KERN HEALTH SYSTEMS

REGULAR MEETING OF THE QI/UM COMMITTEE

Thursday, November 16, 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, November 16th, 2017

7:00 A.M.

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COMMITTEE MEMBERS: Jennifer Ansolabehere, P.H.N; Satya Arya, 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:
4) Closed Session: Allen Kennedy and Dr. Chan Park to be voted into QI-UM Committee, after attending 3rd meeting - APPROVE

CA-5) QI/UM Committee Summary of Proceedings August 24th, 2017 – RECEIVE AND FILE

CA-6) Physician's Advisory Committee (PAC) Summary of Proceedings – RECEIVE AND FILE

- August 02, 2017
- September 06, 2017

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

- July 2017
- August 2017
- September 2017

CA-8) Focus Review Report 3rd Quarter 2017 – RECEIVE AND FILE

- Critical Elements Monitoring Ending September 30th, 2017
- IHEBA Monitoring Ending September 30th, 2017
- IHA Monitoring Ending September 30th, 2017
- KRC Monitoring Ending September 30th, 2017
- CCS Monitoring Ending September 30th, 2017
- Perinatal Care Monitoring Ending September 30th, 2017

CA-9) Site Review Summary Report 3rd Quarter 2017 – RECEIVE AND FILE
CA-10) SHA Monitoring Report 3rd Quarter 2017 – RECEIVE AND FILE

Kaiser Reports

CA-11) Kaiser KHS UM DME Authorization Denial Report – RECEIVE AND FILE

- 2nd Quarter 2017

CA-12) Kaiser KHS Health Plan Dental Report– RECEIVE AND FILE

- 3rd Quarter 2017

CA-13) Kaiser KHS CBA Report – RECEIVE AND FILE

- 3rd Quarter 2017

CA-14) Kaiser KHS APL Grievance Reports – RECEIVE AND FILE

- 2nd Quarter 2017-REVISED
- 3rd Quarter 2017

VSP Reports

CA-15) VSP Medical Data Collection Summary Reports – RECEIVE AND FILE

- September 2016-August 2017

CA-16) VSP QI Work Plan 2017– RECEIVE AND FILE

Member Services

CA-17) Call Center Report 2017 Q3 – RECEIVE AND FILE

- Kern Health Systems/Kaiser

CA-18) Comparative Tabulated Grievance Reports – RECEIVE AND FILE

- 2nd Quarter 2017

CA-19) Grievance Summary Reports – RECEIVE AND FILE

- 2nd Quarter 2017

CA-20) Expanded Transportation Benefits Memo – RECEIVE AND FILE

Provider Relations

CA-21) Re-Credentialing Report 2017 Q3 – RECEIVE AND FILE

CA-22) Board Approved New Contracts – RECEIVE AND FILE

- Effective September 1, 2017

CA-23 Board Approved Providers Reports – RECEIVE AND FILE

- Effective September 1, 2017
- Effective November 1, 2017

CA-24) 3rd Q 2017 Access Monitoring Report – RECEIVE AND FILE

Disease Management

CA-25) Disease Management Report – RECEIVE AND FILE

- 3rd Quarter 2017

Health Education Reports

CA-26) HECL 2018 Work Plan – RECEIVE AND FILE

27) 3rd Quarter 2017 Health Ed Activities Report - APPROVE

QI Department Reports

28) Policies and Procedures – RECEIVE AND FILE

- 2.45-P Delegation of QI, UM, Care and Case Management
- 2.50-I-Medi-Cal Quality and Performance
- 2.50-Attachment A
- 2.50-Attachment B

UM Department Reports

29) 3rd Q 2017 Combined UM Reporting – APPROVE

30) Policies and Procedures 3.06-3.70 – RECEIVE AND FILE

- 3.06-P Dental Services
- 3.17-P Sexually Transmitted Disease (STD) Treatment
- 3.21-P Family Planning Services and Abortion

- 3.24-P Pregnancy and Maternity Care
- 3.25-P Prior Authorization Services and Procedures
- 3.39-P Continuity of Care by Terminated Providers
- 3.61-I Comprehensive Case Management and Coordination of Care
- 3.69-I Provider Preventable Conditions
- 3.70-I Cultural and Linguistic Services

Next regular meeting: February 23, 2017

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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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, August 24th, 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.; Maridette Schloe MS, LSSBB; Danielle C Colayco, PharmD, MS

Members Absent: Jennifer Ansolabehere, P.H.N; Felicia Crawford, RN; Bruce Taylor, DO

Meeting called to order by Dr. Irwin Harris, M.D. @ 7:03 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.

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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3) Announcements:
   - **Introduction – Dr. Martha Tasinga, M.D. Chief Medical Officer of KHS**
   - **Special Guests: Dr. Philipp Melendez, attending his first of 3 meetings to become a QI-UM Committee member. Dr. Chan Park, and Allen Kennedy from Quality Team Inc. are both here for their second meeting.**

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

CA-5) QI/UM Committee Summary of Proceedings May 25th, 2017 – RECEIVED AND FILED **- Arya-Schloe: All Ayes (Items CA-5 though CA-29)**

CA-6) Physician's Advisory Committee (PAC) Summary of Proceedings – RECEIVED AND FILED
   - April 05, 2017
   - May 03, 2017
   - May 31, 2017

CA-7) Pharmacy 2017 TAR Log Statistics 1st Quarter – RECEIVED AND FILED
   - April 2017
   - May 2017
   - June 2017

CA-8) Focus Review Report 2nd Quarter 2017 – RECEIVED AND FILED
   - Critical Elements Monitoring Ending June 30th, 2017
   - IHEBA Monitoring Ending June 30th, 2017
   - IHA Monitoring Ending June 30th, 2017
   - KRC Monitoring Ending June 30th, 2017
   - CCS Monitoring Ending June 30th, 2017

- Perinatal Care Monitoring Ending June 30th, 2017

CA-9) Site Review Summary Report 2nd Quarter 2017 – RECEIVED AND FILED
CA-10) SHA Monitoring Report 2nd Quarter 2017 – RECEIVED AND FILED
CA-11) Kaiser UM DME Authorization Denial Report – RECEIVED AND FILED

- 1st Quarter 2017

CA-12) Kaiser KHS Health Plan Dental Report– RECEIVED AND FILED

- 2nd Quarter 2017

CA-13) Kaiser APL Grievance Report – RECEIVED AND FILED

- 2nd Quarter 2017

CA-14) Kaiser KHS CBA Report – RECEIVED AND FILED

- 2nd Quarter 2017

CA-15) Kaiser KHS Mental Health Report – RECEIVED AND FILED

- 2nd Quarter 2017

CA-16) Kaiser 2016 QI Program Evaluation – RECEIVED AND FILED (287 pp) Color
Full document can be accessed on the KHS Website at the following link:
http://www.kernfamilyhealthcare.com/page.asp/csasp/DepartmentID.1478/cs/SectionID.2967/cs/PageID.15850/csasp.html
CA-17) Kaiser 2017 QI Program Description – RECEIVED AND FILED (399 pp) Color
Full document can be accessed on the KHS Website at the following link:
http://www.kernfamilyhealthcare.com/page.asp/csasp/DepartmentID.1478/cs/SectionID.2967/cs/PageID.15850/csasp.html
CA-18) Kaiser 2017 Quality Improvement Work Plan– RECEIVED AND FILED (86 pp)
Full document can be accessed on the KHS Website at the following link:
http://www.kernfamilyhealthcare.com/page.asp/csasp/DepartmentID.1478/cs/SectionID.2967/cs/PageID.15850/csasp.html
CA-19) VSP Medical Data Collection Summary Reports – RECEIVED AND FILED

- May 2016-April 2016
- June 2016-May 2017
- July 2016-June 2017
- August 2016- July 2017

Member Services

CA-20) 2017 Q1 Call Center Report – RECEIVED AND FILED

- Kern Health Systems/Kaiser

CA-21) Comparative Tabulated Grievance Reports – RECEIVED AND FILED

- 1st Quarter 2017

CA-22) Grievance Summary Reports – RECEIVED AND FILED

- 1st Quarter 2017

Provider Relations

CA-23) 2nd Q 2017 Re-Credentialing Report – RECEIVED AND FILED
CA-24) Board Approved New Contracts – RECEIVED AND FILED

- Effective May 2017
- Effective June 2017

CA-25 Board Approved Providers Reports – RECEIVED AND FILED

- May 1, 2017
- June 1, 2017

CA-26) 2017 Full Time Equivalency (FTE) & Provider to Enrollee Ratios Report – RECEIVED AND FILED
CA-27) 1st Q 2017 Access Grievance Review Report – RECEIVED AND FILED
CA-28) 2nd Q 2017 Access Monitoring Report – RECEIVED AND FILED

Disease Management

CA-29) Disease Management Report – RECEIVED AND FILED

- 2nd Quarter 2017

Health Education Reports

30) Health Education Activities Reports

- 2nd Quarter 2017 – APPROVED

Colayco-Arya: All Ayes

QI Department Reports

31) HEDIS 2017 Rate Tracking-Final Rates June 14, 2017- RECEIVED AND FILED
32) HEDIS 2017 Compliance Audit Final Report of Findings for KFHC – RECEIVED AND FILED

Arya-Colayco: All Ayes

UM Department Reports

33) 2nd Q 2017 Combined UM Reporting – APPROVED

Arya-Colayco: All Ayes

34) Policies and Procedures 3.10-3.26 – RECEIVED AND FILED

- 3.10-P Alcohol and Substance Abuse Treatment
- 3.14-P Mental Health Services
- 3.26-P New Medical Technology

35) Policies and Procedures 3.73-3.50 – RECEIVED AND FILED

- 3.73-I Medical Decision Making
- 3.40-I Continuity of Care for New Members
- 3.50-P Medical Transportation Services

Meeting adjourned by Dr. Irwin Harris, M.D. @ 8:03 A.M.
to Thursday, November 16, 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, August 2, 2017
7:00 A.M.

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COMMITTEE RECONVENED

Members Present: David Hair, M.D., Miguel Lascano, M.D., Raju Patel, M.D., Jacqueline Paul-Gordon, M.D.

Members Absent: Hasmukh Amin, M.D., Angela Egbikuadje, PD.MS, Ph.D; Ashok Parmar, M.D.

Meeting called to order at 7:05 A.M. by Dr. Irwin Harris, M.D.

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 MEMBER OF THE COMMITTEE 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 CONCERNING THE ITEM BEFORE ACTION IS TAKEN.

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CA-3) Minutes for KHS Physician Advisory Committee meeting on May 31, 2017 – APPROVED
Patel-Lascano: All Ayes

ADJOURNED TO CLOSED SESSION @ 7:11 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 @ 7:41 A.M.

5) Review Policy 3.10-P Alcohol and Substance Abuse Treatment – RECEIVED AND FILED

6) Review Policy 3.14-P Mental Health Services – RECEIVED AND FILED

7) Review Policy 3.73-I Medical Decision Making – RECEIVED AND FILED

8) Review Policy 5.01-I KHS Member Grievance Process – RECEIVED AND FILED
Patel-Paul Gordon: All Ayes (for items 5-8)

9) Process by which KHS can adopt other criterion sources, such as: accepted national criteria, criteria adopted by other large national health plans, standards of practice as described in “Up to Date” and guidelines adopted by medical associations and societies – DISCUSSION
Committee discussed incorporating other plan specific criteria and general criteria guidelines into KHS criteria and policy. Dr. Tasinga provided reasons such as, Medi-Cal coverage guidelines and inconsistencies between outside source criteria as reasons to be cautions and requested additional internal discussions prior to changing policy. After the discussions are had, recommendations will be brought back to the committee for review.

MEETING ADJOURNED BY DR. IRWIN HARRIS, M.D. @ 8:03 A.M.
TO WEDNESDAY, SEPTEMBER 6, 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, September 6, 2017
7:00 A.M.

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COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D., David Hair, M.D., Miguel Lascano, M.D., Ashok Parmar, M.D., Raju Patel, M.D., Jacqueline Paul-Gordon, M.D.

Members Absent: Angela Egbikuadje, PD.MS, Ph.D

Meeting called to order at 7:00 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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CA-3) Minutes for KHS Physician Advisory Committee meeting on August 2, 2017 – APPROVED
Parmar-Amin: All Ayes

ADJOURNED TO CLOSED SESSION @ 7:02 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 6-0, THE COMMITTEE APPROVED PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING AND RECREDENTIALING.**

COMMITTEE RECONVENED TO OPEN SESSION @ 7:12 A.M.

5) Review Policy 2.45-I Delegation of QI, UM, Care and Case Management and Pharmacy Activities and Responsibilities – RECEIVED AND FILED

6) Review Policy 3.06-P Dental Services – RECEIVED AND FILED

7) Review Policy 3.17-P Sexually Transmitted Disease (STD) Treatment – RECEIVED AND FILED

8) Review Policy 3.21-P Family Planning Services and Abortion – RECEIVED AND FILED
Lascano-Parmar: All Ayes (for items 5-8)

9) Venous Ablation Criteria - DISCUSSION
After re-reviewing the Medi-Cal criteria, KHS drafted new criteria regarding venous ablations. The new criteria outlines who can perform the procedures, the training and education required for the provider, criteria for approving the procedures, and procedure quantity limits. The new criteria was distributed for review and discussion, and will be taken to BOD for approval and adoption.

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 8:05 A.M.
TO WEDNESDAY, OCTOBER 4, 2017 AT 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
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Quarter/Year of Audit	**2017**
Month Audited	**July**
Total TAR's for the month	**2428**
APPROVED TAR'S	
Timeliness - Reviewed & Returned in 1 busines day	**60/60**
Date Stamped	**60/60**
Fax copy attached	**60/60**
Decision marked	**60/60**
DENIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**42/42**
Initally Denied - Signed by Medical Director and/or Pharmacist	**42/42**
Letter sent within time frame	**42/42**
Date Stamped	**42/42**
Fax copy attached	**42/42**
Decision marked	**42/42**
Correct form letter, per current policies used	**42/42**
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	**6/6**
Date Stamped	**6/6**
Fax copy attached	**6/6**

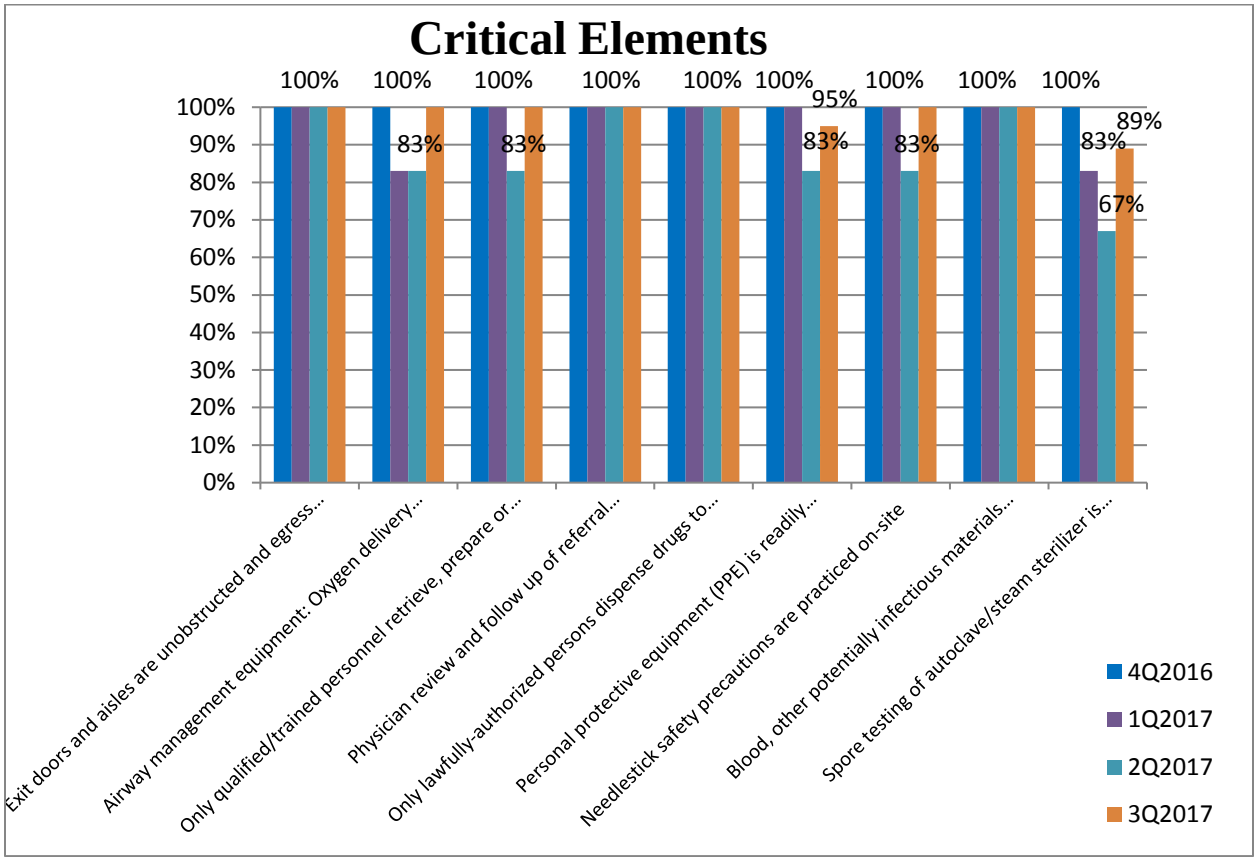
Quarter/Year of Audit	**2017**
Month Audited	**August**
Total TAR's for the month	**3276**
APPROVED TAR'S	
Timeliness - Reviewed & Returned in 1 busines day	**92/92**
Date Stamped	**92/92**
Fax copy attached	**92/92**
Decision marked	**92/92**
DENIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**41/41**
Initally Denied - Signed by Medical Director and/or Pharmacist	**41/41**
Letter sent within time frame	**41/41**
Date Stamped	**41/41**
Fax copy attached	**41/41**
Decision marked	**41/41**
Correct form letter, per current policies used	**41/41**
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	**11/11**
Date Stamped	**11/11**
Fax copy attached	**11/11**

Quarter/Year of Audit	**2017**
Month Audited	**September**
Total TAR's for the month	**2628**
APPROVED TAR'S	
Timeliness - Reviewed & Returned in 1 busines day	**69/69**
Date Stamped	**69/69**
Fax copy attached	**69/69**
Decision marked	**69/69**
DENIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**38/38**
Initally Denied - Signed by Medical Director and/or Pharmacist	**38/38**
Letter sent within time frame	**38/38**
Date Stamped	**38/38**
Fax copy attached	**38/38**
Decision marked	**38/38**
Correct form letter, per current policies used	
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	**11/12**
Date Stamped	**11/12**
Fax copy attached	**11/12**

Focus Review Summary Report

Critical Elements Reviews: Nineteen (19) providers were evaluated in 3rd Quarter 2017.

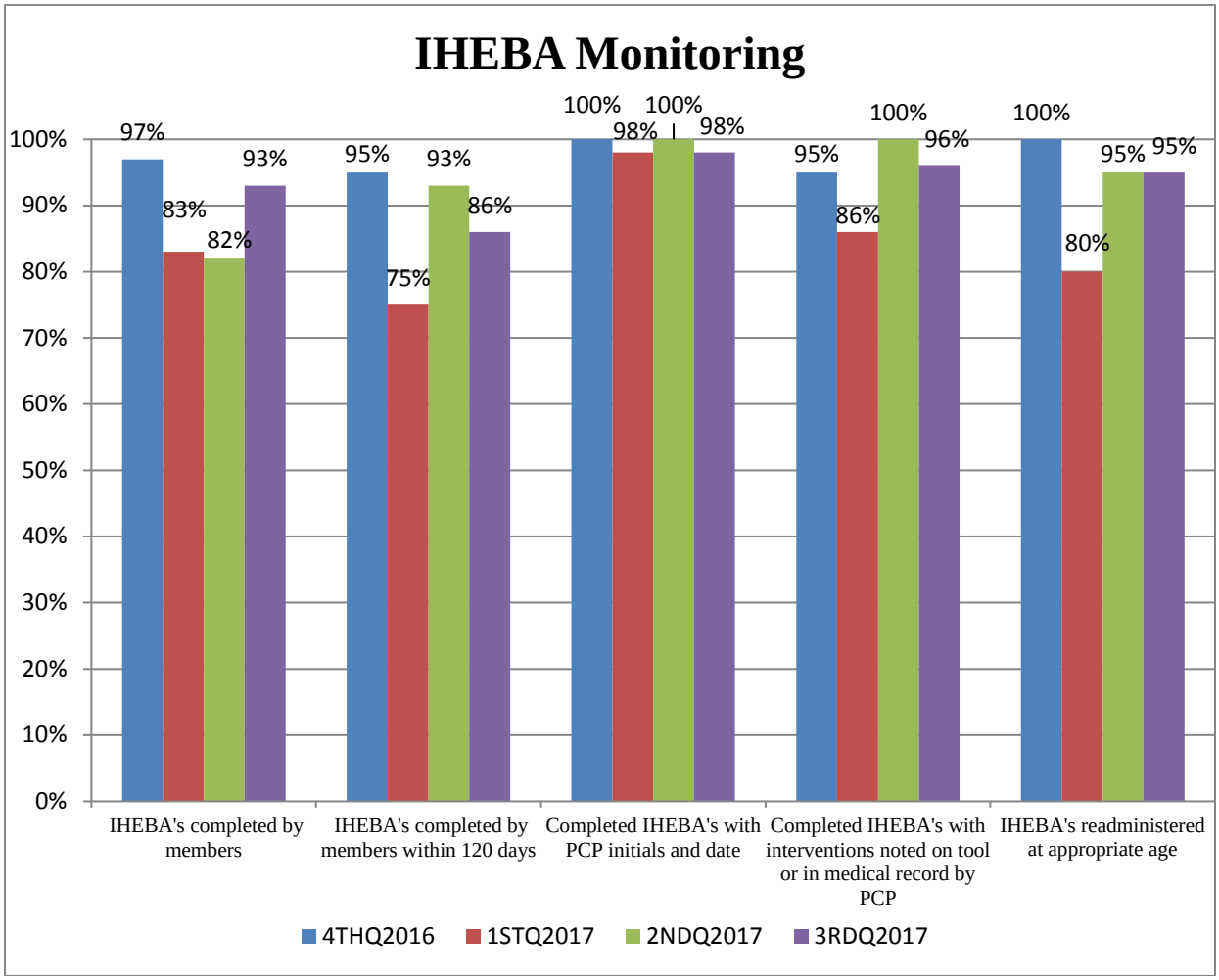
SUMMARY: KHS is responsible for systematic monitoring of all PCP sites between each regularly scheduled full scope site review surveys. This monitoring includes the nine (9) critical elements. Other performance assessments may include previous deficiencies, patient satisfaction, grievance, and utilization 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 nineteen providers evaluated in the 3rd Quarter scored 100% in 7 out of 9 areas. The areas with the most opportunity for improvement remain related to spore testing of autoclave/steam sterilizer and using personal protective equipment. Correction Action Plans (CAPs) have been given to providers showing deficiencies and follow-up visits are scheduled.

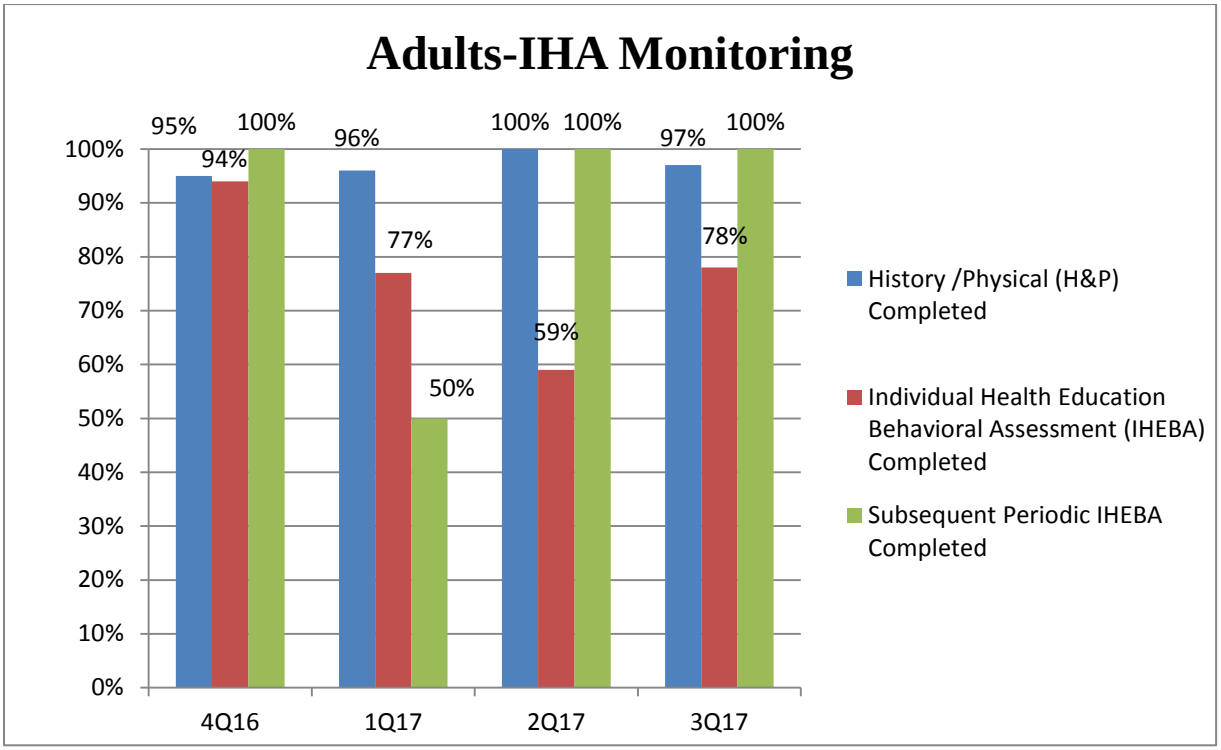
IHEBA Reviews: In 3rd Quarter 2017, 141 charts were reviewed from nineteen (19) providers. Four (4) providers met all the requirements of this review. The remaining providers found the greatest difficulty in seeing their members within 120 days and completing the IHEBA.

SUMMARY: The initial Individual Health Education Behavioral Assessment (IHEBA), commonly referred to as the Staying Healthy Assessment, is performed during the Initial Health Assessment (IHA). Thereafter, the PCP must re-administer the IHEBA at the appropriate age intervals. This remains a problem prone process despite offering P4P for timely member engagement.



Initial Health Assessment Reviews: In the 3rd Quarter 2017, nineteen (19) providers were reviewed. There were nineteen (19) Adult records and twenty-five (25) Pediatric records reviewed.

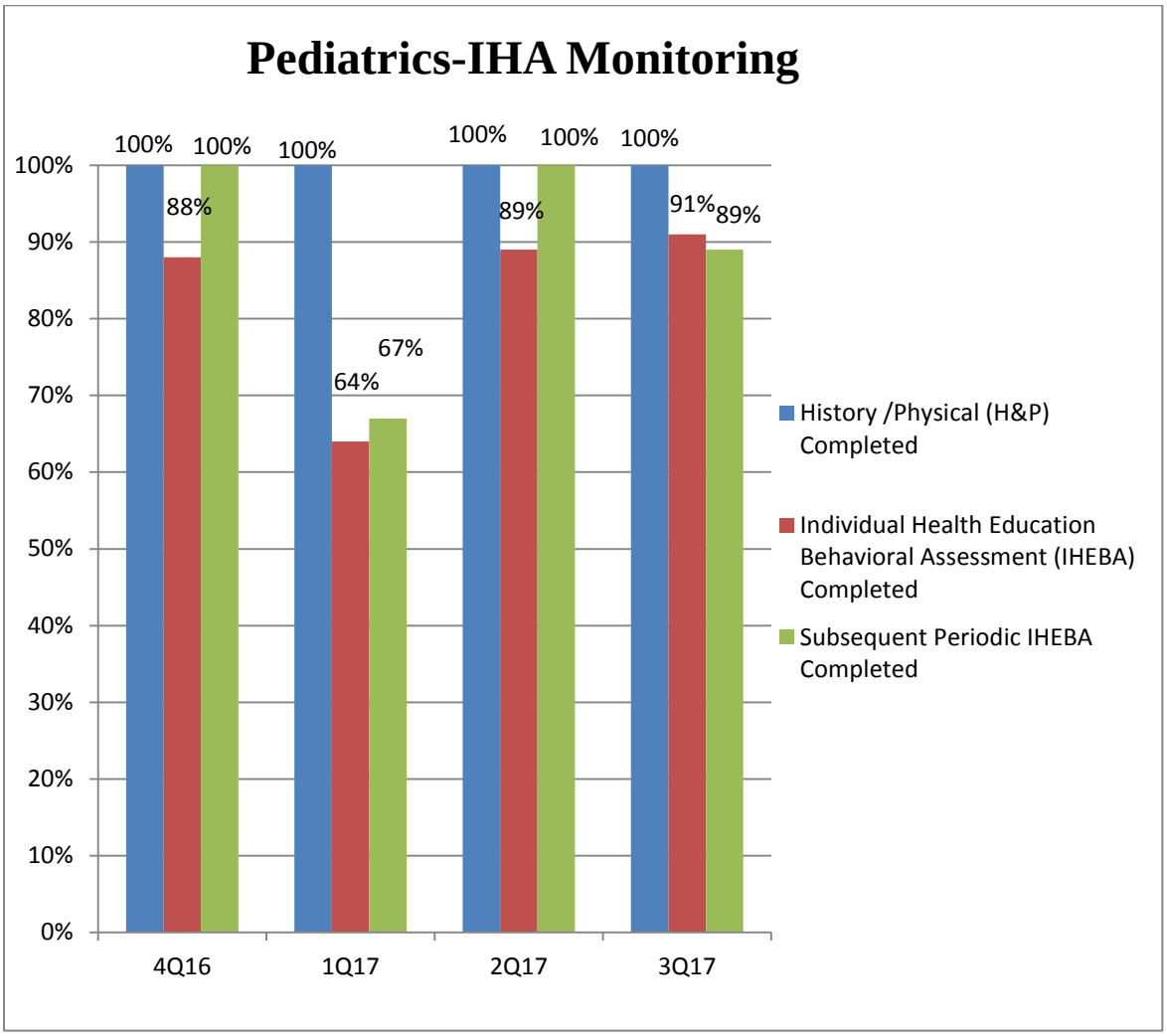
SUMMARY: An Initial Health Assessment (IHA) must be provided to each member within 120 days of enrollment. As PCP's receive their assigned panels, the Practitioner's office should contact members to schedule an IHA to be performed within the 120 day time limit. If the practitioner/staff is unable to 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.



Six (6) providers serving adults met all the requirements of IHA monitoring. All but one had an H&P completed for each member. The most problem prone element of this audit remains completing the Staying Health Assessment. However, in this sample, all periodic HEBAs were completed.

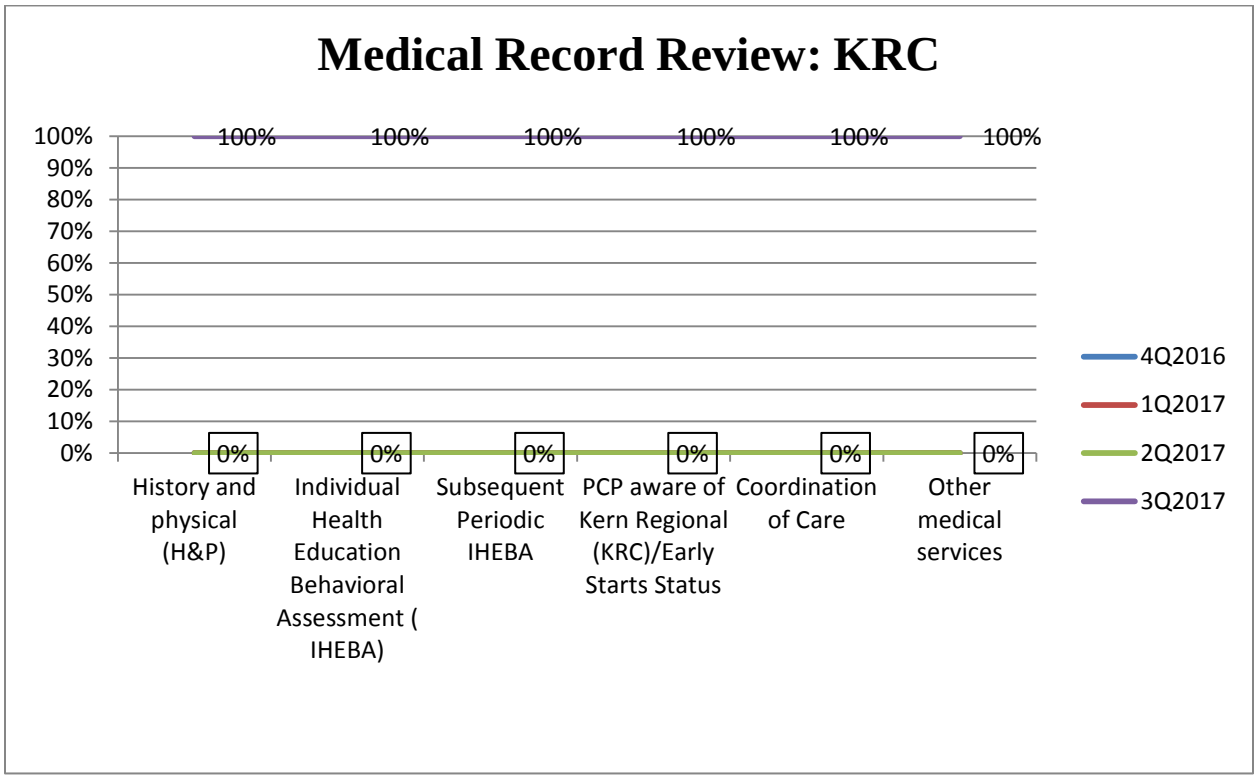
Both adult and pediatric providers perform H&Ps during the initial health assessment. The initial IHEBA/Staying Health Assessment should be performed during the IHA. Performance in Pediatric IHEBA use remains higher than in the adult population for all elements. Corrective Action Plans were implemented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

This quarter, all providers completed the History/Physicals (H&P) in pediatric records reviewed. This element has been 100% for the last 4 quarters. Seven (7) of the ten completed the Staying Health Assessments during the IHA. Three of four providers completed Subsequent Periodic IHEBAS for their members. Corrective Action Plans for deficiencies have been implemented and follow-up visits will be conducted.



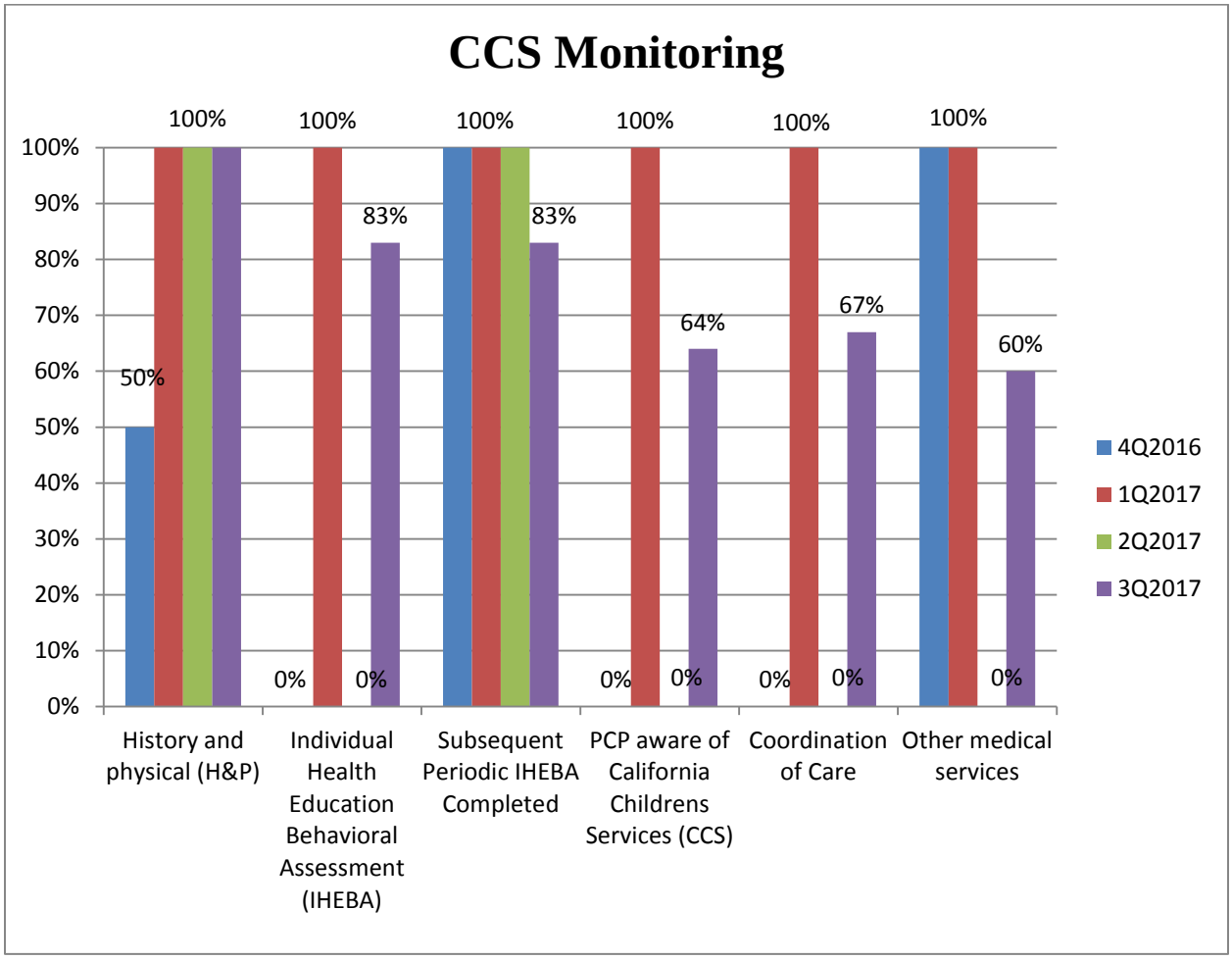
KRC Reviews: In the 3rd Quarter 2017, five (5) pediatric providers were reviewed. Though the previous 3 quarters had no KRC charts reviewed, in 3Q17 there were 2 KRC Pediatric charts reviewed. The providers scored 100% in all areas.

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. Medical record review showed appropriate primary care and other necessary intervention although historically, the denominator for this measure is small.



CCS Reviews: In 3rd Quarter 2017, five (5) pediatric providers and five (5) CCS charts 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 3rd quarter 2017 CCS monitoring all providers surveyed scored 100% in this area:

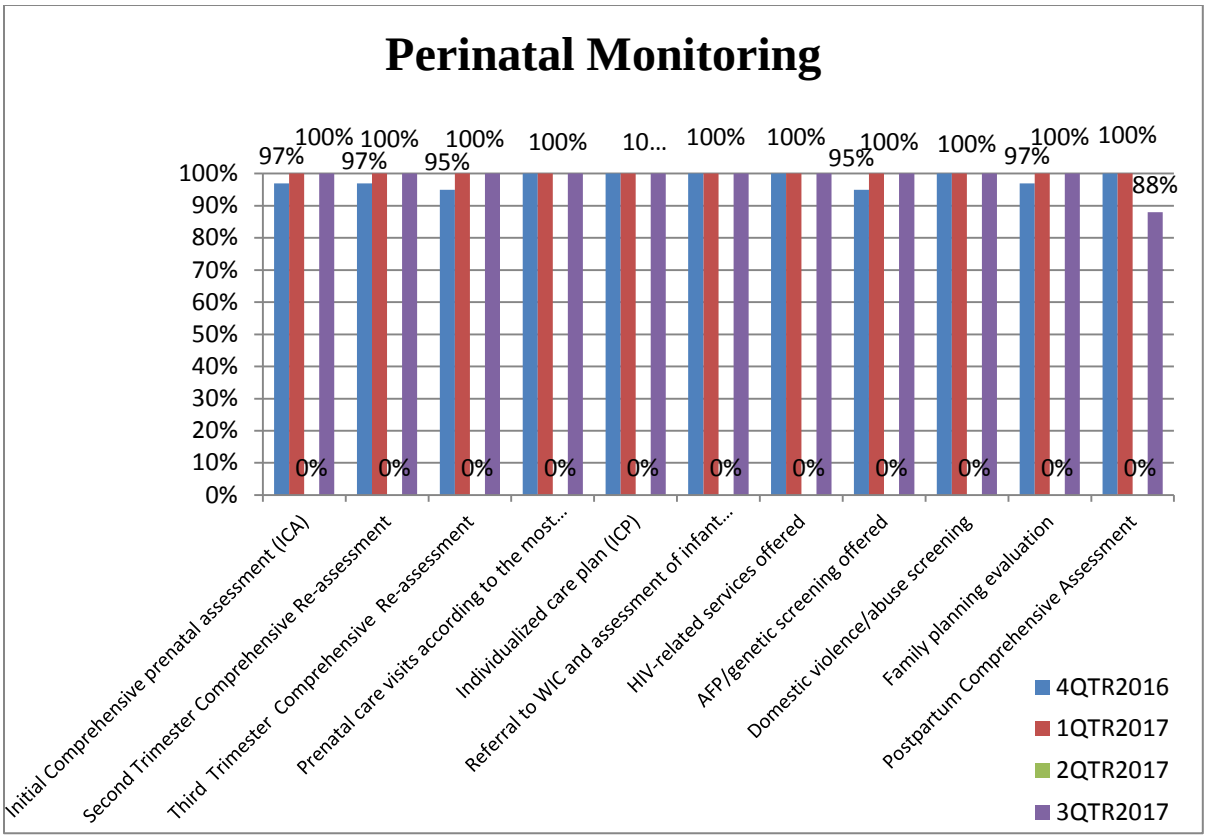
- History and physical (H&P)

Opportunities for Improvement were found in the remaining five areas.

Perinatal Reviews: Out of the nineteen (19) providers surveyed in 3rd Quarter 2017 there were ten OB/GYN providers and 52 perinatal charts were reviewed.

SUMMARY: KHS encourages 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 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. In 3Q17 Providers scored 100% in all areas except Postpartum Comprehensive Assessments completed (88%). Corrective Action Plans for this area of deficiency have been implemented and follow-up visits will be conducted

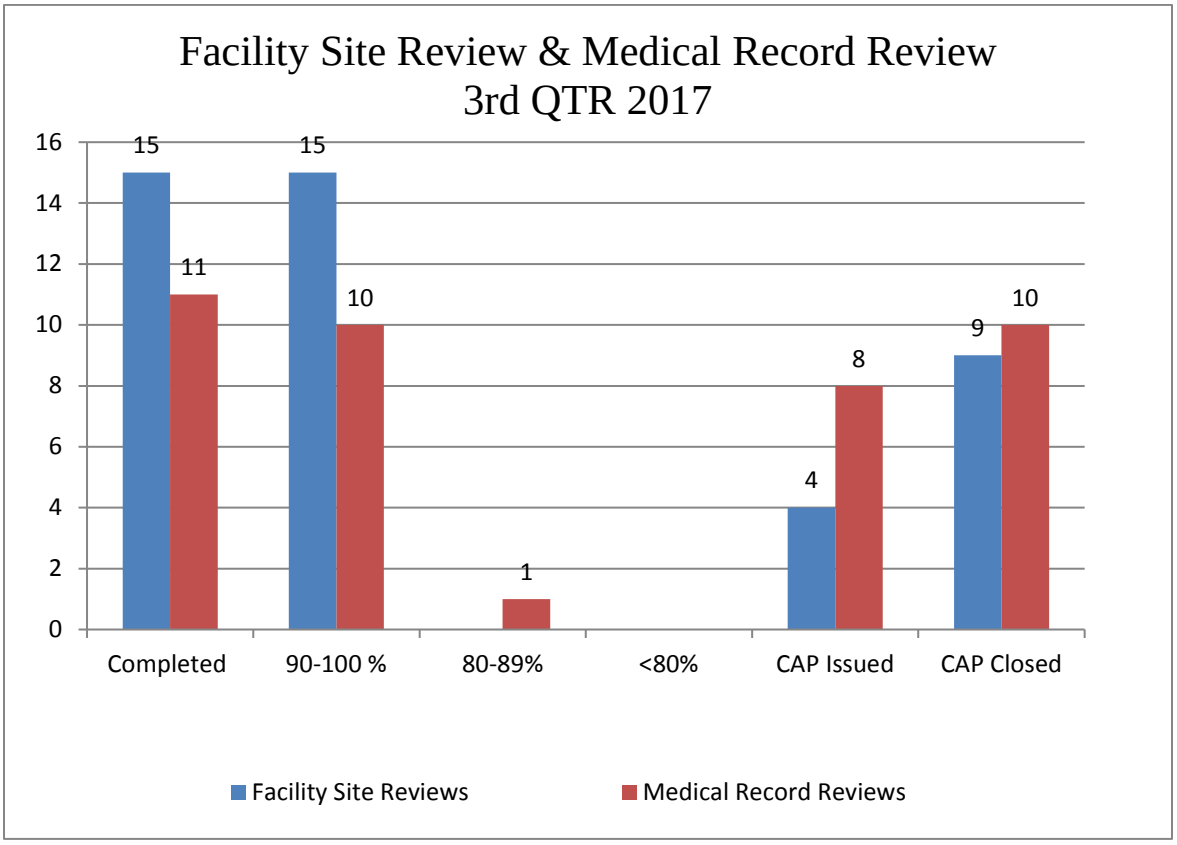


KERN HEALTH SYSTEMS
SITE REVIEW SUMMARY REPORT

Disciplinary Involvement: Quality Improvement and Provider Relations
Data Retrieval Method: Chart Review, Observation, Interview/Survey, Physical Inspection
Department: Quality Improvement
Monitoring Period: July 1, 2017- September 30, 2017

A total of fifteen (15) Office Site Reviews were completed in the 3rd Quarter. Out of the fifteen (15) completed, eight (8) were Initial Reviews and seven (7) were Periodic Reviews. Two (2) out of the fifteen (15) performed were Urgent Care and one (1) was for Health Net..

A total of eleven (11) Medical Record Reviews were completed in the 3rd Quarter. Five (5) were Initial Medical Record Reviews and six (6) were Periodic Medical Record Reviews. There were three (3) Facility Site Review Caps issued and eight (8) Medical Record Review Caps issued. Ten (10) Medical Record Review caps were closed, and eight (8) Full Site Review Caps were closed.



Description of Process: Certified Site Reviewers perform a facility site review on all contracted primary care providers (including OB/GYNs and pediatricians) as well as providers who serve a high volume of SPD beneficiaries. Per APL 15-023, APL 16-002 and PL 14-004, certified site reviewers complete site and medical record reviews for providers credentialed per DHCS and 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 Deficiencies

- Spore testing of autoclave/steam sterilizer with documented results (at least monthly)
- Sterilized packages are labeled with sterilization date and load identification information
- Documentation of education/training for non-licensed medical personnel in maintained on site

Top Medical Record Review Deficiencies

- IHEBAs are completed for new members and an age appropriate IHEBA is re-administered when the member has reached to next specific age interval.
- 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
- TB screening

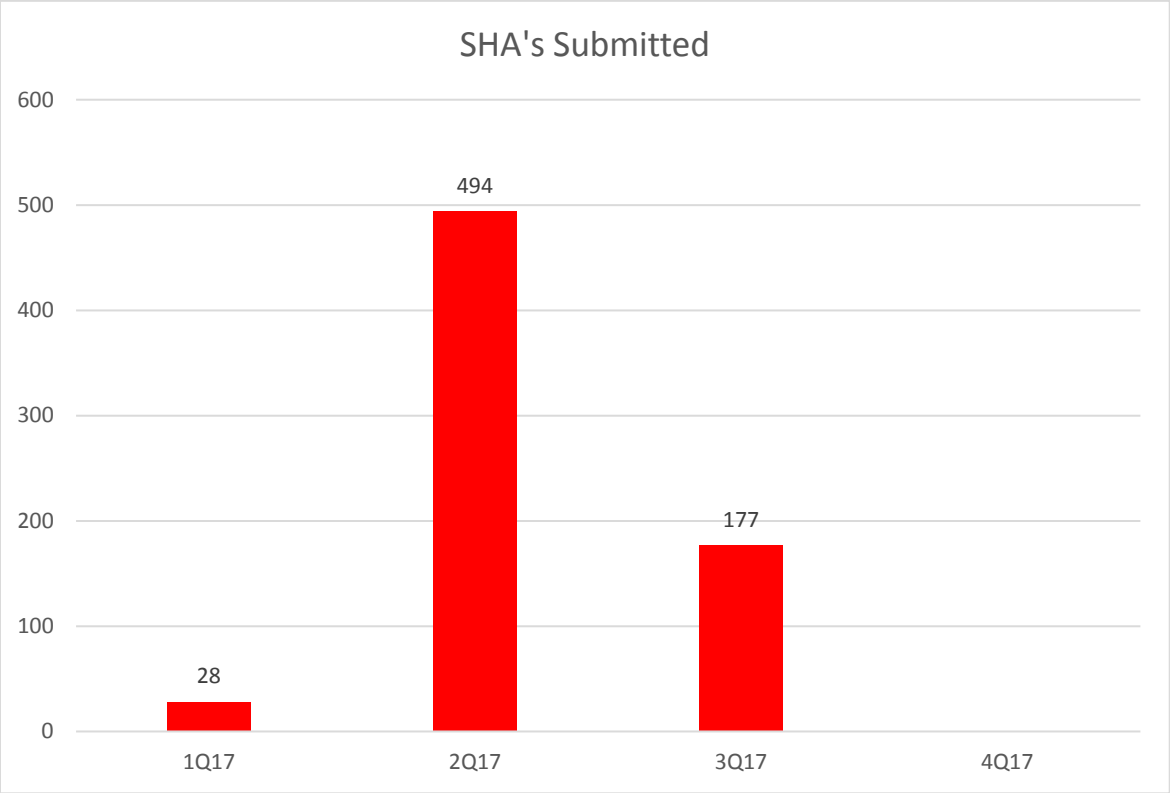
Providers are responsible for coming into compliance with the full site review criteria. If a site remains out of compliance and/or has a recurrent failing score through subsequent follow-up visits, disciplinary action may be imposed.

KERN HEALTH SYSTEMS
STAYING HEALTH ASSESSMENTS MONITORING

SUMMARY: KHS attempts to identify members with unmet health needs. During the course of P4P and HEDIS audits QI nurses identify members 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 records reviewed.

Staying Healthy Assessment Monitoring

During routine audits of medical records, QI RNs validate that a Staying Healthy Assessment was completed yearly. During 3rd Quarter 2017, there were 177 positive SHAs sent to Health Education. As stated in our previous SHA report, this number has decreased since the 2nd Quarter where the majority were obtained during HEDIS.



Kaiser Foundation Health Plan
Southern California Region
1st Quarter UM DME Report 2017

Kern Family Health

Q1 2017	ALL PLAN MEDI-CAL	Kern Family Health
ENROLLMENT	419061.67	7691.00
ACUTE DAYS/1000 MEMB	161.17	124.62
ACUTE DISCHARGES/1000 MEMB	44.01	44.60
ACUTE ALOS	3.64	2.50
ACUTE READMISSION RATE	0.13	0.09
SNF DAYS/1000 MEMB	16.08	25.28
SNF DISCHARGES/1000 MEMB	0.98	1.03
SNF ALOS	22.09	26.00
INPT PSYCH DAYS/1000 MEMB	5.74	0.00
INPT PSYCH DISCHARGES/1000 MEMB	1.00	0.00
INPT PSYCH ALOS	5.95	0.00
OUTPATIENT VISITS/MEMB	4.78	6.00
ER VISITS/1000 MEMB	331.08	121.74
UM DENIALS**		1
UM AUTHORIZATIONS**		21
TOTAL		22
UM DENIAL RATE		4.5%
UM APPEALS***		0
DME DENIALS**		0
DME AUTHORIZATIONS**		306
TOTAL		306
DME DENIAL RATE		0.0%
DME APPEALS***		0

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

***Appeals includes member appeals, complaints, and grievances only for denials subject to prior authorization.

Kaiser KHS HP Dental Report
Screen Shot Q3 2017

1. Non-DD Adults Dental General Anesthesia Reporting

A	B	C	D	E	F	G	H	I	J
Plan Code	Plan Name	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
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	0	0	0	0	0	

2. DD Adults Dental General Anesthesia Reporting

A	B	C	D	E	F	G	H	I	J
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	Number of Denials for DD Adults Due to Not Meeting Medical Necessity	Number of Denials for DD Adults Due to Other Reasons	Other Denial Reasons for DD Adults
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	0	0	0	0	0	

3. Non-DD Children Dental General Anesthesia Reporting

A	B	C	D	E	F	G	H	I	J
Plan Code	Plan Name	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	Number of Denials for Non-DD Children Due to Other Reasons	Other Denial Reasons for Non-DD Children
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	0	0	0	0	0	

4. DD Children Dental General Anesthesia Reporting

A	B	C	D	E	F	G	H	I	J
Plan Code	Plan Name	County	Reporting Period	Number of Requests for DD Children	Number of Approvals for DD Children	Number of Denials for DD Children Due to Requested Documentation Not	Number of Denials for DD Children Due to Not Meeting Medical Necessity	Number of Denials for DD Children Due to Other Reasons	Other Denial Reasons for DD Children
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	0	0	0	0	0	

Kaiser KHS CBA Report
Screen Shot Q3 2017

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	Q3 2017	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	Q3 2017	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	Q3 2017	0	0	0	0	0	0	0

1. Grievance & Appeal Reporting														
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Plan Code	**Plan Name**	**County**	**Reporting Quarter**	**CIN** 9- characters, 8 digits and 1 letter character	**Accessibility** 1- Excessive long wait time/apt. schedule time 2- Lack of primary care provider availability 3- Lack of Specialist availability 4- Lack of telephone accessibility 5-Lack of language accessibility 6- Lack of facility physical access	**Resolved Accessibility Grievance** 0- Unresolved 1- Resolved in Favor of Member 2- Resolved in Favor of Plan	**Benefits/ Coverage** 1- Dispute over covered services	**Resolved Benefits/ Coverage Grievance** 0- Unresolved 1- Resolved in Favor of Member 2- Resolved in Favor of Plan	**Referral** 1- Plan Refusal to Refer 2- Provider Refusal to Refer 3- Delay in Referral	**Resolved Referral Grievance** 0- Unresolved 1- Resolved in Favor of Member 2- Resolved in Favor of Plan	**Quality of Care/ Service** 1- Inadequate facilities, non-access related 2- Inappropriate ancillary care 3- Inappropriate Hospital Care 4- Inappropriate Provider Care 5- Plan Denial of Treatment 6- Provider Denial of Treatment 7- Poor Provider/Staff Attitude	**Resolved Quality of Service Grievance** 0- Unresolved 1- Resolved in Favor of Member 2- Resolved in Favor of Plan	**Other** Please specify 1 = Complaint about referral/TAR Process 2 = No evidence/record incident happened 3 =Non-Care.	**Resolved Other Grievance** 0- Unresolved 1- Resolved in Favor of Member 2- Resolved in Favor of Plan
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	99534134F							4	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	94247978F							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	91563072F							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	90702148D							4	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	90732141G	5	1								
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	91817129A							4	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	99787824F							4	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	95043016E							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	94497276E							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	94497276E							4	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	92091121A							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	91377370F							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	99439170F							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	96318116A			1	2						
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	96318116A			1	2						
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	92352773A					1	2				
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	93836855C							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	90931542A							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	94834613A							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	99105893F							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	92881540A							4	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	97217191C							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	98511047F							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	94735877D					1	2				
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	98576832C							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	90696404A							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	90909060D							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	92013189C	3	1								
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	93848565D							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	94633208E							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	96813243C							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	93592676A							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	95048874A							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	93781188A							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	94901997F							4	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	94236749D							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	91281987A							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	93188242D							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	90304336A							4	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	96949086F			1	1						
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	95022664C							7	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	93224046C							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	91874000F							7	2		

303	KERN HEALTH SYSTEMS	Kern	Q2 2017	98513349E							4	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	98513349E							4	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	94907408F							7	1		

1. Grievance & Appeal Reporting														
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Plan Code	**Plan Name**	**County**	**Reporting Quarter**	**CIN** 9- characters, 8 digits and 1 letter character	**Accessibility** 1- Excessive long wait time/apt. schedule time 2- Lack of primary care provider availability 3- Lack of Specialist availability 4- Lack of telephone accessibility 5-Lack of language accessibility 6- Lack of facility physical access	**Resolved Accessibility Grievance** 0- Unresolved 1- Resolved in Favor of Member 2- Resolved in Favor of Plan	**Benefits/ Coverage** 1- Dispute over covered services	**Resolved Benefits/ Coverage Grievance** 0- Unresolved 1- Resolved in Favor of Member 2- Resolved in Favor of Plan	**Referral** 1- Plan Refusal to Refer 2- Provider Refusal to Refer 3- Delay in Referral	**Resolved Referral Grievance** 0- Unresolved 1- Resolved in Favor of Member 2- Resolved in Favor of Plan	**Quality of Care/ Service** 1- Inadequate facilities, non-access related 2- Inappropriate ancillary care 3- Inappropriate Hospital Care 4- Inappropriate Provider Care 5- Plan Denial of Treatment 6- Provider Denial of Treatment 7- Poor Provider/Staff Attitude	**Resolved Quality of Service Grievance** 0- Unresolved 1- Resolved in Favor of Member 2- Resolved in Favor of Plan	**Other** Please specify 1 = Other	**Resolved Other Grievance** 0- Unresolved 1- Resolved in Favor of Member 2- Resolved in Favor of Plan
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	99376060F			1	1						
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	98376060F			1	1						
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303	KERN HEALTH SYSTEMS	Kern	Q3 2017	95905335F							4	1		
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	92119772A							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	91822042C			1	1						
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	95905335F									1	1
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	99841268C									1	1
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	91822042C							4	1	1	1
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	90610321G									1	1
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	94205011F							4	1		
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	91822042C			1	1						
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	90051418C							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	91556283C	1	1					4	1		
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	97693137F							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	96608292E	1	1								
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	96246432D							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	91948144C			1	1						
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	98087078D			1	1						
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	95724906A									1	1
303	KERN HEALTH SYSTEMS	Kern	Q3 2017	90419001F			1	1						

Medical Data Collection Summary Report

Period Covered: September, 2016 through August, 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:	20,345	
Diabetes?:	853	4.2%
Diabetic Retinopathy:	82	.4%
Glaucoma:	64	.3%
Hypertension:	760	3.7%
High Cholesterol	239	1.2%
Macular Degeneration:	39	.2%

Estimated Number of Cases

Total Members:	239,716	
Diabetes?:	5,485	2.3%
Diabetic Retinopathy:	464	.2%
Glaucoma:	910	.4%
Hypertension:	23,908	10.0%
High Cholesterol	36,224	15.1%
Macular Degeneration:	290	.1%

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

2017 Quality Improvement Work Plan

Quality Improvement Goals and Monitoring

Goal	Tactics and Interventions	Target and Dept.	Quarterly Update	Potential Barriers
<u>Clinical Practice Guidelines:</u> **Diabetes** Achieve a 50% rate of compliance with CPG for patients with diabetes who receive eye exams 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	• Provide education regarding PCP communication and dilation on QAR result letter as applicable • Reinforce with doctors the need to document reasons for no PCP referral and/or dilation in patient medical record • Perform focus reviews for diabetic patients to gather a larger, more accurate sampling then currently obtained through random patient record requests	QM	QI: <u>Patients with Diabetes > 113 Cases (Quality Assurance Reviews)</u> Overall the CPG was followed 57% of the time. The medical record documentation indicates doctors communicate exam findings with the PCP or document a valid rationale for not communicating with the PCP 63% of the time for patients with diabetes. The medical record reviews show dilation or valid rationale for no dilation is currently at 88%. <u>Patients with Diabetes > 140 Cases (Focused Reviews)</u> Overall the CPG was followed 86% of the time. The medical record documentation indicates doctors communicate exam findings with the PCP or document a valid rationale for not communicating with the PCP 83% of the time for patients with diabetes. The medical record reviews show dilation or valid rationale for no dilation is currently at 100%. QI: The medical record documentation indicates the rate of doctors following the CPG for glaucoma is 100%	**Discrepancy between QAR and Focused Reviews:** Doctors providing more expansive documentation when they know our focus is diabetic exams **PCP Comm. Barriers**: • Lack of established relationship between ODs and PCPs • PCP is an institution (Kaiser) • Letter previously sent • Patient under care of Ophthalmologist **Other:** Retinal imaging technology perceived to be a procedure in lieu of dilation

Goal	Tactics and Interventions	Target and Dept.	Quarterly Update	Potential Barriers
Complaints & Grievances (C&G) Trending	• Monitor C&Gs to determine doctors with a trend, and take appropriate action as needed • Monitor C&Gs to determine common complaints and provide recommendations as needed to business partners.	All year QM	Q1: Due to data discrepancies, this information will not be available until May 10, 2017. An updated report will be provided to the committee at that time.	
Quality of Care Process and resolve all PQC cases within required timeframes	• Monitor and effectively resolve all potential quality care complaints • Take appropriate action with providers		Q1: There were 186 Potential Quality of Care complaints reviewed based on clinical guidelines, with 20 opened for investigation. Of the 20 cases reviewed by clinical staff, 18 were determined as Severity Level A : No quality of care issue identified. Two cases were identified as Severity Level C: Moderate quality of care issue identified.	
Ensure auditors consistently apply quality care standards 100% of the time.	• Perform Interrater Study • Report findings to QM Committee • Report findings to auditors • Implement improvement plan when necessary	Q4		
Quality Assurance Achieve 90% or greater overall pass rate on Quality Assurance Reviews Complete 100% of reviews within department service	• Continue to perform QA reviews, analyze trends. • Implement corrective action plans as needed • Develop process to ensure consistent handling of PQC issues discovered during QAR	All year QM	Q1: The pass rate was only 89.4% which did not meet our goal of 90% this quarter. The OD pass rate of 89.9% is down from 92.4% in Q4 2016. The MD pass rate was only 81%, which is down from 83.3 in Q4 2016. All QAR reviews were completed within service standards.	

Goal	Tactics and Interventions	Target and Dept.	Quarterly Update	Potential Barriers
standards Ensure OD Auditors consistently apply QA review standards for doctor patient record reviews 100% of the time	• Monitor QAR completion timeframe • Perform Interrater study and report to QM Committee • Report findings to auditors and provide education/training as needed	Q4		
Eye Health Management (EHM) Monitor rate of annual eye exams for known patients with diabetes	• Track and report on the percent of practices that report diabetic patients through EHM on claims • Report number of exam reminders sent to diabetic patients • Monitor patient return rate		Q1: 135,521 DER letters sent in Q1, 2017. Twelve month effectiveness is 15%.	
Accessibility Nationally maintain a 95% or higher accessibility in all classifications	• Determine and apply appropriate intervention when feasible • Provide overall trends and measure outcomes	All year ND	Q1: Staff completed the quarterly access and availability study. We are still meeting or exceeding all accessibility goals nationally and in California. All goals met within standards with no interventions needed.	
Credential/recredential Complete 100% of doctors with clean applications within standards	• Ongoing monitoring of VSP's network of doctors through the credentialing/recredentialing process • Monitor credentialing and recredentialing activities to ensure delegate is meeting all delegated tasks, timeframes and quality standards	All year ND	Q1: 100% of doctors with clean applications were credentialed and recredentialed within standards	

Goal	Tactics and Interventions	Target and Dept.	Quarterly Update	Potential Barriers
Cultural Competency and Linguistics Achieve 95% accuracy of CA doctors reporting of language capabilities	• Conduct annual CA Doctor Office Language Capabilities monitoring, and ensure doctor directory is updated if applicable. • Continue to provide information and education on cultural sensitivity and awareness to VSP network doctors	Q2 QM All year	Q1: The CA Doctor Office Language Capability monitoring survey was completed with a 95% compliance rate, meeting our goal. VSP's Provider Network Development continues to support specific reporting for overall compliance with the LAP. The Semi-annual report was completed and presented to the Committee. The VSP LAP program currently meets DMHC requirements. Staff continues to monitor the program.	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	• Staff to research technology as directed by the QMC • QMC to discuss staff research findings and make recommendation to the Board or appropriate committee for consideration	QM	Q1: The committee has reviewed various companies and delivery models for remote refractions. Due to concerns related to vision and health risks that may be missed without direct ECP contact with patients the committee will continue to monitor.	

Kaiser KHS Call Center Report
3rd Quarter 2017

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	Q3 2017	54832	891	53941	0:00:25	0:07:30	1.6%	93%	Y	Y
KAISER FOUNDATION HEALTH PLAN	Q3 2017	386	11	375	0:00:20	0:05:00	2.8%	88%	N	Y
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2016-2017 COMPARATIVE TABULATED GRIEVANCES

Kern Family Health Care Grievances	1st Quarter 2017	2nd Quarter 2017	2nd Quarter 2016
Access to Care (PCP)	**6**	**7**	**16**
Difficulty Accessing Specialist	**3**	**3**	**5**
Quality of Care	**36**	**38**	**82**
Quality of Service	**119**	**163**	**167**
Medical Necessity	**18**	**14**	**38**
Coverage Dispute	**19**	**13**	**26**
Cultural and Lingustic Dissatisfaction	**2**	**1**	**0**
Other Issue	**5**	**4**	**15**
Total Grievances	**208**	**243**	**349**
MCAL (NonSPD) Grievances	**105**	**129**	**164**
SPD Grievances	**52**	**50**	**80**
Expansion Grievances	**51**	**64**	**105**
Cases Upheld by Plan	**158**	**198**	**286**
Cases Found in Favor of the Enrollee	**49**	**45**	**63**
Pending at the time of report	**1**	**0**	**0**
Kaiser Permanente Grievances			
Access to Care (PCP)	**2**	**3**	**1**
Difficulty Accessing Specialist	**1**	**2**	**1**
Quality of Care	**7**	**4**	**2**
Quality of Servive	**9**	**14**	**6**
Medical Necessity	**6**	**5**	**2**
Coverage Dispute	**0**	**2**	**0**
Cultural and Lingustic Dissatisfaction	**0**	**0**	**0**
Other Issue	**1**	**2**	**3**
Total Grievances	**26**	**32**	**15**
State Fair Hearings			
Coverage Dispute	**3**	**2**	**0**
Medical Necessity	**6**	**4**	**1**
Quality of Care	**0**	**0**	**0**
Access to Care	**0**	**0**	**0**
Quality of Service	**1**	**0**	**0**
Other Issues	**0**	**0**	**0**
Total	**10**	**6**	**1**
Cases Found in Favor of the Plan	**1**	**2**	**1**
Cases Found in Favor of the Enrollee	**0**	**0**	**0**
Waiting on Decision or Case not Heard Yet	**9**	**4**	**1**
DMHC Complaints			
Coverage Dispute	0	1	2
Medical Necessity	2	3	1
Quality of Care	1	0	0
Access to Care	0	0	0
Quality of Service	1	0	0
Other Issues	0	1	0
Total	**4**	**5**	**3**
DMHC Complaints Found in Favor of the Plan	3	4	2
DMHC Complaints Found in Favor of the Enrollee	1	1	1
Decisions Pending at the time of report	0	0	0

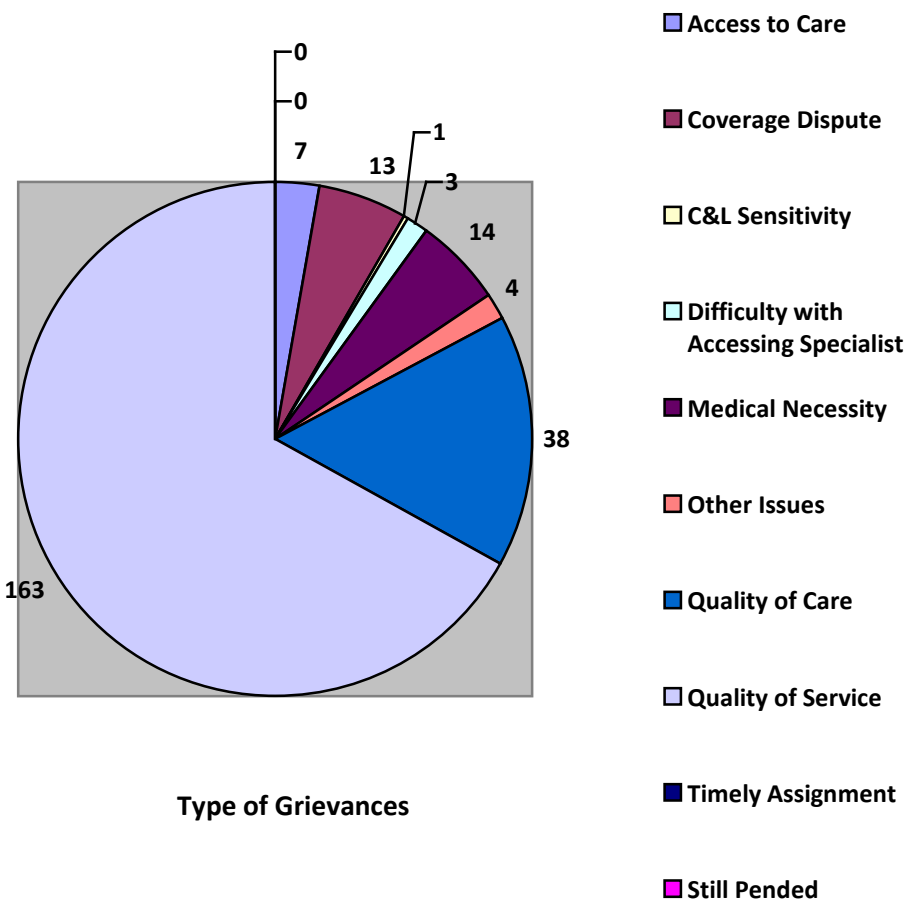
LEGEND OF CATEGORIES
Access to Care (PCP) - Issues related to long wait times or difficulty scheduling PCP appointments.
Difficulty Accessing Specialist - Issues related to difficulty scheduling specialty appointments.
Quality of Care - Dissatisfied with care received from provider, staff or facility staff.
Quality of Service - Dissatisfied with serive received from provider, staff or facility staff.
Medical Necessity - Appeals for denied authorization or medication requests that are denied based on medical necessity.
Coverage Dispute - Appeals for denied authorization or medication requests that are not a covered benefit under KFHC and/or FFS Medi-Cal.
Cultural and Linguistic Dissatisfaction - Issues related to a language barrier or interpretation services.
Other Issue - Any other dissatisfaction not related to any of the above categories.

