REGULAR MEETING OF THE QI/UM COMMITTEE

Thursday, May 24, 2018
at
7:00 A.M.

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

The public is invited

For more information, call (661) 664-5000

AGENDA

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

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

Regular Meeting
Thursday, May 24, 2018

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.

COMMITTEE MEMBERS: Jennifer Ansolabehere, PHN; Satya Arya, MD; Danielle C Colayco, PharmD, MS; Felicia Crawford, RN; Allen Kennedy; Philipp Melendez, MD; Chan Park, MD; Maridette Schloe MS, LSSBB; Martha Tasinga, MD, CMO

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" ARE CONSIDERED TO BE ROUTINE AND NON-CONTROVERSIAL BY KERN HEALTH SYSTEMS STAFF. THE "CA" REPRESENTS THE CONSENT AGENDA. CONSENT ITEMS WILL BE CONSIDERED FIRST AND MAY BE APPROVED BY ONE MOTION IF NO COMMITTEE MEMBER OR AUDIENCE WISHES TO COMMENT OR ASK QUESTIONS. IF COMMENT OR DISCUSSION IS DESIRED BY ANYONE, THE ITEM WILL BE REMOVED FROM THE CONSENT AGENDA AND WILL BE CONSIDERED IN LISTED SEQUENCE WITH AN OPPORTUNITY FOR ANY MEMBER OF THE PUBLIC TO ADDRESS THE COMMITTEE MEMBERS CONCERNING THE ITEM BEFORE ACTION IS TAKEN.

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Committee Members on any matter not on this agenda but under the jurisdiction of the Committee Members. Committee Members may respond briefly to statements made or questions posed. They may ask a question for clarification, make a referral to staff for factual information or request staff to report back to the Committee Members at a later meeting. Also, the Committee Members may take action to direct the staff to place a matter of business on a future agenda. SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Committee Members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Gov. Code Sec. 54954.2[a])

3) Announcements
   - Form 700

4) Closed Session

5) CMO Report

CA-6) QI/UM Committee Summary of Proceedings February 22, 2018 – RECEIVE AND FILE

CA-7) Physician's Advisory Committee (PAC) Summary of Proceedings 1st Quarter – RECEIVE AND FILE
   - February 2018
   - March 2018

CA-8) Pharmacy TAR Log Statistics 1st Quarter 2018 – RECEIVE AND FILE
   - January 2018
   - February 2018
   - March 2018

CA-9) QI Focus Review Report 1st Quarter 2018 – RECEIVE AND FILE
   - Critical Elements Monitoring Ending March 31, 2018
   - IHEBA Monitoring Ending March 31, 2018
   - IHA Monitoring Ending March 31, 2018
   - KRC Monitoring Ending March 31, 2018
   - CCS Monitoring Ending March 31, 2018
   - Perinatal Care Monitoring Ending March 31, 2018

CA-10) QI Site Review Summary Report 1st Quarter 2018 – RECEIVE AND FILE

CA-11) QI SHA Monitoring Report 1st Quarter 2018 – RECEIVE AND FILE

Kaiser Reports

CA-12) Kaiser KHS UM DME Authorization Denial Report – RECEIVE AND FILE

- 4th Quarter 2017

CA-13) Kaiser KHS Health Plan Dental Report– RECEIVE AND FILE

- 1st Quarter 2018

CA-14) Kaiser KHS Mental Health Report – RECEIVE AND FILE

- 4th Quarter 2017

CA-15) Kaiser CBA Reports – RECEIVE AND FILE

- 1st Quarter 2018

CA-16) Kaiser APL Grievance Report – RECEIVE AND FILE

- 1st Quarter 2018

CA-17) Kaiser Volumes Report – RECEIVE AND FILE

- 1st Quarter 2018

VSP Reports

CA-18) VSP Medical Data Collection Summary Reports – RECEIVE AND FILE

- March 2017-February 2018

CA-19) QI Program Description Policy 4010
CA-20) VSP QI Work Plan Evaluation 2017
CA-21) VSP QI Work Plan 2018

Member Services

CA-22) Call Center Report 1st Quarter 2018 – RECEIVE AND FILE

- Kern Health Systems/Kaiser

CA-23) Comparative Tabulated Grievance Reports – RECEIVE AND FILE

- 4th Quarter 2017

CA-24) Grievance Summary Reports – RECEIVE AND FILE

- 4th Quarter 2017

Provider Relations

CA-25) Re-credentialing Report 2018 1st Quarter – RECEIVE AND FILE
CA-26) Board Approved New Contracts – RECEIVE AND FILE

- Effective March 1, 2018
- Effective April 1, 2018
- Effective May 1, 2018

CA-27) Board Approved Providers Reports – RECEIVE AND FILE

- Effective March 1, 2018
- Effective April 1, 2018
- Effective May 1, 2018

CA-28) Access Monitoring Report 1st Quarter 2018 – RECEIVE AND FILE

Disease Management

CA-29) Disease Management 1st Quarter 2018 Report – RECEIVE AND FILE

Policies and Procedures

CA-30) Health Education Policies and Procedures 2.30 and 3.70 – RECEIVE AND FILE

- 2.30-I Health Education 2017-12
- 3.70-I Cultural and Linguistic Services 2018-01

CA-31) UM Policies and Procedures 2.45-3.77 – RECEIVE AND FILE

- 2.45-I Delegation of QI, UM, Care and Case Management and Pharmacy 2017-12
- 3.10-P Alcohol and Substance Abuse Treatment 2018-03
- 3.13-P EPSDT Supplemental Services and Targeted Case Management 2018-01
- 3.14-P Mental Health Services 2018-01
- 3.23-P Provider Appeals Regarding Authorization 2017-11
- 3.61-I Comprehensive Case Management and Coordination of Care 2017-11
- 3.69-I Provider Preventable Conditions 2018-03
- 3.75-I Health Risk Assessment 2018-01
- 3.77-I Palliative Care 2018-02

Health Education Reports

32) Health Ed Activities Report 1st Quarter 2018 - APPROVE

QI Department Reports

33) 2017 QI Program Evaluation – APPROVE

34) 2018 QI Program Description – APPROVE

35) 2018 QI Work Plan – APPROVE

36) HEDIS – APPROVE

UM Department Reports

37) 2017 UM Evaluation – APPROVE

38) 2018 UM Program Description – APPROVE

39) Combined UM Reporting 1st Quarter 2018 – APPROVE

ADJOURN TO THURSDAY, AUGUST 23, 2018 AT 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

The meeting facilities at Kern Health Systems are accessible to persons with disabilities. Disabled individuals who need special assistance to attend or participate in a meeting of the Board of Directors may request assistance at the Kern Health Systems office, 9700 Stockdale Highway, Bakersfield, California or by calling (661) 664-5000. Every effort will be made to reasonably accommodate individuals with disabilities by making meeting material available in alternative formats. Requests for assistance should be made five (5) working days in advance of a meeting whenever possible.

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, February 22, 2018
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.; LSSBB; Danielle C Colayco, PharmD, MS; Allen Kennedy; Chan Park, MD; Maridette Schloe MS, Martha Tasinga, M.D., C.M.O.

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

Meeting called to order by Dr. Martha Tasinga, M.D., C.M.O. @ 7:01 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

1) This portion of the meeting is reserved for persons to address the Committee Members on any matter not on this agenda but under the jurisdiction of the Committee Members. Committee Members may respond briefly to statements made or questions posed. They may ask a question for clarification, make a referral to staff for factual information or request staff to report back to the Committee Members at a later meeting. Also, the Committee Members may take action to direct the staff to place a matter of business on a future agenda. SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Committee Members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Gov. Code Sec. 54954.2[a])

3) Announcements:
- Form 700 **– Committee members that were present at today's meeting turned in their 700 forms for 2018.**

4) Closed Session: Philipp Melendez, MD to be voted into QI-UM Committee, after attending 3rd meeting - APPROVED
Colayco-Arya: All Ayes

CA-5) QI/UM Committee Summary of Proceedings November 16, 2017 – RECEIVED AND FILED
Arya-Colayco: All Ayes (Items CA-5 through CA-24)

CA-6) Physician's Advisory Committee (PAC) Summary of Proceedings 4th Quarter RECEIVED AND FILED
- October 2017
- November 2017
- December 2017

CA-7) Pharmacy 2017 TAR Log Statistics 4th Quarter – RECEIVED AND FILED
- October 2017
- November 2017
- December 2017

CA-8) QI Focus Review Report 4th Quarter 2017 – RECEIVED AND FILED
- Critical Elements Monitoring Ending December 31, 2017
- IHEBA Monitoring Ending December 31, 2017

- IHA Monitoring Ending December 31, 2017
- KRC Monitoring Ending December 31, 2017
- CCS Monitoring Ending December 31, 2017
- Perinatal Care Monitoring Ending December 31, 2017

CA-9) QI Site Review Summary Report 4th Quarter 2017 – RECEIVED AND FILED

CA-10) QI SHA Monitoring Report 4th Quarter 2017 – RECEIVED AND FILED

Kaiser Reports

CA-11) Kaiser KHS UM DME Authorization Denial Report – RECEIVED AND FILED
- 3rd Quarter 2017

CA-12) Kaiser KHS Health Plan Dental Report– RECEIVED AND FILED
- 4th Quarter 2017

CA-13) Kaiser KHS Mental Health Report – RECEIVED AND FILED
- 3rd Quarter 2017

CA-14) Kaiser CBA Reports – RECEIVED AND FILED
- 4th Quarter 2017

CA-15) Kaiser APL Grievance Report – RECEIVED AND FILED
- 4th Quarter 2017

VSP Reports

CA-16) VSP Medical Data Collection Summary Reports – RECEIVED AND FILED
- January 2017-December 2017

Member Services

CA-17) Call Center Report 4th Quarter 2017 – RECEIVED AND FILED
- Kern Health Systems/Kaiser

***Nate Scott, Director of Member Services, replaced the Q4 2017 Call Center Report with an updated version during the meeting as a hand-out, due to incorrect data in the original report.**

CA-18) Comparative Tabulated Grievance Reports – RECEIVED AND FILED
- 3rd Quarter 2017

CA-19) Grievance Summary Reports – RECEIVED AND FILED
- 3rd Quarter 2017

Provider Relations

CA-20) Re-credentialing Report 2017 4th Quarter – RECEIVED AND FILED

CA-21) Board Approved New Contracts – RECEIVED AND FILED
- Effective January 1, 2018

CA-22) Board Approved Providers Reports – RECEIVED AND FILED

- Effective January 1, 2018

CA-23) 4th Quarter 2017 Access Monitoring Report – RECEIVED AND FILED

Disease Management

CA-24) Disease Management 4th Quarter 2017 Report – RECEIVED AND FILED

Health Education Reports

25) 4th Quarter 2017 Health Ed Activities Report – APPROVED
Arya-Kennedy: All Ayes

UM Department Reports

26) 4th Quarter 2017 Combined UM Reporting – APPROVED
Arya-Kennedy: All Ayes

Meeting adjourned by Dr. Martha Tasinga, M.D., C.M.O. @ 7:30 A.M.
to Thursday, May 24, 2018

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

The meeting facilities at Kern Health Systems are accessible to persons with disabilities. Disabled individuals who need special assistance to attend or participate in a meeting of the Board of Directors may request assistance at the Kern Health Systems office, 9700 Stockdale Highway, Bakersfield, California or by calling (661) 664-5000. Every effort will be made to reasonably accommodate individuals with disabilities by making meeting material available in alternative formats. Requests for assistance should be made five (5) working days in advance of a meeting whenever possible.

AGENDA

PHYSICIAN ADVISORY COMMITTEE MEETING

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

Wednesday, January 31, 2018
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.

PLEASE REMEMBER TO TURN OFF ALL CELL PHONES, PAGERS OR ELECTRONIC DEVICES DURING MEETINGS.

COMMITTEE TO RECONVENE

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

Members Absent: Miguel Lascano, M.D.

Meeting called to order at 7:02 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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.

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Committee on any matter not on this agenda but under the jurisdiction of the Committee. Committee members may respond briefly to statements made or questions posed. They may ask a question for clarification; make a referral to staff for factual information or request staff to report back to the Committee at a later meeting. Also, the Committee may take action to direct the staff to place a matter of business on a future agenda.
SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Committee members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Gov. Code Sec. 54954.2[a])

CA-3) Minutes for KHS Physician Advisory Committee meeting on December 6, 2017 – APPROVED
Patel-Amin: All Ayes

ADJOURNED TO CLOSED SESSION @ 7:04 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 @ 7:29 A.M.

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

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

7) Review Policy 3.23-P Provider Appeals Regarding Authorization – RECEIVED AND FILED

8) Review Policy 3.42-P Nursing Facility Services and Long Term Care – RECEIVED AND FILED

9) Review Policy 3.53-P Cancer Treatment – RECEIVED AND FILED

10) Review Policy 3.61-I Comprehensive Case Management and Coordination of Care – RECEIVED AND FILED

11) Review Policy 5.15-I Member Transportation Assistance – RECEIVED AND FILED

12) Review Policy 12.02-I Translation of Written Member Informing Materials – RECEIVED AND FILED

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 8:02 A.M. TO WEDNESDAY, MARCH 7, 2018 AT 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

The meeting facilities at Kern Health Systems are accessible to persons with disabilities. Disabled individuals who need special assistance to attend or participate in a meeting of the KHS Finance Committee may request assistance at the Kern Health Systems office, 9700 Stockdale Highway, Bakersfield, California or by calling (661) 664-5000. Every effort will be made to reasonably accommodate individuals with disabilities by making meeting material available in alternative formats. Requests for assistance should be made five (5) working days in advance of a meeting whenever possible.

SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE MEETING

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

Wednesday, March 7, 2018
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.

PLEASE REMEMBER TO TURN OFF ALL CELL PHONES, PAGERS OR ELECTRONIC DEVICES DURING MEETINGS.

COMMITTEE RECONVENED

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

Members Absent: Hasmukh Amin, M.D., Raju Patel, M.D.

Meeting called to order at 7:02 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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.

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Committee on any matter not on this agenda but under the jurisdiction of the Committee. Committee members may respond briefly to statements made or questions posed. They may ask a question for clarification; make a referral to staff for factual information or request staff to report back to the Committee at a later meeting. Also, the Committee may take action to direct the staff to place a matter of business on a future agenda.
SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Committee members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Gov. Code Sec. 54954.2[a])

CA-3) Minutes for KHS Physician Advisory Committee meeting on January 31, 2017 – APPROVED
Paul Gordon-Parmar: All Ayes

ADJOURNED TO CLOSED SESSION @ 7:05 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 @ 7:25 A.M.

5) Review of “Up To Date” for use as a reference for decision making – APPROVED
Paul Gordon-Egbikuadje: All Ayes

- **PAC approved the use of Up to Date as part of the evidence based hierarchy of medical criteria used by the KHS medical directors for medical necessity determinations in the utilization management process.**

6) Varicose Vein Treatment Modalities Criteria – APPROVED
- **The revised criteria for venous ablation and venous dopplers was approved by committee.**
- **Outlined the Primary Care doctor’s responsibilities to preform prior to referring the patient.**

- **Outlined the vascular specialist's requirements before requesting interventional procedures.**
- **Clarified the American Board of Vascular Medicine's qualifications interventionalists must fulfill prior to performing vein procedures, and clarified saphenofemoral junction being the sole source of reflux.**

7) IV Iron Criteria – APPROVED
Paul Gordon-Parmar: All Ayes

- **The committee approved the modifications to the existing Parenteral Iron Supplementation Criteria. Changes were made to align with current national guidelines and best practices for IV iron supplementation.**

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 8:07 A.M. TO WEDNESDAY, APRIL 4, 2018 AT 7:00 A.M.

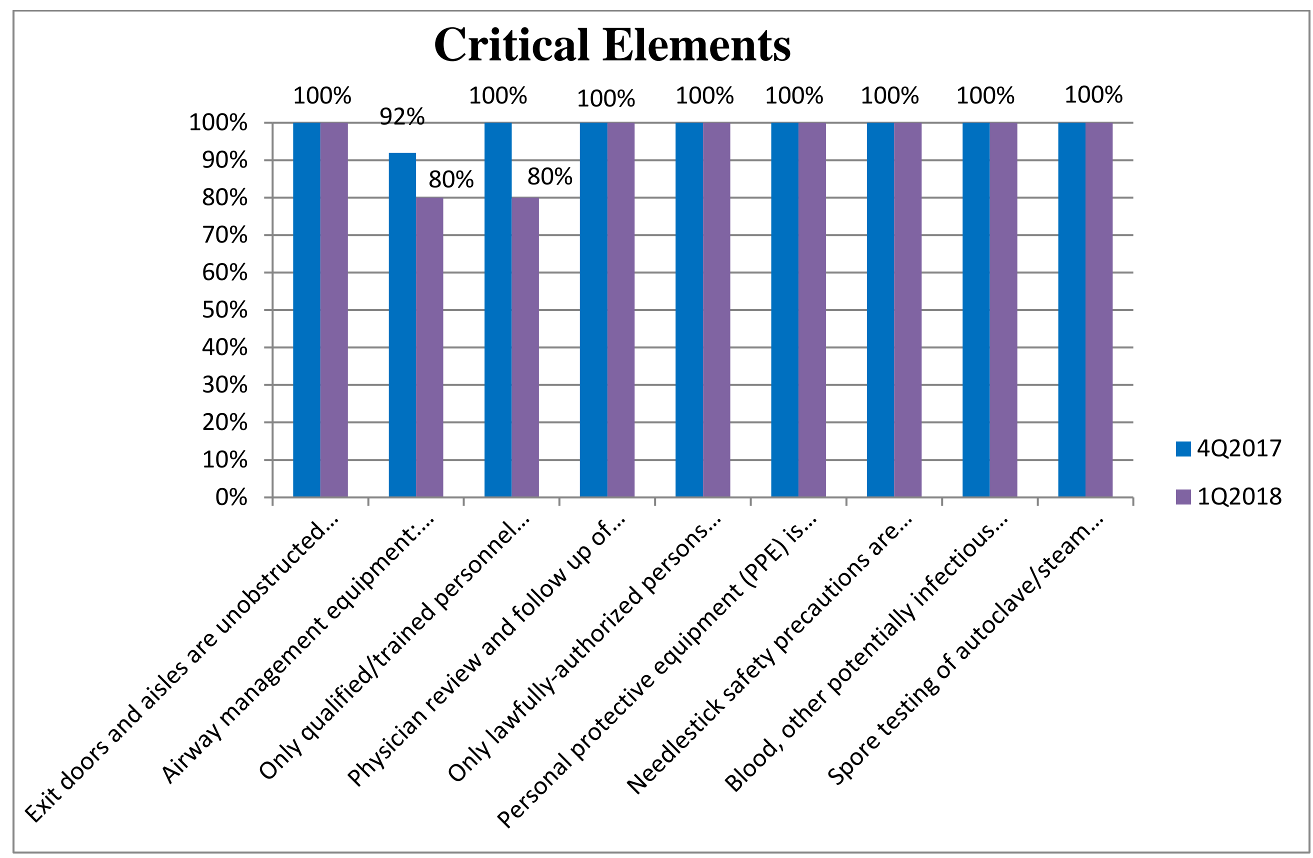
AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

The meeting facilities at Kern Health Systems are accessible to persons with disabilities. Disabled individuals who need special assistance to attend or participate in a meeting of the KHS Finance Committee may request assistance at the Kern Health Systems office, 9700 Stockdale Highway, Bakersfield, California or by calling (661) 664-5000. Every effort will be made to reasonably accommodate individuals with disabilities by making meeting material available in alternative formats. Requests for assistance should be made five (5) working days in advance of a meeting whenever possible.

Quarter/Year of Audit	2018	2018	2018	2018	2018	2018	2018	2018	2018	2018	2018	2018
Month Audited	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Total TAR's for the month	3359	3056	3812									
Compliant	100%	99%	99%									
APPROVED TAR'S												
Timeliness - Reviewed & Returned in 1 busines day	76/76	72/72	87/88									
Date Stamped	76/76	72/72	88/88									
Fax copy attached	76/76	72/72	88/88									
Decision marked	76/76	72/72	88/88									
DENIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	63/63	53/53	63/63									
Initally Denied - Signed by Medical Dir and/or Pharm	63/63	53/53	63/63									
Letter sent within time frame	63/63	53/53	63/63									
Date Stamped	63/63	53/53	63/63									
Fax copy attached	63/63	53/53	63/63									
Decision marked	63/63	53/53	63/63									
Correct form letter, per current policies used	63/63	53/53	63/63									
MODIFIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	0	0	0									
Date Stamped	0	0	0									
Fax copy attached	0	0	0									
Decision marked	0	0	0									
Correct form letter, per current policies used	0	0	0									
DUPLICATE TAR'S												
Timeliness - Reviewd & Returned in 1 business day	12/12	9/10	17/17									
Date Stamped	12/12	10/10	17/17									
Fax copy attached	12/12	10/10	17/17									

Critical Elements Reviews: Five (5) providers were evaluated in 1st Quarter 2018.

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.

