	57%	5%								
AUTHS PER MO/MEMBER	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	
DHCS TRANSITION	25	48	34	38	43	32	27	11	41			
NEW CASES	19	35	27	19	22	27		20	7	3	44	
TOTAL	44	83	61	57	65	59	27	31	48	3	44	
SEVERITY	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
MILD	4	2	1	5	6	7	5	4	7	4	3	48
MODERATE	5	9	8	18	16	11	12	15	13	8	18	133
SEVERE	1	1			1	2	2	6	2	2	2	19
Approved FBA	2	8	6	25	19	44	19	28	24	16	17	208
Approved Treatment	8	23	14	22	20	19	22	24	26	10	24	212
PENDING DX				39	45	29	19	39	15	15	19	220
TOTAL	20	43	29	109	107	112	79	116	87	55	83	840
	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
AGE 7 OR LESS	5	7	4	36	31	26	21	42	31	14	21	238
AGE 8 OR GREATER	5	5	5	25	36	22	17	28	17	15	23	198
TOTAL	10	12	9	61	67	48	38	70	48	29	44	436
% < 7	50%	58%	44%	59%	46%	54%	55%	60%	65%	48%	48%	55%
% > 8	50%	42%	56%	41%	54%	46%	45%	40%	35%	52%	52%	45%
CDE'S PENDING	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
INTEGRAL											3	
GARCIA											3	
TOTAL												
PROVIDER	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Total					
INTEGRAL	3						3					
GARCIA	3						3					
							6					
J.Pollock 12/15/16												

Diabetic Exam Reminder Effectiveness Report

Client: - 12049397

Reminder Year:	Reminder Month:	Reminders Sent	Received Exam Within 0-90 Days	Received Exam Within 91-180 Days	Total Exams Within 180 Days
2016	January	788	27	33	60
	February	127	6	8	14
	March	116	4	2	6
	April	60	10	0	10
	May	594	19	3	22
	June	309	10	2	12
	July	372	5	2	7
	August	4	0	0	0
	September	380	29	2	31
	October	39	6	0	6
	November	83	2	0	2
	December	5,008	9	0	9
Totals		**7,880**	**127**	**52**	**179**

LTM Effectiveness* : 2 %

12-Month Effectiveness (Jul 2015 - Jun 2016) : 7 %

KERN HEALTH SYSTEMS
CASE MANAGEMENT DEPARTMENT MONTHLY REPORT

Reporting Period: January 31st, 2017 – March 31st, 2017

CASE MANAGEMENT DEPARTMENT OVERVIEW:

The goal of the Case Management Department is to help members maintain optimum health and/or improved functional capability, educate members regarding their health and reinforce the PCP prescribed treatment plan. These efforts are anticipated to decrease costs and improve quality through focusing on the delivery of care at the appropriate time and in the appropriate setting.

Complex Case Management is the systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management. Basic Case Management means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered basic case management services.

Members in the Complex Case Management Group and members assigned to the Case Management Team will be assigned a Nurse Care Manager and respective support staff. The team will focus on comprehensive coordination of services based on patient-specific needs to improve increase the quality and impact of the health care and supportive services the member is receiving. This will be accomplished through:

- Promotion and support of the Medical Home as the source of the member's primary healthcare and source of specialty referrals, and enhancing this with the necessary social, care management and medical support to facilitate comprehensive patient-centered planning
- Identification and elimination of potential barriers to seeking and receiving appropriate care within their designated medical home (e.g., housing, transportation, child care, nutrition, mental and behavioral health needs, identification of culturally competent providers and appropriate access, discharge and transitional care planning, health education, etc.)
    - Potential assessment and education modules may include:
        1. Social needs
        2. Medical and/or behavioral health home
        3. Appointment attendance
        4. Urgent symptom management
        5. Medication and treatment adherence
        6. Behavioral risk
        7. Condition-specific self-management

As a result of this assessment, the Case Manager will:

- Contact the Primary Care Physician as needed to identify areas where he/she would like assistance (e.g., improving medication compliance)
- Identify communication preferences when more than one provider is involved in the medical care (e.g., does the PCP prefer all coordination go through his/her office or should the disease manager reach out to the specialist as appropriate?)
- Determine the type and frequency of information the PCP wants going forward
- Develop the person-centered care plan in conjunction with the PCP using predictive modeling risk scores with clinical based rules and medical management platforms (e.g., Milliman Care Guidelines, KHS internal criteria, etc.)

The following processes and activities are in place for Case Management/Coordination of Care:

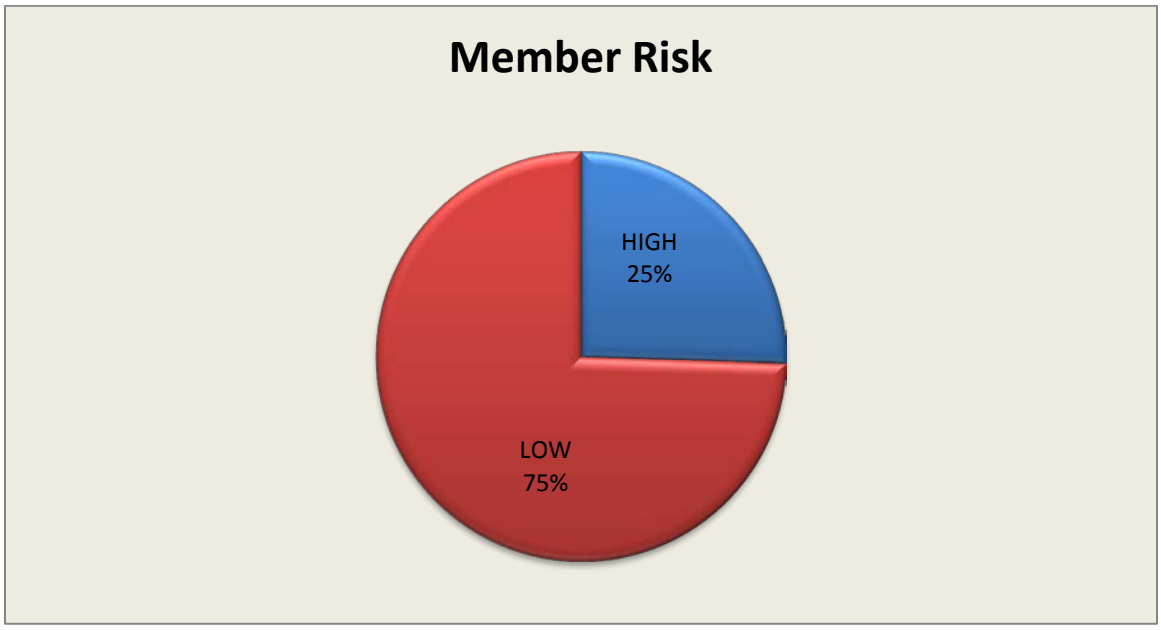
- Collaborate with PCPs for basic CM services
- Arrange and track referrals to specialists
- Track referrals and coordination of car for carved out and other out-of-network services and providers
- Identify community resources and refer members
- Offer health education services
- Implement continuous quality improvement activities

Case Management Team Staffing:

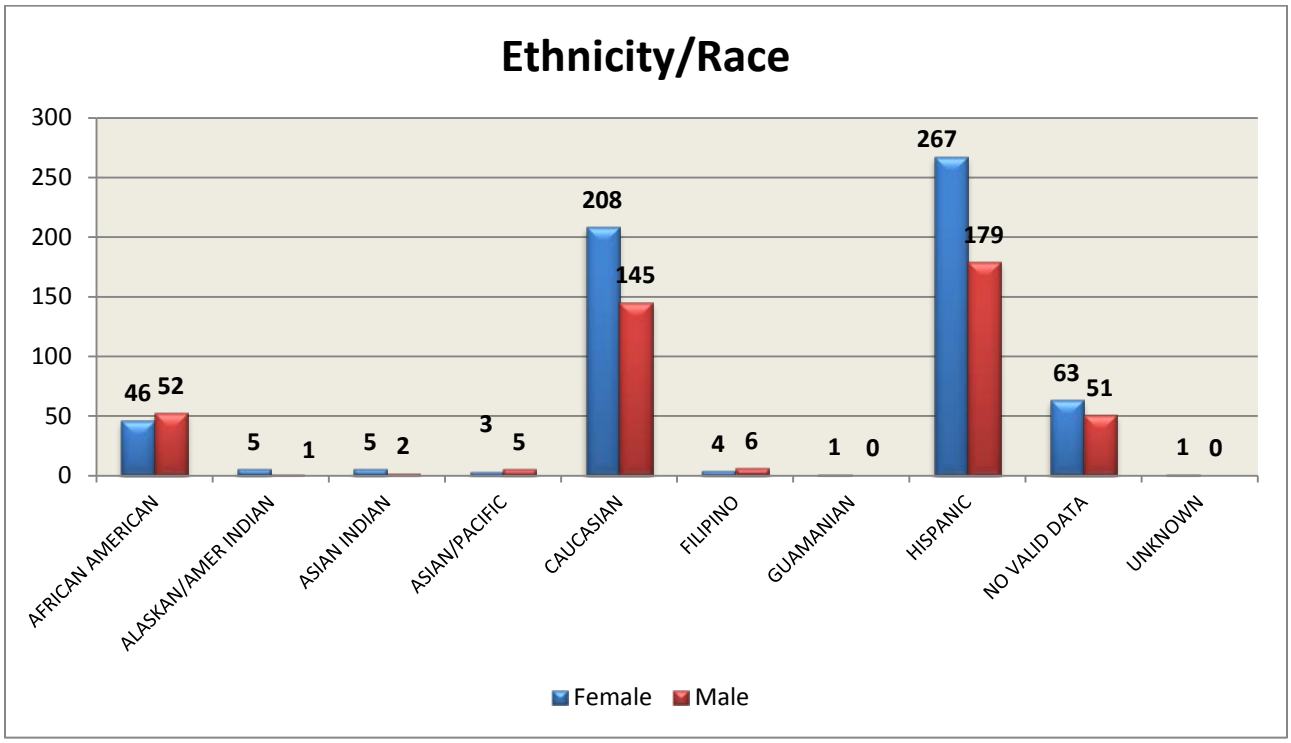
January – March 2017 Case Management Staffing:

Position	Quantity
Case Management RN	8
Case Management CMA's	5
Case Management MSW	6
Case Management Sr. Analyst and Trainer	1

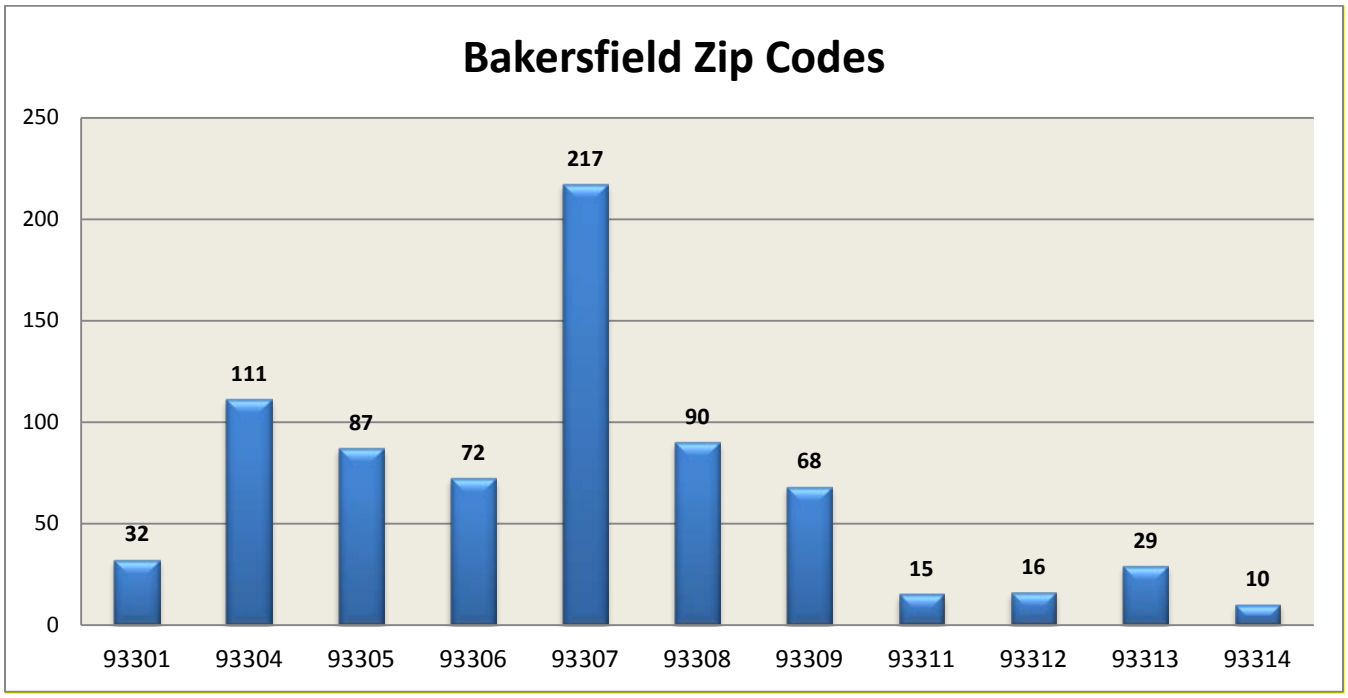
During this 1st Quarter 2017, there were a total of 1,642 KFHC members that were managed by the CM staff department. The majority of the members at 75% are low risk.



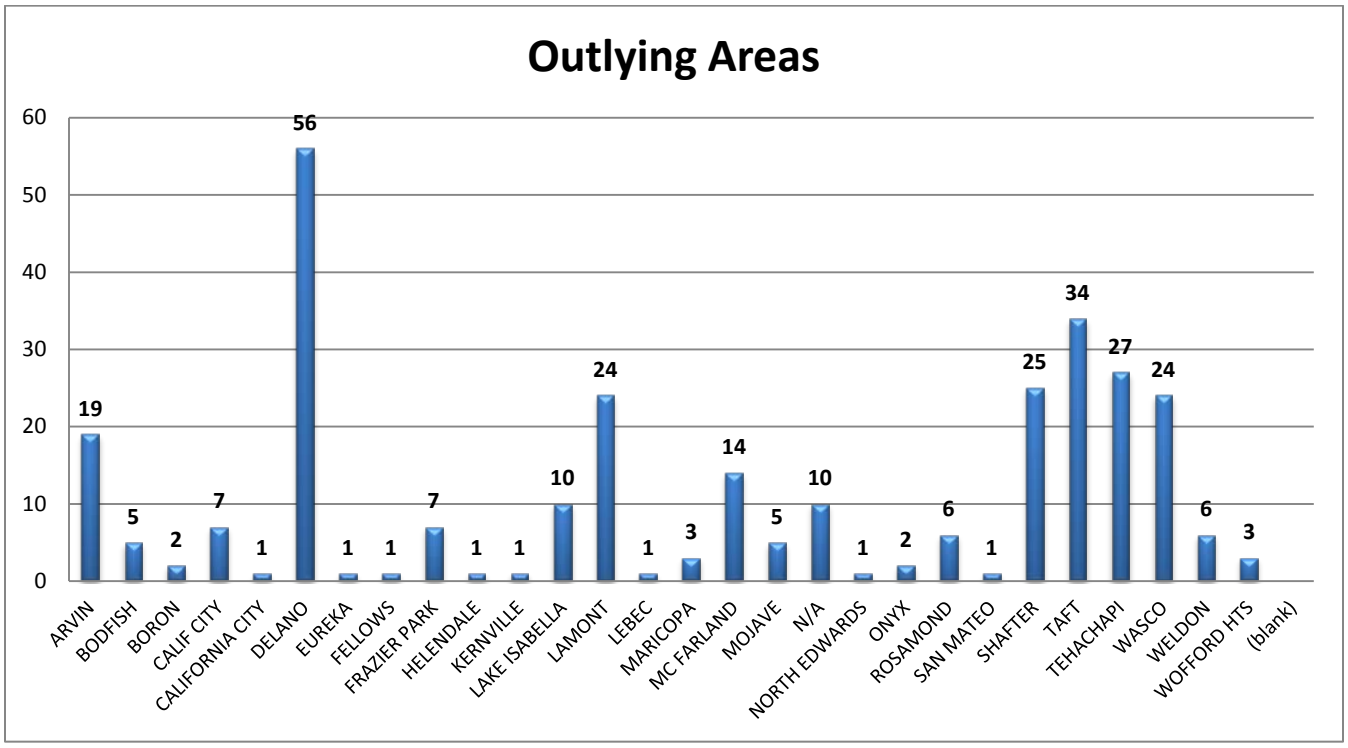
Majority of the members managed during the 1st Quarter 2017 were female at 58%. The majority of the members managed this quarter at 43% are Hispanic.



The majority of the members that were managed during the 1st Quarter 2017 reside in Bakersfield at 72%. Of the members from Bakersfield, the majority at 29% reside in the 93307 zip code.

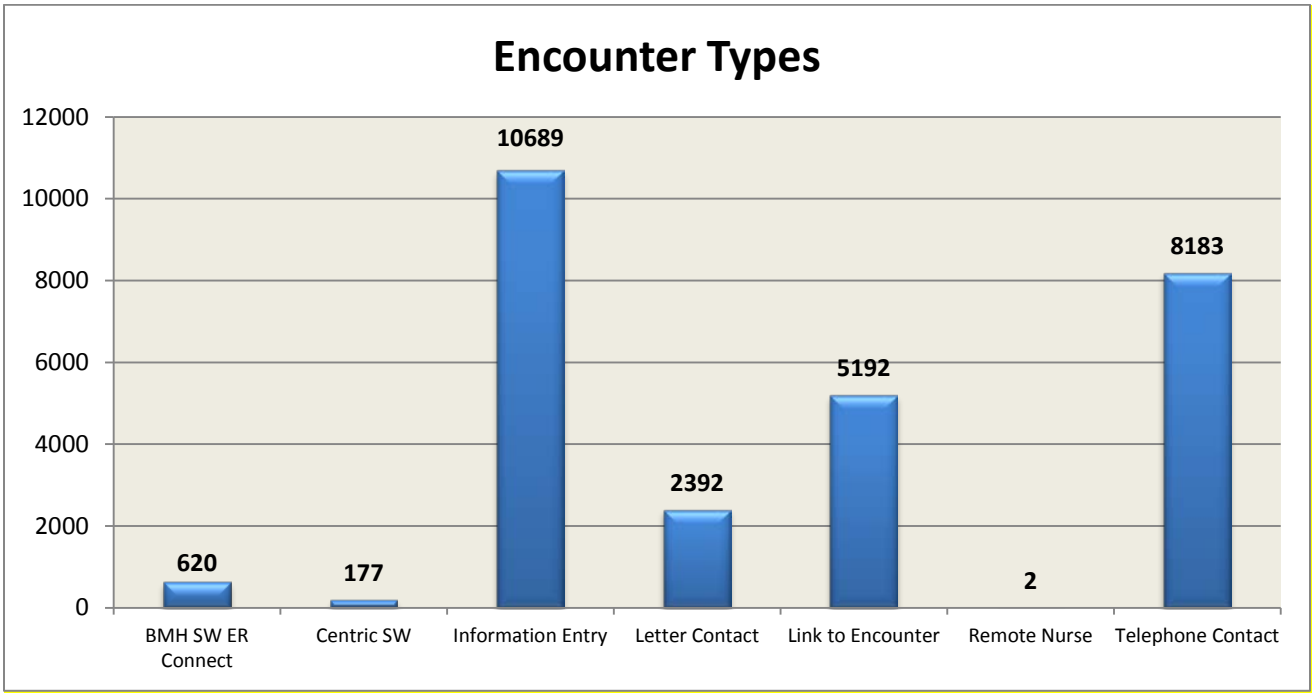


Of the outlying areas, majority of the members at 19% reside in Delano.