2016-2017 COMPARATIVE TABULATED GRIEVANCES

Independent Medical Reviews	4th Quarter 2016	2nd Quarter 2017	2nd Quarter 2016
Delay of Services	0	0	0
Modification of Services	0	0	0
Denial of Services	3	4	6
Total	**3**	**4**	**6**
IMR Cases Found in Favor of the Plan	0	2	3
IMR Cases Found in Favor of the Enrollee	3	1	3
Decisions Pending at the time of report	0	1	0
Enrollment Counts vs Grievances Received Per Quarter - Total Enrollment			
Total Enrollment	247,774	249,461	234,266
Grievances per 1,000 Members	0.84	0.97	1.49
Percentage of Grievances	0.084%	0.097%	0.149%
Enrollment Counts vs Grievances Received Per Quarter - MCAL (Non SPD) Members			
Total Enrollment	234,100	235,456	220,712
Grievances per 1,000 Members	0.67	0.85	0.74
Percentage of Grievances	0.067%	0.085%	0.074%
Enrollment Counts vs Grievances Received Per Quarter - SPD Members			
Total Enrollment	13,674	14,005	13,554
Grievances per 1,000 Members	3.80	3.57	5.90
Percentage of Grievances	0.38%	0.36%	0.59%
Enrollment Counts vs Grievances Received Per Quarter - Expansion Members			
Total Enrollment	58,015	58,690	53,316
Grievances per 1,000 Members	0.88	1.09	1.97
Percentage of Grievances	0.88%	0.10%	0.20%
Enrollment Counts vs Grievances Received Per Quarter - Kaiser Members			
Total Enrollment	7,466		6,193
Grievances per 1,000 Members	3.48		2.42
Percentage of Grievances	0.35%		0.24%

2nd Quarter 2017 Grievance Summary

Issue	Number	In Favor of Health Plan	In Favor of Enrollee
Access to care	7	6	1
Coverage dispute	13	12	1
Cultural and Linguistic Sensitivity	1	0	1
Difficulty with accessing specialists	3	2	1
Medical necessity	14	13	1
Other issues	4	4	0
Quality of care	38	31	7
Quality of service	163	130	33
Timely assignment to provider	0	0	0
Still under review	0	0	0



Type of Grievances

Grievances per 1,000 Members = 0.97

During the second quarter of 2017, there were two hundred and forty three grievances received. Forty five cases were closed in favor of the Enrollee and one hundred and ninety eight were closed in favor of the Plan. All of the cases were closed within thirty days of receipt. Fifty cases were received from SPD (Seniors and Persons with Disabilities) members. Sixty four were received from Medi-Cal Expansion members.

2nd Quarter 2017 Grievance Summary

Access to Care

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

Three members complained about the lack of available appointments with their Primary Care Provider (PCP). All of the cases closed in favor of the Plan after the responses indicated the office provided appropriate access to care based on the Access to Care Standards for PCP appointments.

Four members complained about the wait time to be seen for a Primary Care Provider (PCP) appointment. Three cases 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. One case closed in favor of the Enrollee after the response indicated the member was not seen within the appropriate wait time for an appointment.

Coverage Dispute

There were thirteen grievances pertaining to a Coverage Dispute issue. Twelve of the cases closed in favor of the Plan. One case closed in favor of the Enrollee. The following is a summary of these issues:

Nine 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.

Four members complained about the denial of a referral authorization request. Three of 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. One of the cases closed in favor of the Enrollee after it was determined member may have been inappropriately denied services.

Cultural and Linguistic Sensitivity

There was one grievance pertaining to Cultural and Linguistic Sensitivity. This case closed in favor of the Enrollee. The following is a summary of these issues.

A provider with a specialist's office complained on member's behalf about the lack of a sign language interpreter for a scheduled appointment. This case closed in favor of the Enrollee after it was determined a KFHC MSR failed to submit the request for an American Sign Language (ASL) interpreter timely.

2nd Quarter 2017 Grievance Summary

Difficulty with Accessing a Specialist

There were three grievances pertaining to Difficulty Accessing a Specialist. Two of the cases closed in favor of the Plan. One case closed in favor of the Enrollee. The following is a summary of these issues.

> Three members complained about the lack of available appointments with a specialist. Two 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 specialty appointments. One case closed in favor of the Enrollee after the responses indicated the office did not provide appropriate access to care based on the Access to Care Standards for specialty appointments.

Medical Necessity

There were fourteen grievances pertaining to Medical Necessity. Thirteen of the cases were closed in favor of the Plan. One case closed in favor of the Enrollee. The following is a summary of these issues.

> Thirteen members complained about the denial or modification of a referral authorization request. Twelve 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. One of the cases closed in favor of the Enrollee after it was determined the authorization may have been denied inappropriately.
>
> One member complained about the denial or modification of a TAR. This case closed in favor of the Enrollee as it was determined that there was no supporting documentation submitted with the TAR to support the criteria for medical necessity of the requested medication and the denial was upheld.

Other Issues

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

> One member complained that KFHC denied a medication at the pharmacy level. This case closed in favor of the Plan after it was determined the medication denied appropriately at the pharmacy level. No TAR was submitted for review.
>
> One member complained about the KFHC TAR process. This case closed in favor of the Plan after it was determined that KFHC followed our policies and procedures.
>
> One member complained about an unpaid claim for specialty services. This case closed in favor of the Plan after it was determined member was showing Other Health Coverage (OHC) at the time the claim was denied.

One member complained about his information being released by staff at a provider's office. This case closed in favor of the Plan after it was determined member's information was not released by the staff in the provider's office.

Quality of Care

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

Twenty three members complained about the quality of care received from a Primary Care Provider (PCP). Eighteen 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. Five 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.

Six members complained about the quality of care received from a specialty provider. Five cases were closed in favor of the Plan after it was determined that the specialist provided the member with the appropriate care. One case 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 the provider or staff with a hospital or urgent care. Seven 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 case 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.

One member complained about the quality of care received from a pharmacy. This case closed in favor of the Plan after it was determined that the provider or their staff 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 sixty three grievances pertaining to Quality of Service. One hundred and thirty were closed in favor of the Plan. Thirty three cases were closed in favor of the Enrollee. The following is a summary of these issues:

Seventy nine members complained about the service they received from a provider. Sixty 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. Nineteen 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.

Thirty three members complained about the service they received from a provider and their staff. Twenty nine 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. Four 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 seven members complained about the service received from the staff at a health care facility, pharmacy, or provider's office. Thirty seven 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. Ten 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 staff at the health care facility, pharmacy or provider's office. These cases were sent to PR for Tracking and Trending.

Four members complained about the services received from the staff with Kern Family Health Care (KFHC). All of the cases closed in favor of the Plan after it was determined the member received appropriate service from the KFHC staff.

Timely Assignment to Provider

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

Kaiser Permanente Grievances

During the second quarter of 2017, there were thirty two grievances received by KFHC members assigned to Kaiser Permanente. Twenty five cases were closed in favor of the Enrollee, five cases were closed in favor of the Plan, and two were pending review at the time of reporting.

Access to Care

There were three grievances pertaining to Access to Care. All three cases closed in favor of the Enrollee. The following is a summary of these issues.

Three members complained about the excessive wait time to be seen for an appointment. All cases closed in favor of the Enrollee.

Coverage Dispute

There were two grievances pertaining to Coverage Dispute. The following is a summary of these issues:

One member complained about an out of network service they requested not being covered. This case closed in favor of the Plan as the same services were available in network.

One member complained about not having a lost or stolen medication replaced. This case was closed in favor of the Plan as replacement of lost or stolen medication is not covered.

Difficulty Accessing a Specialist

There were two grievances pertaining to Difficulty Accessing a Specialist. The following is a summary of these issues.

Two members complained about the excessive wait time to be seen for a specialty appointment. One case closed in favor of the Enrollee as a delay was identified. One case closed in favor of the Plan as no difficulty or delay was identified.

Medical Necessity

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

Five members complained about services they requested not being approved. All five cases were closed in favor of the Enrollee and services were authorized.

Quality of Care

There were four grievances pertaining to Quality of Care. Three cases closed in favor of the Enrollees and one case is still open for review. 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 is still open for review.

Quality of Service

There were fourteen grievances pertaining to Quality of Service. Thirteen cases were closed in favor of the Enrollees and one was closed in favor of the Plan. The following is a summary of these issues:

Fourteen members complained about the service they received from their providers, non-clinical staff, or the condition of a facility. Thirteen cases were closed in favor of the Enrollees and one case was closed in favor of the plan.

Other Issues

There were two grievances pertaining to Other Issues. The following is a summary of this issue:

Two members complained about operations or policy issues. One case closed in favor of the Plan and the other case is still open, pending review.

INTEROFFICE MEMO

DATE: 10/30/2017

TO: Department Stakeholders

CC: Marketing; Member Services

FROM: Lela Criswell

RE: Expanded Transportation Benefit

Effective October 1, 2017 transportation to all Medi-Cal covered services became the responsibility of Medi-Cal Managed Care Plans (MMCP) for their members. This means that members receiving services that are carved out of the contractual agreements between the Department of Health Care Services (DHCS) and Kern Family Health Care may receive transportation through us for that service.

The DHCS only requires that MMCPs cover Non-Medical Transportation (NMT) to carve out services. However, a business decision was made to allow Non-Emergency Medical Transportation (NEMT) for qualifying members who have a PCS form on file.

Tracking these services is a challenge that our transportation broker, ALC, is assisting us with. Please refer all member requests for transportation services to our "Transportation Department" except for those services not handled by our Transportation Department such as after-hours hospital discharges requiring NEMT, ambulance and air transport.

KERN HEALTH SYSTEMS
2nd Quarter 2017
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Report Date: October 3, 2017

Department: Provider Relations

Monitoring Period: July 1, 2017 through September 30, 2017

Population:

Providers	Credentialed	Recredentialed
MD's	47	57
DO's	4	1
AU's	0	1
DC's	5	0
AC's	0	0
PA's	10	5
NP's	23	2
CRNA's	7	6
DPM's	3	0
OD's	0	0
ND's	0	0
BCBA's	2	0
Mental Health	8	1
Ocularist	0	0
Ancillary	7	30
OT	0	0
TOTAL	**116**	**103**

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Acupuncture	0	0	0	0
Allergy & Immunology	0	0	0	0
Anesthesiology / CRNA	10	10	20	0
Audiology	0	1	1	0
Autism / Behavioral Analyst	2	0	2	0
Cardiology	3	3	6	0
Chiropractor	5	0	5	0
Colon & Rectal Surgery	0	0	0	0
Critical Care	0	0	0	0
Dermatology	1	1	2	0
Emergency Medicine	3	0	3	0
Endocrinology	1	0	1	0
Family Practice	14	3	17	0
Gastroenterology	0	1	1	0
General Practice	4	0	4	0
General Surgery	0	1	1	0
Genetics	0	0	0	0
Gynecology	0	0	0	0
Gynecology/Oncology	0	0	0	0
Hematology/Oncology	2	1	3	0
Hospitalist	2	0	2	0
Infectious Disease	1	0	1	0
Internal Medicine	16	10	26	0

KERN HEALTH SYSTEMS
2nd Quarter 2017
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Mental Health	8	1	9	0
Mid Wife	0	0	0	0
Naturopathic Medicine	0	0	0	
Neonatology	0	3	3	0
Nephrology	0	1	1	0
Neurological Surgery	0	0	0	0
Neurology	0	0	0	0
Obstetrics & Gynecology	8	8	16	0
Ocularist	0	0	0	0
Occupational Therapy	0	0	0	0
Ophthalmology	0	4	4	0
Optometry	0	0	0	0
Orthopedic Surgery / Hand Surg	0	0	0	0
Otolaryngology	3	0	3	0
Pain Management	0	0	0	0
Pathology	1	3	4	0
Pediatrics	1	4	5	0
Physical Medicine & Rehab	3	2	5	0
Plastic Sugery	3	0	3	0
Podiatry	3	0	3	0
Psychiatry	5	3	8	0
Pulmonary	1	1	2	0
Radiation Oncology	2	0	2	0
Radiology	9	12	21	0
Rheumatology	0	0	0	0
Sleep Medicine	0	0	0	0
Thoracic Surgery	0	1	1	0
Vascular Medicine	0	0	0	0
Vascular Surgery	0	0	0	0
Urology	0	0	0	0
TOTAL	**111**	**74**	**185**	**0**
ANCILLARY				
Ambulance	0	0	0	0
Cardiac Sonography	0	0	0	0
Comm. Based Adult Services	0	0	0	0
Dialysis Center	1	0	1	0
DME	1	3	4	0
Hearing Aid Dispenser	0	0	0	0
Home Health	0	2	2	0
Home Infusion/Compounding	0	0	0	0
Hospice	0	1	1	0
Hospital	0	3	3	0
Laboratory	0	5	5	0
Lactation Consultant	0	0	0	0
MRI	0	0	0	0
Ocular Prosthetics	0	0	0	0
Pharmacy	1	11	12	0
Pharmacy/DME	0	0	0	0

KERN HEALTH SYSTEMS
2nd Quarter 2017
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

ANCILLARY				
Physical / Speech Therapy	0	0	0	0
Prosthetics & Orthotics	0	1	1	0
Radiology	0	0	0	0
Skilled Nursing	2	0	2	0
Sleep Lab	1	0	1	0
Surgery Center	0	3	3	0
Transportation	1	1	2	0
Urgent Care	0	0	0	0
TOTAL	**7**	**30**	**37**	**0**

Defer = 0 **Denied = 0**

KHS BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
AUGUST 10, 2017

Name	DBA	Specialty	Address	Comments	Contract Effective Date
ACE Eyecare, inc.	ACE Eyecare, Inc.	Opthalmology & Optometry	1721 Westwind Dr. Ste. B Bakersfield CA 93309	New TIN & Name change from Advanced Center for Eyecare. Providers already credentialed	9/1/2017
Autism Response Team	Autism Response Team	ABA	4500 California Ave Bakersfield CA 93309		8/1/2017
Clinica Del Pueblo Lamont/ Dr. Leopoldo Puga	Clincia Del Pueblo Lamont	IM/ PCP	10200 Main Street Ste A, Lamont CA 93241	New owner; new name & TIN but same staff. Providers already cred. No need for Site review per Stephanie in QI.	9/1/2017
Gohar Gevorgyan, MD	Gevorgyan Medical Center	Family Practice	2601 16th St. Bakersfield CA 93301	Additional Location / private practice	9/1/2017
Jum Min, MD	Jum Min, MD	OB/GYN	4050 San Dimas #A Bakersfield, CA 93301		8/1/2017

KHS BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
AUGUST 10, 2017

Arnold Lim, DO	Arnold Lim, DO Inc.	Orthopedic Surgery	300 Old River Road, Ste. 200, Bakersfield, CA 93311	Received contract July 26th. Provider was already credentialed and will start this contract 9/13/17 at Mercy Ortho	9/13/2017
St Therese Medical Group	St Therese Medical Group	Internal Medicine	901 Olive Drive Suite B	Provider Already Credentialed - Oriente Esposo MD	9/1/2017

KERN HEALTH SYSTEMS

Approved Providers Effective 9-01-17

	A	B	C	D	E	F
1	NAME	DBA/ADDRESS	SPECIALTY	Provider #	Pay To #	Effective
2	Avancena, Yessica LMFT	Kern County Hospital Authority Grow Clinic 820 34th Street Bakersfield CA 93301	Marriage/Family Therapy	PRV040173	ALL KMC	**9/1/2017**
3	Alleyne, Robin MD	Clinica Sierra Vista (CSV) 1611 1st Street Bakersfield CA 93304	Internal Medicine	PRV040357	PRV000002	**9/1/2017**
4	Adjei, Phyllis NP	The Heart Center 5020 Commerce Drive Bakersfield CA 93309	Cardiovascular Disease	PRV041412	PRV000310	**9/1/2017**
5	Angle, Lesley PA-C	Grossman Medical Group, Inc. 420 34th Street Bakersfield CA 93301	Plastic Surgery (Burn)	PRV037765	PRV000405	**9/1/2017**
6	Bautista-Azores, Richelle MD	Ridgecrest Regional Hospital RHC 1111 N China Lake Blvd Ridgecrest CA 93555	Pediatrics	PRV041413	PRV029495	**9/1/2017**
7	Beaird, Chyle MD	Clinica Sierra Vista (CSV) 1611 1st Street Bakersfield CA 93304	Family Practice	PRV040017	PRV000002	**9/1/2017**
8	Beaty, Rodney PA-C	Comprehensive Blood & Cancer Center 6501 Truxtun Avenue Bakersfield CA 93309	Radiation Oncology	PRV000619	PRV013881	**9/1/2017**
9	Bourelle, Janine NP-C	Centennial Medical Group 1801 16th Street Bakersfield CA 93301	Endocrinology	PRV039470	PRV032371	**9/1/2017**
10	Bramlett, Bobby DC	Omni Family Health 4151 Mexicali Drive Bakersfield CA 93313	Chiropractic	PRV040966	PRV000019	**9/1/2017**
11	Camacho, Cecilia LCSW	Omni Family Health 655 S. Central Valley Highway Shafter CA 93263	Clinical Social Worker	PRV040356	PRV000019	**9/1/2017**
12	Casanova, Michelle NP-C	Omni Family Health 655 S. Central Valley Highway Shafter CA 93263	Family Practice	PRV039871	PRV000019	**9/1/2017**
13	Cerro, Joan NP-C	Truxtun Psychiatric Medical Group, Inc. 6001 Truxtun Ave. Suite 160 Bakersfield CA 93309	Psychiatry	PRV010113	PRV014120	**9/1/2017**
14	Chang, Elbert DO	Comfort Anesthesia Associates, Inc. 3001 Sillect Avenue Bakersfield CA 93309 Alternate Locations: DRMC - 1401 Garces Highway Delano	Anesthesiology	PRV029534	PRV013775	**9/1/2017**

KERN HEALTH SYSTEMS
Approved Providers Effective 9-01-17

	A	B	C	D	E	F
15	Cheng, Ryan FNP-C	Omni Family Health 1022 Calloway Drive Bakersfield CA 93312 Alternate Locations: Omni - 1215 Jefferson Street Delano	Family Practice	PRV011993	PRV000019	**9/1/2017**
16	Cheng, Vanesa Francis NP-C	Omni Family Health 4151 Mexicali Drive Bakersfield CA 93313 Alternate Locations: 4131 Ming Avenue Bakersfield 93309	Family Practice	PRV039540	PRV000019	**9/1/2017**
17	Dejean, Andre MD	GMA Healthcare Providers 9500 Stockdale Highway Ste. 203 Bakersfield CA 93311	Family Practice	PRV039794	PRV000386	**9/1/2017**
18	Delano District Skilled Nursing Facility	North Kern South Tulare Hospital District 1509 Tokay Avenue Delano CA 93215	Skilled Nursing Facility	PRV006729	PRV006729	**9/1/2017**
19	Delano Family Pharmacy	Central California Foundation for Health 1401A Garces Highway Delano CA 93215	Pharmacy	PRV041417	PRV041417	**9/1/2017**
20	Dilmore, Heather FNP-C	Accelerated Urgent Care - Stockdale 9500 Stockdale Highway Ste. 100 Bakersfield CA 93311	Emergency Medicine	PRV034648	PRV032603 stockdale PRV033690 white lane	**9/1/2017**
21	Doctor, Niraj MD	Centric Health Central Cardiology Medical Clinic 2901 Sillect Avenue Ste. 100 Bakersfield CA 93308	Cardiovascular Disease	PRV040838	PRV000503	**9/1/2017**
22	Dolland, Steven CRNA	Regional Anesthesia Associates, Inc. 1700 Mt. Vernon Avenue Bakersfield CA 93306	Certified Nurse Anesthetist	PRV038777	PRV037540	**9/1/2017**
23	Enunwa, Rita NP-C	LAGS Spine and Sportscare Medical Centers 3550 Q Street Ste. 103-105,201,202 Bakersfield CA 93301	Physical Medicine & Rehabilitation	PRV041414	PRV000403	**9/1/2017**
24	Golden, Luis MD	Renaissance Imaging Medical Associates, Inc 1600 Avenue J Lancaster CA 93534 Alternate Locations: 44105 W. 15th Street Ste. 100 Lancaster 38925 Trade Center Drive Ste. E Palmdale	Diagnostic Radiology	PRV041415	PRV000324	**9/1/2017**
25	Hashemi, Emad MD	Clinica Sierra Vista (CSV) 815 Dr. Martin Luther King Jr. Blvd Bakersfield CA 93307	OB/GYN	PRV039539	PRV000002	**9/1/2017**

KERN HEALTH SYSTEMS
Approved Providers Effective 9-01-17

	A	B	C	D	E	F
26	He, Heidi NP-C	Alpha J. Anders MD, Inc 2811 H Street Bakersfield CA 93301	Pulmonary Disease	PRV005584	PRV029633	**9/1/2017**
27	Hepfer, Michael MD	Renaissance Imaging Medical Associates, Inc 1600 Avenue J Lancaster CA 93534 Alternate Locations: 44105 W. 15th Street Ste. 100 Lancaster 38925 Trade Center Drive Ste. E Palmdale	Diagnostic Radiology	PRV038906	PRV000324	**9/1/2017**
28	Hoosier, Michael PA-C	LAGS Spine and Sportscare Medical Centers 3550 Q Street Ste. 103-105,201,202 Bakersfield CA 93301	Pain Medicine	PRV039406	PRV000403	**9/1/2017**
29	Igbinosa, Ngozi MD	Parikshat Sharma, MD, Inc. Dba: Golden State Hospitalists 2215 Truxtun Avenue Bakersfield CA 93301	Internal Medicine / Hospitalist	PRV039068	PRV000438	**9/1/2017**
30	Khalkhali, Iraj MD	Renaissance Imaging Medical Associates, Inc 1600 Avenue J Lancaster CA 93534 Alternate Locations: 44105 W. 15th Street Ste. 100 Lancaster 38925 Trade Center Drive Ste. E Palmdale	Diagnostic Radiology	PRV039106	PRV000324	**9/1/2017**
31	Khokar, Jaswant MD	Truxtun Psychiatric Medical Group, Inc. 6001 Truxtun Ave. Suite 160 Bakersfield CA 93309	Psychiatry & Psychiatry Child/Adolescent	PRV041510	PRV014120	9/1/2017
32	Lem, Kelli PA-C	Accelerated Urgent Care - Stockdale 9500 Stockdale Highway Ste. 100 Bakersfield CA 93311 Alternate location: Accelerated UC - 4871 White Lane Bakersfield	Emergency Medicine	PRV041416	PRV032603 stockdale PRV033690 white lane	**9/1/2017**
33	Lyons, Shenaye NP-C	Ridgecrest Regional Hospital RHC 1111 N China Lake Blvd Ridgecrest CA 93555	Internal Medicine	PRV041065	PRV029495	**9/1/2017**
34	Mangat, Charanpal MD	Rahul Sharma, MD, Inc. 9610 Stockdale Highway Ste. B Bakersfield CA 93311 Alternate Locations: 323 Lexington Street Delano 1217 7th Street Wasco	OB/GYN	PRV040968	PRV000361 bakersfield PRV039571 delano PRV039573 Wasco	**9/1/2017**

KERN HEALTH SYSTEMS
Approved Providers Effective 9-01-17

	A	B	C	D	E	F
35	Mangat, Geeteshwar MD	Parikshat Sharma, MD, Inc. Dba: Golden State Hospitalists 2215 Truxtun Avenue Bakersfield CA 93301	Internal Medicine / Hospitalist	PRV012241	PRV000438	**9/1/2017**
36	Mangat, Ramneet MD	Rahul Sharma, MD, Inc. 9610 Stockdale Highway Ste. B Bakersfield CA 93311 Alternate Locations: 323 Lexington Street Delano 1217 7th Street Wasco	OB/GYN	PRV040968	PRV000361 bakersfield PRV039571 delano PRV039573 Wasco	9/1/2017
37	McDowell, Deborah NP-C	GMA Healthcare Providers 9500 Stockdale Highway Ste. 203 Bakersfield CA 93311	Family Practice	PRV039594	PRV000386	**9/1/2017**
38	Michalski, Ann Marie NP	Truxtun Psychiatric Medical Group, Inc. 6001 Truxtun Ave. Suite 160 Bakersfield CA 93309	Psychiatry	PRV040928	PRV014120	**9/1/2017**
39	Nieto, Ruben DPM	Stockdale Podiatry Group Inc 110 New Stine Road Bakersfield CA 93309	Podiatry	PRV041506	PRV000332	**9/1/2017**
40	Price, Helen WHCNP	Clinica Sierra Vista (CSV) 301 Brundage Lane Bakersfield CA 93304	OB/GYN / Women's Health	PRV040721	PRV000002	**9/1/2017**
41	Prime Pulmonary & Sleep Center	Prime Pulmonary & Sleep Medicine Center 8305 Brimhall Road Ste. 1601 Bakersfield CA 93312	Sleep Lab	PRV039731	PRV039731	**9/1/2017**
42	Ringle, Dan CRNA	Comfort Anesthesia Associates, Inc. 3001 Sillect Avenue Bakersfield CA 93308 Alternate Location: DRMC - 1401 Garces Highway Delano	Certified Nurse Anesthetist	PRV037340	PRV013775	**9/1/2017**
43	Rodriguez, Ruby CRNA	Premier Anesthesia Medical Group 3200 21st Street Ste. 301 Bakersfield CA 93301	Certified Nurse Anesthetist	PRV005116	PRV000227	**9/1/2017**
44	Rubolino-Gallego, Maria NP-C	A Linn Medical Practice 4000 San Dimas Street Ste. 2 Bakersfield CA 93301	Certified Nurse Anesthetist	PRV041507	PRV000233	**9/1/2017**
45	Sanya, Rahima MD	Rahul Sharma, MD, Inc. 9610 Stockdale Highway Ste. B Bakersfield CA 93311 Alternate Locations: 323 Lexington Street Delano 1217 7th Street Wasco	OB/GYN	PRV040611	PRV000361 bakersfield PRV039571 delano PRV039573 Wasco	**9/1/2017**

KERN HEALTH SYSTEMS
Approved Providers Effective 9-01-17

	A	B	C	D	E	F
46	Silverman, Jeffrey MD	Renaissance Imaging Medical Associates, Inc 1600 Avenue J Lancaster CA 93534 Alternate Locations: 44105 W. 15th Street Ste. 100 Lancaster 38925 Trade Center Drive Ste. E Palmdale	Diagnostic Radiology	PRV040311	PRV000324	**9/1/2017**
47	Singh, Gurmit PA-C	Comprehensive Blood & Cancer Center 6501 Truxtun Avenue Bakersfield CA 93309	Hematology/Oncology	PRV007340	PRV013881	**9/1/2017**
48	Wang, Jane MD	LAGS Spine and Sportscare Medical Centers 3550 Q Street Ste. 103-105,201,202 Bakersfield CA 93301	Physical Medicine & Rehabilitation	PRV041508	PRV000403	**9/1/2017**
49	Wong, Reynold MD	Direct Dermatology 165 Saint Dominics Drive Ste. 140 Manteca CA 95337	Dermatology	PRV041509	PRV012901	**9/1/2017**
50	Yacoub, Robert MD	Comfort Anesthesia Associates, Inc. 3001 Sillect Avenue Bakersfield CA 93309	Anesthesiology	PRV006426	PRV013775	**9/1/2017**
51	Yeh, Jekwon MD	Rio Bravo Oncology Inc. 4500 Morning Drive Ste. 105 Bakersfield CA 93306	Radiation Oncology	PRV040574	PRV035588	**9/1/2017**

Kern Health Systems

Board Approved Providers Effective November 1, 2017

NAME	DBA/ADDRESS	Specialty	Provider #	Pay To #	Effective
Kang, Yadwinder MD	1st Choice Urgent Care 6515 Panama Lane Suite 106-107 Bakersfield CA 93311	Family Medicine	PRV004162	PRV042402	**Yes** **10/01/2017**
San Joaquin Valley Health Group, Inc	1st Choice Urgent Care 6515 Panama Lane Suite 106-107 Bakersfield CA 93311	Urgent Care Center	PRV042402	PRV042402	**Yes** **10/01/2017**
Unal, Berkay MD	Berkay Unal MD PC 300 Old River Road Ste. 200 Bakersfield CA 93311	Orthopedic Surgery / Sports Medicine	PRV042303	PRV041756	**Yes** **10/12/2017**
Ratl Mrad, Yasser MD	Omni Family Health 210 N. Chester Avenue Bakersfield CA 93308 Alternate Location: Omni - 4600 Panama Lane Ste. 102B Bakersfield Omni - 1100 Fourth Street Taft Pinnacle Women's Health Group, Inc. at: 1700 Mt Vernon Avenue 2615 Chester Avenue	OB/GYN	PRV008795	PRV000019	**Yes** **11/01/2017**
Arthington, Jason PA-C	Accelerated Urgent Care - Stockdale 9500 Stockdale Highway Ste. 100 Bakersfield CA 93311 Alternate Location: Accelerated UC - 4871 White Lane	Emergency Medicine	PRV004013	PRV032603 STOCKDALE PRV033690 WHITE LANE	**Yes** **11/01/2017**
Ayad, Amira MD	Adventist Health Physicians Network 2701 Chester Ave. Ste. 201 Bakersfield CA 93301	Family Practice	PRV002039	PRV029329	**Yes** **11/01/2017**
Chawla, Arthi MD	Clinica Sierra Vista (CSV) 1305 Bear Mountain Blvd. Arvin, CA 93203 Alternate Location: CSV - 815 Dr. Martin Luther King Jr. Blvd	Family Practice	PRV041527	PRV000002	**Yes** **11/01/2017**
Fernando, Gerard MD	Truxtun Psychiatric Medical Group, Inc. 6001 Truxtun Avenue Ste. 160 Bakersfield CA 93309	Psychiatry	PRV041952	PRV014120	**Yes** **11/01/2017**
Hallum, Tracine, LEP	Special Explorers Center 401 19th Street Bakersfield CA 93301	Licensed Educational / School Psychologist	PRV041878	PRV038625	**Yes** **11/01/2017**

Kern Health Systems

Board Approved Providers Effective November 1, 2017

Harrison, Antonio BCBA-D	Holdsambeck & Associates, Inc. 1112 S. Broadway Santa Maria CA 93454 Alternate Location: 2535 16th Street Ste. 215 & 210 93301	Behavior Analyst / Qualified Autism Services Provider	PRV042518	PRV031922	**Yes 11/01/2017**
Honari, Sara MD	Hao D Bui, MD, Inc. 4901 Centennial Plaza Way Bakersfield CA 93312	Vascular Surgery	PRV041155	PRV013705	**Yes 11/01/2017**
Morales, Kimberly BCBA	Special Explorers Center 401 19th Street Bakersfield CA 93301	Behavior Analyst / Qualified Autism Services Provider	PRV042306	PRV038625	**Yes 11/01/2017**
Olegario-Nebel, Marissa MD	LAGS Spine and Sportscare Medical Centers, Inc. 3550 Q Street Ste. 103-105,201,202 Bakersfield CA 93301	Physical Medicine & Rehabilitation	PRV042520	PRV000403	**Yes 11/01/2017**
Santa Monica UCLA Medical Center & Orthopaedic Hospital	Santa Monica UCLA Med Ctr & Orthopaedic Hosp 1250 16th Street Santa Monica CA 90404	Acute Hospital	PRV006213	PRV006213	**Yes 11/01/2017**
Seitz, Christopher PA-C	Accelerated Urgent Care - Stockdale 9500 Stockdale Highway Ste. 100 Bakersfield CA 93311 Alternate Location: Accelerated UC - 4871 White Lane	Family Practice	PRV042519	PRV032603 STOCKDALE PRV033690 WHITE LANE	**Yes 11/01/2017**
Singh, Jasbir MD	Kern County Hospital Authority KM - 1700 Mt Vernon Avenue Bakersfield CA 93306	Psychiatry	PRV040833	ALL KMC	**Yes 11/01/2017**
Tidwell, John MD	Kern County Hospital Authority KM - 1700 Mt Vernon Avenue Bakersfield CA 93306	Orthopedic Surgery	PRV039773	ALL KMC	**Yes 11/01/2017**
Wade, Gary MD	Renaissance Imaging Medical Associates, Inc 1600 Avenue J Lancaster CA 93534 Alternate Locations: 44105 W. 15th Street Ste. 100 Lancaster 38925 Trade Center Drive Ste. E Palmdale	Diagnostic Radiology	PRV042521	PRV000324	**Yes 11/01/2017**
Westfahl, Danessa NP-C	Vanguard Medical Corporation 565 Kern Street Shafter CA 93263	Family Practice	PRV041835	PRV029452	**Yes 11/01/2017**

Kern Health Systems

Board Approved Providers Effective November 1, 2017

Wilder, Inga MD	Omni Family Health 21138 Paso Robles Highway Lost Hills CA 93249 Alternate Location: Omni - 2101 7th Street Wasco	Family Practice	PRV041285	PRV000019	**Yes** **11/01/2017**
Win, Theingi MD	Kern County Hospital Authority KM - 1700 Mt Vernon Avenue Bakersfield CA 93306 Alternate Location: Sagebrush - 1111 Columbus Street	Internal Medicine & Cardiovascular Disease	PRV040834	ALL KMC	**Yes** **11/01/2017**
Wong, Arthur MD	Premier Anesthesia Medical Group 3200 21st Street Ste. 301 Bakersfield CA 93301	Anesthesiology	PRV034762	PRV000227	**Yes** **11/01/2017**

KERN HEALTH SYSTEMS

Access Monitoring 2017 - Quarter 3

- **After Hours Calls Results**
- **Appointment Availability Survey Results**
- **Geographic Accessibility Analysis**
- **Access Grievance Review**

KERN HEALTH SYSTEMS

After Hours Calls Results
2017 - Quarter 3

Access Monitoring

Q3, 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:

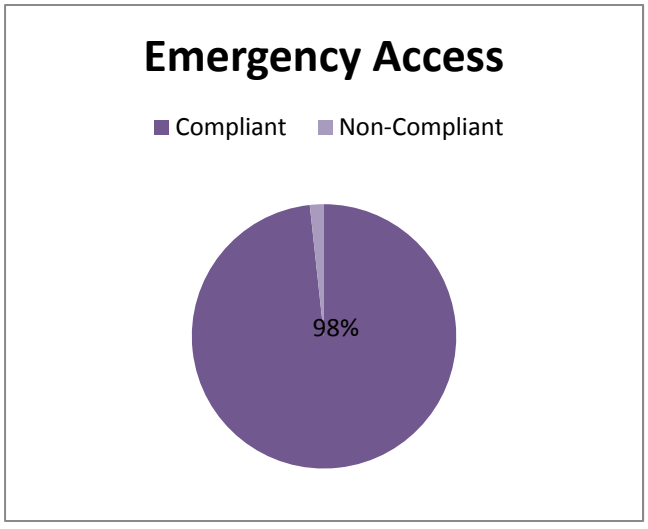
1.) Provider's answering machine or answering service must instruct the member to call 911 if the purpose of the call is a medical emergency.

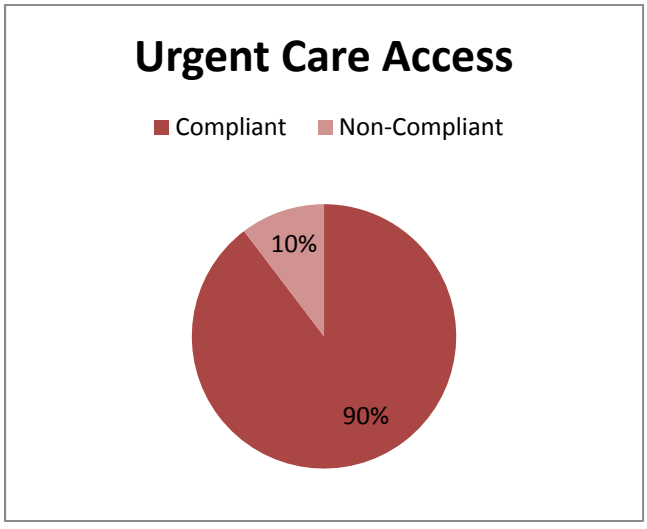
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

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

Results

116 provider offices were contacted during Q3. Of those offices, 114 were compliant with the Emergency Access Standards and 104 were compliant with the Urgent Care Access Standards.





Trending / Follow –Up / Outreach

The Plan reviewed results against past quarters and found that seven provider groups were found to be out of compliance with the urgent care access standards for a second quarter in a row (*Italicized* below). The Plan's Provider Network Analysts will make additional after hours calls and outreach to the provider groups out of compliance for a second quarter in a row, separate from the vendor conducted survey calls. Notices and copies of the policy will be mailed to all providers who were found to be out of compliance this quarter.

Out of Compliance Providers:

Bakersfield Health Services (Emergency Care Access Standard & Urgent Care Access Standard)

James Im, MD (Emergency Care Access Standard & Urgent Care Access Standard)

Bakersfield Medical and Mental Health Services (Urgent Care Access Standards)

Cal City Clinic (Urgent Care Access Standards)

California Medical Clinic (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)

Kern Pediatrics (Urgent Care Access Standards)

Ridgecrest Regional Hospital RHC (Urgent Care Access Standards)

Rosamond Medical Clinic (Urgent Care Access Standards)

Vanguard Medical Corporation (Urgent Care Access Standards)

KERN HEALTH SYSTEMS

Appointment Availability Survey Results 2017 - Quarter 3

Access Monitoring

Q3, 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.

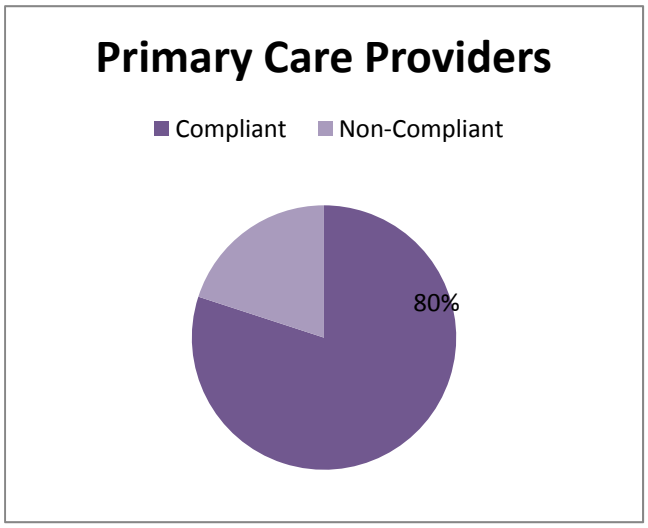
KHS policy and Department regulation require that members must be offered appointments within the following timeframes:

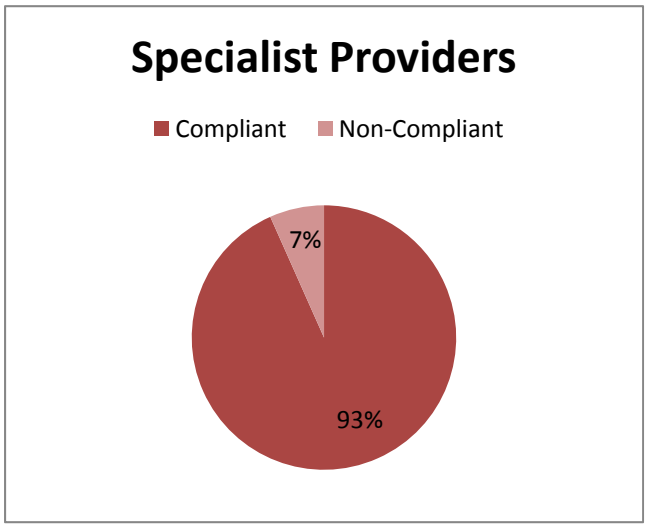
1) Non-urgent primary care appointments – within ten (10) business days of request.
2) Appointment with a specialist – within 15 business days of request;

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 primary care provider offices and 15 specialist offices were contacted during Q3 2017. Of the 15 primary care providers surveyed, 12 were compliant with the non-urgent primary care appointment within 10 business day standard and 3 were non-compliant with the standard. Of the 15 specialist providers surveyed, 14 were compliant with the specialist appointment within 15 business day standard, 1 was non-compliant with the standard.





Follow –Up / Outreach / Training

Notices of non-compliance with applicable policy language were mailed to the 4 non-compliant providers. 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:

*Lynous Hall, MD – Clinica Sierra Vista – Delano Community Health Center - (PCP Appointment within 10 days)

Antonio Garcia, MD – Kern Women's Health Group - (PCP Appointment within 10 days)

Mary Collignon, NP-C – Omni – Shafter Community Medical & Dental Center (PCP Appointment within 10 days)

+*Jose Soto-Velasco, MD – Jose Velasco, MD (Specialist Appointment within 15 days)

*First two appointments offered by the provider were compliant with applicable standard. KHS bases compliance off the third appointment offered.

+Only schedules in-office appointments one day a week.

KERN HEALTH SYSTEMS

Geographic Accessibility Analysis

2017 - Quarter 3

Access Monitoring

Q3, 2017

Background

As required by the Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS), Kern Health Systems (KHS) is required to maintain time and distance standards for certain provider types.

Per Section 1300.51 (d)(H) of the California Code of Regulations, KHS shall ensure, "all enrollees have a residence or workplace within **thirty (30) minutes or fifteen (15) miles** of a contracting or plan-operated **primary care provider**" as well as "**within thirty (30) minutes or fifteen (15) miles** of a contracting or plan-operated **hospital**". Further, per Section 1300.67.2.1(b), if "a plan's standards of accessibility […] are unreasonable restrictive […] the plan may propose alternative access standards of accessibility for that portion of its service area.

Per Exhibit A, Attachment 6 of the KHS contract with the DHCS, KHS, "shall maintain a network of **Primary Care Physicians** which are located **within thirty (30) minutes or ten (10) miles** of a member's residence unless [KHS] has a DHCS-approved alternative time and distance standard.

In May 2016 the DMHC finalized their process and template for requesting alternative access standards as outlined in Section 1300.67.2.1(b), and released them to plans. In November 2016, the DHCS finalized their process/template and stated that all Knox-Keene Act licensed MCPs should submit alternative time and distance standard requests directly to the DMHC, and the departments would review collaboratively. Utilizing the DMHC template per regulatory instruction, KHS proposed alternate access standards for portions of its service area and received DMHC approval of those proposed alternate standards in November 2016. Approval is still pending with the DHCS and in June 2017 KHS was informed the DHCS is currently in the process of reviewing all alternative access standard requests submitted by plans.

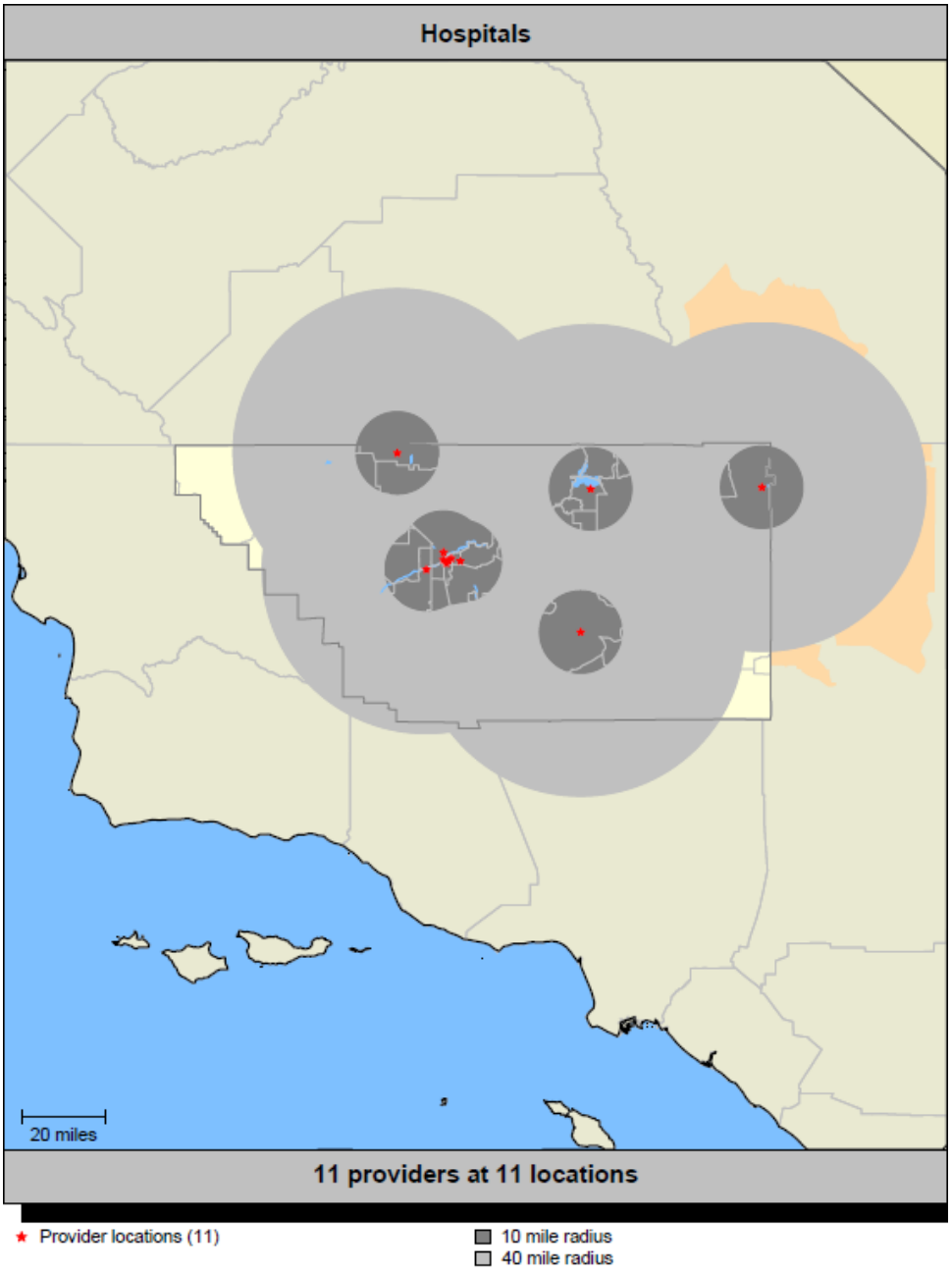
These requirements are currently memorialized in KHS policy and procedure 4.30-P *Accessibility Standards.*

As a part of its ongoing monitoring to ensure compliance with state regulation and reasonable geographic access to care for enrollees, in Q3 2017, KHS had an external vendor (Optum) conduct a geographic accessibility analysis.

DMHC Approved Alternative Access Standards

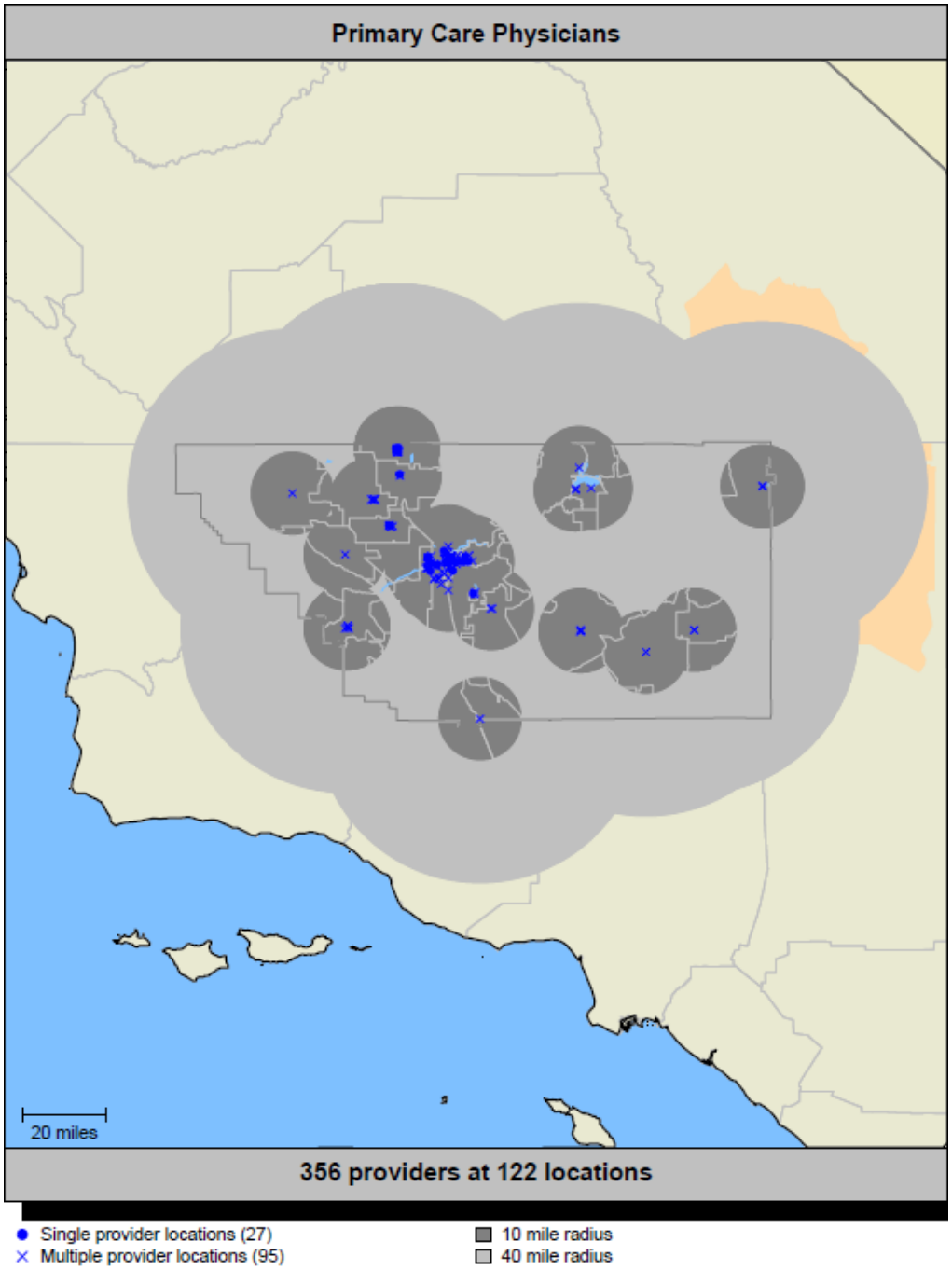
Primary Care Provider - Alternative Access Standards		
Zip Code	**City**	**Alternative Standard (miles)**
93516	Boron	35
93519	Cantil	35
93528	Johannesburg	30
93249	Lost Hills	40
93252	Maricopa	35
93255	Onyx	30
93524	Edwards	45
Hospital - Alternative Access Standards		
Zip Code	**City**	**Alternative Standard (miles)**
93203	Arvin	30
93313	Bakersfield	25
93516	Boron	50
93596	Boron	50
93206	Buttonwillow	40
93504	California City	35
93505	California City	35
93519	Cantil	40
93523	Edwards	45
93524	Edwards	60
93224	Fellows	40
93225	Frazier Park	50
93528	Johannesburg	30
93243	Lebec	50
93249	Lost Hills	60
93252	Maricopa	55
93251	Mc Kittrick	45
93501	Mojave	35
93255	Onyx	35
93222	Pine Mountain Club	40
93560	Rosamond	40
93263	Shafter	30
93268	Taft	40
93276	Tupman	30
93280	Wasco	30
93287	Woody	35

Results



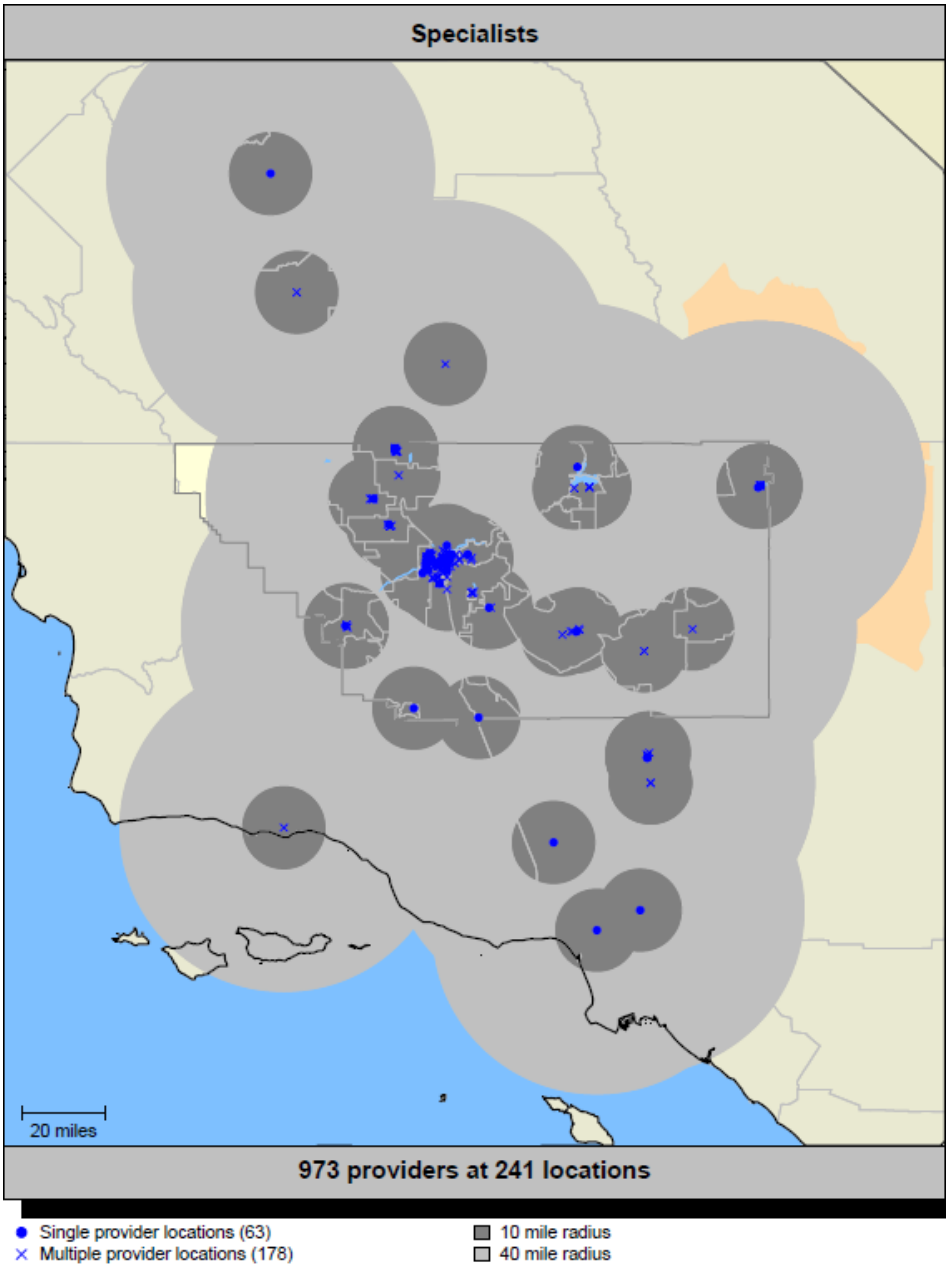
Hospitals

KHS currently maintains DMHC-approved alternative hospital accessibility standards for 26 zip codes within Kern County. The Q3 2017 geographic accessibility analysis found that enrollees in all zip codes within Kern County had access to a hospital within 15 miles, 30 minutes, or an alternate distance standard approved by the DMHC.



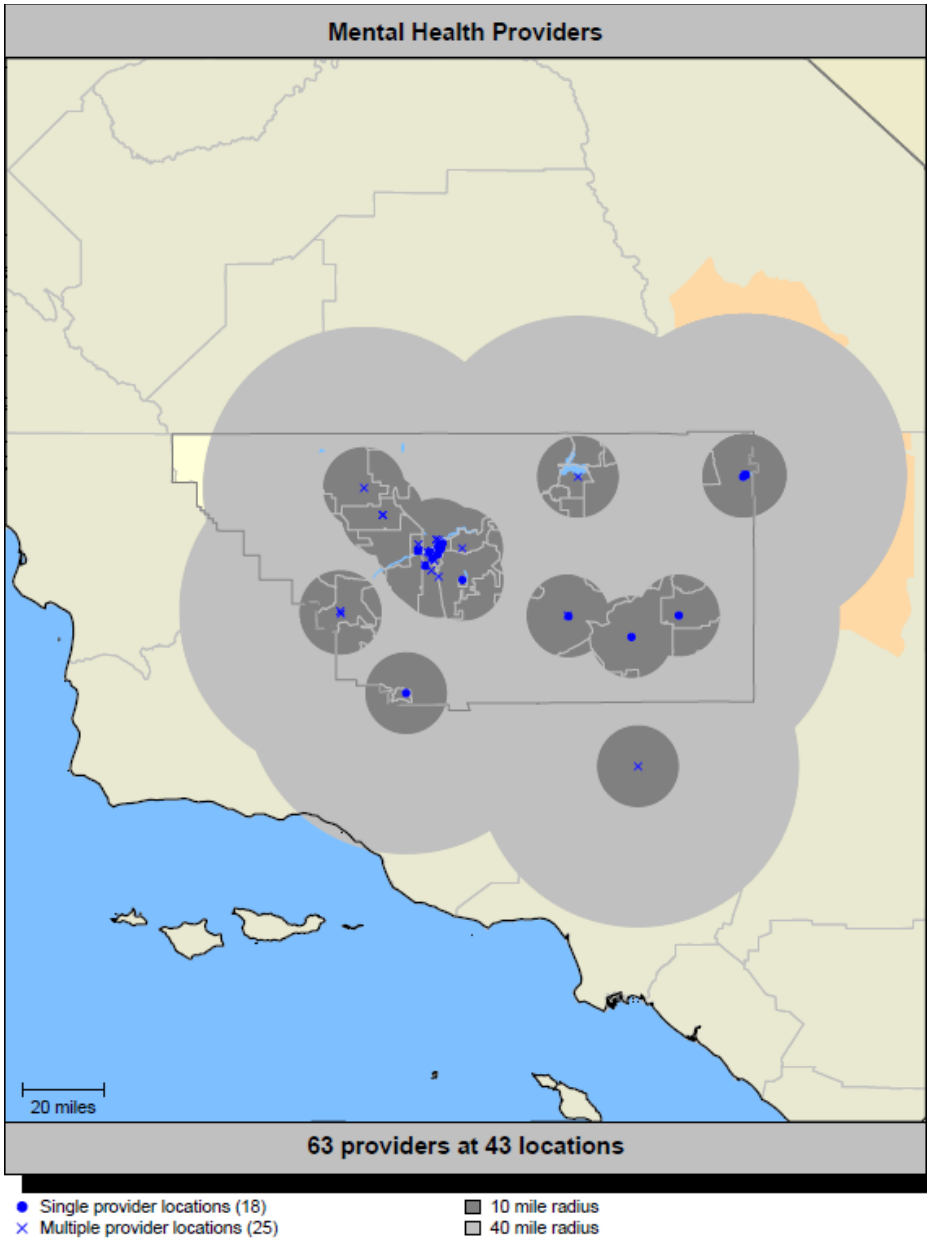
Primary Care Providers

KHS currently maintains DMHC-approved alternative primary care provider accessibility standards for 7 zip codes within Kern County. The Q3 2017 geographic accessibility analysis found that enrollees in all zip codes within Kern County had access to a primary care provider within 10 miles, 30 minutes, or an alternate distance standard approved by the DMHC.



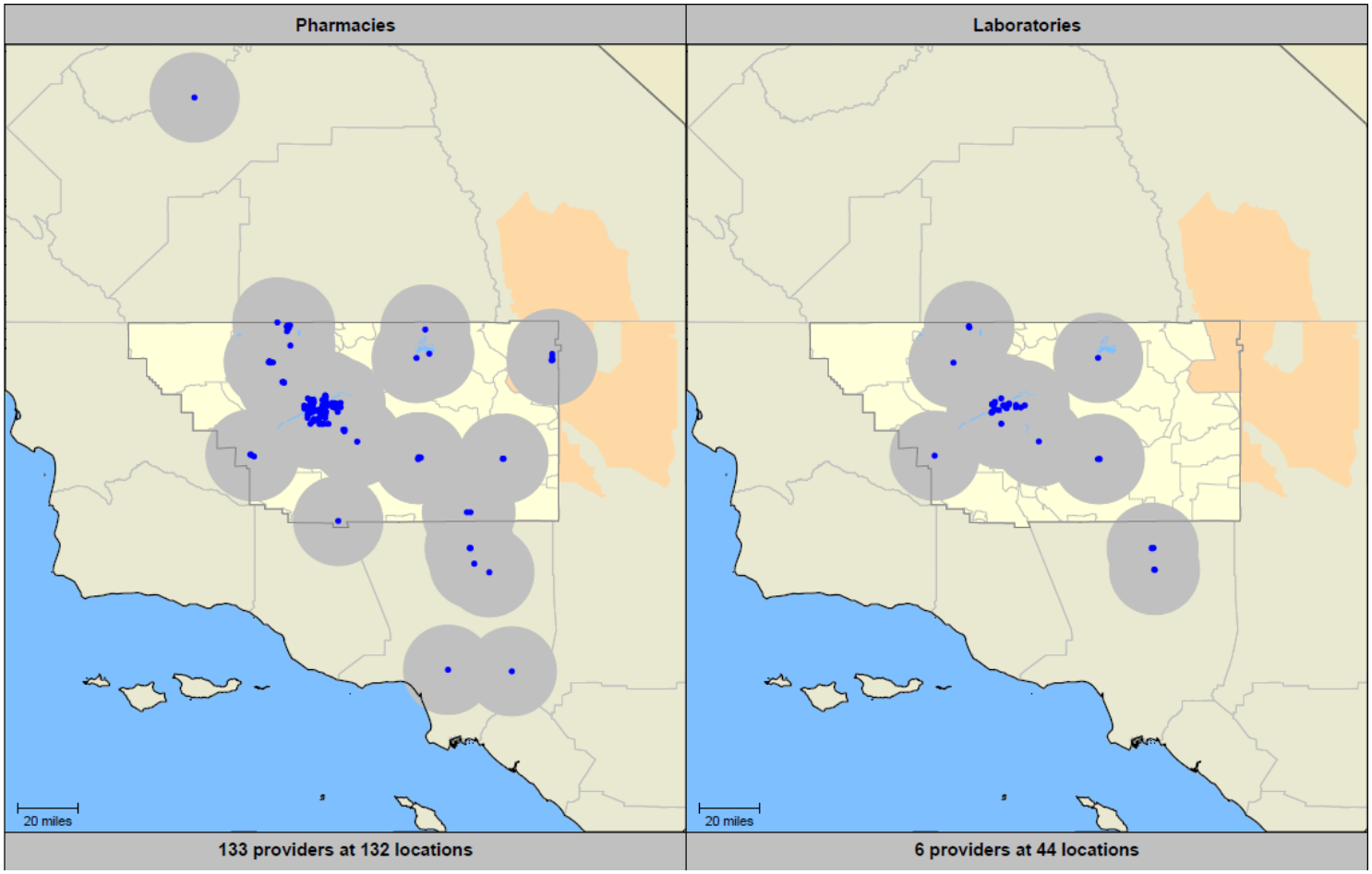
Specialists

Currently, there are no regulatory required standards and KHS does not maintain time or distance standards for accessibility to specialist care. The DHCS is in the process of finalizing new standards for specialist care based on county population. In addition to the Q3 2017 geographic accessibility analysis to specialty care, in Q2 2017, KHS conducted an in-depth geographic accessibility analysis to monitor enrollee access to specific specialty types.



Mental Health Providers

Currently, there are no regulatory required standards and KHS does not maintain time or distance standards for geographic access to mental health providers. The DHCS is in the process of finalizing new standards for mental health providers based on county population. Additionally, KHS utilizes telemedicine to provide mental health services at certain rural locations within the service area that may have not been captured in this analysis.



Laboraties and Pharmacies

Per Section 1300.51 (d)(H)(iv) of the California Code of Regulations, KHS shall ensure that, "[Ancillary laboratory, pharmacy and similar services and goods dispensed by order or prescription on the primary care provider are available from contracting or plan-operated providers at locations (where enrollees are personally served) within a reasonable distance from the primary care provider. Additionally, DHCS is in the process of finalizing new standards for certain ancillary provider types based on county population.

As there is no established time or distance standard for determining geographic accessibility to laboratory and pharmacy services, KHS utilized a 15 mile radius standard in conducting its analysis. KHS found that though there are geographic areas in which enrollees would have to travel farther than the 15 mile standard, these areas were the same in which KHS has DMHC-approved alternative access standards for primary care providers and hospitals.

Conclusions

Based on the results of the Q3 2017 geographic accessibility analysis, KHS found that we are in compliance with all DMHC and DHCS standards, and enrollees throughout the county have reasonable geographic access to care and services. The analysis provided the following results:

Primary Care Providers: All KHS enrollees have access to a Primary Care Provider within the regulatory required standard, or an approved alternative standard.

Hospitals: All KHS enrollees have access to a Hospital within the regulatory required standard, or an approved alternative standard.

Specialists/Mental Health Providers: For provider types in which regulatory agencies, nor KHS, currently maintain a geographic access standard, the analysis assisted in monitoring distance and time access to those services for enrollees.

Pharmacies/Laboratories: KHS found that while there is limited geographic access to these services in certain regions of KHS' service area, these are the same regions in which KHS maintains alternative access standards for PCP and Hospital care; based on these alternative standards, KHS found the access to pharmacy and laboratory services in these regions reasonable.

Looking Forward

Currently the DHCS only maintains standards for access to a Primary Care Physician, the department is in the process of updating and expanding on geographic access standards for other provider types. Upon completion and release of the updated standards, KHS will update applicable internal policies and procedures and monitoring processes to ensure compliance with regulatory requirements, and ensure access to services and care for our enrollees.

Access Grievance Review
2017 - Quarter 3

Access Monitoring

Q3, 2017

Introduction

On a quarterly basis, KHS' Provider Relations Department reviews all grievances from the previous quarter that were categorized as "Access to Care" or "Difficulty Accessing a Specialist".

During Q3 2017, twenty-five (25) grievances were received and reviewed by the KHS grievance committee. In fifteen (15) of the cases no issues were identified and were closed in favor of the plan. The remaining ten (10) cases, were closed in favor of the enrollee; these cases were forwarded to the Plan's Provider Relations Department for further review. At this time, the Provider Relation Department's analysis of these grievances is still ongoing and will be presented in next quarter' Access Monitoring.