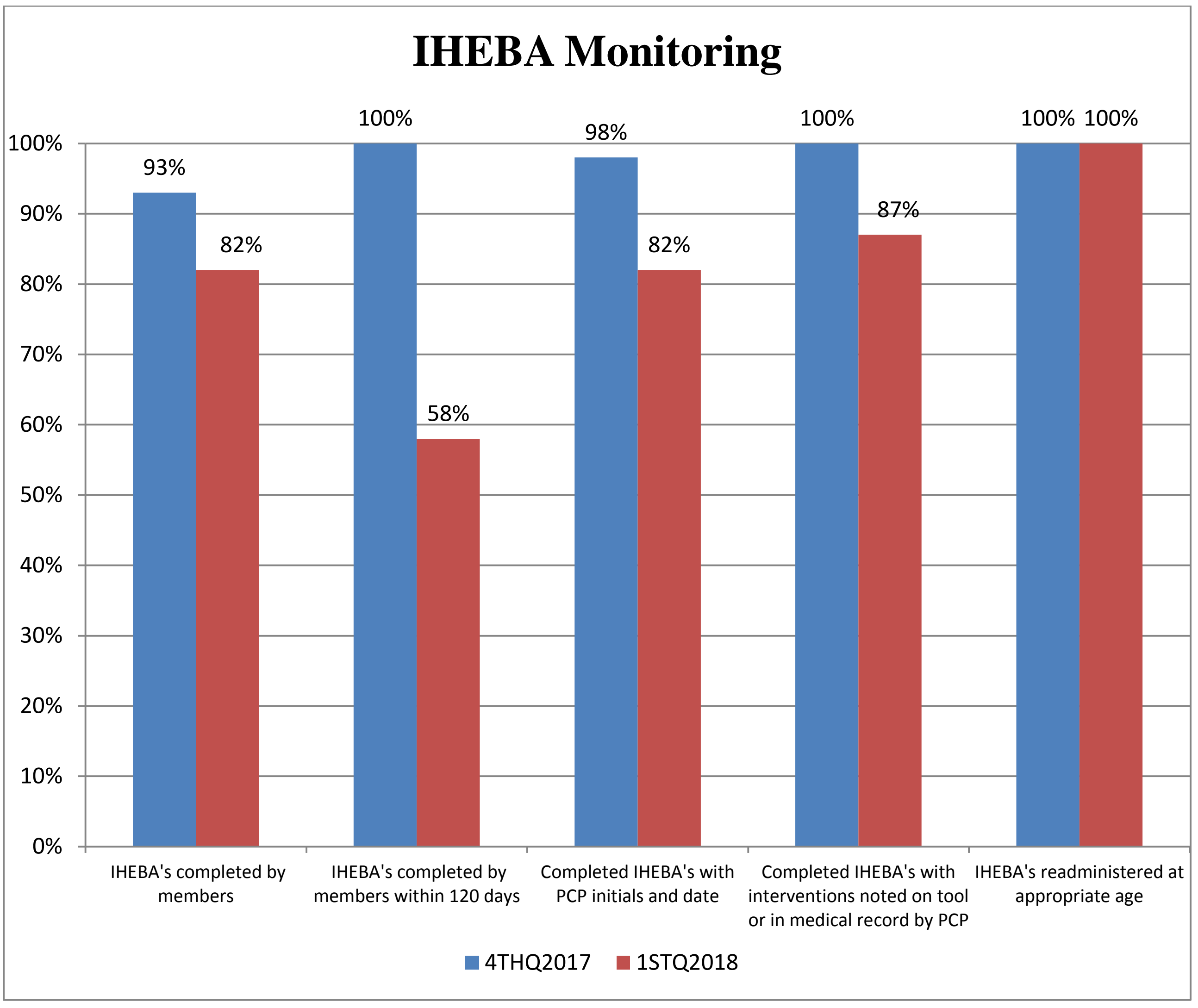


The five providers evaluated in the 1st Quarter scored 100% in 7 out of 9 areas. The two areas with opportunities for improvement were related to qualified personnel preparing and administering medications and Physician Review and Follow-up on referral and diagnostic test results. Correction Action Plans (CAPs) were issued and the deficiencies were corrected.

IHEBA Reviews: In 1st Quarter 2018, 26 charts were reviewed from five (5) providers. Only one (1) provider met all the requirements of this review. The areas for improvement noted were:

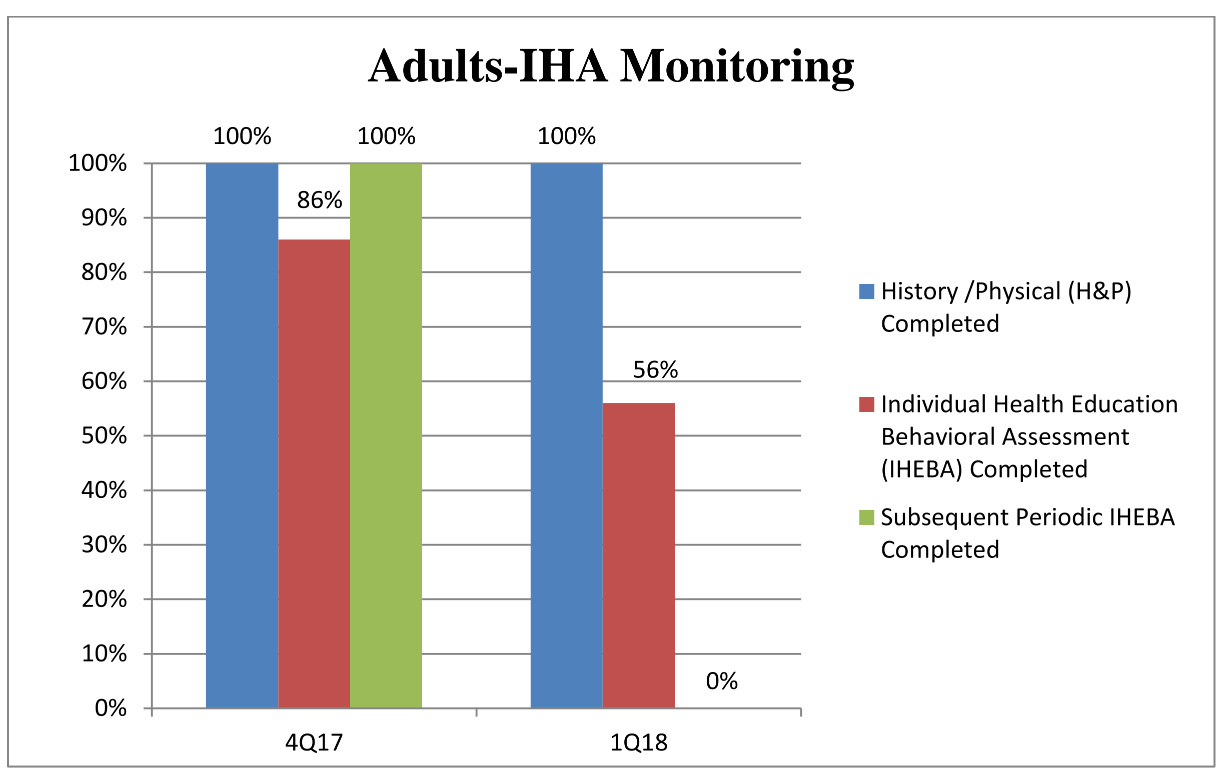
- member completion of IHEBAs,
- member completion of IHEBAs within 120 days,
- PCP initialing and dating of completed IHEBAs,
- PCP notation of IHEBA interventions in medical records.

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 1st Quarter 2018, five (5) providers were evaluated. There were four (4) Adult records and seven (7) Pediatric records reviewed.

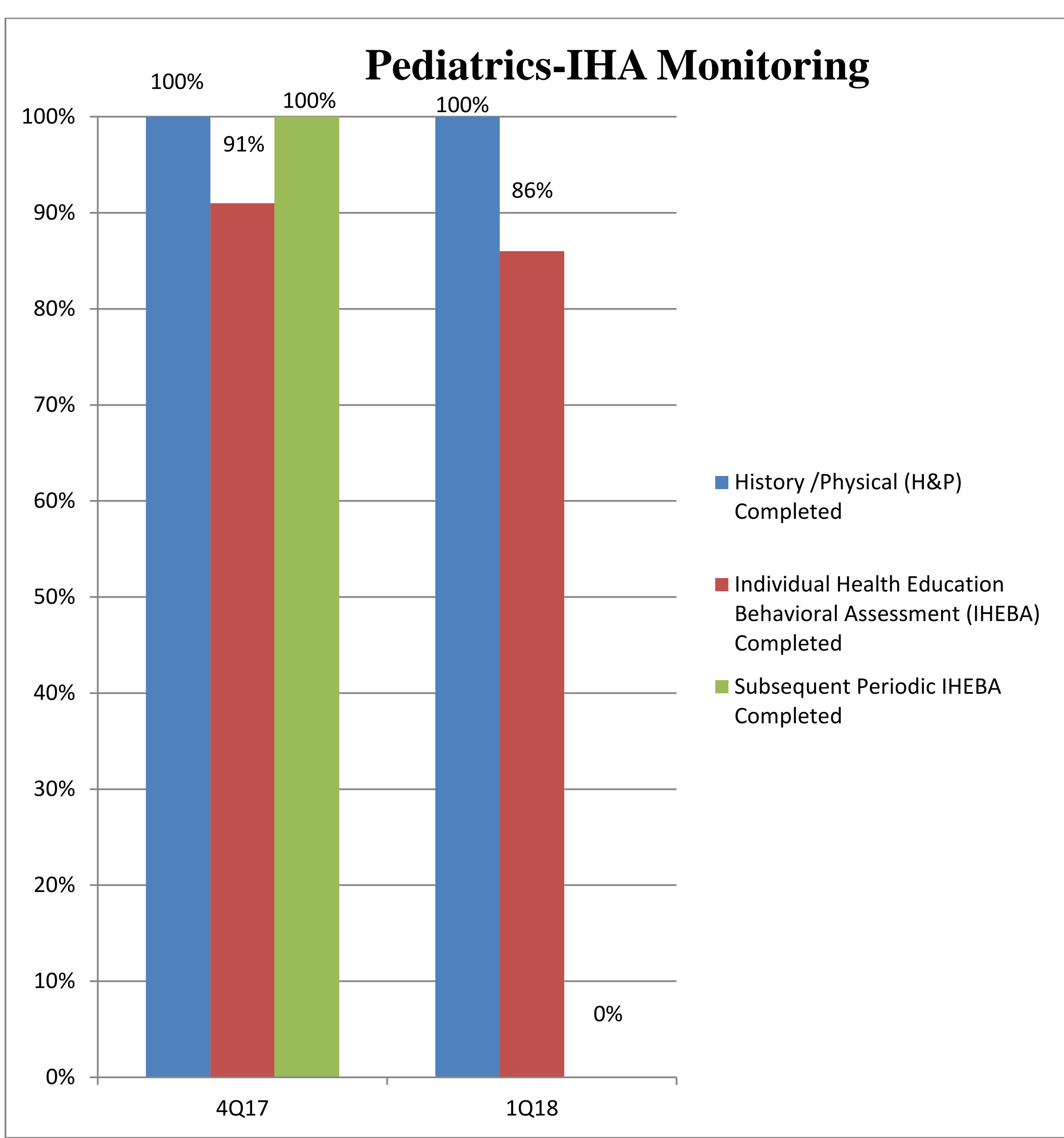
SUMMARY: An Initial Health Assessment (IHA) must be provided to each member within 120 days of enrollment. As PCP's receive their assigned panels, the Practitioner's office should contact members to schedule an IHA to be performed within the 120 day time limit. If the practitioner/staff is unable to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



All Five (5) of the providers reviewed serving adults had the H&Ps completed in the 1st quarter. The area in most need of improvement this quarter was the Staying Health Assessment, and the Subsequent periodic IHEBA component was not applicable to the charts reviewed in 1Q18.

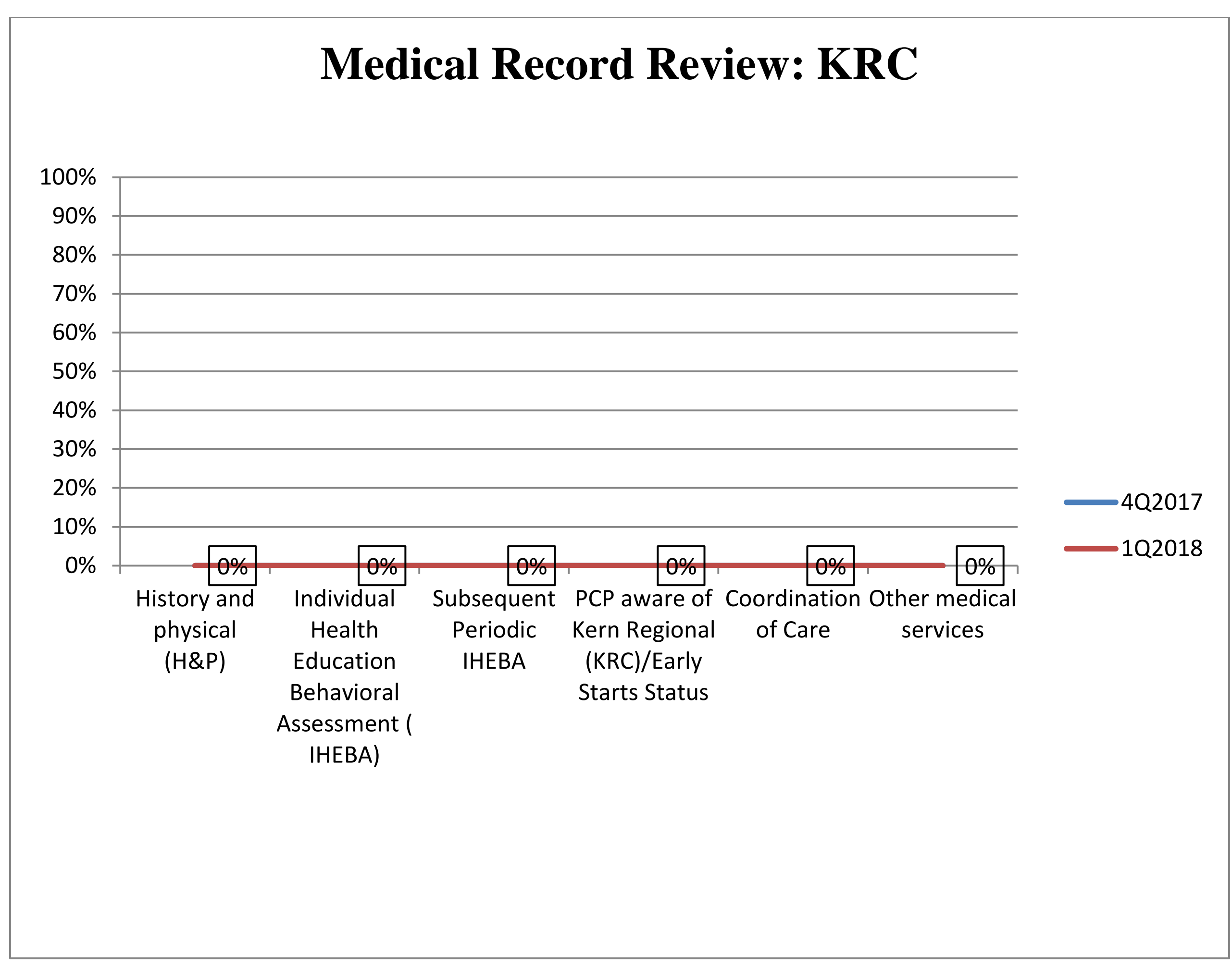
Both adult and pediatric providers perform H&Ps during the initial health assessment. The initial IHEBA/Staying Health Assessment should be performed during the IHA. Performance in Pediatric IHEBA use remains higher than in the adult population for all elements. Corrective Action Plans were implemented 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 was 100% for the last 2 quarters. Two (2) out of five providers completed all the Staying Health Assessments during the IHA, and the Subsequent Periodic IHEBA component was not applicable to the charts reviewed for 1st Quarter 2018.. Corrective Action Plans for deficiencies have been implemented and follow-up visits will be conducted.



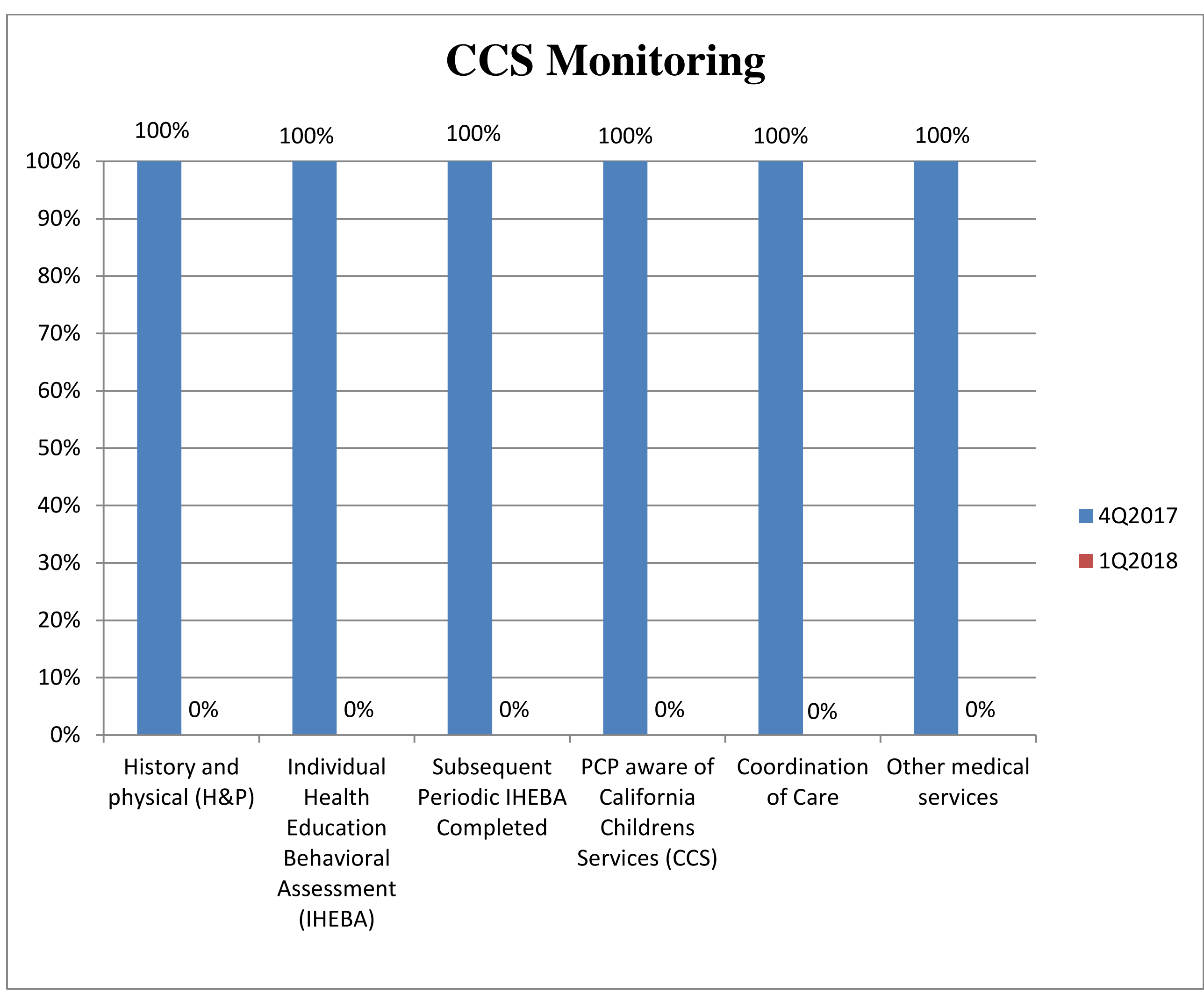
KRC Reviews: In 1st Quarter 2018 there were no KRC charts reviewed.

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: Out of the five (5) providers surveyed in 1st Quarter 2018, there were no CCS charts reviewed.