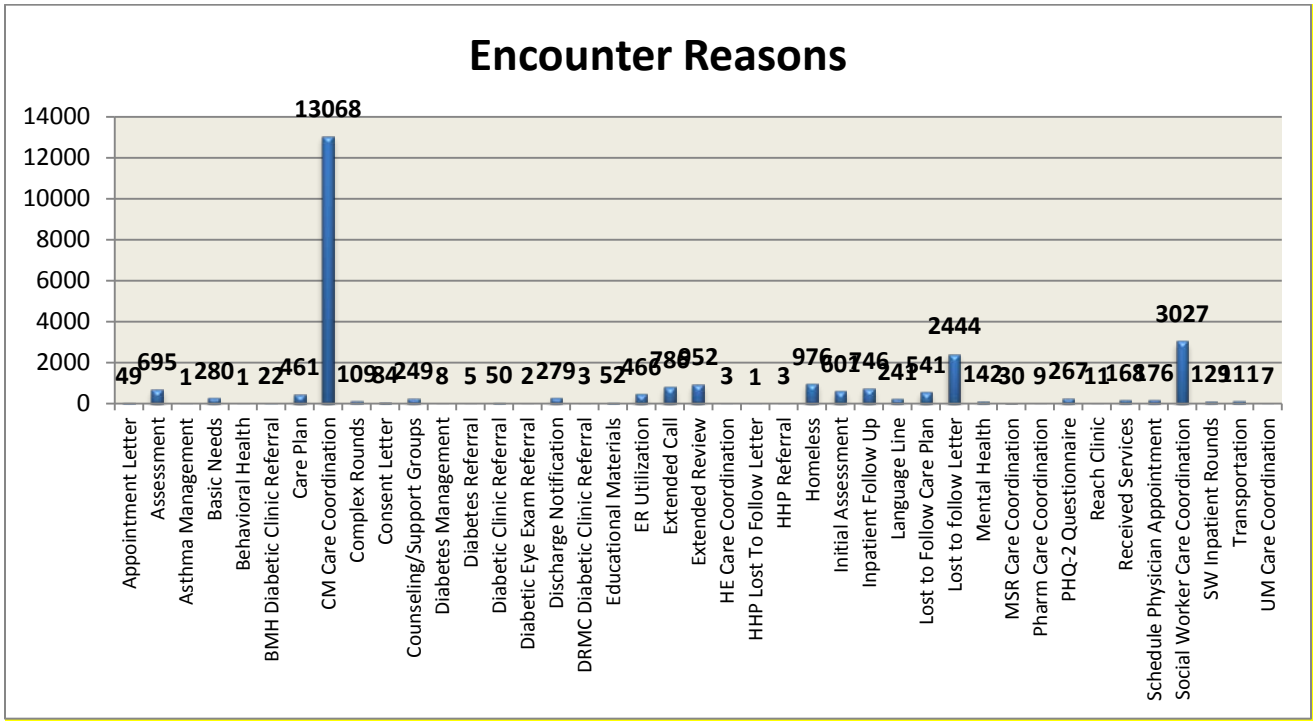


Encounters:

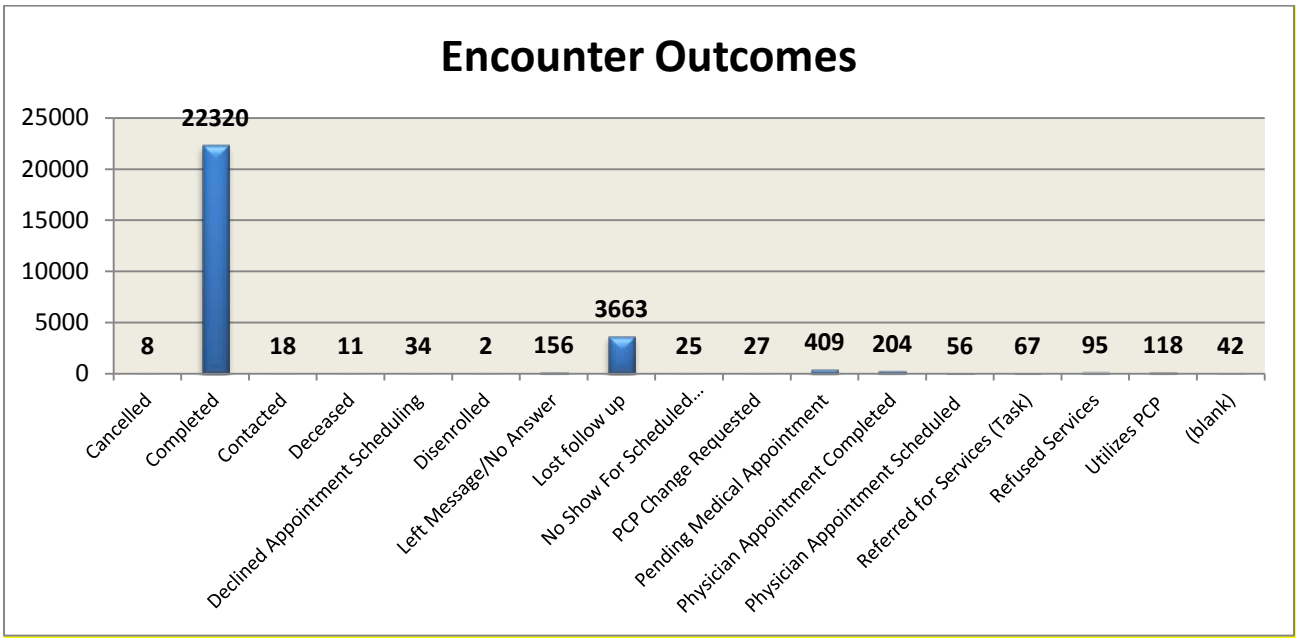
There were a total of 27,255 encounters submitted during the 1st Quarter for 1,442 KFHC members and the majority of the encounter types were listed as Information Entry at 39%.



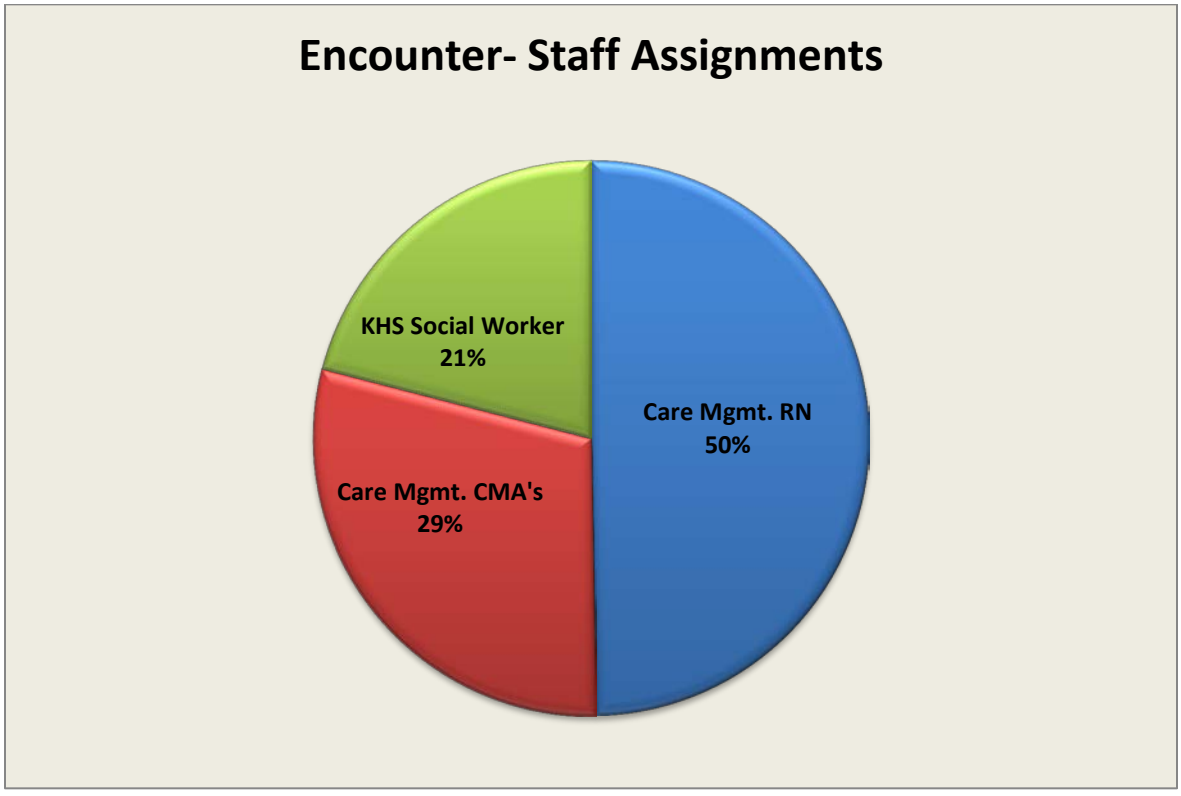
Majority of the encounter reasons at 48% was listed as CM Care Coordination.



Majority of the encounter outcomes at 82% are listed as Completed.

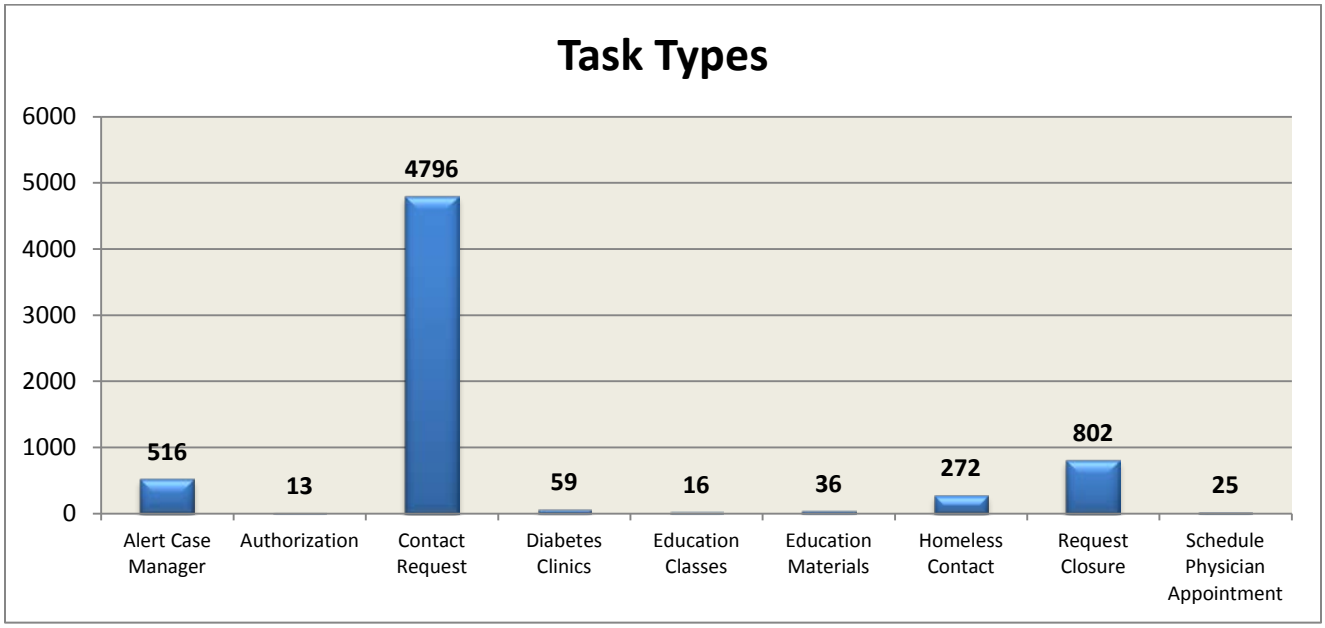


Majority of the encounters were completed by the Care Management RN's at 50%.

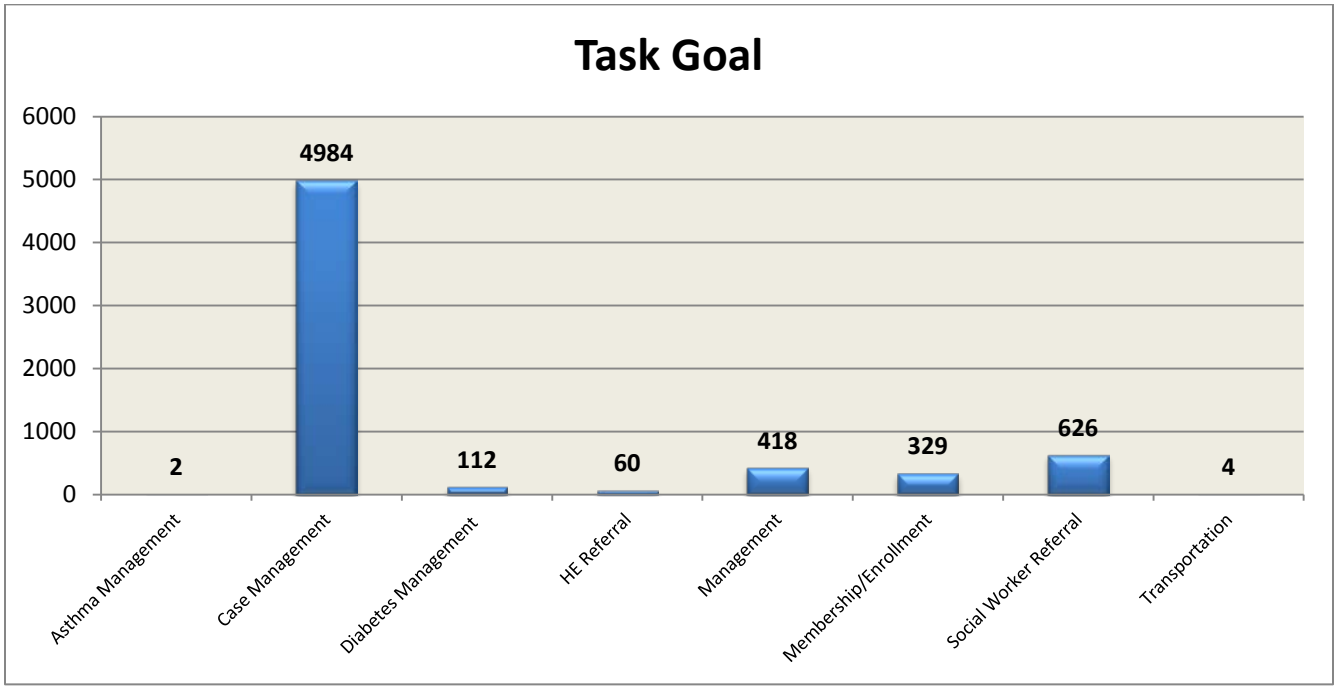


Tasks:

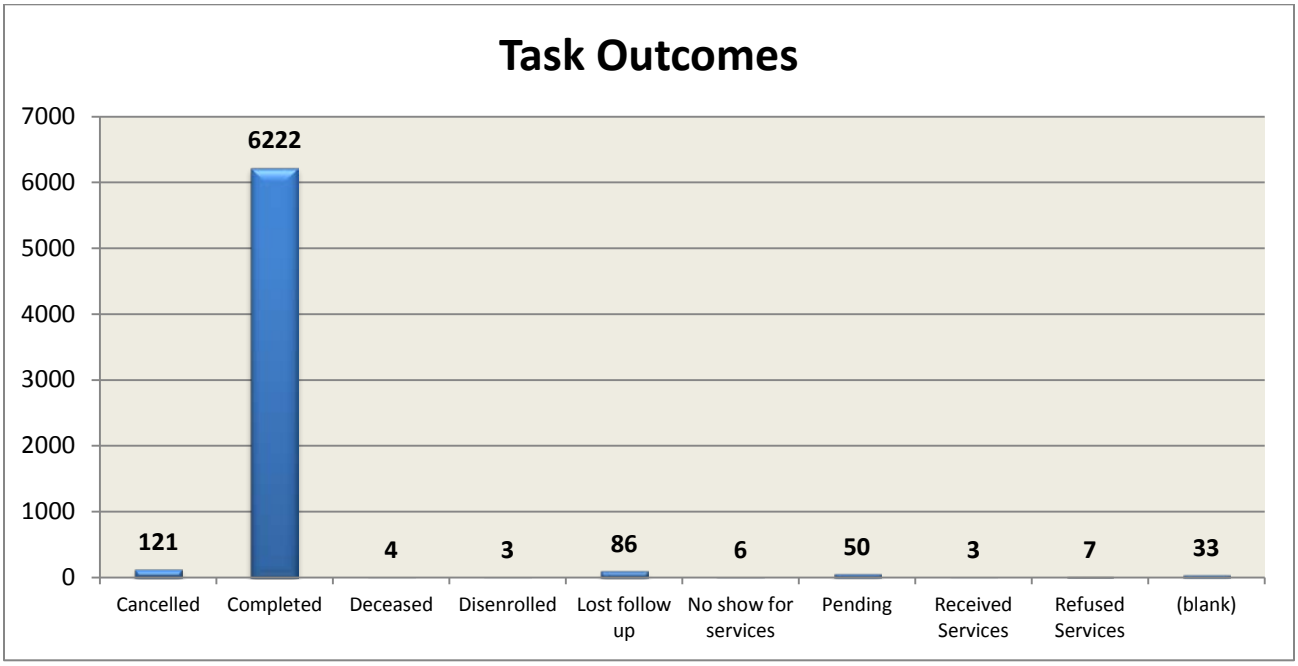
There were a total of 6,535 tasks submitted during the 1st Quarter for 1,642 KFHC members. The majority of Task Types were Contact Request at 73%.



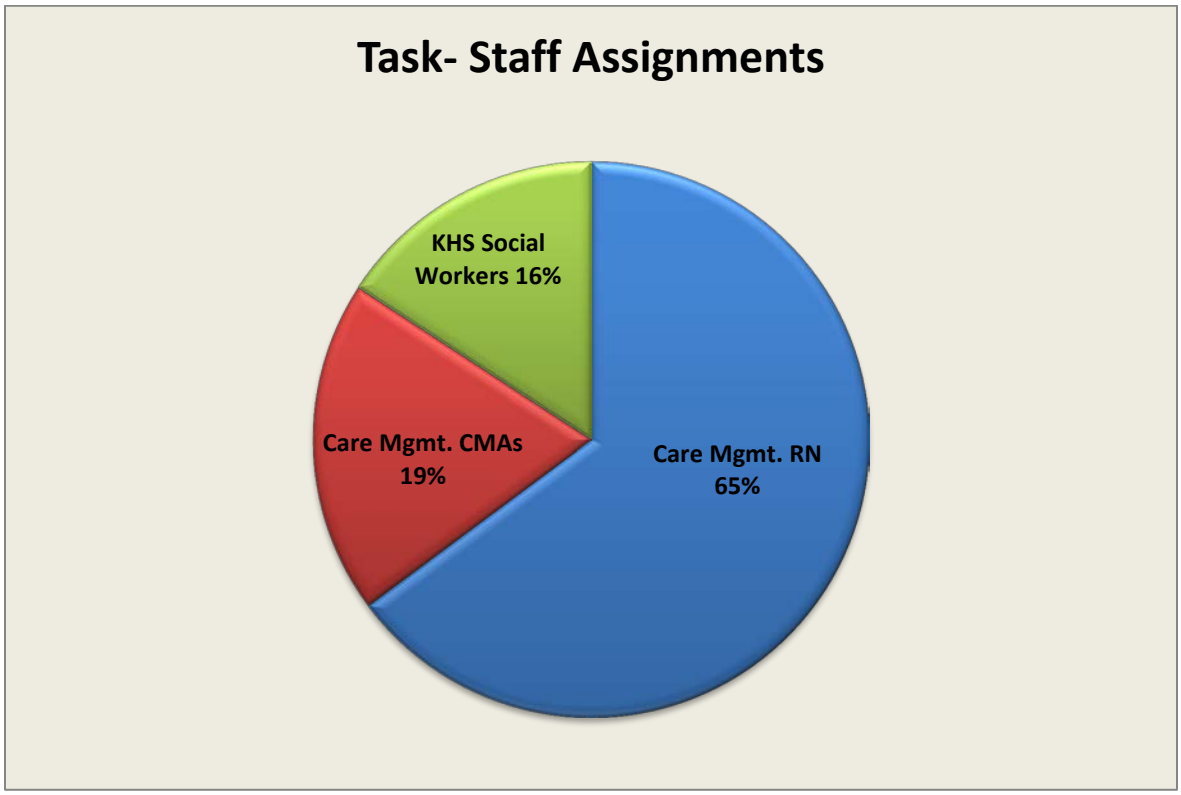
Majority of task goals during the 1st Quarter at 76% were listed as Case Management.



Majority of the task outcomes at 95% are completed.



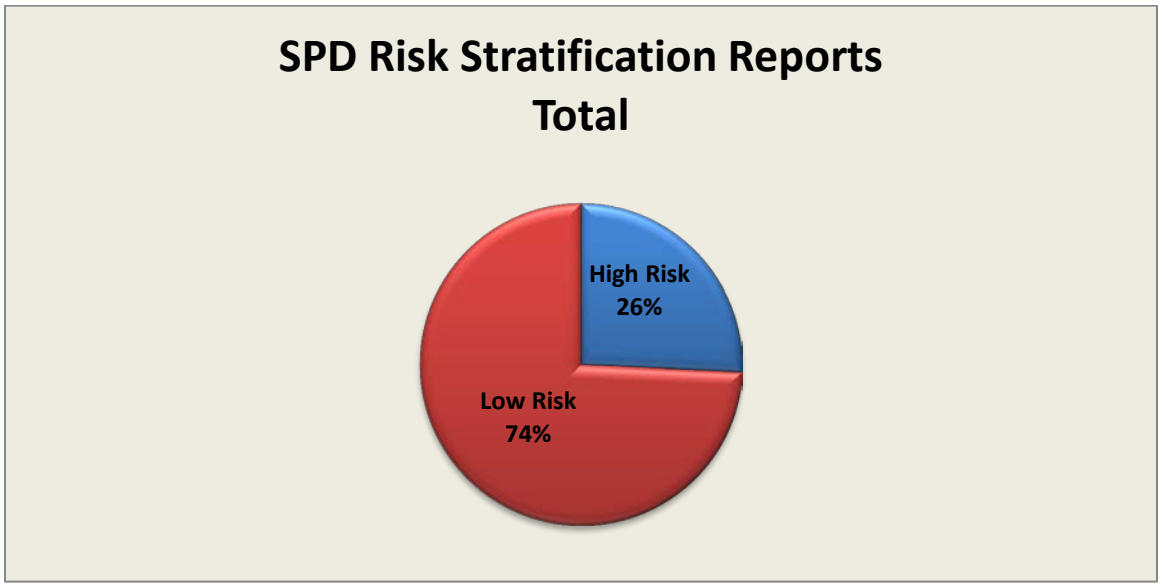
Majority of the tasks were assigned by the Case Management RN' at 65%.



Seniors and Persons with Disabilities (SPDs):

There were a total of 443 SPD members that were enrolled during the 1st Quarter 2017, according to the high risk stratification report. Of the 443 SPD members, 20% are stratified as high risk.