KERN HEALTH SYSTEMS
DISEASE MANAGEMENT DEPARTMENT QUARTERLY REPORT

Report Date: October 10, 2017

Reporting Period: July 1, 2017 – September 30, 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:

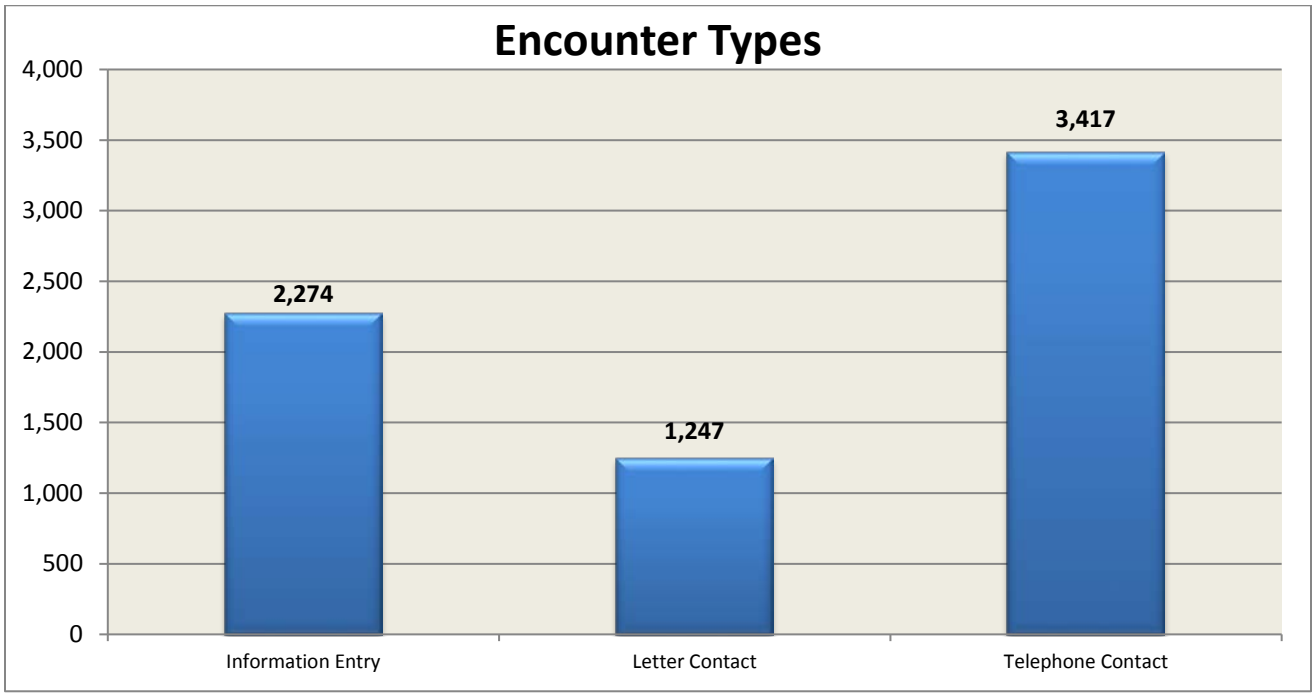
Staff	Caseload
RN 1	176
RN 2	189
RN 3	108
RN 4	195
TOTAL	**668**

DM Program Caseload:

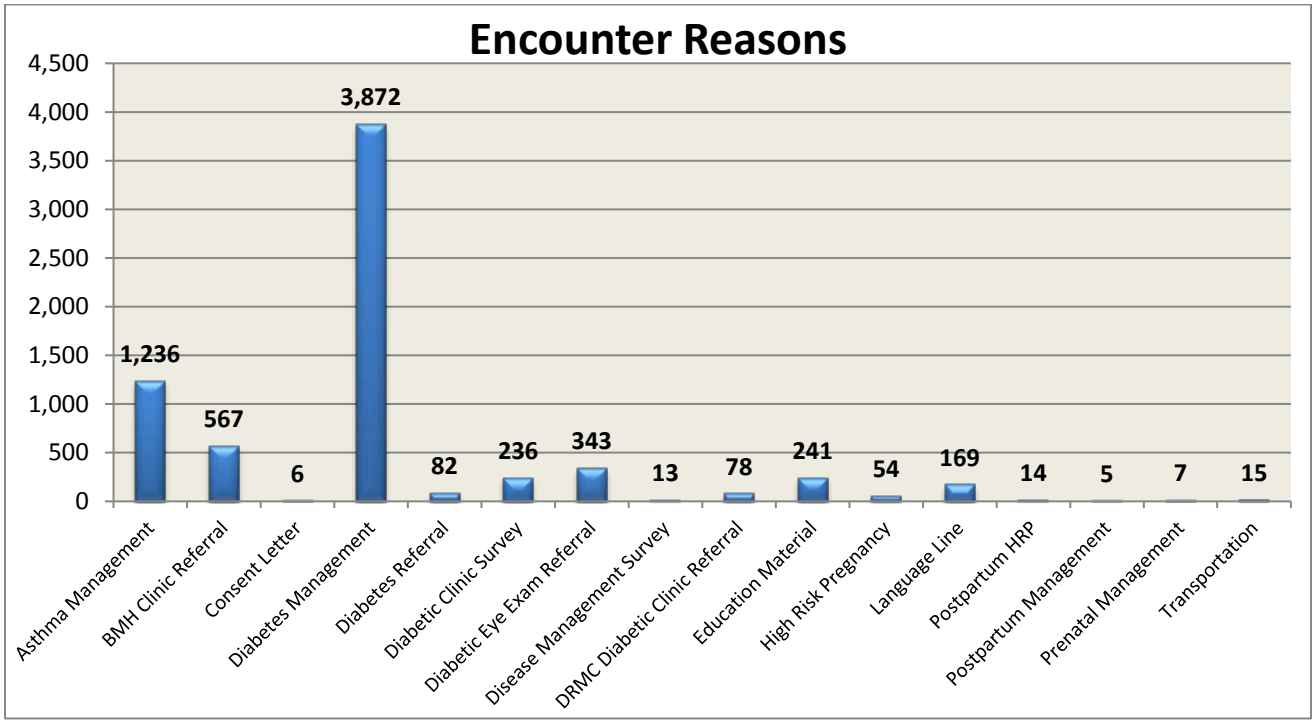
DM Program	Caseload
Asthma	183
Diabetes and Hypertension	474
High Risk Pregnancy	11
TOTAL	**668**

Encounters:

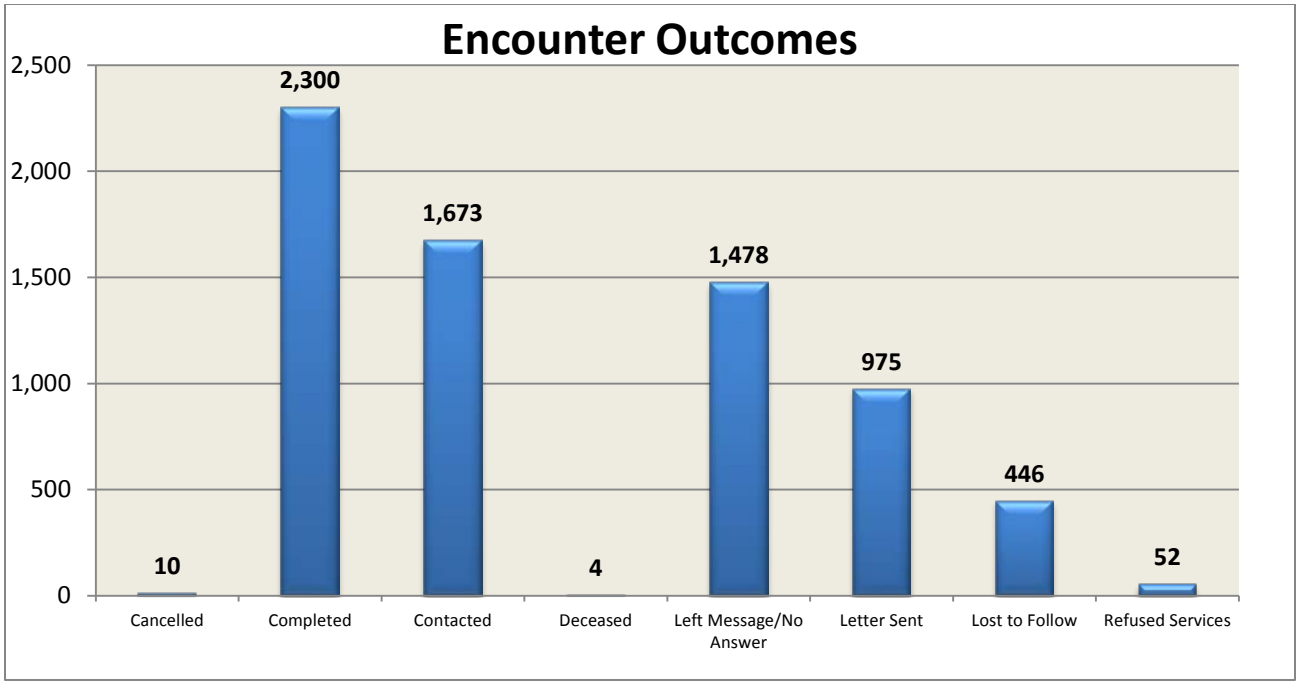
There were a total of 6,938 encounters submitted during this quarter for 2,260 KFHC members and the majority of the encounter types were listed as a Telephone Contact at 49%



The majority of the encounter reasons at 56% was listed as Diabetes Management.

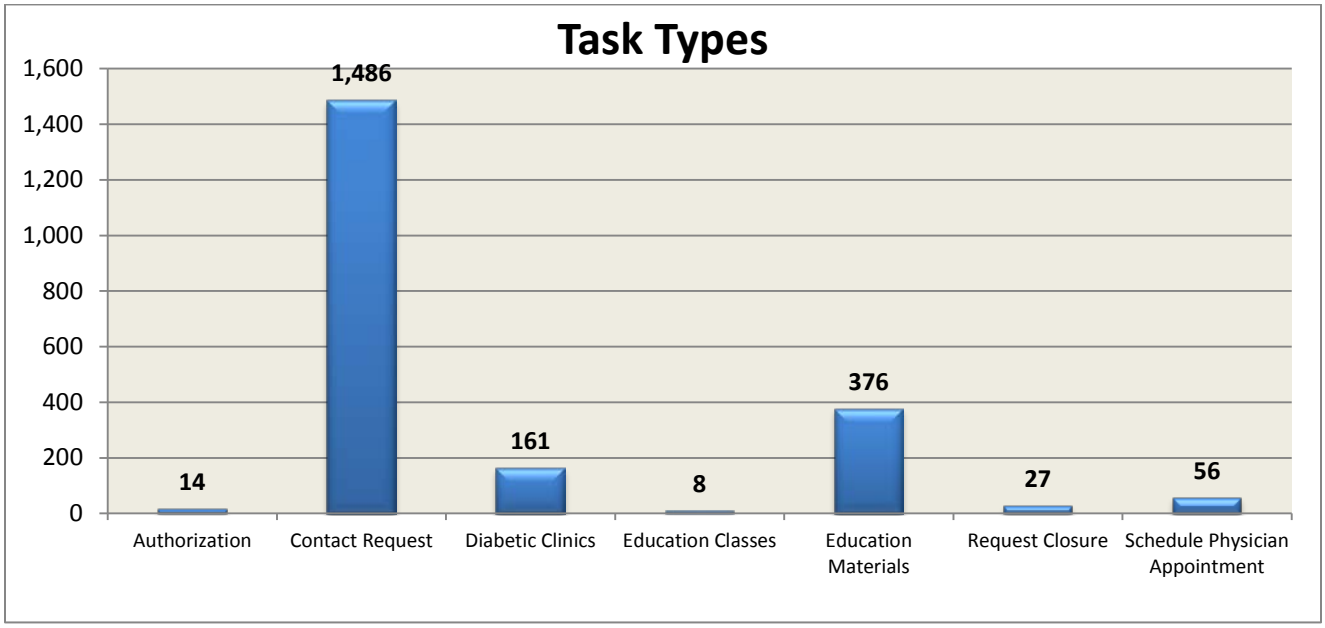


The majority of the encounter outcomes at 33% are listed as completed.

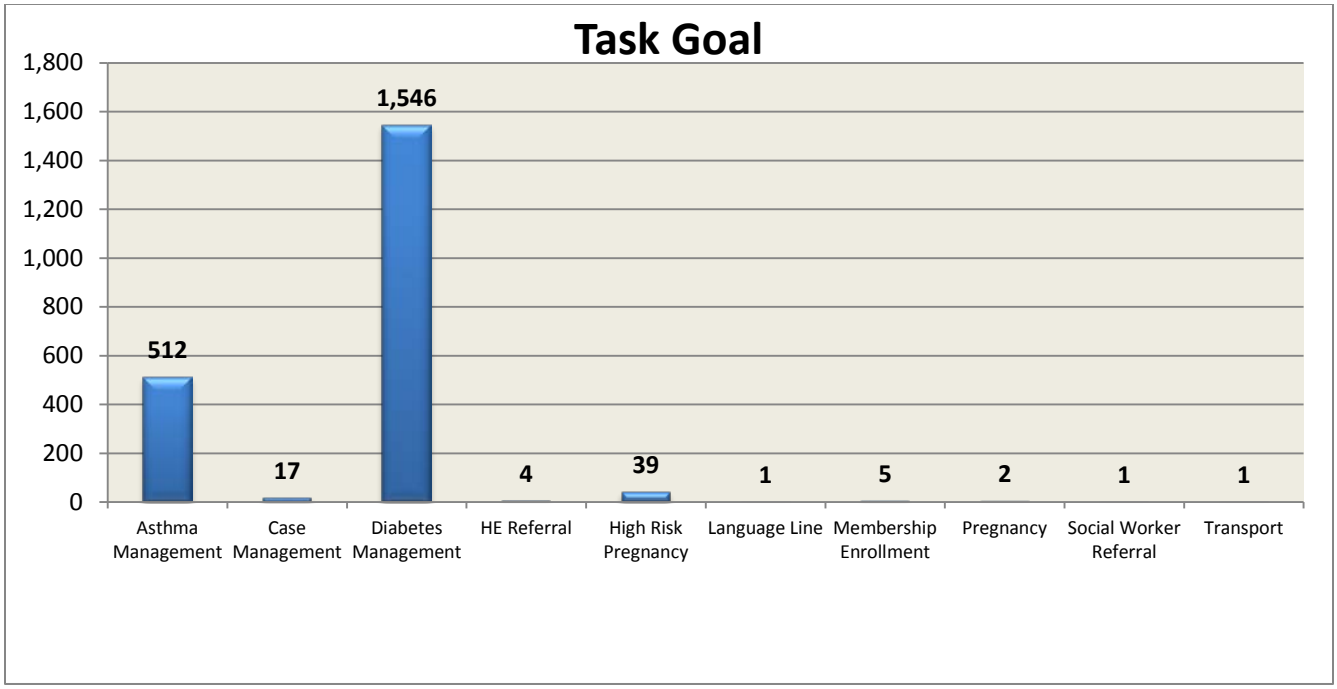


Tasks:

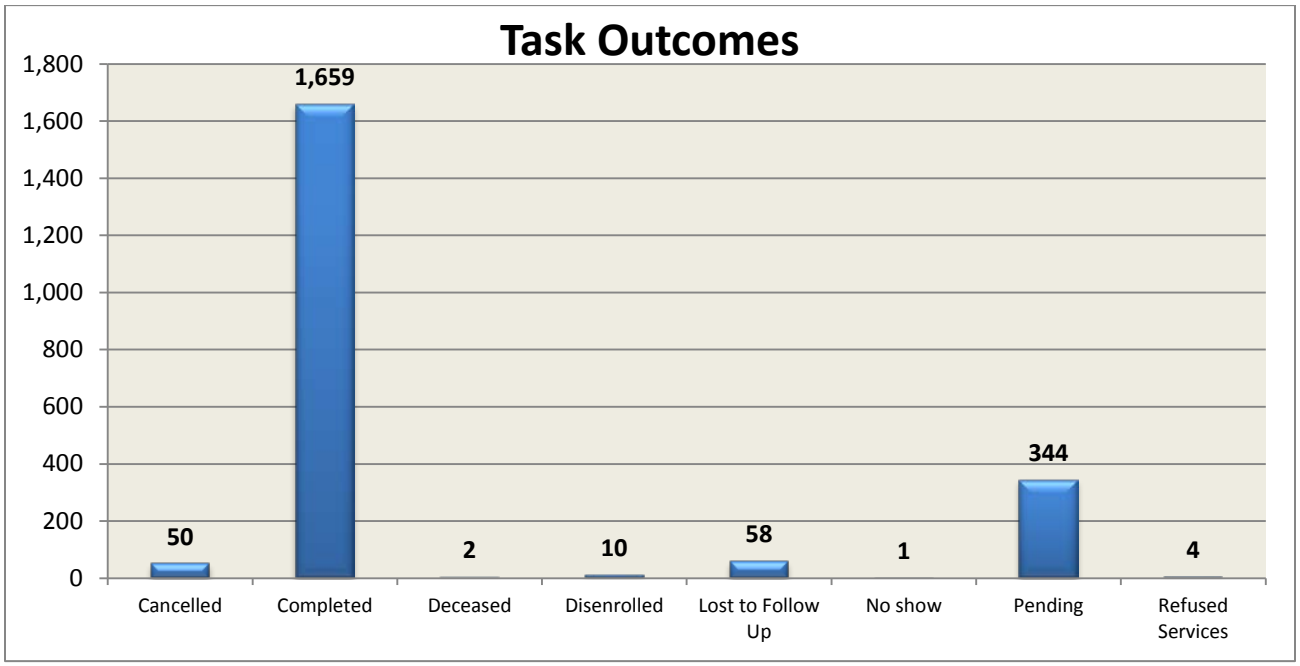
There were a total of 2,128 tasks assigned to the Disease Management department during the quarter for 1,231 KFHC members. The majority of Task Types were Contact Request at 70%.



The majority of task goals at 73% was listed as Diabetes Management.

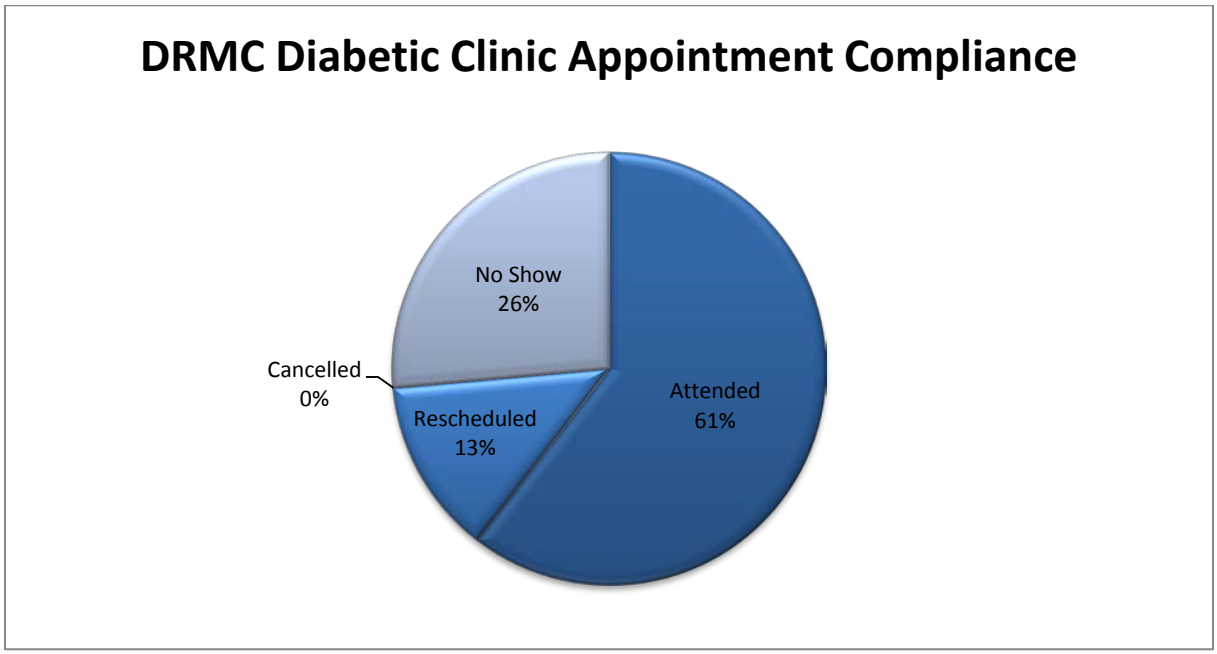


The majority of the task outcomes at 78% are completed.



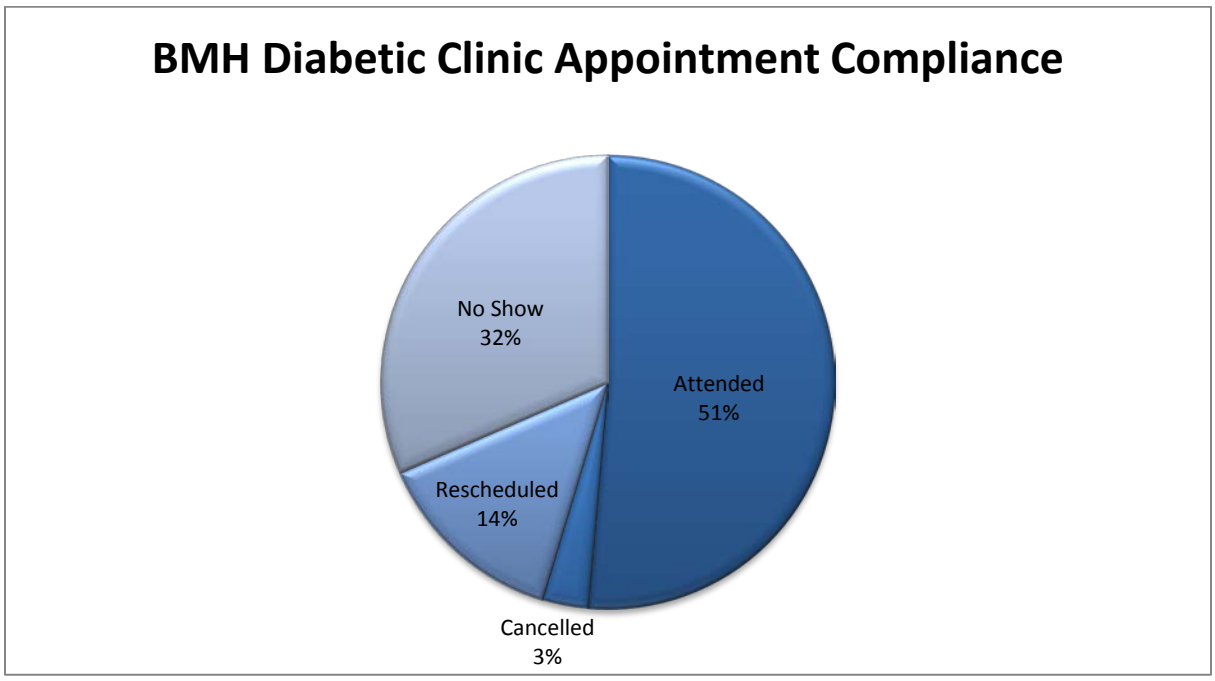
Delano Regional Medical Center (DRMC) Diabetic Clinic

Appointment compliance at the DRMC Diabetic Clinic revealed 60% of members attended their scheduled appointment. 473 appointments were scheduled.



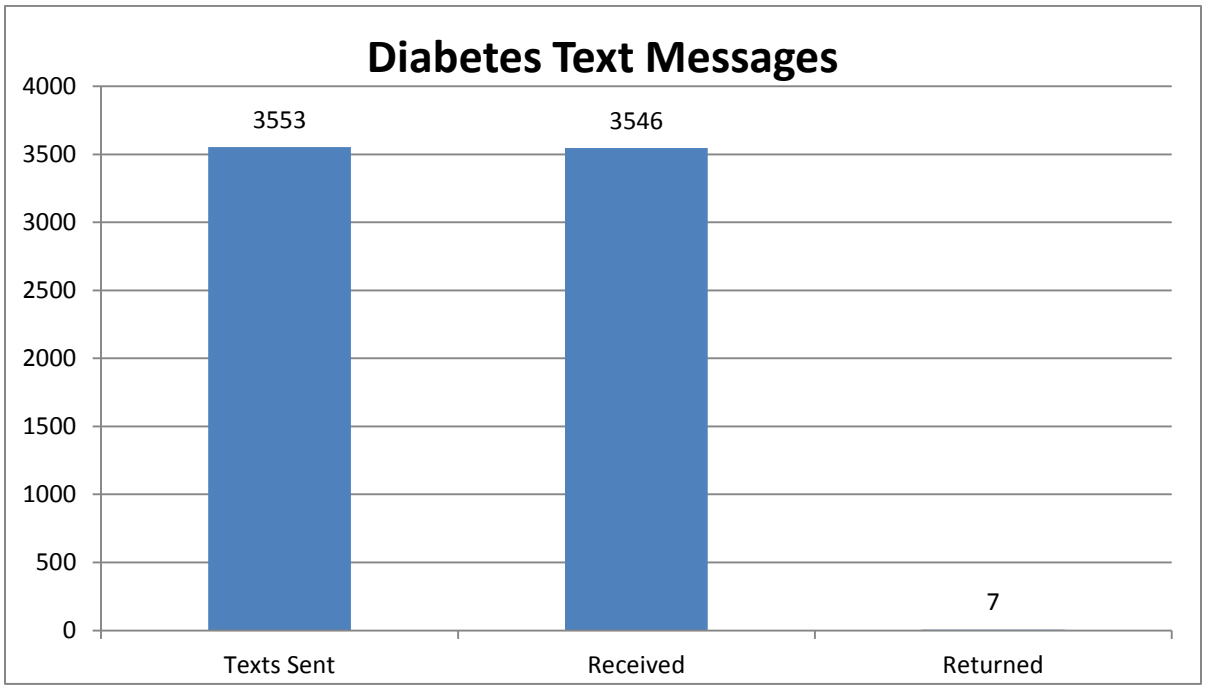
Bakersfield Memorial Hospital (BMH) Diabetic Clinic

Appointment compliance at the BMH Diabetic Clinic revealed 51% of members attended their scheduled appointment. 580 appointments were scheduled.



Diabetes Text Messaging Program

Thirteen diabetes related text messages, totaling 3,553 were sent to members during this quarter. 99.8% of those messages were successfully received by the members. The various topics included Medication Adherence, Blood Pressure, Promoting the Advance Nurse Line, Cholesterol, Nutrition, and Foot Care.



2018 Health Education and Cultural and Linguistic Work Plan

	Goals	Objectives	Activities	Timeline	Responsible Department(s)
1	Promote access to free interpreting services among members and providers.	A. Educate members on the availability of free interpreting services. B. Educate providers on how to access KHS interpreting services. C. Offer video remote interpreting services for American Sign Language (ASL) members.	1. Article in the member newsletter 2. Message to members on IVR, member portal, KHS social media pages 3. Include information on free interpreting services in community presentations and health education workshops. 4. Distribute brochures and posters to provider offices on how to access KHS interpreting services. 5. Generate provider bulletin or equivalent to remind providers. 6. Implement process for allowing targeted providers access to video remote interpreting services for ASL members.	12/31/2018	Health Education Member Services Provider Relations Marketing
2	Improve member health literacy and communication skills with providers and KHS.	A. Educate members on how to communicate their health needs with their medical team and KHS using a variety of communication methods.	1. Tools and talking tips in member newsletter. 2. Message to members on IVR, member portal, KHS social media pages 3. Create a 3 Question "Ask Your Doctor" educational campaign targeted at specific chronic conditions. 4. Incorporate 3 Question "Ask Your Doctor" into health education workshop curriculum. 5. Provide educational tools for providers to distribute to KHS members on communicating health needs.	12/31/2018	Health Education Member Services Provider Relations Marketing Quality Improvement

3	Reduce the rate of unnecessary ED visits and increase the proper utilization of urgent care and preventive care services	A. Educate members on how to access and appropriately use the health plan benefits and health care services. B. Educate members on how the benefits of the 24 hour advice nurse line and how to access the service. C. Participate in community collaboratives targeting unnecessary ED visits.	1. Article in member newsletter on how to access health care services and benefits. 2. Article in member newsletter on advice nurse line. 3. Message to members on portal, IVR, and KHS social media pages. 4. Participate in community meetings and event, such as Building Healthy Communities in South Kern that address ED, urgent care and preventive care services. 5. Incorporate information on appropriate use of services in health education workshops. 6. Provide self-care materials to members that target prevention and home treatment of common illnesses that can be treated at home and prevented, such as URIs and UTIs. 7. Provide educational tool to providers to distribute to KHS members.	12/31/2018	Health Education Member Services Provider Relations Marketing Quality Improvement
4	Increase member participation in KHS health education workshops.	A. Promote KHS health education services among members and providers. B. Conduct member focus groups and/or follow up calls among members who have attended or did not show for services. C. Evaluate current workshop incentive and raffle items available to members. D. Evaluate staff promotion of health education services and incentives. E. Identify strategies to assist staff with promoting health education services and incentives.	1. Provider bulletin reminder on health education services and incentives. 2. Create a strategy document with best practices, including a suggested script and conduct staff training on service promotion. 3. Provide copies of health education workshop flyer to provider offices to distribute. 4. Article in member newsleter. 5. Message to members on portal, IVR, and KHS social media pages.	12/31/2018	Health Education Member Services Provider Relations Marketing Quality Improvement

5	Provide KHS members and providers access to health education materials, programs and resources.	A. Utilize KHS social media channels to provide health education. B. Offer health education workshops throughout the county. C. Enhance member experience in accessing health education services through the member portal. D. Enhance provider experience in requesting health education services for KHS members. E. Expand library of health education materials. F. Educate members and providers on available tobacco/smoking cessation services. G. Educate members and providers of resources targeted at chronic disease self-management.	1. Produce 2 health education social media videos (i.e.YouTube, Facebook live, Twitter live or Instagram live). 2. Facilitate health education workshops within the identified top 3-5 high priority areas. 3. Upload web-based printer friendly versions of the KHS health education brochure series. 4. Make enhancements to member portal to allow members to view a schedule of health education workshops and sign up for specific workshops. 5. Make enhancements to provider portal to allow providers more visibility of available health education services and direct access to requesting health education services. 6. Make available additional health education materials and resources that target common childhood illnesses that can be prevented or self-treated at home. 7. Continue to research the possibility of identifying or developing high demand health education material in non-threshold languages. 8. Provider bulletin on tobacco/smoking cessation programs and resources for KHS members. 9. Annual educational mailing to members on the KHS tobacco registry report. 10. Research, identify and share evidence based best practices for management of chronic disease in primary care settings.	12/31/2018	Health Education Member Services Provider Relations Marketing

6	Improve the readability and member engagement of health education and promotion materials.	A. Evaluate the layout and images of health education and promotion materials due for review in 2018. B. Increase staff knowledge in producing and identifying easy to read health education materials.	1. Review and recommend revisions or replacement of health education materials. 2. Research and identify additional health education material produced by vendors that is easy to read. 3. Modify health education workshop flyers. 4. Participate in health literacy webinars, conferences, etc. 5. Distribute a readability training document to KHS departments who create written member material.	12/31/2018	Health Education
7	Maintain and establish new relationships with community partners to help address policy, systems and environmental (PSE) factors of health.	A. Collaborate with schools and other community partners on programs and services that address community health. B. Support community partners on projects and programs that address PSE factors of health. C. Increase staff knowledge on best practices to address PSE factors of health.	1. Partner with schools and districts to provide health education workshops that address asthma, obesity and other chronic conditions. 2. Implement School Wellness Grant program. 3. Provide letters of support, grant funding, donations, and/or staff time towards community projects and programs. 4. Participate in webinars, conferences, events and meetings that help address PSE factors of health.	12/31/2018	Health Education Marketing

8	Promote programs and resources targeted for SPD members.	A. Collaborate with KHS Departments and community partners to address the needs of SPD members. B. Educate SPD members on new and existing programs and resources. C. Educate providers on the programs and resources available for SPD members.	1. Participate in community meetings and events that address the needs of SPD members. 2. Research and identify new programs and resources. 3. Collaborate with Case and Disease Management Departments and community partners on the development of member newsletter articles. 4. Provide health education and promotion messages to SPD members through the member newsletter, IVR, member portal, and KHS social media sites. 5. Update the KHS community resource list, as needed.	12/31/2018	Health Education Case Management Disease Management Member Services Marketing
9	Initiate member and provider outreach and engagement strategies regarding pregnancy, lower back pain and childhood immunizations.	A. Collaborate with KHS Departments and community partners to identify best practices for addressing timely prenatal care, childhood immunizations and lower back pain. B. Identify strategies for receiving notification of positive pregnancy results. C. Evaluate effectiveness of pregnancy incentive program D. Expand Text For Baby promotion efforts. E. Research options for pregnancy management programs. F. Research and identify best practice strategies for notifying and engaging members through printed material.	1. Identify and implement interventions with QI that address lower back pain, timely prenatal care and childhood immunizations at the member and provider level. 2. Partner with Black Infant Health to perform outreach and education to African American pregnant members for timely prenatal care and childhood immunizations. 3. Revise pregnancy and postpartum education packet. 4. Complete pregnancy incentive evaluation. 5. Pursue agreement with Text For Baby to provide plan or member level participation data. 6. Participate in meetings and product demonstrations of pregnancy management programs offered by vendors.	12/31/2018	Health Education Disease Management Quality Improvement

			7. Create a resource list of best practice strategies for member engagement/communication through printed material.		

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
THIRD QUARTER 2017

Report Date: November 02, 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.

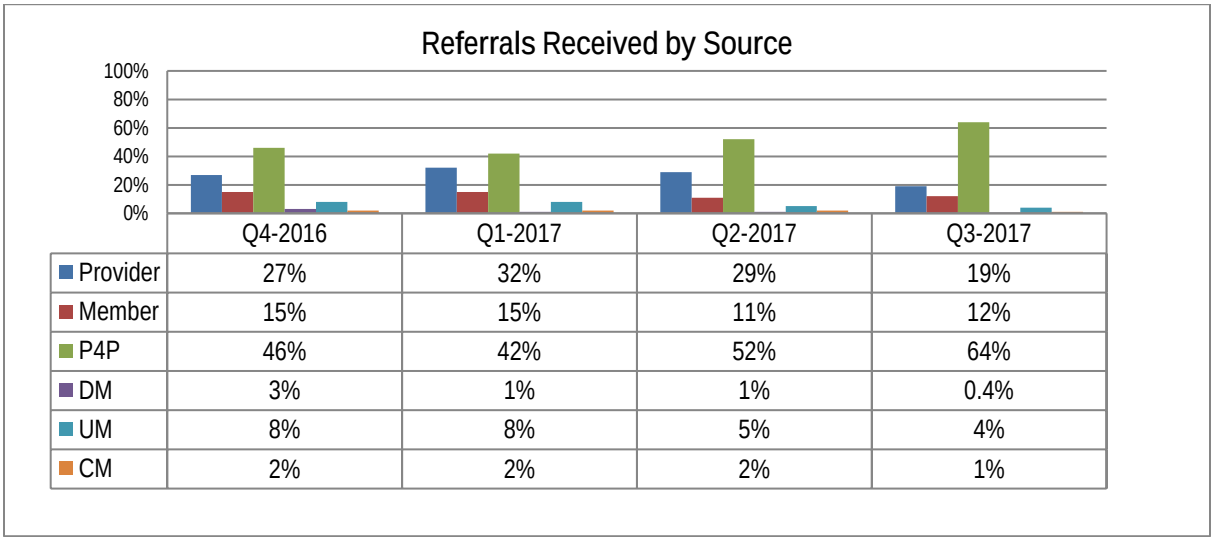
- School Wellness Grant and Internship Programs
- Winter Member Newsletter
- Asthma and Nutrition Workshops in Delano and Lost Hills
- KHS Cooking Demonstrations Workshops
- KHS Member Incentives for Workshop participation
- Annual Tobacco Cessation Education Mailing

The following pages reflect statistical measurements for the Health Education department detailing the ongoing activity for 3rd quarter 2017.

Respectfully submitted,
Isabel Silva, MPH, CHES
Director of Health Education, Cultural and Linguistic Services

REFERRALS FOR HEALTH EDUCATION SERVICES

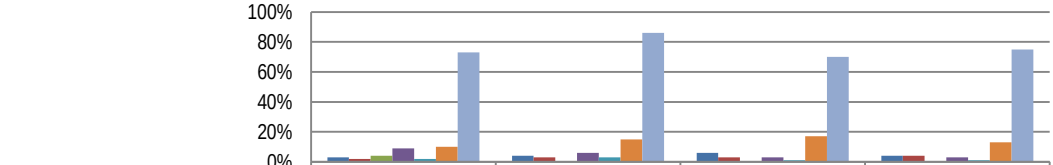
The Health Education Department (HE) receives referrals from various sources. Internal referrals are received from the Kern Health Systems (KHS) Utilization Management Department (UM), the Disease Management Department (DM), Case Management (CM), and the Provider Pay for Performance Program (P4P). Externally, 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.



	Q4-2016	Q1-2017	Q2-2017	Q3-2017
Provider	27%	32%	29%	19%
Member	15%	15%	11%	12%
P4P	46%	42%	52%	64%
DM	3%	1%	1%	0.4%
UM	8%	8%	5%	4%
CM	2%	2%	2%	1%

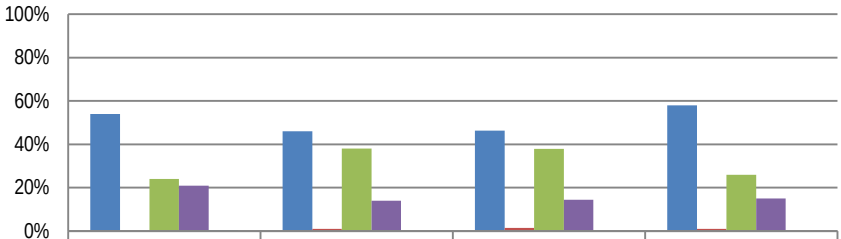
During this quarter, 1,883 referrals were received which is an 8.7% decrease in comparison to the previous quarter. This decrease is attributed to a decline in provider requests for health education services.

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
THIRD QUARTER 2017



	Q4-2016	Q1-2017	Q2-2017	Q3-2017
Asthma	3%	4%	6%	4%
Diabetes	2%	3%	3%	4%
Gestational Diabetes	4%	0.0%	0.1%	0.0%
Other Nutritional Counseling	9%	6%	3%	3%
Tobacco Cessation	2%	3%	1%	1%
Weight Mgmt - Adult	10%	15%	17%	13%
Weight Mgmt - Ped/Teen	73%	86%	70%	75%

The HE department receives referrals for various health conditions. Weight management education continues to be the most requested service for members. It accounted for 88% of all referrals received in the 3rd Quarter of 2017.



	Q4-2016	Q1-2017	Q2-2017	Q3-2017
Accepted Services	54%	46%	46%	58%
Disenrolled	0%	1%	1%	1%
Declined Services	24%	38%	38%	26%
Unable to Contact	21%	14%	14%	15%
Withdrawn	0%	0%	0%	0%

The rate of members who accepted to receive health education services increased from 46% in the 2nd quarter to 58% in the 3rd quarter in 2017.

Member reasons for declining health education services were also collected. During this quarter, the top 3 reasons for referral refusal were due to the following:

1. The member prefers to be mailed educational material.
2. The member is not interested in the services.
3. The member is unable to receive service due to work/school schedule.

HEALTH EDUCATION SERVICE PROVIDERS

The HE department offers various types of services through KHS or through community partnerships.

Kern Family Health Care (KFHC):

- Healthy Eating and Active Lifestyle Workshop
- Breathe Well Asthma Workshop

Bakersfield Memorial Hospital (BMH):

- Diabetes Management Classes (English only)
- Heart Healthy Classes
- Small Steps to a Healthier Weight (English only)
- Individual Nutrition Counseling
- Kids Weight Management Classes

Community Wellness Program (CWP):

- In-home or group setting for Asthma, Diabetes, Nutrition or Stroke Prevention Education
- Freedom from Smoking Program

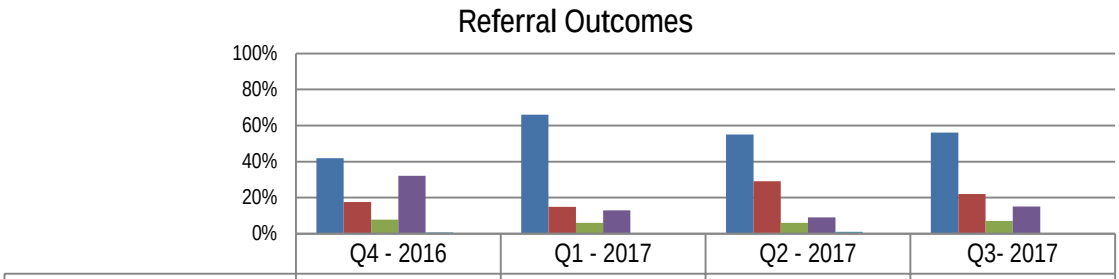
Clinica Sierra Vista (CSV) WIC:

- Diabetes Management Classes
- Heart Healthy Classes

California Smokers' Helpline (CSH):

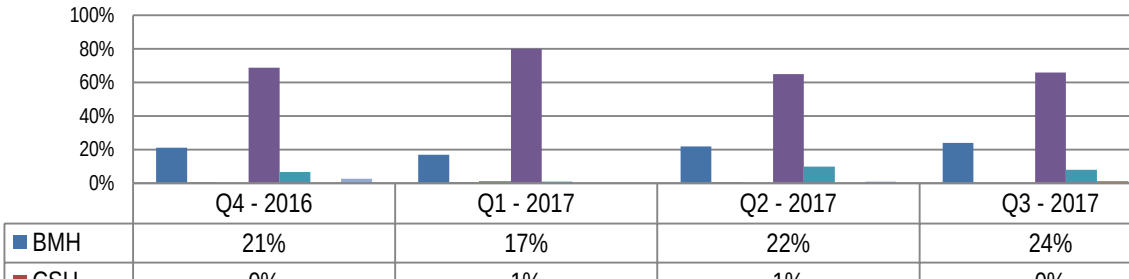
- Telephone Smoking Cessation Counseling

REFERRAL OUTCOMES



	Q4 - 2016	Q1 - 2017	Q2 - 2017	Q3- 2017
Attend	42%	66%	55%	56%
No Show	18%	15%	29%	22%
Refused	8%	6%	6%	7%
Unable to contact member	32%	13%	9%	15%
Disenrolled	1%	0%	1%	0%
Withdrawn	0%	0%	0%	0%

During this quarter, the rate of members who attended or received health education services out of all members who accepted services increased from a 55% to a 56%.

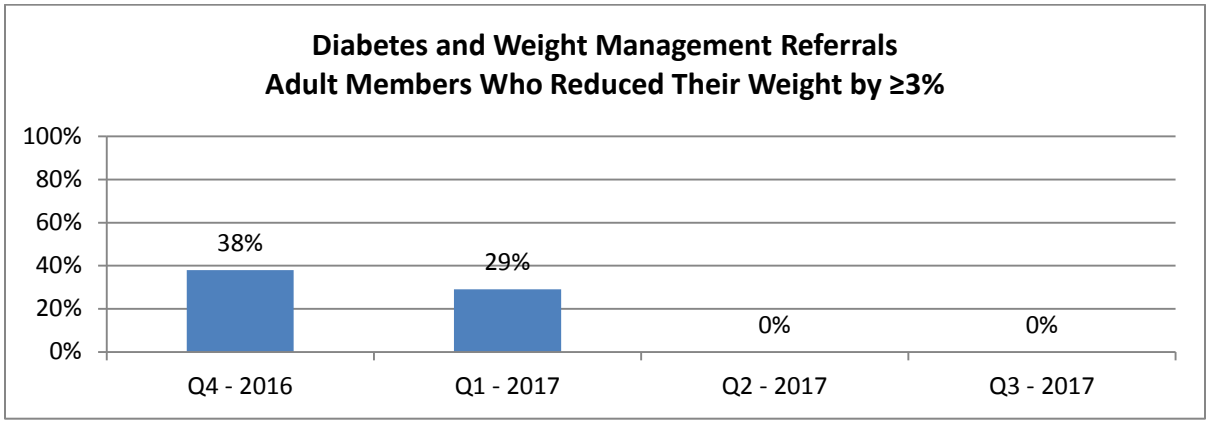


	Q4 - 2016	Q1 - 2017	Q2 - 2017	Q3 - 2017
BMH	21%	17%	22%	24%
CSH	0%	1%	1%	0%
CSV WIC	0%	1%	0%	0%
CWP	69%	80%	65%	66%
KFHC	7%	1%	10%	8%
SJCH	0%	0%	0%	1%
DRMC	3%	0%	1%	1%

Services through CWP continue to account for the largest share of referral outcomes. CWP's share of attended outcomes increased from 65% to 66%.

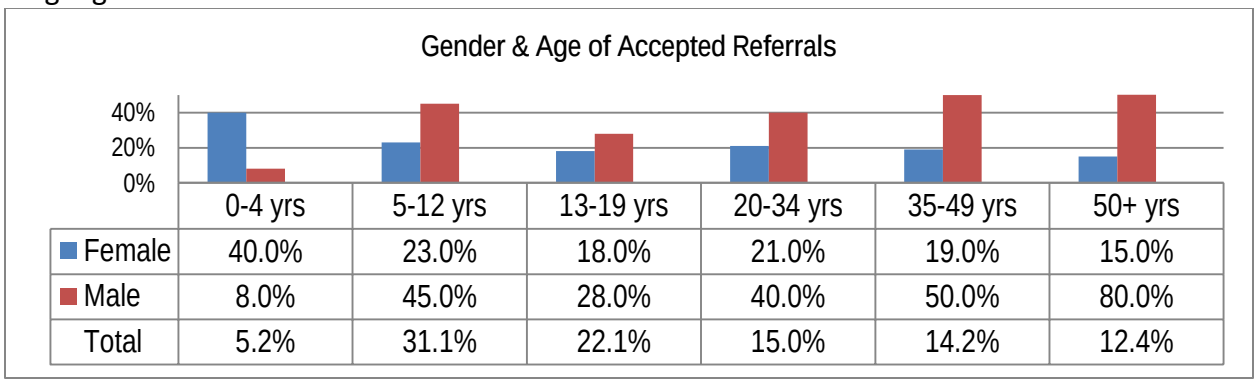
Effectiveness of Health Education Services

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. The Health Education department is in the process of revising the evaluation metrics for its health education services which resulted in no follow up calls performed during the 3rd quarter.



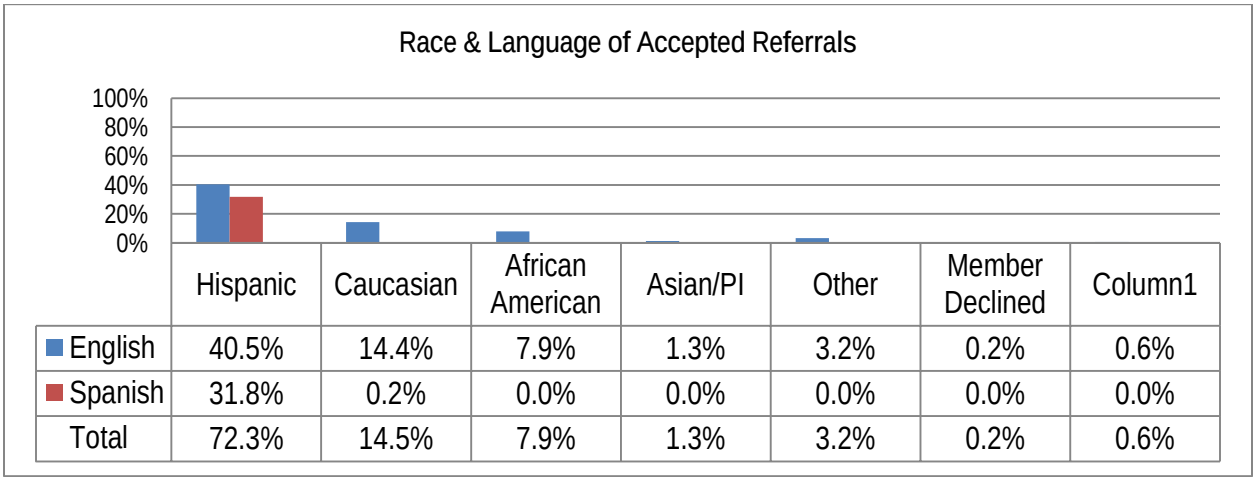
Demographics of Members Served

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.



	0-4 yrs	5-12 yrs	13-19 yrs	20-34 yrs	35-49 yrs	50+ yrs
Female	40.0%	23.0%	18.0%	21.0%	19.0%	15.0%
Male	8.0%	45.0%	28.0%	40.0%	50.0%	80.0%
Total	5.2%	31.1%	22.1%	15.0%	14.2%	12.4%

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	Other	Member Declined	Column1
English	40.5%	14.4%	7.9%	1.3%	3.2%	0.2%	0.6%
Spanish	31.8%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	72.3%	14.5%	7.9%	1.3%	3.2%	0.2%	0.6%

A breakdown of member classifications by race and language preferences revealed that 40.5% of members who accepted services are Hispanic and prefer to speak English.

Referrals Accepted by Top Bakersfield Zip Codes			
Q4-2016	**Q1 - 2017**	**Q2-2017**	**Q3-2017**
93307	93306	93307	93307
93306	93307	93306	93306
93304	93304	93305	93304
93305	93305	93304	93301
93309	93301	93308	93305

KHS serves members in the Kern County area. During this quarter, 76% of the members who accepted services reside in Bakersfield and the highest concentration of members were in the 93307 area.

Referrals Accepted by Top Outlying Areas			
Q4-2016	**Q1 - 2017**	**Q2-2017**	**Q3-2017**
Delano	Delano	Delano	Delano
Wasco	Shafter	Shafter	Wasco
McFarland	Wasco	Wasco	Shafter
Arvin	Lamont	McFarland	Taft
Shafter	Arvin	Arvin	McFarland
		Taft	

Additionally, 24% of the members who accepted services reside in the outlying areas of Kern County and the highest concentration of members continue to be in Delano.

Health Education Mailings

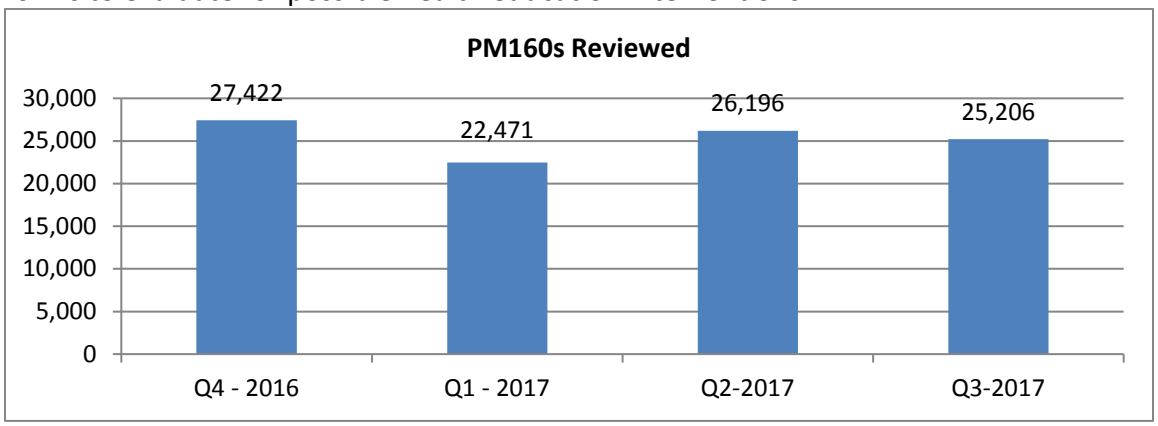
In addition to referrals, the HE department mails out a variety of educational material in an effort to assist members with gaining knowledge on their specific diagnosis or health concern. During this quarter, the HE department mailed 2,773 educational packets to members on the following health topics:

Educational Mailings

	Q4-2016	Q1 - 2017	Q2-2017	Q3-2017
Anemia	151	147	1	0
Asthma	129	84	52	36
High Cholesterol	11	24	8	4
Diabetes	40	31	33	25
Gestational Diabetes	2	0	0	1
High Blood Pressure	52	48	28	19
Nutrition	0	0	0	0
COPD	0	0	1	0
Postpartum Care	676	666	300	953
Prenatal Care	417	354	73	241
Smoking Cessation	27	32	18	22
Weight Management	2433	2111	1497	1472
Postpartum Incentive	511	513	0	0
Total	**4449**	**4010**	**2011**	**2773**

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

Face-to-Face Interpreter Requests

During this quarter, there were 37 requests for face-to-face interpreting services received. KHS employs qualified staff interpreters in Spanish and contracts with the interpreting vendor, CommGap. The majority of these requests were for a Spanish interpreter.

Top Languages Requested
Q3-2017
Spanish
Arabic
Cantonese

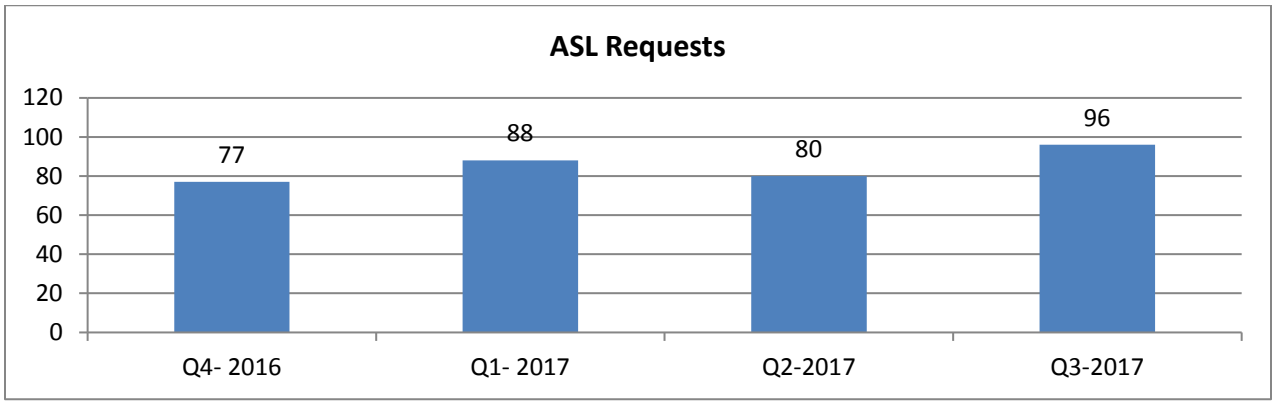
Telephonic Interpreter Requests

During this quarter, there were 701 requests for telephonic interpreting services through KHS' interpreting vendor, Language Line Solutions. The majority of these requests were for a Spanish interpreter.

Top Languages Requested			
Q4-2016	**Q1 - 2017**	**Q2-2017**	**Q3-2017**
Punjabi	Spanish	Spanish	Spanish
Spanish	Punjabi	Punjabi	Punjabi
Arabic	Arabic	Arabic	Arabic
Tagalog	Vietnamese	Tagalog	Tagalog
Vietnamese	Tagalog	Mandarin	Vietnamese

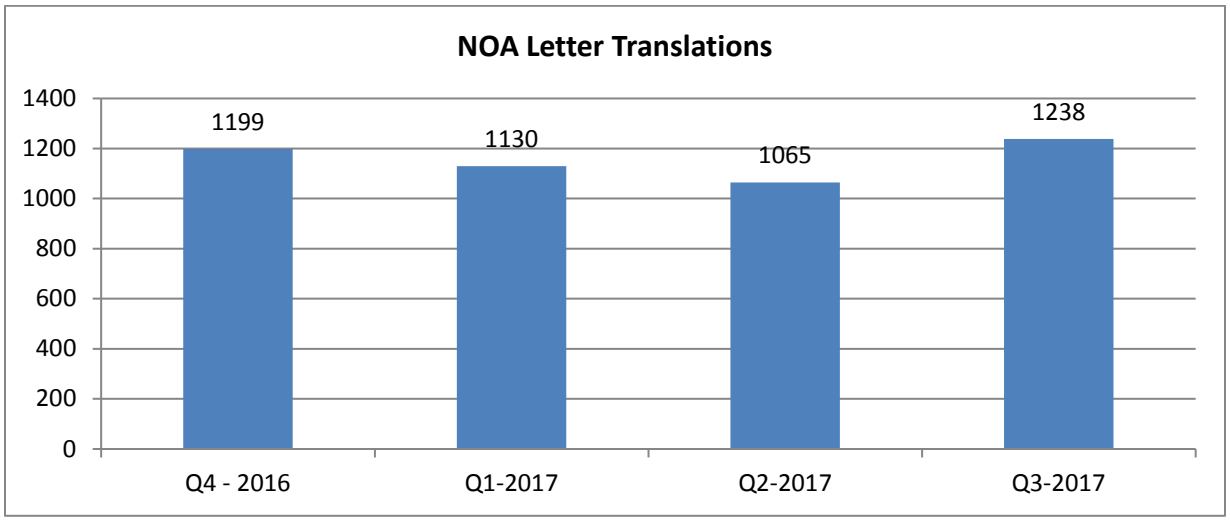
American Sign Language (ASL) Requests

During this quarter, there were a total of 96 requests received for an American Sign Language interpreter, which was an increase in comparison to the previous quarter.



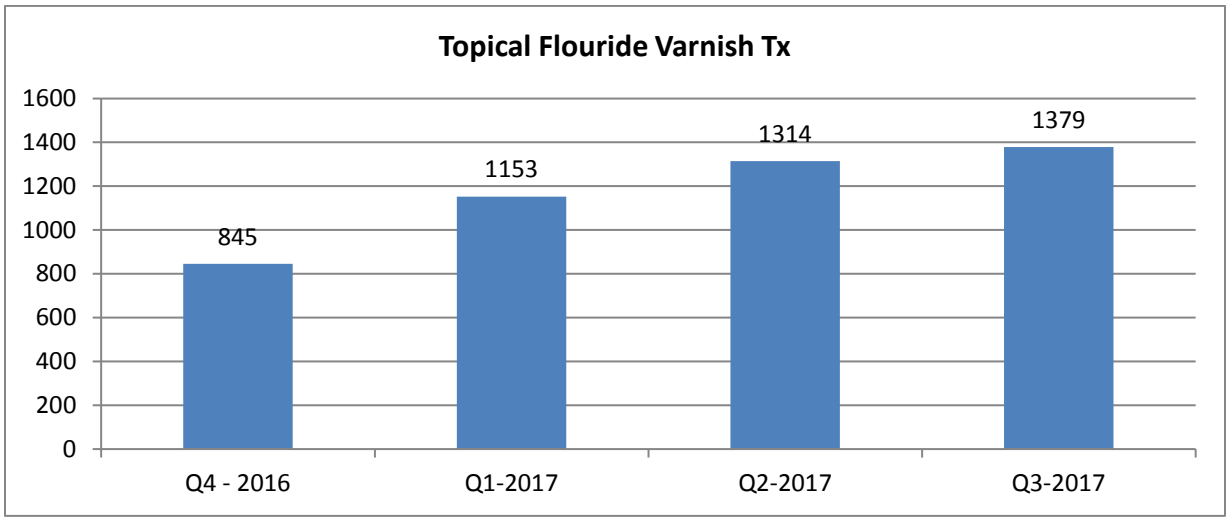
DOCUMENT TRANSLATIONS

The Health Education department coordinates the translation of written documents for members. Translations are performed in-house by qualified translators or outsourced through a contracted translation vendor. During this quarter, 1,238 Notice of Action letters were translated into Spanish for the UM and Pharmacy departments.



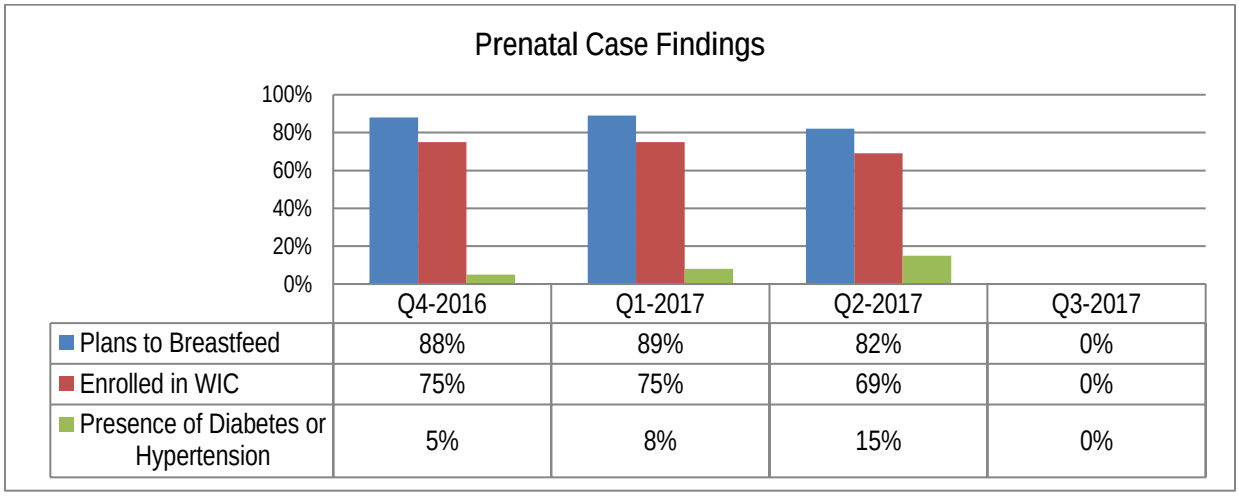
TOPICAL FLUORIDE VARNISH TREATMENTS

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.

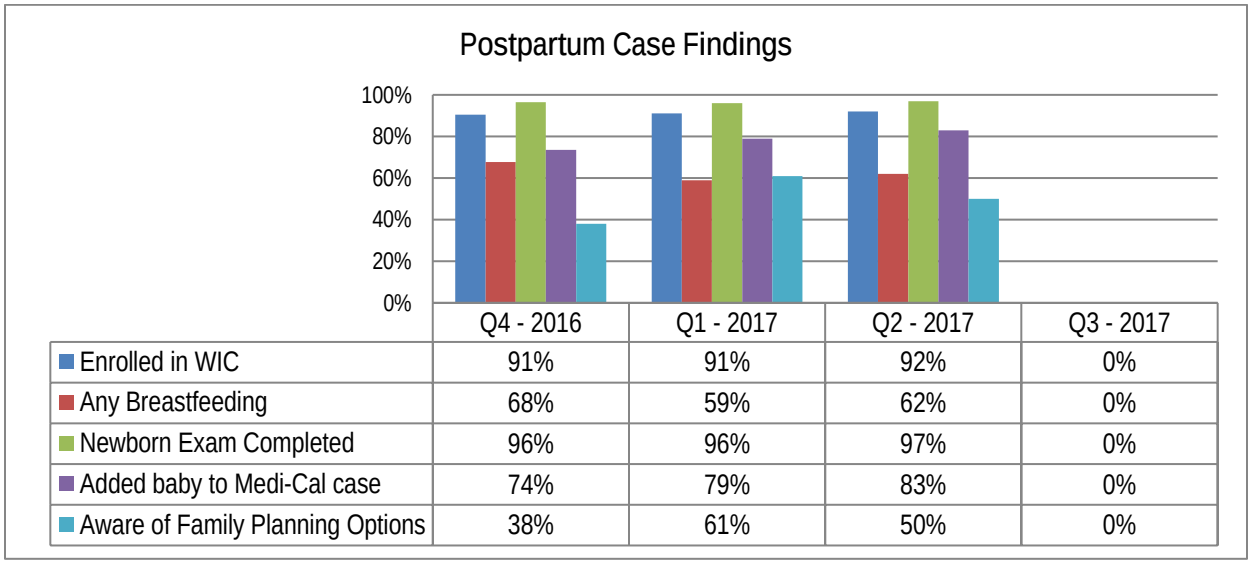


OB CASE MANAGEMENT PROJECT

The HE department performs outreach education calls to all members identified as being pregnant or postpartum. Due to pending program revisions, the prenatal and postpartum outreach education calls were put on hold during 3rd quarter; however, educational mailings were still conducted.



	Q4-2016	Q1-2017	Q2-2017	Q3-2017
Plans to Breastfeed	88%	89%	82%	0%
Enrolled in WIC	75%	75%	69%	0%
Presence of Diabetes or Hypertension	5%	8%	15%	0%

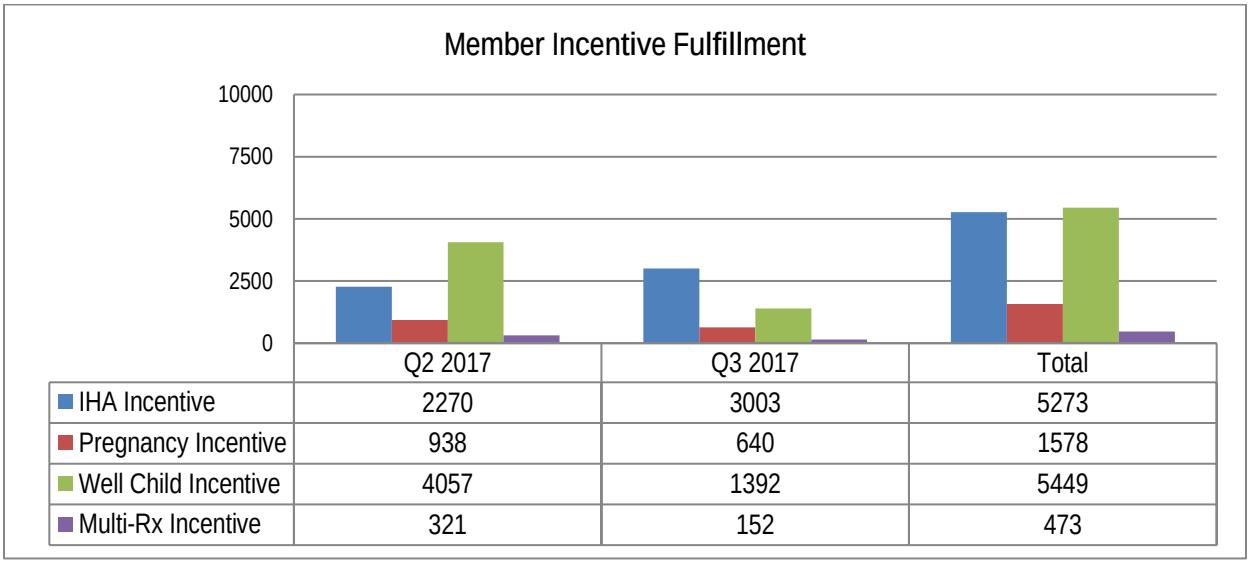


	Q4 - 2016	Q1 - 2017	Q2 - 2017	Q3 - 2017
Enrolled in WIC	91%	91%	92%	0%
Any Breastfeeding	68%	59%	62%	0%
Newborn Exam Completed	96%	96%	97%	0%
Added baby to Medi-Cal case	74%	79%	83%	0%
Aware of Family Planning Options	38%	61%	50%	0%

MEMBER WELLNESS AND CHRONIC CONDITION BASED INCENTIVES

During the 2nd quarter of 2017, KHS implemented three wellness based incentives and one chronic condition based incentive for members.

- **Initial Health Assessment (IHA)** – newly enrolled members who complete the IHA visit within 120 days of enrollment are mailed a first aid kit. There is a limit of one incentive per household.
- **Pregnancy** – pregnant members who completed at least 6 prenatal visits and the postpartum visit within 3-8 weeks are mailed a $65 voucher to redeem diapers, wipes or a portable play yard at Toys R Us or Babies R Us.
- **Well Child** – members ages 12 -23 months who complete a well child visit are mailed a $25 voucher to redeem an umbrella stroller at Toys R Us or Babies R Us.
- **Multi-Medication** – members on multiple medications and would benefit from a pill box. KHS disease and case management departments identify and mail this incentive to members.



	Q2 2017	Q3 2017	Total
IHA Incentive	2270	3003	5273
Pregnancy Incentive	938	640	1578
Well Child Incentive	4057	1392	5449
Multi-Rx Incentive	321	152	473

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Delegation of Quality Improvement, Utilization Management, Care and Case Management and Pharmacy Activities and Responsibilities				POLICY #: 2.45-I	
DEPARTMENT: Quality Improvement					
Effective Date: 07/2013	Review/Revised Date: 07/12/2017	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 7/12/17

Chief Medical Officer — Date

Director of Pharmacy — Date 7/11/17

Director of Compliance and Regulatory Affairs — Date 7-10-17

Administrative Director Health Services — Date 7/7/17

POLICY:
Kern Health Systems (KHS) may delegate Quality Improvement (QI), Utilization Management (UM, Case Management (CM), and Pharmacy activities and responsibilities to qualified entities in accordance with the provisions of this policy. Each delegated entity will sign a delegation agreement that describes the responsibilities of KHS, the delegated entity, the evaluation process of the delegated entity's performance, and all other criteria outlined in this policy. The delegation process will adhere to applicable state law and requirements of KHS' Medi-Cal State contract.

KHS will maintain policies and procedures, approved by DHCS, to ensure all delegated entities or subcontractors fully comply with all terms and conditions of the agreement. KHS will evaluate the prospective Subcontractor's ability to perform the subcontracted services, oversee and remain responsible and accountable for any functions and responsibilities delegated in order to meet the subcontracting requirements as stated in 42 CFR 438.230(b)(3), (4)(1), (c)(1)(i)-(iii), (c)(2), (c)(3), and Title 22 CCR Section 53867, and the DHCS Contract.

KHS has delegation and delegation oversight activities/processes for pre-delegation evaluation, delegation oversight activities, and regular reporting used to monitor delegates according to the standards established by KHS, licensing and regulatory bodies.

KHS may delegate Utilization Management (UM) and Pharmacy functions/activities to entities with established Quality Improvement and Utilization Management programs and policies consistent with licensure and regulatory requirements.

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

DEFINITIONS:

Delegation	The process whereby KHS gives another entity authority to perform certain functions on its behalf. While KHS may delegate the authority to perform a function, it cannot delegate the responsibility for assuring that the function is performed appropriately.
Oversight	The monitoring of a set of activities in order to assess performance
Delegation Audit	An annual evaluation of a delegate's capacity to perform delegated activities using established criteria.
Delegated Entity	Any party to an agreement with KHS which is entered into for the purpose of providing any goods or services connected with the obligations under the Health Plan's requirements

PROCEDURES:

1.0 Scope:

The scope of this Policy includes the QI, UM and Pharmacy activities delegated to all entities that provide services to KHS members.

2.0 Criteria

2.1 Organizations accredited by a national or international accreditation organization such as JCAHO, TJC, JCI, NCQA, COA, CARF are deemed as meeting delegation standards once they produce evidence of current:

A. State license
B. Accreditation in good standing
C. Lack of Medicare/Medi-Cal/State sanctions
D. Policies and procedures relating to the delegation activities
E. QI program, system and processes

2.2 Organizations not accredited by a national or international accreditation organization must allow an oversight audit in addition to producing evidence of current:

A. State license
B. Lack of Medicare/Medi-Cal/State sanctions
C. Policies and procedures relating to the delegation activities
D. QI program, system and processes

3.0 Responsibilities:

3.1 Written Delegation Agreement: Any delegation of QI, UM and/or Pharmacy activities must be pursuant to a mutually agreed upon, written and signed agreement between KHS and the delegate. The written delegation agreement:

- Is mutually agreed upon.
- Describes the responsibilities of KHS and the delegated entity including by not limited to:
- Transfer of Care
- Notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.
- Provide interpreter services
- Submit grievances and process for resolution
-
- Describes the delegated activities.
- Requires at least quarterly reporting and submission of claims/encounter data by the delegate to KHS.
- Describes the process by which KHS evaluates the delegate's performance including edits and reporting systems to ensure accuracy of data prior to submission to DHCS.
- Describes the remedies available to KHS if the delegate does not fulfill its obligations, including revocation of the delegation agreement.

3.2 The Written Delegation Agreement will include the following requirements:

A. The delegate must have an established QI and/or UM program and policies and procedures, consistent with Department of Managed Health Care (DMHC) regulations, and as applicable, Department of Health Services (DHS) Medi-Cal contractual requirements, and other regulations as required, including defining methodology for detecting and preventing fraud, waste, and abuse.

B. At the time of initial delegation and at least annually, the delegate shall provide KHS with copies of its QI and/or UM program description(s) and policies and procedures.

C. The delegate will cooperate with KHS's QI, UM and Pharmacy monitoring activities including providing KHS with copies of QI, UM and/or Pharmacy documentation when requested to meet the oversight activities of state licensing and regulatory agencies.

3.3 If deemed necessary, the delegate will provide to KHS, at reasonable times upon request, on-site access to the delegate's files and records pertaining to QI, UM and/or Pharmacy activities/functions performed on behalf of KHS.

A. Access will be provided as necessary for KHS to monitor and assess the delegate's performance of the delegated activities.

B. The delegate also agrees to provide access to any authorized regulatory or accredited agency or contracted entity with KHS.

3.4 KHS has the right to terminate the delegation agreement with or without cause at any time by providing at least 120 days prior written notice to the delegate.

3.5 Prior to entering into a Delegated Credentialing Agreement, KHS evaluates the capability of the delegated entity to perform the credentialing functions according to KHS standards, applicable state standards and those established by pertinent governing bodies including DHCS, DMHC and NCQA. The evaluation includes review of the following:

1. The delegated entity's credentialing criteria, policies, and procedures to assure they meet or exceed those of KHS' applicable state standards including those established by the National Committee for Quality Assurance (NCQA).
2. The delegated entity's quality assurance written plan and/or policies & procedures to assure that the entity's network panel is sufficient to provide accessibility, availability and continuity of the covered by the health care services being delegated to this entity.
3. Minutes of the delegated entity's Credentials Committee meetings to verify critical review of the practitioners' credentials.
4. Five percent (5%) or twenty-five (25) of individual practitioners' credentialing files, whichever is less. A minimum of ten (10) initial credentialing files and (10) ten re-credentialing files are audited.
5. The pre-delegation assessment and evaluation may include a site visit, written review of the delegate's understanding of the standards and delegated tasks, staffing capacity, and performance records. The pre-delegation evaluation may be accomplished through a site visit, the exchange of documents and/or through pre-delegation meetings.
6. If the GROUP is NCQA Accredited or the delegate possesses NCQA-Certification, KHS may use the accredited health plan audit results in its pre-delegation evaluation as an additional mechanism of ensuring the GROUP's credentialing program and quality assurance program meets or exceeds KHS' applicable state, federal standards including those established by the National Committee for Quality Assurance (NCQA). NCQA Accreditation or Certification is not the sole method for determining if the GROUP is deemed capable to complete the specific delegation functions (i.e., credentialing and recredentialing),
7. KHS must evaluate any changes made by the GROUP prior to the implementation date.