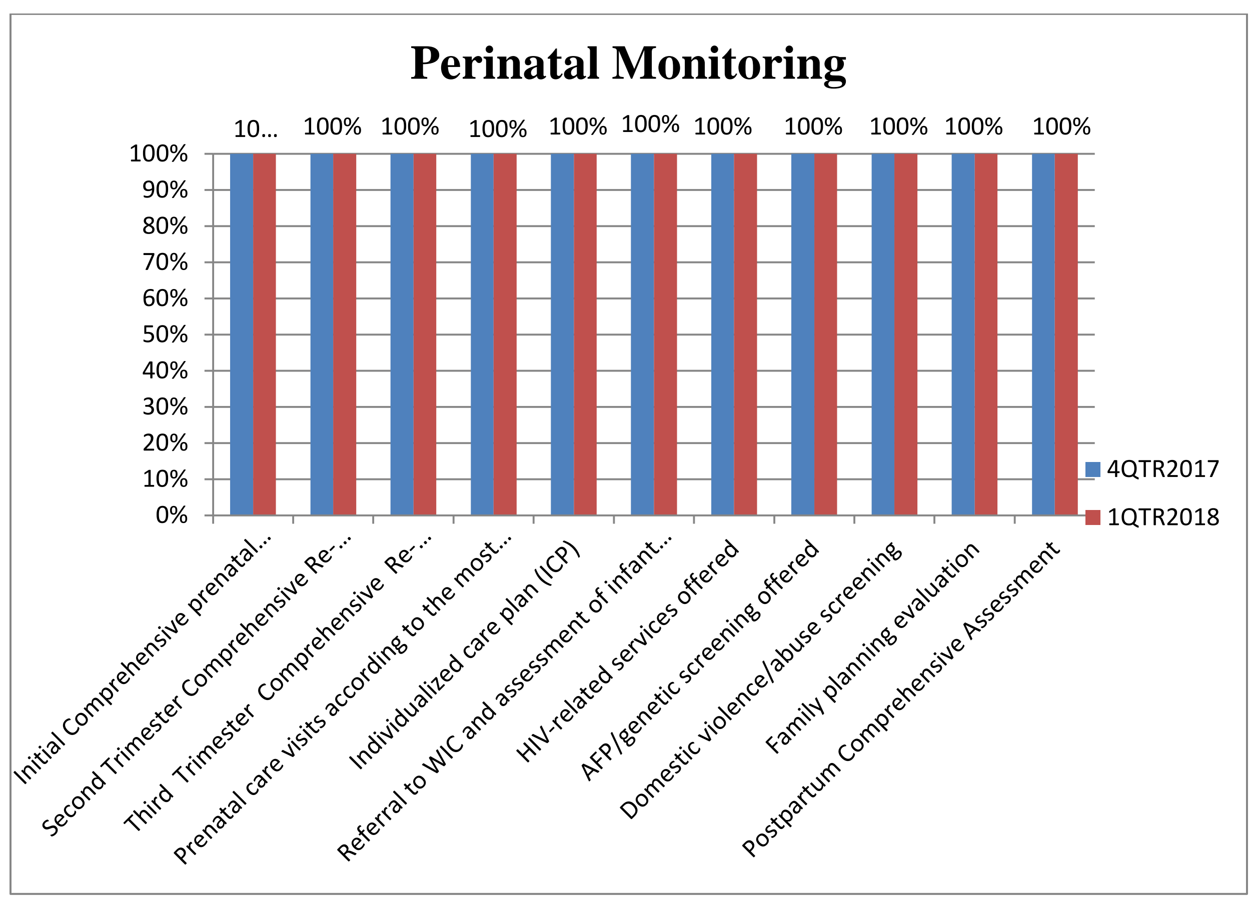
SUMMARY: KHS ensures the provision of primary care interventions and other medically necessary covered services unrelated to the CCS eligible condition through medical record review evidenced by appropriate primary care and other necessary intervention. KHS collaborates with CCS, the CCS Specialist,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



Perinatal Reviews: Out of the five (5) providers surveyed in 1st Quarter 2018 there were 15 perinatal charts 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).

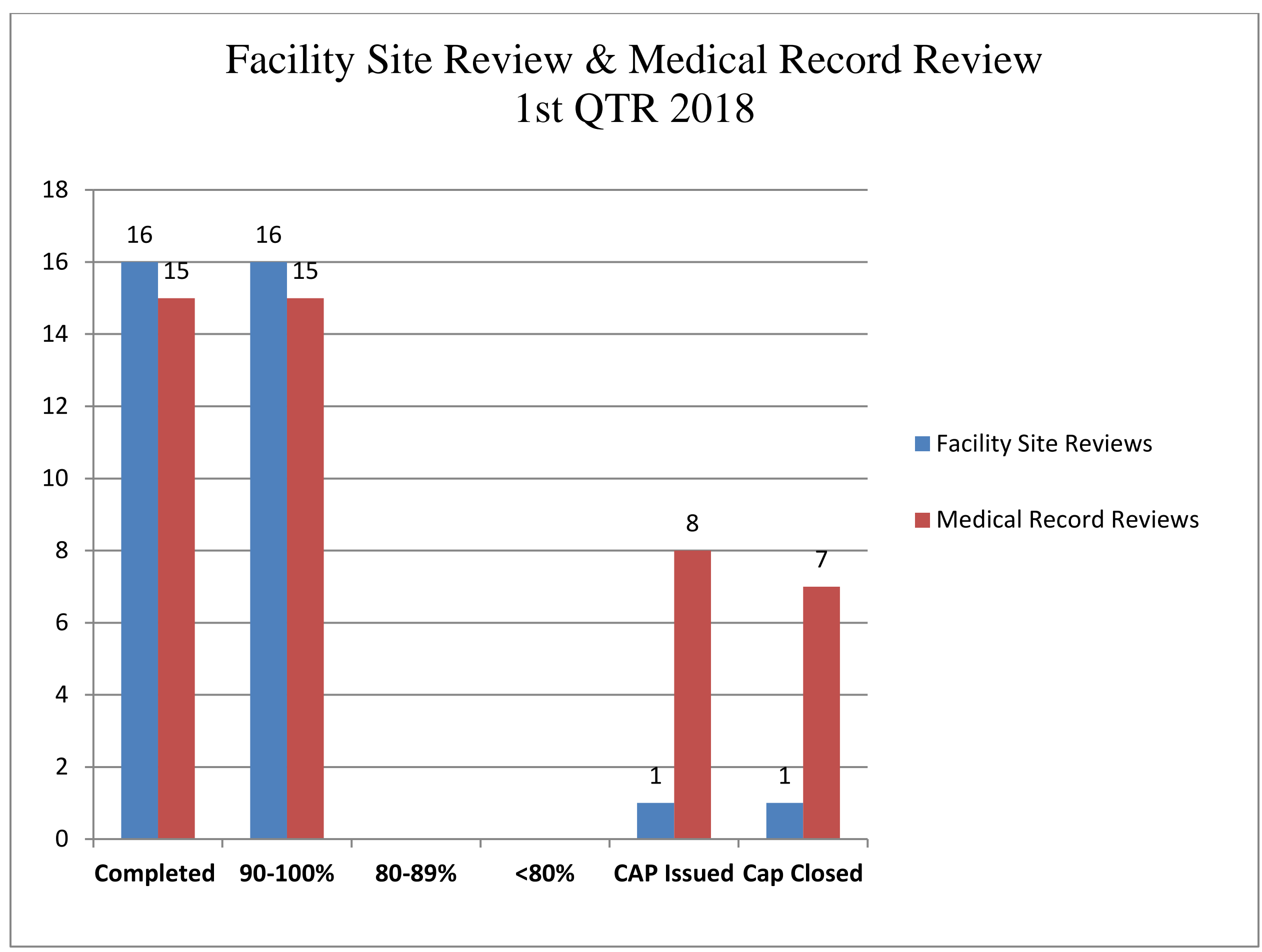
OB patients are routinely monitored through the QI Department's medical record reviews. Timeliness of prenatal and postpartum care is monitored for HEDIS. When appropriate, the QI nurse implements a CAP for the KHS provider and notifies Provider Relations for follow-up. The QI department collects data 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 1Q18 all Providers scored 100% in all areas.



Disciplinary Involvement: Quality Improvement and Provider Relations
Data Retrieval Method: Chart Review, Observation, Interview/Survey, Physical Inspection
Department: Quality Improvement
Monitoring Period: January 1, 2018- March 31, 2018

A total of sixteen (16) Office Site Reviews were completed in the 1st Quarter of 2018. Out of the sixteen (16) completed, four (4) were Initial Reviews and twelve (12) were Periodic Reviews. Three (3) out of the sixteen (16) performed were for Urgent Care Centers and two (2) were OB only.

A total of fifteen (15) Medical Record Reviews were completed in the 1st Quarter of 2018. One (1) was an Initial Medical Record Reviews and fourteen (14) were Periodic Medical Record Reviews. There was one (1) Facility Site Review CAP and eight (8) Medical Record Review CAPs issued. Seven (7) Medical Record Review CAPs were closed, and one (1) Full Site Review CAP was closed. One Medical Record Review CAP remains open.



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

- Airway management equipment, appropriate to practice and populations served, are present on site.
- Only qualified/trained personnel retrieve, prepare or administer medications

Top Medical Record Review Deficiencies

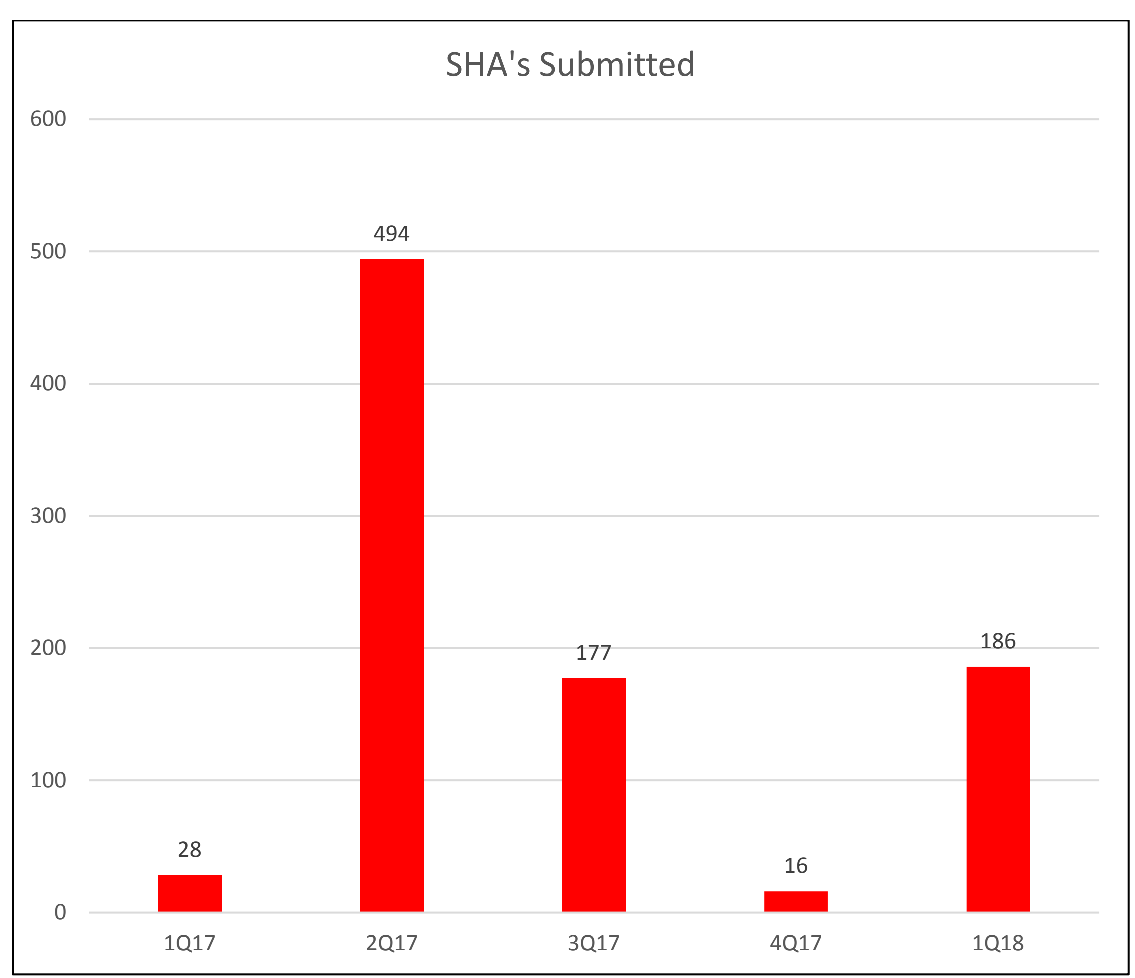
- IHEBAs completed by members.
- IHEBAs completed by member within 120 days.
- PCP initials and dates on completed IHEBAS,
- PCP Notation of Interventions noted in medical records.

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.

SUMMARY: KHS works 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 1st Quarter 2018, there were 186 positive SHAs sent to Health Education. This increase was related to the number of records reviewed for HEDIS.



Kaiser Foundation Health Plan
Southern California Region
4th Quarter UM DME Report 2017

Kern Family Health

Q4 2017	ALL PLAN MEDI-CAL	Kern Family Health
ENROLLMENT	422125.00	7874.00
ACUTE DAYS/1000 MEMB	171.73	128.53
ACUTE DISCHARGES/1000 MEMB	45.90	48.70
ACUTE ALOS	3.73	2.59
ACUTE READMISSION RATE	0.14	0.03
SNF DAYS/1000 MEMB	16.58	0.00
SNF DISCHARGES/1000 MEMB	0.86	0.00
SNF ALOS	31.25	0.00
INPT PSYCH DAYS/1000 MEMB	2.75	3.14
INPT PSYCH DISCHARGES/1000 MEMB	0.82	0.35
INPT PSYCH ALOS	3.65	8.59
OUTPATIENT VISITS/MEMB	5.04	5.95
ER VISITS/1000 MEMB	331.25	146.12
UM DENIALS		3
UM AUTHORIZATIONS*		2
TOTAL		5
UM DENIAL RATE		60.0%
UM APPEALS**		0
DME DENIALS		0
DME AUTHORIZATIONS		363
TOTAL		363
DME DENIAL RATE		0.0%
DME APPEALS**		0

*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 Dental Report 1st Quarter 2018
Screenshot

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	Q1 2018	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 Submitted	Number of Denials for DD Adults Due to Not Meeting Medical Necessity Criteria	Number of Denials for DD Adults Due to Other Reasons	Other Denial Reasons for DD Adults
303	KERN HEALTH SYSTEMS	Kern	Q1 2018	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 Not Submitted	Number of Denials for Non-DD Children Due to Not Meeting Medical Necessity Criteria	Number of Denials for Non-DD Children Due to Other Reasons	Other Denial Reasons for Non-DD Children
303	KERN HEALTH SYSTEMS	Kern	Q1 2018	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 Submitted	Number of Denials for DD Children Due to Not Meeting Medical Necessity Criteria	Number of Denials for DD Children Due to Other Reasons	Other Denial Reasons for DD Children
303	KERN HEALTH SYSTEMS	Kern	Q1 2018	0	0	0	0	0	

Kaiser KHS Mental Health Report 4Q 2017
Screenshot

1. MH Referrals Reporting

A	B	C	D	F	G	H	I	J	K
Plan Code	Plan Name	County	Reporting Quarter	Total # of Plan Members	# of Referrals by SMHP to MCP	# of Referrals by MCP to SMHP (Within County)	# Referrals to MCP Mental Health Provider	# of Referrals by MCP to SMHP (Other County)	County Code for Referrals to SMHP Outside the County
303	KERN HEALTH SYSTEMS	Kern	Q4 2017	7,891	0	2	151	0	0

2. MH Grievance & Appeal Reporting

C	D	F	G	H	I	J	K	L	M	N	O	P	Q	R
County	Reporting Quarter	Total Grievances Do not fill in	Reason for Grievance: Psychotherapy (Evaluation & Treatment)	Reason for Grievance: Outpatient Services	Reason for Grievance: Laboratory, Supplies, etc.	Reason for Grievance: Access to SMHP	Reason for Grievance: Authorization/ Referral to SMHP	Reason for Grievance: Medication/ Pharmacy	Reason for Grievance: All Other	Other Grievance Description	# of Grievances Resolved Within 30 Days	# of Grievance Pending in Plan's Internal Grievance System Less Than 30 Days	# of Grievance Pending in Plan's Internal Grievance System Greater Than 30 Days	# of Grievances Resolved from a Previous Reporting Period
Kern	Q4 2017	0	0	0	0	0	0	0	0		0	0	0	0

3. MH Continuity Of Care Reporting

B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Plan Name	County	Reporting Quarter	Total # of Mental Health COC Approvals	The Average # of Days it took to Approve Request	The Average # of Sessions the COC Request was Approved For	Total # of COC Denials Do not fill in	The Average # of Days it took to Deny COC	Denial Reason: Care Relationship Not Established	Denial Reason: Quality of Care	Denial Reason: Disagreement on the Rate	Denial Reason: Provider Refused to Work with a Managed Care Plan	Denial Reason: Other	Explanation of Denial Reason: Other	# of COC Requests In Process
KERN HEALTH SYSTEMS	Kern	Q4 2017	0	0	0	0	0	0	0	0	0	0	0	0

2. MH Reporting Comments

Referrals:
Data is not available for column G, J and K
Column H reflects SMHP referrals from Kaiser to the County
Column I reflects Sum of Total MH visits within Kaiser (initial visits) + referrals to outside Kaiser providers (Value Option & Magellan)

Kaiser KHS CBAS Report Q1 2018

Screenshot

1. CBAS Services and Assessment Reporting

C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
										CBAS Outcome					
County	Reporting Quarter	No. of Requests for CBAS	No. of Members Assessed for CBAS	No. of Members Ineligible to Receive CBAS	No. of Members Received ECM services	No. of Members Provided CBAS	No. of Members Provided Unbundled Services	No. of CBAS Providers	Average # Days Between Request & Notice of Eligibility	Discharged: Death	Discharged: Long-Term Nursing Facility Placement	Discharged: Other Services	Patient Moved Out of Plan	Patient Chose to Leave CBAS	Patient Transferred to Different CBAS Center
Kern	Q1 2018	0	0	0	0	0	0	0	0	0	0	0	0	0	0

2. CBAS Grievance Reporting

A	B	C	D	E	F	G	H
Plan Code	Plan Name	County	Reporting Quarter	# of Grievances Regarding CBAS Providers	# of Grievances Regarding Contractor Assessment or Reassessment	# of Grievances Regarding Excessive Travel Times to Access CBAS	# of Other CBAS Grievances
303	KERN HEALTH SYSTEMS	Kern	Q1 2018	0	0	0	0

3. CBAS Appeals Reporting

A	B	C	D	E	F	G	H	I	J	K
				(E+F+G)=(H+I+J+K)			(E+F+G)=(H+I+J+K)			
Plan Code	Plan Name	County	Reporting Quarter	# of CBAS Appeals Approved	# of CBAS Appeals Denied	# of CBAS Appeals Withdrawn	# of Appeals Related to Denials or Limited Services	# of Appeals Related to Denial to See Requested Provider	# of Appeals Regarding Excessive Travel Times to Access CBAS	# of Other CBAS Appeals
303	KERN HEALTH SYSTEMS	Kern	Q1 2018	0	0	0	0	0	0	0

4. CBAS Call Center Complaints Reporting

A	B	C	D	E	F
Plan Code	Plan Name	County	Reporting Quarter	Member Calls	Provider Calls
303	KERN HEALTH SYSTEMS	Kern	Q1 2018	0	0

Kaiser KHS 1Q2018

APL Grievance Report

1. Grievance & Appeal Reporting

A	B	C	D	F	G	H	I	J	K	L	M	N	O
Plan Code	**Plan Name**	**County**	**Reporting Quarter**	**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-	**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	**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
303	KERN HEALTH SYSTEMS	Kern	Q1 2018							7	1	5	1
303	KERN HEALTH SYSTEMS	Kern	Q1 2018			1	1			7	1		
303	KERN HEALTH SYSTEMS	Kern	Q1 2018							1	1		
303	KERN HEALTH SYSTEMS	Kern	Q1 2018					1	1			8	1
303	KERN HEALTH SYSTEMS	Kern	Q1 2018							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q1 2018							4	1		
303	KERN HEALTH SYSTEMS	Kern	Q1 2018									5	1
303	KERN HEALTH SYSTEMS	Kern	Q1 2018							1	1		
303	KERN HEALTH SYSTEMS	Kern	Q1 2018							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q1 2018			1	2			4	1		
303	KERN HEALTH SYSTEMS	Kern	Q1 2018							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q1 2018							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q1 2018			1	1			4	1		
303	KERN HEALTH SYSTEMS	Kern	Q1 2018					2	2			5	1
303	KERN HEALTH SYSTEMS	Kern	Q1 2018					2	2			5	1
303	KERN HEALTH SYSTEMS	Kern	Q1 2018	1	1			2	1				
303	KERN HEALTH SYSTEMS	Kern	Q1 2018							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q1 2018							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q1 2018	1	1			2	1			5	1
303	KERN HEALTH SYSTEMS	Kern	Q1 2018							4	1		
303	KERN HEALTH SYSTEMS	Kern	Q1 2018	2	1	1	2			4	1		
303	KERN HEALTH SYSTEMS	Kern	Q1 2018			1	2					1	1
303	KERN HEALTH SYSTEMS	Kern	Q1 2018							4	1		
303	KERN HEALTH SYSTEMS	Kern	Q1 2018							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q1 2018			1	1	2	2				

Kern Family Health Care Report, 2018Q1
Overall Grievance Volumes, Northern and Southern California Regions

Category	Total All Grievance Types	Coverage Disputes	Disputes Involving Medical Necessity	Quality of Care	Access to Care (including appts.)	Quality of Service	Other
Medi-Cal	*19*	1	0	0	2	16	0
	19	*1*	*0*	*0*	*2*	*16*	*0*