There are a total of 12,855 SPD members to date. Of the 12,855 SPD members, 26% are stratified as high risk.



SPD Members are stratified into the Complex Case Management Group through use of the John Hopkins Predictive Modeler and represent on the average 50 percent of the Complex Group during the 1st Quarter.

KERN HEALTH SYSTEMS
DISEASE MANAGEMENT DEPARTMENT QUARTERLY REPORT

Reporting Period: January 1, 2017 – March 31, 2017

DISEASE MANAGEMENT DEPARTMENT OVERVIEW:

Disease Management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant variables in achievement of desirable outcomes. Disease Management supports the physician or practitioner/member relationship and plan of care; emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines, and member empowerment strategies, and; evaluates clinical, humanistic, and economic outcomes.

The Disease Management Department performs assessments, coordinates care, monitors and evaluates medical services for members with an emphasis on quality of care, continuity of services, and cost-effectiveness. The three program areas of the Disease Management Department are Diabetes and Hypertension, Asthma and High Risk Pregnancies.

Disease Management Department Staffing:

Position	Quantity
Disease Management RN	4
Disease Management SSC's	4

Case Manager RN Caseload:

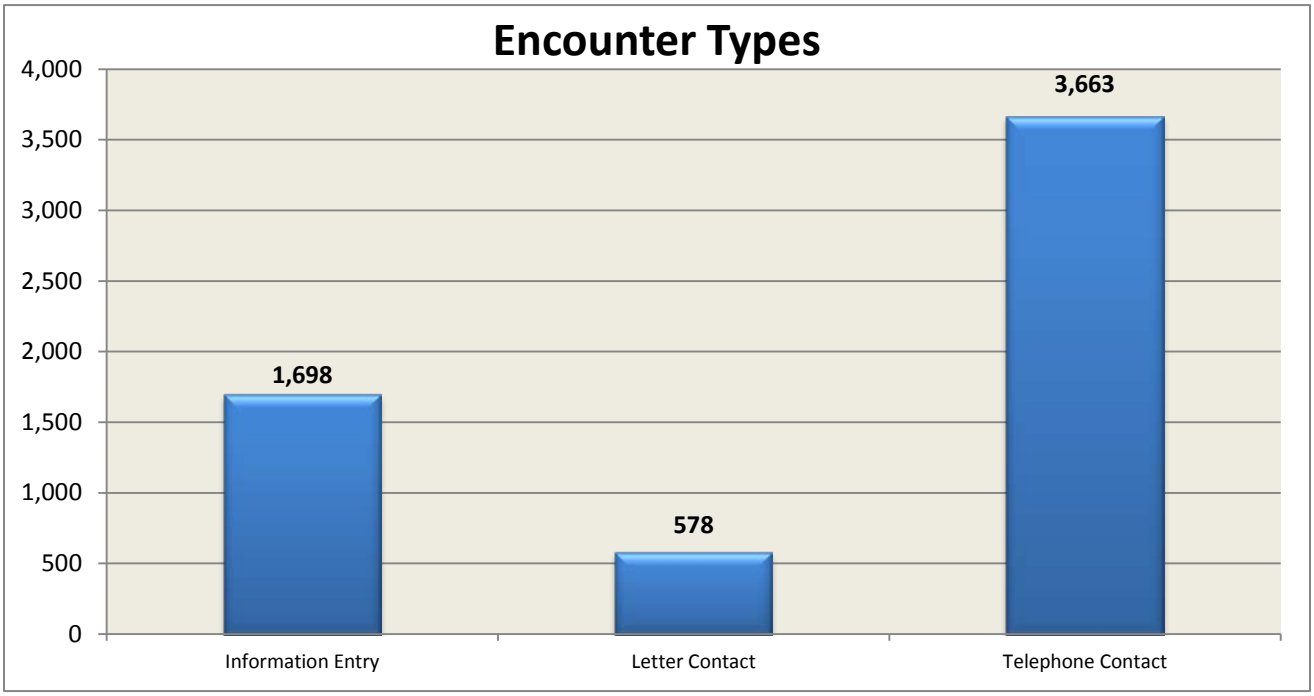
Staff	Caseload
RN 1	160
RN 2	135
RN 3	50
RN 4	12
TOTAL	357

DM Program Caseload:

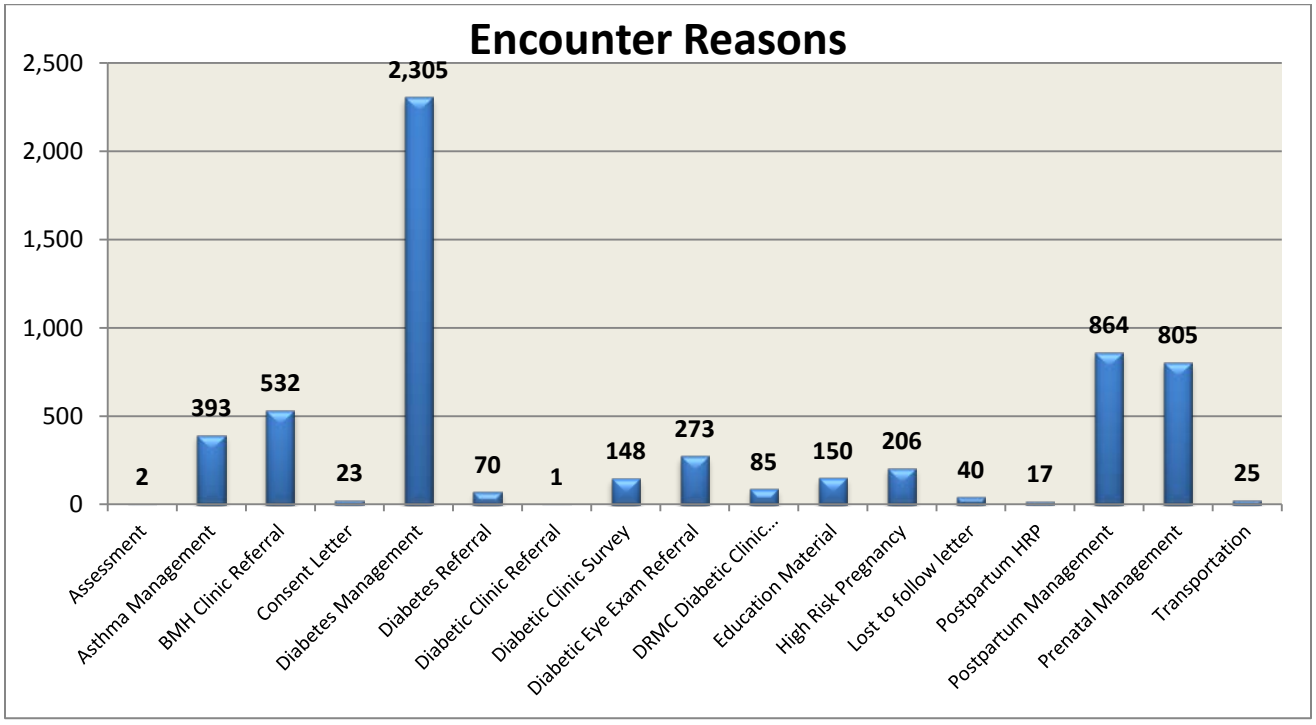
DM Program	Caseload
Asthma	94
Diabetes and Hypertension	232
High Risk Pregnancy	31
TOTAL	357

Encounters:

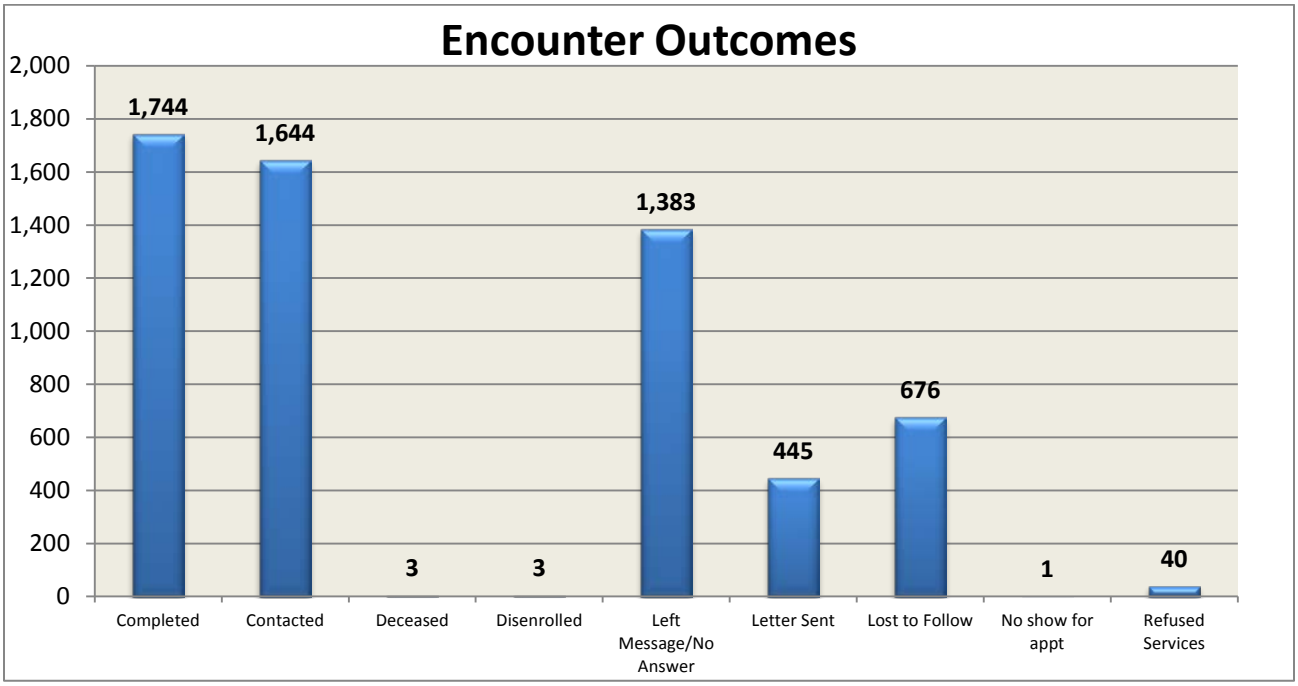
There were a total of 5,939 encounters submitted during this quarter for 1,989 KFHC members and the majority of the encounter types were listed as a Telephone Contact at 62%.



The majority of the encounter reasons at 39% was listed as Diabetes Management.

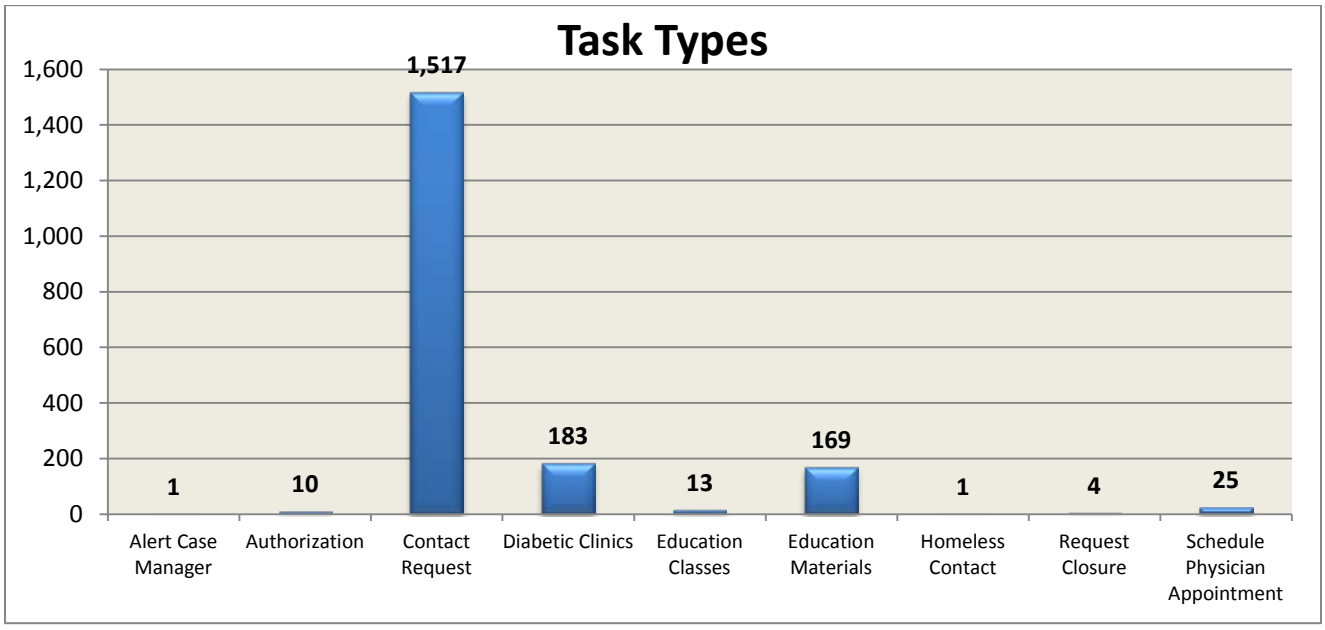


The majority of the encounter outcomes at 29% are listed as completed.



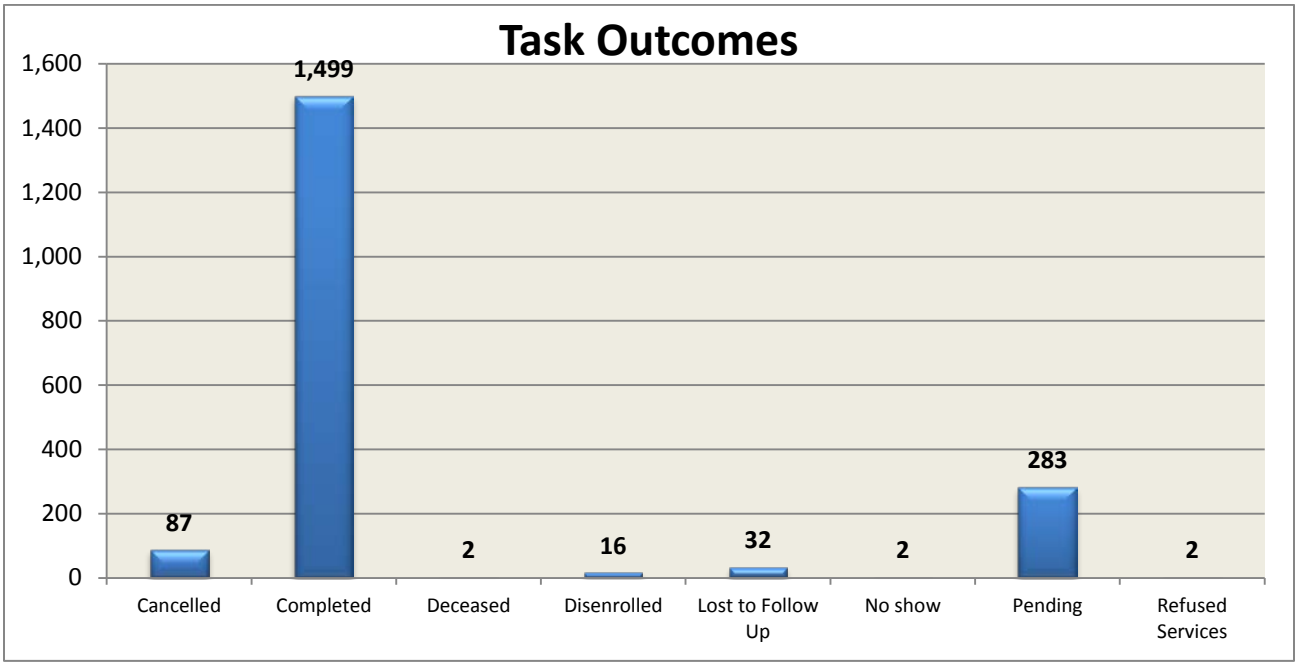
Tasks:

There were a total of 1,923 tasks assigned to the Disease Management department during the quarter for 896 KFHC members. The majority of Task Types were Contact Request at 79%.



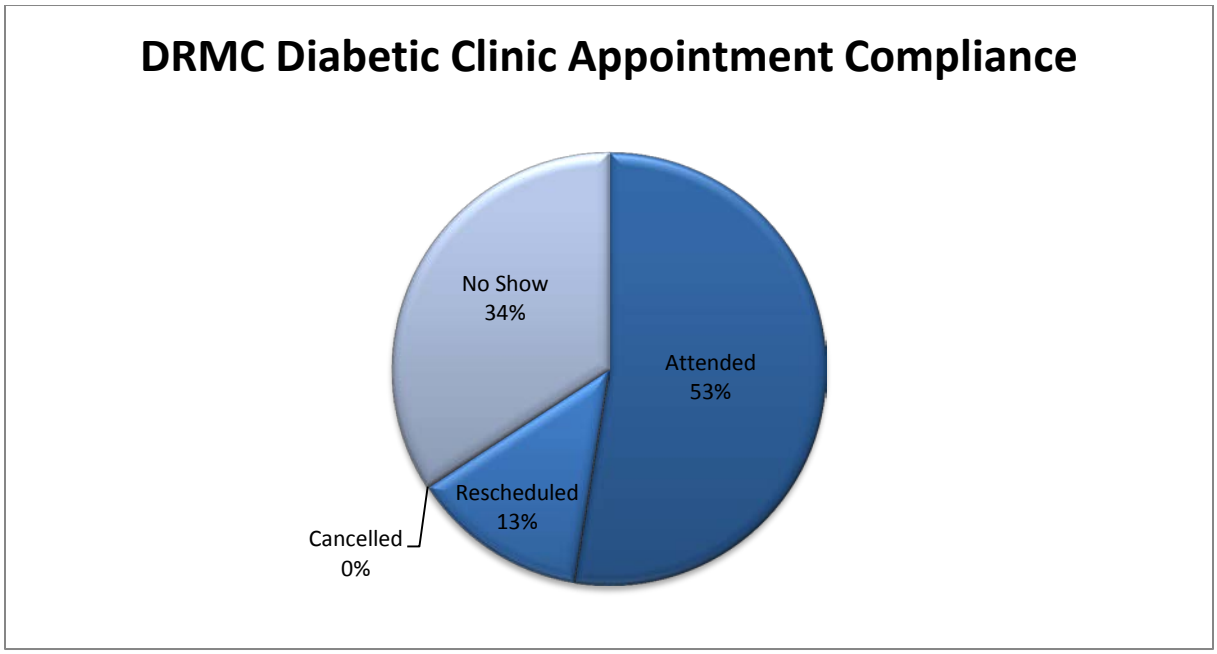
The majority of task goals at 69% was listed as Diabetes Management.

The majority of the task outcomes at 78% are completed.



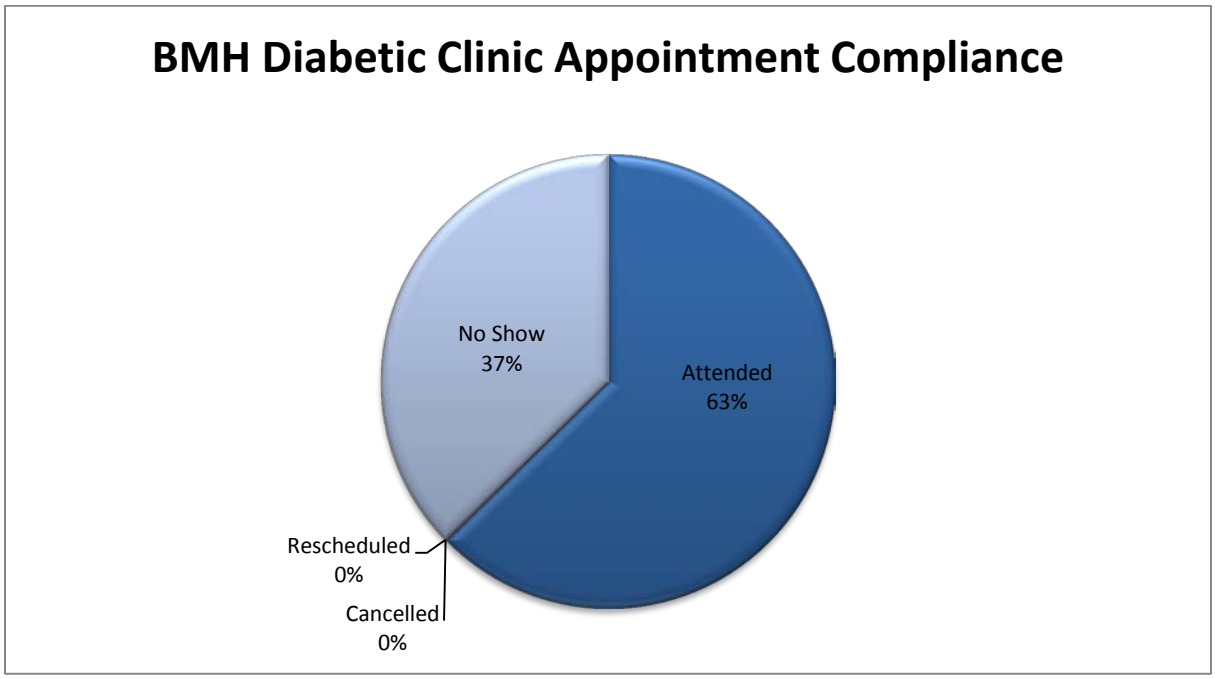
Delano Regional Medical Center (DRMC) Diabetic Clinic

Appointment compliance at the DRMC Diabetic Clinic revealed 53% of members attended their scheduled appointment.