3.6 Qualified delegated entities shall conduct plan and practitioner reviews, including utilization review, quality assurance and peer review within the meaning of California Health and Safety Code Section 1370 *et seq*., and California Evidence Code Section 1157. Pursuant to these obligations, qualified entities' responsibilities will include, but not be limited to, the following:

1. Accept applications, reapplications and attestations from the delegated entity's participating practitioners and collect all data elements from NCQA approved "primary sources".
2. Collect and verify the following practitioner credentials from "primary sources", as defined by NCQA, and document and date this verification in writing according to NCQA standards:
   a. All current and valid Medical Licensure information
   b. Drug Enforcement Administration (DEA) Certificate or Controlled Dangerous Substances (CDS), if applicable
   c. Education and training
   d. Work history
   e. History of liability claims
   f. Licensure sanction(s)
   g. Medicare and Medicaid sanction(s)
3. Ensure the protected health information (PHI) of KHS members treated by participating practitioners remains protected. The delegated entity's credentialing policies and procedures must address the following:
   a. allowable uses of PHI
   b. safeguards to protect the information from inappropriate use or further disclosure
   c. requirements to ensure sub-delegates have similar safeguards
   d. how are individual practitioners are allowed access to their PHI
   e. KHS will be informed within one business day if inappropriate use of PHI occurs
   f. safeguards to ensure that PHI is returned, destroyed, or protected if the delegation agreement ends
4. Notify KHS of any changes to NCQA healthcare accreditation status within thirty (30) days of change notification.
5. Adhere to the following in accordance to KHS, NCQA and DHCS standards:
   a. Ongoing review and evaluation of practitioner qualifications
   b. Ongoing monitoring of practitioner sanctions, complaints and quality issues
   c. Conducting site visits and medical record reviews
   d. Conduct site visits of practitioners who reach member complaint threshold
   e. Reporting of practitioner credentialing, re-credentialing, and demographic information to KHS' Provider Relations Department
   f. Reporting of credentialing and re-credentialing decisions to KHS' Provider Relations Department
   g. Maintaining written policies and procedures for credentialing and re-credentialing activities. KHS must be notified of all revisions to policies and procedures within fifteen (15) days of approval.
6. Responding to KHS' Corrective Action Plan (CAP) in a timely manner.

7. At a minimum of once a week, KHS must be notified in writing of any changes to practitioner logistics, scheduling, or contact information as required for compliance with California Health and Safety Code Section 1367.27. *Refer to Policy 4.32 Delegated Credentialing for delegated agreements and additional details.*
8. Submit practitioner data per DHCS Health Care Provider Directory (274) requirements to KHS on a monthly basis via file format upon validation of data completeness, accuracy, reasonable, and timely.
9. Timely submission of requested credentialing documents during a KHS audit by a regulatory entity.
10. Sub-Delegation: If a delegated entity sub-delegates any or all of the delegated credentialing or re-credentialing functions to a third party, the delegated entity shall provide to KHS i) written description of the delegated activities, and ii) documentation of any sub-delegate oversight performed by delegated entity for KHS review.

4.0 Overview of the Delegation Oversight Process:

4.1 Prior to contracting with the entity, KHS performs a pre-delegation evaluation of current practices to assess compliance with KHS, DMHC and DHS standards as applicable. See *Attachment A: QI Delegation Oversight Audit Tool and Attachment B: UM Delegation Oversight Audit Tool.*

4.2 Monitoring and Oversight:

KHS monitors and oversees the delegate's performance of the delegated activities/functions through reports from the delegate as defined in the Delegation Agreement. Monitoring will focus on ensuring that the delegated activities continue to be performed in compliance with KHS standards, policies and procedures and within the terms of the written QI, UM and/or Pharmacy delegation agreement

A. In cases where regulatory body standards or requirements differ, the KHS Compliance Department has determined that the stricter standard will always prevail.

B. KHS will alert the DHCS contract manager within three business days upon discovery that a subcontractor is out of compliance with the requirements, and/or if a disclosure reveals any potential violation(s) of the ownership and control requirements

B. KHS works collaboratively with the delegate when deficiencies have been identified through the oversight process.

a. The delegate is given a Corrective Action Plan (CAP) through KHS's Compliance Department and asked to respond according to the timeframes as determined by Compliance.

The delegated entities and Subcontractor's agreement will ensure that they make all of its premises, facilities, equipment, books, and records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Subcontract, available for the purpose of an

audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor by the following:

a. DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, and the Comptroller General, Department of Justice (DOJ), or their designees.

b. At all reasonable times at the Subcontractor's place of business or at such other mutually agreeable location in California.

c. In a form maintained in accordance with the general standards applicable to such book or record keeping.

d) For a term of at least 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

e) Including all Encounter Data for a period of at least 10 years.

f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Subcontractor from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Subcontract due to fraud.

h) Full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor from KHS.

Subcontractor's agreement will ensure they maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Subcontractor:

Make all premises, facilities, equipment, applicable books, and records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees.

Retain all records and documents for a minimum of at least 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

4.3 Monitoring for Oversight and Renewal of Delegation Agreement

1. The delegated entity agrees, upon delegation, to make available to KHS the credentialing and re-credentialing status on the delegated entity's participating practitioners, including credentialing data elements as well as documents and quarterly reports, as appropriate, using the standardized ICE form or another approved KHS format.

2. KHS annually evaluates the delegated entity's credentialing and quality assurance process to assure it continues to meet or exceed KHS' standards, applicable state standards and those established by NCQA. The evaluation includes review of the following:
   a. The delegated entity's credentialing criteria, policies and procedures to assure they meet or exceed KHS' standards, applicable state standards and those established by NCQA.
   b. The delegated entity's quality assurance written plan and/or policies & procedures to ensure that the entity's network panel is sufficient to provide accessibility, availability and continuity of the covered health care services being delegated to this entity
   c. Minutes of the delegated entity's Credentials Committee meeting to verify critical review of the practitioner's credentials.
   d. Five percent (5%) or fifty (50) of the individual practitioner' credentialing files, whichever is less. A minimum of ten (10) initial credentialing files and ten (10) re-credentialing files are audited. In lieu of KHS conducting its own file review, KHS may request results from the delegated entities annual ICE or NCQA reaccreditation audit results.

3 KHS annually evaluates the delegated entity enrollee/member experience survey process to validate and assess the GROUP's accessibility, availability and continuity of care including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and timely access to primary care & specialty appointments. The GROUP, will be required to submit quarterly reports to the plan regarding accessibility and availability to validate compliance and ensure GROUP's network of providers are sufficient to provide accessibility, availability and continuity of care of the covered health services.

4. The KHS Chief Medical Officer or designee(s) and the Physician Advisory Committee review results of the annual audit. Upon discovery of noncompliance with defined subcontract requirements during the evaluation, KHS may choose to work with the delegated entity to develop a corrective action plan, impose financial sanctions for improvement within specified time frames and actions to achieve KHS standards. If the improvement process is unsuccessful, KHS reserves the right to terminate the Delegated Credentialing Agreement.

5. Results of KHS' oversight audits may be reported to the delegated entity in writing, including a corrective action plan (CAP) if deficiencies area noted. The delegated shall implement such a corrective action plan within the specified time period and shall permit a re-audit by KHS or its agent if requested. KHS may perform a

follow-up review within sixty (60) days.

4.4 Reports:

KHS receives required reports from delegated entities from the delegate as established in their delegation agreement. At minimum the reports will include:

a. QI program evaluation yearly
b. QI Work Plan yearly
c. Evaluation of QI projects yearly
d. QI Committee agendas and minutes
e. Any breeches of confidentiality or PHI access
f. Sentinel or other reported events

4.5 Other Monitoring Activities:

Other monitoring activities are used to provide more comprehensive and timely oversight in selected areas where opportunities for improvement have been identified. Areas related to patient safety are weighed higher when determining what to monitor.

g. Additional monitoring occurs as frequently as necessary to achieve desired results.
h. A sampling methodology is used to select member records to ensure a representative sample from the delegated entity for monitoring.

The delegated entity must implement the following:

1. Process for monitoring practitioner sanctions, complaints and the occurrence of adverse events between re-credentialing cycles. The delegated entity must conduct on-going monitoring of all practitioners who fall within the scope of credentialing. The delegated entity must be fully compliant with KHS, NCQA, and DHCS and use approved current sources of sanction information.
2. Policies and procedures for on-going monitoring of practitioner sanctions, complaints and quality issues between re-credentialing cycles and takes appropriate action against practitioners when it identifies occurrence of poor quality. Delegated entity identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.
3. Collect and evaluate ongoing monitoring information (OIG, Medi-Cal Suspended & Ineligible List, Medicare Opt-Out, etc.) and maintain current and accurate information about contracted participating practitioners.
4. Conduct site visits and medical record reviews as applicable under NCQA healthcare accreditation organization standards.

KHS retains the right, based on quality, facility site review, adverse events, criminal actions, or changes in privileges, accusations, and/or probation to close practitioners to new member assignment until such time the KHS Physician Advisory Committee determines otherwise.

KHS has the responsibility to the Delegated or Subcontractor's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or KHS determine that

the Subcontractor has not performed satisfactorily.

To the extent that the Subcontractor is responsible for the coordination of care for Members, as outlined in Policy 3.61, KHS is responsible to share with the Subcontractor any utilization data that DHCS has provided to KHS, and provide the data to the Subcontractor to use as they are able for the purpose of Member care coordination per any current or future APL or Contract requirements. As part of the monitoring oversight, KHS will ensure the subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and APL's.

KHS is responsible to inform the Subcontractor of the prospective requirements added by DHCS before the requirement would be effective, and the Subcontractor must comply with the new requirements within 30days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

Attachments:

Attachment A: *QI Delegation Oversight Audit Tool*
Attachment B: *UM Delegation Oversight Audit Tool*

REFERENCE:

Revision 06/2017: Policy revised to comply with DHCS Final Rule Deliverable #1 and Subcontractual Relationships and Delegation APL 17-004. DHCS approved 6/23/2017. **Revision 2016-12:** Formatting changes and updated signatory list. **2014-08:** Revised to include: delegation of nationally and internationally certified organizations, review for sanctions, and inclusion of audit tools. **2013-07:** New policy created to provide areas of responsibility, process, criteria used and potential disciplinary actions for delegated activities. Policy developed by Director of Quality Improvement, Disease Management and Health Education. KHS Board approved 08/08/2013.

KERN HEALTH SYSTEMS

Delegation Oversight Audit Tool
Quality Improvement

Organization Name: _____

Reviewed by: _____

The Organization meets federal, state and local regulations. If currently accredited from a national or international quality improvement organization, proof of accreditation fulfills the intent of oversight per KHS Policy # 2.45 Delegation of Authority

I. Regulatory/Licensing (Desktop Review)	Yes	No	N/A
The organization provides evidence of federal, state and local regulations and licensing			
1. The Program produces evidence of:			
a) Business license			
b) Recent state or federal regulatory audit			
COMMENTS:			
2. The Program is accredited from one of the following institutions			
a) TJC/JCI			
b) NCQA			
c) ISO			
d) other			
COMMENTS:			

II. QI Structure and Processes – Written Program Description (Desktop Review)	Yes	No	N/A
The QI program may be contained in a separate document or within QI policies and procedures. The Behavioral health aspects of QI may be included in the program description or in a separate document referenced in the description. The Organization's QI program description includes the following factors:			
1. Program structure has:			
a) A written description of its QI program that is reviewed and updated annually			
b) An annual QI work plan			
c) QI Committee oversight of the QI program			
d) The roles, structures and functions of the QI Committee and other committees described in the QI program defined			
f) The organization's governing body accountability for the QI program			
g) A process to identify, monitor and work to improve clinical issues relevant to its members			

Organization Name: _____

Reviewed by: _____

II.	QI Structure and Processes – Written Program Description (Desktop Review)	Yes	No	N/A
COMMENTS:				
2.	**QI Program:**			
a)	Meets regularly and take action on quality improvement activities			
b)	Includes documentation of QI committee meetings			
c)	Involves practitioners in the planning, design, implementation and review of the QI program			
d)	Informs the organization's practitioners and members about its QI program			
e)	Includes a plan for collecting and providing information on provider and practitioner safety and quality			
f)	Demonstrates meaningful improvement in the quality of clinical care and service it renders			
COMMENTS:				

III.	Privacy and Security of Health Information (Desktop Review)	Yes	No	N/A
The Organization has policies, procedures and protocols to protect Protected Health Information under HIPAA, HITECH and the California Confidentiality of Medical Information Act.				
1.	**Program has policies that explain the processes to maintain compliance with:**			
a)	HIPAA			
b)	HITECH			
c)	California Confidentiality of Medical Information Act			
COMMENTS:				

IV.	Accessibility of Services (Desktop Review)	Yes	No	N/A
The organization provides appropriate access to care.				
1.	**The organization measures and analyses its access to the following:**			
a)	Regular and routine appointments			
b)	Urgent care			
c)	After-hours care			

COMMENTS:			
V. Continuity and Coordination of Care (Desktop Review)	**Yes**	**No**	**N/A**
1. The organization collaborates between behavioral healthcare and medical care.			
a) The organization has policies promoting the continuity and coordination of care between practitioners			
COMMENTS:			

VI. Cultural and Linguistic Services (Desktop Review)	**Yes**	**No**	**N/A**
1. The Organization provides cultural and linguistic sensitive services for its members			
a) TDD/TTY services for deaf, hard of hearing or speech-impaired members are offered.			
b) There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members.			
COMMENTS:			

VII. Quality and Safety of Care (Desktop Review)	**Yes**	**No**	**N/A**
1. The Organization has policies and processes to promote member safety			
a) Medical/Behavioral health records are available for the practitioner at each scheduled member and are updated at each encounter			
b) Providers communicate to facilitate coordination of care			
c) Polypharmacy evaluation and/or Medication reconciliation is performed			
d) There is a process to report Adverse incidents and other reportable events			
COMMENTS:			

VIII. Use of Board-Certified Consultants and Specialist (Desktop Review)	**Yes**	**No**	**N/A**
2) **The Organization has written procedures for using board-certified consultants and evidence that it uses these consultants**			

VIII. Use of Board-Certified Consultants and Specialist (Desktop Review)	Yes	No	N/A
a) The Organization has written procedures for using board-certified consultants that include a list of available consultants that are used in appropriate circumstances.			
b) The Organization demonstrates the use of appropriate board-certified specialists.			
COMMENTS:			

IX. Licensed Health Professionals (Desktop Review)	Yes	No	N/A
The Organization has written procedures on:			
a) Professional health care personnel have current California licenses and certifications.			
b) Professional licensed and certifications are verified using primary sources			
c) Professional health care personnel have been checked for CMS/Medicare sanctions against them			
d) Scope of practice for non-physician practitioners is clearly defined.			
e) Non-physician practitioners are supervised according to established standards.			
COMMENTS:			

KERN HEALTH SYSTEMS

Kern Health Systems
Oversight Audit Tool 2014
Utilization Management

ORGANIZATION Name: _____

Reviewed by: _____

The Organization clearly defines its structures and processes within its utilization management (UM) program and assigns responsibility to appropriate individuals. The Organization has a well-structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner.

UM I: UM Structure – Written Program Description(Desk Review)	Yes	No	N/A
The Organization's UM program description includes the following factors: The UM program may be contained in a separate document or within UM/Case Management policies and procedures. Behavioral health aspects of UM may be included in the program description or in a separate document referenced in the description.			
1. Program structure must describe:			
a. Staff members responsible for specific activities, including those members with the authority to deny coverage			
b. The extent of involvement of a designated senior behavioral health practitioner in the UM Program implementation, supervision, oversight, and evaluation.			
c. How the ORGANIZATION evaluates, approves, and revises the UM program, the frequency of evaluations and who is responsible for the evaluation			
d. The UM program's role in the QI program, including how the ORGANIZATION collects UM information and uses it for QI activities			
e. Procedures by which a member or practitioner can appeal a determination			
f. Triage and referral process – how Organization evaluates service sites and levels of care			
2. Scope of the program and the processes and information sources used to make determinations of benefit coverage and medical necessity. The scope of the UM program must describe:			
a. The ORGANIZATION's UM functions, the services covered by each function or protocol and the criteria used to determine medical necessity, including:			
(1) The method by which the ORGANIZATION develops and chooses criteria			
(2) The method by which the ORGANIZATION reviews, updates and modifies criteria			
b. The processes by which the ORGANIZATION makes determinations of medical necessity and benefit coverage for inpatient and outpatient			
c. Data and information the ORGANIZATION uses in making determinations (e.g., patient records, conversations with appropriate physicians)			
d. Clinical information used for making determinations of coverage (office notes, history, treatment plan, etc.)			
COMMENTS:			

ORGANIZATION Name: _____

Reviewed by: _____

Physician Involvement	Yes	No	N/A
A senior physician is actively involved in implementing the ORGANIZATION's UM program. The UM program description must clearly define the involvement of a senior behavioral health practitioner in the implementation and supervision of the program. In addition to defining the role, there must be evidence of the senior behavioral health practitioner involvement in key aspects of the UM program, such as setting policies, reviewing cases and participating in UM committee meetings. A behavioral health practitioner is a Behavioral Health Medical Director or Behavioral Health Associate Medical Director or equivalent.			
COMMENTS:			

Annual Evaluation (Desk Review)	Ye	No	N/A
The ORGANIZATION annually evaluates and updates the UM program as necessary			
COMMENTS:			

ORGANIZATION Name: _____

Reviewed by: _____

UM 2: Clinical Criteria for Utilization Management Decisions	Yes	No	N/A

To make utilization decisions, the ORGANIZATION uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria. The ORGANIZATION applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services.

Utilization Management Criteria – Desk and Onsite Review
1. The Organization has written UM decision making criteria to evaluate the necessity of medical services. There must be written criteria for all UM activities that the Organization conducts. These criteria can be widely applicable principles or more diagnosis or procedure specific detailed protocols. They must be objective and based on medical evidence and must take into account the local delivery system and individuals' needs. The Organization must use criteria base on medical evidence.
2. Nationally developed procedures for applying criteria, particularly those for lengths of hospital stay, are often designed for uncomplicated patients and for a complete delivery system. The criteria may not be appropriate for patients with complications or for a delivery system with insufficient alternatives to inpatient care. The organization may include the factors listed as part of the UM criteria or as separate overriding instructions to the staff. The written UM procedures must direct decision makers to alternatives when the factors listed indicate that UM guidelines are not appropriate. Possible alternatives in these instances include use of a secondary set of UM criteria and individual case discussion.
3. The Organization must consider at least the following factors when applying criteria to a given individual:
1. Age
2. Co-morbidity
3. Complications
4. Progress of treatment
5. Psychosocial situation
6. Home environment, when applicable
4. The ORGANIZATION has written policies for applying the criteria based on an assessment of the local delivery system:
a. Availability of skilled nursing facilities, sub-acute care facilities or home care in the ORGANIZATION's service area to support the patient after hospital discharge
b. Coverage of benefits for skilled nursing facilities, sub-acute care facilities or home care where needed
c. Local hospitals' ability to provide all recommended services within the estimated length of stay
5. The ORGANIZATION involves appropriate practitioners in developing, adopting and reviewing criteria applicability. The ORGANIZATION documents those practitioners with professional knowledge or clinical expertise in the area being reviewed have an opportunity to give advice or comment on development or adoption of UM criteria and on instructions for applying the criteria. The ORGANIZATION can solicit opinions through practitioner participation on a committee or by considering comments from practitioners to whom it has circulated the criteria.
6. The ORGANIZATION has a process to annually review UM criteria and the procedures for applying them and to update them as appropriate. The ORGANIZATION may either adopt national criteria or develop its own. The ORGANIZATION and its practitioners must review national criteria for local use annually.

ORGANIZATION Name: _____

Reviewed by: _____

Comments:

Availability of Criteria (Desk Review)	Yes	No	N/A
The ORGANIZATION states in writing: The ORGANIZATION may: • Copy criteria • Read them over the phone • Make them available for review at its offices • Distribute them via the Internet. The ORGANIZATION will provide a paper copy upon request.			
1. How members and practitioners can obtain the UM criteria			
2. Makes the criteria available to its practitioners and Members upon request.			
COMMENTS:			

Consistency in Applying Criteria (Desk and Onsite Review)	Yes	No	N/A
The ORGANIZATION annually evaluates the consistency with which health care professionals involved in UM apply criteria in decision-making and acts on opportunities for improvement, if applicable. The ORGANIZATION must use an appropriate mechanism to assess the consistency with which physician and non-physician reviewers apply UM criteria. The assessment of inter-rater reliability applies only to determinations made as part of a UM process. Any referral that requires prior approval is considered a UM determination.			
Consistency in Applying Criteria (Desk and Onsite Review)	**Yes**	**No**	**N/A**
The assessment mechanism can include any of the following: • A supervisor's periodic review of determinations (which include side-by-side comparisons of how different UM staff members manage the same case) • Weekly UM "rounds" attended by UM staff members and physicians to evaluate determinations and problem cases • Periodic audits of determination against criteria			
COMMENTS:			

ORGANIZATION Name: _____

Reviewed by: _____

UM 3 – Communication Services
The Organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.

ACCESS to Staff (desk review)	**Yes**	**No**	**N/A**
The Organization provides the following communication services for practitioners and members: Inbound and outbound communications may include directly speaking with practitioners and members or fax, electronic or telephone communications, e.g., sending e-mail, messages or leaving voicemail messages.			
1. Availability of staff at least eight hours a day during normal business hours regarding UM issues.			
2. Ability of staff to receive inbound communication after normal business hours regarding UM issues.			
3. Outbound communication from staff regarding inquiries about UM during normal business hours, unless agreed upon otherwise.			
4. Staff identifies themselves by name, title and Organization name when initiating or returning calls regarding UM issues.			
5..A toll free number or staff that accepts collect calls regarding UM issues.			
6. Access to staff for callers with questions about the UM process. Vendors may refer general UM inquiries to its customer service staff. However, inquiries regarding specific UM cases must be triaged to and handled by UM staff, e.g. inquiries about decisions beyond the confirmation of approval or denial of services			
7. TDD/TTY services for deaf, hard of hearing or speech-impaired members are offered.			
8. Language assistance for members to discuss issues is available.			
COMMENTS:			

ORGANIZATION Name: _____

Reviewed by: _____

UM 4 – APPROPRIATE PROFESSIONALS

Qualified licensed health professionals assess the clinical information used to support UM decisions UM decisions are made by qualified health professionals.

Licensed Health Professionals	Yes	No	N/A
The Organization has written procedures:			
1. Requiring appropriately licensed professionals to supervise all medical necessity decisions. People who are not qualified health professionals, under the supervision of appropriately licensed health professionals, collect data for pre-authorization and concurrent review. They may also have the authority to approve (but not to deny) services for which there are explicit criteria.			
2. Specifying the type of personnel responsible for each level of UM decision-making. Staff who are making behavioral healthcare decisions are supervised by a licensed behavioral health practitioner.			
COMMENTS:			

Use of Behavioral Health Practitioners for UM Decisions (Desk Review)	Yes	No	N/A
The ORGANIZATION has a written job description with qualifications for behavioral health practitioners who review denials of care based on medical necessity that requires:			
1. Education, training or professional experience in medical or clinical practice.			
2. Current license to practice without restriction.			
COMMENTS:			

Behavioral Health Practitioner Review of Denials (FILE REVIEW)
The ORGANIZATION ensures that a behavioral health practitioner reviews any denial of care based on medical necessity. The evaluation of this element is assessed during the monthly retrospective review of the ORGANIZATION's monthly UM denials based on medical necessity, or decisions on services that are, or that could be considered, covered benefits. Documentation may consist of a handwritten signature, handwritten initials, or unique electronic identifier on the letter of denial or on the notation of the denial in the file. For electronic signatures, the ORGANIZATION must be able to demonstrate appropriate controls to ensure that the signature can be entered into
COMMENTS:

Use of Board-Certified Consultants (Desk and Onsite Review)	Yes	No	N/A
1. The ORGANIZATION has written procedures for using board-certified behavioral health consultants and evidence that it uses these procedures to assist in making medical necessity determinations. The ORGANIZATION must have written procedures for using board-certified consultants that include a list of available consultants that are used in appropriate circumstances.			

ORGANIZATION Name: _____

Reviewed by: _____

2. The ORGANIZATION demonstrates the use of appropriate board-certified specialists. The ORGANIZATION must have available for review at least two cases demonstrating that consultants are board certified and that the ORGANIZATION uses them in appropriate circumstances.			
COMMENTS:			
Affirmative Statement About Incentives (Desk and Onsite Review)	**Yes**	**No**	**N/A**
The organization distributes a statement to all members and to all practitioners, providers and employees who make UM decisions affirming the following: The ORGANIZATION must distribute an affirmative statement to all of its practitioners, providers, and staff regarding its incentives to encourage appropriate utilization and discourage underutilization. In addition, the organization must clearly indicate that it does not use incentives to encourage barriers to care and service. The statement must have been distributed at least once since the last survey. Distribution via the Internet is permitted. Written information about the availability of the information on the Web must be mailed to all participating practitioners, providers, and employees. A paper copy of the affirmative statement posted on the Web must be made available upon request. Element F does not preclude the use of appropriate incentives for fostering efficient, appropriate care.			
1. UM decision-making is based only on appropriateness of care and service and existence of coverage.			
2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage of care.			
3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.			
COMMENTS:			

ORGANIZATION Name: _____

Reviewed by: _____

UM 5 Timeliness of Behavioral Health UM Decision Making (FILE REVIEW) The Organization makes utilization decisions in a timely manner to minimize any disruption in the provision of health care – accommodating clinical urgency of each request.	**Yes**	**No**	**N/A**

The ORGANIZATION adheres to the following standards for timeliness of UM decision making:

This applies to all UM decisions, whether they are made on the basis of benefits or on medical necessity and whether they are approvals or denials. Documentation in the UM files must include the date of receipt of each request and the date of the resolution.

1. **For non-urgent pre-service decisions, the ORGANIZATION makes decisions within 5 working days from receipt of the request.**

   Pre-service decision is any case or service that the ORGANIZATION must approve, in whole or part, in advance of the member obtaining medical care or services. Preauthorization and pre-certification are pre-service decisions.

2. **For urgent pre-service decisions, the ORGANIZATION makes decisions immediately or within 72-hours from receipt of request.**

   Urgent care is any request for medical care or treatment with respect to which application of time periods for making non-urgent care determinations:
   - Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment or
   - In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request

3. **For urgent concurrent review, the ORGANIZATION makes decisions within 24-hours from receipt of the request.**

   Concurrent review decision is any review for an extension of a previously approved ongoing course of treatment over a period of time or number of treatments, typically associated with inpatient or ongoing ambulatory care. If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the organization – and does not meet the "urgent" definition – the request may be treated as a new request & handled within the appropriate time frames.

COMMENTS:

Notification of Behavioral Health Decisions (FILE REVIEW)	**Yes**	**No**	**N/A**

The ORGANIZATION adheres to the following standards for notification of UM decision-making:

The date of the electronic or written notification is evaluated for timeliness of notification. For oral notifications, the ORGANIZATION must record the time and date that the notification occurred, as well as who spoke with the practitioner or member. Members must be notified of a UM denial except, when a denial is either concurrent or post service and the member is not a financial risk.

1. **For non-urgent pre-service decisions, the practitioner must be initially notified within 24 hours of the decision either by telephone or fax.**
2. **For non-urgent pre-service denial decisions, the ORGANIZATION gives electronic or written notification of the decision to practitioners and members within 2 working days of request.**
3. **For urgent pre-service decisions, the practitioner must be initially notified within 24 hours of the decision either by telephone or fax.**
4. **For urgent pre-service denial decisions, the ORGANIZATION gives electronic or written notification of the decision to practitioners and members within 72 hours of the request.**
5. **For urgent concurrent decisions, the ORGANIZATION gives oral, electronic or written notification of the decision to practitioners and members within 24 hours of the request.**

6. For urgent concurrent denial decisions, the ORGANIZATION gives electronic or written notification of the decision to practitioners and members within 24 hours of the request or no later than 3 calendar days after the verbal notification.
7. For post–service denial decisions, the ORGANIZATION makes the decision and gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the
COMMENTS:

When making a determination of coverage based on medical necessity, the ORGANIZATION obtains relevant clinical information and consults with the treating practitioner. The ORGANIZATION uses all information relevant to an individual member's care when making UM decisions.

Information for UM Decision Making (Desk Review)	Yes	No	N/A
The ORGANIZATION has a written description that identifies the information that is needed to support the UM decision-making. The UM process must ensure that the information needed to make a determination of medical necessity has been collected. A written policy must guide this process, which must not be overly burdensome for the member, the practitioner or the health delivery ORGANIZATION's staff.			
COMMENTS:			

Behavioral Healthcare Documentation of Relevant Information (FILE REVIEW)
There is documentation that relevant behavioral health clinical information is gathered consistently to support UM decision-making. This element is based on a review of a random selection of medical necessity denials. There must be evidence that the ORGANIZATION has followed its own policies and procedures. Denial files must contain clinical information appropriate to each case.
COMMENTS:

ORGANIZATION Name: _____

Reviewed by: _____

UM 6 – DENIAL NOTICES – The Organization clearly documents and communicates the reasons for each denial. Practitioners and members receive sufficient information to understand and decide about appealing a decision to deny care or coverage.
Discussing a Denial with a Reviewer
The Organization provides practitioners with the opportunity to discuss any behavioral healthcare UM denial decisions with a behavioral health practitioner reviewer. This element is based on review of a random same of the Organization's medical necessity denial files. There is evidence that the Organization notified each treating practitioner how to contact the Organization's reviewer to discuss a denial.
COMMENTS:
Reason for Behavioral Healthcare Denial – The Organization provides written notification to members and their treating practitioners that contains the following:
This element applies to all denials, whether they are made on the basis of benefits or on the basis of medical necessity. The evaluation is based on a review of a random sample of denials based on behavioral health clinical necessity. Documentation must show that the decision was communicated in writing to the practitioner and the member involved. Members do not need to be notified when a denial is either concurrent or retrospective and the member is not at financial risk. The practitioner must be notified of all denials that pertain to the patients they are treating. Must include the following:
1. The specific reason for the denial, in easily understandable language. The reasons for denials must be clearly documented in a permanent case record, which can be either manual or automated. A copy of the specific denial notification can demonstrate compliance. Samples of denial notifications or examples of form letters do not meet the intent of the standard.
2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based. The Organization must provide the reason for denial and include an easy to understand summary of UM criteria. The reason is to give the practitioner and member sufficient information to make a decision about appealing the denial.
3. Notification that the member, upon request, can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based.
COMMENTS:

ORGANIZATION Name: _____

Reviewed by: _____

UM 7 – Organization has written policies and procedures for thorough and appropriate and timely resolution of member appeals. Behavioral Healthcare Notification of Appeal Rights and Appeal
The ORGANIZATION provides written notification that contains the following: This element applies to all denials, whether they are made on the basis of benefits or on the basis of medical necessity. The evaluation is based on a review of a random sample of medical necessity denials.
1. Description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.
2. Explanation of the appeal process, including the right to member representation and timeframes for deciding appeals.
3. If a denial is an urgent pre-service or urgent concurrent denial, a description of the expedited appeal process is included.
COMMENTS:

The ORGANIZATION provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs. Members can obtain needed emergency services.

UM 8 Emergency services Policies and Procedures (Desk Review)	**Yes**	**No**	**N/A**
The ORGANIZATION's emergency services policies and procedures require: The ORGANIZATION must have policies and procedures for handling emergency room claims, to ensure that retrospective denials or billing adjustment of payment include consideration of presenting symptoms and are not based solely on discharge diagnoses.			
1. Coverage of emergency services to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed. A **prudent layperson** is a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment. A prudent layperson is considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of the observation of the medical symptoms at hand, that emergency medical treatment was necessary.			
2. Coverage of emergency services if an authorized representative, acting for the ORGANIZATION, has authorized the provision of emergency services. The ORGANIZATION's policies and procedures must clearly state that the ORGANIZATION covers emergency services when authorized by a practitioner participating within the ORGANIZATION's network or other authorized representative. **Authorized representative** may be any employee or contractor of the ORGANIZATION who directs the member to seek services, e.g., advice nurse, network physician, physician assistant, and customer service representative.			
COMMENTS:			

ORGANIZATION Name: _____

Reviewed by: _____

The following criteria apply to California audits only; and are applicable as the contract between the health plan and ORGANIZATION dictate.

California Senate Bills (Desk and Onsite Review)	Yes	No	N/A
1. Written process to obtain second opinion from PCPs and specialists: Members are allowed to obtain a second opinion from a specialist outside the ORGANIZATION, but within the health plan network. Members must stay within the ORGANIZATION if requesting a second opinion from			
2. Written description of Independent External Review (IER) file review. Member may request an independent, external review for any referral that is denied, modified or delayed because of lack of medical necessity. **DMHC:** Denial letter must have the DMHC required Independent Medical Review Language when treatment or services has been denied as not medically necessary or experimental.			
Comments:			

POLICY AND PROCEDURE (DESK REVIEW)	Yes	No	N/A
Policies and procedures for notification to members of denials and modification of prior authorization requests. The organization has a written policy regarding the notification to members of denial or modification of prior authorization requests.			
COMMENTS:			

ORGANIZATION Name: _____

Reviewed by: _____

NOA SECTION:

Notice of Action Letters (FILE REVIEW)

The notice of action letters must be a Health Plan/DHCS approved denial letter and include:

The notice of action letters include instructions regarding how to file an appeal that is in compliance with all regulatory requirements (DHCS, DMHC, etc.)

1. **Ombudsman contacts – DHCS Ombudsman 1(888) 452-8609**
2. **State Fair Hearing information for Medi-Cal**
3. **DMHC information with TTY and Internet website information included**
4. **Health Plan address and member services telephone number**
5. **Health Plan approved denial letter**
6. **Non-covered benefit denials must specify the provision in the contract that excludes the benefit**
7. **"Your Rights" attachments for Medi-Cal, Healthy Families and Healthy Kids**

COMMENTS:

Approved Referral Audit (FILE REVIEW)
1. Approved referral turn-around time **Guidelines** Referral turn-around time • 5 working days from receipt of the request • Urgent requests must be adjudicated immediately or within 72 hours from receipt of the request • Emergency services will not require prior authorization Scoring • 100% – 80% = Pass • Less than 79% = Focused Audit
2. Proof service was delivered or member notified **Guidelines** There must be documented evidence that the member was notified of the approved authorization or that the member received the requested service.
COMMENTS:

DENIED REFERRALS:

DENIED REFERRAL AUDIT (FILE REVIEW)
1. Denied referral overall score Scoring: 100% - 80% = PASS Less than 79% = FOCUSED AUDIT The final medical management audit score is determined based on the total points achieved through the medical management audit period. The Organization must achieve a passing score of 80% or > in each of these major categories (Overall audit, Turn around time compliance, and use of the correct denial letter template and required "your rights" attachments.
2. The following components are reviewed as part of the denied referral audit: • Evidence that a behavioral health practitioner conducts a review on every denial decision of

appropriateness
- And benefit coverage. Qualified licensed health professionals assess the clinical information used to support
- UM decisions.
- Evidence that the member was given alternative direction for follow up care when a service is denied
- Timeliness of UM decisions

DENIED REFERRAL AUDIT: (FILE REVIEW)

The Organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. Referral turn around time:
- 5 working days from receipt of request
- Urgent request must be adjudicated immediately or within 72 hours from receipt of the request
- Emergency services will not require prior authorization.

The Organization notifies the practitioner of the decision of non-emergent requests within the appropriate time frame:
Initial notification of the provider:
- Routine and urgent referrals within 24 hours of the decision
- Urgent requests notification includes information on how to file expedited appeal within 2 working days of the decision, but not to exceed 72 hours from receipt of the request for urgent referrals.
- Member may be initially notified within 24 hours of the decision by telephone for urgent referrals.

The Organization provides written notification regarding denial decisions of non-emergent requests within appropriate timeframes to the following:
Timeliness of written notification to the Member and Practitioner with appeals information to the member and provider of denial determinations:
- Within 2 working days of the decision for routine referrals
- Within 72 hours from receipt of the request for urgent referrals

There is evidence that the Organization consistently gathers relevant clinical information to support UM decision making prior to making determination.

The Organization notifies the practitioner that a behavioral health practitioner will be available to discuss determinations based on medical appropriateness. Evidence that the Organization notifies the practitioner how to contact the physician reviewer to discuss determinations based on medical appropriateness.

The Organization clearly documents the reason for the denial in the written notification to the Member and Practitioner. The notification includes specific utilization review criteria or benefit provisions used in the determination.

The Organization includes information about the appeals process in denial notifications to the Member.

Denied Referral Audit (FILE REVIEW)

OVERALL SCORE:

2014 Audit (Timeframe:_____) Denial File Review Audit Total Points Earned:
- **Overall score =**
- **TAT compliance score =**
- **Use of correct templates and all required "Your Rights" attachments score =**

COMMENTS: (Insert detail regarding corrective action taken during the MMA period in regards to the score < 80%)

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Medi-Cal Managed Care Quality and Performance Improvement Program Requirements				POLICY #: 20.50-I	
DEPARTMENT: Health Services - Quality Improvement					
Effective Date: 01/2005	Review/Revised Date: ~~06/05~~10/11/2017	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Administrative Director of Health Services

POLICY[1]:

This policy is developed in response ~~to All~~to All Plan Letter ~~16-018~~ 17-014, which delineates the requirement for external reporting of performance measurement results including results of a consumer satisfaction survey.

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KHS reports annual performance measures results to DHCS and will produce a Plan-Do-Study-Act (PDSA) Cycle Worksheet for poor performance as applicable. The plan will conduct ongoing performance improvement project (PIPs) and participates in the administration of consumer satisfaction surveys every three years.

PROCEDURES:

1.0 EXTERNAL ACCOUNTABILITY SET (EAS)

1.1 Performance Measures

KHS's primary contact for performance Measurement is the Supervisor of Quality Improvement. Secondary or back-up contact is the Quality Improvement Business Analyst.

The Quality Improvement Department, including the primary and secondary contacts participates in all technical assistance conference calls. Other appropriate subject matter experts from other KHS departments are invited to participate in these calls based on subject matter.

Annually, Kern Health Systems (KHS~~) collects~~) collects and reports EAS Compliance Audit as defined by DHCS. Currently the Healthcare Effectiveness Data and Information Set (HEDIS~~) is~~) is used as a standardized method to objectively evaluate delivery of services. KHS also reports rates for any statewide collaborative measure chosen by DHCS when applicable. See Attachment A for the list of all HEDIS and DHCS-developed measure required for the current reporting year.

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KHS participates in an annual onsite performance measure validation audit. The audit consists of an assessment of KHS's information system capabilities, followed by an evaluation of KHS's ability to comply with HEDIS and non-HEDIS specifications. The EQRO follows NCQA HEDIS Compliance Audit methodology to assure standardization reporting.

KHS uses the Department of Healthcare Services (DHCS)-selected contractor for conducting the performance measure validations. The Compliance Audits are performed by an External Quality Review Organization (EQRO) at DHCS's expense. Health Services Advisory Group (HSAG) was selected in July 2015 as the EQRO for the Medi-Cal Managed Care (MCMC) program. The EQRO may conduct the future audits or may subcontract with one or more firms licensed by the National Committee of Quality Assurance (NCQA) to conduct some of the EAS audits.

2.0 EAS REPORTING REQUIREMENTS

2.1 Calculating and Reporting Rates. KHS will calculate its rates for the required performance measures and these rates will be audited by the EQRO or its subcontractor and reported to DHCS. KHS will report the results for each of the performance measures required while adhering to HEDIS® or other specifications for the reporting year to the EQRO. KHS will follow NCQA's timeline for collecting, calculating, and reporting rates.

2.2 Reporting Units. KHS calculates and reports performance measure rates at the county level.

2.3 Public Reporting of Performance Measurement Results. DHCS will publicly report the audited results of HEDIS® and other performance measure rates for each MCP, along with the Medi-Cal managed care average and comparisons to national data, as applicable, for each DHCS-required performance measure.

3.0 EAS PERFORMANCE STANDARDS ESTABLISHED by DHCS

3.1 Minimum Performance Levels (MPLs): KHS strives to meet or exceed the DHCS established MPL for each required HEDIS® measure (~~excluding~~ exempting those measures note by DHCS on the most recent EAS.~~the utilization/"use of services" measures).~~

3.2 High Performance Levels (HPLs). KHS strives to meet the DHCS established HPL for each required performance measure.

4.0 MCP PERFORMANCE RESULTS and COMPLIANCE

4.1 HEDIS® PDSAs. KHS will submit a PDSA Cycle Worksheet (see Attachment B) ~~for measure~~ for measure(s) with a rate that does not meet the MPL or is given an audit result of "Not Reportable.'

4.2 Per DHSC requirements, KHS will not submit a PDSA if:

4.2.1 ~~the~~The MPL is not met in the first year measurement

4.2.2 F~~f~~or measures with significant changes to the technical specifications.

4.2.3 Additional Exceptions. DHCS may also determine that PDSA cycle submissions are not required for reasons in addition to those listed above. DHCS will notify MCPs in instances where it has made such a determination.

4.3 PDSA Cycle Submission Requirements (for EAS measures with rates below the MPLs).

4.3.1Using the final, audited measurement year rates submitted to the NCQA, DHCS and KHS will identify measures with rates below the MPLs.

4.3.2 KHS will complete and submit a PDSA Cycle Worksheet for each measure with a rate below the MPL in accordance with the PDSA instructions (see Attachment B).

4.3.2.1 KHS will conduct ~~at least quarterly~~ongoing evaluations of their ~~ongoing,~~ rapid-cycle quality improvement efforts and document the Do, Study, and Act portions of the PDSA Cycle Worksheet once these phases are completed. The DHCS nurse consultant liaison will work with KHS to develop a schedule for submissions and teleconferences to monitor progress over the year.

4.4 MCPs with No Measures with Rates below the MPLs. If KHS's rates for all measures meet or exceed the MPLs, KHS is not required to submit a PDSA Cycle Worksheet for any measures. KHS will continue to evaluate ongoing quality improvement efforts on a quarterly basis and use the PDSA Cycle Worksheet to help guide ongoing, rapid-cycle improvement processes. Evaluation will include but is not limited to indicators with rates that are declining or showing worsening trends. KHS will work proactively to address these indicators.

4.5 Development of PDSA Cycle. PDSA cycle development will include the setting of a Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) objective; establishing measures; selecting, testing and implementing interventions; and spreading changes. The PDSA methodology is a rapid-cycle/continuous quality improvement process designed to perform small tests of change, which allows more flexibility to make adjustments throughout the improvement process. As part of this approach, KHS will perform real-time tracking and evaluation of their interventions.

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4.6 Reporting Requirements.

4.6.1 Medical Director Signature. PDSA Cycle Worksheets must be signed by the KHS's Chief Medical Officer who approved the PDSA cycle prior to it being submitted to DHCS.

4.6.2 Timeline. DHCS will notify KHS of submission due dates.

4.6.3 Submission. KHS will submit PDSA Cycle Worksheets to DHCS's mailbox at: dhcsquality@dhcs.ca.gov.

5.0 CAPs

DHCS may require a CAP for MCPs that have numerous measures with rates below the MPLs, measures with rates below the MPLs for multiple years, or when DHCS determines that a CAP is necessary, as outlined in the DHCS Quality of Care CAP Process. CAP requirements may include, but are not limited to:

5.1 Reporting of HEDIS® PDSA Cycle Worksheets with corresponding continuous rapid-cycle improvement activities.

5.2 Additional PIPs.

5.3 Additional technical assistance calls.

6.0 CONSUMER SATISFACTION SURVEYS

Full scope MCPs are required to participate in EQRO ~~–~~ conducted member satisfaction surveys at intervals determined by DHCS, as per the contract.

6.1 Survey Instrument. DHCS uses the Consumer Assessment of Healthcare Providers and Systems (CAHPS®3~~2~~) surveys to assess member satisfaction with MCPs. DHCS may ~~—~~additional customized survey questions, in compliance with NCQA standards, to assess specific problems and/or special populations.

6.2 CAHPS® Survey Administration. The EQRO administers the CAHPS® survey for the adult Medicaid population every three years and for the Child Health Insurance Program (CHIP) Medicaid population annually. The EQRO will administer the CAHPS and CAHPS CHIP survey in 2016, reflecting members' perceptions of care for a six-month period of time during the prior year.

6.3 Reporting of Survey Results. In years when DHCS's EQRO administers the CAHPS® surveys, the EQRO will provide a reporting unit-level analysis for each MCP, when applicable, in the CAHPS® Summary Report. Reporting unit-level analysis allows DHCS, MCPs, and other stakeholders to better understand how member satisfaction and MCP services vary among counties/regions.

7.0 PIPs.

7.1 Number of Required PIPs. MCPs are required to conduct a minimum of two PIPs per year. ~~for each Medi-Cal contract held with DHCS, but if the areas in need of improvement are similar across contracts, then DHCS may allow the MCP to only conduct two PIPs total~~. DHCS will provide guidance to each MCP and SHP on topic selection and may require MCPs and SHPs to participate in collaborative discussions.

~~**7.2 New PIP Approach.** The PIP Transition Plan, PIP Companion Guide, and submission forms will be provided by the EQRO.~~

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7.23 PIP Topic Selection. MCPs will choose PIP topics in consultation with DHCS. DHCS strongly ~~DHCS strongly~~ recommends that PIP topics align with demonstrated areas of poor performance, such as low HEDIS® or CAHPS® scores, and/or DHCS/EQRO recommendations.

76.3.1 Topic Proposal Timelines and Format. DHCS will notify MCPs of the due date for PIP topic selection and the format to use for selection proposal.

76.3.2 Topic Proposal Submission. Each MCP must submit its completed PIP topic proposal form to DHCS's quality mailbox at dhcsquality@dhcs.ca.gov.

76.3.3 DHCS's Approval of PIP Topic. After receiving an MCP's proposed PIP topic, DHCS will send the MCP a notice of approval, a request for additional information, or suggest that the MCP participate in a technical assistance call with the EQRO.

7.4 PIP Module Submissions. The ~~new~~ rapid-cycle PIP process ~~will~~ requires the submission of five modules. MCPs must submit and pass Module 1 (PIP Initiation) and Module 2 (SMART Aim Data Collection) prior to submitting Module 3 (Intervention Determination). DHCS's EQRO will conduct technical assistance calls to guide MCPs through the process. The EQRO will review module submissions and provide feedback to the MCPs, which will have multiple opportunities to fine-tune Modules 1 through 3. Module 4 is Intervention Testing, utilizing PDSA cycles. This is the longest phase of the five modules. Module 5 concludes the PIP process by summarizing the project. MCPs will have opportunities for technical assistance with both DHCS and the EQRO throughout the entire PIP process.

7.5 PIP Duration. DHCS will notify MCPs regarding the length of the PIP cycle. PIPs typically will last approximately 12–18 months, employing a rapid-cycle improvement process to pilot small changes. MCPs that would like to conduct longer PIPs must seek DHCS approval.

7.6 **Assessment of Results**. Upon completion of each PIP, the EQRO provides a confidence level on the validity and reliability of the results.

7.7 Communication and Meetings with DHCS and Among MCPs.

7.7.1 Designated Contacts. MCPs must provide DHCS with one primary contact (PIP lead) and at least one backup contact for each PIP who is familiar enough with the PIP to step in during the PIP lead's absence. Only under certain circumstances will DHCS approve an MCP's request for an extension of time to submit PIP-related documentation due to staff absence. KHS's designated contact is the QI Supervisor and the HEDIS RN

7.7.2 Technical Assistance. To ensure that PIPs are valid and result in real improvements in the care and services provided to MCP members, DHCS periodically holds technical assistance conference calls for all MCPs to: (1) present changes in methodologies or processes; and, (2) assist MCPs that are having difficulties with a PIP. MCPs are required to participate in these technical assistance calls.

8.0 Focus Studies. DHCS may require MCPs to participate in focus studies of specific quality priority areas by submitting data or participating in surveys.

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9.0 Member-Level Reporting. DHCS ~~is requiring~~ requires all full scope MCPs to report member-level ~~demographic~~ data to ~~DHCS~~the EQRO as part of the HEDIS audit process.~~. DHCS and the EQRO will communicate with the MCPs on the file formatting and frequency of these submissions.~~

9.1 Reporting Requirements Impacting Alternative Health Care Services Plans (AHCSPs). All full scope MCPs will be required to include an AHCSP identifier as part of their member-level reporting. AHCSP is defined in California Code of Regulations, Title 22, Section 53810.

10.0 ADDRESSES FOR ELECTRONIC SUBMISSIONS:

10.1 EQRO's File Transfer Protocol (FTP) Website. DHCS's EQRO, Health Services Advisory Group (HSAG), uses an FTP website. All current MCPs have identified FTP users who have been assigned user names and passwords by HSAG to access each MCP's specific folder. To establish additional user profiles or remove previous users, MCP staff should contact the EQRO or the MCP's Nurse Consultant.

10.2 DHCS's Submission E-Address. DHCS's quality mailbox: dhcsquality@dhcs.ca.gov.

ATTACHMENTS:

- Attachment A - *External Accountability Set (EAS) Measures: 2015-2016*
- Attachment B - *PDSA Cycle Worksheet*

REFERENCE:

Revision 2017-10 Updated by QI Supervisor to meet APL 17-014 verbiage.
Revision 2017-06: Policy reviewed by Compliance Auditor to comply with APL 16-018. Reviewed by QI Supervisor, no revisions required. Revision **2016-08:** Revisions to conform to APL 15-024, Rename Attachment A and update with final requirements. Add Attachment 2, PDSA Cycle Worksheet.

[1] **Revision 2015-06:** Revisions to conform to APL 14-003. Update Attachment A with 2015-2016 requirements (draft), removed Attachment B and Attachment C. **Revision 2011:** Updated attachment, "Required Hedis Measures for 2010-2011. **Revision 2009-09:** Policy reviewed against MMCD Letter 08-009. **Revision 2005-02:** No revision needed per Quality Improvement Manager. Revision 2004-02: MMCD Letter 03-01 (June 5, 2003)

Attachment 1.

External Accountability Set – Full-Scope Plans

Measurement Year (MY) 2017 (to be reported in 2018)

#	Measure Acronym	Measure	Measure Type Methodology	SPD** Stratification Required	Auto Assignment Algorithm ****
1.	ACR*	All-Cause Readmissions	Administrative (non-NCQA), defined by ACR collaborative	Yes	No
2.	AMB-OP* AMB-ED*	Ambulatory Care: • Outpatient visits • Emergency Department visits **(Children)***** • Emergency Department visits **(Adults)** • Emergency Department visits **(Total)**	Administrative	Yes	No
3.	MPM-ACE MPM-DIU	Annual Monitoring for Patients on Persistent Medications (2 indicators): • ACE inhibitors or ARBs • Diuretics	Administrative	Yes	No
4.	AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Administrative	No	No
5.	BCS	Breast Cancer Screening	Administrative	No	No
6.	CCS	Cervical Cancer Screening	Hybrid	No	Yes
7.	CIS-3	Childhood Immunization Status – Combo 3	Hybrid	No	Yes
8.	CAP-1224* CAP-256* CAP-711* CAP-1219*	Children & Adolescents' Access to Primary Care Practitioners (4 indicators): • 12-24 Months • 25 Months – 6 Years • 7-11 Years • 12-19 Years	Administrative	Yes	No
9.	CDC-E CDC-HT CDC-H9 CDC-H8 CDC-N CDC-BP	Comprehensive Diabetes Care (6 indicators): • Eye Exam (Retinal) Performed • HbA1c Testing • HbA1c Poor Control (>9.0%) • HbA1c Control (<8.0%) • Medical Attention for Nephropathy Blood pressure control (<140/90 mm Hg)	Hybrid	No	Yes, for *HbA1c Testing* **only**
10.	CBP	Controlling High Blood Pressure < 140/90 mm Hg (except < 150/90 mm Hg for ages 60-85 without diabetes)	Hybrid	No	Yes
11.	IMA-2^	Immunizations for Adolescents (meningococcal, Tdap, HPV)	Hybrid	No	No

Attachment 1. (continued)

External Accountability Set –Full-Scope Plans
Measurement Year (MY) 2017 (to be reported in 2018)

#	Measure Acronym	Measure	Measure Type Methodology	SPD** Stratification Required	Auto Assignment Algorithm ****
12.	AMR	Asthma Medication Ratio	Administrative	No	No
13.	PPC-Pre PPC-Pst	Prenatal & Postpartum Care (2 indicators): • Timeliness of Prenatal Care • Postpartum Care	Hybrid	No	Yes, for *Prenatal* ***only***
14.	DSF*	• Depression Screening and Follow-Up for Adolescents and Adults	Electronic Clinical Data Systems (ECDS)	No	No
15.	LBP	Use of Imaging Studies for Low Back Pain	Administrative	No	No
16.	WCC-N WCC-PA	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents • Counseling for nutrition • Counseling for physical activity	Hybrid	No	No
17.	W-34	Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life	Hybrid	No	Yes

Total Number of Measures = 1 ECDS + 8 Hybrid + 8 Admin measures (29 indicators total)

^ MCPs will be held to a benchmark for HEDIS 2018 pending the availability of the benchmark from the National Committee on Quality Assurance'^'.* MCPs will not be held to an MPL for measures marked with "*"

** Seniors and Persons with Disabilities (SPD)

*** Same age bands that Plans already report to NCQA

**** Data from MY 2016 will be used in 2017 auto assignment algorithm. Subsequent years to be determined.

Attachment 3.

PDSA CYCLE WORKSHEET

A. Managed Care Plan:

B. Topic/Performance Measure:

C. County(ies):

D. Time frame of PDSA cycle:

E. Person Responsible for Implementing PDSA:

F. Medical Director Responsible for Approving PDSA:

G. Submission Date:

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1. What is the **Global Aim** of this project?

2. Based on the *Pre-Planning Phase*, what is the **Identified Barrier** that this PDSA cycle will address?

3. For ***NEW*** interventions – submit the data analysis and evidence validating why you chose this intervention to test:

   ☐ Data and/or supporting documentation submitted as attachment

   ☐ Data and/or supporting documentation imbedded in Plan portion of PDSA Worksheet

   ☐ N/A

4. What is the **SMART Objective** for this PDSA cycle?

   Reminder: The SMART objective should lead to the Global Aim and it must include these elements:

   - Time frame: *by when?*
   - Change: *an increase or decrease?*
   - From baseline to goal: *baseline rate/value to goal rate/value?*
   - Target population: *who/what subgroup will be the target of your intervention?*
   - Where: *county(ies)?*

Attachment 3. (continued)

Plan	• **What** is the intervention for this PDSA cycle? (Only ONE intervention per PDSA cycle) • **What** is the desired outcome of the intervention?
	• Develop a plan to test the intervention. • **Who** will conduct the intervention? • **How** will they conduct the intervention? • **When** will they conduct the intervention? • **Where** will they conduct the intervention?
	• Predict what will happen, and why. • How will you measure that the change is an improvement?
	• Plan for the collection of data. • What data needs to be collected? Include data elements and data sources. • Who is responsible for collecting the data? • When and how often will the data be collected?

Do	• Conduct the intervention. • Collect and record data, and begin your analysis of the data. • Describe what you and/or your external partner(s) did. • What did you observe? Include unexpected barriers.

Attachment 3. (continued)

Information and Instructions for the Plan-Do-Study-Act (PDSA) Cycle Worksheet

SMART Objective for a PDSA cycle

Rules for writing your SMART objective:

- **DO NOT** use an overall HEDIS measure rate for the PDSA cycle.
- **DO NOT** use data based on claims when there is a delay of claims.

Objectives Must:

- Be well defined and clear.
- Specify a "change" in the target population as an "increase" or "decrease".
- Consist of a narrowed focus and contribute towards the Global Aim.
- Include the baseline (rate or value) and the goal (rate or value).
- Include the relevant time period (no longer than 4 months).
- Include a small "sub-group" as the target population (e.g., one to three providers; one to three providers from a provider group; a specific sub-population of members; a specific geographic area; etc.).

Objectives must be SMART:

- **Specific:**
  - *What*: *What* is your goal? *What* do you want to accomplish?
  - *Target population*: *Who* is your target population?
  - *Where*: *Where* will this intervention be implemented?
- **Measurable:**
  - *Change*: How much change is expected, and in what direction (increase or decrease) will the change be?
  - Include baseline rate/value, if known, and goal rate/value. If the baseline rate is not known, the MCP should provide an explanation and collect a baseline rate over a three-month or longer time period.
  - Do you have data to measure and prove the desired change has occurred?
- **Achievable:**
  - Can you achieve this objective within the selected time frame?
  - Have you identified any limitations or constraints/challenges you may encounter?
  - Can you meet the objective with the resources/support available?

Attachment 3. (continued)

Study	• Complete the data analysis (quantitative and qualitative). • Compare the data to your predictions. • Discuss findings and summarize what was learned (e.g., barriers, successes).
Act	• Based on what was learned from the intervention, are you going to (*choose <u>one</u> of the following*): ☐ ADOPT (keep/expand the intervention) o Are you going to expand and further test the intervention? o Is there a plan to test the sustainability of the intervention? ☐ ADAPT (modify the intervention) o What are the modifications to the intervention? o What are the lessons learned? o What changes to the SMART objective will you make in the next PDSA cycle? ☐ ABANDON (end the intervention) o What are the lessons learned? • Answer all corresponding question(s). • Provide the rationale for your choice. • What will you do for the next PDSA cycle? *Note*: Once an intervention has resulted in improvement with the narrowed focus, the MCP should develop a plan to further test the intervention in additional settings. As additional improvement is achieved, the intervention should be considered for MCP-wide implementation.

Attachment 3. (continued)

The SMART objective must include all the elements, but it does not need to be in the exact order as shown in the template below.

_____
_____

Example: *By 12/31/2015, increase the percent of Plan's pediatric providers who use the California Immunization Registry (CAIR) in one high volume/low performing provider group in X County, from 50% as of 9/2015, to 70%.*

Filling out the P-D-S-A Section on the Worksheet

PLAN: Answer all questions in the space provided on the Worksheet.

- **Intervention**: The intervention must answer the following questions:
  - What are you going to test?
    - Be specific – you can only test ONE intervention per PDSA cycle.
  - Who is involved with testing the intervention?

Example: *QI staff will develop a 'CAIR Checklist' to be tested by the provider office staff as part of their regular workflow. QI staff will provide a 30-60 minute training on how to use the Checklist.*

DO: Answer all questions in the space provided on the Worksheet. You may submit data documentation, but it is not required.

STUDY: Answer all questions in the space provided on the Worksheet.

ACT: What was learned from testing the intervention? What are you going to do next?

- Choose whether you will:
  - **Adopt** (keep/expand the intervention)
  - **Adapt** (modify the intervention)
  - **Abandon** (end the intervention)

Mark your choice by checking one of the boxes on the Worksheet. Answer the corresponding questions and provide the rationale for your choice.

Read the note at the end of the Worksheet and answer the final question.

If you have questions related to PDSA cycles or filling out the Worksheet, please contact your DHCS Nurse Consultant Liaison.

- **Relevant:**
  - Will this objective have an effect on the global aim?
  - Does it seem reasonable and worthwhile to measure this objective?
- **Time-Bound:**
  - *Time Frame*: When will the objective be completed (data: mm/dd/yyyy)? Each PDSA cycle should be ≤ 4 months.
  - Is the specific time frame realistic? Will you be able to test the intervention in this time frame?

Filling out the PDSA Cycle Worksheet

Answer all questions in the space provided on the PDSA Cycle Worksheet.

Global Aim: What is the Global Aim of the project? (e.g., Improve HEDIS rate to above the Medi-Cal state average, Improve HEDIS rate to above the MPL, etc.)

Example: *To improve CIS-3 HEDIS rate above the MPL.*

Identified Barrier: Based on the Pre-Planning Phase, what is the barrier that this PDSA cycle will address?

Example: *Providers and office staff lack knowledge about how to log on and enter vaccines into CAIR.*

New Interventions: Why did you choose this intervention to test?

- Justify your choice of intervention with a description of the planning process (e.g., key driver diagram, fishbone, work flow process maps, literature review, etc.).
- Submit the data analysis and evidence supporting your choice of intervention (e.g., quantitative or qualitative data).

SMART Objective: What is the SMART objective for this PDSA cycle?

The SMART objective should lead to the Global Aim, and it must include these elements:

- Time frame: *by when?*
- Change: *an increase or decrease?*
- From baseline to goal: *baseline rate/value to goal rate/value?*
- Target population: *who/what subgroup will be the target of your intervention?*
- Where: *county(ies)?*

Health Services Quarterly Committee Reporting- Reporting Period July 1, 2017 to September 30, 2017

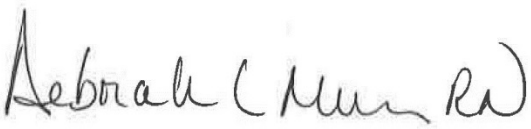
Health Services Overview

The 2017 membership enrollment remained stable at 248,000 in Q3 2017. Additional benefit coverage and broadening interdisciplinary collaboration to support the membership growth will continue through 2017.

- Palliative Care-benefit 1/1/2018
- Provider Appeals-formerly Prior auth disputes-member consent requirement
- Other Health Coverage-MC/Commercial-changes to process
- Inpatient Concurrent Review process-DRG and hospitalist
- Opioid Coalition
- Synagis RSV-CCS partnership
- Diabetic Clinics-Kern Medical, Delano Regional, and Bakersfield Memorial
- Urgent Care, Specialty Care, and PCP Utilization Comparison

The following pages reflect statistical measurements for Utilization Management, Case Management and Disease Management detailing the ongoing compliance activity for the 3rd Quarter 2017.

Respectfully submitted,



Deborah Murr RN, BS HCM
Administrative Director of Health Services
Kern Health System

Utilization Management Reporting

Timeliness of Decision Trending

Summary:

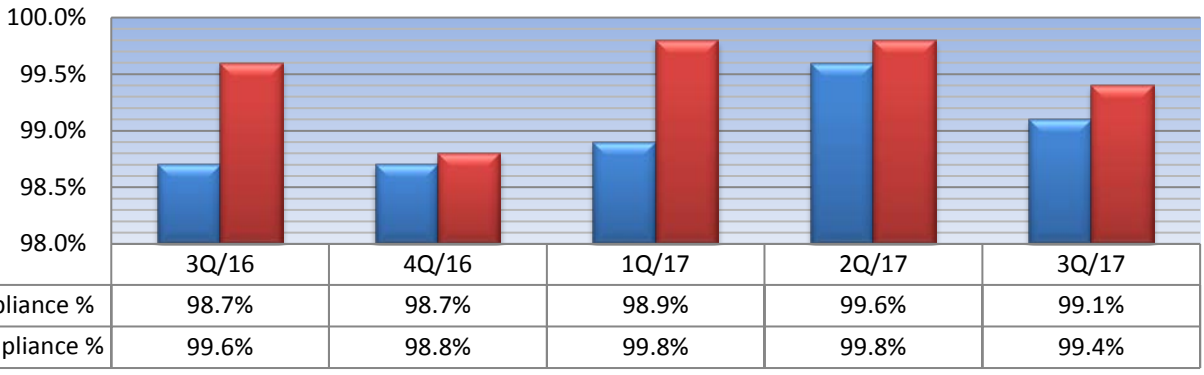
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

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

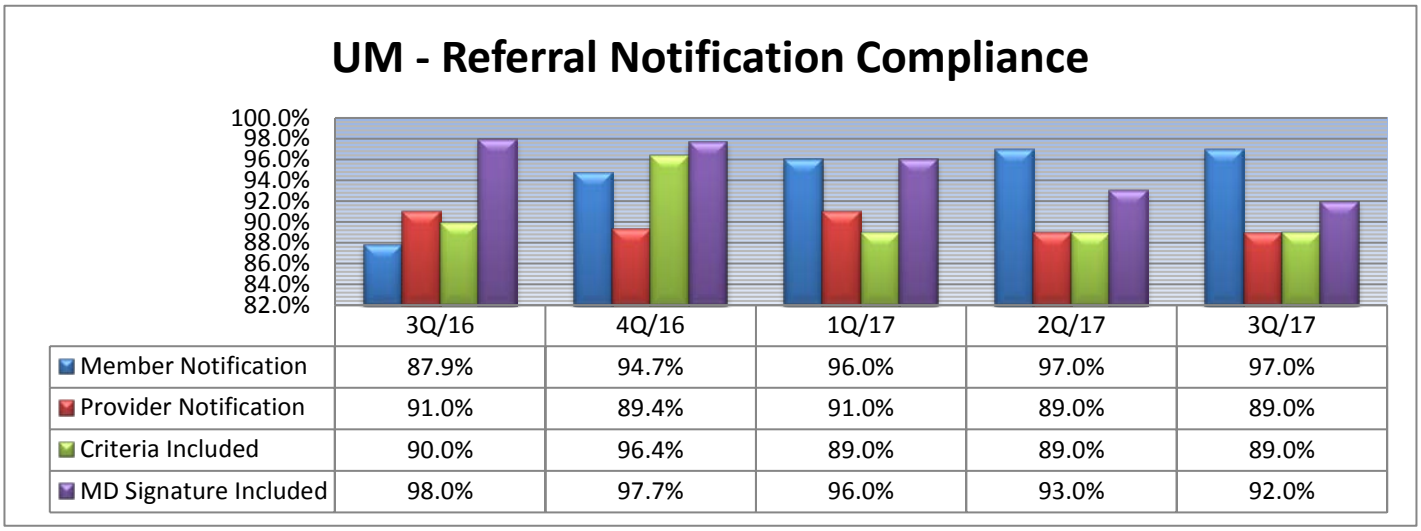
There were 25,814 referrals processed in the 3rd quarter 2017 of which 2,280 referrals were reviewed for timeliness of decision. In comparison to the 2nd quarter's processing time, the routine referrals decreased from the 3rd quarter which was 99.8% to 99.4%, and urgent referrals decreased from 3rd quarter which was 99.6% to 99.1%.



	3Q/16	4Q/16	1Q/17	2Q/17	3Q/17
Urgent Compliance %	98.7%	98.7%	98.9%	99.6%	99.1%
Routine Compliance %	99.6%	98.8%	99.8%	99.8%	99.4%

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

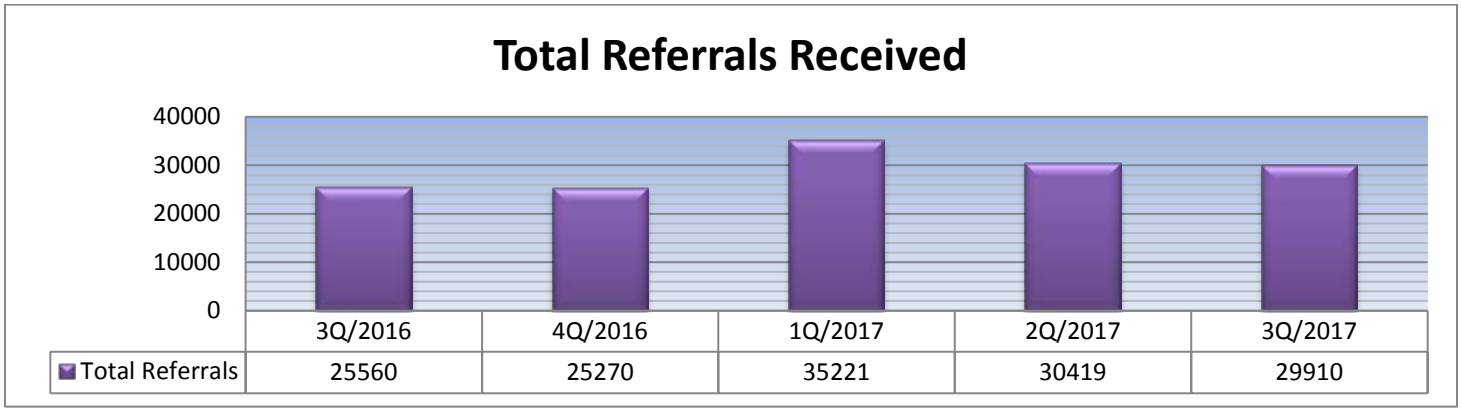


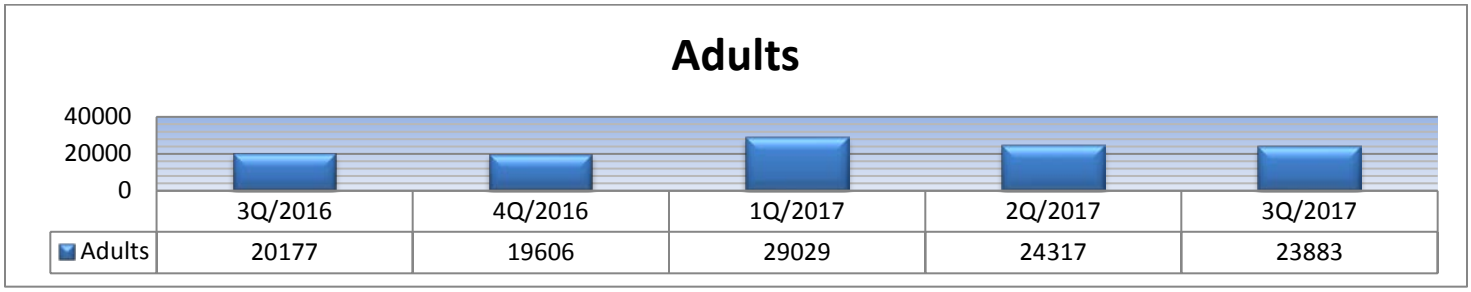
	3Q/16	4Q/16	1Q/17	2Q/17	3Q/17
Member Notification	87.9%	94.7%	96.0%	97.0%	97.0%
Provider Notification	91.0%	89.4%	91.0%	89.0%	89.0%
Criteria Included	90.0%	96.4%	89.0%	89.0%	89.0%
MD Signature Included	98.0%	97.7%	96.0%	93.0%	92.0%

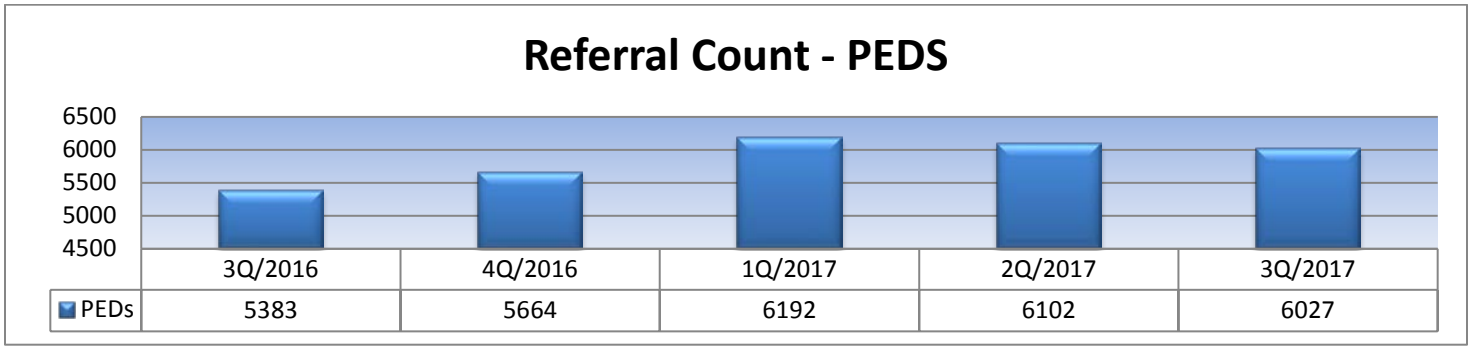
Summary: Overall compliance rate from the 3rd Qtr of 2017 is 91.7% which slight decrease from the 2nd Qtr which was 92%. **Action:** This compliance audit will be discussed at the UM Staff meeting. Compliance deficiencies have been discussed with individual staff members as appropriate.