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

Vision care for life

Medical Data Collection Summary Report

Period Covered: **March, 2017 through February, 2018**
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:	20,119	
Diabetes?:	978	4.9%
Diabetic Retinopathy:	118	.6%
Glaucoma:	163	.8%
Hypertension:	785	3.9%
High Cholesterol	234	1.2%
Macular Degeneration:	43	.2%

Estimated Number of Cases

Total Members:	249,668	
Diabetes?:	5,742	2.3%
Diabetic Retinopathy:	492	.2%
Glaucoma:	955	.4%
Hypertension:	25,028	10.0%
High Cholesterol	37,733	15.1%
Macular Degeneration:	308	.1%

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

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

OVERVIEW

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

SCOPE

PURPOSE

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

POLICY

It is the policy of the organization to ensure:

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

GOALS

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

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

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

LOCAL REVIEW AND COMMENT

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

DELEGATION OF PRIMARY SOURCE VERIFICATION ACTIVITIES

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

ORGANIZATIONAL STRUCTURE AND RESPONSIBILITY

OVERVIEW

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

BOARD OF DIRECTORS

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

DIRECTOR OF NETWORK DEVELOPMENT

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

OPTOMETRY DIRECTOR

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

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

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

ASSOCIATE OPTOMETRY DIRECTOR

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

MEDICAL DIRECTOR

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

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

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

ASSOCIATE MEDICAL DIRECTOR

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

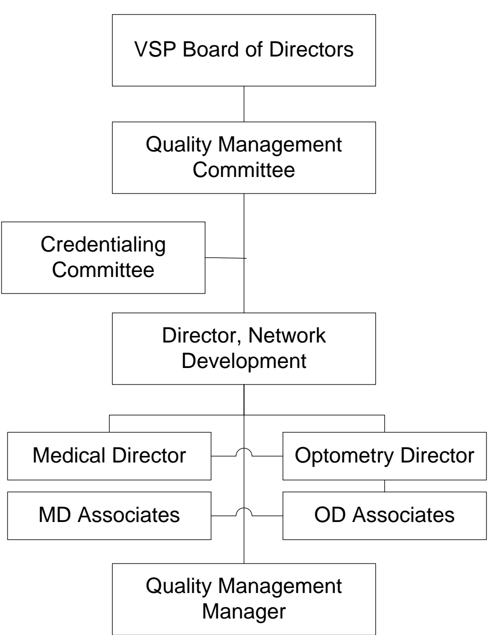
MANAGER, QUALITY MANAGEMENT

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

AVAILABILITY

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

THE ORGANIZATION CHART BELOW EXHIBITS THE COMMITTEE AND OVERSIGHT STRUCTURE



COMMITTEES

COMMITTEE TITLES

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

- QM Committee
- Credentialing Committee

CREDENTIALING COMMITTEE REPORTING AND ACCOUNTABILITY

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

MEMBERSHIP

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

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

CHAIR RESPONSIBILITY

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

RESPONSIBILITIES

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

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

VOTING RIGHTS

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

MINUTES

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

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

QUALITY IMPROVEMENT PROCESS

OVERVIEW

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

POLICY

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

PATIENT SAFETY

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

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

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

QI WORK PLAN

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

IMPROVEMENT ACTIVITIES

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

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

- Company Satisfaction Survey Results

Risk Management
- Clinical Practice Guidelines and Algorithms
- Assessment of New Technology

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

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

DISSEMINATION OF QI INFORMATION

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

REPORTING

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

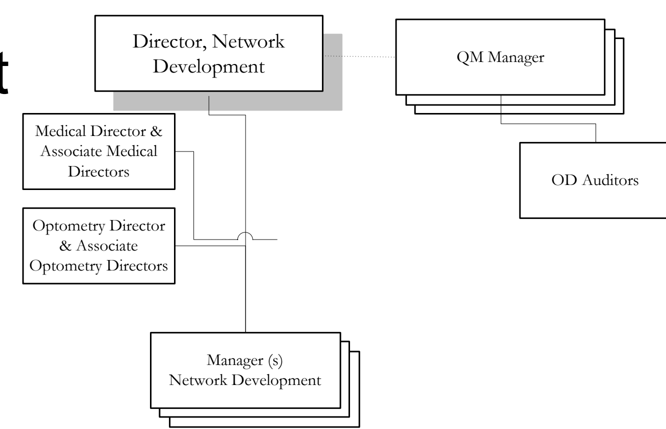
CONFIDENTIALITY

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

QUALITY IMPROVEMENT PERSONNEL

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

Network Development



REFERENCES

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

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

2017 Quality Improvement Work Plan Evaluation

The following are Quality Improvement Goals and Monitoring for 2017 with year-end evaluation of each goal.

Overall Effectiveness: In evaluating efforts and results for 2017, we were successful in meeting or exceeding goals related to the Diabetic CPG, Quality Assurance reviews, Accessibility and Cultural Competency and Linguistics. Additionally, our year end results for credentialing/recredentialing only fell short of our 100% goal due to a 99.994% in Q2 which was rectified by Q3 and 4. Based on these results, we find the 2017 Plan was effective and successful.

GOAL	RESULTS
<u>Clinical Practice Guidelines:</u> **Diabetes**	
Achieve a 50% rate of compliance with CPG for patients with diabetes who receive an eye exam	The overall rate of doctors following the clinical practice guidelines for diabetes averaged 74% for 2017. This significantly exceeds our goal of 50% for the year. Additionally, the rate of dilation or valid rationale documented for no dilation averaged 95.4%. The high was Q4 in which we achieved a dilation rate of 96%. The PCP communication rate averaged 77% in 2017, which exceeds our goal by 27%.
Achieve a 50% rate of PCP communication for patients with diabetes who receive eye exams on chart review	Potential barriers to PCP communication remain a lack of established relationship between ODs and PCPs; PCP is an institution (Kaiser); or the patient does not know PCP. We also believe that while PCP communication may have occurred, it is not always reflected in the medical record, or information supporting that communication is not included when records are sent to VSP.
Achieve 90% dilation (or valid clinical rationale for no dilation) for patients with diabetes who receive eye exams	Potential Barriers to dilation or valid rational remains technology advances and increased use of of retinal imaging technology in lieu of dilation.
Glaucoma Achieve 100% rate of adherence to CPG for patients with glaucoma who receive eye exams on chart review	The average rate of doctors following the clinical practice guidelines for glaucoma was 100% in every quarter of 2017.

GOAL	RESULTS
Complaints & Grievances (C&G) Trending	The total number of providers on the C&G trend report in 2017 was 1,160. The percent of VSP network providers on the report was .87% for the year. The two most common complaint categories remain charges and billing medical.
Quality of Care • Process and resolve all PQC cases within required timeframes • Ensure auditors consistently apply quality care standards 100% of the time.	The QA Department received a total of 556 Potential Quality of Care complaints from our Customer Care Division. After review, only 59 of the complaints 11% were opened for investigation. Of the 59 cases investigated 3 were identified as having a moderate quality of care issue. The remaining 56 were found to have no quality of care issues.
Quality Assurance Achieve 90% or greater overall pass rate on Quality Assurance Reviews Complete 100% of reviews within department service standards Ensure O.D. Auditors consistently apply QA review standards for doctor patient record reviews 100% of the time	The average pass rate for 2017 was 93%, which exceeds our goal of 90% for the year. We fell below 90% in the 1st quarter (89.4%), but strong results in the last three quarters resulted in scores exceeding our goal. 100% of reviews were completed within department service standards.
Eye Health Management (EHM) Monitor rate of annual eye exams for known patients with diabetes	In 2017 VSP mailed 599,051 Diabetic Exam Reminder letters with an overall effectiveness rate of 19%.
Accessibility (urban/suburban/ rural) Nationally maintain a 95% or higher accessibility in all classifications	Staff completed quarterly access and availability studies which demonstrate that VSP met and exceeded all accessibility goals nationally and in California throughout 2017. No interventions were needed.

GOAL	RESULTS
Credential/recredential Complete 100% of doctors with clean applications within standards	Doctors with clean applications were credentialed and recredentialed within standards 100% of the time in the 1st, 3rd and 4th quarters of 2017. In Q2, 99.994% of applications were credentialed and recredentialed within standard. A corrective action plan was implemented to prevent future occurrences. Potential Barriers: Doctors failing to return application or requested information; vendor failing to deliver provider profiles according to service level agreement
Cultural Competency and Linguistics Achieve 95% accuracy of CA doctors reporting of language capabilities	California Provider Language Reporting survey indicates 95% accuracy which meets our 2017 goal. Appropriate education and follow-up was provided to practices out of compliance.
Technology Monitor and evaluate the impact of new and emerging technology as it relates to the delivery of quality eye care	In 2017 the committee continued to monitor and evaluate technology advances related to remote refractions and telehealth services. State legislation addressing these services within the scope of optometric practice is inconsistent and still being refined. Additionally, there remain concerns about possible risks to patients in the absence of direct contact with eye care providers. While the committee did not recommend any changes to VSP policy in 2017, they will continue to monitor the impact of this type of care to consumers/patients, quality, and access.

2018 Quality Improvement Work Plan

Quality Improvement Goals and Monitoring

Goal	Tactics and Interventions	Target and Dept.	Quarterly Update	Potential Barriers
Clinical Practice Guidelines: **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		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		
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			
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 standards	• 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 • Monitor QAR completion timeframe	All year QM		
Ensure OD Auditors consistently apply QA review standards for doctor patient record reviews 100% of the time	• Perform Interrater study and report to QM Committee • Report findings to auditors and provide education/training as needed	Q4		

Goal	Tactics and Interventions	Target and Dept.	Quarterly Update	Potential Barriers
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		Potential Barriers:
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			
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		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		Potential Barriers: System and resource requirements Client requirements Doctor and staff engagement

Goal	Tactics and Interventions	Target and Dept.	Quarterly Update	Potential Barriers
<u>Technology</u> 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		

Call Center Q1 2018
Screenshot

A	B	C	D	E	F	G	H	I	J	K
Plan Name	Reporting Quarter	Number of Calls Received Do not fill in	Number of Calls Abandoned	Number of Calls Answered	Average Wait Time (H:MM:SS)	Average Talk Time (H:MM:SS)	Abandonment Rate = D/C Do not fill in	Service Level (0-100)	Member Only Calls (Y/N)	Medi-Cal Only Calls (Y/N)
KERN HEALTH SYSTEMS	Q1 2018	248	1	247	00:00:14	00:05:04	0.4%	93.95%	Y	Y

2016-2017 COMPARATIVE TABULATED GRIEVANCES

Kern Family Health Care Grievances	3rd Quarter 2017	4th Quarter 2017	4th Quarter 2016
Access to Care (PCP)	22	20	7
Difficulty Accessing Specialist	4	5	0
Quality of Care	46	26	31
Quality of Service	178	44	150
Medical Necessity	53	67	26
Coverage Dispute	44	37	17
Cultural and Lingustic Dissatisfaction	1	0	0
Other Issue	1	0	2
Total Grievances	349	199	233
MCAL (NonSPD) Grievances	150	81	112
SPD Grievances	76	59	44
Expansion Grievances	123	59	77
Cases Upheld by Plan	301	185	182
Cases Found in Favor of the Enrollee	48	14	51
Pending at the time of report	0	0	0
Kaiser Permanente Grievances			
Access to Care (PCP)	2	2	3
Difficulty Accessing Specialist	0	0	0
Quality of Care	5	3	2
Quality of Servive	4	14	3
Medical Necessity	0	4	2
Coverage Dispute	7	8	0
Cultural and Lingustic Dissatisfaction	0	0	0
Other Issue	5	12	6
Total Grievances	23	43	16
State Fair Hearings			
Coverage Dispute	2	0	1
Medical Necessity	1	1	0
Quality of Care	0	0	0
Access to Care	0	0	0
Quality of Service	1	0	0
Other Issues	0	0	0
Total	4	1	1
Cases Found in Favor of the Plan	1	0	1
Cases Found in Favor of the Enrollee	0	0	0
Waiting on Decision or Case not Heard Yet	3	1	0
DMHC Complaints			
Coverage Dispute	0	3	0
Medical Necessity	1	1	2
Quality of Care	0	0	1
Access to Care	0	0	0
Quality of Service	0	0	0
Other Issues	0	0	0
Total	1	4	3
DMHC Complaints Found in Favor of the Plan	0	0	2
DMHC Complaints Found in Favor of the Enrollee	1	3	1
Decisions Pending at the time of report	0	1	0

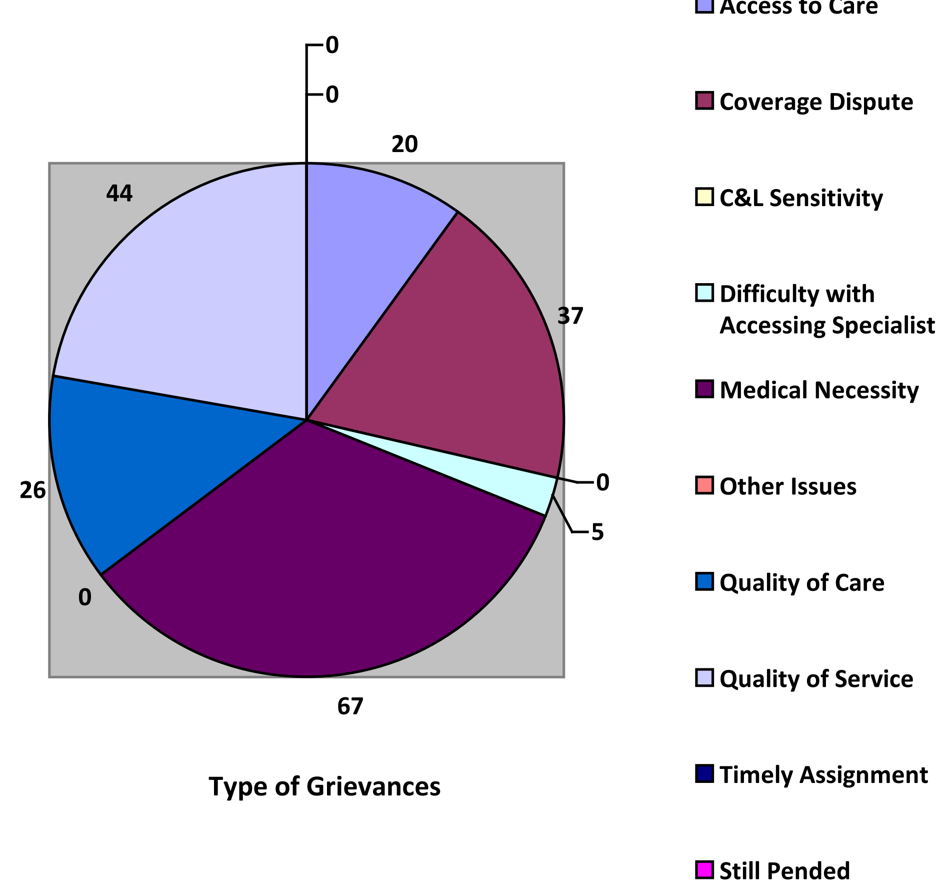
LEGEND OF CATEGORIES
Access to Care (PCP) - Issues related to long wait times or difficulty scheduling PCP appointments.
Difficulty Accessing Specialist - Issues related to difficulty scheduling specialty appointments.
Quality of Care - Dissatisfied with care received from provider, staff or facility 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	3rd Quarter 2017	4th Quarter 2017	4th Quarter 2016
Delay of Services	0	0	0
Modification of Services	0	0	0
Denial of Services	0	3	2
Total	**0**	**3**	**2**
IMR Cases Found in Favor of the Plan	0	1	1
IMR Cases Found in Favor of the Enrollee	0	1	1
Decisions Pending at the time of report	0	1	0
Enrollment Counts vs Grievances Received Per Quarter - Total Enrollment			
Total Enrollment	248,346	249,457	241,607
Grievances per 1,000 Members	1.41	0.80	0.96
Percentage of Grievances	0.141%	0.080%	0.096%
Enrollment Counts vs Grievances Received Per Quarter - MCAL (Non SPD) Members			
Total Enrollment	234,157	234,968	227,973
Grievances per 1,000 Members	0.64	0.34	0.83
Percentage of Grievances	0.064%	0.034%	0.083%
Enrollment Counts vs Grievances Received Per Quarter - SPD Members			
Total Enrollment	14,189	14,489	13,634
Grievances per 1,000 Members	5.36	4.07	3.22
Percentage of Grievances	0.54%	0.41%	0.32%
Enrollment Counts vs Grievances Received Per Quarter - Expansion Members			
Total Enrollment	57,894	58,789	55,730
Grievances per 1,000 Members	2.12	1.00	1.39
Percentage of Grievances	0.21%	0.10%	0.14%
Enrollment Counts vs Grievances Received Per Quarter - Kaiser Members			
Total Enrollment	7,782	7,890	7,103
Grievances per 1,000 Members	2.96	8.79	3.66
Percentage of Grievances	0.30%	0.90%	0.37%

4th Quarter 2017 Grievance Summary

Issue	Number	In Favor of Health Plan	In Favor of Enrollee
Access to care	20	16	4
Coverage dispute	37	37	0
Cultural and Linguistic Sensitivity	0	0	0
Difficulty with accessing specialists	5	4	1
Medical necessity	67	65	2
Other issues	0	0	0
Quality of care	26	25	1
Quality of service	44	38	6
Timely assignment to provider	0	0	0
Still under review	0	0	0



Type of Grievances

Grievances per 1,000 Members = 0.80

During the forth quarter of 2017, there were one hundred and ninety nine grievances received. Fourteen cases were closed in favor of the Enrollee and one hundred and eighty five were closed in favor of the Plan. There were three grievances not closed within thirty days and had to be pended for further review. Fifty nine cases were received from SPD (Seniors and Persons with Disabilities) members. Fifty nine were received from Medi-Cal Expansion members.

4th Quarter 2017 Grievance Summary

Access to Care

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

Twelve members complained about the lack of available appointments with their Primary Care Provider (PCP). Ten 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. Two of the cases closed in favor of the Enrollee after the responses indicated the office may not have provided appropriate access to care.

Eight members complained about the wait time to be seen for a Primary Care Provider (PCP) appointment. Six 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. Two cases 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 thirty seven grievances pertaining to a Coverage Dispute issue. All of the cases closed in favor of the Plan. The following is a summary of these issues:

Twenty eight members complained about the denial of a TAR for non-formulary or restricted medications. All of 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.

Nine members complained about the denial of a referral authorization request. All 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.

Cultural and Linguistic Sensitivity

There was no grievance pertaining to Cultural and Linguistic Sensitivity.

Difficulty with Accessing a Specialist

There were five grievances pertaining to Difficulty Accessing a Specialist. Four 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.

Two members complained about the lack of available appointments with a specialist. One case 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.

Three members complained about the wait time to be seen for a specialist appointment. All of the cases closed in favor of the Plan after the responses indicated the member was seen within the appropriate wait time for an appointment.

Medical Necessity

There were sixty seven grievances pertaining to Medical Necessity. Sixty five of the cases were closed in favor of the Plan. Two of the case closed in favor of the Enrollee. The following is a summary of these issues.

Fifty members complained about the denial or modification of a referral authorization request. Forty eight 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. Two of the cases closed in favor of the Enrollee after it was determined the authorization may have been denied inappropriately.

Seventeen members complained about the denial or modification of a TAR. All of the cases were closed in favor of the Plan as it was determined 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 no grievance pertaining to Other Issues.

Quality of Care

There were twenty six grievances involving Quality of Care issues. Twenty five cases were closed in favor of the Plan. One case was closed in favor of the Enrollee. The following is a summary of these issues:

Thirteen members complained about the quality of care received from a Primary Care Provider (PCP). Twelve cases were closed in favor of the Plan after it was determined that the provider or their staff provided the member with the appropriate care. 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 a specialty provider. All of the cases were closed in favor of the Plan after it was determined that the specialist provided the member with the appropriate care.

Five members complained about the quality of care received from the provider or staff with a hospital or urgent care. All 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.

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 forty four grievances pertaining to Quality of Service. Thirty eight were closed in favor of the Plan. Six cases were closed in favor of the Enrollee. The following is a summary of these issues:

Twenty four members complained about the service they received from a provider. Twenty one 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. Three 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.

Ten members complained about the service they received from a provider and their staff. All of the 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.

Ten members complained about the service received from the staff at a health care facility, pharmacy, or provider's office. 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. Three 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.

Timely Assignment to Provider

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

Kaiser Permanente Grievances

During the fourth quarter of 2017, there were forty three grievances and appeals received by KFHC members assigned to Kaiser Permanente. All cases were closed in favor of the Enrollee.

Access to Care

There were two grievances pertaining to Access to Care. The following is a summary of these issues.

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

One member complained about the lack of PCP appointments available. This case closed in favor of the Enrollee.

4th Quarter 2017 Grievance Summary

Coverage Dispute

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

> Eight members complained about a non-covered or out of network service they requested however, were not being covered. Four cases closed in favor of the Enrollee and services were provided. Four cases were closed in favor of the Plan.

Medical Necessity

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

> Four members complained about a requested service that was denied, delayed or otherwise modified. Two cases closed in favor of the Enrollee and services were provided. Two cases were closed in favor of the Plan.