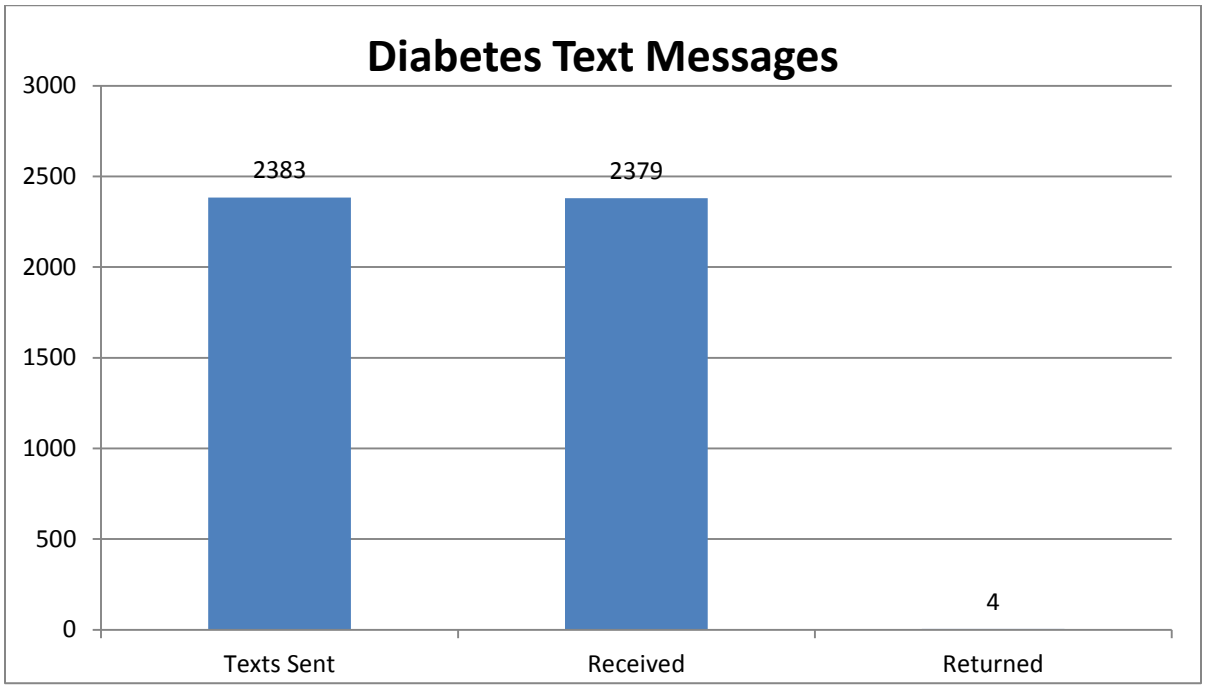
Bakersfield Memorial Hospital (BMH) Diabetic Clinic

Appointment compliance at the BMH Diabetic Clinic revealed 63% of members attended their scheduled appointment.



Diabetes Text Messaging Program

Thirteen diabetes related text messages, totaling 2,383 were sent to members during this quarter. 99.8% of those messages were successfully received by the members.



Propeller Asthma Management Pilot

KHS' Disease Management Department and Dignity Health have partnered with Propeller Health to pilot a digital asthma management program for 20 KHS members with asthma. Through the use of medication sensors, mobile applications and an online dashboard, KHS is able to track the frequency of the controller and rescue asthma inhalers used by each participating member, receive email notifications when a member is identified as in poor control of his/her asthma and identify the geographic location of where the member used their medication (smartphone enrolled members only). Members do not need internet access or a smartphone to participate. By the end of this quarter, 15 members are actively engaged in this pilot and are sending data to the online patient health dashboard hosted by Propeller Health.

Automated Reminder Calls

KHS sends automated reminder calls to members in need of completing specific health actions. During this quarter, there were no automated reminder calls sent with regards to diabetes related screenings.

KERN FAMILY HEALTH CARE
UTILIZATION MANAGEMENT
2017 PROGRAM DESCRIPTION

Introduction

Kern Health Systems (KHS), d.b.a. Kern Family Health Care (KFHC), is the Local Initiative for the arrangement of medical and behavioral health care for Medi-Cal enrollees in Kern County. The Kern County Board of Supervisors established KHS in 1993. The Board of Supervisors appoints a Board of Directors, who serves as the governing body for KHS.

The purpose of the Utilization Management (UM) Program is to provide members with comprehensive health care and health education, within available resources, and to achieve the optimum level of quality health care in a cost-effective manner. Coordination with various internal departments such as Case Management, Pharmacy, Disease Management, and Health Education, and partnering with our contracted and community entities assists KHS with the provision of a holistic and patient centered approach to providing health care to our membership. Success of the UM Program begins with positive patient-practitioner relationships and depends, not on the portioning of services, but on the management and delivery of medically necessary, cost-effective health care designed to achieve optimal health status.

In order to ensure efficiency and continuity in this program, policies and procedures have been developed to define major functions and accountabilities. All activities described in the UM Program are conducted with oversight by the Quality Improvement/Utilization Management (QI/UM) Committee.

Most requests for routine, non-emergent medical care (unless otherwise specified) are authorized prospectively by the UM department for Kern Family Health Care (KFHC) members. Prior authorization is required for specific identified services in order for that care to be covered by Kern Health Systems (KHS). Authorization may also be obtained verbally from the KHS Chief Medical Officer or their designee(s) or a UM Nurse or Clinical Intake Coordinator. Exceptions to the requirement for prior authorizations include but are not limited to: Primary Care Provider Services, specific OB/GYN services, Abortion Services, Treatment for Sexually Transmitted Diseases, HIV Services, Family Planning Services, Maternity Care, Vision, Sensitive Services, Emergent Care, and other procedures as identified.

The UM department nursing staff function primarily as Clinical Intake Coordinators evaluating utilization of services, while providing ongoing monitoring of patient care for quality and continuity in collaboration with the QI department. Authority to accomplish this is delegated to UM department staff by the KHS Chief Medical Officer, or designee (Medical Director or the Associate Medical Director). Essential to this process and success is strong support and understanding of the UM Program by the KHS Chief Medical Officer, Medical Director(s), and Board of Directors. The KHS Utilization Management Program Description is a written description of the overall scope and responsibilities of the UM Program. The UM Program clinical team actively monitors, evaluates, and takes effective action to address any needed improvements in the quality, appropriateness, safety and/or outcomes of covered health care

services delivered by all contracting providers rendering services to members. This is done through the development and maintenance of an interactive health care system that includes the following elements:

- The development and implementation of a structure for the assessment, measurement and problem resolution of the medical , behavioral health, and vision needs of the members;
- To provide the process and structure for monitoring contracted providers referral patterns;
- To provide oversight and direction for processes affecting the delivery of covered health care to members, either directly or indirectly;
- To ensure that members have access to covered health care in accordance with state legal standards;
- To monitor and improve the quality and safety of clinical care for covered services for members.

Purpose

The UM Program is comprised of various systems and processes which interface with other departments and administrative systems in the delivery of quality and value enhanced care. The link between UM and other administrative systems must be collaborative in order to deliver quality care and have effective resource management.

- Provide the coordination of medically necessary services to all KFHC; members as defined by contractual obligations under the Department of Health Care Services, Department of Managed Care, and the regulations outlined in our Knox-Keene license in the State of California; and KHS Policy and Procedures;
- Monitor appropriateness of medical care and related services delivered to KFHC members;
- Provide systematic monitoring of the delivery of medical care and related services in a timely, effective, efficient manner consistent with the delivery of high quality and value enhanced care;
- Continually monitor, evaluate and optimize health care resource utilization and medical outcomes;
- Monitor utilization practice patterns of practitioners and provider organizations;
- Identify the need for case management through the referral/authorization review process;
- Educate members, practitioners and provider organizations of objectives for providing high quality and value enhanced managed health care; and
- Identify potential quality of care issues.

Objectives

The KHS UM Program develops, implements, continuously updates, and annually improves a UM program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services.
The UM program includes:

- Qualified clinical staff responsible for the UM program;
- Separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management concerns. The provision for a second opinion from a qualified health professional is provided at no cost to the Member;
- Established criteria for approving, modifying, deferring, delaying, or denying requested services.

The KHS UM Program utilizes nationally recognized evaluation criteria and standards in making decisions to approve, modify, defer, or deny services. The KHS UM Program will also review and present internally generated and other outside criterions the QI/UM Committee for direction in the development and/or adoption of specific criteria to be utilized by the KHS UM staff.

When making medical-necessity decisions, UM staff obtains relevant clinical information to finalize UM decisions. 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:

- History and physicals
- Progress notes
- Diagnostic results, such as laboratory results, or x-rays
- Specialty Consultation reports
- Telehealth communications
- Hospital records
- Physical/Occupational therapy notes
- Behavioral Health/Mental Health
- Telephonic and fax reviews from inpatient facilities

The KHS UM Program verifies that its pre-authorization, concurrent reviews, and retrospective review procedures, meet the following minimum requirements:

- Qualified health care professionals supervise review decisions, and a qualified physician will make the determination to deny any services based on medical necessity;
- Annual competency evaluation for all clinical staff assigned to medical necessity determinations;
- There are a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed and updated;
- Reasons for decisions are clearly documented and communicated to the provider and member.

The KHS UM Program utilizes several approved sources to determine benefit coverage and to make decisions based on medical necessity. Many decisions are outlined in state regulatory guidelines and law. In addition, clinical guidelines are available as a guide for medical-necessity

decisions. Medical judgment regarding the particular patient is also considered when making decisions. Regulations and guidelines areas are as follow:

Regulations

- California Code of Regulations Title 22
- California Code of Regulations Title 28
- California Code of Regulations Title 42
- California Health and Safety Code §§1363.5; 1367.01; 1371.4; 1374.16
- MCG Hearst Health Network
- Lippincott Care Plan Guidelines
- Medi-Cal /Medicare Guidelines
- KHS Internally generated Medical Criteria
- DHCS/DMHC Guidelines
- All Plan Letters (APL)

Scope

Kern Health Systems Utilization Management Program provides comprehensive health care services. The scope of covered services defined by the UM Program includes

- Prior authorizations/referral management
- Primary and Specialty Care
- Tertiary referral coordination
- Behavioral/Mental Health management
- Autism Spectrum Disorder Management
- Concurrent review
- Retrospective review
- Recommendations for policy decisions
- Guidance of studies and improvement activities
- Case management
- Community Based Adult Services
- Maternity Care
- Gender Dysphoria
- Acupuncture
- Chiropractic
- Discharge planning/Rehabilitation Services
- Prescription Drug Program in coordination with the Director of Pharmacy
- Out-of-area Case management
- Emergency service management
- Emergent/Non-emergent Medical Transportation
- Ancillary service management
- Home Health
- Hospice Services

- Palliative Care
- Diagnostic Services; including laboratory, radiology, and genetic counseling
- Inpatient certification
- Skilled Nursing and Long Term Care
- Denial/appeals management
- Utilization data management
- Social Services (i.e. tracking of appropriate usage of services, mental health service assistance, social services assistance
- After Hours Nurse Triage Services
- Recommendations for any additional needed actions

The UM Program addresses the technical, professional and clinical aspects of patient care, which includes but is not limited to:

- Indication for services
- Fraud, waste, and abuse monitoring
- Efficient ordering practices
- Appropriate level(s) of hospital care
- Appropriate and efficient use of resources
- Effective coordination and communication
- Reduction in the duplication of services
- Timeliness and access to care
- Valid data management to include the following data sources:
  - Claims and encounter submission
  - Medical Records
  - Medical Utilization data
  - Pharmacy Utilization data
  - Predictive Modeler data
- Identification of potential quality of care issues

Collaboration of Services

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

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

KHS is required to provide beneficiaries with the completion of certain covered services that the beneficiary was receiving 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 the higher of the KHS's contract rates or Medi-Cal FFS 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 and the Department of Public Health, Department of Mental Health, Homeless Coalition, Department of Aging and Health and Human Services, California Children Services 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 in order 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) services with Kern Regional Center (KRC) 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 schedule Joint Operations Meetings are held to promote coordination, quality, and timely decisions regarding member's identified needs.

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 schedule Joint Operations Meetings are held to promote coordination, quality, and timely decisions regarding member's identified needs.

Member health education and disease management is an important component in member Case Management. Improvement of the member's health is a collaborative effort between the member, KHS Health Education, UM Nurse and Clinical Intake Coordinator, Community partnerships and the member's practitioner.

Authority and Responsibility

KHS Board of Directors

The Board of Directors for KHS assigns the responsibility to lead, direct, and monitor the activities of the UM and QI Programs to the QI/UM Committee. The QI/UM Committee is responsible for the ongoing development, implementation, and evaluation of the UM and QI Programs. All the activities described in this document are conducted under the oversight of the QI/UM Committee.

Structure

1 Board Chair
1 Rural PCP Representative
1 Urban PCP Representative
1 Safety Net Provider Representative
1 Hospital Representative
1 Pharmacist Representative
2 1st District Community Representative
2 2nd District Community Representative
2 3rd District Community Representative
2 4th District Community Representatives
2 5th District Community Representatives

The Board is directly involved with the UM process in the following ways:

- Approve and support the UM Program direction, evaluate effectiveness and resource allocation. Support takes the form of establishing policies needed to implement the plan;
- Appoint individual and/or departments within the KHS organization to provide oversight of the UM Program;
- Approve policies and procedures needed to maintain the UM Program;
- Receive and review periodic summary reports on quality and safety of clinical care and quality of service, and make decisions regarding corrective actions that require the Board's level of intervention;
- Receive, review, and make final decisions on issues involving provider credentialing and recredentialing recommendations from the Physician Advisory Committee (PAC);
- Receive reports representing actions taken and improvements made by the QI/UMC, at a minimum on a quarterly basis;
- Evaluate and approve the UM Program Description annually;

- Evaluate and approve the UM Program Evaluation annually, providing recommendations as appropriate and track findings.

Monitor the following activities delegated to the KHS Chief Medical Officer or designee:

- Oversight of the UM Program
- Chairperson of the QI/UM Committee
- Chairperson of associated subcommittees
- Supervision of Health Services staff to include UM, QI, Pharmacy, Health Homes, Health Ed, Case and Disease Management;
- Oversight and coordination of Continuity of Care activities for members;
- Proactive incorporation of quality outcomes into operational policies and procedures;
- Oversight of all committee reporting activities so as to link information.

The Board of Directors delegate's responsibility for monitoring the quality of health care delivered to members to the Chief Medical Officer or designee, and the QI/UMC with administrative processes and direction for the overall UM Program initiated through the Chief Medical Officer.

Chief Medical Officer (CMO) Responsibilities:

The Chief Medical Officer reports to the Chief Executive Officer (CEO) and the KHS Board of Directors and, as Chairperson of the QI/UMC and Subcommittees provide direction for internal and external UM Program functions, and supervision of the KHS staff including:

- Application of the UM Program, by KHS staff and contracting providers;
- Participation in provider quality activities, as necessary;
- Monitoring and oversight of provider QI and UM programs, activities and processes including policies;
- Oversight of KHS delegated credentialing and recredentialing activities;
- Retrospective review of KHS credentialed providers for potential or suspected deficiencies related to quality of care;
- Final authority and oversight of KHS non-delegated credentialing and recredentialing activities;
- Monitoring and oversight of any delegated UM activities;
- Supervision of Health Services staff involved in the UM Program, including: Administrative Director of Health Services, Director of Pharmacy, and other related staff;
- Supervision of all Utilization Management activities performed by the UM Department;
- Monitoring that covered medical care provided meets industry and community standards for acceptable medical care;
- Actively participating in the functioning of the plan grievance procedures;
- Resolving grievances related to medical quality of care.

Medical Director and/or Associate Medical Director(s):

The Medical Director and/or Associate Medical Director(s) support the Chief Medical Officer with projects as assigned and serves the role of Chief Medical Officer in the CMO's absence or when the CMO's position is not filled. KHS may have one or more Associate Medical Directors performing the functions of the Medical Director when the Medical Director position is not filled. The Medical Director and or Associate Medical Director provide oversight for the following including:

- Serve as a member of the following committees of the KHS Board of Directors: Physician Advisory Committee; Pharmacy Committee; Quality Management, Grievance and Utilization Management Committees (Serve as Chairperson of these committees as delegated by CMO). Attend committee meetings as scheduled. Participates in carrying out the organization's mission, goals, objectives, and continuous quality improvement of KHS;
- Represents KHS in the medical community and in general community public relations;
- Participates in the implementation of the KHS Credentialing Program;
- Identify fraud, waste, and abuse through multi-disciplinary internal staff participation;
- Obtains support of the medical community for QI, UM, DM, HE, and CM programs;
- Directly communicates with primary care physicians and other referring physicians in order to resolve referral issues, research treatment protocols, solicit advice on problem cases, and to assist in development of referral criteria and practice guidelines;
- Supports, communicates, and collaborates with KHS Clinical Intake Coordinators and UM Nurses in order to resolve case management and referral issues;
- Implements the Disease Management and Quality Improvement Program

Program Structure

Committees

Quality Improvement/Utilization Management (QI/UM) Committee

The QI/UM Committee reports to the Board of Directors and retains oversight of the UM Program with direction from the CMO or designee. The QI/UM 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, subcommittees and internal KHS functional areas with oversight by the CMO.

Key Responsibilities

- Assure that practitioner/provider organizations participate in specific QI/UM activities as assigned;
- Oversee the effectiveness of UM activities within KHS (internal and external);

- Review, investigate and make recommendations to the appropriate individual or department regarding utilization issues affecting member care; or, in the case of review of individual practitioners/provider organizations performance, refer such review/investigation to the CMO /Physician Advisory Committee (PAC) Corrective Action Plans (CAP);
- Promote communication of UM activities across KHS and to practitioner/provider organizations;
- Maintain processes to promote confidentiality of the UM Program information as well as avoidance of conflict of interest on the part of practitioner reviewers;
- Identify methods to increase the quality of health care and service for members;
- Design and accomplish UM Program objectives, goals and strategies;
- Recommend policy direction;
- Review and evaluate results of UM activities at least annually and revise as necessary;
- Institute needed actions and ensure follow-up;
- Develop and assign responsibility for achieving goals;
- Monitor clinical safety;
- Oversee the identification of trends and patterns of care;
- Monitor grievances and appeals for clinical issues;
- Develop and monitor Corrective Action Plan (CAP) performance;
- Report progress in attaining goals to the Board of Directors;
- Ensure incorporation of findings based on member and provider input/issues into KHS policies and procedures;
- Provide oversight for the KHS UM Program;
- Provide oversight for KHS credentialing;
- Assist in the development of clinical practice guidelines.

Structure

1	KHS Chief Medical Officer(Chairperson), or designee
2	Participating Primary Care Physician-Family Practitioner and Pediatrician
2	Participating Specialty Physicians-OB/GYN and ENT
1	Participating Home Health Representative
1	Kern County Public Health Officer or designee
1	Participating Mid-Level Practitioner
2	Other Participating Ancillary Representatives
1	Participating Hospital Representative

The QI/UMC is responsible for periodic assessment and review of subcommittee activities and recommendations for changes, with subsequent reporting to the Board of Directors at least quarterly.

Meeting Schedule

The QI/UM Committee meets at least quarterly, but as frequently as necessary to demonstrate follow-up on all findings and required actions. Issues needing immediate assistance that arise prior to the next scheduled meeting are reviewed by the CMO and reported back to the QI/UM Committee when applicable.

Physician Advisory Committee (PAC)

Key Responsibilities

- Serve as advisor to the Board of Directors on health care issues, peer review and provider discipline. Review and comment on Credentialing/Recredentialing Policies and Procedures;
- Review and comment on other issues such as grievances and/or appeals, provider quality issues, and other peer review matters as directed by the KHS Chief Medical Officer or designee or as requested by the Board of Directors;
- Perform assigned functions under the Credentialing policies and procedures, the QI program, the UM program, the complaint/grievance process, and the practitioner/provider organizations appeal process;
- Serve as the committee for clinical quality review of contracting providers;
- Evaluate, assess and make decisions regarding contracting provider issues, grievances and clinical quality of care issues referred by the KHS CMO or designee and develop and recommend actions plans as required;
- Review provider qualifications, including adverse findings and recommend to the Board of Directors approval or denial of participation with initial credentialing and every three years in conjunction with recredentialing. When indicated, the time frame form credentialing/recredentialing may be shortened. Report Board action regarding credentialing/recredentialing to the QI/UMC at least quarterly;
- Review contracting providers referred by the KHS CMO or designee due to grievance and/or complaint trend review, other quality indicators or other information related to contracting provider quality of care or qualifications;
- Review, analyze and recommend any changes to the KHS Credentialing and Recredentialing program policies and procedures on an annual basis or as deemed necessary;
- Monitor any delegated credentialing/recredentialing process, facility review and outcomes for all delegated actions related to providers;
- Review and distribute preventive care guidelines for members, including infants, children, adults, elderly, Seniors and Persons with Disabilities, and perinatal patients;
- Base preventive care and disease management guidelines on scientific evidence or appropriately established authority;
- Develop, review and distribute disease management and behavioral health guidelines for selected diagnosis and treatments administered to members;
- Periodically review and update preventive care and clinical practice guidelines as presented by the CMO or designee;
- Review and assess new medical technologies and new applications of existing technologies for potential addition as covered benefits for members;

- Assess standards of health care as applied to members and providers, assist with development of indicators for studies and review guidelines that are promulgated to contracting providers;
- Assess industry and technology trends with updates to KHS standards as indicated.