Referral Activity

Outpatient Referral Denial Statistics
The overall denial rate for the 3rd quarter is 10%. After elimination of CCS requests, the denial rate is 9% 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 : 07/01/2017-09/30/2017

	20 and Under	Over 20	Totals
Total Inpatient:	1250	6180	7430
Total LOS:	5973	24411	30384
Average LOS:	4.8	4.0	4.1

PAR Facilities	Admits	LOS	Average LOS
Totals :	6905	26604	3.9
Adult Inpatient	4,366	15215	3.5
Adult Observation	854	1411	1.7
Adult Rehab/SNF	507	4386	8.7
Pediatric Inpatient	1161	5392	4.6
Pediatric Rehab/SNF	17	200	11.8

NPAR Facilities	Admits	LOS	Average LOS
Totals :	525	3780	7.2
Adult Inpatient	298	1463	4.9
Adult Observation	18	23	1.3
Adult Rehab/SNF	137	1913	14.0
Pediatric Inpatient	69	323	4.7
Pediatric Rehab/SNF	3	58	19.3

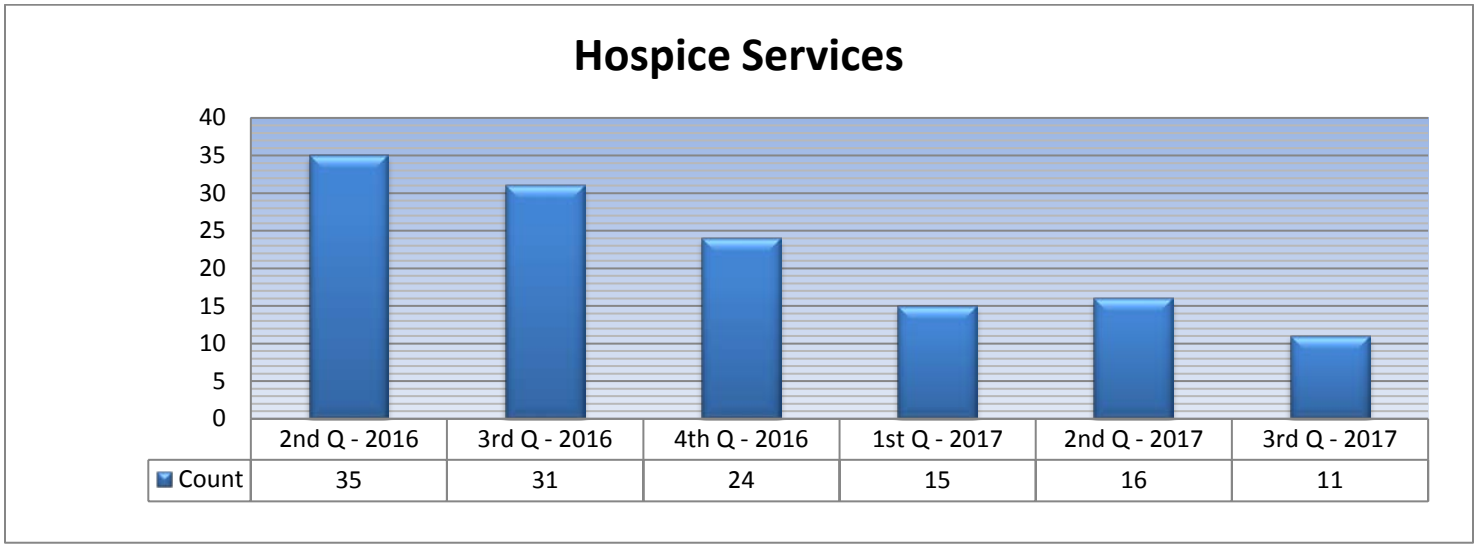
Activity by Facility	Total Inpatient	Total LOS	Average LOS
ABRAZO CENTRAL CAMPUS- VHS OF	1	2	2.0
ADVENTIST HEALTH BAKERSFIELD	1191	3901	3.3
ADVENTIST HEALTH COMMUNITY CAR	9	14	1.6
ADVENTIST HEALTH MEDICAL CENTE	1	4	4.0
ADVENTIST MEDICAL CENTER	1	1	1.0
AHMC ANAHEIM REG MEDICAL CENTE	1	3	3.0
AMALFI IN THE DESERT	21	288	13.7
ANAHEIM MEMORIAL EMERGENCY PHY	2	10	5.0
ANTELOPE VALLEY HOSP	54	138	2.6
ARROWHEAD REGIONAL MED	1	0	0.0
BAKERSFIELD HEART HOSPITAL	281	888	3.2
BAKERSFIELD MEMORIAL HOSPITAL	1489	5272	3.5
BARSTOW COMM HOSPITA	2	8	4.0
BELLAGIO IN THE DESERT	37	468	12.6
CAPRI IN THE DESERT	22	202	9.2
CEDARS SINAI MEDICAL CENTER	5	19	3.8
CHILDRENS HOSPITAL OF LOS ANGE	59	371	6.3
CHILDRENS HOSPITAL OF ORANGE C	1	0	0.0
COOK CHILDREN'S MEDICAL	2	2	1.0

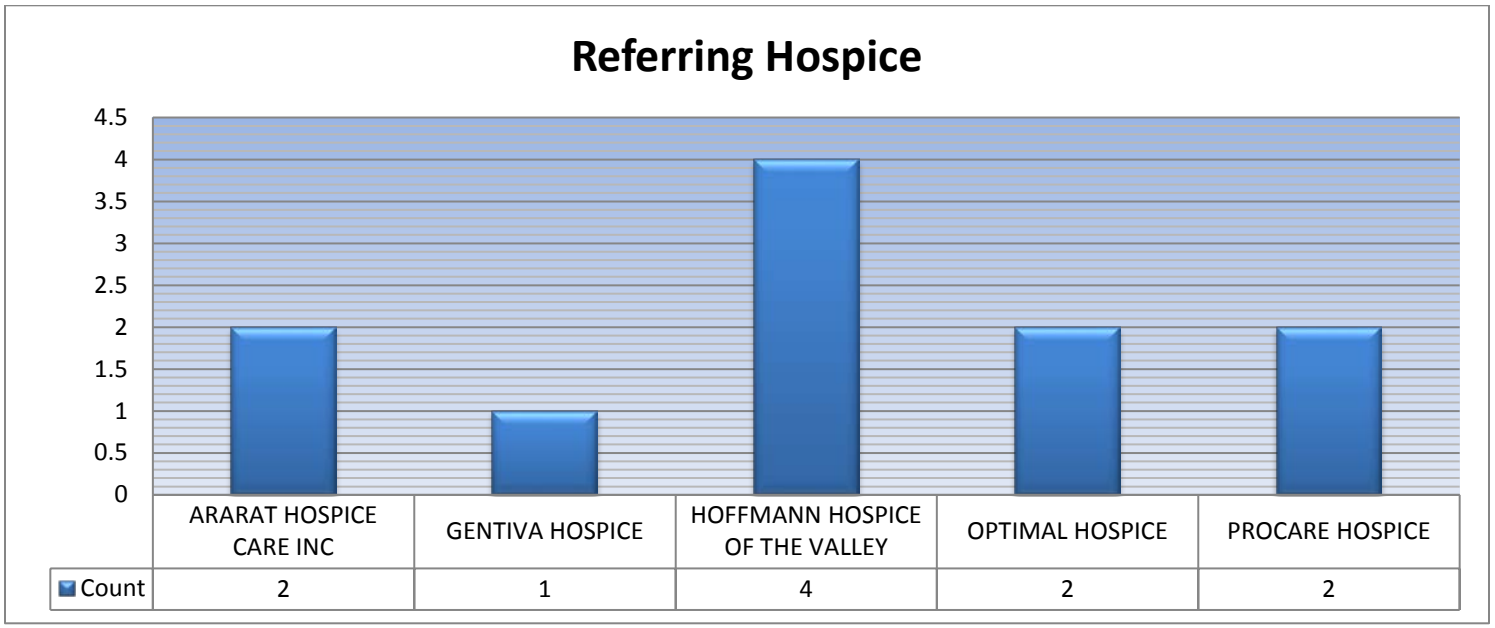
DELANO REGIONAL MEDICAL CENTER	261	566	2.2
DESERT REGIONAL MEDICAL CENTER	1	9	9.0
DESERT VIEW REGIONAL	3	3	1.0
EL CENTRO REGIONAL MEDICAL CEN	1	8	8.0
EMANUEL MEDICAL CENTER	1	2	2.0
ENLOE MEDICAL CENTER	4	4	1.0
EVERGREEN AT ARVIN HEALTHCARE	15	231	15.4
EVERLASTING HEALTHCARE	4	50	12.5
FRESNO COMMUNITY HOSPITAL AND	38	188	4.9
GARFIELD MEDICAL CNT	2	0	0.0
GOLDEN LIVING CENTER - BAKERSF	5	20	4.0
GOLDEN LIVING CENTER - SHAFTER	12	157	13.1
GOLETA VALLEY COTTAGE HOSPITAL	1	2	2.0
GOOD SAMARITAN HOSPITAL	459	1130	2.5
HARBOR - UCLA MED FOUNDATION	2	14	7.0
HEALTHSOUTH BAKERSFIELD REHABI	311	2128	6.8
HEIGHT STREET SKILLED CARE	2	12	6.0
HEMET VALLEY MED	1	1	1.0
HENRY MAYO NEWHALL MEMORIAL HO	7	15	2.1
HOFFMANN HOSPICE OF THE VALLEY	11	69	6.3
HOLLYWOOD PRESBYTERIAN MEDICAL	1	1	1.0
HUNTINGTON MEMORIAL HOSPITAL	1	5	5.0
JFK MEMORIAL HOSPITAL	1	1	1.0
KAWEAH DELTA DIST HO	1	10	10.0
KECK HOSPITAL OF USC	4	15	3.8
KECK HOSPITAL OF USC	58	312	5.4
KERN COUNTY MEDICAL AUTHORITY	1102	4413	4.0
KERN MEDICAL CENTER	24	99	4.1
KERN VALLEY HEALTHCARE DISTRIC	84	298	3.5
KINDRED HOSPITAL	18	210	11.7
KINDRED HOSPITAL BALDWIN PARK	12	140	11.7
KINGS NURSING AND REHABILITATI	3	34	11.3
LAC/USC MEDICAL CENTER	3	9	3.0
LAC-USC MEDICAL CTR	12	42	3.5
LIFEHOUSE HEALTH SERVICES	22	217	9.9
LOMA LINDA UNIVERSITY CHILDREN	2	1	0.5
LOMA LINDA UNIVERSITY MEDICAL	14	86	6.1
LONG BEACH MEMORIAL MEDICAL CE	4	29	7.3
LUCILE SALTER PACKARD CHILDREN	6	62	10.3
MARIAN REGIONAL MEDICAL CENTER	1	0	0.0

MARTIN LUTHER KING, JR COMMUNI	6	14	2.3
MAUI MEMORIAL MEDICAL CENTER	1	5	5.0
MEMORIAL HOSPITAL OF GARDENA	3	0	0.0
MERCY HOSPITAL	992	2844	2.9
MOUNTAIN VIEW CHILD CARE	2	31	15.5
NAPOLI IN THE DESERT	7	82	11.7
OAK FENCE SENIOR LIVING, LLC	3	19	6.3
OPTIMAL HOSPICE	8	140	17.5
OUR LADY OF THE LAKE	1	4	4.0
PACIFICA HOSPITAL OF THE VALLE	4	62	15.5
PALMDALE REGIONAL MEDICAL	14	91	6.5
PARADISE VALLEY HOSPITAL	1	2	2.0
PARKVIEW JULIAN CONVALESCENT H	5	75	15.0
PROCARE HOSPICE	1	3	3.0
PROVIDENCE ALASKA MEDICAL CENT	2	8	4.0
PROVIDENCE HOLY CROSS MEDICAL	1	23	23.0
PROVIDENCE SAINT JOSEPH MEDICA	4	17	4.3
PROVIDENCE TARZANA MEDICAL CEN	3	4	1.3
QUEEN OF THE VALLEY MEDICAL CE	1	3	3.0
RANCHO LOS AMIGOS	1	8	8.0
REGIONAL MEDICAL CENTER	2	2	1.0
RENOWN REGIONAL	4	65	16.3
RIDEOUT MEMORIAL HOS	1	1	1.0
RIDGECREST REGIONAL HOSPITAL	10	12	1.2
RIVERSIDE GENRL HOSP	2	8	4.0
ROSEWOOD	4	82	20.5
SAINT AGNES MEDICAL CENTER	6	24	4.0
SALINAS VALLEY HOSPITAL	2	0	0.0
SAN MARINO IN THE DESERT	8	97	12.1
SANTA BARBARA COTTAGE HOSPITAL	3	10	3.3
SANTA CLARA VALLEY MEDICAL	3	40	13.3
SANTA MONICA UCLAMC AND ORTHOP	2	10	5.0
SANTA ROSA MEMORIAL HOSPITAL	1	2	2.0
SEQUOIA HEALTH SERVICES	1	2	2.0
SIERRA VIEW DISTRICT HOSPIATL	3	8	2.7
SORRENTO IN THE DESERT	26	329	12.7
SOUTHERN HILLS HOSPT	2	0	0.0
SOUTHWEST HEALTHCARE	4	16	4.0
SPRING VALLEY HOSPITAL	1	1	1.0
ST FRANCIS MEDICAL CENTER	1	11	11.0

ST JOHNS REGIONAL MEDICAL CENT	3	6	2.0
ST MARY MEDICAL CENTER	2	5	2.5
ST MARY MEDICAL CNTR	1	3	3.0
ST. JOSEPHS HOSP	3	43	14.3
STANFORD MEDICAL	2	13	6.5
STONEBRIDGE MANOR	4	47	11.8
SUNRISE HOSPITAL AND MEDICAL	3	6	2.0
TEHACHAPI HOSPITAL	4	5	1.3
TEMECULA VALLEY HOSPITAL INC	3	3	1.0
THE REHABILITATION CENTER OF B	31	606	19.5
TIMPANOGOS REGIONAL HOSPITAL	1	6	6.0
TULARE REGIONAL MEDICAL CENTER	1	1	1.0
UCI MEDICAL CENTER	3	10	3.3
UCLA MEDICAL CENTER	76	510	6.7
UCSD MEDICAL CENTER	2	5	2.5
UCSD MEDICAL GROUP	6	34	5.7
UCSF MEDICAL CENTER	11	101	9.2
UNITED CARE FACILITIES	69	776	11.2
UNITED CARE NETWORK	4	75	18.8
UNIVERSITY OF PENN MEDICAL GRO	2	4	2.0
USC NORRIS CANCER	16	44	2.8
VALLEY CHILDRENS HOSPITAL	272	1402	5.2
VALLEY CHILDREN'S HOSPITAL	9	26	2.9
VALLEY HEALTHCARE CENTER	2	15	7.5
VALLEY HOSPITAL MEDICAL CENTER	3	22	7.3
VALLEY LIVING CENTER	1	4	4.0
VALLEY PRESBYTERIAN HOSPITAL	2	0	0.0
VENTURA COUNTY MEDICAL CENTER	5	3	0.6
VFP HOMES	11	38	3.5
WASHINGTON HOSP	2	2	1.0
WATSONVILLE COMM HOS	1	14	14.0
WATSONVILLE POST ACUTE CENTER	2	1	0.5
WEST ANAHEIM MEDICAL CENTER	2	4	2.0
WHITTIER HOSPITAL MEDICAL CENT	1	2	2.0

Hospice Utilization has decreased in the 3rd 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.

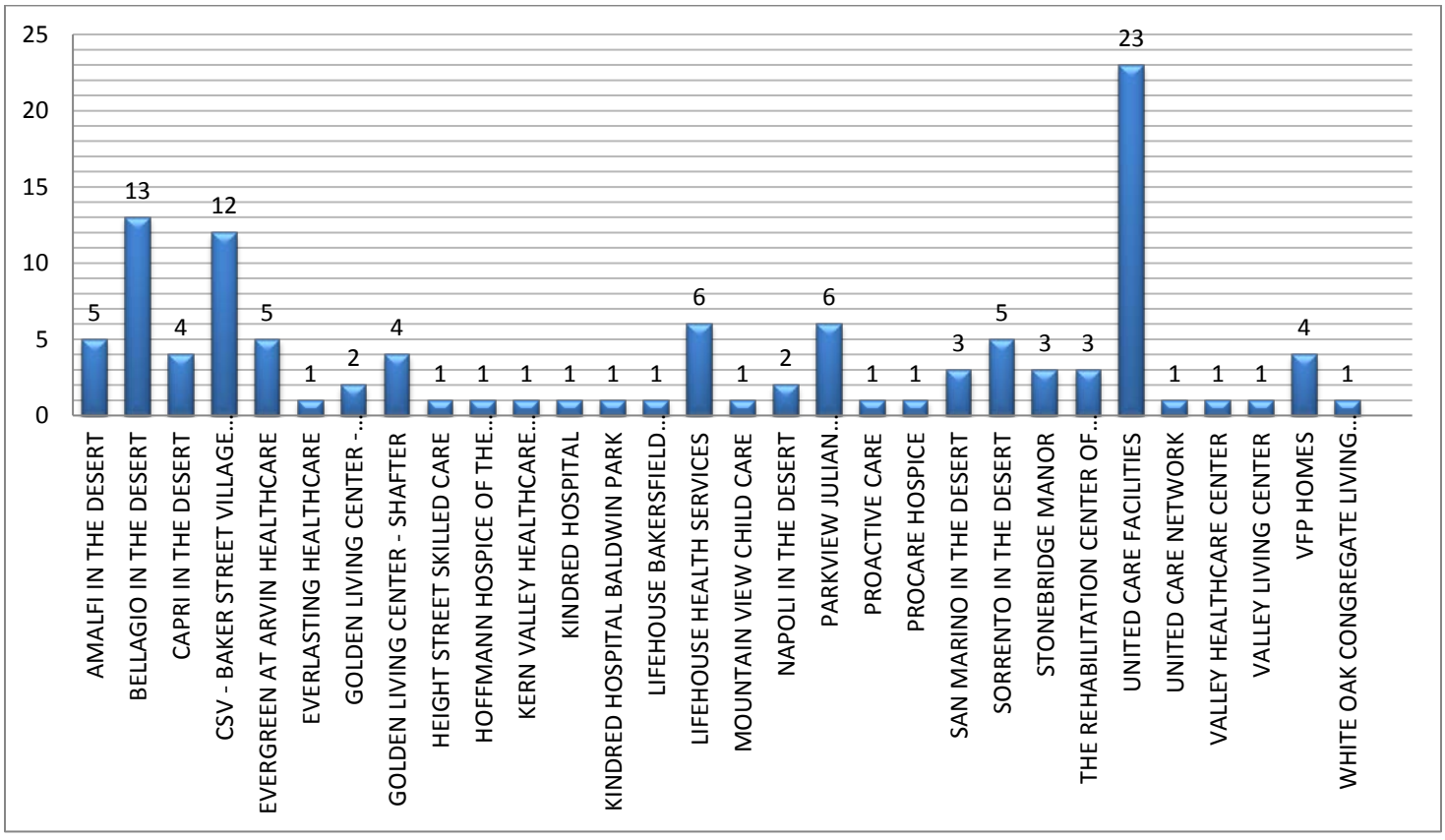




Nursing Facility Services Report

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.

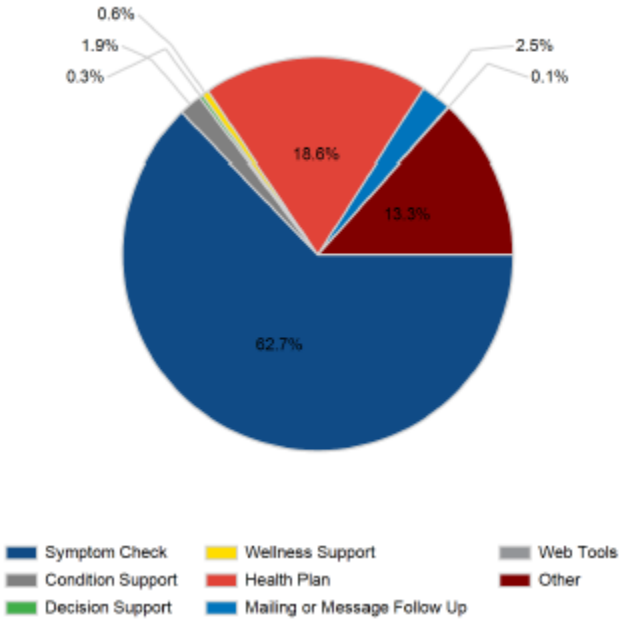
Summary: Summary: During the 3rd quarter 2017, there were 115 referrals for Nursing Facility Services. The average length of stay was 21 days for these members. During the 2nd quarter there was only 1 denial of the 69 referrals.



Health Dialog Report

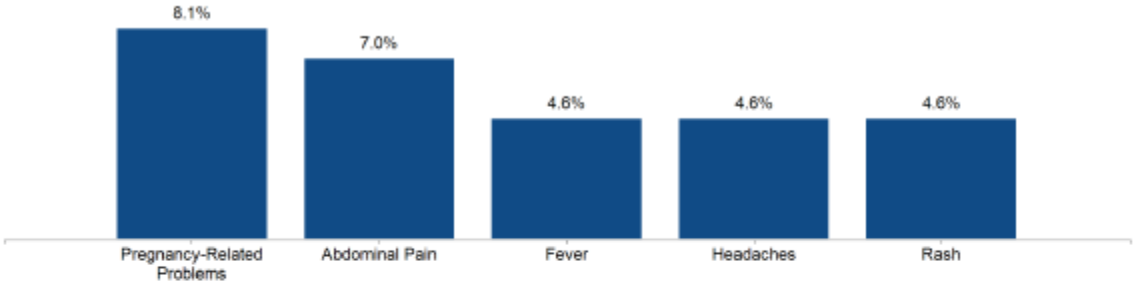
July:

Member Inbound Call Reasons (Rolling Twelve Months)

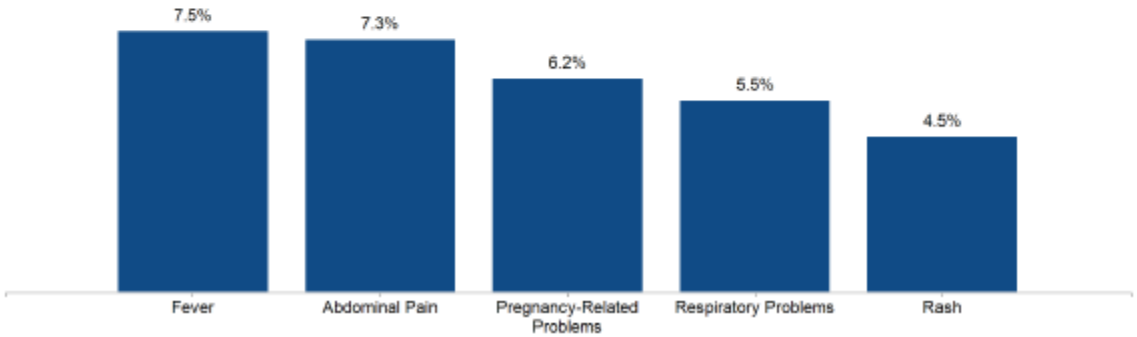


REASON	NUMBER
Symptom Check	2,646
Condition Support	79
Decision Support	13
Wellness Support	24
Health Plan	786
Mailing or Message Follow Up	106
Web Tools	3
Other	561

Top Symptoms - Inbound Symptom Check Calls (Jul-2017)

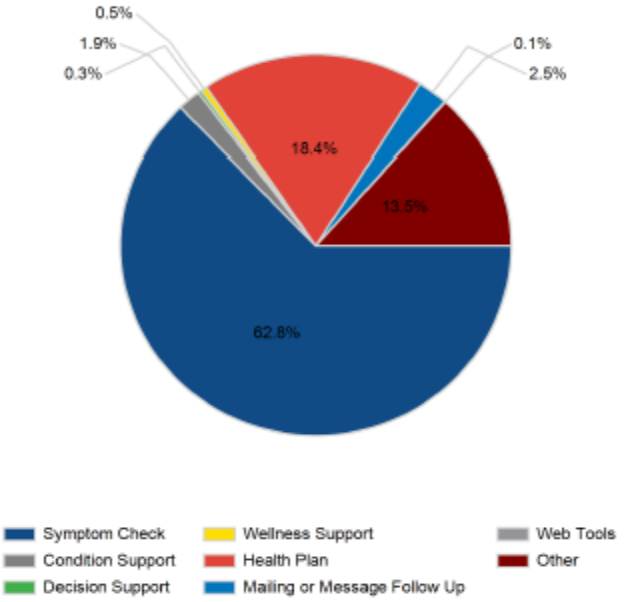


Top Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



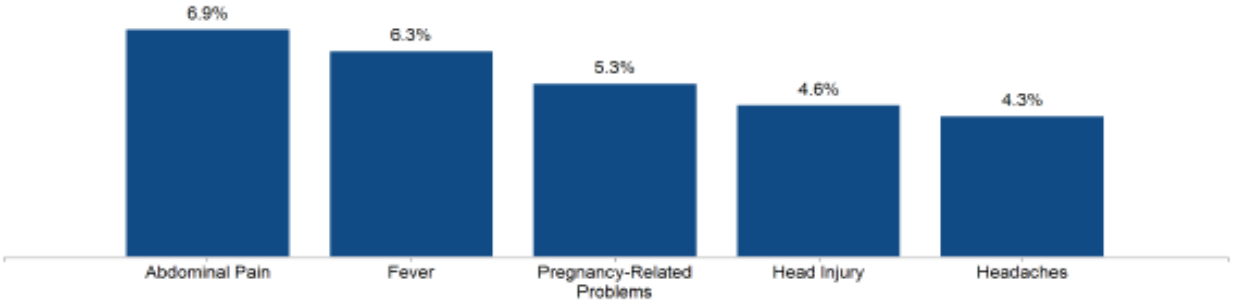
August:

Member Inbound Call Reasons (Rolling Twelve Months)

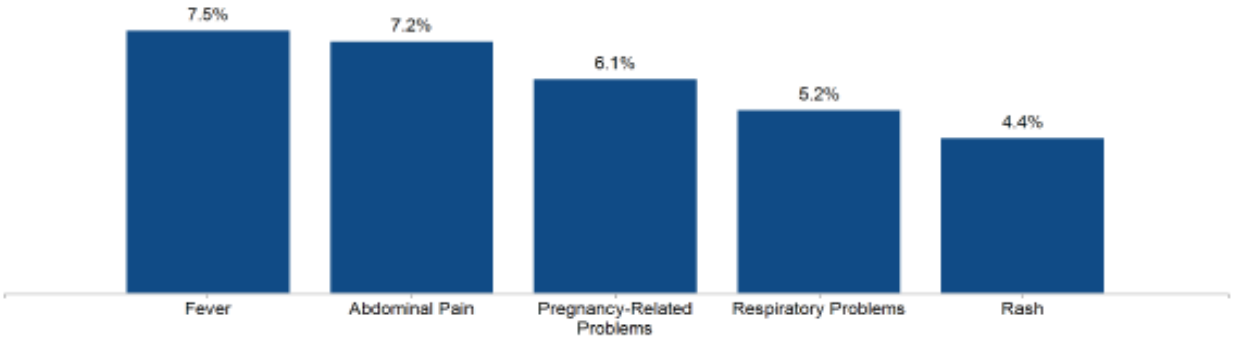


REASON	NUMBER
Symptom Check	2,908
Condition Support	88
Decision Support	14
Wellness Support	24
Health Plan	853
Mailing or Message Follow Up	117
Web Tools	3
Other	623

Top Symptoms - Inbound Symptom Check Calls (Aug-2017)

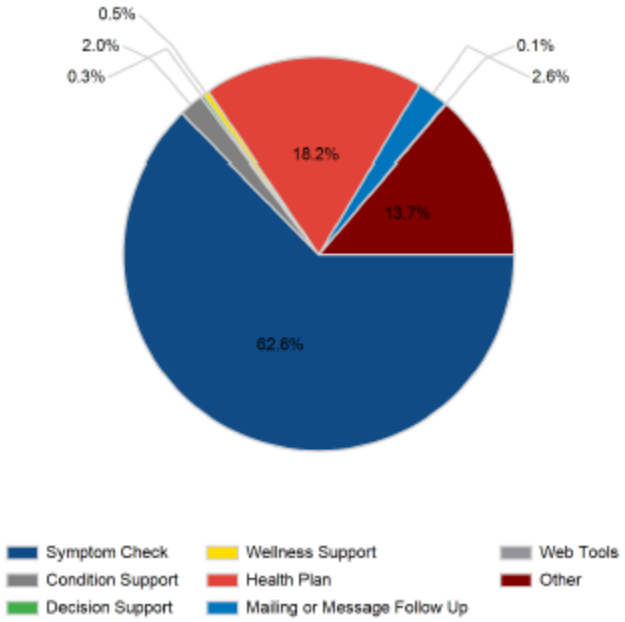


Top Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



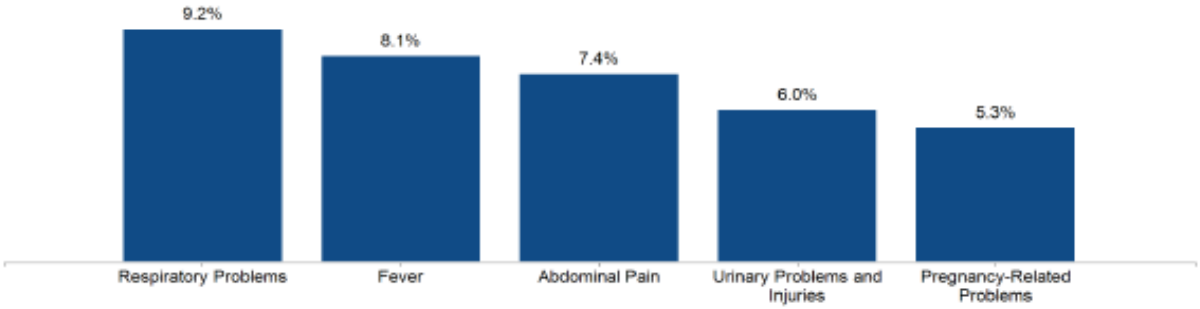
September:

Member Inbound Call Reasons (Rolling Twelve Months)

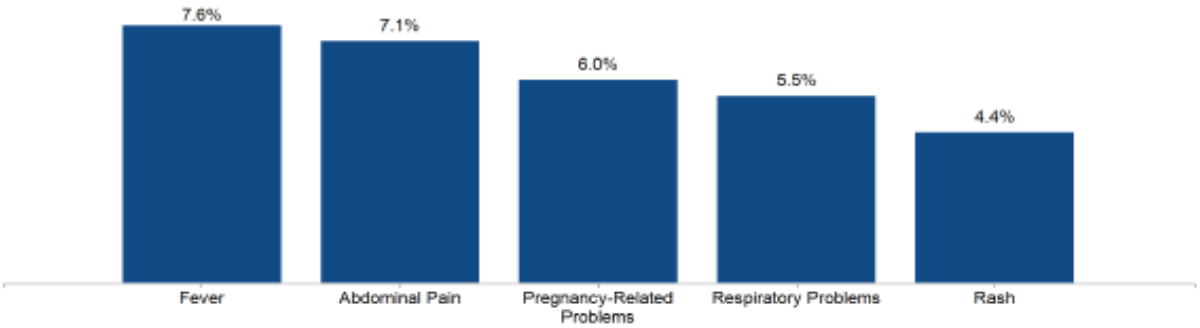


REASON	NUMBER
Symptom Check	3,161
Condition Support	102
Decision Support	14
Wellness Support	25
Health Plan	921
Mailing or Message Follow Up	130
Web Tools	4
Other	691

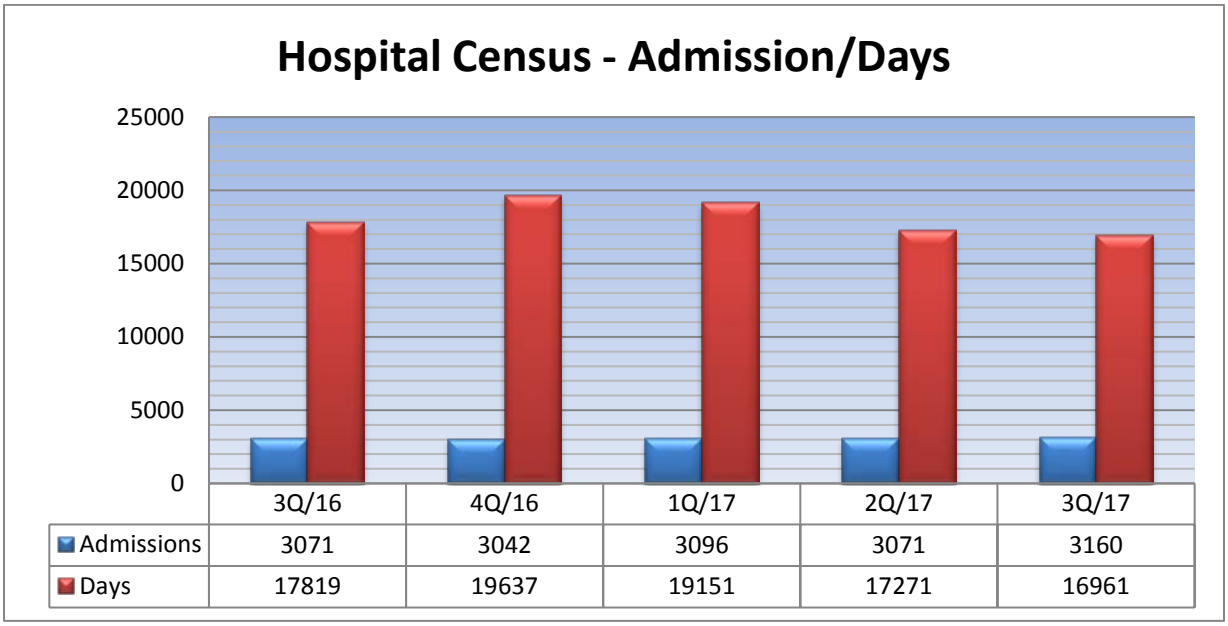
Top Symptoms - Inbound Symptom Check Calls (Sep-2017)



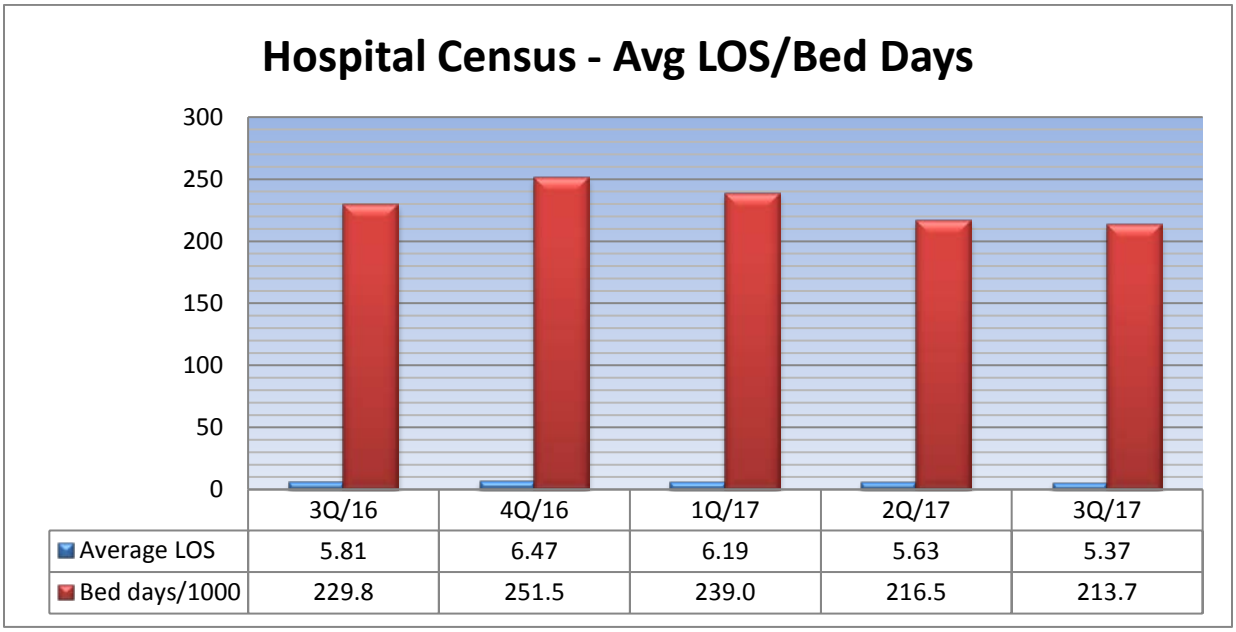
Top Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



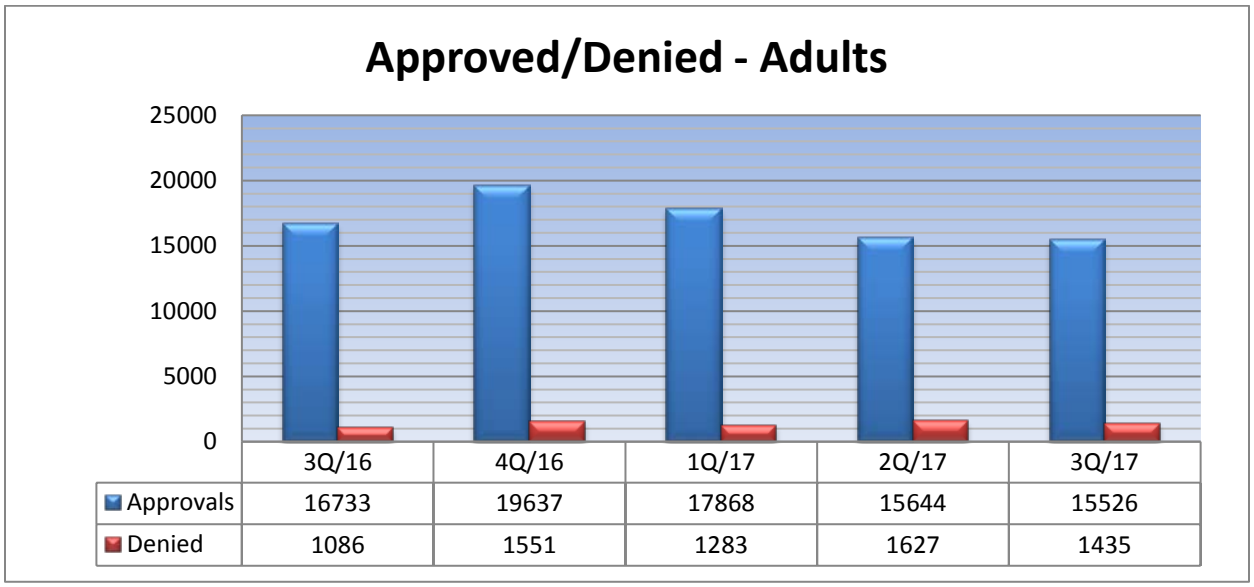
Inpatient 3rd Quarter Trending

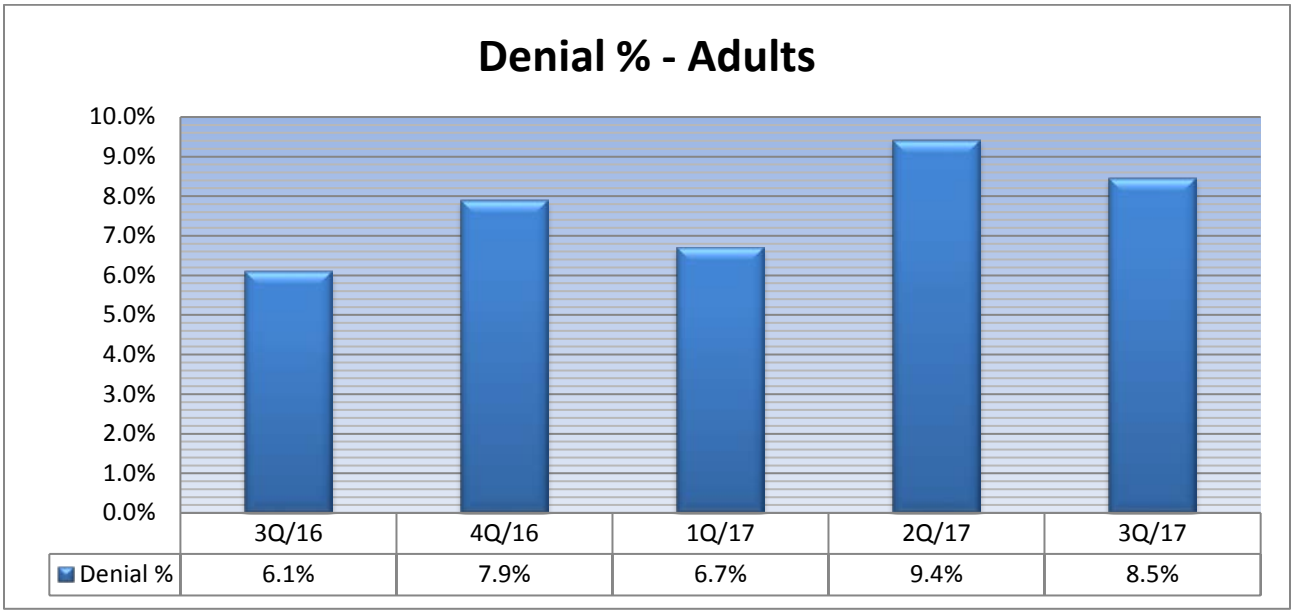


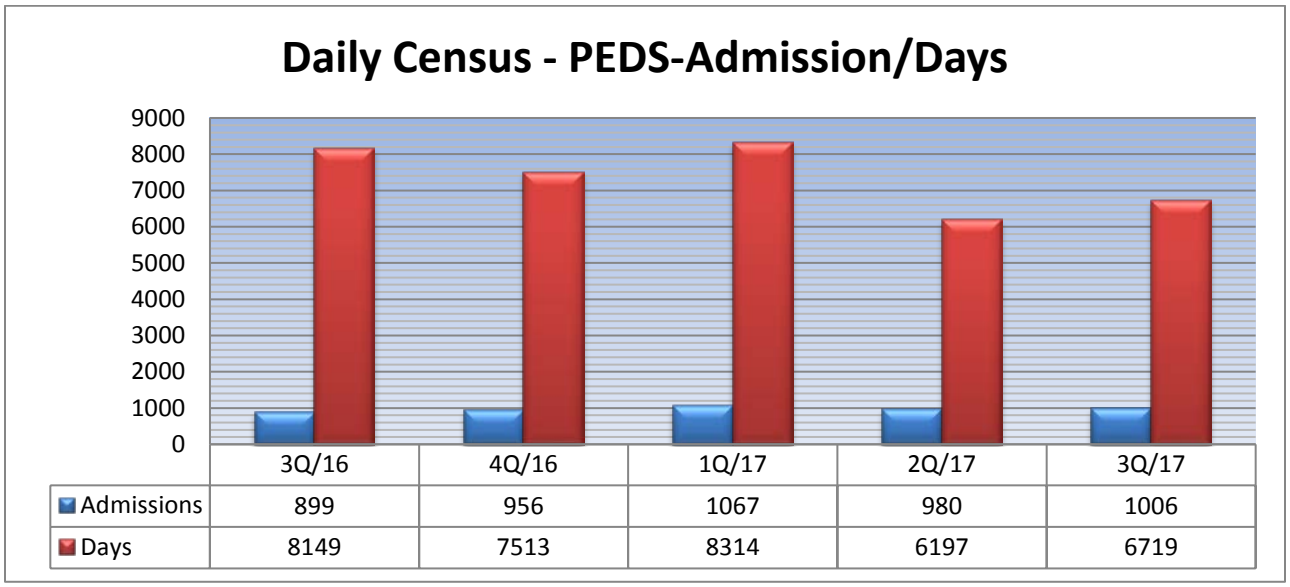
	3Q/16	4Q/16	1Q/17	2Q/17	3Q/17
Admissions	3071	3042	3096	3071	3160
Days	17819	19637	19151	17271	16961



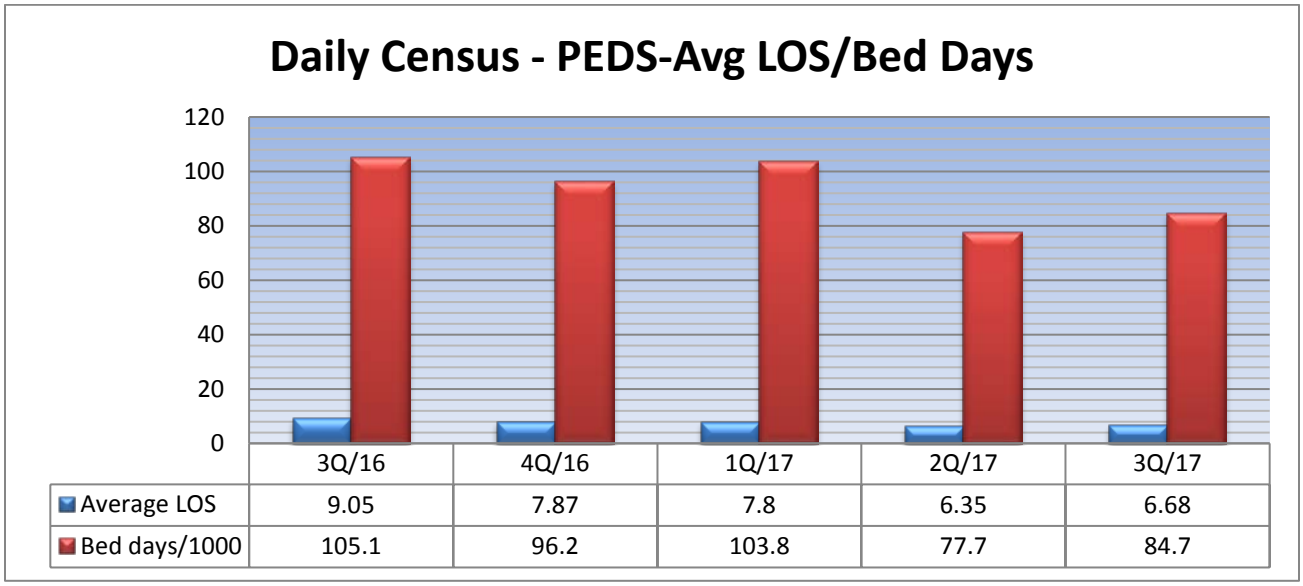
	3Q/16	4Q/16	1Q/17	2Q/17	3Q/17
Average LOS	5.81	6.47	6.19	5.63	5.37
Bed days/1000	229.8	251.5	239.0	216.5	213.7


Approved/Denied - Adults
25000
20000
15000
10000
5000
0
3Q/16 4Q/16 1Q/17 2Q/17 3Q/17
Approvals 16733 19637 17868 15644 15526
Denied 1086 1551 1283 1627 1435

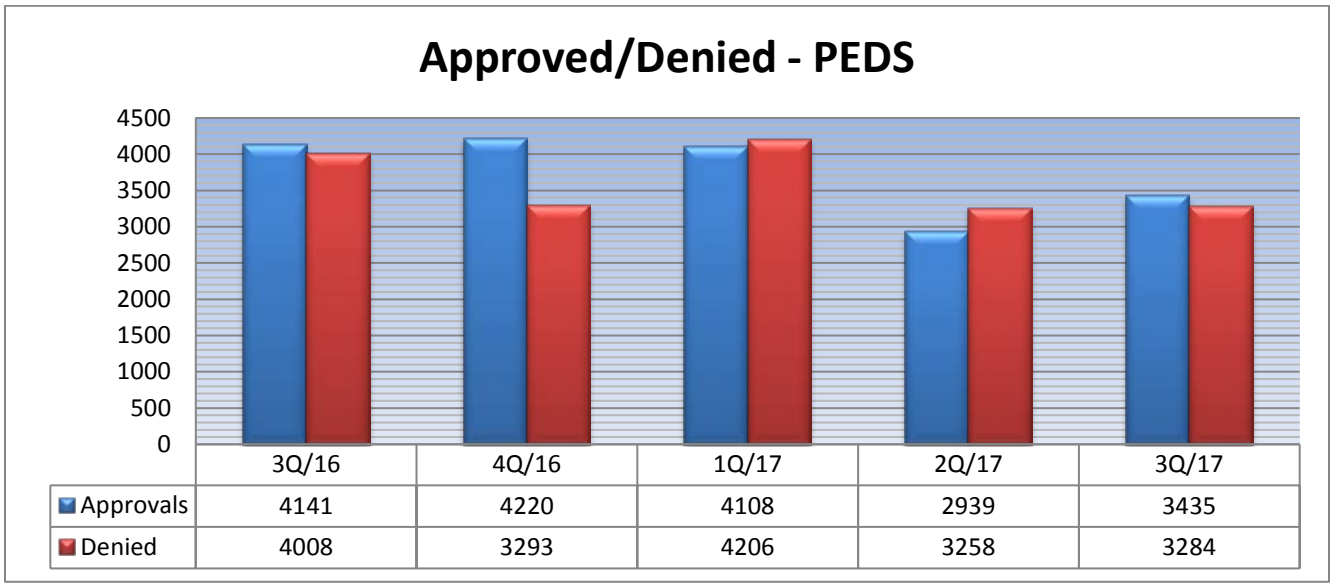

Denial % - Adults
10.0%
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
3Q/16 4Q/16 1Q/17 2Q/17 3Q/17
Denial % 6.1% 7.9% 6.7% 9.4% 8.5%



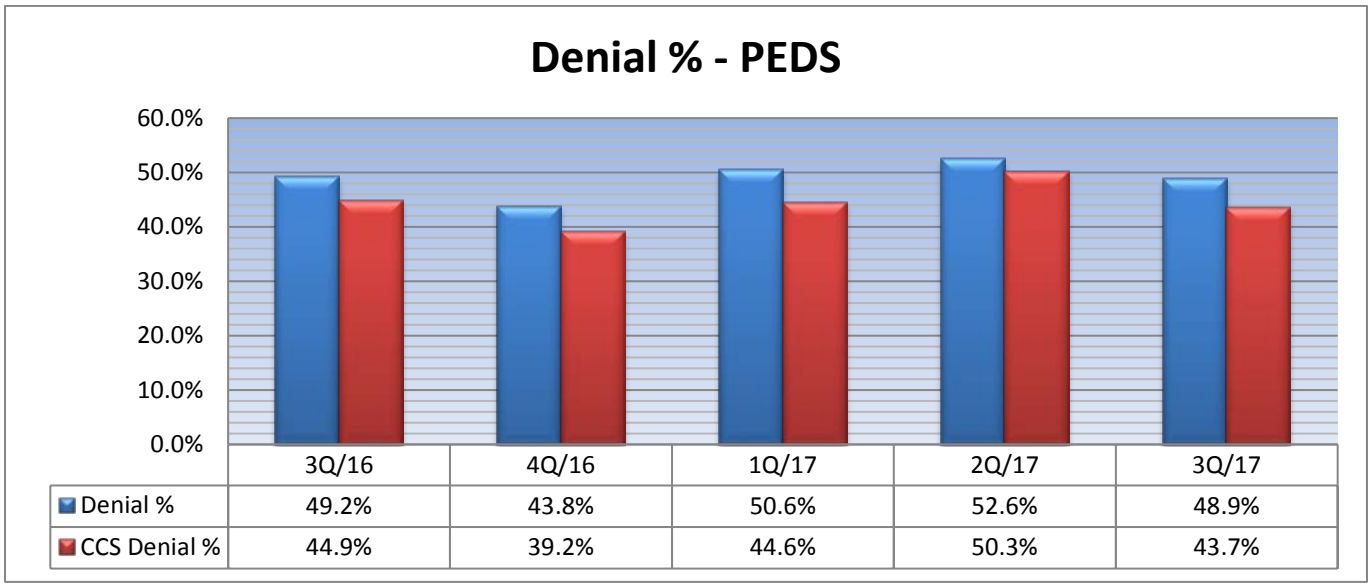
	3Q/16	4Q/16	1Q/17	2Q/17	3Q/17
Admissions	899	956	1067	980	1006
Days	8149	7513	8314	6197	6719



	3Q/16	4Q/16	1Q/17	2Q/17	3Q/17
Average LOS	9.05	7.87	7.8	6.35	6.68
Bed days/1000	105.1	96.2	103.8	77.7	84.7



	3Q/16	4Q/16	1Q/17	2Q/17	3Q/17
Approvals	4141	4220	4108	2939	3435
Denied	4008	3293	4206	3258	3284



	3Q/16	4Q/16	1Q/17	2Q/17	3Q/17
Denial %	49.2%	43.8%	50.6%	52.6%	48.9%
CCS Denial %	44.9%	39.2%	44.6%	50.3%	43.7%

Continuity of Care

Total Referral – 0

Total Approval – 0

Total SPD COC -0

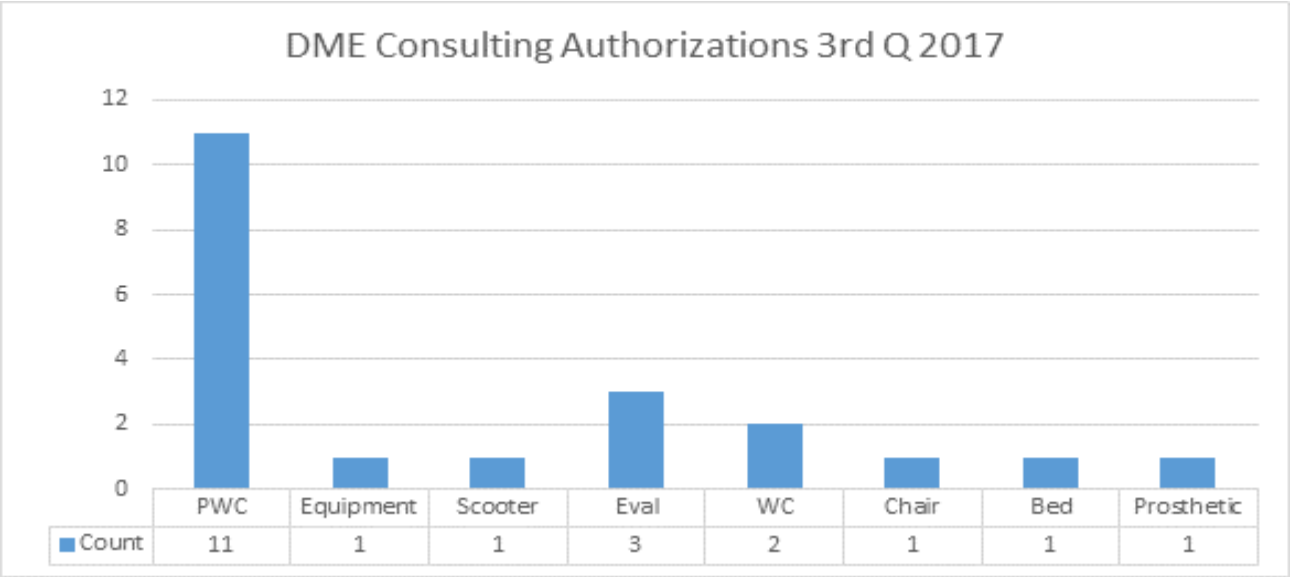
UM Provider Disputes

Total Disputes – 9

Favor of Provider -5

Favor of Plan – 4

DME Consulting



Autism Reporting

UNIQUE CASES		Mild	Moderate	Severe	Total	Undetermined
MEMBER COUNT	166	23	60	12	95	71
Severity %		24.21%	63.16%	12.63%	1	
SEVERITY	JUL	AUG	SEP	TOTAL		
MILD	8	12	3	23		
MODERATE	25	17	18	60		
SEVERE	3	6	3	12		
Approved FBA	22	37	34	93		
Approved Treatment	37	35	24	96		
PENDING DX	12	32	27	71		
	JUL	AUG	SEP	TOTAL		
AGE 7 OR LESS	29	36	36	101		
AGE 8 OR GREATER	19	31	15	65		
TOTAL	48	67	51	166		
% < 7	60.42%	53.73%	70.59%	60.84%		
% > 8	39.58%	46.27%	29.41%	39.16%		

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	October	39	7	3	10
	November	83	8	4	12
	December	5,008	208	142	350
2017	January	687	31	23	54
	February	224	10	6	16
	March	188	19	5	24
	April	155	16	6	22
	May	105	10	4	14
	June	516	26	2	28
	July	98	15	0	15
	August	348	20	0	20
	September	101	3	0	3
Totals		**7,552**	**373**	**195**	**568**

LTM Effectiveness* : 8 %

12-Month Effectiveness (Apr 2016 - Mar 2017) : 7 %

KERN HEALTH SYSTEMS
CASE MANAGEMENT DEPARTMENT MONTHLY REPORT

Report Date: October 4th, 2017

Reporting Period: July 1st, 2017 - September 30th, 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:

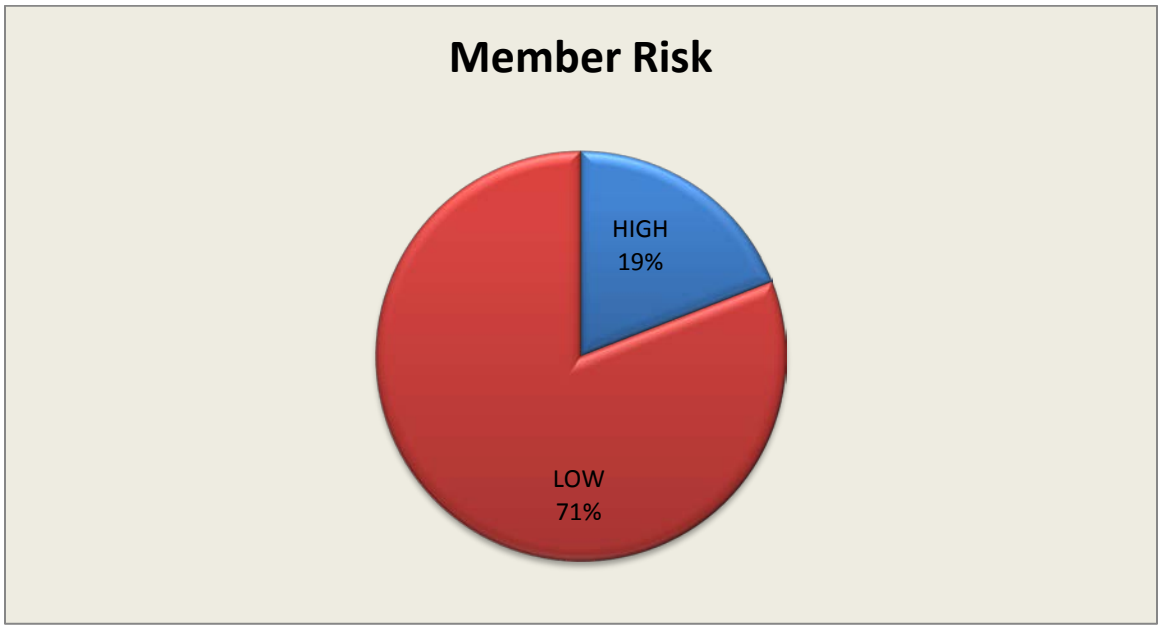
- Collaborate with PCPs for basic CM services
- Arrange and track referrals to specialists
- Track referrals and coordination of car for carved out and other out-of-network services and providers
- Identify community resources and refer members
- Offer health education services
- Implement continuous quality improvement activities

Case Management Team Staffing:

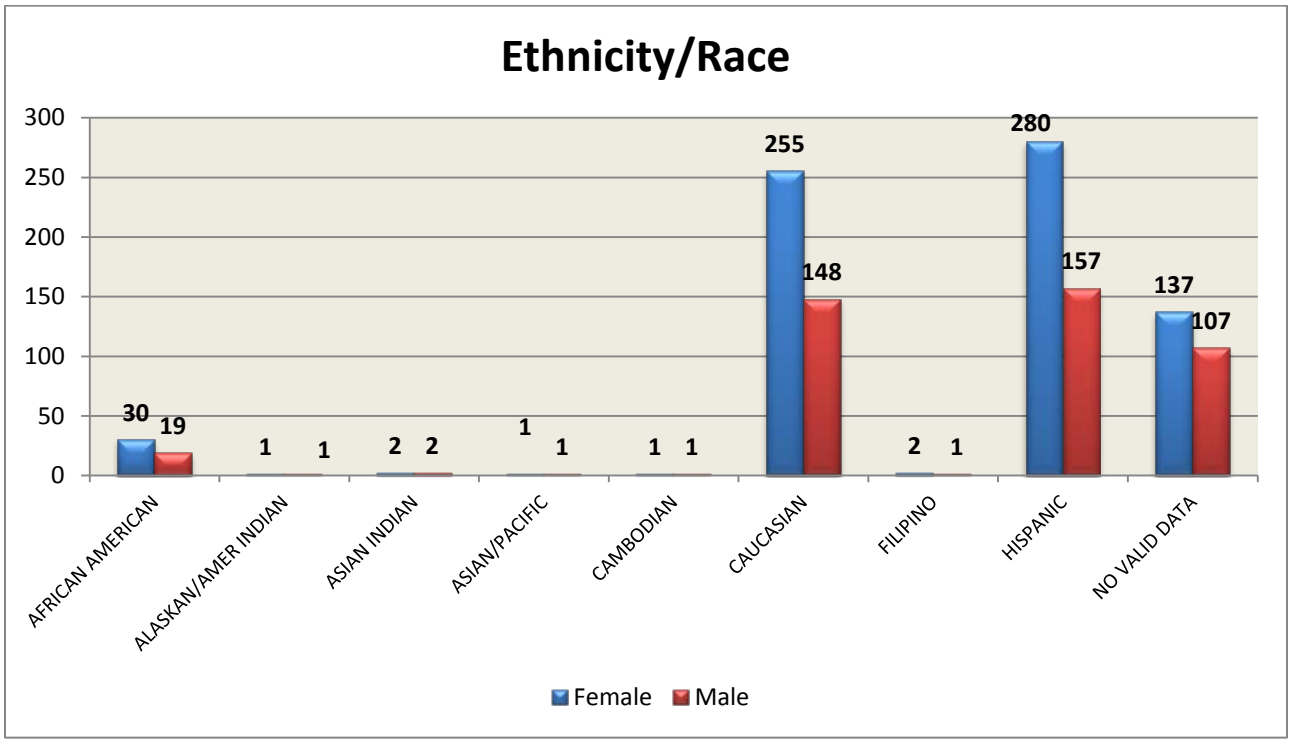
July-September 2017 Case Management Staffing:

Position	Quantity
Case Management RN	8
Case Management CMA's	6
Case Management MSW	6
Case Management Sr. Analyst and Trainer	1

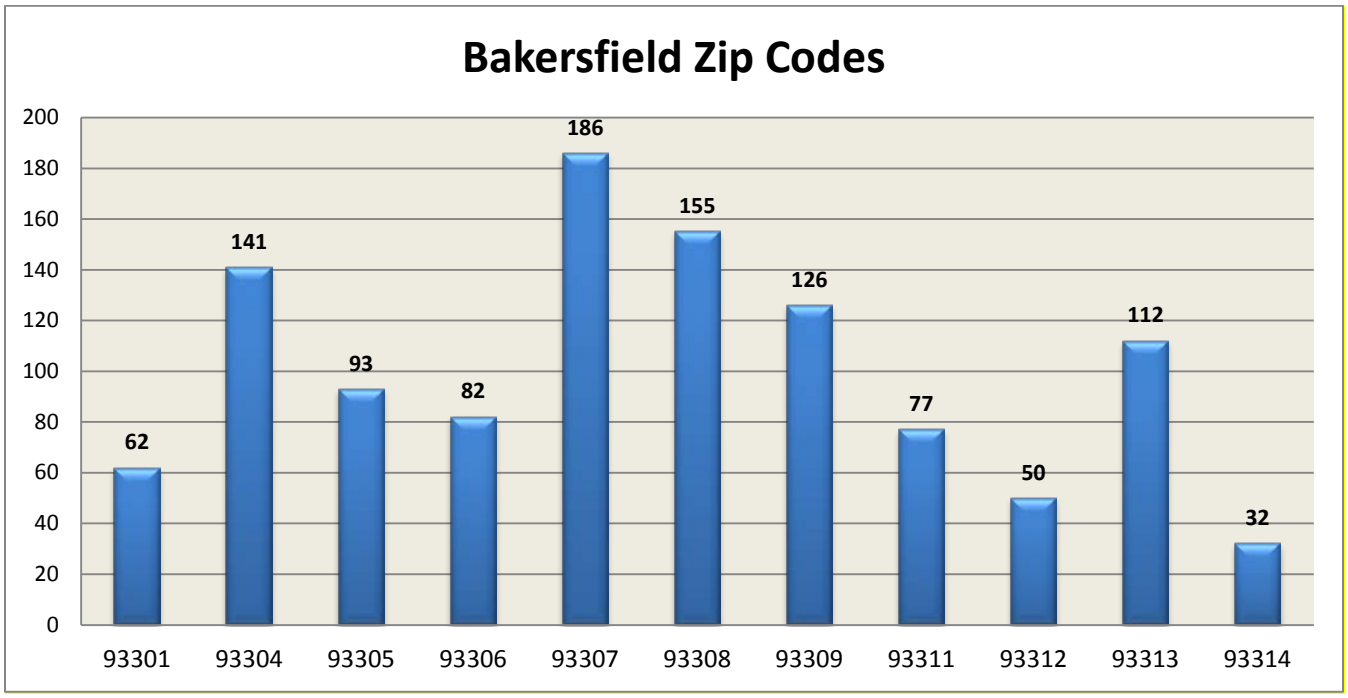
During this 3rd Quarter 2017, there were a total of 1717 KFHC members that were managed by the CM staff department. The majority of the members at 71% are low risk.



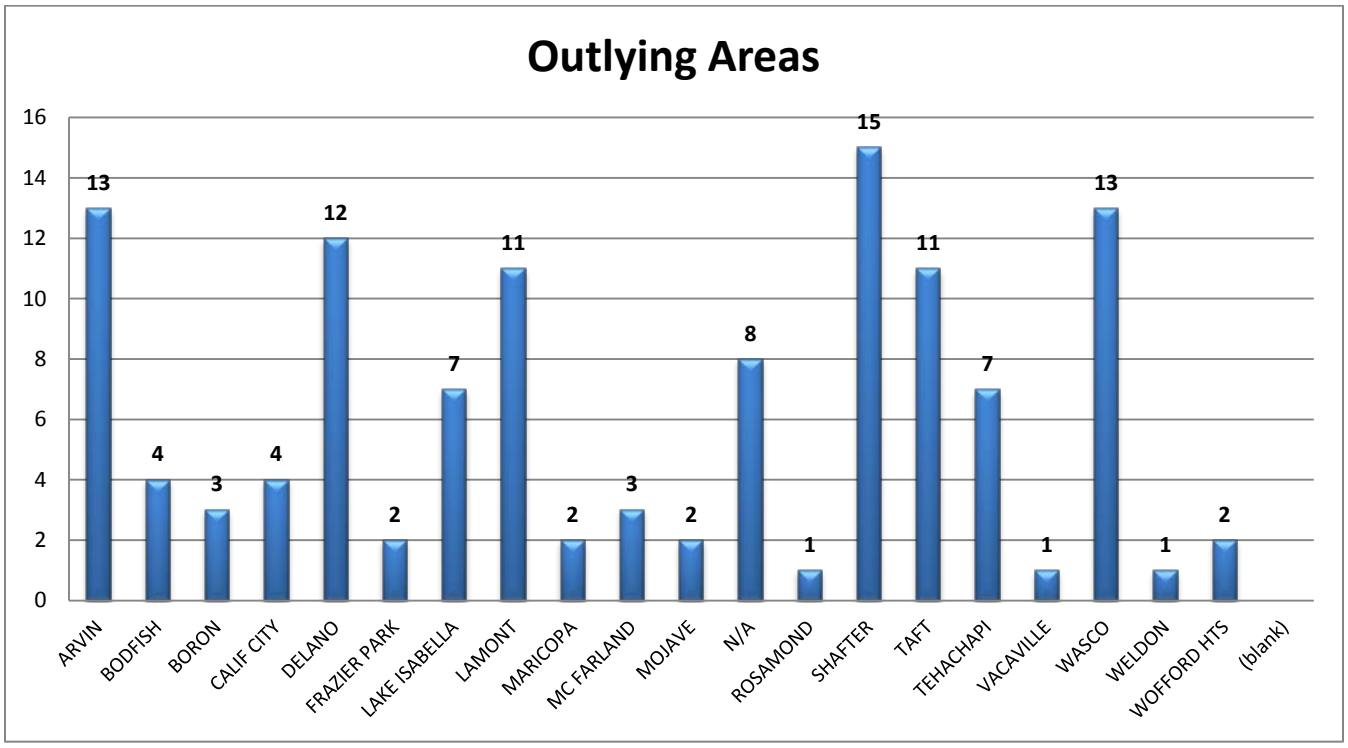
Majority of the members managed during the 3rd Quarter 2017 were female at 69%. The majority of the members managed this quarter at 42% are Hispanic.