Quality of Care

There were three grievances pertaining to Quality of Care. The following is a summary of these issues:

> Three members complained about the care they received from their providers or non-clinical staff. Four cases were closed in favor of the Enrollees and four cases were closed in favor of the Plan.

Quality of Service

There were fourteen grievances pertaining to Quality of Service. 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. Twelve cases were closed in favor of the Enrollees while two were closed in favor of the Plan.

Other Issues

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

> Twelve members complained about operations or policy issues. Eleven cases closed in favor of Enrollee and one closed in favor of the Plan.

KERN HEALTH SYSTEMS
1st Quarter 2018
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Report Date: April 2, 2018

Department: Provider Relations

Monitoring Period: January 1, 2018 through March 31, 2018

Population:

Providers	Credentialed	Recredentialed
MD's	26	41
DO's	3	0
AU's	0	0
DC's	1	0
AC's	0	0
PA's	2	2
NP's	13	8
CRNA's	7	1
DPM's	1	1
OD's	0	1
ND's	0	0
BCBA's	9	0
Mental Health	5	2
Ocularist	0	0
Ancillary	7	15
OT	0	0
TOTAL	**74**	**71**

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	8	3	11	0
Audiology	0	0	0	0
Autism / Behavioral Analyst	0	0	0	0
Cardiology	3	2	5	0
Chiropractor	1	0	1	0
Colon & Rectal Surgery	0	0	0	0
Critical Care	0	1	1	0
Dermatology	0	0	0	0
Emergency Medicine	2	0	2	0
Endocrinology	1	1	2	0
Family Practice	13	5	18	0
Gastroenterology	0	0	0	0
General Practice	3	3	6	0
General Surgery	2	1	3	0
Genetics	0	0	0	0
Gynecology	0	0	0	0
Gynecology/Oncology	0	0	0	0
Hematology/Oncology	0	1	1	0
Hospitalist	0	0	0	0
Infectious Disease	0	1	1	0
Internal Medicine	7	5	12	0

KERN HEALTH SYSTEMS
1st Quarter 2018
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Mental Health	14	2	16	0
Mid Wife	0	0	0	0
Naturopathic Medicine	0	0	0	0
Neonatology	0	0	0	0
Nephrology	0	1	1	0
Neurological Surgery	0	0	0	0
Neurology	1	0	1	0
Obstetrics & Gynecology	0	3	3	0
Ocularist	0	0	0	0
Occupational Therapy	0	0	0	0
Ophthalmology	2	3	5	0
Optometry	0	1	1	0
Orthopedic Surgery / Hand Surg	0	1	1	0
Otolaryngology	0	0	0	0
Pain Management	0	2	2	0
Pathology	0	0	0	0
Pediatrics	4	4	8	0
Physical Medicine & Rehab	0	1	1	0
Plastic Sugery	0	1	1	0
Podiatry	1	1	2	0
Psychiatry	2	1	3	0
Pulmonary	0	1	1	0
Radiation Oncology	0	0	0	0
Radiology	3	14	17	0
Rheumatology	0	0	0	0
Sleep Medicine	0	0	0	0
Thoracic Surgery	0	0	0	0
Vascular Medicine	0	0	0	0
Vascular Surgery	0	0	0	0
Urology	1	0	1	0
KHS Medical Directors	3	0	3	0
TOTAL	**71**	**59**	**130**	**0**
ANCILLARY				
Ambulance	0	1	1	0
Cardiac Sonography	0	0	0	0
Comm. Based Adult Services	0	0	0	0
Dialysis Center	0	1	1	0
DME	0	1	1	0
Hearing Aid Dispenser	0	0	0	0
Home Health	1	1	2	0
Home Infusion/Compounding	0	0	0	0
Hospice	1	1	2	0
Hospital	0	1	1	0
Laboratory	0	3	3	0
Lactation Consultant	0	0	0	0
MRI	0	0	0	0
Ocular Prosthetics	0	0	0	0
Pharmacy	1	2	3	0

KERN HEALTH SYSTEMS
1st Quarter 2018
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

ANCILLARY				
Pharmacy/DME	0	1	1	0
Physical / Speech Therapy	0	0	0	0
Prosthetics & Orthotics	0	0	0	0
Radiology	0	0	0	0
Skilled Nursing	1	0	1	0
Sleep Lab	0	0	0	0
Surgery Center	0	0	0	0
Transportation	0	3	3	0
Urgent Care	3	0	3	0
TOTAL	**7**	**15**	**22**	**0**

Defer = 0 **Denied = 0**

KERN HEALTH SYSTEMS
1st Quarter 2018
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

KERN HEALTH SYSTEMS
1st Quarter 2018
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
APRIL 12, 2018

Legal Name	DBA or Credentialed Provider	Specialty	Address	New Contract	Contract Effective Date
PAC 03/07/2018					
Bandri Inc.	People's Pharmacy	Pharmacy	5913 Niles Street Ste. 2 Bakersfield CA 93306	New Contract	04/01/2018
Veritas Anesthesia, A Professional Nursing Corporation	Daniel Vera, CRNA	CRNA / Anesthesiology	901 Olive Dr. Bakersfield, CA 93308	New Contract	04/01/2018
Graceful Care Hospice, Inc.	Graceful Care Hospice	Hospice	2082 Newerry Rd. Ste 12, Newbury Park, CA 91320	New Contract	04/01/2018
George Alexandrakis, M.D., Inc	George Alexandrakis, MD	Ophthalmology	1851 Oak St. Ste B Bakersfield, CA 93301	New Contract	04/01/2018
Global Care Solutions, Inc.	Villa Martha	Skilled Nursing Facility	22411 Villa Martha St. Woodland Hills, Ca 93167	New Contract	04/01/2018
Timothy M. Wiebe, M.D., A Professional Corporation	Timothy Wiebe, MD	Physician	3545 San Dimas St. Bakersfield, CA 93301	Already credentialed & changing to individual contract	04/01/2018

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
FEBRUARY 8, 2018

Name	DBA	Specialty	Address	Contract Effective Date
Philip Rosenthal, MD	Neurological Surgery Associates PC	Neurosurgery	3838 San Dimas St Ste A-140 Bakersfield CA	03/01/2018
Benjamin Serxner, MD	Benjamin Serxner, Md, Inc	Neurosurgery	3838 San Dimas St Ste A-140 Bakersfield CA	03/01/2018
Ace 1 Homehealth Services, Inc.	Ace 1 Homehealth Services, Inc.	Skilled Nursing, Home Health	2112 24th St. Ste. 5 Bakersfield CA	03/01/2018

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
APRIL 12, 2018

Legal Name	DBA or Credentialed Provider	Specialty	Address	New Contract	Contract Effective Date
PAC 04/04/2018					
Auromira Corporation	Dimas Pharmacy	Pharmacy	3805 San Dimas Street Suite A Bakersfield CA 93301	New Contract	05/01/2018

Kern Health Systems
Board Approved Providers Effective March 1, 2018

NAME	DBA/ADDRESS	Specialty	Provider #	Pay To #	Effective
Ace 1 Homehealth Services Inc	Ace 1 Homehealth Services, Inc 2112 24th St Ste. 5 Bakersfield CA 93301	Home Health	PRV044286	PRV044286	**03/01/2018**
Baxter, Melissa CRNA	Coffee Surgery Center dba: All Kids Dental 2525 Eye Street Ste. 100 Bakersfield CA 93301	Certified Nurse Anesthetist	PRV043953	PRV0003969	**03/01/2018**
Harish, Gorli MD	San Joaquin Valley Pulmonary Med Group 3551 Q Street Ste. 100 Bakersfield CA 93301	OB/GYN (General Practice Only)	PRV043821	PRV000354	**03/01/2018**
Shaheen, Aisha MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306 Additional Location: 9300 Stockdale Highway Ste. 100 & 300 Bakersfield	General Surgery / Surgical Critical Care	PRV043139	ALL KM	**03/01/2018**
Adjei, Phyllis NP-C	GMA Healthcare Providers 3838 San Dimas Street Ste. B-231 Bakersfield CA 93301	Urology	PRV041412	PRV000386	**03/01/2018**
Alcantar, Violet LCSW	Clinica Sierra Vista (CSV) 2000 Physicians Blvd Bakersfield CA 93301	Clinical Social Worker	PRV043539	PRV000002	**03/01/2018**
Arambulo, Maria MD	Telehealthdocs Medical Group 2215 Truxtun Avenue Ste. 100 Bakersfield CA 93301 Alternate Location: 100 E North Street Taft	Endocrinology	PRV044458	PRV036952	**03/01/2018**
Bhavan, Sathy MD	Retina Institute of California 9500 Stockdale Highway Ste. 108 Bakersfield CA 93311	Ophthalmology	PRV044287	PRV000181	**03/01/2018**
Burnett, Kimberly LCSW	Omni Family Health 4600 Panama Lane Ste. 102B Bakersfield CA 93313	Clinical Social Worker	PRV043785	PRV000019	**03/01/2018**
Capehart, Helen NP-C	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306 Additional Location: 1111 Columbus Street Bakersfield	Family Practice	PRV043784	ALL KM	**03/01/2018**

Kern Health Systems
Board Approved Providers Effective March 1, 2018

Chacon, Minerva, NP-C	Shafter Urgent Care 501 Munzer Street Ste. A Shafter CA 93263	Pediatrics	PRV040413	PRV043577	**03/01/2018**
Davis, Succura NP-C	Clinica Sierra Vista (CSV) 815 Dr. Martin Luther King Jr. Blvd Bakersfield CA 93307	Pediatrics & Family Practice	PRV043411	PRV000002	**03/01/2018**
Duenas, Michael BCBA	California Psychcare, Inc. 4500 California Avenue Ste. 101 Bakersfield CA 93309	Behavior Analyst / Qualified Autism Services Provider	PRV044288	PRV011225	**03/01/2018**
Esteva, Juan MD	Renaissance Imaging Medical Assoc Inc *All Locations 1600 West Avenue J Lancaster CA 93534	Diagnostic Radiology	PRV043622	PRV000324	**03/01/2018**
Fordham, Liberty NP-C	Omni Family Health 1133 N Chelsea Street Ridgecrest CA 93555 Additional Location: 161 N. Mill Street Tehachapi	Family Practice	PRV035099	PRV000019	**03/01/2018**
Guerena, Enrique DC	Omni Family Health 1014 Calloway Drive Bakersfield CA 93312	Chiropractic	PRV042684	PRV000019	**03/01/2018**
Huoh, Karen BCBA	Center for Autism & Related Disorders 5300 Lennox Avenue Ste. 100 Bakersfield CA 93309	Behavior Analyst / Qualified Autism Services Provider	PRV043563	PRV032083	**03/01/2018**
Jupiter, Gaboy NP	Priority Urgent Care 4821 Panama Lane Ste. A-C Bakersfield CA 93313	Emergency Medicine	PRV039798	PRV038192	**03/01/2018**
Hardman, Caroline BCBA	California Psychcare, Inc. 4500 California Avenue Ste. 101 Bakersfield CA 93309	Behavior Analyst / Qualified Autism Services Provider	PRV044535	PRV011225	**03/01/2018**
Janakiraman, Venkatesh MD	Kern County Neurological Medical Group 1711 28th Street Ste. A Bakersfield CA 93301	Neurology	PRV041040	PRV000308	**03/01/2018**
Joolhar, Fowrooz MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	Cardiovascular Disease	PRV003792	ALL KM	**03/01/2018**
Jurich, Daniel DO	Clinica Sierra Vista (CSV) 815 Dr. Martin Luther King Jr. Blvd Bakersfield CA 93307	Internal Medicine	PRV039611	PRV000002	**03/01/2018**

Kern Health Systems
Board Approved Providers Effective March 1, 2018

Khan, Samra MD	Omni Family Health 210 N. Chester Avenue Bakersfield CA 93308	Internal Medicine	PRV042305	PRV000002	**03/01/2018**
Lavrenov, Alekasander DPM	Premier Valley Medical Group - White Ln 5401 White Lane Bakersfield CA 93309 Alternate Location: Nephrology Med Grp of Bakersfield - Comprehensive Wound Care 5401 White Lane - Bakersfield	Podiatry	PRV044462	PRV00040	**03/01/2018**
Lilly, Bryanna BCBA	Center for Autism & Related Disorders 6601 McDivitt Drive Bakersfield CA 93313 Additional Location: 5300 Lennox Avenue Ste. 100 Bakersfield	Behavior Analyst / Qualified Autism Services Provider	PRV044055	PRV032083	**03/01/2018**
Loewen, Kiranjeet DO	Priority Urgent Care 4821 Panama Lane Ste. A-C Bakersfield CA 93313	Family Practice	PRV038725	PRV038192	**03/01/2018**
Martinez, Amanda BCBA	California Psychcare, Inc. 4500 California Avenue Ste. 101 Bakersfield CA 93309	Behavior Analyst / Qualified Autism Services Provider	PRV044289	PRV011225	**03/01/2018**
McDonald, Joseph BCBA	Center for Autism & Related Disorders 5300 Lennox Avenue Ste. 100 Bakersfield CA 93309 Additional Location: 6601 McDivitt Drive Bakersfield	Behavior Analyst / Qualified Autism Services Provider	PRV044290	PRV032083	**03/01/2018**
Meave, Olga MD	Clinica Sierra Vista (CSV) 815 Dr. Martin Luther King Jr. Blvd Bakersfield CA 93307	General Practice	PRV043786	PRV000002	**03/01/2018**
Momen, Mary LCSW	Omni Family Health 1022 Calloway Drive Bakersfield CA 93312	Clinical Social Worker	PRV042408	PRV000019	**03/01/2018**
Niameh, Francisca PsyD	Integral Psychological Consulting Services 5401 Business Park South Ste. 124 Bakersfield CA 93309	Psychology	PRV044291	PRV000365	**03/01/2018**

Kern Health Systems
Board Approved Providers Effective March 1, 2018

O'Donohoe, Ona CRNA	Ridgecrest Regional Hospital 1081 N. China Lake Blvd. Ridgecrest CA 93555	Certified Nurse Anesthetist	PRV044292	PRV029495	**03/01/2018**
Orozco, Jonathan BCBA	Center for Autism & Related Disorders 5300 Lennox Avenue Ste. 100 Bakersfield CA 93309	Behavior Analyst / Qualified Autism Services Provider	PRV044054	PRV032083	**03/01/2018**
Parker, Sharon NP-C	Clinica Sierra Vista (CSV) 6310 Lake Isabella Blvd. Lake Isabella CA 93240 Additional Location: 67 Evans Road Wofford Heights	Family Practice	PRV043293	PRV000002	**03/01/2018**
Patel, Ajay MD	Centric Health 2901 Sillect Avenue Ste. 100 Bakersfield CA 93308	Cardiovascular Disease	PRV041521	PRV000503	**03/01/2018**
Pelaez, Rhett Anthony MD	Clinica Sierra Vista (CSV) 815 Dr. Martin Luther King Jr. Blvd Bakersfield CA 93307	General Practice	PRV043787	PRV000002	**03/01/2018**
Quintana, Rony-Nichole NP-C	Omni Family Health 1100 Fourth Street Taft CA 93268 Alternate Locations: 655 S. Central Valley Highway Shafter 210 N. Chester Avenue Bakersfield	Family Practice	PRV042557	PRV000019	**03/01/2018**
Rocha, Renee NP-C	Pinnacle Primary Care, Inc. 1520 Brundage Lane Bakersfield CA 93304	Internal Medicine	PRV044294	PRV000353	**03/01/2018**
Scully, William, NP-C	Clinica Sierra Vista (CSV) 301 Brundage Lane Bakersfield CA 93304 Additional Location: 1305 Bear Mountain Blvd. Arvin	Family Practice	PRV000353	PRV000002	**03/01/2018**
Sohi, Rupinder NP-C	Premier Valley Medical Group - White Lane 5401 White Lane Bakersfield CA 93309 Additional Locations: 5401 White Lane - Urgent Care 901 Olive Drive - Urgent Care	Family Practice	PRV044464	PRV000404	**03/01/2018**

Kern Health Systems

Board Approved Providers Effective March 1, 2018

Varela, Ruby LCSW	Omni Family Health 4151 Mexicali Drive Bakersfield CA 93313	Clinical Social Worker	PRV043292	PRV000019	**03/01/2018**

Name	DBA	Address	Effective Date
Philip Rosenthal, MD	Neurological Surgery Associates PC	3838 San Dimas St Ste A-140 Bakersfield CA	03/01/2018
Benjamin Serxner, MD	Benjamin Serxner, Md, Inc	3838 San Dimas St Ste A-140 Bakersfield CA	03/01/2018
Ace 1 Homehealth Services, Inc.	Ace 1 Homehealth Services, Inc.	2112 24th St. Ste. 5 Bakersfield CA	03/01/2018

Kern Health Systems
Board Approved Effective April 1st, 2018

NAME	LEGAL NAME AND ADDRESS	Specialty	Provider #	Pay To #	Effective
Alexandrakis, George MD	George Alexandrakis, MD, Inc 1851 Oak Street Ste. B Bakersfield CA 93301	Ophthalmology	PRV040519	PRV001820	**4/1/18**
Graceful Care Hospice	Graceful Care Hospice, Inc. 1851 Oak Street Ste. B Bakersfield CA 93301	Hospice	PRV038429	PRV038429	**4/1/18**
People's Pharmacy	Bandri Inc 5913 Niles Street Ste. 2 Bakersfield CA 93306	Pharmacy	PRV044833	PRV044833	**4/1/18**
Vera, Daniel CRNA	Veritas Antesthesia, A Prof Nursing Corp 901 Olive Drive Bakersfield CA 93308	Certified Nurse Anesthetist	PRV012818	PRV042327	**4/1/18**
Villa Martha	Global Care Solutions, Inc 22411 Martha Street Woodland Hills CA 93167	Skilled Nursing Facility	PRV042668	PRV042668	**4/1/18**
Strickland, Jeffrey MD	Valley Anesthesia Associates *All Locations 2635 G Street Bakersfield CA 93301	Anesthesiology	PRV032124	PRV000376	**04/01/2018**
Accelerated Urgent Care - K St	Emergency Physicians Urgent Care, Inc. 2400 K Street Bakersfield CA 93301	Urgent Care Clinic	PRV044709	PRV044709	**3/1/18**
Accelerated Urgent Care - Olive	Emergency Physicians Urgent Care, Inc. 9917 Olive Drive Bakersfield CA 93312	Urgent Care Clinic	PRV044710	PRV044710	**3/1/18**
Bains, Jasmeet MD	Clinica Sierra Vista (CSV) 815 Dr. Martin Luther King Jr. Blvd Bakersfield CA 93307	Family Practice	PRV043990	PRV000002	**4/1/18**
Barroso-Perez, Arlenis MD	Clinica Sierra Vista (CSV) 815 Dr. Martin Luther King Jr. Blvd Bakersfield CA 93307	Family Practice	PRV043991	PRV000002	**4/1/18**
Camenisch, Marci PA-C	Adventist Health Community Care-Taft 501 6th Street Taft CA 93268	Family Practice	PRV000598	PRV032339	**4/1/18**

Kern Health Systems
Board Approved Effective April 1st, 2018

Del Castillo, Jan Richel BCBA	California Psychcare, Inc. 624 Commerce Drive Unit E Palmdale CA 93551 Additional Location: 732 N. Norma Street Ste. B Ridgecrest	Behavior Analyst / Qualified Autism Services Provider	PRV044835	PRV011225	**4/1/18**
Fine, Stephen MD	Renaissance Imaging Medical Assoc Inc *All Locations 1600 West Avenue J Lancaster CA 93534	Diagnostic Radiology	PRV044850	PRV000324	**4/1/18**
Florentino, Christopher CRNA	Valley Anesthesia Associates And Comfort Anesthesia 2635 G Street Bakersfield CA 93301	Certified Nurse Anesthetist	PRV039142	PRV000376	**4/1/18**
Giesbrecht, Mark MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306 Additional Location: KCHA - 1111 Columbus Street	Psychiatry	PRV044846	ALL KM	**4/1/18**
Goodrich, Jaime BCBA	Center for Autism & Related Disorders 5300 Lennox Avenue Ste. 100 Bakersfield CA 93309 Additional Location: 6601 McDivitt Drive Bakersfield	Behavior Analyst / Qualified Autism Services Provider	PRV044847	PRV032083	**4/1/18**
Grim, Clarence MD	Ridgecrest Regional Hospital RHC 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	Internal Medicine	PRV044851	PRV029495	**4/1/18**
Guha, Arpita DO	Universal Urgent Care *All Locations 8325 Brimhall Road Ste. 100 Bakersfield CA 93312	Family Medicine/ Urgent Care	PRV044708	PRV12894 BRIMHALL PRV36257 NILES	**4/1/18**
Hilt, Garrett CRNA	Valley Anesthesia Associates *All Locations 2635 G Street Bakersfield CA 93301	Certified Nurse Anesthetist	PRV034008	PRV000376	**4/1/18**