The QI/UMC has delegated credentialing and recredentialing functions for KHS to the PAC. The PAC is responsible for reviewing individual providers for denial or approval of participation with KHS.

The PAC is charged with the assessment of standards of health care as applied to members and providers; assist with development of indicators for studies; and regularly review guidelines that are promulgated to contracting providers and members. This committee consists of a variety of practitioners in order to represent the appropriate level of knowledge to adequately assess and adopt healthcare standards. The committee obtains an external independent review and opinion when necessary to assist with a decision regarding preventive care guidelines, disease management or coverage of a new technology as a covered benefit for members.

The PAC reviews and comments upon pertinent KHS standards and guidelines with updates as needed. The PAC evaluates improvements in practice patterns of contracting providers and the development of local care standards. Development of educational programs includes input from the PAC. The PAC also reviews and comments on other issues as requested by the Board of Directors.

Structure

1	KHS Chief Medical Officer(Chairperson) or designee
2	General/Family Practitioners
1	General Internist
1	Pediatrician
1	Obstetrician/Gynecologist
1	Non-invasive Specialist
1	Invasive Specialist
1	Practitioner at Large

The PAC consists of a variety of practitioners to represent a broad level of knowledge to adequately assess and adopt healthcare standards.

Meeting Schedule
The PAC meets monthly or more frequently if necessary.

Reporting Relationship
- The PAC reports recommendations to the QI/UM Committee quarterly
- The QI/UM Committee reports PAC recommendations to the Board of Directors quarterly through the Chief Medical Officer or their designee.

Pharmacy and Therapeutics Committee (P&T)

Key Responsibilities

- Objectively appraise, evaluate and select pharmaceutical products for formulary addition or deletion. 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-formulary 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 Formulary;
- Review parameters of prescribing practices for frequency of refills and the number of refills that may be dispensed at one time;
- Make recommendations to the QI/UM Committee for prescribing parameters;
- Review quality of care issues that arise pertaining to the prescribing and dispensing of medications;
- Report to the QI/UM Committee situations that may indicate substandard quality of care.

Membership

1	KHS Chief Medical Officer (Chairperson) or designee
1	KHS Director of Pharmacy (Alternate Chairperson)
1	KHS Board Member
1	Retail/Independent Pharmacist
1	Retail Chain Pharmacist
1	Specialty Practice Pharmacist
1	Pediatrician
1	Internist
1	PCP/General Practice Medical Doctor
1	OB/GYN Practitioner

Meeting Schedule

The P&TC meets quarterly with additional meetings as necessary

Reporting Relationship

Reports to the QI/UM Committee quarterly

Public Policy/Community Advisory Committee (PP/CAC)

The PP/CAC provides a mechanism for structured input from members regarding how KHS operations impact the delivery of their care. The role of the PP/CAC is to implement and maintain community linkages.

The functions of the PP/CAC are as follows:

- Culturally appropriate service or program design;
- Priorities for health education and outreach program;
- Member satisfaction survey results;
- Findings of health education and cultural and linguistic Group Needs Assessment;
- Plan marketing materials and campaigns;
- Communication of needs for provider network development and assessment;
- Community resources and information;
- Periodically review the KHS grievance processes;
- Review changes in policy or procedure that affects public policy;
- Advise on educational and operational issues affecting members who speak a primary language other than English;
- Advise on cultural and linguistic issues.

The PP/CAC is delegated by the Board of Directors to provide input in the development of public policy activities for KHS. The committee makes recommendations and reports findings to the Board of Directors.

Appointed members include:

1	Ex-officio Non-Voting Member: KHS Director of Marketing and Public Affairs (Chairperson)
5	KHS Subscribers/Enrollees
2	Community Representatives
2	Participating Health Care Practitioner
1	Kern County Health Officer or Representative
1	Director, Kern County Department of Human Services or Representative

The PP/CAC meets at least quarterly with additional meetings as necessary.

Grievance Review Team (GRT)

The GRT provides input towards satisfactory resolution of member grievances and determines any necessary follow-up with Provider Relations, Quality Improvement, Pharmacy and/or Utilization Management.

Key Responsibilities

- Ensure that KHS' policies and procedures are applied in a fair and equitable manner;
- Hear submitted grievances in a timely manner and recommend action to resolve the grievance as appropriate within the stipulated time-frame;
- Review and evaluate KHS' practices and procedures that consistently produce dissatisfaction, and recommend, when appropriate, modification to such practices and procedures;
- Participate in the State Fair Hearing process as warranted to resolve grievances;
- Provide prompt and accurate information to the member detailing the resolution outcome of the grievance.

Structure

1	KHS Chief Medical Officer (Chairperson) or designee
1	KHS Director of Compliance and Regulatory Affairs
1	KHS Director of Provider Relations
1	KHS Chief Operations Officer
1	KHS Grievance Coordinator (Staff)
1	KHS Quality Improvement, Health Education and Disease Management representative(s), or designee(s)
1	KHS Director of Pharmacy
1	KHS Administrative Director of Health Services, or designee
1	KHS Director of Member Services

Meeting Schedule Grievance Review Team meets on a weekly basis or sooner if necessary.

Program Staff Responsibilities

Chief Executive Officer (CEO)

Appointed by the Board of Directors, the CEO has the overall responsibility for KHS management and viability. Responsibilities include:

- Lead KHS mission, vision and direction, organization and operation;
- Developing strategies for each department including the QI Program; Human Resources direction and position appointments;
- Fiscal efficiency;
- Public relations;
- Governmental and Community liaison;
- Contract approval.

The CEO directly supervises the Chief Operating Officer (COO), Chief Financial Officer (CFO), Chief Medical Officer (CMO), Chief Information Officer, and the Director of Governmental Affairs and Business Development. The PAC reports to the CEO and contributes information regarding provider issues. The CEO interacts with the Chief Medical Officer regarding ongoing QI/UM Program activities, progress towards goals, and identified health care problems or quality issues requiring corrective action.

Chief Medical Officer (CMO)

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

As Chairperson of the QI/UM Committee and associated committees, the CMO provides assistance 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 Director of Provider Relations with provider network development and works with the CFO to ensure that financial considerations do not influence the quality of health care administered to members.

The duties of the position include:

- 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;
- Medical oversight on provider selection, provider coordination, and peer review;
- Principal accountabilities include development and implementation of 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).

Medical Director and /or Associate Medical Director

- Ensure that medical decisions are rendered by qualified medical personnel;
- Are not influenced by fiscal or administrative management considerations;
- Ensure 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;

- Develop and implements medical policy;
- Resolve grievances related to medical quality of care and service;
- Actively participate in the functioning of KHS' grievance procedures and implementation of the plan Quality Improvement Program;
- Provide direction and oversight to administration of the QI, UM and Credentialing Programs;
- Detect and correct inadequate practitioners/provider organizations performance within responsibility level Supports the CMO with projects as assigned

Administrative Director of Health Services

Position requires a licensure to practice as a Registered Nurse in the State of California. Qualifications for the Director of Health Services include two years of management level experience in utilization management in managed care environment AND one year of experience as a utilization review or medical (physical medicine) nurse OR four years of experience as a utilization review or medical (physical medicine) nurse AND two years of supervisory experience; OR any equivalent combination of experience. A Bachelor's degree in Nursing is desirable.

The Administrative Director of Health Services reports to the CMO or designee and is responsible for managing the functions and activities associated with the health services department within KHS to ensure appropriate medical care is provided by the health plan's network of providers. The Health Services Department includes: Utilization Management, Case Management, Quality Improvement, Disease Management, Health Education, and Pharmacy.

The Administrative Director of Health Services will provide direct clinical support to the UM Nurse and Clinical Intake Coordinators, Health Services Manager, Health Services Program Administrator, Business Analyst, and the UM Clinical Inpatient and Outpatient Nurse Supervisor(s), ensuring that the appropriate level of member care is being provided through referral processing.

Monitoring of case management activity and accuracy of decision making is reported to the executive team. This position will also ensure that direct interaction between the UM and QI departments occurs to facilitate identification of Health Education, Case Management and Disease Management opportunities for medical service referrals such as diabetes and asthma control. Ongoing development and monitoring of activities related to identification and tracking of members needing disease management, case management, behavioral health or autism services, tracking of inpatient members including authorizations of level of care, appropriateness of admissions to non-par facilities and timely transfer to participating facilities are critical to the effectiveness of the UM program.

- Establish, initiate, evaluate, assess, and coordinate processes in the areas of Utilization Management;
- Develop, draft, and implement policy and procedure changes to ensure compliance with DHCS and DMHC contractual requirements;

- Assist in the delivery of the KHS UM Program by collaborating activities pertaining to the quality of care;
- Ensure Parity for both medical and behavioral or mental benefit execution;
- Monitors activities of the Health Services Department to ensure compliance with State regulatory agencies;
- Provides liaison support for the CMO, Director of Pharmacy and contract providers and facilities;
- Providers direction to the UM and CM Clinical Nurse Supervisor(s) and clinical staff;
- In coordination with the CMO, develops internal criteria for use by UM Nurse and Clinical Intake Coordinators;
- Participates and drafts Memorandum of Understandings (MOU) with various community and state regulated agencies to promote coordination of care and carved out services not covered as benefits under the Kern Health Systems health plan.

Health Services Manager

The Health Services Manager reports to the Administrative Director of Health Services 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 Business Analyst and Health Services Program Administrator. 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.

- 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;
- Responsible for payroll activities, including approval of time cards, for all clerical hourly staff in the UM;
- 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 MHC systems as it relates to the UM and Pharmacy processes;
- Generates reports for CMO and Administrative 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 Business Analyst(s) and Health Services Program Administrator;

- Works in collaboration with the Health Services Program Administrator to develop and facilitate new program processes and guidelines under the supervision of the Administrative Director of Health Services

UM Outpatient Clinical Supervisor

The UM Outpatient Clinical Supervisor reports to the Administrative Director of Health Services and is responsible for supervising the functions and activities for clinical level positions associated with Outpatient Medical, Behavioral, and Social Services within the UM Department. The UM Outpatient Clinical Supervisor will work in a coordinated effort with the Health Services Manager to ensure smooth, efficient and productive operations within the UM Department, as directed by the Administrative Director of Health Services. 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.

- Educate and develop UM nursing staff regarding organizational policies, procedures and UM decision making skills;
- Monitor the UM case management 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 clinical staff, including CMO and Medical Directors to facilitate consistent decisions based on evidence based guidelines;
- Supervise the appropriate case management in compliance with UM guidelines and KHS Policy and Procedures;
- Monitors and reports production and quality of work by outpatient clinical staff;
- 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 outpatient 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 Member Services, Claims, MIS, and Provider Relations on referral data entry functions.

UM Inpatient Clinical Supervisor

The UM Inpatient Clinical Supervisor reports to the Administrative Director of Health Services and is responsible for supervising the functions and activities for clinical level positions

associated with Outpatient Medical, Behavioral, and Social Services within the UM Department. The UM Outpatient Clinical Supervisor will work in a coordinated effort with the Health Services Manager to ensure smooth, efficient and productive operations within the UM Department, as directed by the Administrative Director of Health Services. 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.

- Educate and develop UM nursing staff regarding organizational policies, procedures and UM decision making skills;
- Monitor the UM case management 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 clinical staff, including CMO and Medical Directors to facilitate consistent decisions based on evidence based guidelines;
- Supervise the appropriate case management in compliance with UM guidelines and KHS Policy 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 Case Management Supervisor to facilitate needs for members identified as High Risk or requiring coordination of services;
- Assist the UM clinical staff in the review of claims for the accuracy and appropriateness of billed charges;
- In coordination with the UM Auditor, perform periodic audits of the UM Nurse RN and Social Workers 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 Member Services, Claims, MIS, and Provider Relations on referral data entry functions.

Health Services Program Administrator

The Program Administrator is responsible for oversight, coordination, planning, management, execution, and finalization of Business related programs that require Business resources. The Program Administrator will be required to conduct program analysis, comprehend technical requirements, define plans for execution, coordinate technical resources assigned to tasks or programs, create program tracking reports, and accurately report to all levels of management on a program(s) status. This position requires the ability to maintain an interdependent relationship with providers, staff and members by providing administrative support on sponsored projects.

- Consult with medical, business, and community groups to discuss service problems, respond to community needs, coordinate activities and plans, and promote programs;
- In a liaison role, assist in the design, review and testing of system generated processes used within KHS;
- Works closely with the MIS Department as needed to ensure proper processing of internal data processing technology, government regulations, health insurance changes and financing options;
- Interviews department personnel, researches existing procedures and requirements in sufficient detail to yield statistics concerning volumes, timing, personnel requirements and representative transactions; analyzes and documents study findings; coordinate the system design between all users and data processing; designates controls and audit trails; writes program specifications; conducts user education
- Review and analyze facility activities and data to aid planning and cash and risk management and to improve service utilization;
- Act as a program management resource for Health Services on projects as assigned and may have to establish objectives and evaluative or operational criteria;
- Evaluate KHS Health Services preparedness recommend/suggest change in integrated health care delivery systems, such as work restructuring, technological innovations, and shifts in the focus of care;
- Participate in the preparation of business plans, analyses, financial projections, and programmatic and operational reports; work with internal teams to develop and implement strategic initiatives for any issues that may require root cause analysis evaluation(s);
- Demonstrate an analytical aptitude to learn and understand business segment processes, including understanding issues of data integrity, security and confidentiality according to the Health Insurance Portability and Accountability Act (HIPAA).

Business Analyst

This position is responsible for providing an advanced role in the analysis of health care information as it relates to multiple disciplines for functional departments within the

organization. The Business Analyst (BA) position is a resource with an ability in providing experience within integrated reporting, data analytics, process improvement, departmental metrics, and data integrity based on the collection, association, review, and the interpretation of data and operational processes. The BA will provide the skills necessary for report writing and presentation, and performs detailed business analytics that contribute to and support the company's dashboard reporting efforts.

The Business Analyst is responsible for eliciting and projecting the actual needs of stakeholders, not simply their expressed desires, through an experienced methodical analytic process and seasoned ability to expose data reporting requirements. The position plays a central and critical role in aligning the needs of multiple business units with capabilities delivered by Information Technology and other operational departments, and will lead or facilitate complex analytical discussions between all groups.

Some of the key fundamental goals and objectives of the incumbent include but are not limited to:

- Providing professional skills to mentor and assist team members in the most complicated analytics and report writing;
- Perform complex analytics in support of the overall achievement of strategic goals set out by the Board of Directors and Chief Executive Officer;
- Identify and address operational issues as to why a certain behavior or outcomes are exhibited in a department's data metrics;
- Ability to analyze and answer difficult operational questions under the direction of the Chief Medical Officer to provide validity as to why a certain measured artifact exists in data and brings meaningful context with a clear presentation to all levels of management.

<u>UM Nurse and Clinical Intake Coordinators (RN /LVN)</u>

Under the direction of the Kern Health Systems (KHS) Chief Medical Officer or designee and Administrative Director of Health Services, 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 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 on a monthly basis.

- Promote coordination and continuity of care and quality improvement in both the inpatient and ambulatory care setting;
- Evaluate the appropriateness of care using established criteria and KHS' benefit guidelines;
- Review and approve specialty and ancillary service referrals using established criteria for purposes of pre-authorization of payment;
- 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, Long Term Care, State Waiver Programs;
- Participates in UM and QI data and statistical gathering, collation, and reporting.

UM Clinical Auditor/Trainer (RN)

- Train other UM clinical licensed staff as appropriate regarding use of the 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.
- Assist the UM clinical staff in the review of claims and disputes for the accuracy and appropriateness of billed charges;
- In coordination with the UM Senior Auditor/Analyst, perform spot audits of performance of UM Clinical Intake Coordinators and Social Workers and summarize and report the results of the audit to UM Management for process improvement;
- Perform periodic spot audits of inpatient and outpatient clinical decisions for appropriateness and accuracy of documentation; Assists in data collection and compilation, of various committee and quarterly reports; and
- Summarize and prepare necessary production reports for management.

Claims and Disputes Review Nurse (RN)

Under the direction of the Administrative Director of Health Services and in coordination with the Kern Health Systems (KHS) Chief Medical Officer or designee, the Medical Claims Review RN will be responsible for retroactive review of medical service claims and disputes for payment and medical necessity following accurate contract and non-contract guidelines for both Inpatient and Outpatient services. The review will evaluate the appropriateness of care using established criteria and Plan benefit guidelines.

- Reports, track and documents all claims and disputes review activity in appropriate programs such as QNXT, as well as specially developed internal logs for tracking and trending purposes;
- Perform retro review and approval of specialty and ancillary services referrals using established criteria for purposes of payment;
- Perform retro review and approval of hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership;

- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan e.g. CCS, Long Term Care, State Waiver Programs.

UM Social Worker (MSW)/Licensed Clinical Social Worker (LCSW)

The Master of Social Worker or Licensed Clinical Social Worker primary duties are to identify and assist members that are displaying a complex variety of social and or emotional needs and usage of services reflective of abuse, lack of compliance to medical or pharmaceutical instructions, or self-destructive habits. The MSW or LSCW coordinates with these members and the member's PCP in an effort to provide better medical management and to track and gauge the effectiveness of that effort.

- Responsible for the promotion of coordination, continuity of care and quality improvement in both the inpatient and ambulatory care settings;
- Assists the members with psychosocial and discharge planning needs as well as community resources;
- Performs reviews available reports for frequent usages of services and inappropriate usage of services by members; Identifies environmental impediments to client or patient progress through both personal or telephonic interviews and review of medical records;
- Investigates suspected child/elder abuse or neglect cases and notify authorized protective agencies when necessary.
- Refers member to community resources to assist in recovery from mental or physical illness and to provide access to services such as financial assistance, legal aid, housing, or education.
- Advocates for members to resolve crises and demonstrate proficiency in de-escalation and interventional techniques
- Provides assistance and education to members as appropriate and in coordination with disease management, works to improve member participation in regular testing and screening along with follow-up visits to their PCP;
- Works collaboratively with the Care Management team to assist with identified social issues;
- Provide guidance and recommendations for the Behavioral and Mental Health Benefits, including Autism Spectrum Disorders.

UM Senior Analyst/Trainer

The purpose of this position is to provide support to the UM Management team for report generation, data collection for providing to the UM Auditor for review. Based on feedback from the UM Auditor, management and clinical staff, assist in training criteria for staff improvement along with providing one-on-one training to improve staff efficiencies.

- Performs utilization management activities related to data collection, data review and report preparation per KHS Utilization Management Program;
- Assists in the reporting of DHCS and DMHC required reports and Utilization Management's quality studies in order to meet State contractual requirements.
- Develop and implement staff training for new and existing employees along with internal findings as it relates to the duties of Utilization Management.

UM Senior Auditor/Analyst

This position provides the vital link between inpatient and outpatient as it relates to case managing members moving from hospital to home care. This position will ensure that processes are in place and followed in support of all members seeking care. This is a proactive audit of UM processes as they are in motion to catch and prevent errors. This position will link the social worker, case managers and medical directors in direct support of members under case management.

- Performs audit of staff referral processing as it relates to compliance, accuracy and performance levels;
- Reviews available reports and data to analyze the accuracy of staff performance as it relates to timeliness of referral processing, accuracy of data entry and appropriateness of decisions;
- Reviews post-activity audit findings to UM Management to insure compliance and to review where further training opportunity exist.

UM Non-Clinical Intake Coordinators (NCIC)

The Non-Clinical Intake Coordinators support the Clinical Intake Coordinator staff in the processing of Health Plan referrals for medical services, durable medical equipment, and specialty care. This position will provide the UM Department with administrative support in the implementation of the authorization process to ensure accuracy of service determinations, limitations of Health Plan coverage, and timeliness in the communication and decision-making process. This position will play a key role as provider and member liaison to the KHS UM process.

- Support licensed UM staff in the processing of KHS referrals for specialty care and services;
- Provide technical support in the form of call screening, authorization and precertification data entry, documentation, and member and practitioner liaison to the KHS UM process;
- Act as liaison to KHS members, community providers, and employees to the UM clinical staff;
- Assigns diagnostic and procedural codes using ICD-10, and CPT coding classification system for service requests. Requests input from the Clinical Intake Staff when needing direction or clinical expertise; Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan (e.g. CCS, Long Term Care, and State Waiver Programs);
- Perform referral screening for Auto-Authorization, requested procedure validation to criteria and preparatory review for Nurse review and validation.
- Support licensed staff in review, validation and initial data entry of referrals and inpatient processing. Provide clerical support in data entry, letter generation and closeout of Referral and Inpatient processes.
- Provides clerical support to the UM Staff in the form of faxing, filing, mail processing, referral retrieving, and telephone screening in addition to staff assignment of incoming referral authorization requests from providers via the fax or electronic online authorization platform for review via the electronic workflow process.

UM Case Management Manager

Responsible for oversight of Complex Case management (CCM) activities specific to the Seniors and Persons with Disabilities (SPDs) and Medicaid populations.

- Maintains overall responsibility for staff coverage and assignments related to case management activities.
- Provides direction and acts as resource to Case Management staff in terms of contract and benefit clarifications.
- Key clinical and operational liaison for any subcontracted vendor services related to case management activities.
- Assist with the effective implementation of new programs, i.e. specialty clinics, homeless collaborative, and health home member engagement and reporting;
- Keeps KHS Finance Department continually informed of trends, high cost cases and possible reinsurance cases.