The majority of the members that were managed during the 3rd Quarter 2017 reside in Bakersfield at 73%. Of the members from Bakersfield, the majority at 27% reside in the 93307 zip code.

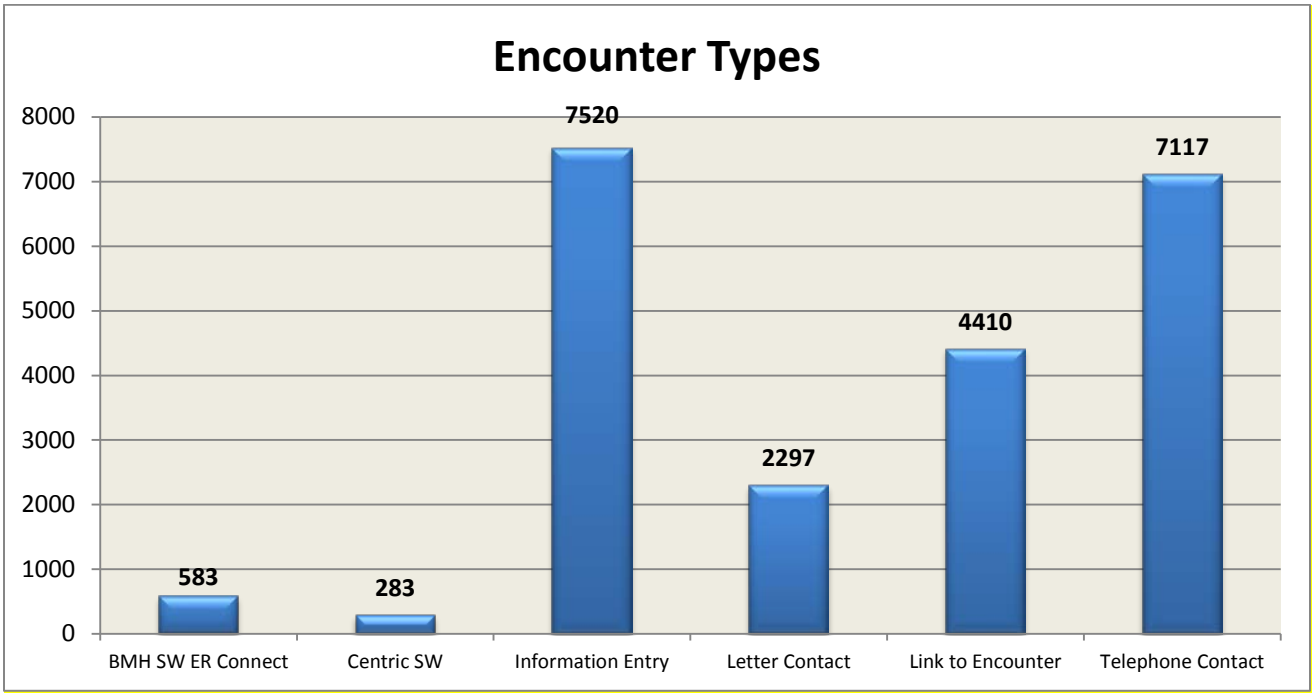


Of the outlying areas, majority of the members at 12% reside in Shafter.

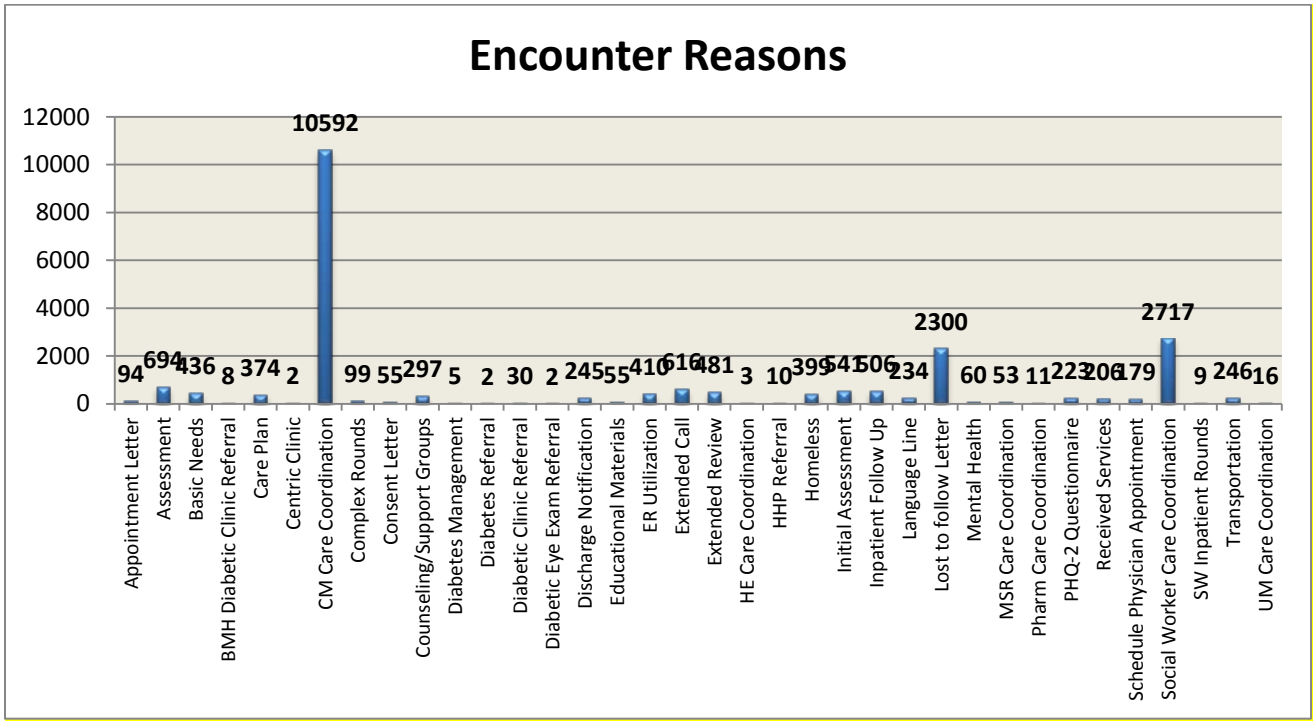


Encounters:

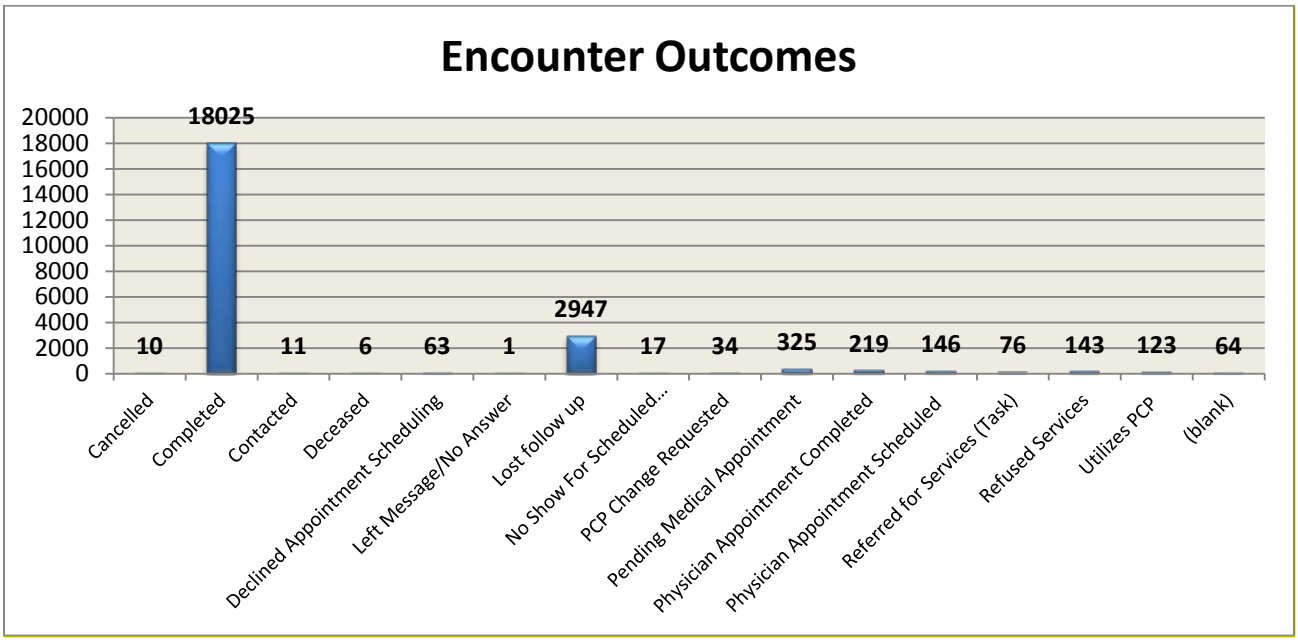
There were a total of 22,210 encounters submitted during the 3rd Quarter for 1717 KFHC members and the majority of the encounter types were listed as Information Entry at 34%.



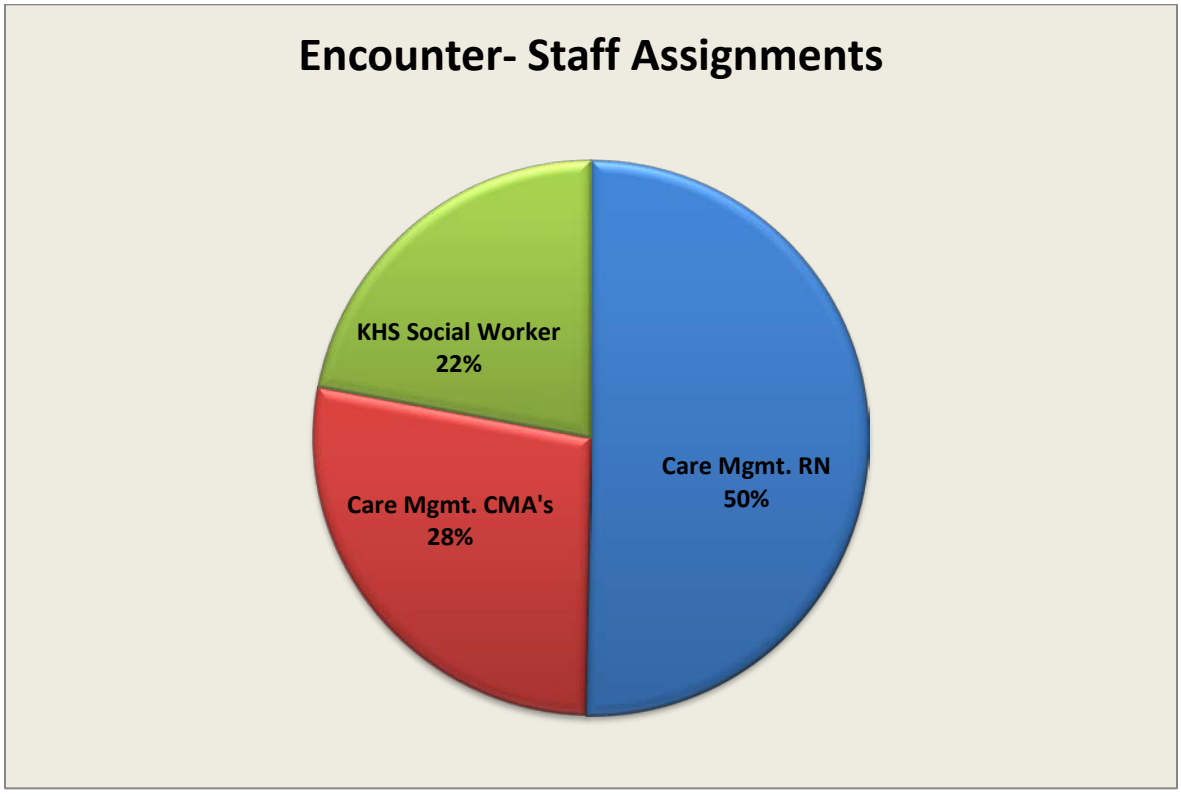
Majority of the encounter reasons at 48% was listed as CM Care Coordination.



Majority of the encounter outcomes at 91% are listed as Completed.

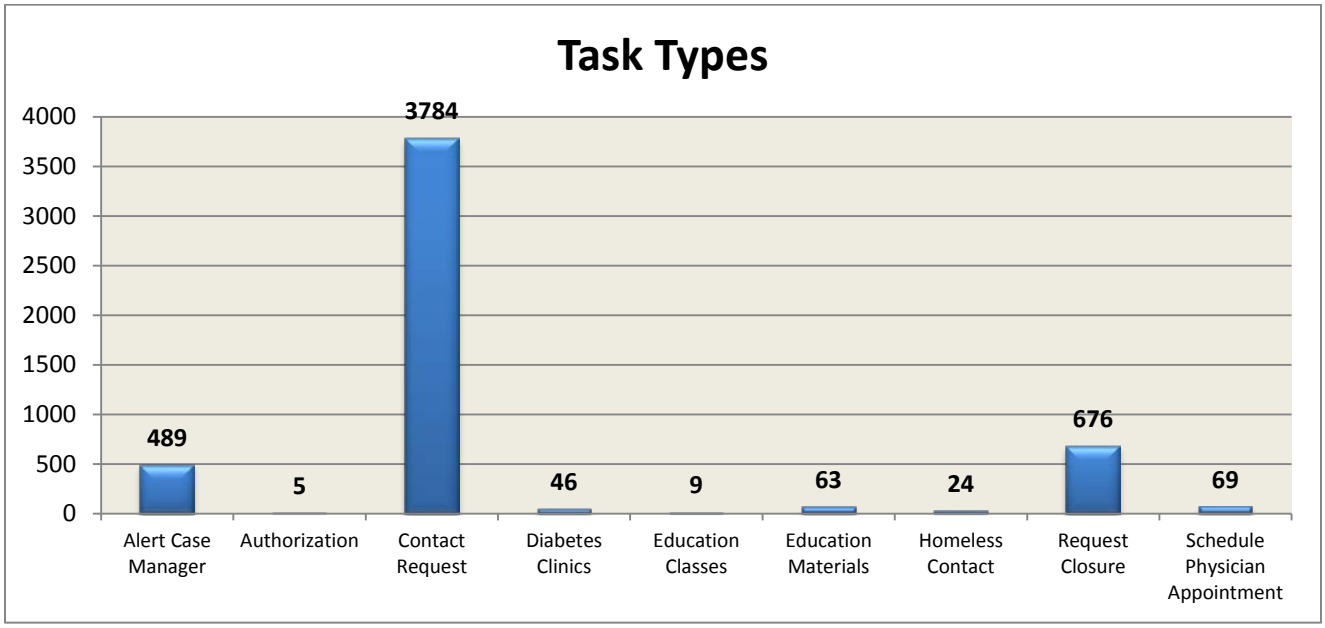


Majority of the encounters were completed by the Care Management RN's at 50%.

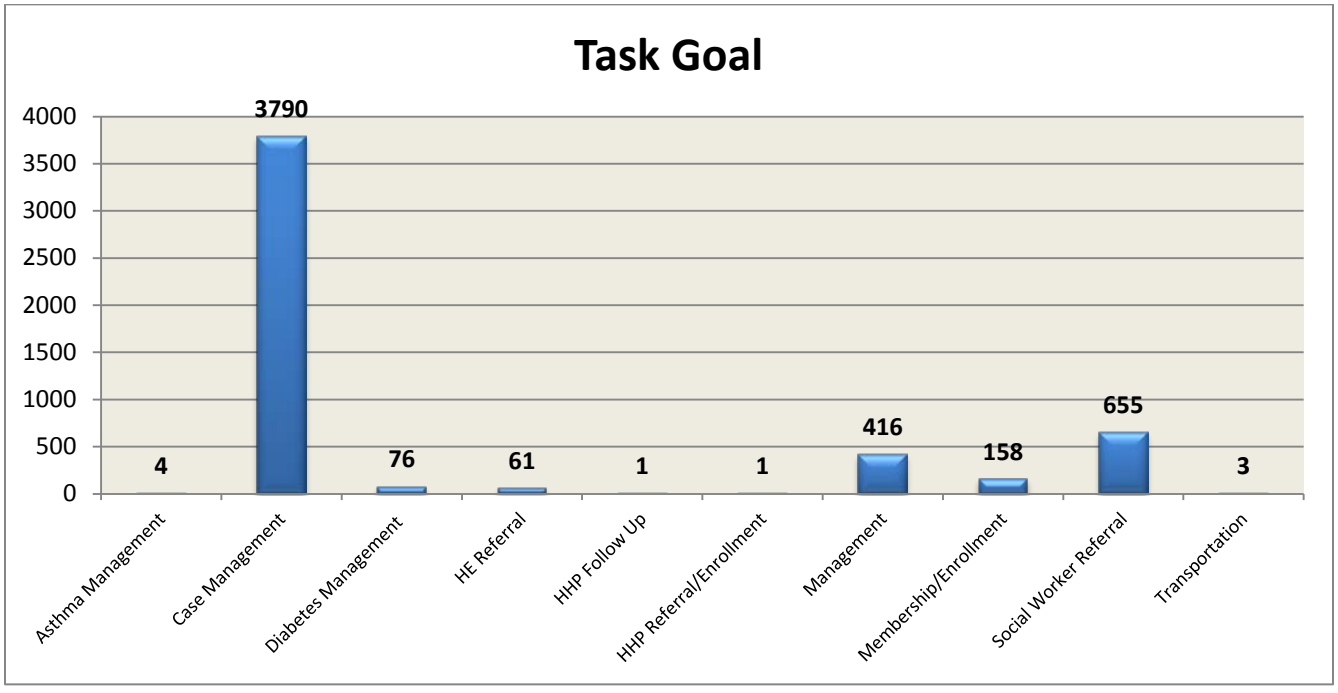


Tasks:

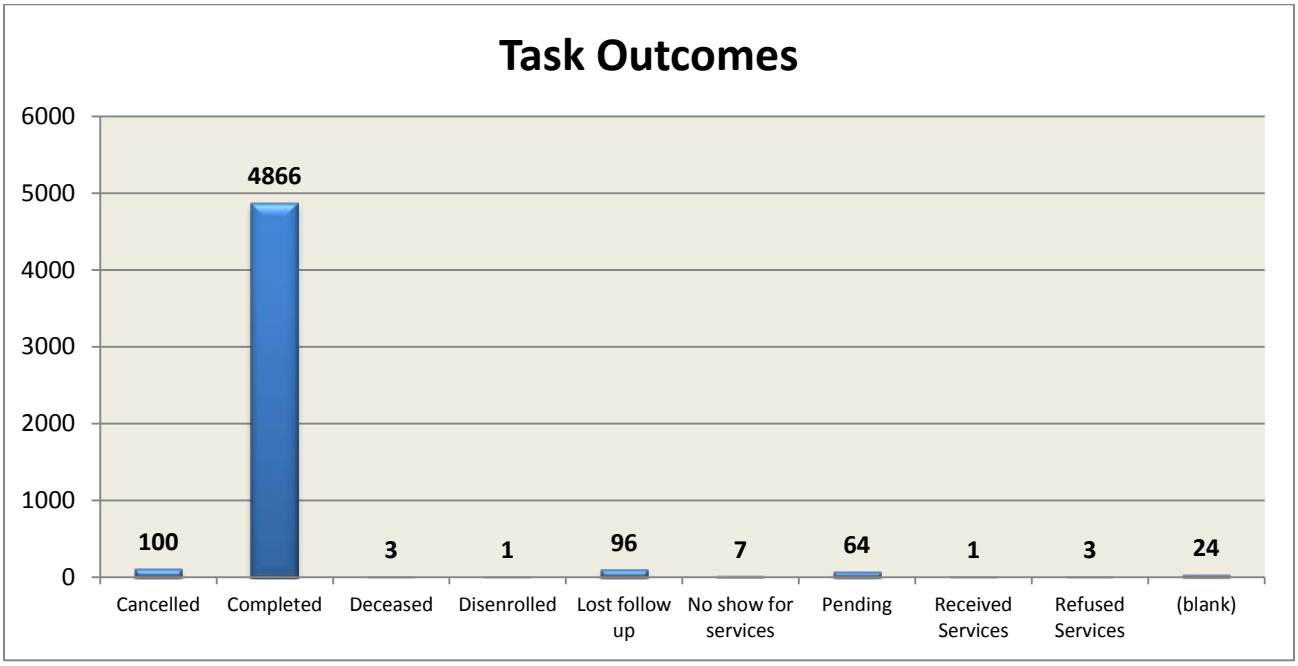
There were a total of 5,165 tasks submitted during the 3rd Quarter for 1717 KFHC members. The majority of Task Types were Contact Request at 73%.



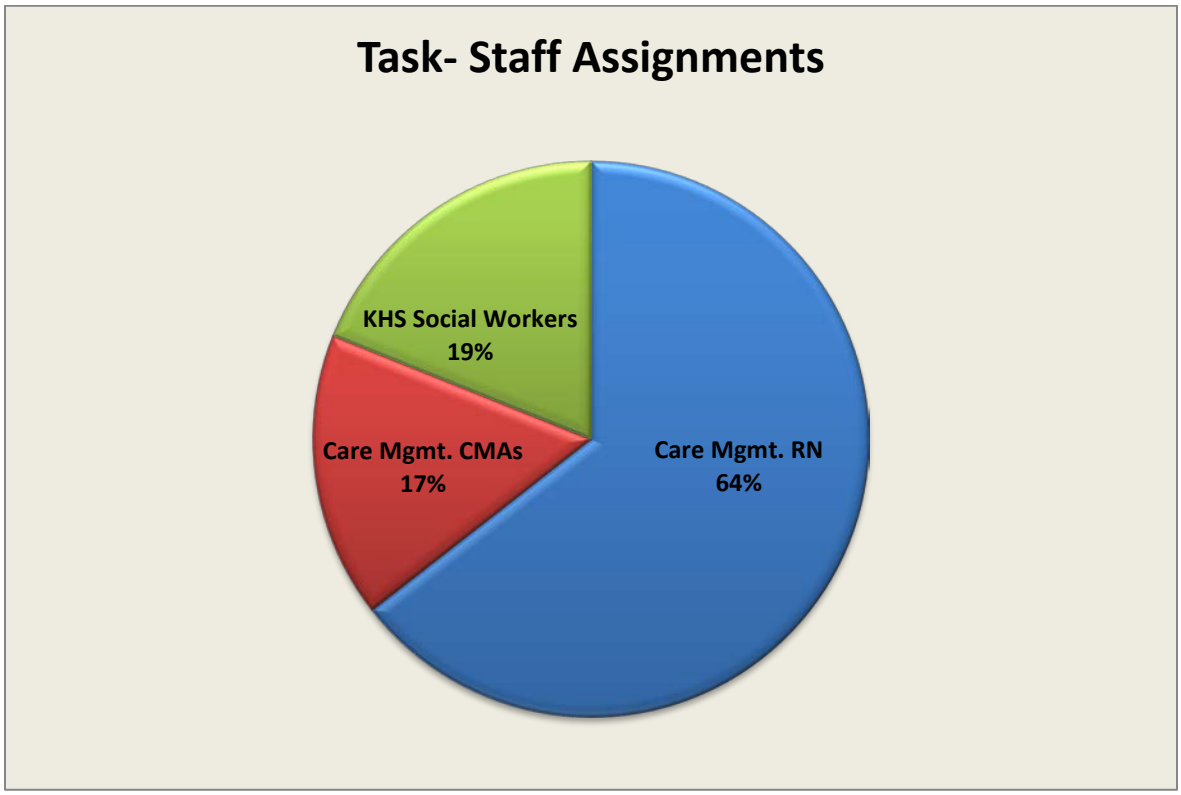
Majority of task goals during the 3rd Quarter at 73% were listed as Case Management.



Majority of the task outcomes at 94% are completed.

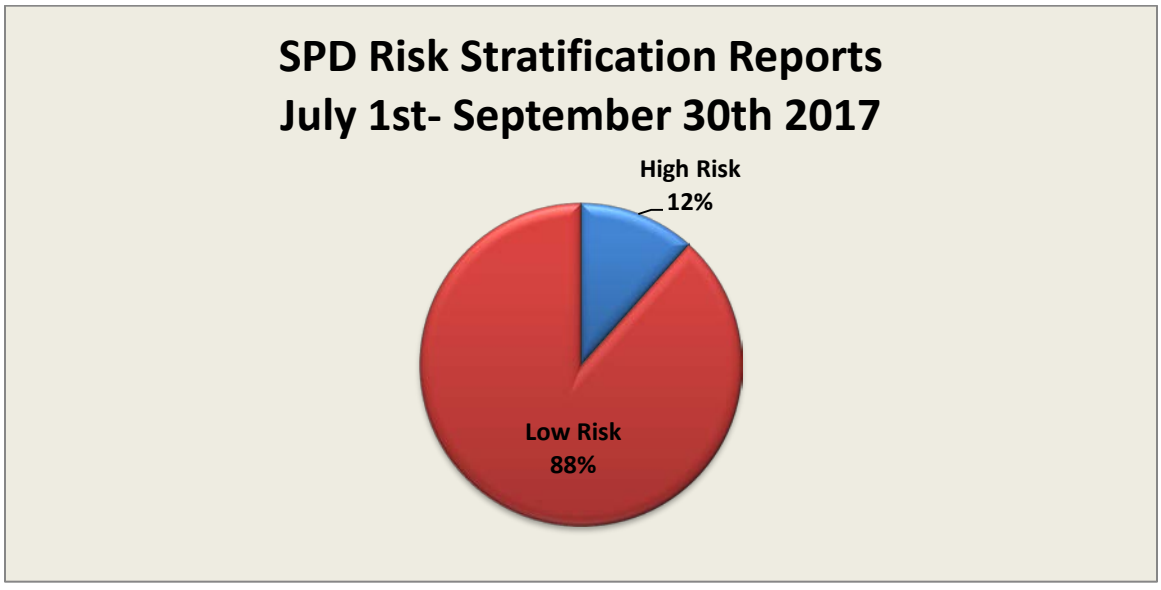


Majority of the tasks were assigned by the Case Management RN' at 64%.

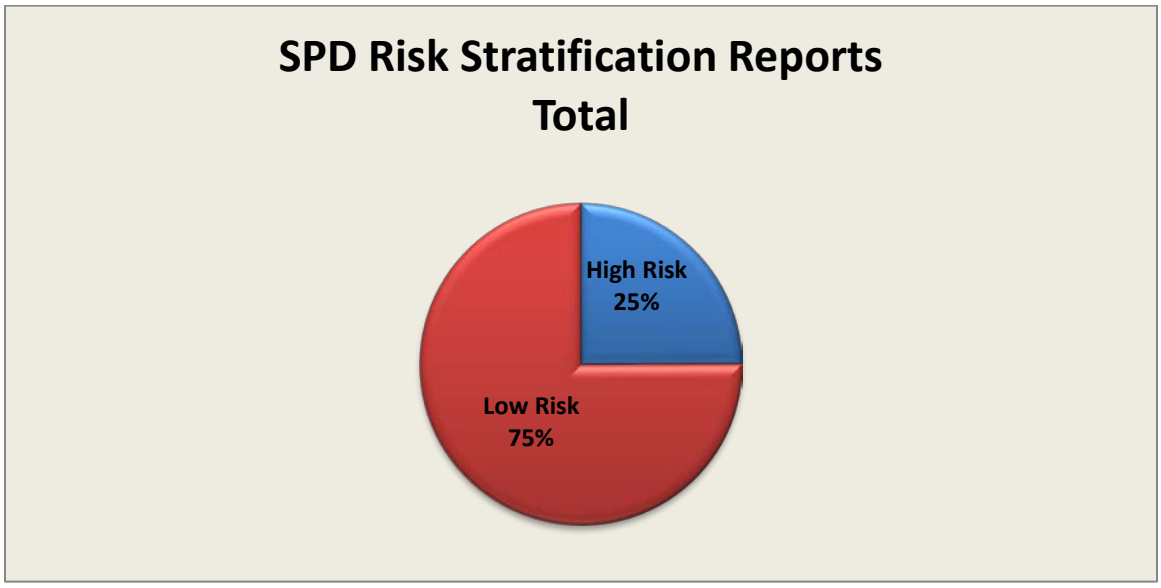


Seniors and Persons with Disabilities (SPDs):

There were a total of 516 SPD members that were enrolled during the 3rd Quarter 2017, according to the high risk stratification report. Of the 516 SPD members, 12% are stratified as high risk.



There are a total of 13,140 SPD members to date. Of the 13,140 SPD members, 25% 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 48 percent of the Complex Group during the 3rd Quarter.

KERN HEALTH SYSTEMS
DISEASE MANAGEMENT DEPARTMENT QUARTERLY REPORT

Reporting Period: July 1, 2017 – September 30, 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:

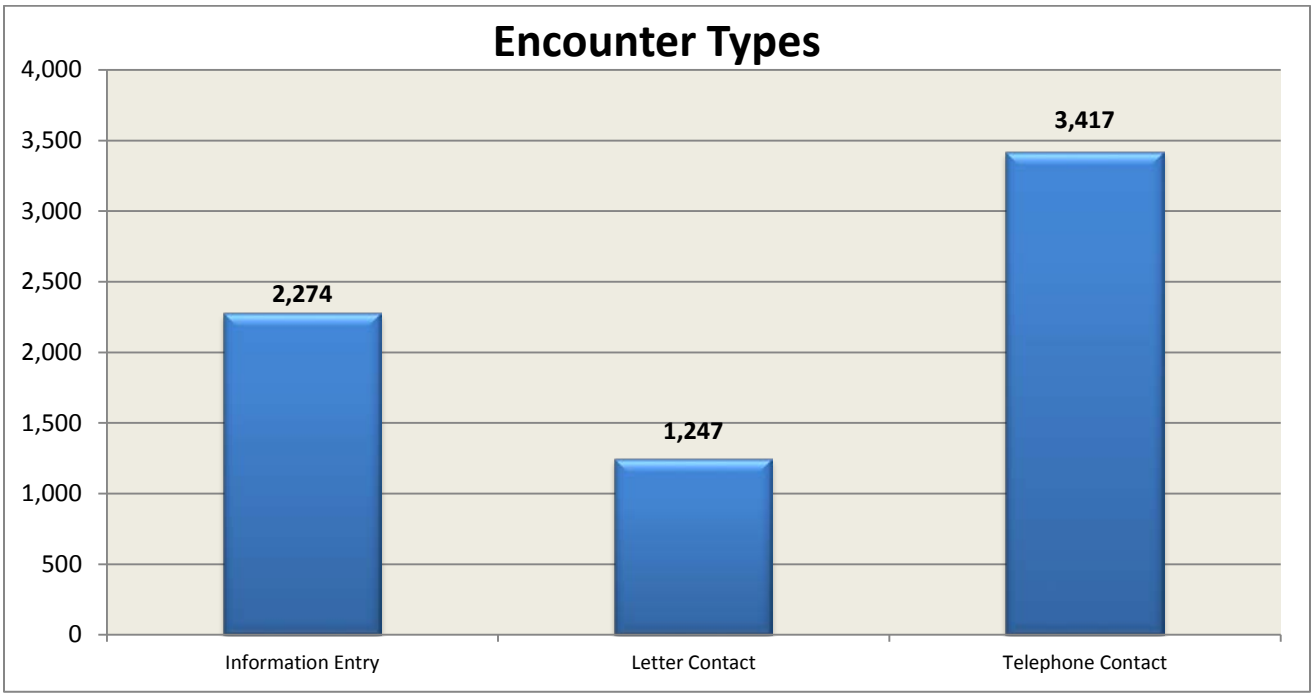
Staff	Caseload
RN 1	176
RN 2	189
RN 3	108
RN 4	195
TOTAL	668

DM Program Caseload:

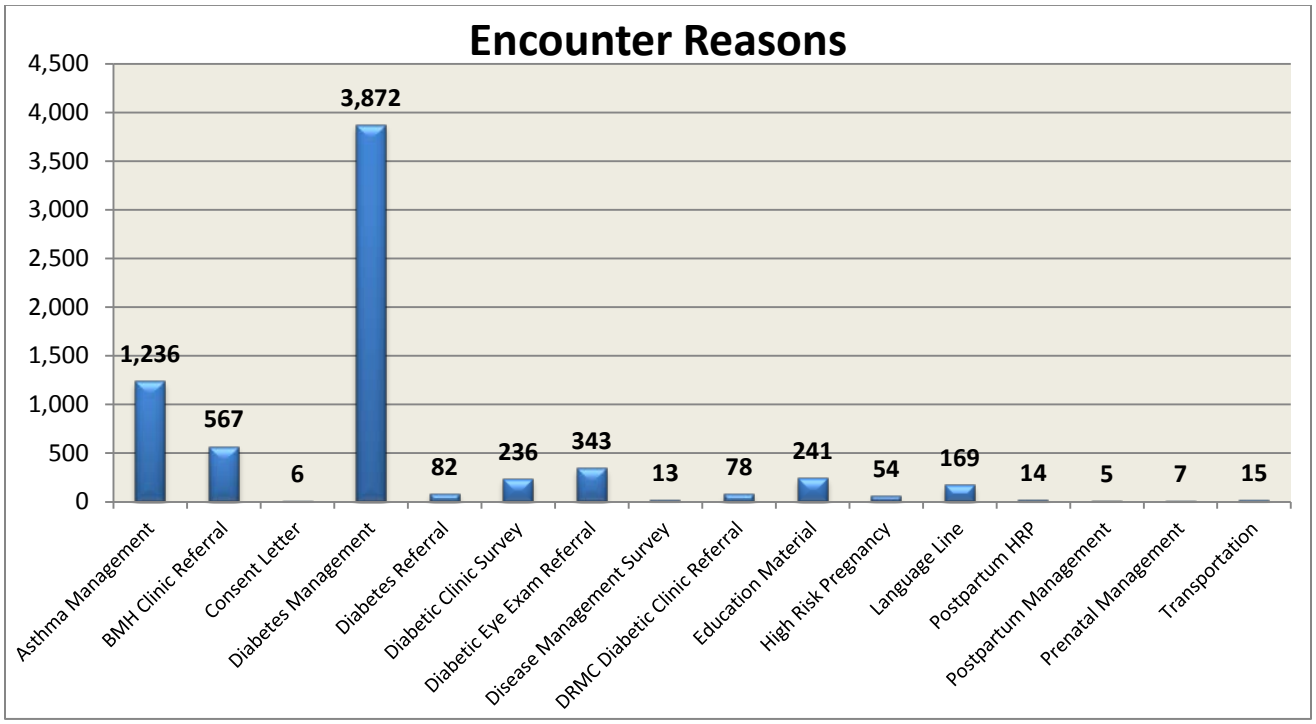
DM Program	Caseload
Asthma	183
Diabetes and Hypertension	474
High Risk Pregnancy	11
TOTAL	668

Encounters:

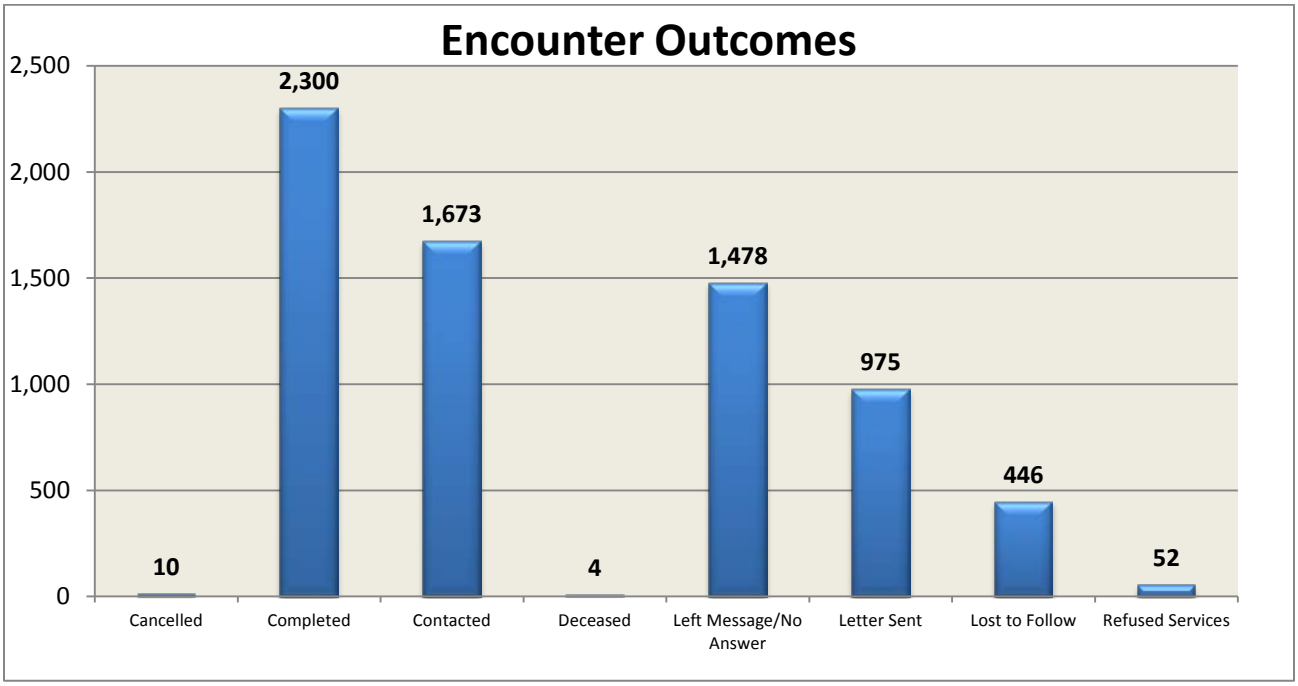
There were a total of 6,938 encounters submitted during this quarter for 2,260 KFHC members and the majority of the encounter types were listed as a Telephone Contact at 49%



The majority of the encounter reasons at 56% was listed as Diabetes Management.

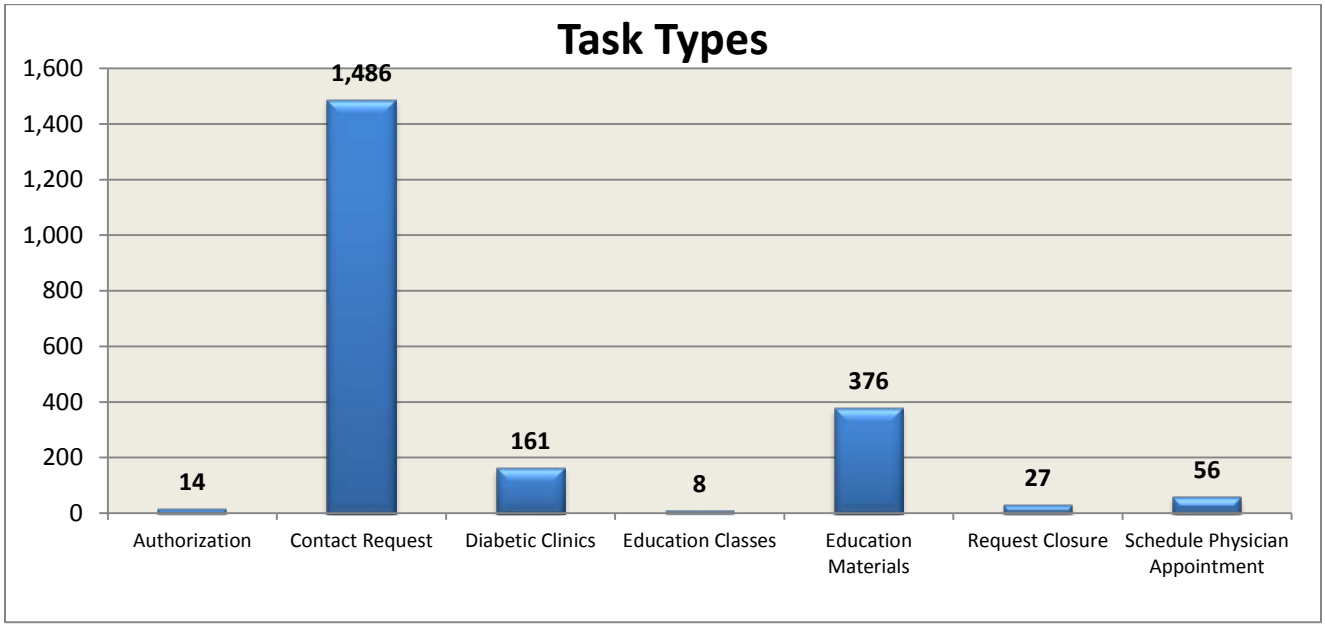


The majority of the encounter outcomes at 33% are listed as completed.

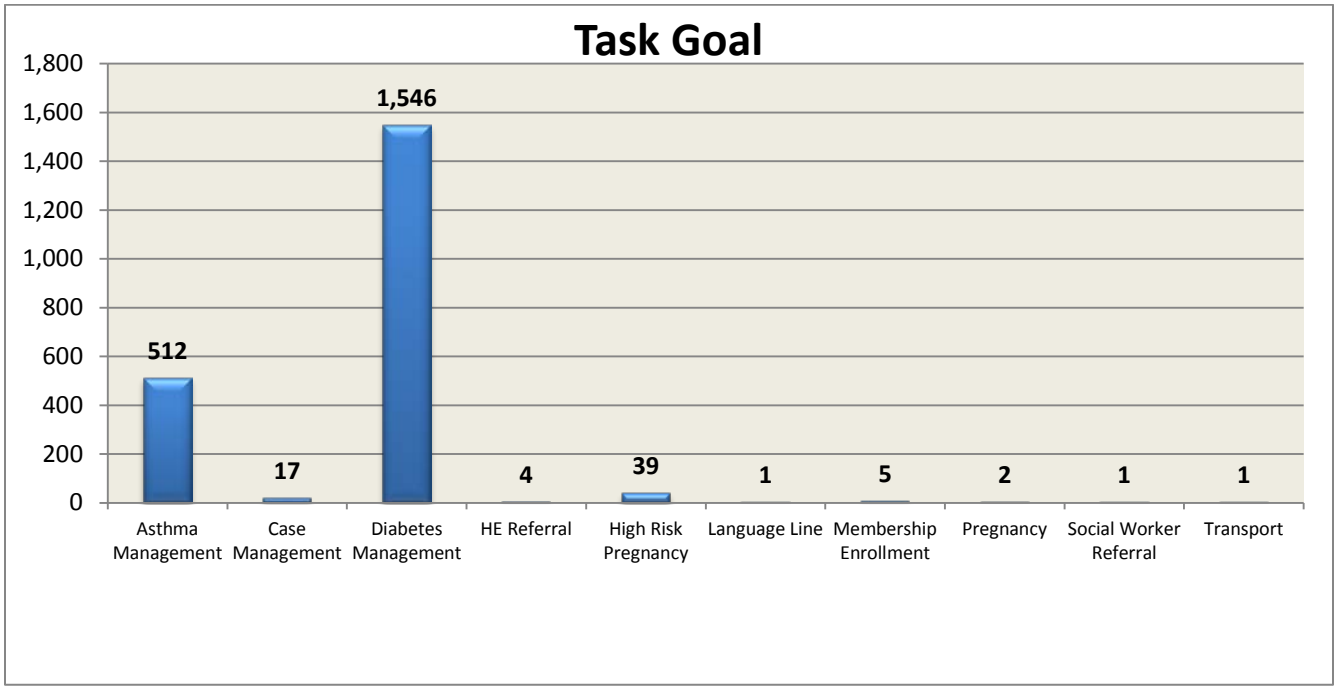


Tasks:

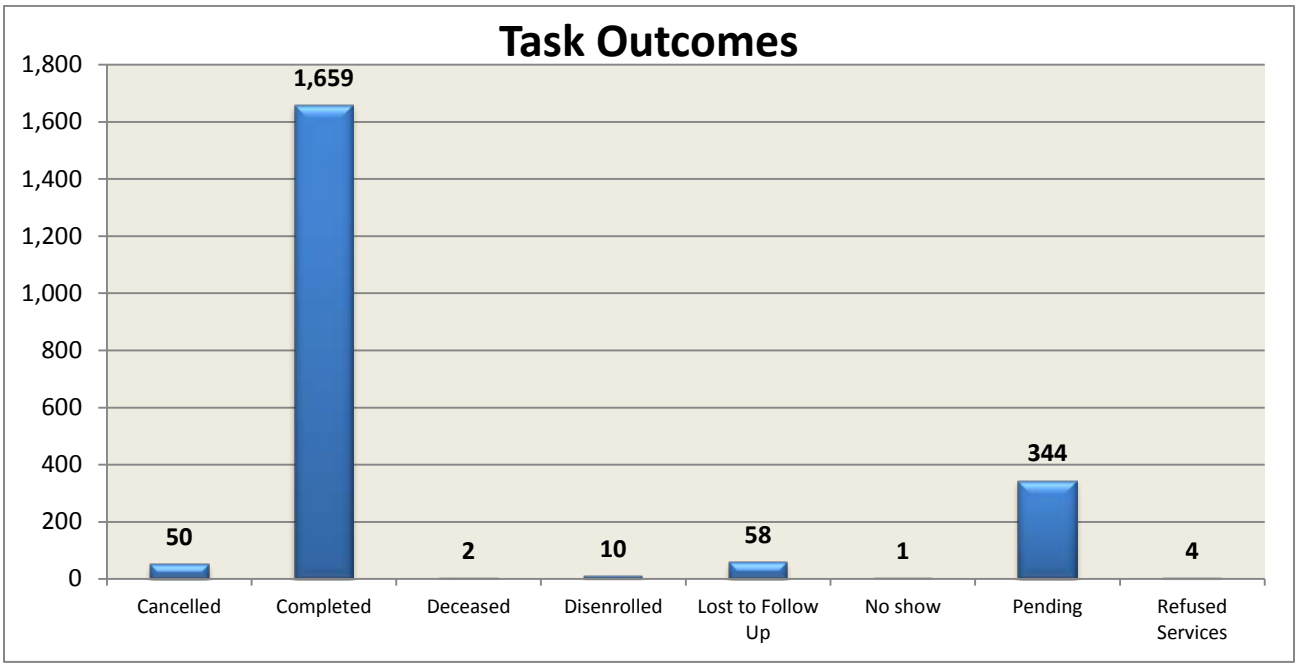
There were a total of 2,128 tasks assigned to the Disease Management department during the quarter for 1,231 KFHC members. The majority of Task Types were Contact Request at 70%.



The majority of task goals at 73% was listed as Diabetes Management.

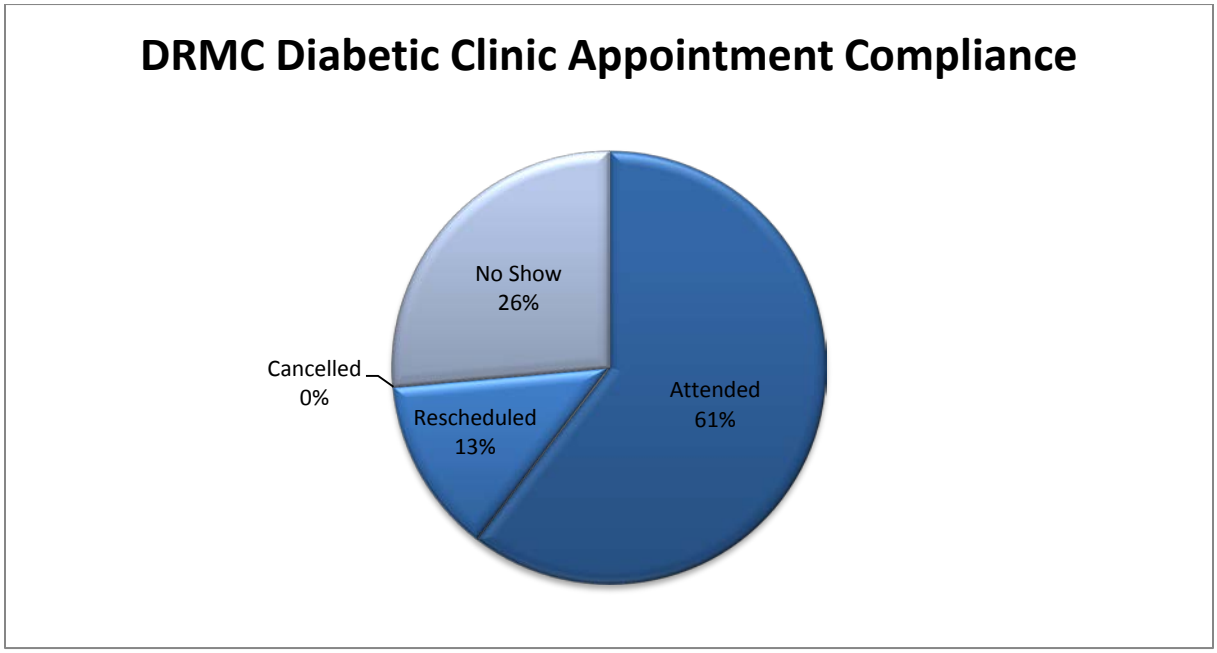


The majority of the task outcomes at 78% are completed.



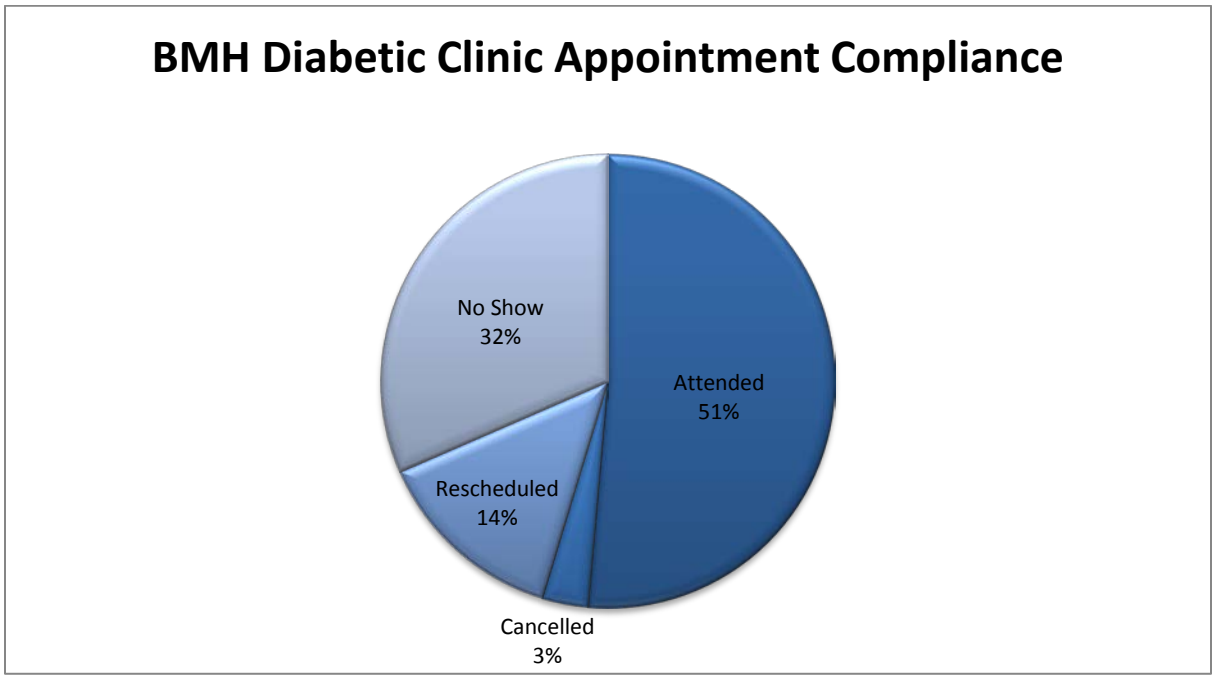
Delano Regional Medical Center (DRMC) Diabetic Clinic

Appointment compliance at the DRMC Diabetic Clinic revealed 60% of members attended their scheduled appointment. 473 appointments were scheduled.



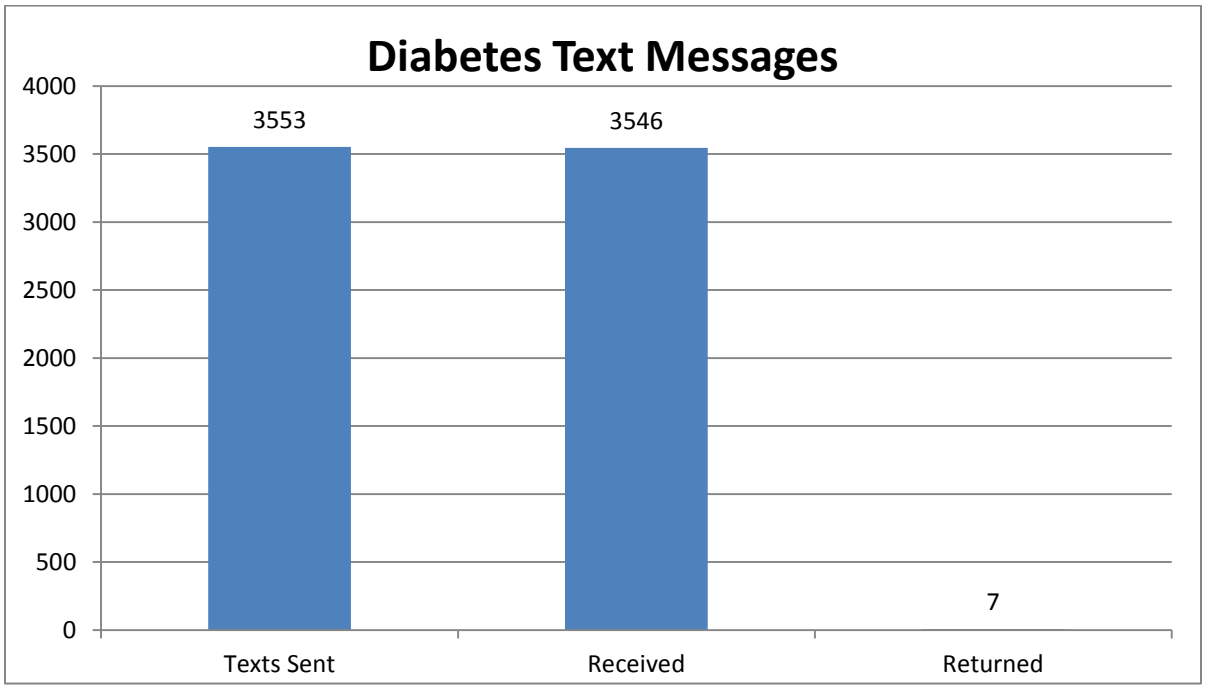
Bakersfield Memorial Hospital (BMH) Diabetic Clinic

Appointment compliance at the BMH Diabetic Clinic revealed 51% of members attended their scheduled appointment. 580 appointments were scheduled.



Diabetes Text Messaging Program

Thirteen diabetes related text messages, totaling 3,553 were sent to members during this quarter. 99.8% of those messages were successfully received by the members. The various topics included Medication Adherence, Blood Pressure, Promoting the Advance Nurse Line, Cholesterol, Nutrition, and Foot Care.



KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Dental Services				POLICY #: 3.06-P	
DEPARTMENT: Administrative Director of Health Services					
Effective Date: 2000/06	Review/Revised Date: 07/10/2017	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer
Date 7/10/17

Chief Medical Officer
Date

Chief Operating Officer
Date 7/10/17

Deborah L Murphy
Administrative Director of Health Services
Date 7/7/17

POLICY:
Most dental services are not covered under Kern Health Systems (KHS) Plans.[1] Dental screenings are included for all members as part of the initial health assessment.[2] KHS will cover intravenous (IV) sedation and general anesthesia services provided by a physician in conjunction with dental services for KHS enrollees in hospitals, ambulatory medical surgical settings, or dental offices when necessary for the treatment of dental conditions which meet specific criteria as outlined in this policy.

KHS providers will refer members to appropriate dental providers.

Dental services will be provided in accordance with the following statutory and contractual requirements:

- California Health and Safety Code §1367.71
- DHS Contract 03-76165 Exhibit A – Attachment 11 (14)
- APL 15-012 with Attachment A

PROCEDURES:

1.0 PROGRAM DESCRIPTION

Medi-Cal members receive dental benefits through the Denti-Cal program.

2.0 ACCESS

Members requiring dental services are identified either through dental screening by KHS Primary Care Practitioners (PCPs) or through members directly requesting referral. Those members are referred to appropriate dental providers, Denti-Cal, or the appropriate Dental Plan.[3]

KHS authorization is required for covered medical services related to dental services that are not provided by dentists or dental anesthetists. KHS authorization is required for use of a surgical facility and the professional services of an anesthesiologist. (For Medi-Cal members, the authorization request must include a denial from Denti-Cal). The dental provider must obtain prior authorization through the customary referral process.[4] See *KHS Policy and Procedure #3.22-P: Referral and Authorization Process* for details.

Those services not covered by KHS do not require authorization from KHS, but may require authorization from Denti-Cal or the appropriate Dental Plan.

3.0 COVERED SERVICES

KHS covers only those dental services described below.

3.1 Dental Screenings

KHS covers dental screenings performed by the member's PCP. This service is included as part of the Initial Health Assessment. For members under 21 years of age, a dental screening/oral health assessment must be performed as part of every periodic assessment, with annual dental referrals made commencing at age 3 or earlier if conditions warrant.[5]

3.2 Covered Medical Services Related to Dental Services that Are Not Provided By Dentists or Dental Anesthetists[6]

KHS covers and encourages the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists. Covered medical services include: contractually covered prescription drugs; laboratory services; and, pre-admission physical examinations required for dental procedures, admission to an out-patient surgical service center or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services).

3.3 Services Performed in a Surgical Center

Certain dental conditions may require treatment in a surgical center rather than in the dentist's office. Treatment in a surgical center may entail using anesthesia due to the prolonged time that the treatment will require, or for the safety of the patient.

KHS members may receive treatment for a dental procedure provided under general anesthesia by a physician anesthesiologist in the settings listed below only if KHS determines the setting is appropriate and according to criteria indicating medical necessity which include:

a) Hospital;
b) Accredited ambulatory surgical center (stand-alone facility);
c) Dental office; and
d) A community clinic that:
    i) Accepts Medi-Cal dental program (Denti-Cal or DMC plan) beneficiaries;
    ii) Is a non-profit organization; and
    iii) Is recognized by the Department of Health Care Services as a licensed community clinic or a Federally Qualified Health Center (FQHC) or FQHC look-alike.

Authorization for general anesthesia provided by a physician anesthesiologist to a beneficiary during an inpatient stay must be part of the authorization for the inpatient admission.

KHS covers general anesthesia and associated facility charges for dental procedures only when rendered in a contracted hospital or surgery center setting, when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting.

Prior authorization is not required prior to delivering IV sedation or general anesthesia as part of outpatient dental procedure in a nursing facility or any category of intermediate care for the developmentally disabled.

Anesthesia or sedation for dental procedures is authorized on a case-by-case basis. Generally, candidates for anesthesia or IV sedation must have tried and failed an attempt to have the dental work performed in an office setting using behavioral management and local anesthesia. Indications for anesthesia or IV sedation may include:

1. Failure of local anesthesia to control pain.
2. Failure of conscious sedation, either inhalation or oral.

If the provider documents any one of conditions below, the member shall be considered for IV sedation or general anesthetic (Attachment A).

a) Failure of effective communicative techniques and the inability for immobilization (patient may be dangerous to self or staff).
b) Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation.
c) Patient has acute situational anxiety due to immature cognitive functioning.
d) Patient is uncooperative due to certain physical or mental compromising conditions.

If sedation is indicated then the least profound procedure shall be attempted first. The procedures are ranked from low to high profundity in the following order:

Low-Conscious sedation via inhalation or oral anesthetics;
Medium- IV sedation; then
High- General anesthesia.

Process for Children referred for dental anesthesia:

a. Referrals to dentists are made by the member's assigned KHS PCP or members may self-refer for dental care.
b. Referrals for oral surgery, IV sedation, and dental anesthesia will be made by the member's dentist. The dentist must also refer the member to his/her KHS contracted PCP for medical clearance if the dentist determines anesthesia is medically necessary and only after there has been a documented failure of behavioral modification, local anesthesia, or inhaled or oral conscious sedation in an office setting.
c. The request for IV sedation or general anesthesia must include the dentist's documentation which must include the copy of a complete history and physical examination completed by the member's PCP or specialist, diagnosis, treatment plan, radiological reports, the indication for IV sedation or general anesthesia and documentation of perioperative care (preoperative, intraoperative, and postoperative care) for the dental procedure.
d. Patients with certain medical conditions, such as but not limited to: moderate to severe asthma, reactive airway disease, congestive heart failure, cardiac arrhythmias, and significant bleeding disorders (to include Coumadin therapy) should be treated in a hospital setting or a licensed facility capable of responding to a serious medical crisis. The screening physician must perform the pre-operative history and physical (H&P) or refer the member to a KHS contracted specialist for clearance.

4.0 COORDINATION OF CARE

Dental providers identifying conditions that could require medical intervention or specialty care are encouraged to contact the member's PCP for case management. If assistance is needed from KHS, the Dental Provider may contact the KHS Utilization Management Department for direction at 1-800-391-2000.

KHS PCPs must share appropriate medical record documentation with Dental providers to ensure safe delivery of dental services. Standards for the release of Protected Health Information are outlined in *KHS Policy and Procedure #2.28-P: Medical Records and Other Protected Health Information – Privacy, Use, and Disclosure*.

5.0 REIMBURSEMENT

Dental Providers must seek reimbursement from EDS or the dental health plan for services not covered by KHS. KHS is only responsible for payment of the fees associated with the authorized use of a surgical facility and the professional services of the anesthesiologist. KHS is not responsible for the services of the oral surgeon or dentist.

6.0 PROVIDER REQUIREMENTS

Any provider or facility involved in the authorized treatment of KHS members must have met

all credentialing requirements appropriate to their scope of practice and executed a contract for services with KHS.

ATTACHMENT:

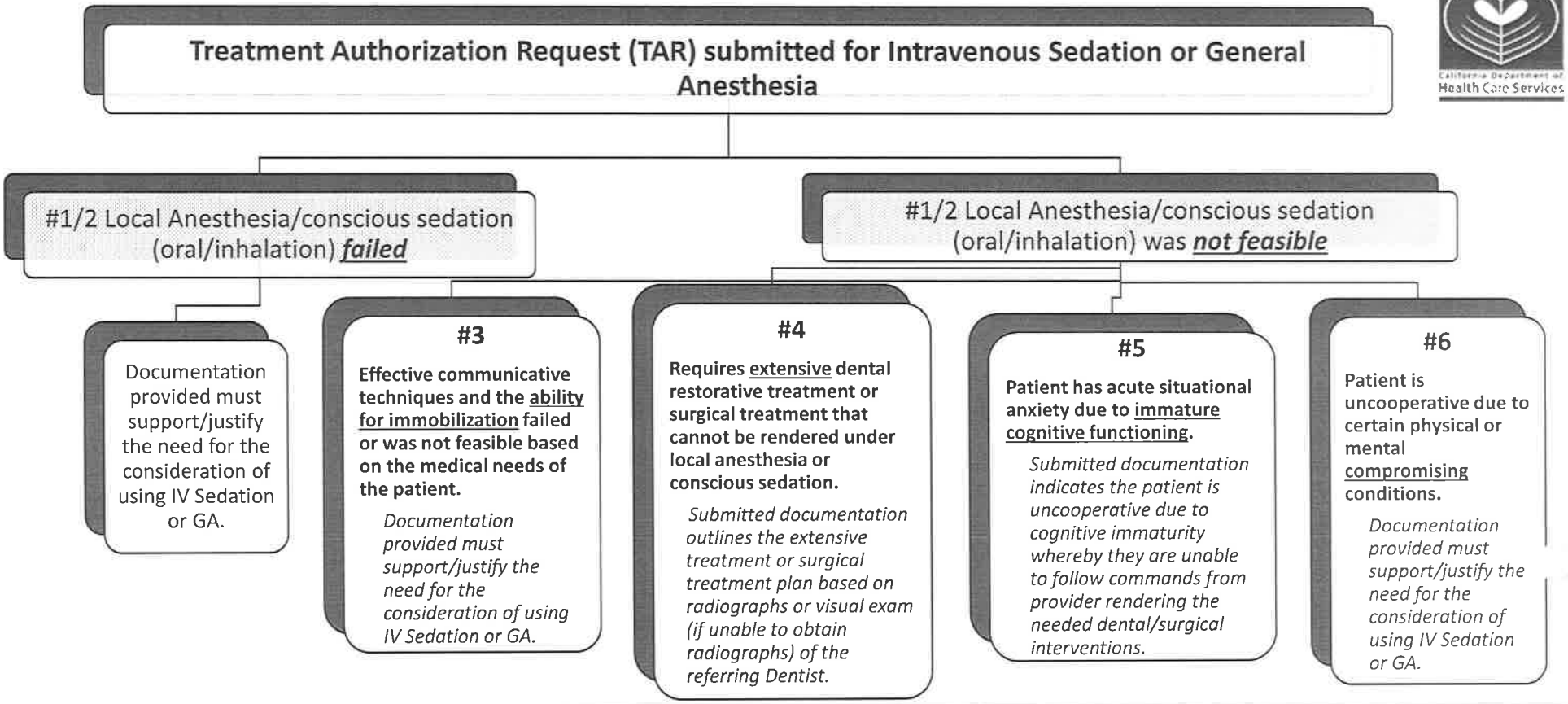
Attachment A – DHCS Dental Flowchart

REFERENCE:

Revision 2017-07: Added Attachment A, Dental Flowchart finalized by DHCS in conjunction with APL 15-012. **Revision 2015-06:** Policy was revised to comply with APL 15-012 per Administrative Director of Health Services. Revision 2013-03: Policy revisions to 3.3 PCP review. **Revision 2010-05; 2013-01:** Policy revisions by Director of Health Services. Policy reviewed by UM Supervisor. No revision necessary. **Revision 2006-02:** Routine review. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004). **Revision 2002-05:** Annual review. Revisions made per 09/19/01 DHS Comment. Policy 3.34 deleted and incorporated into this policy. **Revision No. 2000-06**: Spelling corrections made after approval.

[1] DHS Contract A-11 (14)
[2] DHS Contract A-11 (14)
[3] DHS Contract A-11 (14)
[4] HSC §1367.71(a); DHS Contract A-11 (14)
[5] DHS Contract A-11 (14)
[6] DHS Contract A-11 (14) ;Title 22, Sections 51184; 51340 and 51340.2

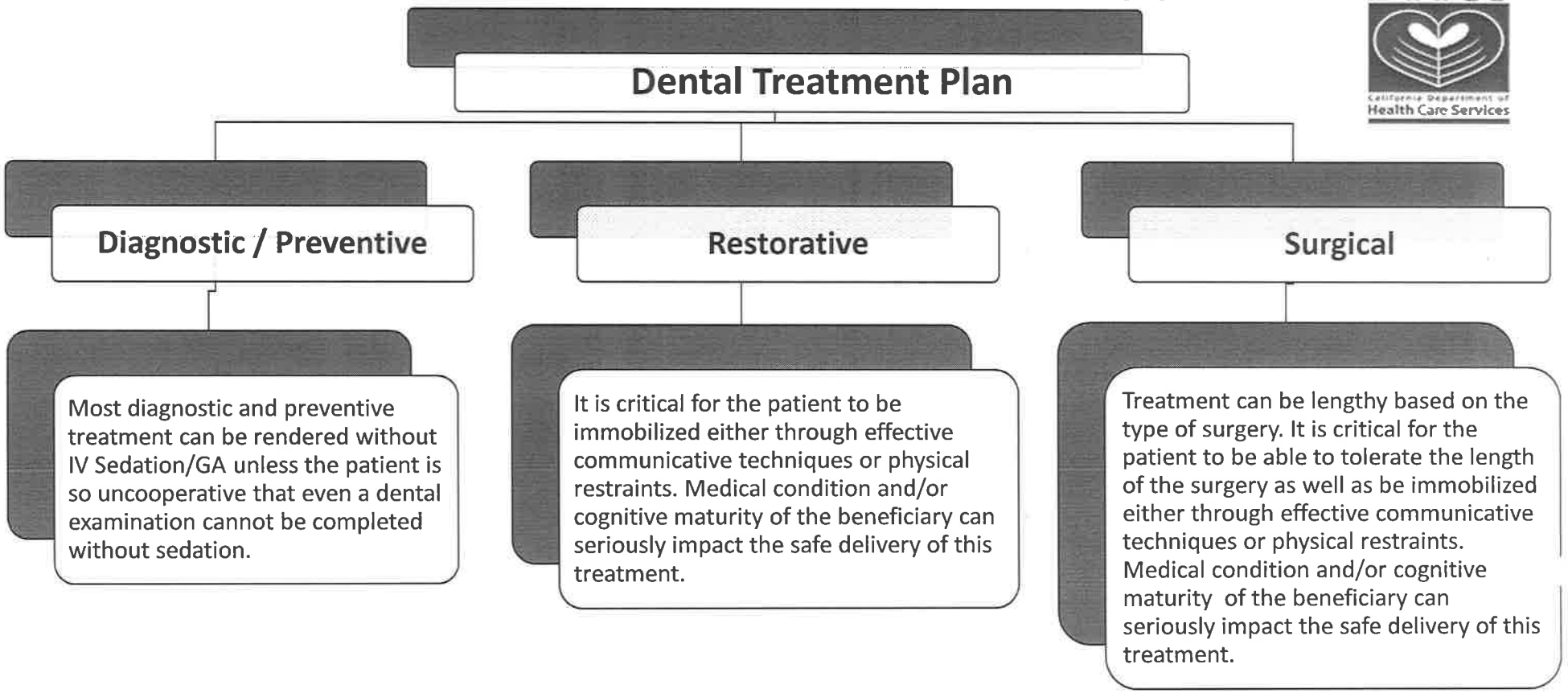
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES



When a provider determines that a beneficiary meets one of the criteria of 3-6, it is not automatically considered to be documentation that conscious sedation or IV sedation was not feasible; rather the submitted documentation of the criteria that was met must be clearly stated in the patient's records and the submitted documentation requesting GA must clearly demonstrate the need for this covered benefit.