Kern Health Systems
Board Approved Effective April 1st, 2018

Kovacs, Ildiko MD	Telehealthdocs Medical Group 2215 Truxtun Avenue Ste. 100 Bakersfield CA 93301 Additional Location: 100 E North Street Taft	Psychiatry	PRV043988	PRV036952	**4/1/18**
Locquiao, Mendeleev PA-C	Priority Urgent Care 4821 Panama Lane Ste. A-C Bakersfield CA 93313	Family Medicine/ Urgent Care	PRV007870	PRV038192	**4/1/18**
Mohsen, Ghassan MD	Ridgecrest Regional Hospital RHC 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	Internal Medicine & Cardiovascular Disease	PRV034803	PRV000279	**4/1/18**
Nisim, Abraham MD	Centric Health William Baker MD & Avi Nisim MD 3008 Sillect Avenue Ste. 240 Bakersfield CA 93308	General Surgery	PRV038257	PRV000503	**4/1/18**
Priority Urgent Care - Airport	Priority Urgent Care 611 Airport Drive Bakersfield CA 93308	Urgent Care Clinic	PRV044694	PRV044694	**3/1/18**
Slanger, Burton MD	West Side Family Health Care - UC 100 E. North Street Taft CA 93268	Emergency Medicine/ Urgent Care	PRV004728	PRV000306	**4/1/18**
Stagg, Russell CRNA	Valley Anesthesia Associates *All Locations 2635 G Street Bakersfield CA 93301	Certified Nurse Anesthetist	PRV042764	PRV000376	**4/1/18**
Villachica, Gabriel FNP-C	Clinica Sierra Vista (CSV) 2400 Wible Road Bakersfield CA 93304	Pediatrics & Internal Medicine	PRV043410	PRV000002	**4/1/18**
Wilkins, Paul CRNA	Coffee Surgery Center 2525 Eye Street Ste. 100 Bakersfield CA 93301	Certified Nurse Anesthetist	PRV043989	PRV000369	**04/01/2018**
Yutan, Elizabeth MD	Renaissance Imaging Medical Assoc Inc *All Locations 1600 West Avenue J Lancaster CA 93534	Diagnostic Radiology / Neuroradiology	PRV044852	ALL SITES	**04/01/2018**

Name	DBA	Address	Effective Date
Bandri Inc.	People's Pharmacy	5913 Niles Street Ste. 2 Bakersfield CA 93306	04/01/2018
Veritas Anesthesia, A Professional Nursing Corporation	Daniel Vera, CRNA	901 Olive Dr. Bakersfield, CA 93308	04/01/2018
Graceful Care Hospice, Inc.	Graceful Care Hospice	2082 Newerry Rd. Ste 12, Newbury Park, CA 91320	04/01/2018
George Alexandrakis, M.D., Inc	George Alexandrakis, MD	1851 Oak St. Ste B Bakersfield, CA 93301	04/01/2018
Global Care Solutions, Inc.	Villa Martha	22411 Villa Martha St. Woodland Hills, Ca 93167	04/01/2018
Timothy M. Wiebe, M.D., A Professional Corporation	Timothy Wiebe, MD	3545 San Dimas St. Bakersfield, CA 93301	04/01/2018

Kern Health Systems

Board Approved Providers Effective May 1, 2018

	A	B	C	D	E	F
1	NAME	LEGAL NAME AND ADDRESS	SPECIALTY	Provider #	Pay To #	Effective
2	Dimas Pharmacy	Auromira Corporation dba: Dimas Pharmacy 3805 San Dimas Street Ste. A Bakersfield CA 93301	Pharmacy	PRV045173	PRV045173	**Eff 5/1/18**
3	Aslam, Rummana MD	LAGS Spine and Sportscare Medical Centers, Inc. 3550 Q Street Ste. 103-105,201,202 Bakersfield CA 93301	Physical Medicine & Rehabilitation	PRV045076	PRV000403	**Eff 5/1/18**
4	Bedassa, Berhanu NP-C	Emergency Physicians Urgent Care, Inc. Accelerated Urgent Care *All Locations 9500 Stockdale Highway Ste. 100 Bakersfield CA 93311	Family Practice / Urgent Care	PRV045175	ALL SITES	**Eff 5/1/18**
5	Dalal, Vivek MD	Valley Anesthesia Associates 2615 Chester Avenue & 2620 Chester Avenue Bakersfield CA 93301 Comfort Anesthesia Associates, Inc @ DRMC 1401 Garces Hwy	Anesthesiology	PRV040438	PRV000376	**Eff 5/1/18**
6	Dhillon, Harbir BCBA	Bowcor Inc dba: Special Explorers Center 401 19th Street & 2441 G Street Ste. B Bakersfield CA 93301	Behavior Analyst / Qualified Autism Services Provider	PRV044849	PRV038625	**Eff 5/1/18**
7	Eskaros, Jakleen CRNA	Valley Anesthesia Associates 2615 Chester Avenue & 2620 Chester Avenue Bakersfield CA 93301 Comfort Anesthesia Associates, Inc @ BHH 3001 Sillect Avenue	Certified Nurse Anesthetist	PRV038309	PRV000376	**Eff 5/1/18**
8	Galdino, Gregory MD	Kern Radiology Medical Group *All Locations 2301 Bahamas Drive Bakersfield CA 93309	Diagnostic Radiology	PRV045320	ALL SITES	**Eff 5/1/18**
9	Garcia, Baudelia NP-C	Universal Urgent Care, PC *All Locations 8325 Brimhall Road Ste. 100 Bakersfield CA 93305	Family Practice / Urgent Care	PRV032444	PRV012894 PRV036257	**Eff 5/1/18**

Kern Health Systems

Board Approved Providers Effective May 1, 2018

	A	B	C	D	E	F
10	Iacoviello, Cecilia NP-C	Ridgecrest Regional Hospital Rural Health Clinic 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	Internal Medicine	PRV045178	PRV29495	**Eff 5/1/18**
11	Keeler, Brittney BCBA	Center for Autism & Related Disorders, Inc. 5300 Lennox Avenue Ste. 100 Bakersfield CA 93309	Behavior Analyst / Qualified Autism Services Provider	PRV045322	PRV032083	**Eff 5/1/18**
12	Lemus, Mario PA-C	Emergency Physicians Urgent Care, Inc. Accelerated Urgent Care *All Locations 9500 Stockdale Highway Ste. 100 Bakersfield CA 93311	Family Practice / Urgent Care	PRV045207	ALL SITES	**Eff 5/1/18**
13	Limjoco, Teresa MD	Bakersfield Pathology Medical Group *All Locations 3000 Sillect Avenue Bakersfield CA 93308	Pathology	PRV045136	PRV001424 PRV001423 PRV000315	**Eff 5/1/18**
14	Maheshwari, Anamika MD	Adventist Health Physicians Network 9900 Stockdale Highway Ste. 200 Bakersfield CA 93311	Family Practice	PRV008713	PRV039909	**Eff 5/1/18**
15	Mattis, Melessa NP-C	Reedley Community Hospital Adventist Health Community Care-Taft 501 6th Street Taft CA 93268	Family Practice	PRV044540	PRV032339	**Eff 5/1/18**
16	Oh, Bryan MD	Kern County Hospital Authority dba: Kern Medical 1700 Mt Vernon Avenue 9300 Stockdale Highway Ste. 100 & 300 Bakersfield CA 93306	Neurosurgery	PRV043596	ALL SITES	**Eff 5/1/18**
17	Paronyan, Marine BCBA	California Psychcare, Inc. 4500 California Avenue Ste. 101 Bakersfield CA 93309 *Additional Location: 624 Commerce Drive Unit E Palmdale	Behavior Analyst / Qualified Autism Services Provider	PRV045325	PRV011225	**Eff 5/1/18**
18	Pempleton, Kaytasha FNP	Omni Family Health 1215 Jefferson Street Delano CA 93215 Additional Locations: 2101 7th Street Wasco 655 S. Central Valley Highway Shafter	Family Practice	PRV003833	PRV000019	**Eff 5/1/18**

Kern Health Systems
Board Approved Providers Effective May 1, 2018

	A	B	C	D	E	F
19	Perrigo, Alexa BCBA	Autism Response Team, Inc 4500 California Avenue Bakersfield CA 93309	Behavior Analyst / Qualified Autism Services Provider	PRV045336	PRV038107	**Eff 5/1/18**
20	Slaughter, Connie PA-C	Sumeet Bhinder, MD Inc. 6001-A Truxtun Avenue Ste. 160 Bakersfield CA 93309	Rheumatology	PRV044806	PRV000285	**Eff 5/1/18**
21	Starrh, Laura NP	Kern County Hospital Authority dba: Kern Medical 1700 Mt Vernon Avenue 1111 Columbus Street Bakersfield CA 93306	Internal Medicine	PRV044706	ALL SITES	**Eff 5/1/18**
22	Tambar, Stuti MD	Comprehensive Blood & Cancer Center 6501 Truxtun Avenue Bakersfield CA 93309	General Surgery	PRV045174	PRV013881	**Eff 5/1/18**
23	Tucker, Kim NP	Adventist Health Medical Center Tehachapi Adventist Health Community Center-Mojave 2041 Belshaw Street Mojave CA 93501 Additional Locations: 105 West E Street Tehachapi 9350 N. Loop Blvd Cal City	Internal Medicine	PRV045335	ALL SITES	**Eff 5/1/18**
24	Vanichsarn, Krystal OD	Ace Eyecare, Inc 1721 Westwind Drive Ste. B Bakersfield CA 93301	Optometry	PRV045212	PRV041736	**Eff 5/1/18**
25	Zisman, Graciela LCSW	Adventist Health Medical Center Tehachapi Adventist Health Community Center-Mojave 2041 Belshaw Street Mojave CA 93501 Additional Locations: 105 West E Street Tehachapi 9350 N. Loop Blvd Cal City	Clinical Social Worker	PRV033957	ALL SITES	**Eff 5/1/18**

Legal Name	DBA or Credentialed Provider	Address	Provider #	Pay to #	New Contract	Contract Effective Date
PAC 03/07/2018						
Bandri Inc.	People's Pharmacy	5913 Niles Street Ste. 2 Bakersfield CA 93306			New Contract	#########
Veritas Anesthesia, A Professional Nursing Corporation	Daniel Vera, CRNA	901 Olive Dr. Bakersfield, CA 93308			New Contract	#########
Graceful Care Hospice, Inc.	Graceful Care Hospice	2082 Newerry Rd. Ste 12, Newbury Park, CA 91320			New Contract	#########
George Alexandrakis, M.D., Inc	George Alexandrakis, MD	1851 Oak St. Ste B Bakersfield, CA 93301			New Contract	#########
Global Care Solutions, Inc.	Villa Martha	22411 Villa Martha St. Woodland Hills, Ca 93167			New Contract	#########
Timothy M. Wiebe, M.D., A Professional Corporation	Timothy Wiebe, MD	3545 San Dimas St. Bakersfield, CA 93301			Already credentiale d & changing to individual contract	#########
PAC 04/04/2018						
Clinica Del Valle	Clinica Del Valle	5917 Niles Street Suite 2 Bakersfield, CA 93306			Provider is already credentiale d.	#########
Auromira Corporation	Dimas Pharmacy	3805 San Dimas Street Suite A Bakersfield CA 93301			New Contract	#########

Access Monitoring

2018 - Quarter 1

- **After Hours Calls Results**
- **Appointment Availability Survey Results**
- **Geographic Accessibility Analysis**
- **Access Grievance Review** (Q4 2017)
- **FTE & Provider to Enrollee Ratios**

AFTER HOURS CALLS RESULTS

2018 - Quarter 1

AFTER HOURS CALLS SURVEY

Q1, 2018

Introduction

As required by the Department of Managed Health Care (DMHC) Health & Safety Code 1348.8, Kern Health Systems (KHS) uses an after-hours caller program to assess compliance with access standards for Kern Family Health Care (KFHC) Members. KHS policy requires that:

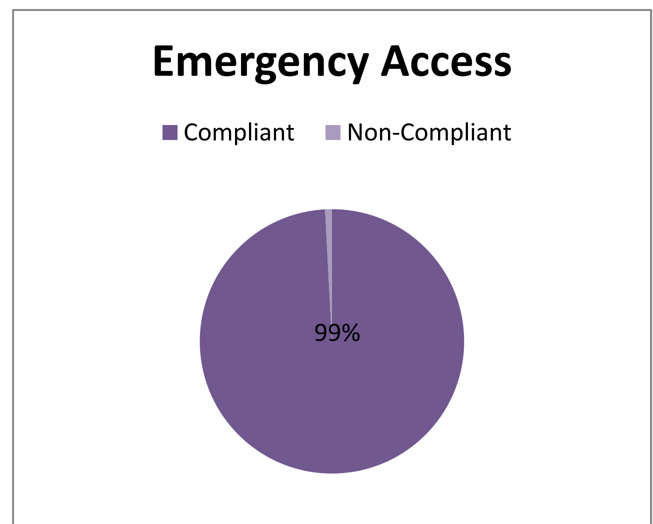
1.) Provider's answering machine or answering service must instruct the member to call 911 if the purpose of the call is a medical emergency.

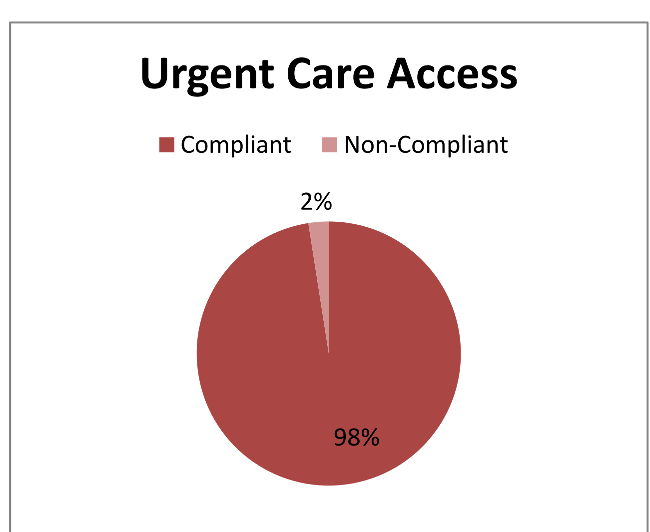
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

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

Results

121 provider offices were contacted during Q1 2018. Of those offices, 120 were compliant with the Emergency Access Standards and 118 were compliant with the Urgent Care Access Standards.





AFTER HOURS CALLS SURVEY

Q1, 2018

Trending / Follow –Up / Outreach

The Plan reviewed results against past quarters and found that one provider group was out of compliance with the emergency care access standard and two provider groups were found to be out of compliance with the urgent care access standards for a second quarter in a row (listed below). These provider groups will be contacted with phone outreach and coached by the Plan's Provider Network Analyst. One provider group was found to be out of compliance with the access to urgent care standard that was compliant during the prior quarter; KHS will conduct phone outreach to this provider group as well.

Q1 2018 Out of Compliance Providers - Trending:

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

William Bichai MD Inc. (Urgent Care Access Standard)

APPOINTMENT AVAILABILITY SURVEY RESULTS

2018 - Quarter 1

APPOINTMENT AVAILABILITY SURVEY

Q4, 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.

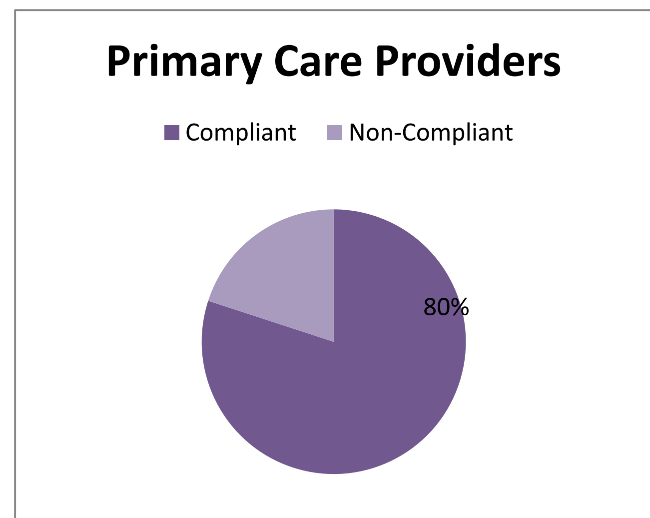
KHS policy and Department regulation require that members must be offered appointments within the following timeframes:

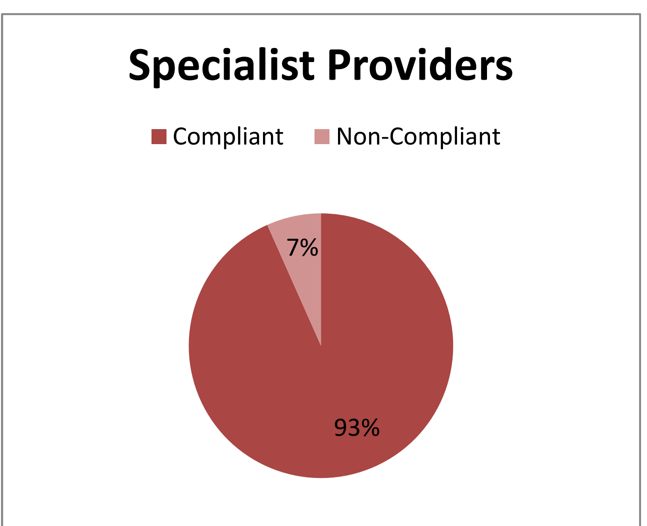
1) Non-urgent primary care appointments – within ten (10) business days of request.
2) Appointment with a specialist – within 15 business days of request;

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 Q4 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.





APPOINTMENT AVAILABILITY SURVEY

Q4, 2017

Follow –Up / Outreach / Training

Notices of non-compliance with applicable policy language were mailed to the 7 non-compliant providers. Providers who were found to be out of compliance or non-responsive this quarter will be included in future appointment availability surveys for further monitoring.

Out of Compliance Providers:

Glenda Orr, NP – San Joaquin Valley Pulmonary Medical Group - (PCP Appointment within 10 days)

Padmaja Kankar, MD – CSV – Family Health Center - (PCP Appointment within 10 days)

Emmanuel Strategos, MD – Adventist Health Community Center – Tehachapi - (PCP Appointment within 10 days)

Hashim Kazmi, MD – Advanced Kidney Medical Group - (Specialist Appointment within 15 days)*

2017 Retrospective

The Plan's Provider Network Analysts compiled a list of all providers found to be out of compliance during Q1-Q4, of 2017. At the time of non-compliance, these providers were mailed letters notifying them of their non-compliance and informing them of KHS' applicable policy language. During Q1 2018 KHS Provider Network Analysts initiated contact to these providers to resurvey compliance with appointment availability standards; while conducting these calls the Plan recognized that providers had moved or termed with the Plan since initial survey. To offset these provider changes, the Plan surveyed the provider group as opposed to the provider and accepted appointment results with any provider at the contracted provider group. Of the 7 primary care provider groups resurveyed, all 7 were compliant with the non-urgent primary care appointment within 10 business day standard. Of the 11 specialist care provider groups resurveyed, all 11 were compliant with the specialist appointment within 15 business day standard.

*Only schedules in-office appointments at this location on Wednesdays.

GEOGRAPHIC ACCESSIBILITY ANALYSIS

2018 - Quarter 1

Provider Relations Department

Geographic Accessibility Analysis

Q1, 2018

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.

On February 16, 2018 the DHCS released APL 18-005 *Network Certification Requirements* that, in part, outlined updated time and distance standards for health plans:

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

As a part of the new annual network certification requirement, the Plan was required to submit geographic access maps outlining compliance with the above referenced standards. For all zip codes in which the Plan was not compliant with the above standard, Plan was able to submit alternative access standards to ensure compliance. During Q2 2017, the Plan received notice from the DHCS that the majority of the alternative access standard requests were approved and the Plan is in discussion with the Department regarding the remaining pending requests.