UM Case Manager (RN)

The UM Case Manager, RN is responsible for providing complex case management (CCM) Complex case management within KHS as identified through predictive modeling tool and ad hoc review to provide coordination of care and services for members who need help navigating the healthcare system to facilitate the appropriate delivery of care and services. These services are provided utilizing available resources across a continuum of care and in collaboration with members, caregivers, medical home providers, and ancillary health care providers. Assessments, including care plan creation and educational support to both the member and the provider network are critical to ensuring the continuum of care associated with all aspects of benefit coverage. Identification of homelessness and the provision of resources to improve health outcomes are a major focus.

UM Case Management Assistant

The UM Case Management Assistant supports the clinical Case Management staff in all activities related to case management and care coordination within the department. The Case Management Assistant will help members navigate the healthcare system and obtain the best care in the most appropriate setting. Appointment reminder calls, pharmaceutical utilization review, and transportation coordination are critical to member's access to medically necessary services.

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 while concurrently managing the total cost of care.

- Participates and serves as the Chairperson on the Pharmacy & Therapeutics Committee. Offers direction for the Committee for continued development of the Formulary.
- Assists providers and members with issues concerning pharmaceuticals. Review of Treatment Authorization Request (TAR) for approval or denial. Encodes TAR information in Pharmacy Benefit Manager desktop system.
- Develops and maintains printed Formulary for providers. Contributes information on Formulary for provider newsletters.
- Accountability for maintaining drug expenditure within an established pharmacy budget
- 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
- Oversight of clinical programs with supervision of the Pharmaceutical Program prior authorization process enabling open lines of communication with pharmacy providers on issues related to the KHS Formulary, pharmacy policies and procedures
- Oversight and management of all clinically related activities with the KHS Pharmacy benefits staff.

Pharmacist

This position is responsible for executing the adherence of the Formulary and associated activities regarding pharmaceuticals for a Knox-Keene licensed health maintenance organization (HMO). Development and maintenance of protocols for disease state management that involves pharmaceuticals while serving as a liaison with pharmaceutical vendor representatives and other vendor representatives regarding pharmaceutical issues is critical to ensure appropriate medication decision making.

Pharmacy Technician

Support the KHS Director of Pharmacy in pharmacy activities related to the review, authorization and TAR preparation. These activities are under the direction of the Director of Pharmacy The Pharmacy Technician assists the Director of Pharmacy and, as necessary, communicates follow-up to members, perform data entry, record keeping, data collection, filing, chart audits, collaboration with other departments at KHS and interaction with regulatory and contracted agencies. The Pharmacy Technician has a current CA Technician license or Certified Pharmacy Technician certificate with at least three years of pharmacy technician experience.

Pharmacy Senior Support Clerk

Assists in the coordination of Pharmacy activities related to data collection, data review, data entry, and report preparation.

UM Department Orientation/Onboarding

Upon completion of the company orientation provided by Human Resources, all new employees assigned to UM and Pharmacy are greeted by the Health Services Manager or designee who then provides initial department orientation. For clerical level staff, the UM Senior Analyst/ Trainer will begin the training process dependent on the role the employee is moving into. For clinical staff (nurses) the UM Clinical Trainer works collaboratively with the Outpatient and Inpatient Clinical Supervisor(s) to complete the orientation process which include introductions to policy and procedures, guidelines and information pertaining to the role of Clinical Intake Coordinator or UM Nurse. Initial training on referral or inpatient processing is cooperative and slowly migrated to allow the new employee autonomy into their role based on their level of understanding and competence demonstrated for the process.

Ongoing Training

KHS provides and encourages ongoing staff training. Areas of opportunity includes: seminars, conferences, workshops, training by KHS Health Education department, and specialty specific training by contracted practitioners and provider organizations. The role of UM Senior Analyst /Trainer and Clinical Auditor/Trainer receives direction on the training needs of specific staff members from the Health Services Management leaders where areas of improvement regarding error rates indicate the need for additional training of staff member(s).

KHS UM Management staff evaluates competency of the clinical decision making staff via the use of the MCG IRR training module for Medical Directors and Clinical Intake Coordinators and UM Nurse staff. The UM Clinical Supervisor(s) selects specific topics of interest to push out to the various Clinical Intake Coordinators and UM Nurse staff for completion. The IRR training module records the completion for each user, along with the test results.

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 inter-rater reliability 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 QI/UM Committee.

Components of the UM Program

The referral and authorization process conforms to the requirements outlined in the following statutory, regulatory, and contractual sources:

- Code of Federal Regulations Title 42 §§431.211; 431.213; and 431.214
- California Health and Safety Code §§1363.5; 1367.01; 1371.4; 1374.16
- California Code of Regulations Title 28 §1300.70(b) and (c)
- California Code of Regulations Title 22 §§51014.1; 51014.2; and 53894
- 2010 DHCS Contract Exhibit
- DHCS MMCD Letters

Pre-authorization

With the exception of OB/GYN, Abortion Services, treatment for Sexually Transmitted Disease, HIV services, Family Planning Services, Maternity Care, Vision, Mental Health, PCP services from a KHS contract PCP, and services listed outside of the Prior Authorization List, most non-urgent specialty care must be pre-authorized by KHS in accordance with KHS referral policy and procedures. There are excluded specialties that require prior authorization to ensure timely access, completion of conservative treatment regimens, and utilization data for staffing model decisions. Requests for services are submitted either by fax or electronic online submission to KHS for review and processing.

For those services requiring pre-authorization, only KHS UM Clinical Staff and/or KHS Chief Medical Officer or designee may give authorization for payment by KHS. Only the KHS Chief Medical Officer, Medical Director or Associate Medical Director can request a modification of a referral or authorize the denial unless Administrative in nature.

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 applied as appropriate. Contract PCPs are obligated to utilize health care services for members provided by KHS contracted providers, and/or providers approved through the Utilization Management process, unless medical necessity or emergency dictates otherwise.

Concurrent Review

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 justify the continued level of care. The concurrent review process is conducted by California licensed Registered Nurses by review of the member's medial 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. Various hospitalist contracted providers support medical oversight at the local inpatient facilities. Through the hospitalist program, the UM Nurse can authorize referral requests on behalf of KHS for member discharge planning during non-business hours. Each referral authorization is faxed to KHS and processed by internal UM staff the next business day. All other hospitals not listed above are case managed directly by KHS UM Nurses.

Additionally, KHS Facility Based UM Nurses perform concurrent inpatient review for members in both acute and post acute local and out of area facilities. The purpose of the services was to provide real time record review and promote early discharge planning as well as assist with decreasing length of stay and facilitate services requested during the hospital admission. Members are also triaged in the ER to assist in decreasing unnecessary admissions through prompt recognition of services needed prior to receiving a retro notification from the hospital regarding an admission.

Retrospective Review

For those services requiring prior authorization, retrospective review for payment of claims is initiated when no prior authorization was obtained by the practitioner or provider organization. Retrospective review is also initiated for services performed by a non-contracted provider. Members, practitioners, and provider organizations are notified by mail of the UM/ claims decision.

Discharge Planning

UM Nurse staff and/or the UM Social Worker will assess member's post hospital continuing care needs and will collaborate with the provider organization's discharge planning staff to make arrangements for placement, DME, Home Health, specialist follow-up visits, and any other services pertinent to the member's recovery. Provision and coordination for immediate post discharge care through Respite, Pulmonary Rehabilitation, and Post Discharge Clinics are designed to address potentially avoidable readmission, recidivism, and improve health through member empowerment and early intervention.

Case Management

Case Management (CM) in the UM department is a diverse system of care coordination. Members with catastrophic illnesses are case managed by the UM Case Managers. This coordination of the member's care enables the case manager to assess individual need, identify and plan resources, monitor, track, and evaluate the care being provided. Case management for the member may be short term or ongoing based on their individual needs. CM coordinates all medically necessary services with the Care Management staff within QI to ensure that all appropriate services are reviewed and any identified barriers to care are removed.

Complex Case Management is the systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management. Basic Case Management means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered basic case management services.

Members in the Complex Case Management Group and members assigned to the Case Management Team will be assigned a Nurse Case Manager and respective support staff. The team will focus on comprehensive coordination of services based on patient-specific needs to improve increase the quality and impact of the health care and supportive services the member is receiving. This will be accomplished through:

- Promotion and support of the Medical Home as the source of the member's primary healthcare and source of specialty referrals, and enhancing this with the necessary social, care management and medical support to facilitate comprehensive patient-centered planning

- Identification and elimination of potential barriers to seeking and receiving appropriate care within their designated medical home (e.g., housing, transportation, child care, nutrition, mental and behavioral health needs, identification of culturally competent providers and appropriate access, discharge and transitional care planning, health education, etc.)

    Potential assessment and education modules may include:

    1. Social needs
    2. Medical and/or behavioral health home
    3. Appointment attendance
    4. Urgent symptom management
    5. Medication and treatment adherence
    6. Behavioral risk
    7. Condition-specific self-management

As a result of this assessment, the Case Manager will:

- Contact the Primary Care Physician as needed to identify areas where he/she would like assistance (e.g., improving medication compliance)
- Identify communication preferences when more than one provider is involved in the medical care (e.g., does the PCP prefer all coordination go through his/her office or should the disease manager reach out to the specialist as appropriate?)
- Determine the type and frequency of information the PCP wants going forward
- Develop the person-centered care plan in conjunction with the PCP using predictive modeling risk scores with clinical based rules and medical management platforms (e.g., Milliman Care Guidelines, KHS internal criteria, etc.)

The following processes and activities are in place for Case Management/Coordination of Care as part of the Transition of Care Program:

- Collaborate with PCPs for basic CM services
- Arrange and track referrals to specialists
- Track referrals and coordination of car for carved out and other out-of-network services and providers
- Medication reconciliation
- Identify community resources and refer members
- Offer health education services
- Implement continuous quality improvement activities

The Complex Case Management Group consists of members identified through a Predictive Modeler identifying high risk scores above 0.65. These members are stratified into the Complex Group monthly and are discharged by Disenrollment, Death, stratification or other criteria established by the Case Closure Policy, such as Achievement of documented targeted outcomes, member opting out of the program, the member is unable to be located, or determination by the case manager that he/she is no longer able to provide appropriate case management services (i.e.

due to member non-compliance, non-adherence to the plan of care). This last reason for case closure involves discussion and decision making between the Case Manager and the Medical Director.

The goal of the Case Management Department is to help members maintain optimum health and/or improved functional capability, educate members regarding their health and reinforce the PCP prescribed treatment plan. These efforts are anticipated to decrease costs and improve quality through focusing on the delivery of care at the appropriate time and in the appropriate setting.

The following processes and activities are in place for Case Management/Coordination of Care:

- Collaborate with PCPs for basic CM services
- Arrange and track referrals to specialists
- Track referrals and coordination of car for carved out and other out-of-network services and providers
- Identify community resources and refer members
- Offer health education services
- Emergency room avoidance program
- Homeless identification and care coordination
- Implement continuous quality improvement activities

Denial Process

All recommended denials are reviewed by the Medical Director, with the exception of administrative denials that are not based on medical necessity. Services denied, delayed, or modified based on medical necessity may be eligible for an Independent Medical Review. The referring practitioner, provider and member are notified of the denial through a Notice of Action (NOA) letter, translated in both English and Spanish.

Appeal Process

KFHC members are notified in writing of his/her right to appeal through the Member Grievance Process. The notice includes member's right to request a State Fair Hearing, member's right to represent himself/herself at the State Fair Hearing or to be represented by legal counsel, friend, or other spokesperson, the name, address, and phone number of KHS, toll free number for obtaining information on legal service organizations for representation, and the right to request an Independent Medical Review.

Practitioners/providers may submit a written dispute for referrals that have been denied. KHS has established a fast, fair and cost-effective dispute resolution mechanism to process and resolve practitioner/provider disputes. A practitioner or provider dispute is defined as "A contracted or non-contracted practitioner's or providers written notice to KHS seeking resolution of a contract dispute or denial of referral. The dispute must contain the practitioner/provider name, tax identification number, contact information, and a clear explanation of the issue and the practitioner/provider's position thereon." Additional medical information pertinent to the dispute should be included at that time. All disputes must be submitted to KHS within 365

calendar days of the date of KHS action, or in the case of inaction, 365 calendar days after the time for action has expired.

Coordination of Mental Health Services

KHS responsibilities are limited to mild to moderate mental health conditions rendered in the outpatient setting. Psychotropic drug therapy remains carved out and provided under the Fee for Service MCAL payment structure. Referrals for behavioral health services may be generated by the practitioner, KHS UM Social Workers, KHS' 24-hour contracted advice and triage nurses, school systems, employers, family, or the member. Members needing immediate crisis intervention may self-refer to the Emergency Room or to the Department of Mental Health, Crisis Stabilization Unit. This information is provided to the members through the member handbook, and periodically, through the member newsletter. Mental Health Services for Medi-Cal participants are a covered benefit as described under the Kern Health Systems Health Plan in the contract with the Department of Health Care Services (DHCS).

KHS administers the behavioral health care benefit in addition to contracting with the Kern Behavioral Health and Recovery Services (KBHRS) and other provider groups for their covered services. Behavioral health care quality issues are assessed through review of member grievances, member satisfaction study results, interactions with members, and meetings with KBHRS. KHS UM staff is available to assist KBHRS with complex cases and facilitate coordination and continuity of care between providers.

Behavioral Health Therapy (BHT)

Autism Spectrum Disorder (ASD) encompasses several conditions that were previously diagnosed separately: autistic disorder, pervasive development disorder not otherwise specified (PDD-NOS) and Asperger syndrome. Transition of eligible members who were currently receiving ABA treatment from the local Regional Center transitioned to coverage under KFHC in 2016. For those Kern Family Health Care members not currently receiving ABA treatment from the local Regional Center, Primary Care Providers or other specialists can submit a prior authorization request for the comprehensive diagnostic evaluation by a psychiatrist, psychologist, or neurologist. Upon completion of the Comprehensive diagnostic evaluation that results in a diagnosis of a qualifying ASD, ABA services will be reviewed in the usual manner as any other medical or behavioral service request to KFHC.

Patient Centered Medical Home

The Health Homes Program (HHP) is an option afforded to states under Section 2703 of the Affordable Care Act and Goal 1.1 of KHS Strategic plan. It allows states to create Medicaid Health Homes to; coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by beneficiaries with chronic conditions.

The HHP will be structured as a health home network with entities functioning as a team to provide whole-person care coordination as outlined by the Department of Health Care Services. These include but not limited to:

• *Improve care coordination*. A primary function of the HHP is to provide increased care coordination for individuals with chronic conditions. This increased care coordination will be

provided through HHP Services, which include homelessness, physical and behavioral health, and care coordination.

• *Integrate palliative care into primary care delivery.* To strengthen the foundation for palliative care delivery, palliative care will be included in an HHP member's needs assessment. Care coordinators may also emphasize the importance of using advanced directives and Physician Orders for Life-Sustaining Treatment (POLST) forms.

• *Strengthen community linkages within health homes.* Linkages to housing and social services are critical to providing comprehensive care coordination in HHP. Requirements for strong linkages to, and assistance and follow-up with, community resources will ensure that these resources are available to HHP members. In addition to linking and coordinating available social services, the multi-disciplinary care team will also encourage HHP members to participate in evidence-based prevention programs such as diabetes management and smoking cessation, and other available programs that are documented to use best practices and have positive outcomes. Information about the availability of these programs will be provided to the member.

• *Strengthen team-based care, including use of community health workers/promotores/other frontline workers.* HHPs will be required to have team-based care, including community health workers where appropriate. Because of the linkages to housing and other social services, and potential outreach activities, community health workers will have a role in providing HHP services.

• Improve the health outcomes of people with high-risk chronic diseases.

Medical Necessity Review Criteria

During the review/case management process, KHS UM department staff uses criteria to assist in the clinical appropriateness determination. The criteria used include, but are not limited to:

- Milliman Care Guidelines (MCG)– Updated annually by vendor in 1st Quarter
- Hospice Criteria – Updated by the Department of Health Services, current year at their discretion
- Durable Medical Equipment Criteria – Updated by the Department of Health Services, current year at their discretion.
- Medi-Cal Criteria – Updated by the Department of Health Services, current year at their discretion
- Medicare Criteria – Updated by the Center of Medicare Services, current year at their discretion
- Internally generated Medical Criteria derived from evidence based medical references and reviewed annually for revisions or appropriateness based on MCAL guidelines.

Clinical Practice Guidelines are developed using current published literature, current practice standards and expert opinions. They are directed toward specific medical problems commonly found with members. The PAC reviews and approves all Clinical Practice Guidelines and/or Preventive Health Guidelines prior to presentation to QI/UMC. The QI/UMC is responsible for

adopting and disseminating Clinical Practice Guidelines for acute, chronic and behavioral health care services. Guidelines are reviewed every two years and updated if necessary.

Review criteria are communicated to practitioners when KHS UM modify, delay, or deny referrals for services requested. The practitioners are notified during their office In-service and through KHS practitioner newsletters of the availability of KHS referral criteria.

Ensuring Appropriate Utilization

KHS monitors under- and over-utilization of services through various aspects of the UM process. Through the referral authorization process, the UM Clinical Intake Coordinator monitors under and over-utilization of services and intervenes accordingly.

- The UM department monitors underutilization of specialty referrals through collaboration with the QI department. The KHS QI department assist the UM department in monitoring and tracking of referrals to the specialist. The UM department also sends correspondence notifying the practitioners and members of the carved-out services and a reminder to see their primary care provider for all other health care services not addressed by the carved-out specialty care provider.
- Over-utilization of services is monitored through several functions. Reports are provided and reviewed by the PCP and KHS UM staff to analyze unfulfilled authorizations and determine interventions to ameliorate any identified adverse trends.

The KHS contracted advice and triage call center reports to KHS the utilization of Urgent Care Centers and Emergency Rooms. The report is reviewed for trending of ER and Urgent Care usage based on total usage compared against deferment back to the PCP and Home/Self Help care.

Hospitalizations are concurrently reviewed for appropriate length of stay and discussed during daily rounding meetings with the KHS CMO (or designee) if medical necessity cannot be established.

Request for prior authorization or the continuations of previously authorized services are tracked for duplication and appropriateness of continued use. Coordination of the member's health care as part of the targeted case management process serves to determine the medical necessity of diagnostic and treatment services recommended but may be covered services through Kern County Public Health, Kern Regional Center, or various community programs and resources.

Evaluation of New Medical Technologies

KHS utilizes Up-to-Date, a web-based interactive application providing support of current, upcoming and possible future medical technologies. Up-to-date is also an evidence-based, physician-authored clinical decision support resource which clinicians utilize to determine point-of-care decisions. UM clinical staff has direct access to various websites 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 MIS department develops and implements new technologies as they emerge to provide efficient methods of tracking member activity and report generation. Remote capability and Telemedicine is a growing trend in the evaluation of a member's health. This allows KHS additional options to serve members in rural areas to improve specialty access and reduce wait times.

Provider and Member Satisfaction

Member Satisfaction Surveys are conducted annually by the KHS Member Services and Provider Relations Department with results are shared with the UM Department. Any unsatisfactory areas of the UM process will be evaluated by the KHS Chief Medical Officer or designee and the Administrative Director of Health Services for process improvement.

KHS contracts with physicians and other types of health care providers. Provider Relations conducts assessments of the network 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.

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.

Pharmaceutical Management

KHS maintains a Formulary for the purpose of delineating specific prescribed treatments that are felt to be the most therapeutically efficacious and cost effective. The Board of Directors is ultimately responsible for supervising the Formulary Process. This responsibility is delegated, with certain restrictions, to the Pharmacy and Therapeutics Committee (P&TC). The P&TC is responsible for reviewing specific medications and treatments for possible inclusion in or deletion from the Formulary and to review all therapeutic categories every two years. Pharmacy benefits are executed via the Pharmacy Benefits Manager (PBM or Argus) contract and managed by the Director of Pharmacy.

Delegation of UM Activities

KHS tracks and processes all UM activity internally with the exception of Kaiser members who are delegated as part of a 2 way agreement under contractual requirement with DHCS. KHS contracts with a third party vendor to provided 24/7, weekend and holiday triage services for all

KHS members. The vendor provides not only triage services but also 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. Vision Care is delegated to a 3rd party vendor and capitated for all vision services as well as Kaiser Membership. All delegated entities are required to support and adhere to the same regulatory reporting and access standards as KHS.

Medical Reviews and Audits by Regulatory Agencies

KHS' Director of Compliance and Regulatory Affairs, in collaboration with the Administrative Director of Health Services and other departmental leadership, manages KHS medical reviews and medical audits by regulatory agencies. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QI/UM Program. CAPs for medical matters are approved and monitored by the QI/UMC.

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.

Statement of Conflict of Interest

UM decision-making is based on established criteria, appropriateness of care and service, and existence of coverage. KHS does not provide financial incentive for practitioners or other individuals conducting utilization review for denials of services or coverage. All committee members are required to sign a conflict of interest statement. Committee members cannot vote on matters where they have an interest and must be recuse until the issue has been resolved.

Statement of Confidentiality

The UM department handles all patient identifiable information used in clinical review, care, and service in a privileged and proprietary manner. The QI/UM Committee develops and implements confidentiality policies and procedures and reviews practices regarding the collection, use, and disclosure of medical information. KHS retains oversight for provider confidentiality procedures. KHS has established and distributed confidentiality standards to contracting providers in the KHS Provider Policy and Procedure Manual. All provider contracts include the provision to safeguard the confidentiality of member medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and federal laws. As a condition of participation with KHS, all contracting providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of members to their practitioners. KHS monitors contracting providers for compliance with KHS confidentiality standards during provider facility and medical records reviews and through the Grievance Process. All members, participating KHS staff and guests of the QI/UMC and subcommittees are required to sign the Committee Attendance Record, including a statement regarding confidentiality and conflict of interest. All KHS employees are required to sign a confidentiality agreement upon hiring. 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.