April 2017

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES



Extensive dental treatment is not defined by the number of procedures rendered but the treatment that can be reasonably tolerated and rendered in a safe and humane fashion based on cognitive maturity and medical condition of the beneficiary. ***April 2017***

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Sexually Transmitted Disease (STD) Treatment				POLICY #: 3.17-P	
DEPARTMENT: Health Services – Utilization Management					
Effective Date: 8/27/1997	Review/Revised Date: 06/05/2017	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 6/5/2017

Chief Medical Officer — Date

Director of Provider Relations — Date 5/30/17

Deborah L. Lewis RN
Administrative Director of Health Services — Date 5/25/17

POLICY:

The purpose of the this policy is to achieve optimum clinical outcomes for Medi-Cal managed care members by facilitating access to prompt evaluation, diagnosis, treatment, and follow-up of sexually transmitted diseases (STDs) and by establishing effective coordination of care between all providers of such care.

This will serve to maximize the opportunities to control the spread of STDs by providing a full range of prevention services including screening, education, and counseling services to Medi-Cal managed care members.

In order to comply with the Department of Health Care Services (DHCS) mandates, Medi-Cal members may access STD services and care from any qualified family planning practitioner or provider, the Public Health Department STD Clinic, or their PCP without prior authorization.

All Kern Health Systems (KHS) members will be treated in accordance with established Center for Disease Control (CDC) guidelines as published in the most recent MMWR

PROCEDURES:

1.0 ACCESS

All members are notified of their right to access treatment for STDs, both in and out of network as applicable, without prior authorization, through new member orientations, the Member Handbook, and periodic member newsletters. Members are encouraged to access network providers for treatment of STDs.

KHS permits all qualified Kern County Family Planning Providers to access out of plan services for the stipulated STDs without prior authorization, procedures to refer members back to the Plan for care, and how to bill for services through provider orientations, the KHS Provider Administrative Manual, and periodic provider bulletins or website postings.

2.0 TREATMENT LIMITATIONS

Out of Plan treatment of STDs is limited to one office visit per disease episode for the purposes of:

A. Diagnosis and treatment of vaginal and urethral discharge, candidiasis or bacterial vaginosis;

B. STDs which are amenable to immediate diagnosis and treatment including syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, genital warts, non-gonococcal urethritis or cervicitis, lymphogranuloma venereum, vulvovaginitis, and granuloma-inguinale; and

C. Evaluation and initiation of treatment of pelvic inflammatory disease (PID)

The Centers for Disease Control and Prevention's (CDC) Sexually Transmitted Diseases Treatment Guidelines, 2015 recommends Chlamydia Trachomatis (CT) and Neisseria gonorrhoeae (GC) screening for all sexually active women under 25 years of age. The California STD Screening Recommendations 2015 recommends only targeted CT and GC screening for women 25 years of age and older with risk factors.

Members treated at the Kern County Public Health Department (KCPHD) may be treated for the disease episode as outlined in the KHS/KCPHD Memorandum of Understanding (MOU).

3.0 COORDINATION OF CARE AND CASE MANAGEMENT

All providers are required to notify the Kern County Public Health Department of all reportable STDs in accordance with reporting requirements for communicable disease found in Title 17, California Code of Regulations and in accordance with CDC requirements.

In order to avoid duplication of services, to promote continuity of care and achieve the optimum outcome for KHS members, the out-of-Plan providers must document

reasonable efforts in coordinating services with Plan providers and educate Plan members to return to Plan providers for continuity of care.

4.0 CONFIDENTIALITY

All KHS providers and employees must comply with KHS confidentiality policies and procedures in the treatment of sensitive communicable diseases, as with any medical condition (See KHS Policy and Procedure #2.24, 2.27, and 2.28 for details on confidentiality requirements).

Members receiving services from Out-of-Plan providers may: elect to sign a release of confidential information; allow billing and treatment information to be sent to the Plan but not shared with the PCP, or may choose not to sign a release of information.

5.0 TRACKING AND FOLLOW-UP

KHS PCPs must report any patient who does not properly complete the prescribed treatment regimen to the KCPHD for follow-up contact and referral for treatment. Appropriate information regarding treatment of STDs will be shared with the contract provider and KCPHD as outlined in the MOU.

6.0 REIMBURSEMENT

6.1 PCPs

PCP reimbursement for STD services is according to contract rates.

6.2 Out of Plan Providers

KHS reimburses out of plan practitioners and providers at the Medi-Cal fee-for-service rates provided that the out-of-plan practitioner or provider submits appropriate encounter data on a HCFA 1500 form along with treatment records or documentation of the member's refusal to release medical records.

The following are conditions under which an Out-of-Plan provider will be reimbursed by a Plan for STD services:

1) The Out-of-Plan provider is qualified to provide STD services based on licensed scope of practice.

2) The Out-of-Plan provider must submit claims according to Plan specified billing procedures.

3) The Out-of-Plan provider must provide medical records sufficient to allow KHS to meet case management responsibilities. If a Plan member refuses the release of medical information, the Out-of-Plan provider must submit

documentation of such refusal.

The KHS Claims Department forwards treatment records to the appropriate PCP.

7.0 APPEALS PROCESS

Claims may be appealed according to KHS Policy and Procedure #6.04 - Appeal of Denied or Modified Claims.

8.0 LINK TO PLAN'S INTERNAL ORGANIZATION

Internal KHS departments coordinate efforts to improve the KHS membership's timely access to STD services while encouraging members to access services through their primary care physician. KHS's Member Services staff and Health Education Department efforts work collaboratively to inform the membership through member newsletters and other member engagement modalities, of the benefits of early treatment and prevention of STDs. Cultural and Linguistics staff are consulted to ensure newsletters and presentations are appropriately tailored to the target population.

REFERENCE:

Revision 2017-05: References to DHCS contract and MMCD Policy letters included. Updated per MCAL benefits outlined Family Planning Family Pact 108 dated 9/2016 by Administrative Director of Health Services; CDC, Sexually Transmitted Diseases Treatment Guidelines 2015, MMWR 2015:64. **Revision 2013-12:** Minor revisions provided by Director of Health Services to remove references to Health Families.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Family Planning Services and Abortion				POLICY #: 3.21-P	
DEPARTMENT: Health Services - Utilization Management					
Effective Date: 08-1997	Review/Revised Date: 07/28/2017	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward — Date 7/28/17
Chief Executive Officer

M Tasinga — Date 7/26/17
Chief Medical Officer

Chief Operating Officer — Date 7/21/17

Director of Member Services — Date 7/19/17

Deborah L Murray — Date 7/18/17
Administrative Director of Health Services

POLICY[1]:
Kern Health Systems (KHS) will provide enrollees full access to Family Planning Services.

Enrollees have the right to choose and access a qualified family planning practitioner/provider without prior authorization. In addition, Medi-Cal members may choose either a contracted or non-contracted practitioner/provider for family planning services. KHS will encourage Medi-Cal members to access contracted practitioners/providers for Family Planning Services but will facilitate the use of non-contracted practitioners/providers as well.

All members must be provided with informed consent when receiving contraceptive services, including sterilization.

The KHS policy on member rights and access to Family Planning Services is in accordance with regulatory requirements, and defines the process for Medi-Cal members who wish to use non-contract practitioners/providers for these services. KHS shall monitor the compliance of delegated entities as applicable to these services.

DEFINITIONS:

Family Planning Services	Services provided to individuals of child bearing age for the purpose of temporarily or permanently preventing or delaying pregnancy.
Qualified Family Planner Practitioner/Provider	Any clinic or private practice physician licensed to furnish family planning services within their scope of practice and is an enrolled Medi-Cal provider willing to furnish family planning services to a member.

PROCEDURES:

1.0 FAMILY PLANNING PROGRAM DESCRIPTION AND ACCESS

Members are informed in writing of their right to access Family Planning Services in the Member Handbook. Members are also reminded of their rights to Family Planning Services through periodic newsletters. Primary Care Practitioners (PCPs) are encouraged to discuss Family Planning Services with their patients.

Enrollees may access Family Planning Services either by self-referral to an appropriate qualified practitioner/provider or by calling Member Services.

Members may self-refer to a contracted or non-contracted practitioner/provider. KHS Member Services and/or Utilization Management (UM) staff shall assist inquiring members with locating a practitioner/provider.

2.0 DESCRIPTION OF FAMILY PLANNING SERVICES

Covered Family Planning Services include the following:

A. Health education and counseling necessary to make informed choices and understand contraceptive methods
B. Limited history and physical examination
C. Laboratory tests if medically indicated as part of decision making process for choice of contraceptive methods
D. Diagnosis and treatment of STDs if medically indicated[2]. (See *KHS Policy and Procedure #3.17- STD Treatment* for details.)
E. Screening, testing and counseling of at risk individuals for human immunodeficiency virus (HIV) and referral for treatment.[3] (See *KHS Policy and Procedure#3.18 - Confidential HIV Testing* for details.)
F. Follow-up care for complications associated with contraceptive methods issued by the family planning provider
G. Provision of contraceptive pills/devices/supplies
H. Tubal ligation
I. Vasectomies

J. Pregnancy testing and counseling. (See *KHS Policy and Procedure #3.24 - Antepartum and Postpartum Care* for details).

K. Pap smear if performed according to the United States Preventive Services Task Force Guidelines which specifies cervical cancer screening every 1-3 years based on the presence of risk factors (early onset of sexual intercourse, multiple sexual partners); however, Pap smear annual frequency may be reduced if 3 or more annual smears are normal.

The following services are NOT reimbursable as family planning services:

A. Routine infertility studies or procedures
B. Reversal of voluntary sterilization
C. Hysterectomy for sterilization purposes only
D. All abortions, including but not limited to therapeutic abortions; spontaneous, missed or septic abortions; and related services[4]. Abortions may be a covered service, but are not considered Family Planning Services).
E. Transportation, parking and child care.

3.0 PCP EDUCATION AND TRAINING

PCPs receive instruction concerning Family Planning Services at practitioner/provider orientations and periodically through Provider Bulletins. The Provider Resources link on the KHS Website also contains a description of these services and how to assist the member in accessing the services and the PCP's responsibilities.

4.0 TRACKING

Any clinical records from non-contract practitioners/providers are reviewed to be certain that the service provided was one of the covered Family Planning Services. Using billing and encounter records, Quality Improvement audits annually the provision of Family Planning Services by either contract practitioner/providers or non-contract practitioners/providers. The results are used to analyze the degree of access being provided and used by enrollees. This access information is reported to the Quality Improvement/Utilization Management Committee.

5.0 REIMBURSEMENT

Member's eligibility with KHS is determined on a month to month basis. KHS will pay for up to thirteen cycles of oral contraceptives, a 12 month supply of patches (36 patches), and a 12 month supply of vaginal rings (12 rings) if such quantity is dispensed in an onsite clinic and billed by a qualified family planning provider, including out-of-plan providers, or dispensed by a pharmacist in accordance with a protocol approved by the California State Board of Pharmacy and the Medical Board of California.

A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to an enrollee, as specified in Title 22, California Code of Regulations, and Section 51200. A physician, physician assistant (under the supervision of a physician), certified nurse midwife, and nurse practitioner, and pharmacist are authorized to dispense medications. Pursuant to the California Business and Professions Code (B&P Code), Section 2725.2, if these contraceptives are dispensed by a registered nurse (RN), the RN must have completed required training pursuant to B&P Code Section 2725.2(b), and the contraceptives must be billed with Evaluation and Management (E&M) procedure codes 99201, 99211, or 99212 with modifier 'TD'

(TD modifier used for RN for behavioral health) as found in the Provider Manual.

Absent clinical contraindications, utilization controls limiting the supply to an amount that is less than a 12-month supply cannot be imposed.

Non-contract practitioners/providers are paid for services provided to Medi-Cal members based on the appropriate Medi-Cal fee-for-service rates. Contracted practitioners/providers are reimbursed according to the contract agreement.

6.0 DOCUMENTATION AND INFORMED CONSENT

All family planning practitioners/providers must give enrollees informed consent whenever contraceptive services are provided. This consent must be documented in the clinical record.

Clinical records (or patient refusal to release records) must be submitted with the claim. Claims received after 180 days from the date of service will be denied.

7.0 REFERRALS

Upon identification of a need for a referral to a specialist or for further testing, contract practitioners/providers should submit a *Referral/Prior Authorization Form* in accordance with *KHS Policy and Procedure #3.22 - Referral Process.*

8.0 COORDINATION OF CARE

Member Services and UM coordinate Family Planning Services to be certain that enrollees have maximum access.

When a non-contracted practitioner/provider sees a patient, it is crucial for continuity of care that the patient's PCP be notified of the service. Non-contract practitioners/providers must, as per customary practice, inform the patient's PCP of the clinical interaction after obtaining a signed release from the member. Exchange of patient information may also be necessary to the non-contract practitioner/provider. The KHS UM Department assists with the coordination of the exchange of this medical information when necessary. The PCP must obtain patient consent to release information to the non-contract practitioner/provider.

KHS, through UM and Member Services, works closely with the Kern County Public Health Department as outlined in the Memorandum of Understanding with the purpose of coordinating efforts to provide the fullest access and most efficient provision of Family Planning Services.

9.0 CONFIDENTIALITY

Information must be handled in accordance with KHS confidentiality policies (#2.27 and #2.28). In the case of a minor, age 12 to 18, KHS ensures that communication regarding sensitive services is protected. For example, no letters and phone calls are sent/made to the minor's home unless authorization was obtained.

10.0 ABORTION

Prior authorization for abortion services is not required unless inpatient hospitalization for the performance of the abortion has been requested. KHS members are educated regarding abortion policies and procedures through new member entry, the member handbook, and member newsletters. Abortion services include access to Mifepristone (RU486) in accordance

with the FDA approved treatment regimen.[6]

KHS members are advised that they may go to the provider of their choice for abortion services; however, some hospitals and other providers may refuse to provide abortion services.

A physician or other health care provider is not mandated to preform abortion services. KHS shall not tolerate retaliation in any form to a physician or other provider of health care services for objecting to perform abortion services[7]. KHS will assist with the redirection of members who are refused abortion services by a provider.

REFERENCE:

Revision 2017-04: Revised to comply with APL16-003R, family planning services for contraceptive supplies by Administrative Director of Health Services.[1] **Revision 2016-05:** Definition of Qualified Family Planner Practitioner/Provider clarified. Additional revisions in §5.0 Reimbursement. **Revision 2016-02:** Revised to comply with APL 16-003, family planning services for contraceptive supplies. **Revision 2015-10:** Policy revised to comply with All Plan Letter 15-020 Abortion Services. **Revision 2012-08:** Added language stating three cycles of oral contraceptives will be reimbursed per visit for family planning services. **Revision 2008-10:** Routine review. Reimbursement revised per MMCD Policy Letter 08-002. **Revision 2002-04:** Add abortion services information. Add information regarding RU486.

[2] Based on HCFA's Medicaid policies, STD diagnosis and treatment and HIV testing and counseling, provided during a family planning encounter, are considered part of family planning services.

[3] See endnote #1.

[4] Pregnancy testing and counseling performed by out-of-plan family planning practitioner/provider are reimbursable regardless of member's decision for abortion.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Pregnancy and Maternity Care				POLICY #: 3.24-P	
DEPARTMENT: Health Services - Utilization Management					
Effective Date: 11/2008	Review/Revised Date: 09/09/2017	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 9/9/17

Chief Medical Officer — Date 9/8/17

Chief Operating Officer — Date 9/6/17

Director of Claims — Date 8/30/17

Administrative Director of Health Services — Date 8/24/17

POLICY:

Kern Health Systems (KHS) will encourage optimum maternity care as appropriate for all pregnant members. Maternity care will include; antenatal 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. This approach establishes a framework for cooperative efforts to reduce perinatal morbidity and mortality. This coordinated system emphasizes professional expertise, consultation, communication and education for the effective use of resources based on local and individualized needs. All pregnant KHS members will receive case coordination of Obstetric and Comprehensive Perinatal Services to the degree warranted by the State Department of Health Care Services (DHCS) combined standardized risk assessment tools.

Maternity care will be performed by qualified network practitioners/providers (referred to as "pregnancy practitioners" in the remainder of this document). If the KHS network does not include a Certified Nurse Midwife (CNM) or Certified Nurse Practitioner (CNP), Medi-Cal members may

receive maternity care from non-contracted CNP's or CNMs.[2] In order to maintain high quality care for pregnant women, KHS will authorize antenatal care only when it is provided by a licensed practitioner who has had special training in this area. This may include Obstetricians, Family Practitioners, and nurse mid-wives or nurse practitioners. Other practitioners who wish to perform antenatal services will need to provide documentation of adequate training and experience. Pregnancy practitioners are exempt from the requirement of certification as Medi-Cal Comprehensive Perinatal Services Providers (CPSP); nevertheless, they are required to follow specified CPSP Guidelines as defined in this policy.[3]

KHS will maintain and communicate maternity care protocols to pregnancy practitioners. Maternity care will be provided in accordance with the following adopted guidelines:

- The most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) [4]

The presence of risk factors in individual patients will affect the type and quantity of maternity services that may be appropriate. Certain members may require additional services or core services at more frequent intervals.

Maternity care will be provided in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources:

- California Code of Regulations Title 22 §§51345; 51348; 51348.1; 51179; and 51179[5] (CPSP Guidelines)
- DHCS Contract Sections Attachment A-5 (2)(F); Attachment A-9; and Attachment A-10 6
- MMCD Policy Letter 96-01: Obstetrical Care
- Newborns' and Mothers' Health Act of 1997 (NMHA)

DEFINITIONS:

Antenatal Care	Care of patients during pregnancy prior to delivery.
Genetic Counseling	A communication process that deals with the occurrence, or the risk of occurrence, of a genetic disorder in the family. The key elements are diagnosis, communication, and options.
Individualized Care Plan (ICP)	Document that assists in the planning, coordination, and documentation of perinatal services. The ICP includes health education, psychosocial, and nutritional components as well as identification and documentation of risk conditions, problems, interventions, and outcome information. The ICP also clearly identifies parties responsible for carrying out proposed interventions.
Free Standing Birth Center	The term "free standing birth center" as a health facility – (i)that is not a hospital; (ii)where childbirth is planned to occur away from the pregnant woman's residence; (iii)that is licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and

	(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the state shall establish.

PROCEDURES:

1.0 ACCESS

Pregnancy testing does not need prior authorization and may be performed by participating or non-participating practitioners/providers.

Members are not required to obtain a referral from their Primary Care Practitioner (PCP) or prior approval from KHS before receiving maternity care from a pregnancy practitioner.[6] Non-emergent specialty care procedures require prior authorization according to *KHS Policy and Procedure #3.22-Referral and Authorization Process*.

Pregnancy services qualify as minor consent services. Minors do not need parental consent to access these services. See *KHS Policy and Procedure 2.17 – Access-Treatment of a Minor* for additional information.[7]

1.1 Appointments and Appointment Follow-Up[8]

An initial obstetrical visit should be offered within two weeks of the request for an appointment, if requested by the member. The member may request an appointment outside the two week period but should be as near as possible to six weeks after the last menstrual period.[9]

Pregnancy practitioners are responsible to take steps to ensure that patients under their care receive appropriate services. Pregnancy practitioners must contact immediately by phone those patients who fail to keep a scheduled appointment. A lack of response by the patient or inability to contact the patient should be followed by a letter within one week of the missed appointment. All attempts must be documented in the member's medical record.

2.0 COVERED SERVICES

The expected number of maternity visits is calculated in accordance with recommended frequency guidelines. This calculation takes into account the date of eligibility, date of initial visit, and estimated confinement date. A woman with active medical or obstetric problems should be seen more frequently, at medically appropriate intervals, as determined by the nature and severity of the problems.

Although KHS does not require prior authorization for maternity visits, the expected number of visits is authorized and noted in the KHS information system for claims payment purposes. Generally, a woman with an uncomplicated pregnancy is examined every 4 weeks for the first 28 weeks of pregnancy, every 2 or 3 weeks until 36 weeks of gestation, and weekly thereafter according to the following guidelines:

Week 1-4	Initial Visit
Week 5-8	Antepartum visit 1
Week 9-12	Antepartum visit 2
Week 13-16	Antepartum visit 3
Week 17-20	Antepartum visit 4

Week 21-24	Antepartum visit 5
Week 25-28	Antepartum visit 6
Week 29-30	Antepartum visit 7
Week 31-32	Antepartum visit 8
Week 33-34	Antepartum visit 9
Week 35-36	Antepartum visit 10
Week 37	Antepartum visit 11
Week 38	Antepartum visit 12
Week 39	Antepartum visit 13
Week 40	Antepartum visit 14
48-96 hours postpartum	Required by law for early discharge patients
1-2 weeks post op C-section	Routine postoperative care
3-8 weeks postpartum	Standard Postpartum Visit

The post hospital visit for early discharge should not be billed and shall not be separately reimbursed as it is intended to include services that would have been provided if the patient had not left the hospital early. The visit 1-2 weeks post C-section shall not be separately reimbursed as that is routine postoperative care expected to be provided in the reimbursement provided for the delivery.

The pregnancy practitioner is required to manage the frequency of antenatal care visits in accordance with the patient's individual needs and risk factors. It is expected that the level of care for members remain consistent with professional standards. Visits that exceed the expected number are reviewed and processed based on medical necessity.

2.1 Pregnancy Testing

Blood pregnancy tests are reimbursed based on medical necessity. KHS does not reimburse participating pregnancy providers for routine blood pregnancy test. Urine pregnancy tests should be performed for routine screening.

2.2 Antenatal Care

Practitioners must notify UM of initiation of care within 5 working days of the initial visit. Notification must include:

A. Estimated date of confinement (EDC)
B. Last menstrual period (LMP)
C. Gravida/Para
D. Pregnancy Practitioner
E. Mode of Delivery
F. Delivery Hospital
G. High Risk conditions

The following table outlines required antenatal services. These services must be documented in the medical record.

Service	Details	Required Referrals
Antibody Screen		
Blood Test	ABO blood group and RH type	
Breastfeeding Education and Counseling	Breast feeding education and counseling are available through prenatal classes, CPSP providers and prenatal packets mailed to pregnant members	
Cervical Cytology		
Comprehensive Health History	Must include a screening for genetic disorders	
Cystic Fibrosis Screening	All pregnant members should be offered cystic fibrosis testing and counseling. Refusal to accept testing must be documented in the member's medical record.	
Gestational Diabetes Screen	Identified either through medical history, initial combined assessment, or routine glucose testing (50 grams glucola) at 24-28 weeks	All pregnant members identified as having a history of diabetes or current gestational diabetes must be either referred to the KMC OB High Risk clinic, referred for support services through the UM referral process, or referred to WIC for follow up support services.
Hemoglobin/ hematocrit		
HIV Testing and Counseling	All pregnant members must be offered HIV testing and counseling.[10] Refusal to accept testing must be documented in the member's medical record.	
Physical Examination	Complete	
Rubella Antibody Titer		
Syphilis Screen		
Urinalysis	Must include microscopic examination or culture	

Any provider who delivers antenatal care must provide notice to UM concerning individuals involved in the delivery and responsible for managing complications of pregnancy, such as miscarriage, pre-term labor, fetal complications, pre-eclampsia, etc.

2.3 Delivery

The pregnancy practitioner must inform the member of the general plan for hospital admission, labor, delivery, and postpartum care.[11] He/she should direct women with high risk pregnancies to the Kern Medical Center advanced obstetrics and neonatal care unit.

After delivery, a pregnancy practitioner may wait up to 48 hours after vaginal delivery or 96 hours after C-Section delivery to discharge the member. With member consent, a pregnancy practitioner may choose to discharge the member from the hospital prior to the 48/96 hour minimum and request a post-discharge visit during that 48/96 hour period. The post-discharge visit may be in the mother's home or the treating practitioner's office.[12] The visit must include, at a minimum, parent education, assistance, training in breast feeding or bottle feeding, and the performance of any necessary maternal or neonatal physical assessment.

No prior authorization is required, but the post-discharge visit must be provided by a participating practitioner/provider. For notification purposes, the practitioner/provider should submit a *Referral Authorization Form* within the next business day. (Included as attachment to *KHS Policy and Procedure #3.22 - Referral Process*). The notification must include:

A. Pertinent member demographic
B. Date of hospital discharge
C. Date of skilled nursing visit
D. Referral physician's orders

The referral is automatically approved and processed by the KHS Case Manager. The approved authorization form is faxed/returned to the referring provider.

2.4 Postpartum Care

The routine postpartum care visit should generally be accomplished on or between 21 and 56 days after delivery. An additional postpartum visit should be accomplished within two weeks after a Cesarean Section delivery. These intervals may be modified if warranted by the needs of the member. The postpartum review should include the following services:

A. Interval history and physical examination, including pelvic examination
B. Laboratory data as indicated
C. Family planning counseling
D. Nutritional, health education, and psychosocial reassessments.

Postpartum visits should be clearly documented as such in the member's medical record.

2.5 Assessments[13]

Assessments of risk factors must be offered in each trimester and postpartum and must include review of obstetrical, nutrition, health education and psychosocial interventions.

	Psychosocial[14]	Nutrition[15]	Health Education[16]
Complete initial assessment	Included in combined initial assessment form	Included in combined initial assessment form	Included in combined initial assessment form
Trimester reassessment by 20 weeks gestation	√	√	√
Trimester reassessment by 28 weeks gestation	√	√	√
Postpartum assessment, care plan, and interventions	Included in combined postpartum assessment form	Included in combined postpartum assessment form	Included in combined postpartum assessment form
Additional services	Treatment, intervention, and referral services with Plan assistance or coordination via the Health Educator.	Prescribing of prenatal vitamins and mineral supplements. Treatment, intervention, and referral services including referral to the local WIC Program or specialized nutritional services through the KHS Health Educator.[17]	Interventions based on identified needs, interests, and capabilities; particularly directed towards assisting the member to make appropriate, well informed decisions about her pregnancy, delivery, and parenting. Referrals via the KHS Health Educator.

Reassessments are not required in the trimester of entry into care.

2.6 High Risk Intervention[18]

Members presenting with high risk factors must receive specific interventions targeted to that risk. Practitioners must determine the appropriate level of intervention and ensure that it is available to the member by providing service on-site, through referral, or by requesting assistance from the Plan. UM should be notified of all high risk cases and will assist with the education of the high risk condition.

UM is responsible for case management of high risk members. The Nurse Case Manager coordinates care between pregnancy practitioners, the KHS Health Educator, and when indicated, the appropriate linked community resource. Pregnancy practitioners should refer high risk members to UM via *Referral/Prior Authorization Forms*. (See Attachment D).

2.7 Genetic Screening, Counseling, and Referral

Pregnant members are provided genetic screening, counseling, and referral as needed.[19]

Pregnancy practitioners must screen for the potential need for these services in accordance with ACOG standards. He/she should submit a referral to UM if he/she determines that there is need for medical geneticist assessment and counseling. (See *KHS Policy and Procedure #3.22 – Referral and Authorization Process* for details).

Counseling should be provided upon diagnosis of a genetic disorder. The counselor should communicate to the family a range of available options. The counselor's function is not to dictate a particular course of action, but to provide information that will allow couples to make an informed decision.

2.7.1 Alpha Feto-Protein (AFP) Testing Program[20]

The AFP Program screens for neural tube and other birth defects. The Genetic Disease Branch develops standards for AFP testing sites and approves Prenatal Diagnostic Centers. The approved centers provide genetic counseling and testing including ultrasonography and amniocentesis.

Pregnancy practitioners are required to discuss and offer AFP Screening to all pregnant women in their care who are seen by the 20th completed week (140 days) of pregnancy counting from the first day of the last normal menstrual period. All KHS pregnant members should be offered the AFP test between 15-20 weeks gestational age. Pregnancy practitioners are encouraged to offer screening tests at the first prenatal visit. If the woman declines, she should sign the waiver form provided by the State. (See Attachment B).

Current standards of practice require that all women who meet one of the following conditions be offered amniocentesis at an approved genetic center:

A. Thirty-five (35) years or older at time of estimated date of confinement (EDC)
B. Previously had chromosomally abnormal fetus
C. Known carrier of a recessive metabolic disorder detectable in utero

Amniocentesis requires prior authorization.

2.7.2 Other Genetic Abnormalities

California law requires that all newborns, prior to discharge from the hospital, be screened for phenylketonuria (PKU), sickle cell anemia, galactosemia, related hemoglobinopathies, and primary congenital hypothyroidism. All pregnancy practitioners must distribute the pamphlet *Newborn Screening Test* to pregnant members prior to their estimated date of delivery.[21] (See Attachment C).

2.7.2.1 PKU

Confirmed positive PKU is a CCS eligible condition and all treatment, which includes formula and special food products, pertaining to the metabolic disease is covered under CCS. KHS and CCS collaborate to assure that any KHS newborns with a positive PKU diagnosis are entered into treatment within the first few weeks of life. KHS ensures that members diagnosed with PKU have access to available and accessible practitioners/provider organizations qualified

to treat the condition.[22]

3.0 INDIVIDUALIZED CARE PLAN (ICP[23])

The ICP is an easily reviewed, condensed summary of the maternity services planned and provided to a KHS member during her pregnancy. Member problems, needs, and risk conditions in the following four areas, as well as the interventions planned for each problem/need/risk should be included in the ICP:

A. Obstetrical
B. Nutrition
C. Psychosocial
D. Health Education

The pregnancy practitioner is responsible for ensuring that an ICP is initiated upon the entry into care. The ICP should be developed in consultation with the KHS member after the initial combined assessment has been conducted. In addition to the pregnancy practitioner, health practitioners who provided the services documented on the ICP (e.g., nurse, physician, nutritionist, social worker, health educator, comprehensive perinatal health worker, or physician assistant who saw the patient and made the assessment, performed the treatments, or recommended the interventions) may complete the ICP form. Practitioners must date and initial their assessments, recommendations and interventions.

The ICP should be updated and reviewed, at least at each trimester, postpartum, and as necessary.

A copy of the ICP must be maintained in the member's medical record. The ICP should be available upon request from UM or the KHS Health Education Department.

Pregnancy practitioners who are currently Comprehensive Perinatal Services Program (CPSP) approved, may use their current CPSP approved ICP form. Pregnancy practitioners who are not CPSP approved may contact the (KCDPH) CPSP Coordinator or the Department of Health Care Services (DHCS), Maternal, Child, and Adolescent Health Department (MCAH), for a camera ready copy of the State approved *Comprehensive Perinatal Services Program – Initial Combined Assessment* form. (See Attachment A).

4.0 COORDINATION OF CARE

Every component of the multi-disciplinary system should promote and provide personal attention to the member, and the original practitioner-member relationship should resume when referral or consultative care is no longer necessary.

Pregnancy practitioners should initiate appropriate referrals when a special need is identified requiring multi-disciplinary management. KHS facilitates the multi-disciplinary case management process with timely processing of the referrals for specialty care, education, or counseling, as needed and authorized. See *KHS Policy and Procedure #3.22 - Referral and Authorization Process* for details.

Pregnancy practitioners must ensure that health education, nutrition and psychosocial assessment, reassessments, and interventions are administered by fully qualified personnel. Components of case coordination include the following:

A. Assessments (obstetrical, nutrition, health education and psychosocial)
B. Written individualized care plan based on all assessments which shall be maintained in patient's medical record
C. Appropriate interventions/treatments provided according to the care plan
D. Continuous assessments of patient's status and progress relative to care plan interventions with appropriate revision of the care plan
E. Case conferences or other appropriate communication involving all team members regarding each patient's care
F. Comprehensive record system where all information relating to patient care is documented and is available to all team members
G. Record-sharing system to exchange information among providers and the Plan, especially referrals, consultations, and pregnancy outcomes

KHS and MCAH share a common interest in insuring that maternal and child health services are available to KHS Plan members. KHS and MCAH have the common goal of achievement of the provision of optimal perinatal care for members. To coordinate perinatal care between KHS and MCAH, a Memorandum of Understanding (MOU) with KCDPH has been established to improve members' obstetrical needs.[24]

5.0 REIMBURSEMENT

Pregnancy practitioners receive negotiated contract rates when claims are submitted in compliance with the guidelines outlined in this policy and *KHS Policy and Procedure #6.01 - Claims Submission/Reimbursement.* Practitioners may file a dispute regarding reimbursement decisions through the KHS dispute process as outlined in *KHS Policy and Procedure #6.04 - Practitioner/Provider Disputes Regarding Claims Payment.*

Pregnancy practitioners are required to perform CPSP services without an additional reimbursable fee from KHS. The State mandated CPSP services are included in the KHS reimbursement fee.

Pregnancy practitioners may choose either the Global or Fee-For-Service billing method.

5.1 Global Method

The practitioner may use this method only if all of the following apply:

A. Member was KHS Plan member at the time of the initial visit
B. Member was KHS Plan member throughout the entire pregnancy
C. Providers who bill for global obstetrical care must render at least 8 antepartum OB visits during the member's entire pregnancy
D. The initial pregnancy-related office visits may NOT be counted as one of the eight visits.

The following codes should be used, as appropriate to the services provided, when billing using the global method.

Code	Definition
Z1032	Initial comprehensive pregnancy related office visit

59400	Global antepartum care, vaginal delivery and postpartum care
59510	Global antepartum care, cesarean delivery and postpartum care
59610	Routine OB including antepartum, vaginal birth after C-section, and postpartum
59618	Routine OB including antepartum, cesarean delivery following attempted vaginal deliver after previous cesarean delivery, and postpartum.

5.2 Fee-For-Service Method

Under this method, a separate fee is paid for the initial visit, each antepartum visit, delivery, and the postpartum visits. Although antepartum visits do not require prior authorization, Claims staff enter the expected number of visits into the KHS information system. Visits in excess of the expected number are forwarded to the UM department for review. Visits determined not medically necessary by UM may be denied D8 - Medical Necessity Not Established.

Reimbursement for a delivery includes hospital admission, patient history and physical, management of labor, vaginal or cesarean section delivery, hospital discharge, and all applicable postoperative care. Also allowed an additional postpartum office visit within 6 months of delivery (Z1038)

The following codes should be used, as appropriate to the services provided, when billing using the global or fee-for-service method.

Code	Definition
Z1032-ZL	Initial comprehensive visit in the first trimester
Z-1032	Initial comprehensive visit if not in first trimester
Z1034	Antepartum visit (up to 9)
Z1036	10th Antepartum office visit (10th and above)
Z1038	Postpartum office visit 3-8 weeks post delivery
59409	Vaginal delivery only
59514	Cesarean delivery only

5.3 Non-Contracted Certified Nurse Midwives[25]

KHS must inform Medi-Cal beneficiaries that they have a right to obtain out-of-plan CNM services. If there is no Certified Nurse Midwife (CNM) or Certified Nurse Practitioner (CNP) in the KHS provider network, KHS shall reimburse non-contracting CNMs for services provided to Medi-Cal Members at no less than the applicable Medi-Cal Fee-For-Service (FFS) rates. KHS will provide coverage for freestanding birth center facility services and services rendered by certain professionals providing services in a freestanding birth center. KHS will contract directly with providers in their networks for these services. If that is not a possibility, KHS will arrange to provide such services through out-of-network providers, per contractual and regulatory requirements. For birthing centers, KHS will reimburse no less than the applicable Medi-Cal FFS rate. Hospitals shall be reimbursed as outlined in *KHS Policy and*

6.0 PROVIDER QUALIFICATIONS

With the exception of pregnancy testing and allowed non-contracted CNM services, maternity care may only be provided by network practitioners credentialed specifically as pregnancy practitioners. Practitioners must meet the standards outlined in the table below in order to be considered for pregnancy practitioner credentialing.

Practitioner Type	Minimum Requirements
Physician	• Documented training in either Obstetrics through a certified Obstetrical Residency Program or Family Practice through a certified Family Practice Residency Program OR • Documented post-graduate training and experience comparable with that received in a family practice residency (a minimum of three months with direct supervision); and will be sponsored by an Obstetrician or Family Practice physician.
Mid-level (Registered Nurse Practitioner, Physician Assistant, or Nurse Midwife)	• Documented training in antepartum care • Will be supervised by a Physician who meets the requirements to provide antenatal care

Pregnancy practitioners must demonstrate that their malpractice insurance carrier is aware that they are providing such service.

KHS uses Title 22, CCR, Section 51179.6, for guidelines in assessing pregnancy practitioners and ancillary practitioners for prenatal services. Comprehensive perinatal practitioners may include any of the following:

A. General practice physician
B. Family practice physician
C. Pediatrician
D. Obstetrician-gynecologist
E. Certified Nurse Midwife
F. Registered nurse
G. Nurse practitioner
H. Physician's assistant
I. Social worker
J. Health educator
K. Childbirth educator
L. Registered Dietician
M. Comprehensive Perinatal Health Worker (CPHW) (Medical Assistant or Aide with at least one year's perinatal experience)

Ancillary services staff who may provide services within specific components of CPSP include the following:

A. Geneticists
B. Other medical specialists
C. Public health services
D. Family planning services
E. Substance abuse prevention services
F. Community based organization
G. Community outreach services
H. Agencies providing transportation
I. Domestic Violence units
J. Child protective Services
K. Sweet Success
L. WIC
M. CHDP
N. Translation services
O. Respite care services

If a KHS contracted hospital is unable to provide the full range of perinatal and neonatal services, it must have formalized arrangements for consultation and transfer of high risk mothers or neonates to Kern Medical Center (KMC). The purpose of such an arrangement is to promote comprehensive, continuous, safe, quality perinatal care for the KHS plan member from the antepartum through the intrapartum and the postpartum period. Transfers for members with identified needs should be arranged by treating pregnancy practitioners.

All assessments should be completed by an OB practitioner or staff member who meets the minimum requirements for ancillary staff.[26].

7.0 PROVIDER RESOURCES

7.1 Training

KHS helps to develop training and evaluation, in coordination with MCAH on the standards and requirements of providing comprehensive perinatal services. [27] Pregnancy practitioners who wish to send their staff to CPHW training for certification of training completion, should contact either MCAH at (661) 868-0523 or the Plan's Health Educator.

Pregnancy practitioners who are unfamiliar with the protocols related to the development of an ICP may contact the local MCAH Program's CPSP Coordinator or the KHS Member Health Education Department for technical assistance.

The KHS Health Education Department, Chief Medical Officer, and Administrative Director of Health Services may also assist with perinatal related practitioner training and education either through site technical assistance, updates on local or State training, Newsletters or mailings.

7.2 Materials and Supplies

Pregnancy practitioners can obtain a copy of ACOG standards (seventh edition) and current CPSP regulations (Title 22) either by contacting the State DHCS, Maternal and

Child Health Section or contacting the local MCAH Program for assistance at (661) 868-0523.

Pregnancy practitioners may purchase the Hollister Maternal/Newborn Medical Record System by calling Hollister's toll free telephone number (1-800-323-4060) or contacting the area representative at 1-800-624-5369, ext. 1091. The approximate cost is $120 for 50 pregnancies or $2.50 per patient record.

ATTACHMENTS:

- Attachment A: *Comprehensive Perinatal Services Program – Initial Combined Assessment*
- Attachment B: *Waiver form*
- Attachment C: *Newborn Screening Test*
- Attachment D: *Referral/Prior Authorization Form*

REFERENCE:

Revison 2017-08: APL 16-017 DHCS requirement by Administrative Director of Health Services. **Revision 2015-07:** Policy revised to comply with All Plan letter 15-017. Revisions made by Administrative Director of Health Services. **Revision 2014-06:** OB guidelines updated by Claims Department. New Global billing requirements included. **Revision 2008-10:** Routine review, revisions by Medical Director. **Revision 2005-08:** Routine review. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004). **Revision 2002-11:** Created per DHS request to combine various pregnancy and maternity care policies. This new policy 3.24 replaces the following policies: 2.07 - Multi Disciplinary Management of Pregnancy and Postpartum Conditions; 2.08 - Delivery of Multi-Disciplinary Services; 2.13 - Obstetric Medical Record; 3.24 - Antepartum and Postpartum Care and Genetic Screening; 3.36 - Postpartum Home Health Visits Newborns' and Mothers' Health Act of 1997; 3.55 - Perinatal Improvement Program; 4.07 - Perinatal Provider Credentialing Standards; 4.24 - Antenatal Care; and 6.23 - Obstetric Billing Guidelines. Original version sent to DHS was revised per comment letter 05/13/02.

[2] DHS Contract Section A-9 7
[3] DHS Contract §6.7.6.7; CCR Title 22 §51249
[4] DHS Contract Section A-10 6(A)
[5] CCR Title 22 §51348; 51348.1; 51179; 51179.6
[6] Health and Safety Code §1367.695; DHS Contract Section A-5 2(F)
[7] DHS Contract Section A-9 8(D)
[8] DHS Contract Section A-9 3(A)
[9] DHS Contract Section A-9 3(B)
[10] SB 889-Leslie
[11] ACOG standards and Health Care Management Guidelines by Milliman and Robertson, Inc.
[12] Newborns' and Mothers' Health Act of 1997 (NMHA)
[13] DHS Contract Section A-10 6(B)
[14] CPSP Regulations 51348(e)(1-4)
[15] CPSP Regulations 51348(c)(1-5)
[16] CPSP Regulations 51348(d)
[17] DHS Contract Section A-11 16
[18] DHS Contract Section A-10 6
[19] DHS Contract Section A-10 6
[20] CCR Title 17 §6521-6531. Reviewed against DHS Letter (07/01/05). No revisions necessary.
[21] CCR Title 17 §6504
[22] Language requested by DMHC in comment to 1999 Legislation filing
[23] CCR Title 22 §51179.8; 51348
[24] DHS Contract §6.7.8.1
[25] DHS Contract Section A-8 8

[26] CCR Title 22 §51179.6
[27] CCR Title 22 §51179.6

COMPREHENSIVE PERINATAL SERVICES PROGRAM
Assessment Risk/Strength Summary

Instructions for Use

The Assessment Risk/Strength Summary is designed to be used as a summary of risk/strengths identified on a completed State Initial Combined Assessment (DHS 4455). The form may be completed by any qualified Comprehensive Perinatal Services Program (CPSP) practitioner, as defined in Title 22, Section 51179. The use of this summary sheet is optional.

Purpose

The Assessment Risk/Strength Summary sheet provides a quick visual summary of the risks and strengths of a CPSP client, as identified at the completion of the initial assessment. It is ***not*** a substitute for the Individual Care Plan. The summary has several potential uses, for example:

- Together, the client and practitioner can review risks and strengths, identify priorities, and develop an Individual Care Plan;
- The form, with prior approval, could be used as documentation for a managed care plan of a client's risk and need for interventions;
- Used as a data summary sheet, with information compiled, analyzed, and tracked over time to give a picture of the needs of the clients for a particular practice site.

Procedures/Documentation

The Assessment Risk/Strength Summary sheet is approved to be completed by any qualified CPSP practitioner.

1. Inform the client of the purpose for completing the summary (this may vary by practice setting).
2. Review each section of the Initial Combined Assessment (DHS 4455) and complete the applicable information in the corresponding section of the summary document.
3. For each section, identify client strengths and document them on the form.
4. Most sections have space to identify other risks that are not already listed on the form; document as necessary.
5. Store document as specified for the practice site.

ASSESSMENT RISK/STRENGTH SUMMARY

(To be used in conjunction with DHS 4455, Initial Combined Assessment)

Personal Information
Age: ☐ <12 yr. ☐ 12–17 yr. ☐ 35+ yr.
Resident: ☐ <1 yr.
☐ Children living out of home
☐ _____
Strengths: _____

Economic Resources
☐ No financial support from FOB
☐ Insufficient food supplies
☐ Needs WIC referral
☐ _____
Strengths: _____

Housing
☐ Transient housing
☐ Substandard housing
☐ No phone ☐ Message phone
☐ Weapons in home
Strengths: _____

Transportation
☐ No reliable transportation
☐ Needs referral for infant car safety seat
☐ No seat belt use
☐ _____
☐ _____
☐ _____
Strengths: _____

Current Health Practices
☐ Needs dental care
☐ Medication use since LMP
☐ Chemical exposure
☐ Poor HX using health care system
☐ _____
☐ _____
☐ _____
Strengths: _____

Pregnancy Care
☐ Ambivalent about pregnancy
☐ Unwanted pregnancy
☐ Lacks support for pregnancy, L&D, postpartum
☐ Using natural remedies
☐ HX pregnancy/child losses
☐ HX STI self/partner
☐ Needs referral for discomforts of pregnancy
Strengths: _____

Nutrition
☐ Anthropometric data outside of NL: _____
☐ Biochemical data outside of NL: _____
☐ Clinical conditions outside of NL: _____
☐ Poor appetite
☐ PICA
☐ Special diet: _____
☐ Inappropriate vitamin/mineral use
☐ Unusual dietary practices

☐ HX or current eating disorder
☐ Inadequate diet (24-Hour Recall)
☐ Inappropriate weight gain (grid)
☐ Excessive caffeine intake
Strengths: _____

Infant Feeding
☐ Has never breast-fed
☐ HX problem with breast feeding
☐ Lacks support for breast feeding
Strengths: _____

Coping Skills
☐ Experiencing significant life stressors
☐ HX domestic violence
☐ Victim of violence/sexual abuse: self/children/parents
☐ HX suicidal ideation/attempt
☐ Depression
☐ Inadequate support system
☐ _____
☐ _____
Strengths: _____

Tobacco, Drug, Alcohol Use
☐ Uses tobacco
☐ Current HX alcohol use/abuse
☐ Current HX drug use/abuse
☐ Partner uses/abuses drugs/alcohol
Strengths: _____

Education and Language
Education: ☐ <8 yr. ☐ 9–11 yr.
☐ Non-English-speaking/reading
☐ Low literacy skills
☐ _____
Strengths: _____

Educational Interests
☐ Barriers to attending classes
☐ Mental, emotional, or physical conditions affecting learning
☐ _____
Strengths: _____

Obstetrics
☐ Diabetes, gestational/overt
☐ Chronic/high risk medical condition
☐ VBAC, repeat C-Section
☐ Multiple gestation
☐ Short pregnancy interval

☐ Late entry to care
☐ Hypertension/PIH
☐ Hyperemesis
☐ Urinary tract infection
☐ Underweight/obese pre-pregnancy
☐ Hx preterm labor

☐ Hepatitis B+/HIV+
☐ Rubella negative
☐ Religious restrictions to procedures
☐ _____
☐ _____
☐ _____

COMPREHENSIVE PERINATAL SERVICES PROGRAM

Name
Birth date
I.D. number
EDD

INITIAL COMBINED ASSESSMENT

(Annotated)

PERSONAL INFORMATION

1. Your name: _____
   Serves as a formal identifier in addition to providing an opportunity to determine how the client prefers to be addressed.

2. Age: ☐ Less than 12 years ☐ 12–17 years ☐ 18–34 years ☐ 35 years or older
   Shaded responses typically will require additional referrals: teens may be at high risk medically in addition to possible referral to AFLP/CAL LEARN; older women may need additional genetic evaluation. Refer to "Steps To Take" (STT) Guidelines: Psychosocial–Teen Pregnancy and Parenting.

3. Place of birth: _____
   May give some indication as to the client's cultural background.

4. How long have you lived in this area? ☐ Less than 1 year ☐ 1–5 years ☐ 5+ years ☐ Life
   Individuals who have lived in an area for a short while may be less familiar with community resources and have a weaker support system.

5. Do you plan to stay in this area for the rest of your pregnancy? ☐ Yes ☐ No
   If the client does not intend to remain in the area she will need assistance in arranging for transfer of her care and counselling on the value of adequate prenatal care.

6. Are you: ☐ Married ☐ Single ☐ Divorced/separated ☐ Widowed ☐ Other: _____
   The response may give some indication of the client's support system.

7. Who lives with you in your home?

Name	Relation	Age	Name	Relation	Age

   This response should include all the people she lives with, not just a nuclear family. The response will give you some idea of the client's support system, the reality of her home environment (especially important when considering referrals) and an opportunity to personalize your care by being able to refer to family members by name. Response to this question may be facilitated by having the patient complete this information on a separate piece of paper in the waiting room which can be copied into the chart.

8. Do any of your children or your partner's children live with someone else? ☐ Yes ☐ No ☐ N/A
   If yes, explain: _____
   A "yes" response may give some indication of her parenting skills if children have been formally removed from the home. Children left behind as a result of migration to this country may result in grief issues. See STT Guidelines: Psychosocial–Parenting Stress, New Immigrant.

ECONOMIC RESOURCES

9. Are you currently working? ☐ Yes ☐ No If yes, type of work and hours per week: _____
   "Work" refers to paid efforts that can occur outside the home or within (child care, laundry, sewing, etc.). This information will help the assessor understand the economic resources of the family in addition to possible health risks for the client. It also provides an opportunity to discuss how long she plans to work. See STT Guidelines: Health Education–Workplace and Home Safety.

10. Do you plan to return to work after the baby is born? ☐ Yes ☐ No
    If yes, this is an opportunity to discuss child care plans and make referrals to community resources as appropriate.

11. Will the father of the baby provide financial support to you and the baby? ☐ Yes ☐ No

In addition to adding another piece to the client's economic picture, it also gives some indication of the father's involvement. Consider not just dollar support, but groceries, transportation, etc.

12. Are you receiving any of the following: (Check all that apply.)

	Yes	No	Needs Information/ Referral
a. WIC	☐	☐	☐
b. Food stamps	☐	☐	☐
c. AFDC	☐	☐	☐
d. Emergency food assistance	☐	☐	☐
e. Pregnancy-related disability insurance benefits	☐	☐	☐

All clients on CPSP should be eligible for WIC and should be referred. The other items need to be individually evaluated. For assistance in making these referrals, see STT Guidelines: Psychosocial–Financial Concerns.

13. Do you have enough clothes for yourself and your family? ☐ ☐

If no, see STT Guidelines: Psychosocial–Financial Concerns, for suggestions of resources.

14. Do you or others in your home skip meals due to lack of money? ☐ ☐

If yes, keep this in mind when assessing nutritional status and also see STT Guidelines: Psychosocial–Financial Concerns, and Nutrition–Stretching Your Food Dollar, for suggestions.

HOUSING

15. What type of housing do you currently live in?

☐ Apartment ☐ House ☐ Hotel/motel ☐ Emergency shelter ☐ Public housing
☐ Traller park ☐ Car ☐ Farm worker camp ☐ Other: _____

Shaded responses are usually indicative of inadequate housing or transciency and can have serious impact on the client's health and well-being. Suggestions for referral resources can be found in STT Guidelines: Psychosocial–Financial Concerns.

16. Do you have the following where you live? (Check all that apply.)

	Yes	No		Yes	No		Yes	No
Tub/shower	☐	☐	Stove	☐	☐	Telephone	☐	☐
Electricity	☐	☐	Heat	☐	☐	Hot water	☐	☐
Refrigerator	☐	☐	Toilet	☐	☐	Cold water	☐	☐

Lack of items identified in shaded responses are important to know when providing instruction regarding personal care and nutritional counseling. Lack of a telephone may have important ramifications on the client's ability to report potential complications (preterm labor, urinary tract infection, bleeding, etc.); alternate methods of communication should be identified prior to their need. See also: STT Guidelines: Nutrition–Cooking and Food Storage.

17. Do you feel your current housing meets your basic needs? ☐ Yes ☐ No

Although previous questions should give the assessor a general sense of the adequacy of the client's home, this question permits the client to make her own assessment. What may seem inadequate to the assessor may not be a problem for the client.

18. Do you feel safe in your home? ☐ Yes ☐ No

If no, why not? _____

Again, this question provides the client with an opportunity to express her own concerns and needs. In this case, "safety" refers to the environment (substandard housing, gang activity, drug-dealing, etc.) rather than domestic violence.

19. If there are guns in your home, how are they stored? _____

Guns should be kept in locked storage, preferably with trigger locks. This question may also include discussion about other dangerous weapons such as knives.

TRANSPORTATION

20. Will you have problems keeping your appointments? ☐ Yes ☐ No

    If yes, is the problem: ☐ Transportation ☐ Child care ☐ Work ☐ School ☐ Other: _____

    Important information to consider when making medical and support service appointments and for referrals.

21. When you ride in a car, how often do you use seat belts? ☐ Always ☐ Sometimes ☐ Never

    An opportunity to determine if a discussion of the importance and proper use of seat belts is needed.

22. Will you be able to get a car safety seat for the new baby by the time it is born? ☐ Yes ☐ No

    If no, this is an opportunity to determine if education is needed regarding the CA Carseat Safety laws and make referrals to local resources. See also STT Guidelines: Health Education–Infant Safety and Health.

CURRENT HEALTH PRACTICES

23. Have you ever had trouble finding a doctor or getting necessary treatment for yourself or your family? ☐ Yes ☐ No

    If yes, please explain: _____

    Difficulties with the health care system in the past may impact how the client perceives her current care and how she responds to referrals.

24. Have you been to the dentist in the last year? ☐ Yes ☐ No

    If no, assist client to arrange dental care (see your provider's application for dental resources). Poor dental health can seriously impact the pregnant woman from chronic infection to impaired eating ability.

25. What do you do for exercise? _____ How often? _____

    Regular exercise can give the client a sense of well-being and relaxation. For suggestions and cautions regarding exercise in pregnancy, see STT Guidelines: Health Education–Safe Exercise and Lifting.

26. Since you became pregnant have you used any over-the-counter medications? ☐ Yes ☐ No

    If yes, what? _____ How much? _____ How often? _____

    If yes, this is an opportunity to instruct the client on the hazards of OTC medications, and an opportunity to evaluate the need for medical evaluation of the condition for which she uses OTC's. For additional suggestions see STT Guidelines: Health Education–Drug and Alcohol Use.

27. Since you became pregnant have you used any prescription medications? ☐ Yes ☐ No

    If yes, what: _____ How much? _____ How often? _____

    If yes, see question 26 and make sure the medical provider is aware of this information.

28. In your home, how do you store: ☐ Vitamins _____

    ☐ Medications _____ ☐ Cleaning agents _____

    All medications, even seemingly "mild" medications such as as vitamins and iron, should be stored in a secure location, such as a locked cabinet, if there are children in the home. Purses are not considered secure. Cleaning agents should be stored in their original containers, away from food, and secure from children. Plan the client's education according to her safety knowledge and habits.

29. Do you have exposure to chemicals:

    a. At work? ☐ Yes ☐ No If yes, what? _____

    b. At home? ☐ Yes ☐ No If yes, what? _____

    c. With hobbies? ☐ Yes ☐ No If yes, what? _____

    If yes, see STT Guidelines: Health Education–Workplace and Home Safety.

PREGNANCY CARE

30. Was this pregnancy planned? ☐ Yes ☐ No

31. How do you feel about being pregnant now? _____

32. Are you considering: Adoption? ☐ Yes ☐ No Abortion? ☐ Yes ☐ No

    Questions 30, 31, and 32 will provide the assessor with information about the client's feelings regarding this pregnancy. For the client who is still ambivalent and/or considering adoption or abortion, refer to STT Guidelines: Psychosocial–Unwanted Pregnancy, for suggestions.

33. How does the father of the baby feel about this pregnancy? _____

a. Your family? _____

b. Your friends? _____

Responses to these questions will provide the assessor with information regarding the client's support system and stressors she may be facing.

34. Do you have any of the following problems now? (Check all that apply.)

	Yes	No		Yes	No
a. Swelling of hands or feet	☐	☐	h. Heartburn	☐	☐
b. Constipation	☐	☐	i. Backache	☐	☐
c. Fatigue/sleeping problems	☐	☐	j. Vomiting	☐	☐
d. Vaginal discharge/bleeding	☐	☐	k. Nausea	☐	☐
e. Varicose veins	☐	☐	l. Headaches	☐	☐
f. Hemorrhoids	☐	☐	m. ☐ Other _____		
g. Leg cramps	☐	☐	_____		

Evaluate "yes" responses on the basis of practice protocols. If appropriate for the assessor, many of these conditions can be addressed by suggestions as outlined in STT Guidelines: Nutrition.

35. In comparison to your previous pregnancies, is there anything you would like to change about the care you receive?

☐ Yes ☐ No ☐ N/A Please explain: _____

"Yes" answers provide assessor with information about past care that was not helpful to client so that these issues can be avoided with this pregnancy (if possible).

36. Do you have any traditional, cultural, or religious customs about pregnancy and childbirth you would like supported?

☐ Yes ☐ No Please explain: _____

Acknowledgement and support of cultural and religious customs important to the client will result in a client who will participate in her care. In some cases these customs may be in conflict with medical care, and it is important to evaluate these situations with the medical provider. For additional suggestions see STT Guidelines: First Steps–Cultural Considerations.

37. Who gives you the most advice about your pregnancy? _____

38. What have you been told that you think is important? _____

_____

Questions 37 and 38 will identify who should also be involved in the client's care. It will be very difficult to provide perinatal education if your information conflicts with this person's advice.

39. Do you use any natural or herbal remedies (example: ginseng, manzanilla, greta, magnesium, yerba buena)?

☐ Yes ☐ No If yes, what and how often: _____

Herbal remedies need to be evaluated for potential harmful effects on the fetus.

40. Do you plan to have someone with you:

a. During labor? ☐ Yes ☐ No ☐ Do not know

b. When you first come home with the baby? ☐ Yes ☐ No ☐ Do not know

If the client cannot identify a support person for labor, the assessor should begin to explore possible resources for both the labor period and childbirth preparation classes. If no support in the immediate postpartum period, this is an opportunity to help the client explore who will be available to help her care for herself, the newborn, including breastfeeding, and other children, if any. See STT Guidelines: Psychosocial–Parenting Stress.

41. If you had a baby before, where was that baby(s) delivered?

☐ Hospital ☐ Clinic ☐ Home ☐ Other _____

Were there any problems? ☐ Yes ☐ No

If yes, please explain: _____

An opportunity to identify problems and plan to avoid them with this pregnancy and/or identify positive experiences to draw upon.

42. Have you had any losses in past pregnancies such as:

	Yes	No		Yes	No		Yes	No
Miscarriages	☐	☐	Adoption	☐	☐	Abortion	☐	☐
Stillborn	☐	☐	SIDS	☐	☐			

If yes, what/who helped you get through this? _____

The client may have unresolved grief issues that can impact this pregnancy and the care of the newborn. It also identifies some strengths that may be helpful in addressing current issues. For additional suggestions see STT Guidelines: Psychosocial–Perinatal Loss.

43. If you have had other children, are they still living? ☐ Yes ☐ No ☐ N/A
If no, please explain: _____

Again, identifies possible unresolved grief issues and/or fears that may affect this pregnancy. See also question 42.

44. Besides having a healthy baby, what are your goals for this pregnancy? _____

An empowerment opportunity for the client. With assistance from the assessor, the client may be able to use this opportunity to make personal changes in her life, rather than focusing in on only a goal of "a healthy baby."

45. Do you plan to use a method of birth control after this pregnancy? ☐ Yes ☐ No ☐ Undecided
If yes, what method: ☐ Birth control pill ☐ Diaphragm ☐ Norplant ☐ IUD
☐ Foam and/or condoms ☐ Natural Family Planning ☐ Abstinence ☐ Sterilization ☐ Depoprovera

Each client should have the opportunity to make a fully informed decision about what method, if any, she wants to use postpartum. See STT Guidelines: Health Education–Family Planning Choices, for suggestions.

46. Have you ever had a sexually transmitted infection, such as gonorrhea, syphilis, chlamydia, herpes? ☐ Yes ☐ No
a. If yes, what and when: _____
b. Has your partner had a sexually transmitted infection? ☐ Yes ☐ No ☐ Do not know

47. Information given on HIV transmission, risk reduction behavior modification, methods to reduce the risk of perinatal transmission; counseling and referral to other HIV prevention and psychosocial services as needed; and referral for HIV testing. ☐ Yes ☐ No Initials: _____

Current state regulations require that all pregnant women, not just those who are at risk, receive counseling on the benefits of HIV testing and pregnancy, treatments available to women who test positive, and referral for HIV testing. This item permits the provider/practitioner to document that they have provided the woman the required services. For additional suggestions on providing HIV education, see STT Guidelines: Health Education–HIV and Pregnancy.

NUTRITION

48. Anthropometric data: (Complete the following.) Height _____ Current weight_____ Date_____
☐ Prepregnancy weight _____ ☐ Normal ☐ Underweight ☐ Overweight ☐ Very overweight
☐ Weight gain goal _____ ☐ Net weight gain _____ ☐ Adequate ☐ Inadequate ☐ Excessive
☐ Weight gain in previous pregnancies: lbs _____ ☐ Unknown ☐ N/A ☐ Weight grid plotted

This information helps determine weight gain goals for the pregnancy and necessary nutritional education. STT Guidelines can provide assistance in helping the assessor complete the weight gain grid and determining weight gain goals. Women who begin pregnancy underweight or overweight may need more comprehensive nutrition care.

49. Biochemical data: (Complete the following.)
☐ Blood: Date _____ Hgb/Hct _____ MCV_____ Glucose Screen _____
☐ Urine: Date _____ (Circle) Glucose + – Ketones + – Protein + –

Abnormal values need to be brought to the medical provider's attention and a plan developed to address needs.

50. Clinical data: (Indicate if any of the following apply.)
☐ Short pregnancy interval ☐ Anemia ☐ Diabetes: ☐ Prepregnancy ☐ Past pregnancy
☐ Serious infection ☐ Dental disease ☐ Hypertension: ☐ Prepregnancy ☐ Past pregnancy
☐ Hx low birth weight baby ☐ High parity (>4) ☐ Currently breastfeeding
☐ Age 17 years or less ☐ Digestive problems ☐ Hx intrauterine growth retardation
☐ Other medical/obstetrical problems: ☐ Past _____ ☐ Current _____

All of the above information has important implications in developing a nutritional care plan for the client. Site specific protocols should be reviewed to determine appropriate care, STT Guidelines: Nutrition–Prenatal Vitamin and Minerals, Iron and Calcium, can also offer suggestions for appropriate education and referrals.

51. Do you take prenatal vitamins? ☐ Yes ☐ No Do you take iron? ☐ Yes ☐ No Other? ☐ Yes ☐ No

52. How would you describe your appetite? ☐ Good ☐ Fair ☐ Poor
Do you sometimes feel you can't stop eating? ☐ Yes ☐ No
Requires additional probing to determine if the client has concerns about or is experiencing an eating disorder.

53. Have your eating habits changed since you became pregnant? ☐ Yes ☐ No
If yes, please explain: _____
Provides additional context to her response to question 52. It is important to know that a client's appetite was poor before she became pregnant vs. the client whose appetite changed as a result of pregnancy.

54. How many times per day do you usually eat? _____
Permits the assessor to develop nutritional recommendations that "fit" with the client's usual habits.
Do you have questions or concerns about your weight and/or weight gain during pregnancy? ☐ Yes ☐ No
If yes, please list: _____
Permits assessor to emphasize an appropriate weight gain goal. See STT Guidelines: Nutrition–Weight Gain During Pregnancy.

55. Have you had cravings for or eaten any of the following? (Circle all that apply.) ☐ Yes ☐ No
laundry starch freezer frost cornstarch clay paste plaster dirt other_____
"Yes" answers require evaluation to determine the extent of the problem and need for referral to the medical provider. Additional suggestions are in STT Guidelines: Nutrition–Pica, Possible Problems From Pica.

56. Do you have any food allergies? ☐ Yes ☐ No If yes, please explain: _____
Are there any foods or beverages you avoid? ☐ Yes ☐ No If yes, please explain: _____
Requires evaluation as to impact on appropriate perinatal diet. See STT Guidelines: Nutrition–Lactose Intolerance, for additional suggestions.

57. Are you on a special diet? ☐ Yes ☐ No
If yes, what kind? ☐ Weight loss ☐ Low salt ☐ Low fat/cholesterol ☐ Vegetarian ☐ Diabetic
☐ Other: _____
Requires evaluation as to impact on perinatal nutritional needs and development of client specific nutritional education. May also require referral for medical nutrition therapy.

58. If vegetarian, do you eat: ☐ Milk and dairy products ☐ Fish/chicken ☐ Eggs
Not all individuals define "vegetarian" in the same way. This question identifies the specifics of your client's vegetarian diet.

59. How many cups of the following do you drink in a day? _____ regular coffee _____ regular tea _____ sodas
General fluid intake is important for proper metabolic functioning. The specific beverages imbibed can indicate sources of excess sugars or caffeine. High diet soda intake may be as a result of a fear of having a larger baby and a perceived more difficult birth.

60. Who usually does the following in your home? Buys food: _____ Prepares food: _____
This information will provide the assessor with some indication as to the control the client has over what food is purchased and how it is prepared.

61. Dietary intake: (check all that apply)

LOW	__ Vitamin A	__ Vitamin C	__ Other fruits and vegetables		__ Bread/grain/cereal	
	__ Protein	__ All groups	__ Fluid	__ Milk	__ Iron	__ Fiber
EXCESS	__ Fat	__ Sugar	__ Salt	__ High Kcal.		

Excess: fat, sugar, salt, high Kcal

INFANT FEEDING

62. If you have other children, did you breastfeed, or try to breastfeed them? ☐ Yes ☐ No ☐ N/A
Did you have trouble breastfeeding? ☐ Yes ☐ No How long did you breastfeed? _____
Provides an opportunity to build on previous positive experiences and/or evaluate difficulties and provide education to support breastfeeding. For additional suggestions, see STT Guidelines: Nutrition–Breastfeeding reference.

63. How are you planning to feed your new baby?
☐ Breast ☐ Formula ☐ Both breast and formula ☐ Other: _____ ☐ Do not know
All women should be provided basic breastfeeding information so they can make an informed decision. The client who plans to give both breast and formula may be inadvertently sabotaging her breastfeeding efforts and probably needs additional assistance in clarifying her decision. See STT Guidelines: Health Education–Infant Feeding Decision-Making.

WIC REFERRAL

_____ _____
Provider signature Date

COPING SKILLS

64. In the past month, how often have you felt that you could not control the important things in your life?
Have you felt that way: ☐ very often ☐ often ☐ sometimes ☐ rarely ☐ never
This question permits the client to give her evaluation of her emotional status. Shaded responses should be further explored to determine if this is a long-standing issue or more related to the emotional swings of early pregnancy.

65. What things in your life do you feel good about? _____
Provides that assessor with an opportunity to build on positives in the client's life.

66. Are you currently having any of these problems: (Check all that apply.)

	Yes	No		Yes	No
a. Financial difficulties	☐	☐	f. Unemployment	☐	☐
b. Housing problems	☐	☐	g. Immigration	☐	☐
c. Divorce/separation	☐	☐	h. Legal	☐	☐
d. Recent death	☐	☐	i. Probation/parole	☐	☐
e. Illness	☐	☐	j. Child Protective Services	☐	☐

Any "yes" responses can provide stress for the client. Suggestions for referrals can be found in STT Guidelines: Psychosocial–Financial Concerns, Legal/Advocacy Concerns, New Immigrant, Depression.

67. What things in your life would you like to change? _____
Provides information on patient hopes and values. Changes that can be attached to these values have a higher probability of success.

68. What do you do when you are upset? _____

69. What do you and your partner do when you have disagreements? _____

70. Do you ever feel afraid or threatened by your partner? ..... ☐ Yes ☐ No
If yes, please explain: _____

71. Within the last year have you been hit, slapped, kicked, or physically hurt by someone? ..... ☐ Yes ☐ No
If yes, please explain: _____

72. Have you ever been a victim of violence and/or sexual abuse? ..... ☐ Yes ☐ No

73. Have your children ever been victims of violence and/or sexual abuse? ..... ☐ Yes ☐ No

74. Have your parents been victims of violence and/or sexual abuse? ..... ☐ Yes ☐ No
Questions 67–73 help the assessor determine the potential and/or presence of domestic violence in the client's relationships. Interventions should be based on legal mandates and practice specific protocols. Additional information is available in STT Guidelines: Psychosocial–Spousal/Partner Abuse.

75. Do you ever get depressed? ..... ☐ Yes ☐ No

76. Have you ever felt so bad you planned or attempted suicide? ..... ☐ Yes ☐ No

77. Have you ever talked to a counselor? ..... ☐ Yes ☐ No
If yes, please explain: _____

78. Would you feel comfortable talking to a counselor if you had a problem? ..... ☐ Yes ☐ No
Provides information on patient's history of serious mental illness and what range of referrals might be possible. For additional information, see STT Guidelines: Psychosocial–Emotional or Mental Health Concerns, Depression.

TOBACCO, DRUG, AND ALCOHOL USE

79. Do you smoke cigarettes? ..... ☐ Yes ☐ No
If yes, how many cigarettes per day? _____ for how many years? _____
It is important to document carefully the client's smoking history, not just whether she smokes or not. Interventions for someone who smokes one–two cigarettes/week are likely to be different from someone who smokes two packages/day.

80. Are you exposed to secondhand smoke at home or at work? ..... ☐ Yes ☐ No
Secondhand smoke can have serious effects on both the mother and the fetus. To help the client identify such exposure and develop a plan to avoid such exposure , see STT Guidelines: Health Education–Secondhand Tobacco Smoke.

81. Are you using chewing tobacco? ..... ☐ Yes ☐ No
The woman who uses chewing tobacco avoids possible lung problems, she and her fetus are still exposed to the harmful effects of nicotine. Some of the suggestions in STT Guidelines: Health Education–Tobacco Use, may also be helpful for this client.

82. If you smoke cigarettes or chew tobacco, have you:

☐ Considered quitting ☐ Set a definite date to quit ☐ Decided to cut down ☐ Decided not to quit at this time

The education and support you provide a client around tobacco use varies in relation to desire to quit. For suggestions for each of the above situations, see STT Guidelines: Health Education–Tobacco Use.

83. How often do you drink alcohol (beer, wine, wine coolers, hard liquor, mixed drinks)?

☐ Daily ☐ Weekends ☐ 1–2 times per month ☐ Rarely or never

84. Have your alcohol habits changed since you got pregnant? ☐ Yes ☐ No
If yes how? _____

85. Are you interested in stopping or cutting down while you are pregnant? ☐ Yes ☐ No

86. Have you ever used street drugs (marijuana, cocaine, PCP, crack, speed, crank, ice, heroin, LSD, other)? ☐ Yes ☐ No
a. If yes, what: _____ How often? _____
b. Are you interested in quitting? ☐ Yes ☐ No

Questions 82–85 provide information on the client's previous and past use of drugs and alcohol. To assist the client in deciding to quit and support her through that process, see STT Guidelines: Health Education–Drug and Alcohol Use.