Exhibit B-1

Kern Family Health Care

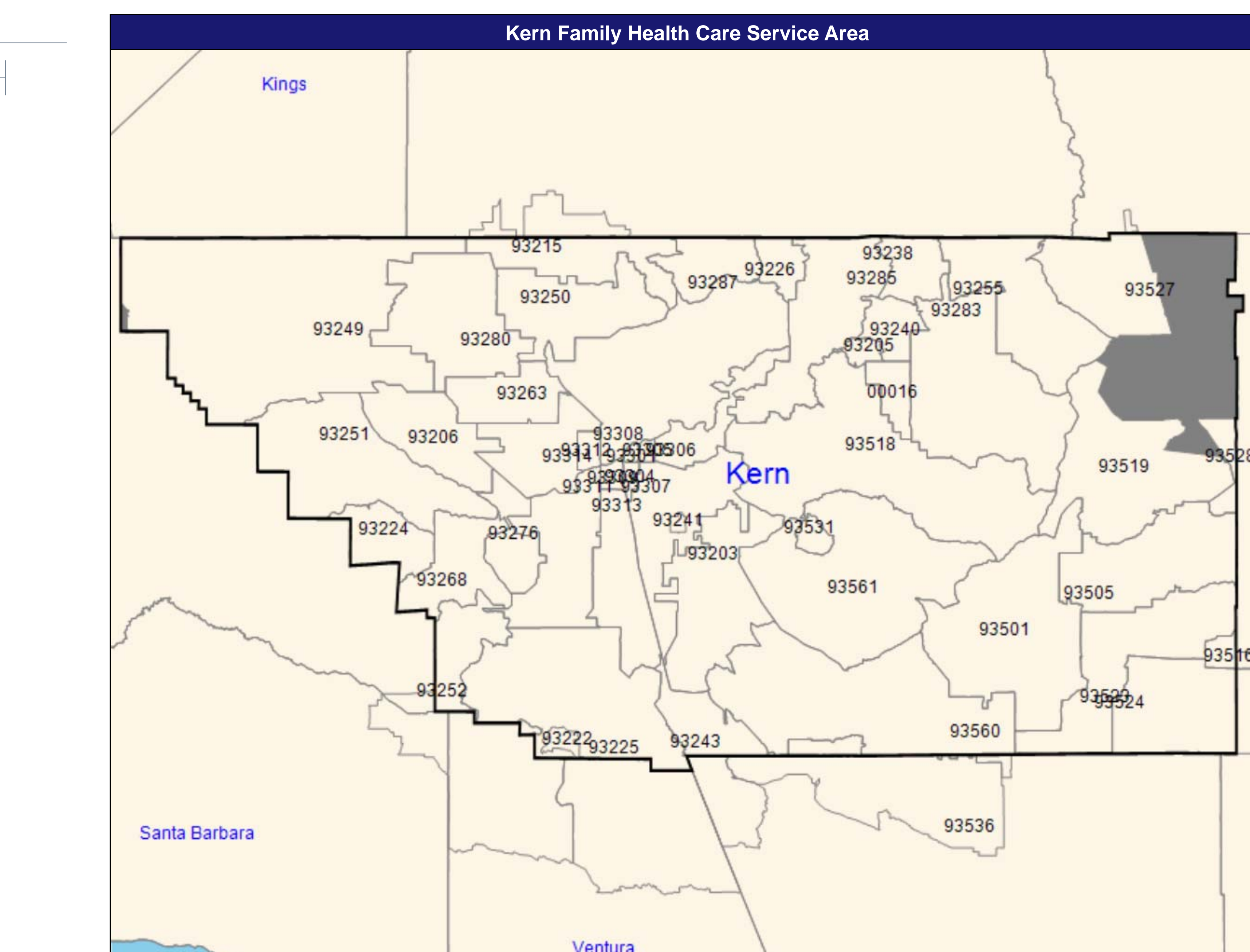


Exhibit B-1

Kern Family Health Care

Kern Family Health Care Service Area - Bakersfield

93263
93308
93314
93312
93301
93305
93306
93518
Kern
93309
93304
93311
93307
93313
93241
93276
93531
93203
93561

© 2018 Quest Analytics, LLC.

Exhibit B-2

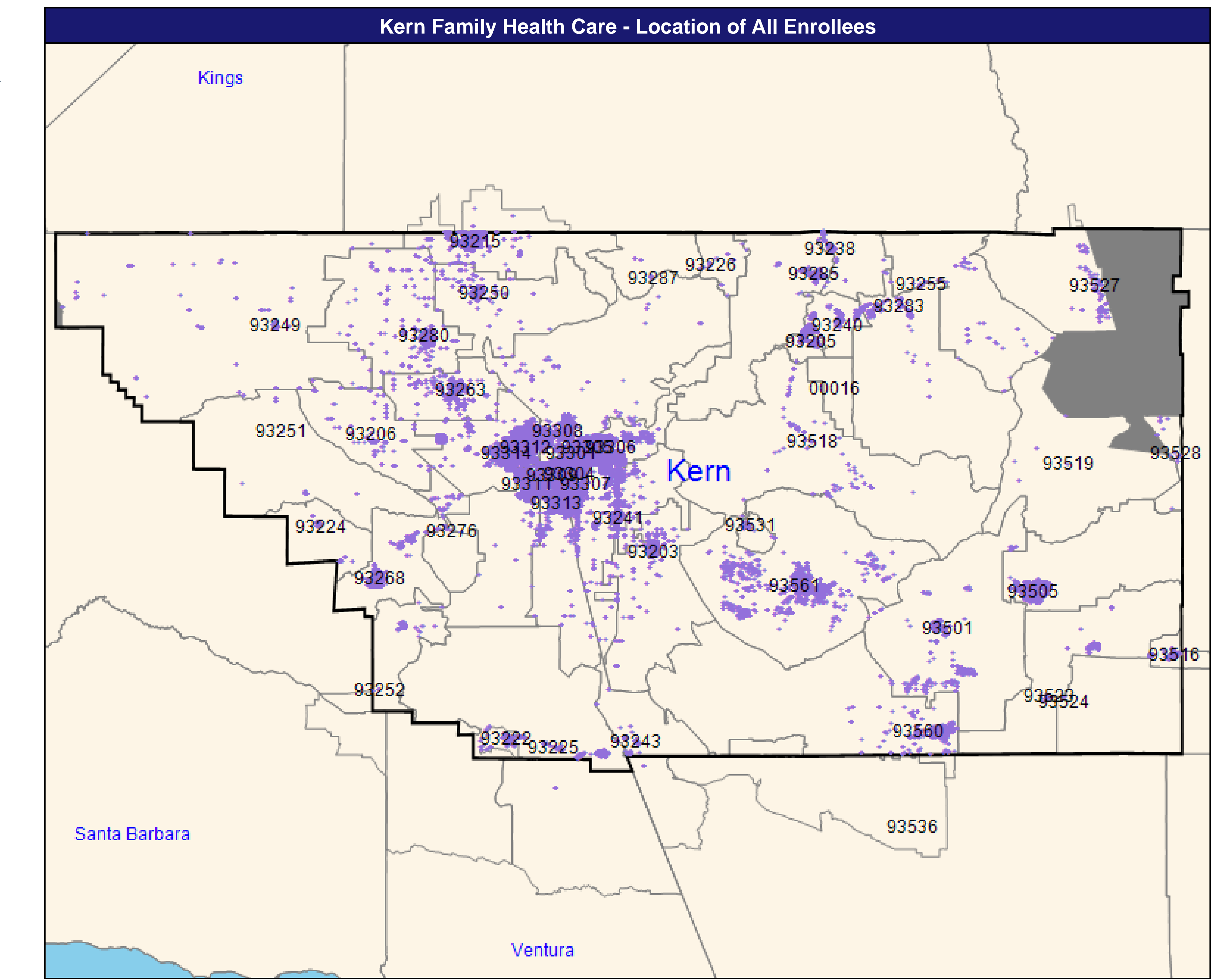
Kern Family Health Care

Kern Family Health Care - All Enrollees

243,028 member locations

◆ All Members

18.17 miles



© 2018 Quest Analytics, LLC.

Exhibit B-2

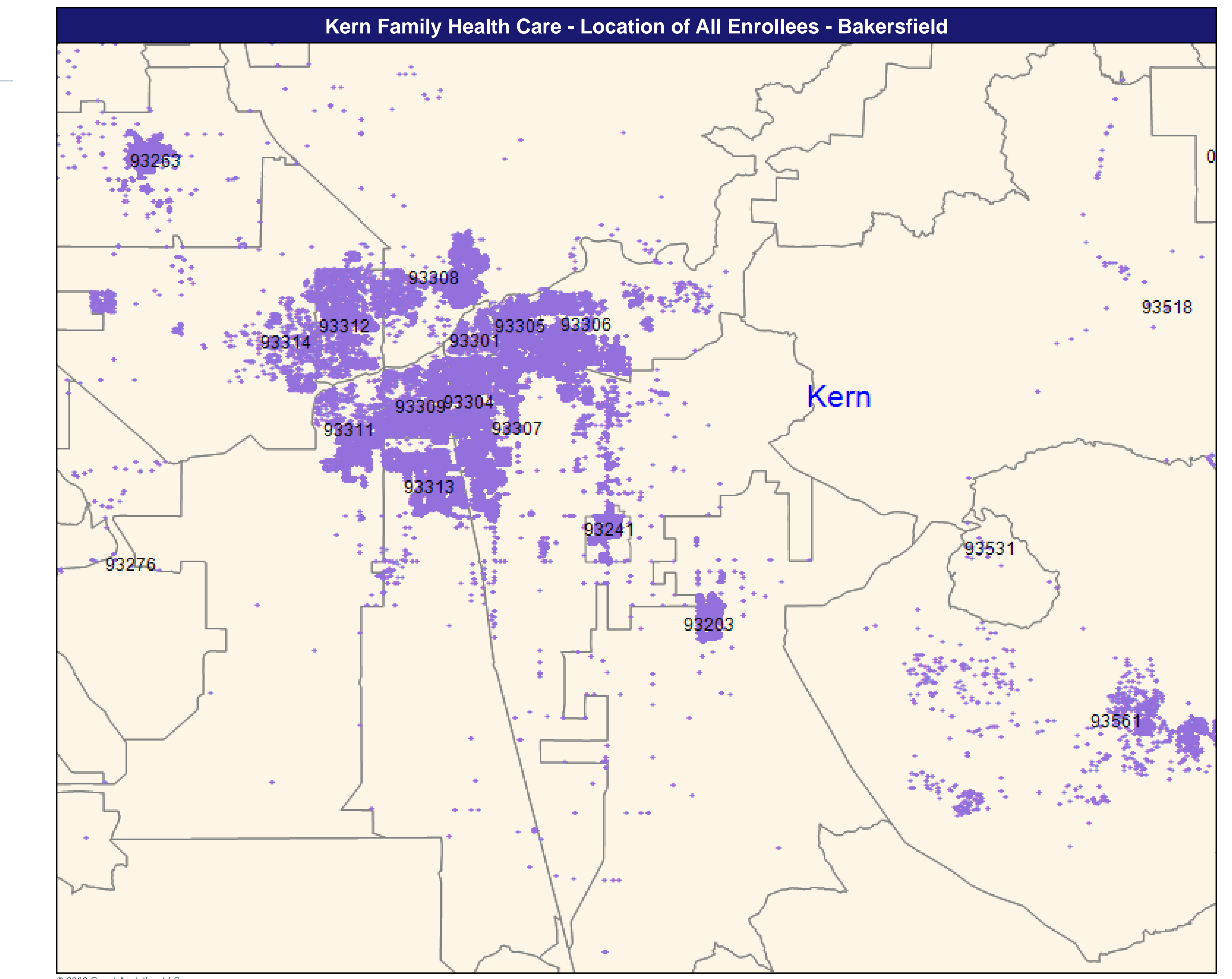
Kern Family Health Care

Kern Family Health Care - All Enrollees

243,028 member locations

◆ All Members

6.30 miles



© 2018 Quest Analytics, LLC.

Exhibit B-3

Kern Family Health Care - Adult Primary Care

Access Analysis

- Kern Family Health Care - Adult Primary Care

Member / Provider Groups

- Kern Family Health Care - All Enrollees
  - Kern Family Health Care - Adult Primary Care

Access Map

Member locations

- ◆ With access
- ● Without access

Comparison Graph

Percent of members with access to a choice of providers over miles

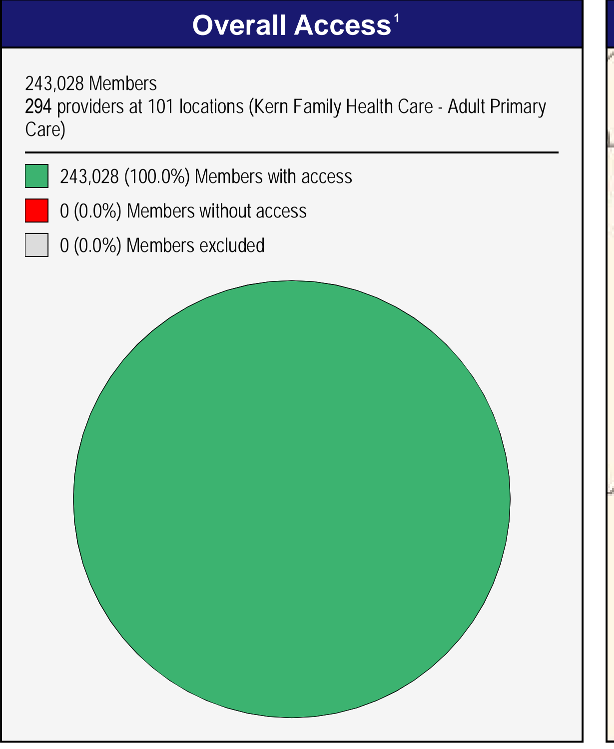
- 1st closest

[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:
1 (Kern Family Health Care - Adult Primary Care) provider in 10 miles or 30 minutes

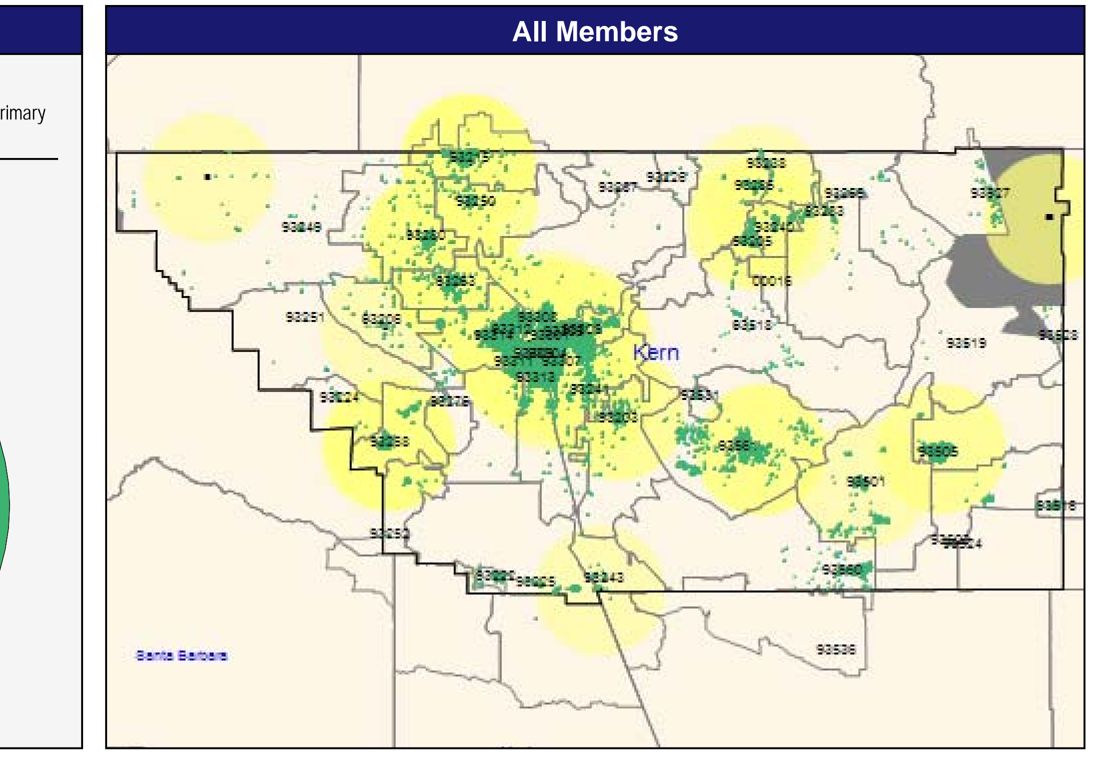
Overall Access[1]

243,028 Members
294 providers at 101 locations (Kern Family Health Care - Adult Primary Care)

- 243,028 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded



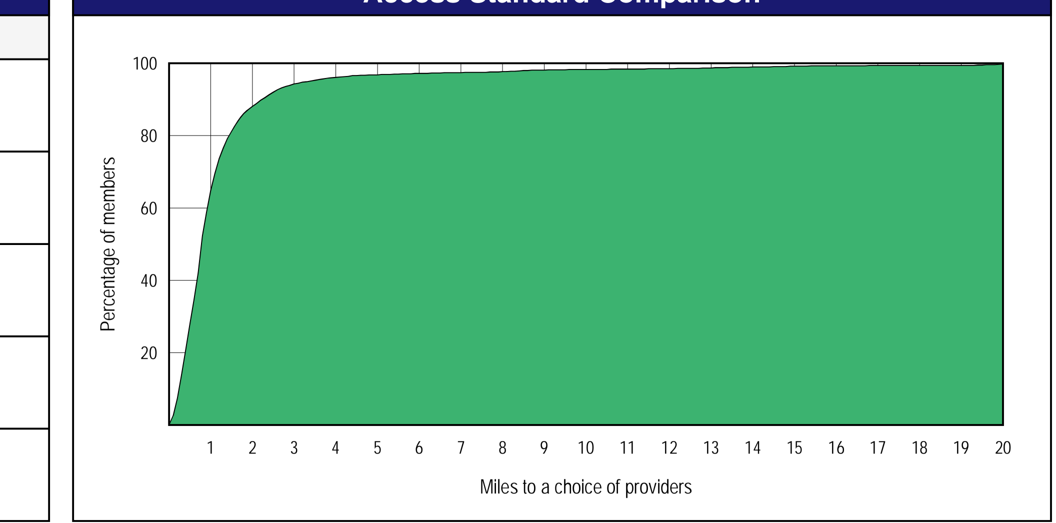
All Members



Distances/Times

	Average
Distance/Time to 1st closest provider	1.3 miles 1.6 mins

Access Standard Comparison



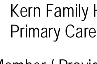
© 2018 Quest Analytics, LLC.

Exhibit B-3

Kern Family Health Care - Pediatric Primary Care

Access Analysis
Kern Family Health Care - Pediatric Primary Care

Member / Provider Groups
Kern Family Health Care - All Enrollees
Kern Family Health Care - Pediatric Primary Care

Access Map
Member locations

- With access
- Without access

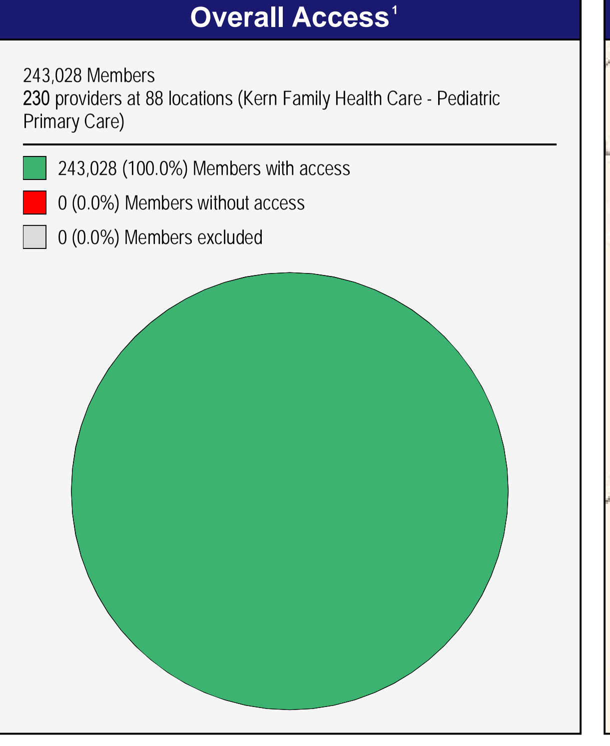
Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest

[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:
1 (Kern Family Health Care - Pediatric Primary Care) provider in 10 miles or 30 minutes

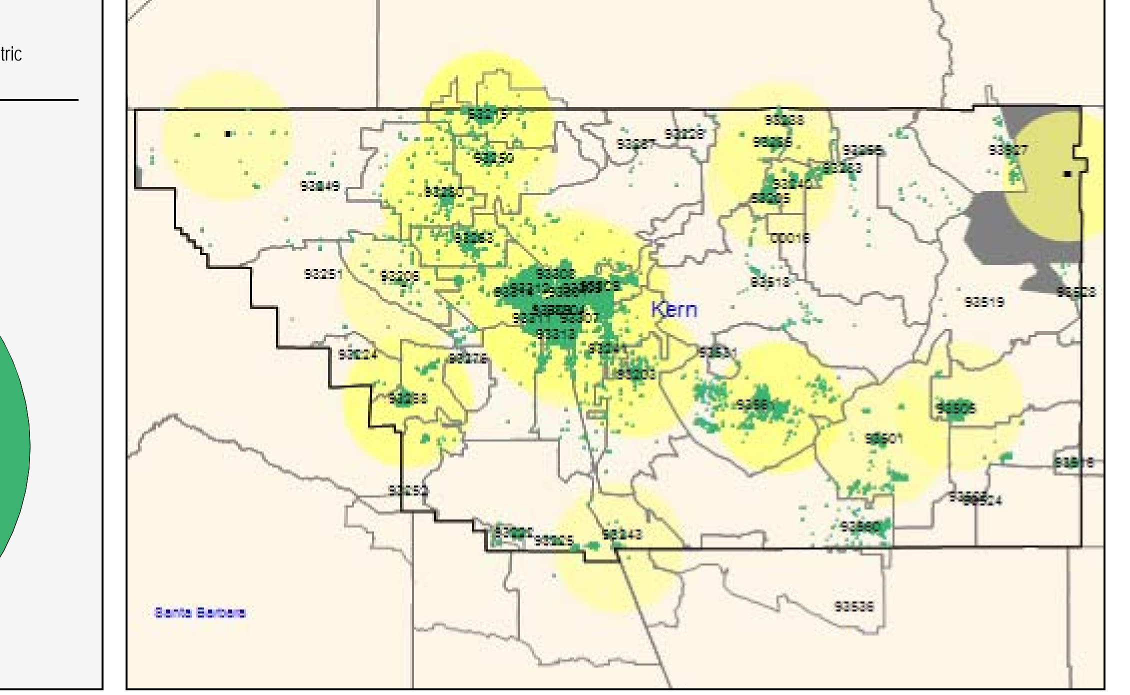
Overall Access[1]