Annual Program Evaluation

On an annual basis KHS evaluates and revises as necessary, the UM Program Description and Evaluation. The Chief Medical Officer, with assistance from the Administrative Director of Health Services; Director of Health Education and Cultural and Linguistics, Disease Management Supervisor; Director of Pharmacy; and Manager of Case Management, documents a yearly summary of all completed and ongoing QI Program activities with documentation of evidence of improved health care or deficiencies, status of studies initiated, or completed, timelines, methodologies used, and follow-up mechanisms. A written evaluation of the UM Program is prepared and reported to the QI/UM Committee and Board of Directors annually.

The Board of Directors is responsible for the direction of the UM Program and actively evaluates the annual plan to determine areas for improvement. Board of Director comments, actions and responsible parties assigned to changes are documented in the minutes. The status of delegated follow-up activities is presented in subsequent Board meetings. A summary of UM activities and progress toward meeting UM goals is available to members and contracting providers upon request by contacting KHS Member Services.

_____

KHS Board of Directors (Chair) Date

_____

Chief Executive Officer Date

_____

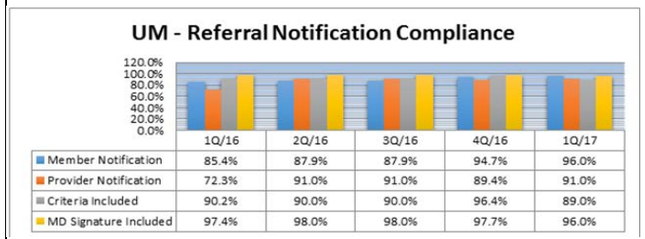
Chairman QI/UMC Date

2016 Utilization Management Program Evaluation

Executive Summary : Kern Health Systems (KHS) Utilization Management (UM) Program is designed to manage the use of limited resources to maximize the effectiveness of the care provided to Kern Health Systems members. It is designed to promote equitable, safe and consistent UM decision- making and coordination of care. The Medi-Cal (MCAL) beneficiary eligible residents have chosen Kern Family Health Care as their managed care plan due to the exceptional quality of care and service provided to the members. UM Management, in coordination with Human Resource and the Executive team, continue to develop alternative methods to attract and retain qualified RN candidates. Ensuring KHS members are provided high quality, cost effective care in an appropriate setting while maintaining compliance with the Department of Health Care Services and the Department of Managed Health Care are goals that are foremost for the Utilization Management Department. The UM Program includes prior authorization, concurrent review, retrospective review and case management components, depending upon the type of service and the identified member's clinical condition. Systems have been established to facilitate the monitoring of the referral process and the evaluation of those processes in collaboration with KHS delegates and the Chief Medical Officer and /or their designee(s), to promote timely services for members. Conducting an annual evaluation of the effectiveness of the UM Program allows an organization to determine how well it has deployed its resources in the recent past to improve the quality and safety of clinical care and the quality of service provided to its membership. 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. KHS experienced unprecedented growth as a result of the Affordable Care Act. With this growth came increasing medical complexity as the addition of the new aid categories and expanded eligibility that primarily consisted of adults. The Statement of Work is as follows:

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	☐ Leadership Support ☐ Mentoring	Met/Not Met	Year End 2016	1. Managerial training is provided to all onboarding of new management staff as well as ongoing opportunities for current levels of management, including Clinical and Non-Clinical staff in UM.	☐ Goal met
UM	☐ Staff Realignment of Health Service Departments	Met/Not Met	Year End 2016	1. Revised organizational structure chart conducted ad hoc 2. Developed, transitioned and implemented chart. 3. Created new job descriptions reviewed and approved by Human Resources. 4. Staffing ratios provided.	☐ Goal met
UM	☐ Update UM Program Description ☐ Completion of 2016 Annual UM Program Evaluation ☐ Development and implementation of 2017 UM Program Description	Met/Not Met	Year End 2016	1. Review, and revise the annual UM Program Description, Program Plan, and Evaluation including Medical and Behavioral Health. 2. Acquire approval of 2017 UM Program Description and the 2016 UM Program Evaluation from the appropriate utilization and quality committees within 12 months of the prior year approval. 3. Evaluate the adequacy of resources, committee structure, practitioner participation and leadership involvement in the UM Program to restructure or change the UM program for the subsequent year as necessary.	☐ Goal met ☐ All documents reviewed, revised, and approved in 2017 ☐ Annual UM Program Evaluation was completed and approved ☐ UM Program Description was reviewed, revised and approved
UM	☐ Resources for growth and development	Met/Not Met	Year End 2016	1. Case Management Society of America – standards of practice provided to the Case Management staff. 2. Organizational Membership recommended for the team that allows for Director, Managers, and Supervisors to both access volumes of educational and training materials as well as allowing for annual conference attendance for leadership team. 3. Local Community Resources information provided. 4. Case Management, MCG Evidence Based Clinical Guidelines, Inpatient Concurrent Review Documentation, Ethics Training – resources on all these provided to team.	☐ Goal met

UM	☐ Oversight of all delegated UM functions for the following services: Kaiser VSP Health Dialog	Met	Year End 2016	1. Evaluate effectiveness of the UM program for policy adherence to include compliance with state, federal, and NCQA standards. 2. Approve 2016 UM program evaluation for delegated services delegated services . 4. Submit delegated UM program information for approval at all applicable UM and Quality Committees	☐ Goal met ☐ Next Steps: o Continue quarterly review of delegated services UM reports, annual audit of Policy and Procedures, collaborations annual denial file review. Ad hoc review as identified. o Report delegated services findings to KHS PAC and UM/QI Committees.
UM	☐ Remote workforce support	Met	Year End 2016	1. VPN/RDP connectivity supports remote workforce in local acute hospitals.	☐ Goal met
UM	☐ Provide UM Training Programs	Met	Year End 2016	1. Review, revise, and implement UM Training Program for UM stakeholders as applicable for ongoing process improvements. This includes inpatient, outpatient, CCS (Peds), Call tracking and QNXT processes.	☐ Goal met ☐ Next Steps: o Continue to update and provide training as needed o Training is based on Regulatory standards and changes o Training needs are identified through a Needs Assessment Trainings included rounds training tools, discharge planning tools, documentation recommendations and ethics training tools.
UM	☐ Review of 2016 Behavioral Health and Non- Behavioral Health UM criteria used for authorization decisions ☐ BH UM criteria revision approvals at Quality Committee and Executive Resource Committee	Met/Not Met	Year End 2016	1. UM Criteria used for Behavioral Health and Non- Behavioral Health authorization decisions reflect updates based on evidence based medicine, DHCS APL notifications, current medical literature, EOC, and formulary changes 2. Transition of all BHT services from Regional Center to Kern Health Systems beginning February 2016 and extending through October 2016.	☐ Goal met ☐ All criteria were reviewed by PAC committee, CMO and designees, and staff at various times throughout the year ☐ Next Steps: o Continue annual review, update and approval of UM Criteria for 2016
UM	☐ Periodic reports to Quality Committee and Executive Committee	Met/Not Met	Year End 2016	1. Establish effective lines of communication regarding UM processes, new programs and issues/concerns: a) Executive Committee b) Physicians Advisory Committee c) UM/QI Committee d) Public Policy 2. Oversee the development, implementation and completion of corrective action plans (CAPS) related to regulatory survey findings.	☐ Goal met ☐ Periodic reporting is ongoing and completed to provide an update on UM processes, new programs and various UM related issues and/or concerns ☐ Determines necessity of implementing corrective action plans ☐ Next Steps: o Continue to review, revise and approve Utilization management policies and procedures. Ongoing and ad hoc report to committees
UM	☐ Periodic reports to the Pharmacy and Therapeutics Committee	Met/Not Met	Year end 2016	1. Review, Revise and approve pharmaceutical management policies and procedures at least annually, update them as new pharmaceutical resource management information become available and provide them to practitioners	☐ Goal met ☐ Completed ☐ Documentation of work completed to review and approved the 2016 pharmaceutical management policies and procedures ☐ Next steps: o Continue to review, revise and approve pharmaceutical management policies and procedures.

UM	☐ Timely and complete notification of denials of care	Met/Not Met	Year end 2016	1. Monitor, analyze and evaluate denial notices for compliance with federal, state, contractual requirements 2. Based on results of the analysis and evaluation: review, revise, approve and implement UM policies and procedures as needed as well as review stafffing ratios to support compliance. 	☐ Goal Met 4th Qtr. 2016 timeliness of decision trending continues at 94% complaint.
UM	☐ Member Satisfaction with UM processes completion and analysis ☐ Physician satisfaction with UM programs; i.e. communication, access, authorization process	Met/Not Met	Year end 2016	1. Annually survey satisfaction with the UM process: Collect and analyze data on member and practitioner satisfaction to identify improvement opportunities and take action designed to improve member and practitioner satisfaction a. Report the annual survey results and opportunities to improve are approved by the appropriate UM and Quality Committees 2. Develop and Implement Corrective Action Plans (CAP) as needed based on results	☐ Goal Met Physician Satisfaction Survey completed in 2016 ☐ Favorable feedback received from various areas in assisting to provide quality patient care ☐ Results remained stable from past years, no significant changes
UM	Health Services P&Ps	Met/Not Met	Year end 2016	1. UM, DM, CM policies and procedures reviewed. Revisions to current UM and QI policies and procedures provided to PAC and QI/UM committee. 2. Delegated services to VSP, Health Dialog, and Kaiser	o Goal Met
UM	Interrater reliability audits	Met/Not Met	Year end 2016	1. Interrater reliability audits completed bi-annually with minimum 80% passing for all clinical staff and Medical Directors who render decision outcomes completed to support consistent application of medical necessity in the decision making process.	o Goal Met
UM	Emergency Room (ER) Utilization	Met/Not Met	Year end 2016	1. ER intensive case management follow up for the top 50 ER utilizers. 2. Regular monthly report and ongoing program. Interventions include contacting the member, providing education, making the follow up appointment, and checking to ensure that the appointment was kept. 3. Partnerships with community entities to support efforts include placement of MSW in high volume local contracted hospital for educational suupport and coordination of care.	o Goal Met

UM	UM Health Services Program Administrator (additional duties)	Met/Not Met	Year end 2016	Medication Therapy Managment, DME effectiveness, Synagis, Hepatitis C, BHT reporting,Diabetic clinics, and community outreach completed. 2. UM Health Services Program Administrator partners with UM Business Analyst to develop more system driven outcomes reporting for new programs and expanded benefits.	o Goal Met
UM	DHCS/DMHC Audit	Met/Not Met	2016 Audit year	DHCS/DMHC performed a medical audit in August 2016. UM had 2 findings by audit- a) *Member rights*- Plan failed to process appeals for prior authorizations in accordance with Contract requirements. The Plan allowed the qualified health professional who initially denied the prior authorization to also make the final appeal decision. b) *Continuity of Care* -The Plan's continuity of care policy does not include a description of the Plan's block transfer process.	o Goal Not Met -CAPS submitted and approved by DHCS. Continued monitoring and oversight for delegated entities continuing process improvement. **Actions taken Member rights**- Re-educated) the clinical RN staff and MD reviewers who are responsible for conducting medical necessity reviews for the health plan of the contract requirement; included monthly Clinical RN meeting agenda item to review the Prior Authorization process and methods to alert MD reviewers to previous decisions in daily workflow. Additionally, revisions were completed to Policy 3.73-I, Medical Decision Making, as well as the creation of a Physician Advisory Panel who will be responsible for reviewing authorizations for medical necessity using MCG Health. **Finding closed** **Actions taken Continuity of Care-**Policy 3.39 Continuity of Care by Terminated Providers will be revised to include language on Block Transfer Policy as outlined in DHCS APL 16-001 dated January 8, 2016 -Medi-Cal Provider and Subcontract Suspensions, Termination, and Decertifications. In addition, reference to KHS Policy 4.39 will be listed for reference to the Block Transfer Policy in its entirety. **Finding closed**
UM	Systems Review	Met/Not Met	Year end 2016	1. Systems review by component completed. 2. Clinical criteria, predictive modeling, care plans, workflows and educational tools integrated within the system.	o Goal Met
UM	Quarterly State Reports Submission	Met/Not Met	Year end 2016	Quarterly report and mailing- a) Out of Network; b) Continuity of Care; c) CBAS; d) Mental Health; e) BHT; f) Dental Anesthesia; g) OTLIC	o Goal Met

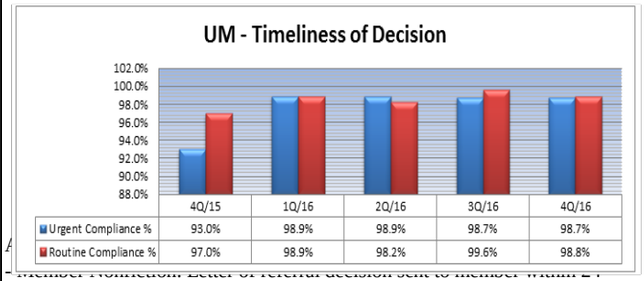
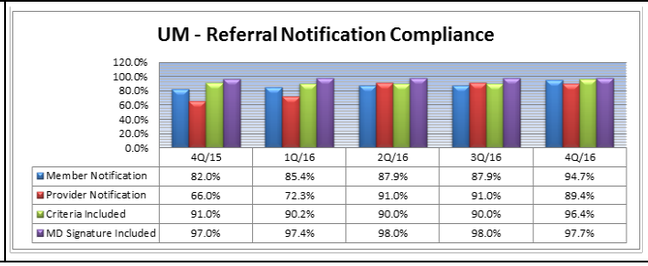
DHCS	Quality Improvement/Utilization Management Committee (QI/UMC)	Met/Not Met	Year end 2016	1. Reports to the Board of Directors and retains oversight of the UM Program with direction from the Chief Medical Officer or their designee. 2. The QI/UMC promulgates the quality improvement process to participating groups and physicians, practitioner/providers, subcommittees, and internal KHS functional areas with oversight by the Chief Medical Officer. 3. Committee also performs oversight of UM activities conducted by KHS to maintain high quality health care and effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services. 4.Practitioner attendance and participation in the QI/UM Committee or subcommittees is required. 5. The participating practitioners represents a broad spectrum of specialties and participate in clinical QI and UM activities, guideline development, peer review committees and clinically related task forces. 6. The extent of participation must be relevant to the QI activities undertaken by KHS.	o Goal Met
DHCS	Quality Improvement/Utilization Management Committee (QI/UMC)	Met/Not Met	Year end 2016	Eleven (11) of the eleven (11) positions were filled; Five (4) QI/UMC meetings were held in the reporting period with attendance Position Attended CMO/Medical Director 4 PCP: #1 Family Practitioner 4 #2 Pediatrician 1 Specialist #1 OB/GYN 3 Specialist #2 ENT 4 Home Health 4 Mid-Level Practitioner 4 Public Health 4 Ancillary #1 4 Ancillary #2 4 Hospital Representative 4	o Goal Met

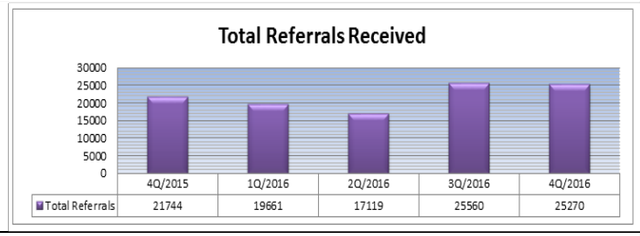
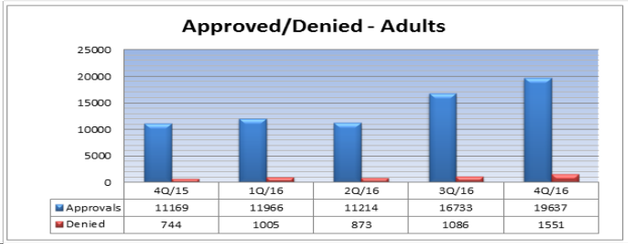
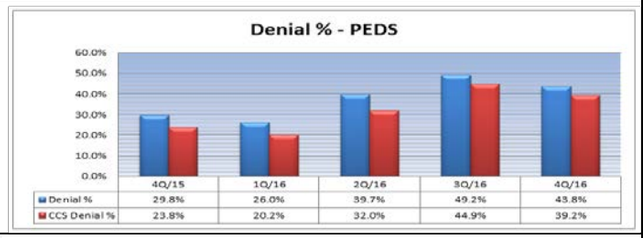
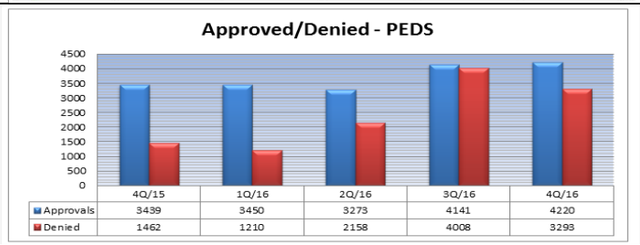
DHCS	Physician Advisory Committee (PAC)	Met/Not Met	Year end 2016	1. Serves as advisor to the Board of Directors on health care issues, peer review, provider discipline, and credentialing/recredentialing decisions. 2. This committee meets on a monthly basis and is responsible for reviewing practitioner/provider grievances and/or appeals, practitioner/provider quality issues, clinical criteria and guidelines, and other peer review matters as directed by the KHS Medical Director. 3. The PAC has a total of eight (8) voting committee positions.	o Goal Met
DHCS	Physician Advisory Committee (PAC)	Met/Not Met	Year end 2016	Eleven (11) PAC meetings were held during the reporting period with attendance as follows: Position Attended Medical Director 11 General Practitioner 10 General Internist 11 Pediatrician 7 Non Invasive Specialist 11 Invasive Specialist 5 Provider at Large 2 OB/GYN 6	o Goal Met
DHCS	Pharmacy and Therapeutics Committee (P&T)	Met/Not Met	Year end 2016	1. Serves to objectively appraise, evaluate and select pharmaceutical products for formulary addition or deletion. 2. This is an ongoing process to ensure the optimal use of therapeutic agents. 3. P&T meet quarterly to review products to evaluate efficacy, safety, ease of use and cost. 4. Medications are evaluated on their clinical use and develop policies for managing drug use and administration.	o Goal Met

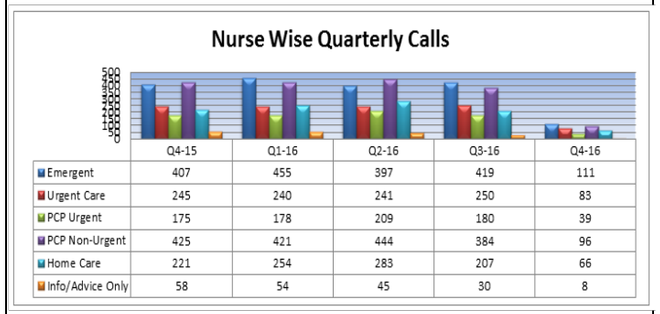
DHCS	Pharmacy and Therapeutics Committee (P&T)	Met/Not Met	Year end 2016	The Pharmacy and Therapeutics Committee has a total of (10) committee positions as follows: Position Attended KHS Chief Medical Officer (Chairperson) or designee 4 KHS Director of Pharmacy (Alternate Chairperson) 4 KHS Board Member 3 Retail/Independent Pharmacist 3 Retail Chain Pharmacist 2 Specialty Practice Pharmacist 3 Pediatrician 3 Internist 2 PCP/General Practice Medical Doctor 0 OB/GYN Practitioner 2	o Goal Met
DHCS	Public Policy/Community Advisory Committee (PP/CAC)	Met/Not Met	Year end 2016	1. Provides a mechanism or structured input from KHS members and community representatives regarding how KHS operations impact the delivery of care. 2. The PP/CAC is supported by the Board of Directors to provide input in the development of public policy activities for KHS. 3. The committee meets every four months and provides recommendations and reports findings to the Board of Directors.	o Goal Met