87. If your partner uses drugs or alcohol, does this create problems for you? ☐ Yes ☐ No
The client may not use drugs or alcohol but her partner may and this can cause significant problems for her: stress, domestic violence, misuse of family income, etc. See pertinent sections of STT Guidelines for additional suggestions.

EDUCATION AND LANGUAGE

88. Years of education completed: ☐ 0–8 years ☐ 9–11 years ☐ 12–16 years ☐ 16+ years

Determining the client's level of education may give the assessor some idea as to the client's reading and comprehension levels, although this will probably require additional evaluation.

a. Are you currently enrolled in school? ☐ Yes ☐ No ☐ N/A
b. Will you return to school after the baby is born? ☐ Yes ☐ No ☐ N/A

These questions are particularly important for teen clients, who should be encouraged to participate in school pregnant minor programs. Older clients who have not completed high school or equivalence may want to consider attending night school or other independent learning centers particularly if they are interested in achieving changes in their lives.

89. What language do you prefer to speak: ☐ English ☐ Other _____

90. What language do you prefer to read: ☐ English ☐ Other _____

To achieve maximum benefit from interventions and education, services must be presented in a spoken or written language that is understandable to the client. For additional suggestions, see STT Guidelines: First Steps–No Language in Common with Staff, Low Literacy Skills (for those patients with low or no reading ability in any language).

91. Which of the following best describes how you read:

☐ Like to read and read often ☐ Can read but do not read often ☐ Do not read

The client's ability to read is separate from her interest in reading. Providing written materials to someone who does not read or who does not like to read is inappropriate. Written materials at a high reading level may also be inappropriate.

EDUCATIONAL INTERESTS

92. Do you have experience with or have you received education in any of the following topics in the past (Column A—Do you know about?), or would like additional information during this pregnancy (Column B—Would you like more information?); both columns may be marked:

TOPIC	COLUMN A Have Previous Experience/ Do You Know About?	COLUMN B Would You Like More Information?
How your baby grows (fetal development)		
How your body changes during pregnancy		
Healthy habits for a healthy baby		
What you should eat while you are pregnant		
Gaining weight in pregnancy		
What happens during labor and delivery		
What you need to know about preterm (premature) labor		
Hospital tour		
How to take care of yourself after the baby comes		
Breastfeeding		
Infant feeding		
Circumcision		
Helping your other children get ready for the new baby		
Information about car seats/passenger safety		
How to take care of your baby and keep it safe		

The educational plan for the client should be based on her interests, previous education, and experience.

93. Will you have any difficulties (language/transportation) scheduling/attending classes? ..... ☐ Yes ☐ No

94. Will someone be able to attend classes with you? ..... ☐ Yes ☐ No
Who? _____
Your practice may have a fine education program but it will not help the client who is not able to attend such classes. The impact of the education will be enhanced if someone can attend with her, and support information given when she is at home.

95. Is there anything special you would like to learn about? _____
This offers the client an opportunity to customize her education.

96. How do you like to learn new things? (Check all that apply.)
☐ Read ☐ Talk one-on-one ☐ Group education ☐ Pictures and diagrams
☐ Watch a video ☐ Being shown how to do it ☐ Other _____
The client will learn best if material is presented in a manner that is most acceptable to her.

97. Do you have any mental, emotional, or physical conditions, such as learning disabilities, Attention Deficit Disorder, depression, hearing, or vision, that may affect the way you learn? ..... ☐ Yes ☐ No
If yes, please explain: _____
Again, if the client has any of these problems, her education may have to be tailored to her specific needs to be of value to her.

In developing a health education plan, also consider:

☐ Does the client have a medical problem or other risk factors related to pregnancy that requires education (i.e.: history of genetic disorder, diabetes, previous preterm labor, hypertension, etc.). This information may be located on the obstetric medical history form and/or question 50.

These issues may require specialized education.

Assessment completed by:

Name _____ Date _____ Minutes _____

Title _____

PATIENT'S COPY

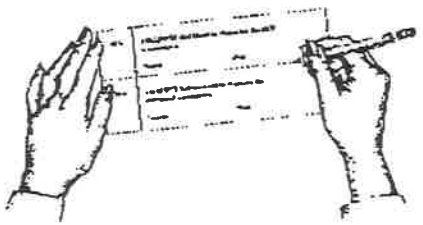
Patient's name_____
(Please print)

ID#_____

CONSENT/REFUSAL

FOR THE CALIFORNIA EXPANDED AFP SCREENING PROGRAM

1. I have read the information about the **California Expanded AFP Screening Program** which is contained in this booklet (or have had it read to me by_____).
2. I have been informed that:
   a) the purpose of the California Expanded AFP Screening Program is to detect most fetuses with neural tube defects, abdominal wall defects, Down syndrome, and trisomy 18. However, not all such defects can be detected by the Program.
   b) there are other birth defects that cannot be detected by this Program.
   c) if the result is "screen positive", I will need to make a decision regarding follow-up testing. Authorized follow-up tests are covered by the Program and will be discussed with me in more detail.
   d) if the result is "screen negative", the Program will not pay for any follow-up testing.
   e) if the fetus is found to have a birth defect, the decision to continue or terminate the pregnancy will be entirely mine.
   f) participation in the California Expanded AFP Screening Program is voluntary. I can refuse any tests at any time.



(over)

3. I have read the detection rates for certain birth defects as they are described in this booklet.
4. I have been informed that a blood specimen for the California Expanded AFP Screening Program is only reliable between 15 and 20 weeks of pregnancy.
5. I have had my questions answered to my satisfaction.

YES	I request that blood be drawn for the Expanded AFP Screening Program. Signed_____ Date_____ I should have my blood drawn between _____ and _____ month day year month day year
NO	I request that blood <u>not</u> be drawn for the Expanded AFP Screening Program. Signed_____ Date_____

I understand that the blood specimen and information obtained during the testing process become the property of the California Department of Health Services. They may be used for program evaluation or research by the Department or Department-approved scientific researchers without identifying the person or persons from whom these results were obtained, unless I specifically prohibit such use in writing. All information procured by the Department of Health Services, or by any other person, agency or organization acting jointly with the Department in connection with such special studies, shall be confidential. I may obtain additional information about the study or prohibit the use of my specimen by writing George Cunningham, MD, MI Genetic Disease Branch, 2151 Berkeley Way, Annex 4, Berkeley, CA 94704.

If new information becomes available about a birth defect detected during this pregnancy, the information may be sent to me unless I specifically prohibit it by writing to George Cunningham, MD, MPH at the above address.

A Test Your New Baby Must Have

Soon after birth, your baby will have a blood test. In California, the law requires that your baby have this Newborn Screening Test for:

- PKU
- Galactosemia
- Hypothyroidism
- Sickle Cell Disease and other Hemoglobin Diseases

Your baby will also need regular well-baby care to check for other health problems.

Make Sure Your Baby Is Tested

Babies can look very healthy at birth and still have one of these disorders. That is why your baby will be tested before leaving the hospital. Ask your doctor or midwife to make sure the test is done.

Babies not born in the hospital must also have this test. It should be done before your baby is six days old. Call your doctor or health department to have your baby tested.

The Test Is Safe

A few drops of blood will be taken from your baby's heel. This is a simple and safe test. The blood will be sent to a State approved lab for testing.

How Much Does The Test Cost?

The fee is subject to change. Please check with your doctor or hospital for the current cost of the test. Medi-Cal, health plans and most private insurance will pay for the test.

How Can I Get The Results?

You can get the test results from your baby's doctor or clinic. It takes about two weeks. If your baby needs more tests you will get a letter or phone call.

If you move after the test is done, make sure your baby's doctor or the clinic staff has your new address and phone number.

Can I Say No To The Test?

You can only say no for religious reasons. If you say "no" you must sign a special form that says your hospital, doctor and the clinic staff are not responsible if your baby develops problems from these disorders.

Early Treatment Can Prevent Serious Problems

These disorders can cause serious health problems. But early treatment can help your baby. Free diagnosis for positive tests is available at a California Childrens Services-approved hospital in your area.

- PKU (Phenylketonuria)

Babies born with PKU have problems when they eat foods high in protein like milk, including breast milk and formula, meat, eggs and cheese. Without treatment these babies become mentally retarded.

- Galactosemia

Babies with this disorder cannot use [illegible] of the sugars in milk, formula, and breast milk and other foods. This disorder harms the baby's eyes, liver and brain. A special diet can prevent these problems.

- Hypothyroidism

Babies born with this problem lack a thyroid hormone. Without this hormone they grow very slowly and become mentally retarded. This can be prevented by giving the baby special medicine every day.

- Sickle Cell Disease and other Hemoglobin Diseases

These diseases affect the baby's red blood cells. These babies can get very sick and even die from common infections. Most infections can be prevented with antibiotics. Affected babies also need lifelong care for problems caused by the diseases.

The information collected in this program is maintained by the Department of Health Services Genetic Disease Branch, 2151 Berkeley Way, Berkeley, CA 94704, (510) 540-2534. The chief of the Genetic Disease Branch is George Cunningham, M.D. Information is collected under the authority of the Health and Safety Code Sections 150,151, 211.1 and 309 and is used to identify infants at risk of birth defects in order to develop programs to prevent such defects. Provision of this information is required by law (17 CCR 6500 through 6507) and if not provided, could result in death or permanent handicap for affected infants.

Unless the person or his/her legally authorized representative specifically prohibits such use in writing, the blood specimen and information obtained during the testing process becomes the property of the State and may be used for program evaluation or research by the Department or Department-approved scientific researchers to improve the health of mothers and children. Such studies are published without identifying the person or persons from whom th results were obtained.

AMERICANS WITH DISABILITIES ACT
Notice and Information Access Statement
Policy of Nondiscrimination on the Basis of Disability and Equal Employment Opportunity Statement

The Department of Health Services, State of California does not discriminate on the basis of disability in employment or in the admission and access to its programs or activities.

Pliney A. Young, Deputy Director, Office of Civil Rights, 714 P Street, Room 1050, Sacramento, CA 95814 has been designated to coordinate and carry out the agency's compliance with the nondiscrimination requirements of Title II of the Americans with Disabilities Act (ADA). Information concerning the provisions of the ADA, and the rights provided thereunder, are available from the ADA Coordinator.

Attachment C

nbs-ip Governor Pete Wilson

Kern Family Health Care
The Friendly Face
Of Kern Health Systems

Referral/Prior-Authorization Form
Phone: 661/664-5083
Fax: 661/664-5190

Please Check Type: ❑ Routine ❑ Urgent/Expedited
Please Check Product: ❑ KFHC Medi-Cal

PLEASE PRINT **Member Information: (Complete in full)**

Patient Name: Alternate Contact Information:

Address City State Zip Daytime Phone

KFHC Member ID# DOB: Age: CCS Eligible Condition: YES NO

Alternate ID# CCS Open Case #:

PLEASE PRINT **Facility / Provider Information: (Complete in full)**

Requesting Provider: Phone: Fax:

Address:

Provider Signature: Date:

Requested Service(s): ICD-10 Code(s) _____

CPT Code(s) _____

Facility _____

❑Patient Request

❑Allergy	❑Endocrine	❑Hem/Onc	❑Neurology	❑ Orthopedics	❑Podiatry	❑Urology
❑Cardiology	❑ENT	❑Home Health	❑Neurosurgery	❑Pain Mgmt	❑Radiology	
❑Dermatology	❑GE/GI	❑Mental Health	❑OB/GYN	❑Pharmacy	❑Rheumatology	
❑DME	❑General Surgery	❑Nephrology	❑Ophthalmology	❑ Physical Therapy	❑Pulmonology	

Requested Provider: Phone: Fax:

Address:

INFORMATION BELOW **MUST** BE COMPLETED TO PROCESS SERVICE REQUEST

Diagnosis / Clinical Problem:

Clinical History / Date of Onset:

KFHC Date Rec'd Stamp

To facilitate processing of request, please attach clinical documentation including progress notes, reports, labs, imaging, etc. (Total additional pages _____)

For Kern Family Health Care Use ONLY:

❑Approved ❑Denied ❑Modified ❑Withdrawn ❑Delayed ❑Duplicate Request ❑Disenrolled

Auth # _____

❑ Commentary/UM Criteria Not Met: _____

_____

Reviewer Signature _____ Date _____

PCP _____

AUTHORIZATION CONTINGENT UPON ELIGIBILITY ON DATE OF SERVICE Eligibility Date _____

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Prior Authorization Services and Procedures				POLICY #: 3.25-P	
DEPARTMENT: Utilization Management					
Effective Date: 2005-11	Review/Revised Date: 09/11/2017	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 9/11/17

Chief Medical Officer — Date 9/8/17

Chief Operating Officer — Date 9/6/17

Director of Claims — Date 8/29/17

Administrative Director of Health Services — Date 8/23/17

POLICY:
Procedures/Services included on the *Prior Authorization List* require prior authorization or submission of a Referral/Authorization to KHS in order for claims to be paid for eligible members. All service and procedure request require submission of a *Referral/Prior Authorization form* for approval and/or tracking purposes.

PROCEDURE:
Authorization paperwork is required of the provider for services indicated on the *Prior Authorization* list. Providers are responsible to determine whether a service is on the aforementioned list requiring prior authorization. If prior authorization is not required as indicated by the procedures absence from the prior authorization list, the provider may directly refer a member for services without submitting a *Referral/Prior Authorization Form, either via the online provider portal or fax* at 661-664-5190 to the KHS UM Department. Providers may make an appointment or make arrangements for eligible

KFHC members to receive services by KHS contract providers. The Prior Authorization list can be accessed via the Kern Health Systems website at *http://www.kernfamilyhealthcare.com/files/PA_List.pdf.*

The table below lists additional services that are automatically paid if the listed restrictions are met.

SERVICE	RESTRICTIONS	ICD-9/CPT CODES
Abortion Services	Prior authorization required for inpatient hospitalization See *KHS Policy and Procedure #3.21 – Family Planning Services and Abortion*	
Family Planning	See *KHS Policy and Procedure #3.21 - Family Planning Services and Abortion* Medi-Cal Members may see any qualified contracted or non-contracted provider.	
Pregnancy Care	The provider must comply with the utilization protocols related to authorization of additional care scheduled after the member's initial visit. Prior authorization is required for specialty procedures in the OB/GYN area (e.g., amniocentesis and hysterectomy) See *KHS Policy and Procedure #3.24 - Pregnancy and Maternity Care*	

REFERENCE:

Revision 2017-08: Updated by Administrative Director of Health Services to include new language and link to new Prior Authorization list. **Revision 2015-03:** Attachment revised by Administrative Director of Health Services. **Revision 2011-11:** Attachment A revised by Director of Health Services. New Attachment D Pediatrics no Authorization list added. **Revision 2011-08:** No revision to policy. Attachment A update by Director of Health Services. **Revision 2010-10:** Routine review, updated Attachment A – No Authorization list. **Revision 2006-05:** Revised Attachment A. Revision 2005-11: Revised Attachment A. Revision 2005-06: Created per CEO request.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Continuity of Care by Terminated Providers				POLICY #: 3.39-P	
DEPARTMENT: Health Services - Utilization Management					
Effective Date: 2000-07	Review/Revised Date: 08/31/2017	DMHC	X	PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 8/31/17

Chief Medical Officer — Date 8/31/17

Chief Operating Officer — Date 8/29/17

Director of Provider Relations — Date 8/28/17

Administrative Director of Health Services — Date 8/24/17

POLICY[1]:

Continuity of care will be provided in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources:

- California Health and Safety Code §§ 1373.65; 1373.95; and 1373.96

Upon member request, KHS' Utilization Management (UM) Department will utilize the guidelines outlined in this policy and procedure to authorize as appropriate continuity of care with a terminated provider. The UM Department and KHS Chief Medical Officer or designee will collaborate with the terminated provider to initiate the transfer of the member to a contracted provider as soon as the

transfer can occur safely or as soon as it has been determined that agreement can not be reached with the terminated provider.

Continuity of care will not be authorized with a provider whose contract has been terminated or not renewed for reasons relating to medical disciplinary cause or reason[2] or fraud or other criminal activity.[3]

DEFINITIONS:

Acute condition[4]	Medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.
Individual Provider[5]	A person who is licensed as defined in Section 805 of the Business and Professions Code or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.
Provider[6]	Any professional person, organization, health facility (including a hospital), or other person or institution licensed by the state to deliver or furnish health care services.
Provider group[7]	Includes a medical group, independent practice association, or any other similar organization.
Serious chronic condition[8]	Medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following: A. Persists without full cure or worsens over an extended period of time B. Requires ongoing treatment to maintain remission or prevent deterioration
Terminal Illness[9]	An incurable or irreversible condition that has a high probability of causing death within one year or less.
Terminated Provider[10]	A practitioner, provider group, or hospital whose contract to provide services for KHS is terminated or not renewed by any of the contracting parties.

PROCEDURES:

1.0 CONDITIONS QUALIFYING FOR CONTINUITY OF CARE[11]

If agreement can be reached with the terminated provider as outlined in *Section 7.0 – Negotiation with the Terminated Provider*, the following conditions warrant authorization for continuity of care if requested:

A. An acute condition for the duration of the condition

B. A serious chronic condition for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by KHS in consultation with the member and terminated provider and consistent with good professional practice. Time period is limited to 12 months from the effective date of contract termination.

C. Pregnancy for the duration of the three trimesters of pregnancy and the immediate postpartum period.

D. A terminal illness for the duration of the illness.
E. The care of a child between birth and age 36 months. Time period is limited to 12 months from the effective date of contract termination.
F. Performance of a surgery or other procedure that is authorized by KHS as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the effective date of contract termination.

Continuity of care will not be authorized with a provider whose contract has been terminated or not renewed for reasons relating to medical disciplinary cause or reason[12] or fraud or other criminal activity.[13]

Reasonable consideration is given to the potential clinical effect on a member's treatment caused by a change of provider.[14]

2.0 REQUEST FOR CONTINUITY OF CARE

A member may submit a request for continued care from a terminated provider by either calling or submitting a written request to the following address/phone number:

Utilization Management Department
Kern Family Health Care
9700 Stockdale Highway
Bakersfield, CA 93311
1-800-391-2000

The request must include the member's name, KHS identification number, employer (if any), current treating provider with address and phone number, clinical diagnosis, when treatment started, and current treatment plan if known. Requests may be made utilizing the *Request for Continuity of Care* form. (See Attachment A). This form is available to members upon request.

3.0 REQUEST REVIEW

Requests are reviewed by an ad hoc committee made up of the, Director of Provider Relations, Chief Medical Officer or designee, and the CEO. The decision regarding the request is made by the Chief Medical Officer or designee and is not unduly influenced by fiscal or administrative management. Non-clinical members are included on the team to implement the Chief Medical Officer's or designee's decision and to provide resources for the continuity of the member's care. Requests are reviewed against the criteria outlined in Section 1.0 – Conditions Qualifying for Continuity of Care. If the request is approved, the following actions are taken:

A. The Clinical Intake Coordinator requests a treatment plan, including the length of time, from the terminated provider. The treatment plan is reviewed and discussed with KHS Chief Medical Officer or designee.
B. The Director of Provider Relations attempts to negotiate an agreement with the terminated provider as outlined in Section 7.0 – Negotiation with the Terminated Provider.

KHS makes a decision on the request in a timely manner appropriate for the nature of the member's medical condition and notifies the member of the decision in writing within 5 business days of the decision.

4.0 CASES IN WHICH CONTINUITY OF CARE MAY BE AUTHORIZED WITHOUT MEMBER REQUEST

If the member has not requested the continuity of care and it is an apparent critical period of the condition, the KHS UM Clinical Intake Coordinator after consultation with the Chief Medical Officer or designee, notifies the provider and member with authorization to continue that care until the acute episode has been resolved.

5.0 TRANSFER OF CARE

The KHS UM Clinical Intake Coordinator initiates the transfer of care to a KHS contract provider by collaborating with the member and the terminated provider. The transfer of care occurs as soon as the current treatment plan has been completed or as soon as it is determined that agreement cannot be reached with the terminated provider. All pertinent medical records are transferred and assistance with making an appointment is provided if necessary.

The KHS UM Clinical Intake Coordinator continues to follow the care of the member by requesting progress notes and coordinating any care that the member may need so that a safe and appropriate transition to a contract provider can be made when the member's condition allows.

6.0 BLOCK TRANSFER PROCESS

KHS members who are affected by a change in the Provider Network (e.g. hospital or provider group contract terminations, PCP terminations, specialist physician terminations, other provider changes, etc.) receive timely notification and accurate information in accordance with the state and federal regulations.

KHS has established protocols within KHS relating to state initiated provider suspensions, terminations, or decertification from participation in the Medi-Cal Program, or providers whose Medi-Cal managed care operations have ceased with limited to no prior notice.
Block transfer policy is defined in its entirety in Policy 4.41.

If, prior to contract termination, KHS successfully negotiates an agreement with the provider after sending a notice of termination to affected members, KHS will send another notice informing the members of the continuation of the contractual relationship. KHS will immediately inform DHCS and/or DMHC as applicable and submit the notice for review and approval.

In the event of an emergency or other unforeseeable circumstance preventing the timely submission of provider contract terminations, KHS shall provide notice of the emergency or other unforeseeable circumstances to DHCS and DMHC as soon as possible.

KHS shall ensure members are informed of their ability to request Continuity of care for an ongoing course of treatment from a terminated provider. If continuity of care services are requested by the member, KHS will follow the appropriate policies and procedures.

Beneficiaries may choose not to transition to a new provider; however, they may become responsible for the costs of the services provided by the suspended, terminated, or decertified provider, and should be informed if they choose not to transition.

7.0 MEMBER LIABILITY

The amount of, and the requirement for payment of, co-payments during the continuity of care period are the same as would be paid if the member were receiving care from a contracted provider.

8.0 NEGOTIATION WITH THE TERMINATED PROVIDER

The terminated provider must agree in writing to continue to meet the contractual requirements that were in place prior to termination. This includes quality management, utilization management, and credentialing. If the provider does not agree to or fails to comply with these requirements, KHS will not be obligated for the continuity of care with the provider.

9.0 TRACKING AND REPORTING

The KHS UM Clinical Intake coordinator logs all requests for continuity of care by a terminated provider. Periodic reports are presented by the Administrative Director of Health Services to the QI/UM Committee.

10.0 PROVIDER AND MEMBER EDUCATION

Every contracted provider receives a copy of this policy and procedure and may supply a copy to members upon request. Members may request a copy of the policy and procedure from KHS either verbally or in writing.

ATTACHMENTS:

- Attachment A: Request for Continuity of Care form

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[1] **Revision 2017-08:** Policy submitted as part of DMHC filing 20171250, approved 6/1/2017. **Revision 2017-05:** Revisions to section 6.0 required to comply with DHCS Audit CAP and to provide continuity of care to affected members in provider terminations or unforeseeable circumstance. **Revision 2017-01:** New Section 6.0 Block Transfer Process added to comply with DHCS potential audit finding #5 and APL 16-001. Policy/titles updated by Administrative Director of Health Services. **Revision 2009-08:** Routine revision. Not reviewed by the AIS Compliance Department **Revision 2004-06:** Created per DMHC Comment 061A. (04/16/04). **Revision 2004-03:** Revised per AB1286(2003). Text rearranged so that both continuity of care policies mirror one another. Text that is simply moved in the document is not marked as a redline change. Effective date is the effective date of the legislation. **Revision 2001-06**: Revised per DHS Comment Letter (04/30/01).

[2] As defined in B&P Code §805(a)

[3] HSC §1376.96(h)

[4] HSC §1373.96(c)(1)

[5] HSC §1373.96(k)(1)
[6] HSC §1345(i) and 1373.96(k)(3). Clarification of hospital requested by DMHC comment 061A (04/16/04).
[7] HSC §1373.65(g)
[8] HSC §1373.96(c)(2)
[9] HSC §1373.96(c)(4)
[10] Definition requested by DMHC Comment 061A (04/16/04). Per M. Punja we can not use the definition included in the Insurance Code. Although there is no definition included in the HSC, DMHC expectation is that terminated providers include those whose contract is terminated or not renewed by either party.
[11] HSC §1373.96(c)
[12] As defined in B&P Code §805(a)
[13] HSC §1376.96(h)
[14] HSC §1373.95(a)(2)(E)

KERN FAMILY HEALTH CARE
REQUEST FOR CONTINUITY OF CARE

You may use this form to request that you be allowed to continue receiving treatment from a provider that is not contracted with KFHC. Requests should be mailed to the following address:

Utilization Management Department
Kern Family Health Care
9700 Stockdale Highway
Bakersfield, CA 93311

If you have questions or need help filling out this form please call our Utilization Management Department at 1-800-391-2000.

We will review your request and send you a letter that explains our decision.

Member Name, Phone Number and Address	
KHS Identification Number	
Employer	
Treating Provider Name, Address, and Phone Number	
Clinical Diagnosis	
Date Treatment Started	
Current Treatment Plan (if known)	

Si usted necesita esta carta en Español, por favor llame al Departamento de Servicios de Miembros al (800) 391-2000

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Comprehensive Case Management and Coordination of Care				POLICY #: 3.61-I	
DEPARTMENT: Utilization Management					
Effective Date: 01-2006	Review/Revised Date: 07/28/2017	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 7/28/17

Chief Medical Officer — Date 7/25/17

Chief Operating Officer — Date 7/21/17

Administrative Director of Health Services — Date 7/18/17

POLICY:

Kern Health Systems (KHS) provides basic comprehensive medical case management to Medi-Cal members ("members"). KHS maintains procedures for monitoring the coordination of care provided to members, including medically necessary services delivered within and outside the KHS provider network.

Comprehensive case management and coordination of care will be provided in accordance with the contractual requirements outlined in KHS' Medi-Cal contract with the DHCS.

DEFINITIONS:

Comprehensive Medical Case Management Services	Services provided by a Primary Care Physician to promote the coordination of medically necessary health care services, the provision of preventive services in accordance with established standards and periodicity

	schedules, and the continuity of care for members. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.

PROCEDURES:

1.0 GENERAL CASE MANAGEMENT AND COORDINATION OF CARE

KHS members receive comprehensive case management and coordination of care services from their assigned Primary Care Physician (PCP), which includes procedures used to monitor the provision of 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.

An Initial Health Assessment (IHA) consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables a provider of primary care services to comprehensively assess the Member's current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract. The PCP is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and IHEBA.

Members' completed IHA and IHEBA tool are to be contained in the Members' medical record and available during subsequent preventive health visits.

KHS PCP's will make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate the PCP's unsuccessful efforts to contact a Member and schedule an IHA shall be considered compliant with the requirement.

Basic Case Management Services are provided by the Primary Care Provider, in collaboration with KHS, and shall include:

- Initial Health Assessment (IHA)) performed within 120 calendar days of enrollment to identify the need for preventive health visits for all Members under 21 years of age at times specified by the most recent AAP periodicity schedule (Bright Futures guidelines) and anticipatory guidance as outlined in the AAP Bright Futures periodicity schedule. KHS providers will provide, as part of the periodic preventive visit, all age specific assessments and services required by the CHDP program and the age-specific health education behavioral assessment IHEBA as necessary. Where the AAP periodicity exam schedule is more frequent than the CHDP periodicity examination schedule, KHS

providers will ensure that the AAP scheduled assessment includes all assessment components required by the CHDP for the lower age nearest to the current age of the child.

- Individual Health Education Behavioral Assessment (IHEBA) performed within 120 calendar days for all members; and that all existing Members who have not completed an IHEBA, must complete it during the next non-acute, preventative care office visit according to the DHCS standardized "Staying Healthy" assessment tools, or alternative approved tools that comply with DHCS approval criteria for the individual health education behavioral assessment IHEBA. The IHEBA tool must be;
    a) administered and reviewed by the primary care Provider during an office visit,
    b) reviewed at least annually by the primary care provider Primary Care Provider with Members who present for a scheduled visit, and
    c) Re-administered by the primary care provider Primary Care Provider at the appropriate age-intervals.
- Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs
- Direct communication between the provider and Member/family
- Member and family education, including healthy lifestyle changes when warranted; and;
- Coordination of carved out and linked services, and referral to appropriate community resources and other agencies.

IHAs for Adults (Age 21 and older)

- KHS covers and ensures that an IHA for adult Members is performed by the PCP within 120 calendar days of enrollment. The performance of the initial complete history and physical exam for adults includes, but is not limited to:

- blood pressure,
- height and weight,
- total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
- clinical breast examination for women over 40,
- mammogram for women age 50 and over,
- Pap smear (or arrangements made for performance) on all women determined to be sexually active,
- Chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
- screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,
- IHEBA.

KHS PCP's are responsible for assuring that all adults are fully immunized. KHS will cover and ensure the member's PCP adheres to the timely provision of vaccines in accordance with the most

current California Adult Immunization recommendations. In addition, PCP will provide age and risk appropriate immunizations in accordance with the findings of the IHA, other preventive screenings and/or the presence of risk factors identified in the health education behavioral assessment.

KHS PCP's will document attempts to provide immunizations. If the Member refuses the immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the Member or guardian of the Member shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record. Documented attempts that demonstrate unsuccessful efforts to provide the immunization shall be considered compliant in meeting this requirement.

Member-specific immunization information will be periodically reported to an immunization registry established in the KHS Service Area as part of the Statewide Immunization Information System. Reports shall be made following the Member's initial health assessment IHA and all other health care visits which result in an immunization being provided. Reporting shall be in accordance with all applicable State and Federal laws.

Dental services are not covered under KHS DHCS contract. KHS covers and ensures KHS providers conduct dental screenings/oral health assessments for all Members as a part of the initial health assessment IHA.

For Members under 21 years of age, PCP's responsible for ensuring that a dental screening/oral health assessment is performed as part of every periodic assessment, with annual dental referrals made commencing at age three (3) or earlier if conditions warrant with the eruption of the child's first tooth or at 12 months of age, whichever occurs first. Members will be referred to appropriate Medi-Cal dental providers for further evaluation and treatment as deemed necessary. KHS PCP's provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish, dental services that may be performed by a medical professional. Dental services that are exclusively provided by dental providers are not covered benefits under KHS.

WIC services are not covered under KHS contract with the DHCS. However, KHS has procedures to identify and refer eligible Members for WIC services. As part of the referral process, KHS providers will furnish the WIC program with a current hemoglobin or hematocrit laboratory value and document the laboratory values and the referral in the Member's medical record.

As part of its initial health assessment IHA of Members, or, as part of the initial evaluation of newly pregnant women, the member's PCP will refer and document the referral of pregnant, breastfeeding, or postpartum women or a parent/guardian of a child under the age of five (5) to the WIC program as KHS will administer and perform ongoing monitoring of the provision of Complex Case Management to Members to include procedures to identify members who may benefit from complex case management services.

Complex Case Management Services are provided by the primary care provider, in collaboration with KHS, and shall include, at a minimum:

- Basic Case Management Services.

- Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team to include the following mental health services performed within the scope of practice for licensed mental health care providers:
  - Individual/group mental health evaluation and treatment (psychotherapy);
  - Psychological testing when clinically indicated to evaluate a mental health condition;
  - Outpatient services for the purpose of monitoring drug therapy;
  - Psychiatric consultation for medication management.
  - Outpatient laboratory, supplies and supplements; and
  - Screening and Brief Intervention (SBI) for substance use conditions.

- Intense coordination of resources to accomplish the goal that the member regains optimal health or improved functionality.
- With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually.
- Coordination of services for members who have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern e.g. homelessness.
- If a Member becomes eligible for Specialty Mental Health Services during the course of receiving medically necessary Outpatient Mental Health Services, KHS shall continue the provision of non-duplicative, Medically Necessary Outpatient Mental Health Services.
- Any time that a Member requires a Medically Necessary Outpatient Mental Health Service that is not available within the provider network, KHS shall ensure access to out-of-network and Telehealth mental health providers as necessary to meet access requirements.
- KHS shall ensure the provision of SBI services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

Mental Health Services that are not a benefit under KHS will be provided by the Mental Health Plan as detailed below:

Services Provided by CMHP for Children and adults who meet medical necessity or EPSDT criteria for Medi-Cal Specialty Mental health Services

Mental Health Services (assessments plan development, therapy, rehabilitation and collateral)
Medication Support
Day Treatment Services and Day Rehabilitation
Crises Intervention and Crises Stabilization
Targeted Case Management
Therapeutic Behavior Services

Residential Services Provided by CMHP
Adult Residential Treatment Services
Crises Residential Treatment Services

Inpatient Services
Acute Psychiatric Inpatient Hospital Services
Psychiatric Inpatient Hospital Professional Services
Psychiatric Health Facility services

Services Provided by County Alcohol or Other Drug Programs for: Children and adults who meet medical necessity or EPSDT criteria for Drug Medi-Cal Substance Use Disorder Services
Outpatient Drug Free
Intensive Outpatient (newly expanded to additional populations)
Residential Services (newly expanded to additional populations)
Narcotic Treatment Program
Naltrexone
Voluntary Inpatient Detoxification Services

KHS shall develop methods to identify Members who may benefit from Complex Case Management services, using utilization data, the Member Evaluation Tool (MET), clinical data, Health Information Form (HIF), Predictive Modeler and any other available data, as well as self and physician referrals.

KHS will use data from the Health Information Form (HIF) and submitted through the /Member Evaluation Tool (MET) to help identify newly enrolled Members who may need expedited services. In accordance with 42 CFR 438.208(b), KHS will ensure the following:

1) Mail a DHCS approved HIF/MET to all new Members as a part of KHS's welcome packet and include a postage paid envelope for response.

2) Make at least two (2) call attempts to remind and/or collect the HIF/MET information from new Members. This outreach can be done to head of household for Members under the care of parents or other authorized representatives.

3) KHS Primary Care Providers (PCP) will conduct an initial screening of all HIF/METs received, within 90 days of the Members effective date of enrollment, utilizing any screening process currently required
4) Upon a Member's disenrollment, KHS will make the HIF/MET assessment results available to their new Medi-Cal Managed Care Health Plan upon request.

Identification of eligible members

Processes used to identify members for enrollment into Complex Case Management may include but are not limited to:

- Claims data
- Encounter data
- Hospital discharge data
- Pharmacy data
- Laboratory data
- Provider referrals

- Referrals from Member Services, Disease Management, Utilization Management, and Quality Improvement departments
- Discharge Planner (Inpatient Case Manager)
- Member self-referral
- Health risk assessments or stratification algorithms
- HIF and MET data
- Predictive Modeler

Complex case management services for SPDs must include the concepts of Person-Centered Planning.

Complex Case Management Enrollment Criteria may include but are not limited to:

- Are residing in an acute hospital setting
- Have been hospitalized within the last 90 days, or have had 3 or more hospitalizations within the past year
- Have had 3 or more ER visits in the past year in combination with other evidence of high utilization of services (e.g. multiple prescriptions consistent with the diagnoses of chronic diseases)
- Have ESRD, AIDS, and/or a recent organ transplant
- Have cancer, currently being treated
- Have been prescribed 15 or more prescriptions in the past 90 days
- Major trauma within the previous 3 months
- Four or more chronic conditions
- Readmission within 30 days with the same /similar diagnosis/condition
- Have been on oxygen within the past 90 days,
- Are Pregnant
- Have been prescribed antipsychotic medication with the past 90 days
- Have a self-report of a deteriorating condition
- Chronic conditions including Asthma, COPD, Diabetes, CHF, CAD, and Cirrhosis/Chronic Liver Disease
- SPD members identified as "high risk" through initial risk stratification, HRA, or one of the data or referral sources listed above
- Coordination of services for members who have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnosis or a social circumstance of concern e.g. homelessness.

Criteria for transition out of Complex Case Management may include but are not limited to:

- Loss of eligibility for the program (member no longer enrolled through client).
- Achievement of documented targeted outcomes.
- Chief Medical Officer or designee Decision
- Member opts out of case management program.
- The member is unable to be located.
- 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 with the Chief Medical Officer or designee.

Person-Centered Planning for SPD Beneficiaries[1]

- Upon the enrollment of a SPD beneficiary, KHS shall provide the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD beneficiary's continuing health care needs.
- Person-Centered Planning shall include identifying each SPD beneficiary's preferences and choices regarding treatments and services, and abilities.
- KHS shall allow the participation of the SPD beneficiary, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.
- KHS shall monitor that SPD beneficiaries receive all necessary information regarding treatment and services so that they may make an informed choice.

For the purpose of this policy, Person-centered Planning means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-centered Planning is an integral part of Basic and Complex Case Management and discharge planning. KHS will arrange the following Person-Centered Planning for services to SPD's upon enrollment.

- KHS shall provide, or arrange the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD member's continuing health care needs through careful review of the individualized care plans and Health Risk Assessment (HRA). KHS will foster community resources and facilitate routine and specialty appointments, transportation or other ancillary services necessary to provide health care needs that are identified. Referrals coordination between KHS Care and Case Management will be maintained to allow for prompt and medically necessary services to be received.
- Person-Centered Planning shall include identifying each SPD member's preferences and choices regarding treatments and services, and abilities. Members can request Continuity of Care with either a PCP or specialist. KHS will coordinate the member's requests with the provider to promote ongoing receipt of necessary services without interruption for up to one year. At that time, transition of care will be reviewed to promote continuity of services with contracted providers within KHS network.
- KHS shall allow or arrange the participation of the SPD member, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services. Care management of the entire family unit, not solely the individual, will be conducted at the request of the member. Members will be encouraged to discuss treatment options with their providers and become an active participant in their healthcare. KHS Member Services Representative may be contacted to inquire as to their membership status as well as any pending services that were previously requested. KHS shall arrange that SPD members receive all necessary information regarding treatment and services so that they may make an informed choice. Information is made available detailing specific services, contracted providers as well as covered benefits in various formats, i.e. newsletters, members mailings or bulletins, provider directory and member handbooks to promote the health care of each individual member. Members are informed of approved services via Approval Letter or Notice of Action (NOA) Letters detailing any modifications or denials for services with alternative treatment options.

Discharge Planning and Care Coordination[2]

KHS shall monitor the provision of discharge planning when a SPD Member is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning shall review the

documentation submitted to determine if the necessary care, services, and supports in the community are available for the SPD Member once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Minimum criteria for a discharge planning checklist must include:

A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received.

B. Documentation of pre-discharge factors, including an understanding of the medical condition by SPD Member or a SPD Member representative as applicable, physical and mental function, financial resources, and social supports.

C. Services needed after discharge, type of placement preferred by the SPD Member/ Member representative and hospital/institution, type of placement agreed to by the SPD Member/Member representative, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD Member/Member representative, and pre-discharge counseling recommended.

D. Summary of the nature and outcome of SPD Member/Member representative involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

It is the PCP's responsibility to track referrals and follow-up care. To assist in this effort, KHS provides the PCP with a quarterly list of open authorizations. The PCP should investigate all open authorizations and follow up with the member, as necessary. PCP follow-up and documentation is monitored by the Quality Improvement Department through facility site review.

2.0 CASE MANAGEMENT AND COORDINATION OF CARE FOR SPECIFIC SERVICES

Case management and coordination of care for specific services are provided as outlined below:

A. Targeted Case Management Services: See *KHS Policy and Procedure #3.13-P: EPSDT Supplemental Services and Targeted Case Management (TCM)*
B. Disease Management Program Services: See *KHS Policy and Procedure #2.35-P: Disease Management*
C. Out-of-Plan Services: See *KHS Policy and Procedure #3.55-I Coordination of Care for Out-of-Network, Seldom Used, and/or Unusual Specialty Services*
D. Specialty Mental Health Services: See *KHS Policy and Procedure #3.14-P Mental Health Services*
E. Alcohol and Substance Abuse Treatment Services: See *KHS Policy and Procedure #3.10-P Alcohol and Drug Treatment Services*
F. Services for Children with Special Health Care Needs: *See KHS Policy and Procedure #3.56-P Services for Children with Special Health Care Needs*
G. California Children's Services: See *KHS Policy and Procedure #3.16-P California Children's Services.*
H. Services for Persons with Developmental Disabilities: See *KHS Policy and Procedure #3.03-P Kern Regional Center Services (Developmental Disabilities and Early Intervention)*
I. Local Education Agency Services: See *KHS Policy and Procedure #3.57-P Local Education Agency Services*

J. School Linked CHDP Services: No local school districts or school sites in Kern County provide CHDP services. For speech services that are not medically necessary and are not covered by Medi-Cal, KHS provides parents of member children with the phone number of *Search and Serve*, a community referral resource for these non-covered services.
K. Foster Care: Foster care and Adoption Assistance Program (AAP) children receive prompt medical care, and KHS promptly authorizes medically necessary services to such children's providers in the county of placement. KHS billing processes are sensitive to the need to make timely payments to providers who treat children placed out-of-county who are KHS members.
L. HIV/AIDS Home and Community Based Services Waiver Program: See *KHS Policy and Procedure #3.11-I Home and Community Based Services (HCBS) Waiver Programs*
M. Dental Services: See *KHS Policy and Procedure #3.06-P Dental Services*
N. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB): See *KHS Policy and Procedure #3.46-P Tuberculosis Treatment*
O. Women, Infants, and Children (WIC) Supplemental Nutrition Program: See *KHS Policy and Procedure #3.08-P WIC*
P. Major Organ Transplants: See *KHS Policy and Procedure #3.02-P Major Organ Transplant*
Q. Waiver Programs: See *KHS Policy and Procedure #3.11-I Home and Community Based Services (HCBS) Waiver Programs*
R. Vision Care: See *KHS Policy and Procedure #3.07-P Vision Care*
S. Nursing Facility and Long Term Care: See *KHS Policy and Procedure #3.42-P Nursing Facility and Long Term Care*
T. Hospice: See *KHS Policy and Procedure #3.43-P Hospice*

REFERENCE:

Revisons 2017-05: Policy revised to comply with Final Rule Deliverable #4. DHCS approved policy on **Revision 2016-08:** Minor revisions by Case Management and Health Services. **Revision 2016-05:** Retrospective audit performed on Policy Letter (PL) 14-005. Specified diagnosis codes excluded to comply with (PL) 14-005. **Revision 2014-08:** Policy still pending approval by DMHC as part of the Material Modification. Policy revised by Director of Health Services to comply with Mental Health Carve-In (2013-12). **Revision 2012-04**: Policy revised to comply with SPD Deliverable 11.C. Policy approved by the Department of Health Care Services (DHCS) March 19, 2012.

[1] 2010 DHS Contract Exhibit A, Attachment 11 (1D)

[2] 2010 DHS Contract Exhibit A, Attachment 11(2D)

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Provider Preventable Conditions				POLICY #: 3.69-I	
DEPARTMENT: Utilization Management – Administrative Director of Health Services					
Effective Date: 02/2015	Review/Revised Date: 07/17/2017	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 7-7-17

Chief Medical Officer — Date

Chief Operating Officer — Date 7/17/17

Deborah L Reuter
Administrative Director of Health Services — Date 7/13/17

POLICY:
Under Section 2702 of the Patient Protection and Affordable Care Act (Pub. L. 111-148) (the ACA) and federal regulations at 42 CFR.447.26, and Title 42 of the Code of Federal Regulations (CFR) Sections 438.3(g), 434.6(a)(12)(i), and 447.26 and Welfare and Institutions Code Section 14131.11, prohibit the payment of Medicaid/Medi-Cal funds to a provider for the treatment of a Provider Preventable Condition (PPC), except when the PPC existed prior to the initiation of treatment for that beneficiary by that provider. A provider must report the occurrence regardless of whether or not the provider seeks Medi-Cal reimbursement for services to treat the PPC. Reporting a PPC for a Medi-Cal beneficiary does not preclude the reporting of adverse events, pursuant to Health and Safety Code (H&S Code), Section 1279.1, to the California Department of Public Health (CDPH).

Kern Health Systems (KHS) implemented policies that conform to the federal requirements on PPCs, effective for dates of service on or after July 1, 2012.

A provider reports a PPC by completing and submitting the Medi-Cal Provider-Preventable Conditions (PPC) Reporting Form (See Attachment A). Providers must submit the form within five days of discovering the event and confirming that the patient is a Medi-Cal beneficiary.

DEFINITIONS:

Provider Preventable Conditions (PPCs) are conditions that meet the definition of a "health care-acquired condition" or an "other provider preventable condition" as defined by the Centers for Medicare & Medicaid Services (CMS) in federal regulations at 42 CFR.447.26(b).

PPCs include both the "Health Care Acquired Conditions" (HCACs) "Other Provider Preventable Conditions" (OPPCs). CMS further defined OPPCs as conditions that: 1) are identified by the State Plan, 2) are reasonably preventable through the application of procedures supported by evidence-based guidelines, 3) have negative consequence for the beneficiary, and 4) are auditable.

Health Care Acquired Conditions (HCACs) are conditions occurring in an inpatient hospital setting that Medicare designates as hospital-acquired conditions (HACs) pursuant to section 1886(d)(4)(D)(iv) of the Social Security Act (SSA) (as described in Section 1886(d)(4)(D)(ii) and (iv) of the SSA), with the exception of deep vein thrombosis (DVT)/pulmonary embolism (PE) as related to total knee replacement or hip-replacement surgery in pediatric and obstetric patients.

Other Provider Preventable Conditions (OPPCs) are conditions that meet the requirements of an "other provider preventable condition" pursuant to 42 CFR §447.26(b). OPPCs may occur in any health-care setting and are divided into two sub-categories.

a) National Coverage Determinations (NCDs)

NCDs are mandatory OPPCs under 42 CFR. 447.26(b) and mean any of the following conditions that occur in any health-care setting:

(i) Wrong surgical or other invasive procedure performed on a patient
(ii) Surgical or other invasive procedure performed on the wrong body part
(iii) Surgical or other invasive procedure performed on the wrong patient

LTC facilities need only report other provider-preventable conditions (OPPCs) include:

LTC facilities include the following:

- Freestanding skilled nursing facilities,
- Freestanding or distinct part intermediate care facilities,
- Intermediate care facilities/developmentally disabled – habilitative,
- Intermediate care facility/developmentally disabled,
- Intermediate care facility/developmentally disabled – nursing,
- Freestanding and distinct part subacute facilities (adult and pediatric), and
- Distinct part skilled nursing facilities.

For each of (i) through (iii) above, the term "surgical or other invasive procedure" is as defined in CMS Medicare guidance on NCDs.

b) Additional Other Provider Preventable Conditions (Additional OPPCs)

Additional OPPCs are state-defined OPPCs that meet the requirements of 42 CFR. 447.26(b).

PROCEDURES:

1.0 Identification of Potential Provider Preventable Conditions

As part of the PPC process, KHS will ensure the following:

a) Review encounter data submitted by network providers for evidence of PPCs that must be reported via the online reporting portal beginning on the date of the issuance of this APL. Internally generated reports utilizing claims data are screened by Claims and Utilization management staff for prompt identification of PPC.
b) Report each PPC per the instructions for the online reporting portal.
c) Issue a special notice informing all of their network providers that they must report PPCs to DHCS using the online reporting portal.
d) Require network providers to also send them a copy of all PPCs submitted to the online portal.
5. Retain copies of all submissions.

Upon notification of admissions to acute care facilities within the provider network and a monthly review of encounter data submitted by network providers who are not enrolled as Medi-Cal providers, KHS staff will reference the DHCS PPC List (See Attachment B) to determine if the diagnoses codes or events are reportable as defined by the DHCS.

Examples of HCAC include:

- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection (UTI)
- Falls and trauma that result in fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock
- Foreign object retained after surgery
- Iatrogenic pneumothorax with venous catheterization (October 1, 2012)
- Manifestations of poor glycemic control
- Diabetic ketoacidosis
- Non-ketotic hyperosmolar coma
- Hypoglycemic coma
- Secondary diabetes with ketoacidosis
- Secondary diabetes with hyperosmolarity
- Stage III and IV pressure ulcers
- Surgical site infection following:
- Mediastinitis following coronary artery bypass graft (CABG)
- Bariatric surgery, including laparoscopic gastric bypass, gastroenterostomy and laparoscopic gastric restrictive surgery
- Orthopedic procedures for spine, neck, shoulder, and elbow
- Cardiac implantable electronic device (CIED) procedures (October 1, 2012)
- Vascular catheter-associated infection
- For non-pediatric/obstetric population, deep vein thrombosis (DVT)/ pulmonary embolism (PE) resulting from:
- Total knee replacement
- Hip replacement

2.0 Notification after discovery of potential Provider Preventable Conditions (PPC)

"Discovery" refers to when a provider first learns that a Medi-Cal patient had a Provider Preventable Condition (PPC) and confirms that the patient is a Medi-Cal beneficiary. The Department of Health Care Services (DHCS) understands that this might be after the patient has been discharged, including discovery during coding and billing. Discovery can occur in 3 locations-hospital or LTC facility, provider office, or health plan level.

If the PPC is identified at the health plan during concurrent review of medical records or other communications, KHS staff will complete the DHCS Form 7107 and forward to the Compliance department for submission to the identified provider involved with the PPC and DHCS. KHS will use DHCS' secure online reporting portal to report PPCs to DHCS. Notification of all pending PPC events are forwarded to Finance for reconciliation for claims payment. *See Policy 6.01-P Claims Submission and Reimbursement.*

KHS is also responsible to ensure that all delegated entities remain compliant with the PPC process outlined in the policy.

ATTACHMENTS:

- ❖ Attachment A – DHCS Form 7107 Provider Preventable Conditions (PPC) Reporting Form
- ❖ Attachment B – Provider Preventable Conditions (PPC) List

REFERENCE:

Revision 2017-06: Policy revised to comply with DHCS Final Rule Deliverable #2 and APL 16-011Repoting Requirements Related to Provider Preventable Conditions. DHCS approved 6/5/2017. **Revision 2015-02:** Policy developed by Utilization Department to comply with DHCS All Plan Letter 13-007.

Medi-Cal Provider-Preventable Conditions (PPC) Reporting Form

By law, providers must identify provider-preventable conditions that are associated with claims for Medi-Cal payment or with courses of treatment furnished to Medi-Cal patients for which Medi-Cal payments would otherwise be available. See instructions for a more detailed description of PPCs.

1. Name of facility where PPC occurred:		
2. National Provider Identifier (NPI):		
3. Billing NPI if different from No. 2:		
4. Facility Address where PPC occurred:		
City:	State:	Zip code:
5. PPC – Other Provider-Preventable Condition (OPPC) in any health care setting:		
Date OPPC occurred:	Admission date:	
☐ Wrong surgery/invasive procedure		
☐ Surgery/invasive procedure on the wrong body part		
☐ Surgery/invasive procedure on the wrong patient		
6. PPC – Health Care-Acquired Condition (HCAC) in an acute inpatient setting:		
Date HCAC occurred:	Admission date:	
☐ Air embolism	☐ Blood incompatibility	
☐ Catheter-associated urinary tract infection	☐ Deep vein thrombosis/pulmonary embolism	
☐ Falls/trauma	☐ Foreign object retained after surgery	
☐ Iatrogenic pneumothorax with venous catheterization		
☐ Manifestations of poor glycemic control	☐ Stage III or IV pressure ulcers	
☐ Surgical site infection	☐ Vascular catheter-associated infection	
7. Patient's name:		
8. Client Index Number (CIN):		
9. Patient's birthdate:		
10. Patient's address:		
City:	State:	Zip Code:	Apt. No.:
11a. Is the patient enrolled in a Medi-Cal Managed Care Plan? ☐ Yes ☐ No (Fee-for Service)		
11b. If "yes" to question No. 11a, what is the plan's three-digit Health Care Plan Code?		
11c. Name of Health Care Plan:	HCP County:	
12a. Do you intend to submit a claim? ☐ Yes ☐ No ☐ Unknown		
12b. If "yes," what is the claim control number?		
13. Name of person completing report:		
14. Title of person completing report:		
15. Submitted by: ☐ Medi-Cal Managed Care Plan ☐ Provider		
16. Phone (including ext.):	Email:	
17. Signature of person completing form:		

Please note: *When applicable, both Medi-Cal Managed Care Plans (MCP) and Medicare-Medicaid Plans (MMP) are required to report PPCs using this form.*

INSTRUCTIONS

Providers must complete and send one form (front page only) for each provider-preventable condition (PPC). ***Please note that reporting PPCs to the Department of Health Care Services for a Medi-Cal beneficiary does not preclude the reporting of adverse events and healthcare associated infections (HAIs), pursuant to the Health and Safety Code sections 1279.1 and 1288.55, to the California Department of Public Health*** *for the same beneficiary. Providers must report any PPC to DHCS that* ***did not exist prior to the provider initiating treatment*** *for a Medi-Cal beneficiary, even if the provider does not intend to bill Medi-Cal.*

Mark "PROTECTED HEALTH INFORMATION: CONFIDENTIAL" and send completed first page only of the report related to a Medi-Cal beneficiary to:

Via Secure Fax
Department of Health Care Services
Audits and Investigations Division
Occurrence of Provider-Preventable Conditions
(916) 327-2835

Via U.S. Post Office
Department of Health Care Services
Occurrence of Provider-Preventable Condition
Audits and Investigations Division, MS 2100
P.O. Box 997413
Sacramento, CA 95899-7413

Via UPS, FedEx, or Golden State Overnight
Department of Health Care Services
Occurrence of Provider-Preventable Condition
Audits and Investigations Division, MS 2100
1500 Capitol Ave., Suite 72.624
Sacramento, CA 95814-5006

Providers must send this form to the Department of Health Care Services (DHCS), Audits and Investigations Division, via fax, U.S. Post Office, UPS, or FedEx. Providers must submit the form after discovery of the event and confirmation that the patient is a Medi-Cal beneficiary. The preferred methods of sending the reports for confidentiality are No. 1, overnight courier with appropriate marking; No. 2, secure fax machine with appropriate marking; and No. 3, U.S. mail with appropriate marking. Providers must comply with HIPAA and any other relevant privacy laws to ensure the confidentiality of patient information. Providers may email questions about PPCs to PPCHCAC@dhcs.ca.gov.

Facility information (boxes 1-4)

1. Enter name of the facility where the PPC occurred.
2. Enter the National Provider Identifier (NPI) of the facility where the PPC occurred.
3. Enter the billing NPI if it is different from the NPI for the facility where the PPC occurred.
4. Enter the street address, city, state, and zip code of the facility where the beneficiary was being treated when the PPC occurred.

Other Provider-Preventable Condition in any health care setting (box 5)

5. If you are reporting an OPPC, enter the date (mm/dd/yyyy) that the PPC occurred and the admission date if the beneficiary was admitted to an inpatient hospital.

   Select one of the following if:
   - Provider performed the wrong surgical or other invasive procedure on a patient.
   - Provider performed a surgical or other invasive procedure on the wrong body part.
   - Provider performed a surgical or other invasive procedure on the wrong patient.

Health Care-Acquired Condition (HCAC) in an acute inpatient setting (box 6)
(HCACs are the same conditions as hospital-acquired conditions (HACs) that are reportable for Medicare, with the exception of reporting deep vein thrombosis/pulmonary embolism for pregnant women and children under 21 years of age, as noted below.)

6. Enter the date (mm/dd/yyyy) that the HCAC occurred and the admission date the beneficiary was admitted to an inpatient hospital.

Select one of the following if the beneficiary experienced:

- A clinically significant air embolism
- An incidence of blood incompatibility
- A catheter-associated urinary tract infection
- Deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement in an inpatient setting. Do **not** check the box if the beneficiary was under 21 or pregnant at time of PPC.
- A significant fall or trauma that resulted in fracture, dislocation, intracranial injury, crushing injury, burn, or electric shock
- Any unintended foreign object retained after surgery
- Iatrogenic pneumothorax with venous catheterization
- Any of the following manifestations of poor glycemic control: diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, or secondary diabetes with hyperosmolarity
- A stage III or stage IV pressure ulcer
- One of the following surgical site infections:
  - Mediastinitis following coronary artery bypass graft (CABG)
  - Following bariatric surgery for obesity: laparoscopic gastric bypass, gastroenterostomy, or laparoscopic gastric restrictive surgery
  - Certain orthopedic procedures: Spine, neck, shoulder, and elbow
  - Following cardiac implantable electronic device (CIED) procedures
- A vascular catheter-associated infection

Beneficiary information (boxes 7-11c)

7. Enter beneficiary's name (first, middle, last) as listed on the Beneficiary Identification Card.
8. Enter beneficiary's Client Index Number (CIN) from the Beneficiary Identification Card.
9. Enter the beneficiary's birthdate (mm/dd/yyyy).
10. Enter the beneficiary's home street address, including city, state, zip code, and apartment number, if applicable.

11a. Check "yes" if the beneficiary is enrolled in a Medi-Cal Managed Care Plan or "no" if the beneficiary has Fee-For-Service (FFS) Medi-Cal.

11b. If the beneficiary has Medi-Cal Managed Care, the beneficiary's Managed Care Plan should enter the Health Care Plan's (HCP) three-digit plan code.

11c. If the beneficiary has Medi-Cal Managed Care, enter the name of the Managed Care HCP and the county of the HCP where the PPC occurred.

Claim information (boxes 12a-12b)

12a. Click "yes" if you intend to submit a claim to Medi-Cal for the course of treatment associated with the PPC, "no" if you do not, or "unknown" if you do not know at this time.

12b. Enter the Claim Control Number (CCN) if you have already submitted a claim for the course of treatment.

Provider Contact information (boxes 13-17)

13. Enter the name of the person completing this report.
14. Enter the title of the person completing this report.
15. Check the appropriate box to indicate whether the person completing this report is a representative for a Medi-Cal Managed Care Plan or a provider.
16. Enter a work phone number, including extension if necessary, and email address where DHCS can contact the person who completed this report.
17. Sign and date the form. Adobe "digital signatures" are accepted.

THE INFORMATION CONTAINED IN THE COMPLETED FORMS IS PROTECTED HEALTH INFORMATION AND PERSONALLY IDENTIFIABLE INFORMATION, UNDER FEDERAL (HIPAA) LAWS AND CA STATE PRIVACY LAWS. THE PROVIDER IS RESPONSIBLE FOR ENSURING THE CONFIDENTIALITY OF THIS INFORMATION.

PROVIDER PREVENTABLE CONDITIONS (PPC) DIAGNOSIS LIST

Note: CC stands for complicating condition and MCC stands for major complicating condition. MCC codes are depicted in bold print on the table.

Provider Preventable Condition	CC / MCC (ICD-9-CM Codes)
Foreign Object Retained After Surgery	998.4, 998.7
Air Embolism	**999.1**
Blood Incompatibility	999.60, 999.61, 999.62, 999.63, 999.69
Pressure Ulcer Stages III & IV	**707.23, 707.24**
Falls and Trauma: • Fracture • Dislocation • Intracranial Injury • Crushing Injury • Burn • Electric Shock	Codes within these ranges: 800-829 830-839 850-854 925-929 940-949 991-994
Catheter-Associated Urinary Tract Infection (UTI)	996.64 Also excludes the following from acting as a CC/MCC: 112.2, 590.10, **590.11**, **590.2**, 590.3, 590.80, 590.81, 595.0, 597.0, 599.0
Vascular Catheter-Associated Infection	999.31
Manifestations of Poor Glycemic Control	**250.10-250.13**, **250.20-250.23**, 251.0, **249.10-249.11**, **249.20-249.21**
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	**519.2 And one of the following procedures codes: 36.10-36.19**
Surgical Site Infection Following Certain Orthopedic Procedures	996.67, 998.59 And one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity	Principle diagnosis - 278.01, 539.01, 539.81, 998.59 And one of the following procedure codes: 44.38, 44.39, or 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11, 415.13, 415.19, 453.40-453.42 And one of the following procedure codes: 00.85-00.87, 81.51-81.52, or 81.54

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Cultural and Linguistic Services				POLICY #: 3.70-I	
DEPARTMENT: Health Services					
Effective Date: 08/1997	Review/Revised Date: 07/17/2017	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 7/12/17

Chief Operating Officer — Date 7/13/17

Director of Marketing & Member Services — Date 6/21/17

Director of Provider Relations — Date 2/2/17

Director of Compliance and Regulatory Affairs, LMC — Date 1/28/17

Deborah L Murray
Administrative Director of Health Services — Date 1/26/17

POLICY:
Kern Health Systems (KHS) will provide equal access to health services for limited English proficient (LEP) and hearing impaired members by arranging appropriate interpreter services. Linguistic services will be provided in accordance with the guidelines outlined in this internal policy and procedure.

Linguistic services will be provided in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources:

- Title VI of the Civil Rights Act of 1964 (42 USC Section 2000d, 45C.F.R. Part 80)
- DHS Contract 03-76165 A11
- MMCD Policy Letter 99-003

- MMCD Policy Letter 99-004
- MMCD Policy Letter 02-003
- MMCD Policy Letter 10-012

PROCEDURES:

1.0 PROVISION OF SERVICES

KHS will not provide LEP or hearing impaired members with services that are more limited in scope or lower in quality than those arranged for others.[1] KHS will monitor that LEP or hearing impaired members are not subjected to unreasonable delays in receiving appropriate interpreter services when the need for such services is identified by the provider or requested by the LEP or hearing impaired member.[2]

Appropriate linguistic services will be available for medical and non-medical points of contact including membership services, appointment services and member orientation sessions.

During regular business hours, members who require assistance with their language needs may call the KHS Member Services Department at (661) 632-1590 (Bakersfield) or (800) 391-2000 through the TDD/TTY line at 711. They will either be assisted by a staff member that is qualified to speak their language or connected to the Language Line for interpreting services.

Members who require after hours assistance with their language needs may call the 24 hour Telephone Triage Line at 1-800-391-2000. The telephone triage contractor employs staff who are bilingual in English and Spanish. For other language requirements, the contractor utilizes the Language Line for interpretive services.

Members who require materials in another language (English or Spanish) or in an alternative format (large print, audio, braille), may call the KHS Member Services Department at (661) 632-1590 (Bakersfield), (800) 391-2000 (outside of Bakersfield) or through the TDD/TTY line at 711 during regular business hours. The Member Services Department will log the request for materials in alternative format in the KHS system. The request will also be forwarded via e-mail to the KHS Health Education Cultural & Linguistics Technician who will add the request to the "Member Material Alternative Format Request Log". This log will be available on the Marketing SharePoint site for all KHS staff. KHS staff will refer to the KHS system or the log when coordinating KFHC member mailings, so that materials are mailed in the appropriate format.

1.1 Language Line

Calls requiring transfer to the Language Line during regular office hours are documented on phone logs by a Member Services Representative (MSR). (See Attachment A). The log includes the following information:

A. Member's name
B. Provider's name
C. Date and time of day
D. Language assistance requested
E. Language Line Operator name or ID
F. Approximate length of call

The toll-free number for the Language Line is dialed and the MSR identifies which language is being requested, if known. If unsure of the language, the MSR asks for assistance from the Language Line. The appropriate Language Line interpreter joins the call and communication occurs between the member, KHS, and/or provider.

Calls requiring transfer to the Language Line after regular office hours are connected by the 24 hour telephone triage contractor.

1.2 Interpreter and Translator Qualifications

KHS staff utilized as interpreters are required to pass an oral assessment of their bilingual skills. KHS staff utilized for translations are required to pass a written assessment of their translation skills. These test are administered by an accredited facility. The documentation is kept in the personnel file for each bilingual staff member. Additionally, KHS staff utilized for interpreting or translation are required to participate in educational training on interpreting ethics, conduct and confidentiality. Documentation of KHS staff who have completed this training is maintained by the Health Education/Cultural and Linguistics Department.

The contracted telephone interpreting service vendor, Language Line, is contractually required to assess their employees utilized as interpreters and provide their employees training on interpreting ethics, conduct and confidentiality.

Sign-language interpreters are assessed by the contracted vendor, LifeSigns. LifeSigns staff and subcontracting interpreters are certified by either the National Association of the Deaf (NAD) or Registry of Interpreters for the Deaf (RID). In addition, most certificate holders have completed professional interpreter training and have extensive professional interpreting experience.

2.0 PROVIDER EDUCATION AND SUPPORT

Contracted providers and KHS staff who interact with members will participate in a cultural, linguistic and disability education and awareness program. This program will be implemented through group instruction, the provider manual, or workshops. KHS will provide documentation for contracted providers so they are aware of how to refer members to appropriate linguistic services via KHS's Policies and Procedures. The educational and informational program may include the following:

A. The United States Department of Health and Human Service's Guidance Memorandum on Title VI Prohibition against National Origin Discrimination—Persons with Limited English Proficiency
B. Information on provider legal vulnerability with respect to inadequate provision of interpreter services.
C. The National Health Law Institute's report on "Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities," 1998, Executive Summary
D. Senate Bill 1840 amended the Section 1259, Health and Safety Code
E. DMHC Title 28, Section 130067.04: Language Assistance Programs
F. A list of resources to assist medical interpreters
G. Information on appropriate skills for persons who interpret

H. Lists of training and testing resources for maintaining and enhancing interpreter skills
I. Training for practitioners on how to work effectively with interpreters.

3.0 MEMBER EDUCATION

LEP and hearing impaired members will be informed of their right to free interpreter services via the Member Handbook.[3] All member materials will be translated into threshold languages. *(See KHS Policy and Procedure #12.02-I Translation of Written Member Informing Materials*).

Members will be informed of the availability of linguistic services through new member orientations and the member handbook. All materials that inform a member of his/her rights will include information regarding the member's right to:

A. Interpreter services at no charge when accessing covered health care
B. Not use friends or family members as interpreters, unless specifically requested by the member
C. Request face to face or telephone interpreter services during discussions of complex medical information such as diagnoses of complex medical conditions or discussions of complex procedures
D. Receive informing documents translated into threshold languages[4] or alternative formats
E. File grievances if linguistic needs are not met
F. Member informing material will have the following notice: IMPORTANT LANGUAGE INFORMATION: You can get an interpreter at no cost to help you talk to your doctor or to Kern Family Health Care. To get an interpreter or to ask about written information in your language, please call Kern Family Health Care at (661) 632-1590 or 1-800-391-2000. Hearing or speech impaired members can call (661) 632-1590 or 1-800-391-2000 through the TDD/TTY line at 711. If you need more help, call the HMO Help Line at 1-888-466-2219.
G. Non-standardized vital documents that contain member specific information will contain the following notice: IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Kern Family Health Care's Member Services Department at (661) 632-1590 or 1-800-391-2000 right away.

4.0 MONITORING

Linguistic services are coordinated by the Health Education Cultural & Linguistic Specialist. The Representative oversees the educational program(s) developed for KHS staff, Contracted providers, and their staff on interpreter services, implementation of bilingual proficiency guidelines, and the coordination and monitoring of interpreter services.

4.1 Via the Credentialing and Recredentialing Process

The Quality Improvement Department performs site review audits at the time of credentialing and recredentialing, which includes checking language services provided at provider offices.

4.2 Via the Updating of the Provider Directory Process
When updating the *Provider Directory*, Provider Relations staff contact each office listed to verify contact information and the language capabilities of the office.

4.3 Via the Group Needs Assessment
The *Health Education and Cultural/Linguistic Group Needs Assessment* considers members preferred languages and the need for interpreters. Through the needs assessment KHS identifies gaps in language needs for our members.

4.4 Via the Grievance Process
Member Services staff log calls related to language barriers with contracted providers. This information is used to track discrepancies between contracted providers stated language capabilities and the services actually received by members.

4.5 Via Survey Calls
KHS' Compliance staff conduct monthly survey calls to contracted providers. These calls assess member access to interpreting services. (See Attachment B).

4.6 Language Line
Monthly, the Language Line bill is compared to phone logs to validate proper billing. Statistics are compiled on a monthly basis as to the language most frequently requested and the providers that request assistance. If the member's demographic information in KHS documentation system has not been documented as to language requirements, the system will be updated with same.

4.7 LifeSigns
Monthly, the LifeSigns invoice is compared to phone logs and request forms to validate proper billing. Statistics are compiled on a monthly basis as to the number of sign language interpreters requested and the providers that request assistance.

ATTACHMENTS:
Attachment A: Language Line *Phone Log*
Attachment B: Call Script and Spreadsheet

REFERENCE:

Revision 01/2017: Revised to include education and training on interpreting ethics, conduct and confidentiality for all KHS staff that provide translation and/or interpretation service to members. New requirement that Compliance staff make monthly access calls to contracted providers. CAP response to 2016 DMHC audit. **Revision 2015-06:** Policy renumbered to Health Education section as requested and approved by Member Services and Health Services Directors (previously 11.01-I). Health Services to oversee Cultural and Linguistics services. **Revision 2014-03:** Policy revised to comply with 1115 Waiver SPD Enrollment Survey; Potential Deficiency #12. **Revision 2013-06:** Policy revised to comply with DMHC comments on Timely Access. Approved by DHCS as SPD Deliverable 7-F. **Revision 2006-08:** Revised as requested (06/23/2006). **Revision 2005-09:** Routine revision. **Revision 2003-11:** Created per Member Education Department request.

[1] Title VI Civil Right Act of 1964

[2] Title VI Civil Right Act of 1964

[3] Title VI Civil Right Act of 1964
[4] MMCD 99-04

LANGUAGE LINE LOG

DATE	START TIME	MBR NAME	MBR#	PROVIDER/REASON	LANGUAGE	INTERPRETER	Length of call	MSR	COMMENTS

1. As a member who does not speak English, do you have interpreters available to help me communicate with my provider?

a. **YES –**
    i. **For which languages do you have interpreters available on site? – *if no interpreters on site, go to iii.***
    ii. **Are your interpreters available at any time during your regular office hours?**
        a. **YES – *go to iii.***
        b. **NO –**
            i. **When are your onsite interpreters available?**
    iii. **How would I access interpreting services if I don't speak the same language as your onsite interpreters? – *end of questions***
b. **NO –**
    i. **As a member who does not speak English, how would I access interpreting services to help me and my provider communicate?**

	PROVIDER NAME	Specialty	OFFICE	TELEPHONE #	ADDRESS	Zip	City	DATE CALLED	Time Called	Spoke With	Q1 Interpreters Available	Q1.a.i Languages Available Onsite	Q1.a.ii.1 Available Anytime During Regular Office Hours	Q1.a.ii.2 If Q1.a.ii.1 Marked "No", then when?	Q1.a.iii Interpreting services if not same language as onsite interpreter	Q1.b If Q1 Marked "No", then how does member access future services?	Notes
1																	
2																	
3																	
4																	
5																	