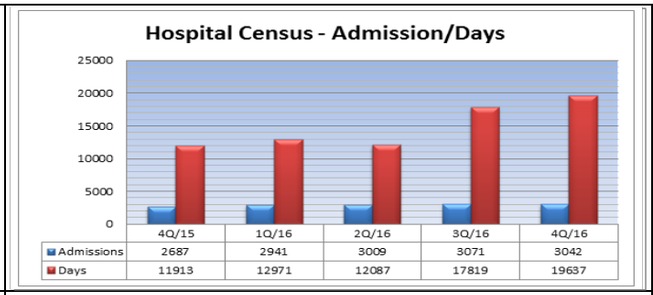
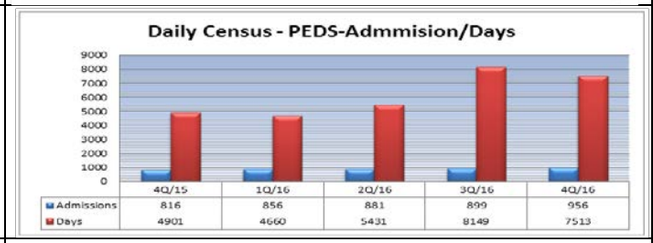
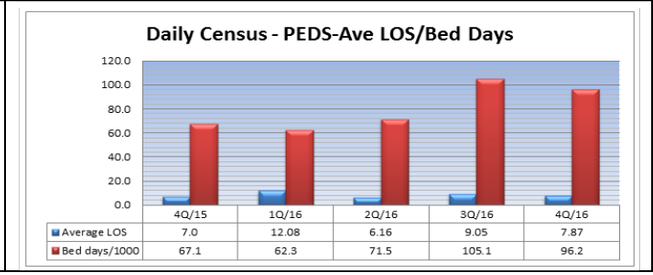
DHCS	Public Policy/Community Advisory Committee (PP/CAC)	Met/Not Met	Year end 2016	PP/CAC has twelve (12) committee positions. Eight (8) of the twelve (12) positions were filled; Four (4) PP/CAC meetings were held in the reporting period with attendance as follows: Position — Attended Public Policy Director of Marketing and Public Affairs — 4 Enrollee #1 — 0 Enrollee #2 — 3 Enrollee #3 — 1 Enrollee #4 — open Enrollee #5 — open General Consumer #1 — 2 General Consumer #2 — 0 Participating Health Care Practitioner #1 — open Participating Health Care Practitioner #2 — open Kern County Health Officer or Representative — 3 Director, Kern County Department of Human Services or Representative — 3	o Goal Met
UM	Utilization Management Process Policy/Procedure Revision/Development and Implementation	Met/Not Met	Year end 2016	1. UM Policies and Procedures are updated at least every 2-3 years as well as reviewed periodically in order to comply with any new regulatory requirements. 2. Each policy and procedure is reviewed against the DHCS contract and regulatory requirements and revised as needed to ensure compliance. 3. A review of UM policies and procedures are performed as well as the creation of new policies in direct relation to the addition of the Mental and Behavioral health benefits, Chiropractic, Tobacco Cessation, Palliative, Transgender, and and others to meet the reporting and medical identification requirements set forth by the Department of Health Care Services (DHCS).	o Goal Met

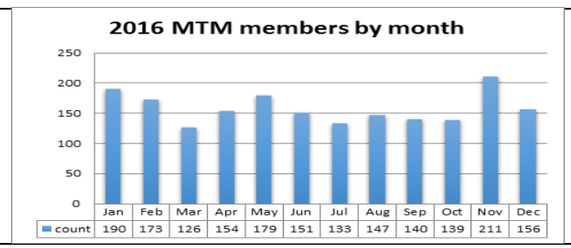
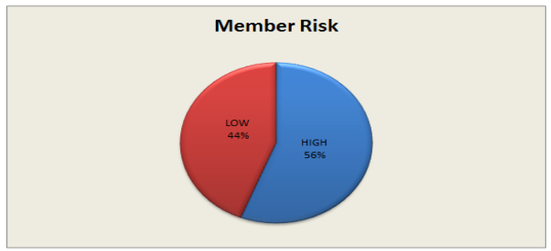
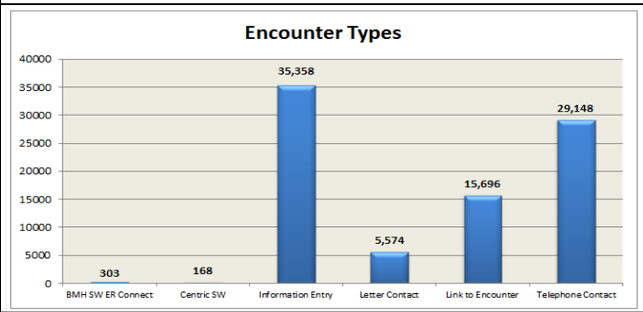
UM	Revisions in Criteria and/or Approach to UM Activities	Met/Not Met	Year end 2016	1. Milliman Care Guidelines (MCG), an evidence based web criteria utilized by KHS, are updated annually by MCG. MCG provides KHS UM with training and documentation of changes that have occurred. 2. The Clinical Intake Coordinators and Chief Medical Officer, and Medical Directors utilize MCG, Medi-Cal Guidelines, DHCS and DMHC contract language, and KHS Internal Guidelines to determine if a referral reviewed for medical necessity should be denied, modified and deferred. 3. MCG Inter-Reviewer Reliability is performed bi-annually to promote consistency of the application of guideline utilization by all clinical UM staff 4. Presently there are 100+ internally created medical guidelines referenced by the staff for decision making. 5. Internal guidelines based on Medi-Cal and other evidence based sources were drafted in 2016 by the Administrative Director of Health Services and approved for implementation by the KHS Chief Medical Officer for presentation to the PAC and QI/UM Committees to provide additional support in the decision making process.	o Goal Met
UM	Monitoring UM Decision Turn-Around Times, Volume, and Denial Rates	Met/Not Met	Year end 2016	1. Timeliness of UM Decisions are monitored on a daily basis through activity reports produced the UM Auditor through the Business Intelligence reporting program, Business Objects. 2. The UM Management staff is able to identify the number of referrals each Clinical Intake Coordinator are required to complete within the state mandated five-day turnaround time. 3. A formal timeliness report is provided by the Administrative Director of Health Services on a quarterly basis to the QI/UM Committee.	o Goal Met for monitoring/oversight

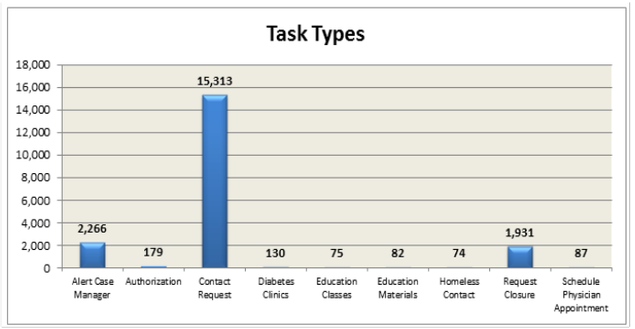
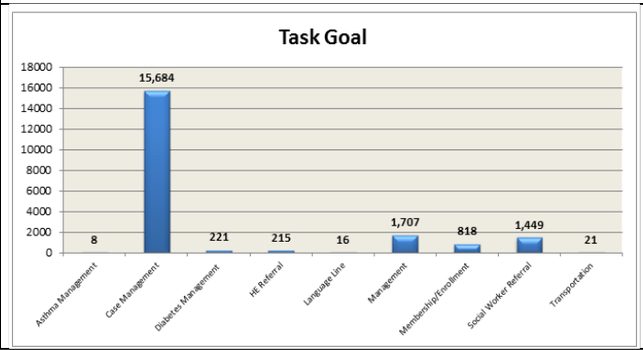
UM	Timeliness of Decision Trending	Met/Not Met	Year end 2016	Quarterly audits are conducted to ensure compliance with regulatory requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral. Urgent: Response back to Provider in 3 business days Routine: Response back to Provider in 5 business day  4Q/15 1Q/16 2Q/16 3Q/16 4Q/16 Urgent Compliance % 93.0% 98.9% 98.9% 98.7% 98.7% Routine Compliance % 97.0% 98.9% 98.2% 99.6% 98.8% hours - Provider Notification: Referral is faxed back to the provider with 24 hours of decision - Criteria Included: Criteria provided to provider on denial reason - MD Signature: MD Signature included all referrals/NOA letters upon denial	o Goal Met in Q4->95%
UM	Timeliness of Decision Trending	Met/Not Met	Year end 2016	 4Q/15 1Q/16 2Q/16 3Q/16 4Q/16 Member Notification 82.0% 85.4% 87.9% 87.9% 94.7% Provider Notification 66.0% 72.3% 91.0% 91.0% 89.4% Criteria Included 91.0% 90.2% 90.0% 90.0% 96.4% MD Signature Included 97.0% 97.4% 98.0% 98.0% 97.7%	o Goal Met

UM	Referral Count	Met/Not Met	Year end 2016		o Goal Met
UM	Denial % - Adults	Met/Not Met	Year end 2016		o Goal Met overall <10%
UM	Approved/Denied Adult Referral Count	Met/Not Met	Year end 2016		o Goal Met
UM	Denial % - Peds	Met/Not Met	Year end 2016		o Goal Met
UM	Approved/Denied Peds Referral Count	Met/Not Met	Year end 2016		o Goal Met

UM	Monitoring of Emergency Services - Previous vendor Jan-October 2016 Nurse Wise- New vendor in November 2016-Health Dialog	Met/Not Met	Year end 2016	1. Health Dialog provides after-hours call and triage services to provide after hours medical triage, eligibility information, and determine appropriate place of service disposition. 2. Health Dialog provides monthly summary reports which are reviewed to monitor trends and reports to the Executive Staff to determine if additional steps are needed to educate the providers and members in efforts to decrease ER usage and increase the member's ability to seek care of their assigned PCP office. 3. Social worker placed in high volume local ER to educate, coordinate post discharge services, and provide access to resources. 	o Goal Met
UM	Monitoring of Inpatient Admissions	Met/Not Met	Ongoing	1. Daily census and rounding reports were expanded in the Business Objects to identify all reported hospital and other facility admissions. 2. These reports are reviewed daily by the UM Management team to assess inpatient volume and determine length of stay appropriateness as documented by the UM Inpatient team. 3. These reports have been refined to provide financial obligations on a daily basis as well as detailed information on discharges, real time level of care and anticipated bed days. 4. Business decisions can be formulated based on details contained in the reports.	o Goal Met

UM	Monitoring of Inpatient Admissions-Adults	Met/Not Met	Ongoing		o Goal Met
UM	Monitoring of Inpatient Admissions-Adults Average LOS	Met/Not Met	Year end 2016		o Goal Met
UM	Monitoring of Inpatient Admissions-PEDS	Met/Not Met	Year end 2016		o Goal Met
UM	Monitoring of Inpatient Admissions-PEDS Average LOS	Met/Not Met	Year end 2016		o Goal Met

UM	Transition of Care Program-30 day Readmissions	Met/Not Met	Year end 2016	Tracking and trending continues as a collaborative effort between UM and QI for 30 readmissions. Care/Case management perform outreach for post discharge members for care coordination and resources allocation. Post Discharge clinics were created to enhance immediate access to either members PCP or specialized clinic to perform medication reconciliation, DME procurement, and promote medical and behavioral condition stabilization.	o Goal Met
UM	Transition of Care Program-Medication Reconciliation with Pharmacist Education and intervention	Met/Not Met	Year end 2016		o Goal Met
CM	Case Management/Coordination of Care-Member Risk	Met/Not Met	Year end 2016	During the year of 2016, there were a total of 5,737 KFHC members that were managed by the CM staff department. The majority of the members at 56% are high risk. 	o Goal Met
CM	Case Management/Coordination of Care-Encounter	Met/Not Met	Year end 2016		o Goal Met

CM	Case Management/Coordination of Care-Tasks	Met/Not Met	Year end 2016		o Goal Met
CM	Case Management/Coordination of Care	Met/Not Met	Year end 2016		o Goal Met

UM	Monitoring Under-utilization	Met/Not Met	Year end 2016	1. The UM department mails correspondence notifications to both the practitioners and members of any carved-out services that are provided outside of KHS benefit coverage for Coordination of care. 2. The KHS QI Department continues to assist the UM department in monitoring and tracking specialty referrals. Referrals for various educational programs, including smoking cessation, obesity, prenatal care, asthma, high blood pressure and diabetes are forwarded to QI/Health Education to assist UM in promoting the member's health through education and facilitating services with community based programs and other contracted service providers. 3. The Prior Authorization (PA) lists' goal is to facilitate timely access of services to members while eliminating barriers to the provider and enhance the provider experience. 4. PA information is communicated to the providers via a quarterly bulletin, as well as posted on the KHS internet site and provider portal. Various departments review trends to determine which services can be included for inclusion in a future PA listing. 5. Audits are conducted to review for under utilization of services that no longer require prior authorization to identify aberrant provider behavior or performed focused reviews on outlier activity and communicate with providers how to become more aligned with the positive trending.	o Goal Met

UM	Process for Monitoring Over-utilization	Met/Not Met	Year end 2016	1. Triage provided by Health Dialog for KFHC member's to receive services in the emergency room and urgent care center are reviewed retrospectively for appropriateness of the triage. On a monthly basis, the UM social worker receives a report that identifies members with multiple ER and/or UC usage for review and follow-up. 2. This helps to identify PCP access issues, members needing guidance on medical services, needs for disease management, and inappropriate behavior of members seeking controlled drugs. Finding solution to ER Overutilization is a major focus for KHS and will continue to be included in the business's ongoing Projects plan. 3. Specialty referrals for the members are reviewed concurrently by the RN Case Managers. The medical necessity for the referral is considered as well as determining the appropriateness of locally provided care versus out of area tertiary facility treatment. 4. Durable medical equipment continues to be tracked for duplication and rental items are monitored for the appropriateness of continued use. Careful review of any DME requests and documentation of the dates of the covered services are performed by the UM Clinical Intake Coordinators and UM Nurse's when processing referrals. 5. If it is determined that the member no longer meets the requirements for the previously approved DME equipment, a termination letter is drafted after review of the documentation by the Chief Medical Officer or designee.	o Goal Met

UM	Process for Monitoring Over-utilization (continued)	Met/Not Met	Year end 2016	6. KHS contracts with a consultant who performs in home evaluations to determine the appropriate equipment and recommend additional functional devices as needed to improve member's mobility and independence. 7. The admission and continued stay of KHS members in an acute or rehabilitation facility are concurrently reviewed for the severity of illness and the intensity of service. Levels of Care are monitored closely to ensure the member receives care in the appropriate setting for promotion of wellbeing and recovery. 8. If ongoing hospitalization is no longer deemed medical necessary, communication between the facility and KHS are initiated to inform of intent to deny for inappropriate setting for care required. 9. Analysis of Primary Care and Specialty physician referral trends are reviewed to determine if requests are appropriate and if aberrancies noted, staff will initiate appropriate through coordination with Provider Relations Department. 10. Providers area contacted directly to begin dialogue and request clarifications to referral requests and provide additional education through criteria and policy and procedure review to increase compliance and reduce unnecessary referral requests and processing.	o Goal Met

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Admission/Discharge Notification and Authorization for Contract Facilities				POLICY #: 3.33-P	
DEPARTMENT: Health Services – Utilization Management					
Effective Date: 08/1997	Review/Revised Date: 1/28/2017	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer
Date 1/28/17

Chief Medical Officer
Date

Chief Operating Officer
Date 1/27/17

Deborah L Murray
Administrative Director of Health Services
Date 1/26/17

POLICY[i]:

Contract facilities will fax admission information face sheets to Kern Health Systems (KHS) Utilization Management (UM) at (661) 664-5169 on the day of admission or by the next working day. The contract facility's Utilization Review (UR). departments will communicate with Kern Health Systems UM staff regarding medical necessity of continued stay and level of care within the first working day of patient admission or by the next working day and throughout the hospital stay as necessary to justify level of care and/or continued stay. OB (case rate) admissions do not require concurrent review reports from participating contract providers as long as the course of the hospital stay remains uncomplicated and/or the member does not require hospitalization beyond the days allowed by the case rate.

PROCEDURE:

All admissions and discharge notifications must be faxed by the contract facilities to KHS (661) 664-5169).

1.0 OBSTETRIC ADMISSIONS (CASE RATE)

1.1 OB Admissions

All OB admissions will be considered emergency admissions and handled as such. Facilities should fax the admission face sheet to the KHS Utilization Management Department at (661) 664-5169. Concurrent review report is not required from the hospital provided that the stay is uncomplicated.

1.2 Length of Stay beyond Case Rates for Medical Necessity

Facilities must notify the Utilization Management Department of the need for extension of stay as soon as the medical necessity is identified or by the next working day.

2.0 ALL OTHER ADMISSIONS

Facilities should fax the admission face sheet to Kern Health Systems' Utilization Management Department at (661) 664-5169 within 24 hours of admission.

2.1 Utilization Review

Facilities must communicate with the KHS Utilization Management Department regarding medical necessity of continued stay and level of care within the first working day of member admission for all types of admissions, including emergent, urgent or elective.

Concurrent reviews are to be provided to the KHS UM Nurse every 24 – 48 hours for authorization for continued stay. If the request for continued facility stay does not support medical necessity, the KHS UM Nurse is to notify the KHS Medical Director or designee for further review.

2.2 Authorization

Authorization for hospital days will be provided through concurrent review. The facility will receive written authorization from Kern Health Systems within 5 working days from notification of member discharge if no denial days. If referral includes denial days and the necessary medical records have not been received, KHS will allow five (5) additional days for receipt of records to complete the referral. Correspondence will include authorization number for authorized length of stay along with level of care for authorized days.

Prior authorization must be obtained for all elective hospital admissions.

2.3 Serious Health Threats

Decision to approve, modify, or deny heath care services shall be made for the nature of the enrollee's condition, not to exceed seventy two (72) hours after the KHS's

receipt of the information reasonably necessary and requested by KHS to make a determination. The decisions are to be communicated to the provider within twenty four (24) hours of the decision.

3.0 DENIALS

Denied days will be communicated by KHS with a denial letter to the facility (and member as required) at the time the denial is determined. If KHS is not notified of a hospital admission, the decision for authorization request will be denied. Providers are required to determine a member's eligibility and obtain prior authorization before initiating services. Authorization for payment may not be given if facility fails to notify KHS of admission and the admission is other than emergent in nature.

REFERENCE:

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[i] **Revision 2017-01:** Routine revision provided by UM Department. **Revision 2013-03**: Section 3.0 Provider obligation and authorization. **Revision 2009-04:** Routine revision provided by the Utilization Management Department. Not reviewed by the AIS Compliance Department. **Revision 2006-11:** Revised by Director of Health Services.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Asthma Treatment and Management				POLICY #: 3.36-P	
DEPARTMENT: Health Services – Utilization Management					
Effective Date: 03/31/2006	Review/Revised Date: 1/19/2017	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer

Date 1/19/17

Chief Medical Officer

Date

Deborah L. Lewis

Administrative Director of Health Services

Date 1/19/17

POLICY[1]:

KHS will provide asthma treatment and management as required by California Health and Safety Code § 1367.06.

PROCEDURES:

1.0 ACCESS

Asthma treatment and management services may be accessed through the PCP. Any necessary authorization should be requested as outlined in *KHS Policy and Procedure #3.22-P: Referral and Authorization Process.*[2]

Prescription medicine that is not covered on the KHS Formulary requires prior authorization. Authorization should be requested as outlined in *KHS Policy and Procedure #13.01-P: Drug Utilization and Non-Formulary Treatment Requests.*

Pediatric asthma education should be accessed as outlined in *KHS Policy and Procedure #2.35-P: Disease Management.*[3]

2.0 COVERED SERVICES

KHS covers all medically necessary care, equipment, and supplies for the treatment and management of asthma. KHS coverage includes, but is not limited to, the following asthma equipment and supplies when medically necessary for the management and treatment of pediatric asthma[4] and adult asthma:

A. Inhaler spacers when medically necessary for the management and treatment of asthma
B. Nebulizers, including face masks and tubing
C. Peak flow meters

Quantities of equipment and supplies may be limited if the limitations do not inhibit appropriate compliance with treatment as prescribed by the member's treating practitioner.[5]

Additional information on the provision of asthma education is outlined in *KHS Policy and Procedure #2.35-P: Disease Management.*

REFERENCE:

[1] **Revision 2017-01:** Review and minor revision provided by Health Services Department. **Revision 2006-02:** Policy created to comply with AB2185 (2004) which was effective 1/1/05. KHS coverage included all elements of AB2185 prior to its effective date. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004).
[2] HSC §1367.06 (c)
[3] HSC §1367.06 (d)
[4] HSC §1367.06(a) and (b)
[5] HSC §1367.06 (c)

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Specialty Nutrition Consultation				POLICY #: 3.37-P	
DEPARTMENT: Health Services					
Effective Date: 02/23/2006	Review/Revised Date: 1/19/2017	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer
Date 1/19/17

Chief Medical Officer
Date

Deborah L Murphy
Administrative Director of Health Services
Date 1/19/17

POLICY[i]:
Kern Health Systems' (KHS) members who are identified, on a case by case basis, as medically high risk and who would benefit from medical nutrition therapy (MNT) will be referred to a contracted Registered Dietician for an initial consultation and appropriate follow-up if needed.

PROCEDURES:

1.0 AUTHORIZATION
Request for MNT does not require prior authorization.

2.0 BENEFITS OF MEDICAL NUTRITION THERAPY
Benefits of MNT include the following:

A. Improved Treatment Outcome - completes interdisciplinary care team, improves patient satisfaction.
B. Efficiency and Accuracy in Education - MNT is provided by a Registered Dietician.
C. Quality Improvement - compliance with managed care regulations.

3.0 FEATURES OF MEDICAL NUTRITION THERAPY

MNT is a professional assessment for conditions such as failure to thrive, COPD, Hyperlipidemia, Type 1 and Type 2 Diabetes, Heart Disease, Hypertension, Gestational Diabetes, etc.

4.0 DESCRIPTION OF SERVICES

MNT by a Registered Dietician may be provided at the following levels without prior authorization, upon referral from any KHS contracted provider or by a KHS Utilization Management Nurse:

A. Initial Assessment
B. Follow-up Assessment
C. Group Education

4.1 Language Assistance

A Spanish speaking dietician or interpreter will be made available if needed.

REFERENCE:

[i] **Revision 2017-01:** Policy revised by Health Education and Disease Management Manager. MNT services do not require prior authorization. **Revision 2008-10:** Revised by Member Health Educator. Policy has not been reviewed by AIS. Revision 2005-11: Revised by Quality Improvement Manager. Policy has not been reviewed by AIS.