243,028 Members
230 providers at 88 locations (Kern Family Health Care - Pediatric Primary Care)

- 243,028 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded



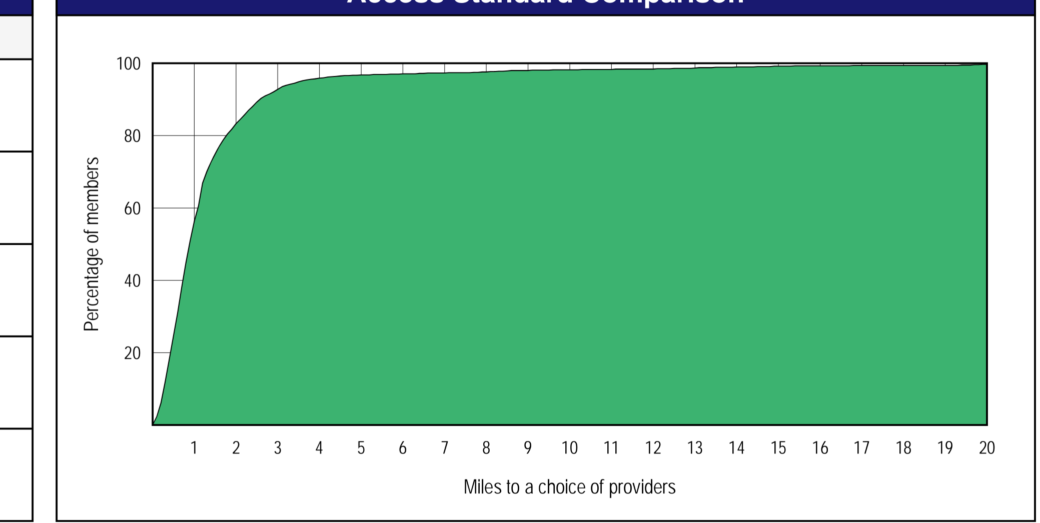
All Members

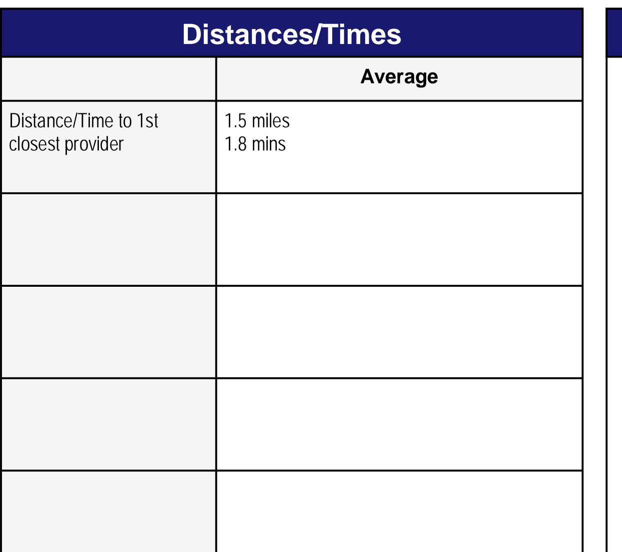


Distances/Times

	Average
Distance/Time to 1st closest provider	1.5 miles 1.8 mins

Access Standard Comparison





© 2018 Quest Analytics, LLC.

Exhibit B-4

Kern Family Health Care - Cardiology

Access Analysis
- Kern Family Health Care - Cardiology

Member / Provider Groups
- Kern Family Health Care - All Enrollees
  - Kern Family Health Care - Cardiology

Access Map

Member locations
- ◆ With access
- ● Without access

Comparison Graph

Percent of members with access to a choice of providers over miles
- 1st closest

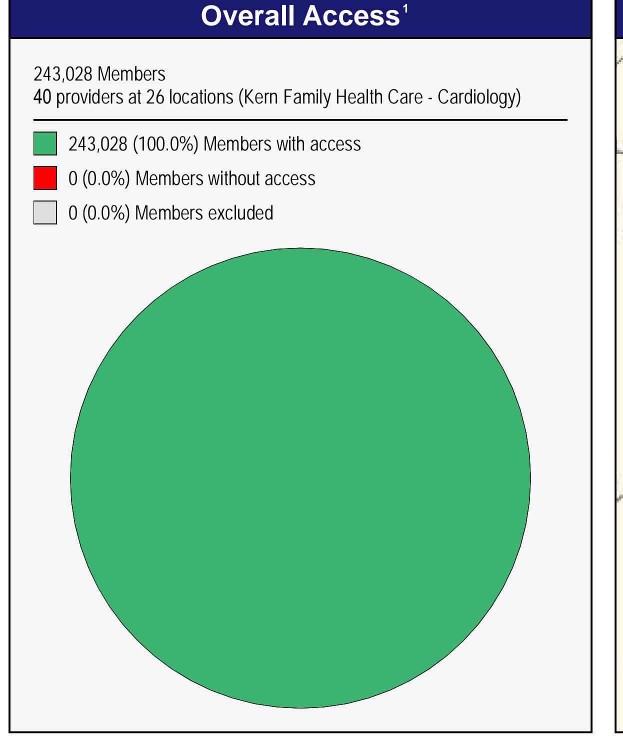
[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:

1 (Kern Family Health Care - Cardiology) provider in 45 miles or 75 minutes

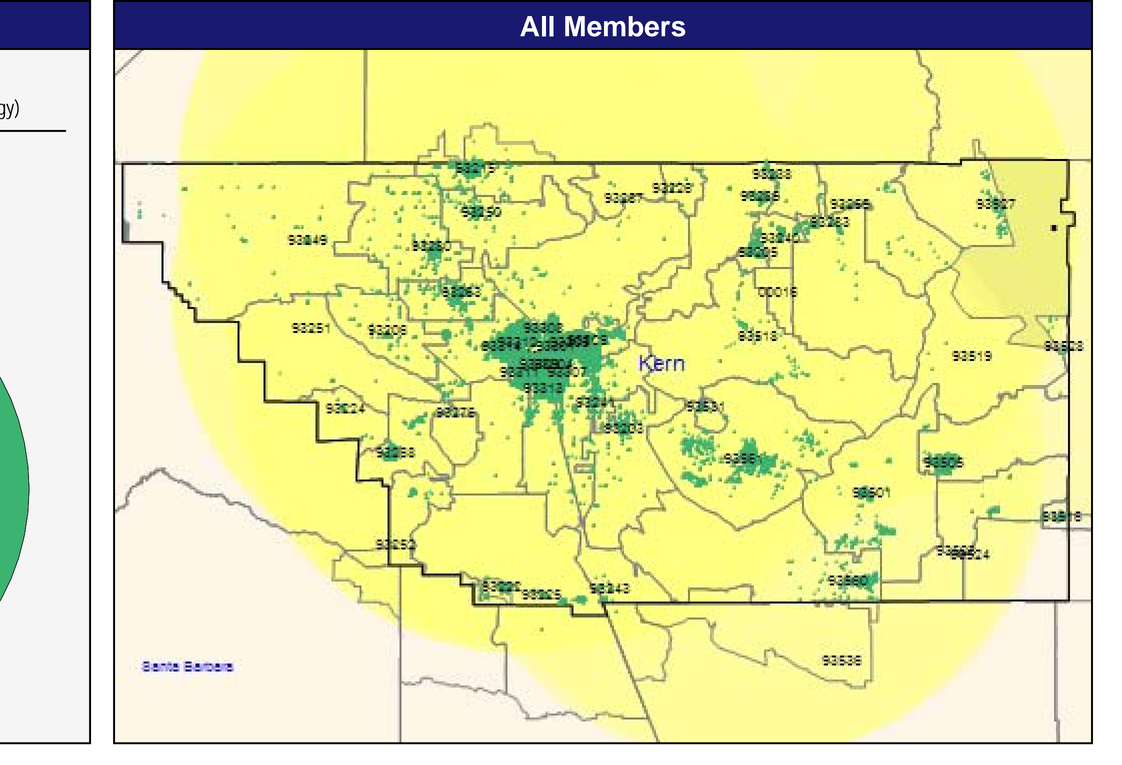
Overall Access[1]

243,028 Members
40 providers at 26 locations (Kern Family Health Care - Cardiology)

- 243,028 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded



All Members



Distances/Times

	Average
Distance/Time to 1st closest provider	5.4 miles 6.4 mins

© 2018 Quest Analytics, LLC.

Access Standard Comparison

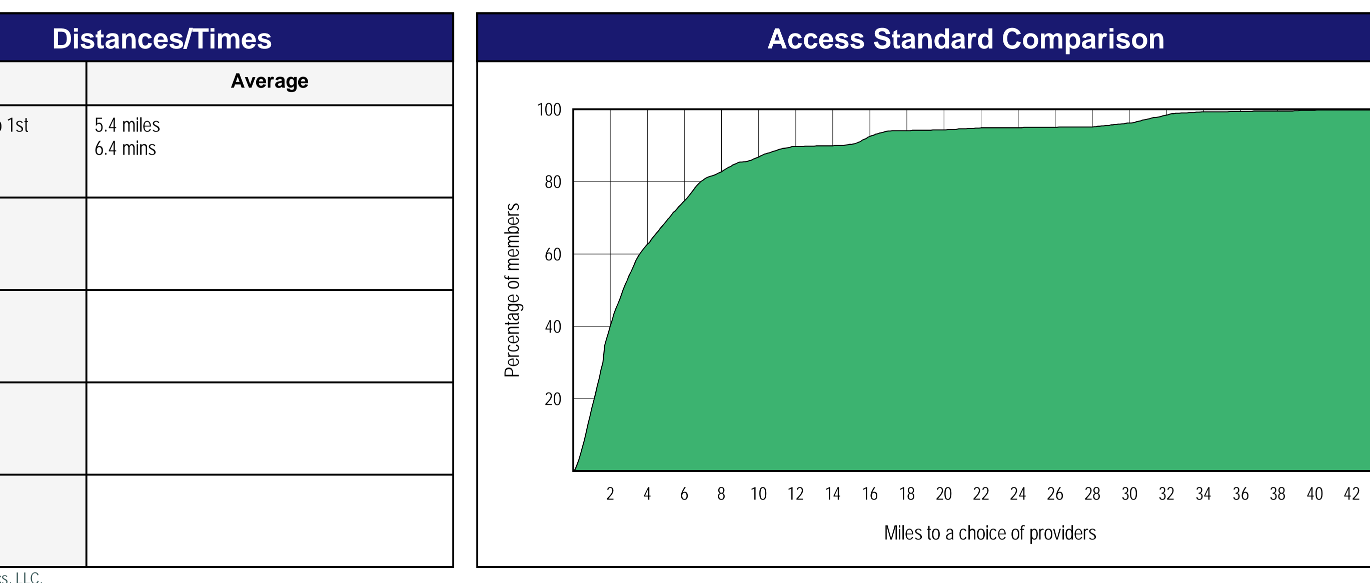


Exhibit B-4

Kern Family Health Care - Dermatology

Access Analysis

Kern Family Health Care - Dermataology

Member / Provider Groups

Kern Family Health Care - All Enrollees

Kern Family Health Care - Dermatology

Access Map

Member locations

- With access
- Without access

Comparison Graph

Percent of members with access to a choice of providers over miles

- 1st closest

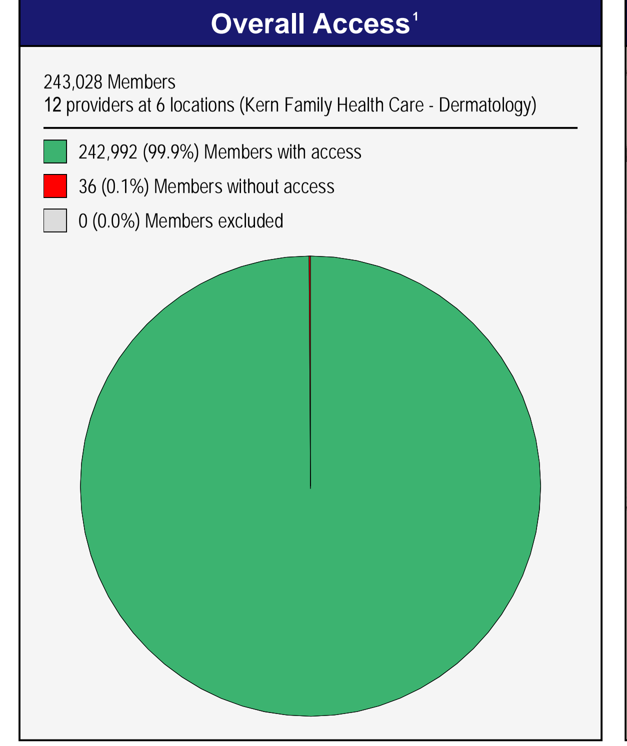
[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:

1 (Kern Family Health Care - Dermatology) provider in 45 miles or 75 minutes

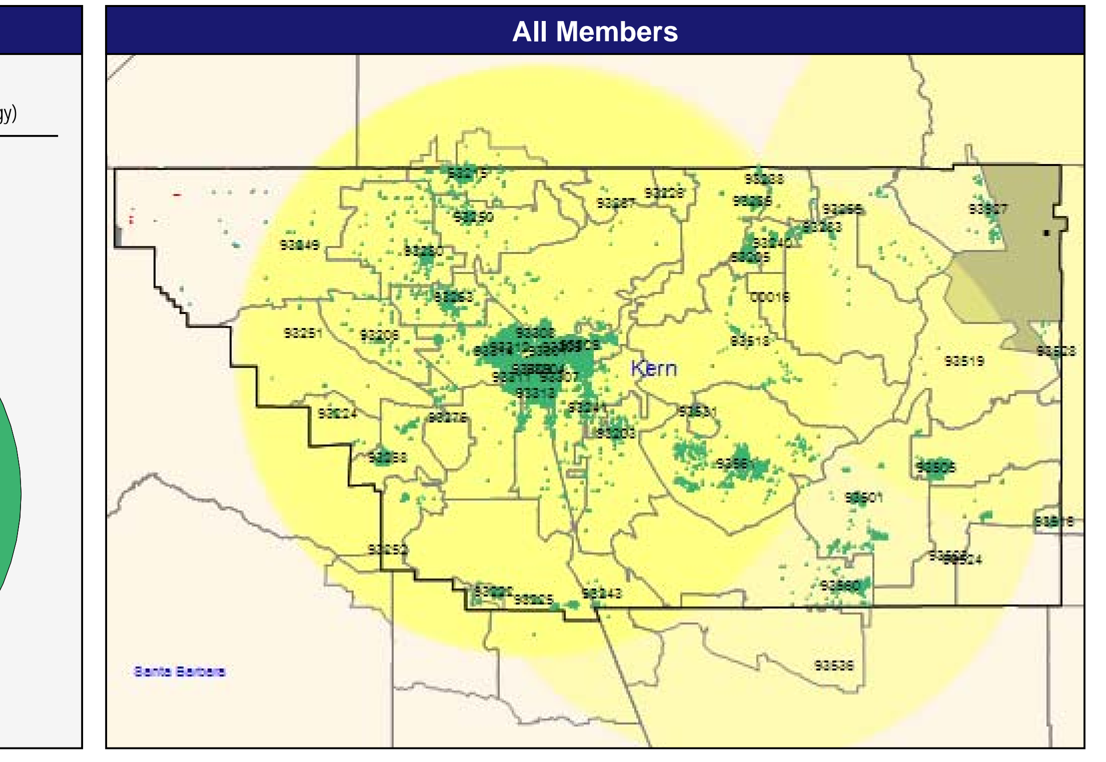
Overall Access[1]

243,028 Members
12 providers at 6 locations (Kern Family Health Care - Dermatology)

- 242,992 (99.9%) Members with access
- 36 (0.1%) Members without access
- 0 (0.0%) Members excluded



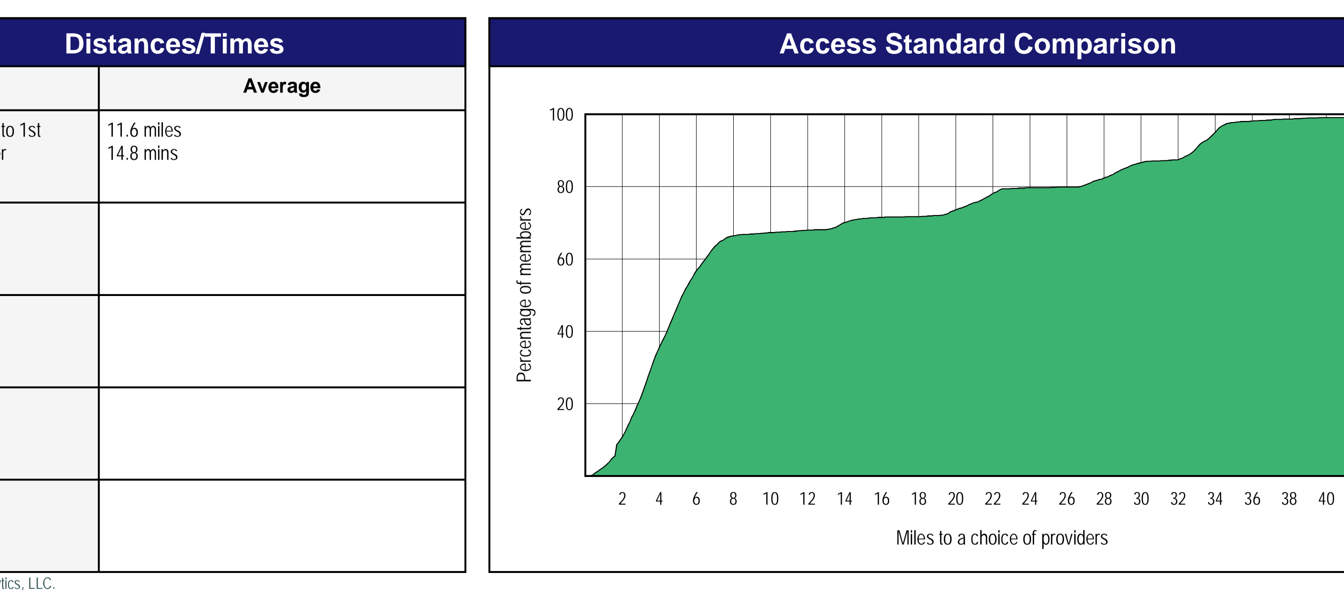
All Members



Distances/Times

	Average
Distance/Time to 1st closest provider	11.6 miles 14.8 mins

Access Standard Comparison



© 2018 Quest Analytics, LLC.

Exhibit B-4

Kern Family Health Care - Endocrinology

Access Analysis
- Kern Family Health Care - Endocrinology

Member / Provider Groups
- Kern Family Health Care - All Enrollees
  - Kern Family Health Care - Endocrinology

Access Map

Member locations
- With access
- Without access

Comparison Graph

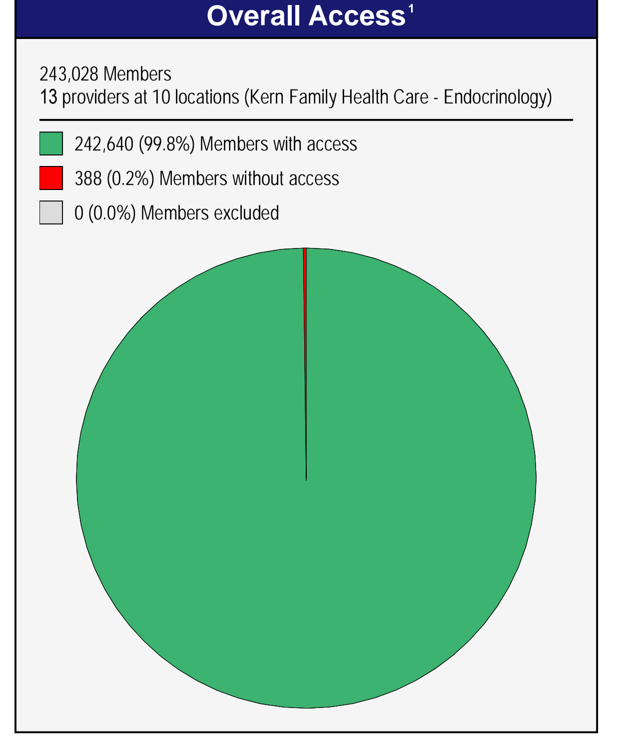
Percent of members with access to a choice of providers over miles
- 1st closest

[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:
1 (Kern Family Health Care - Endocrinology) provider in 45 miles or 75 minutes

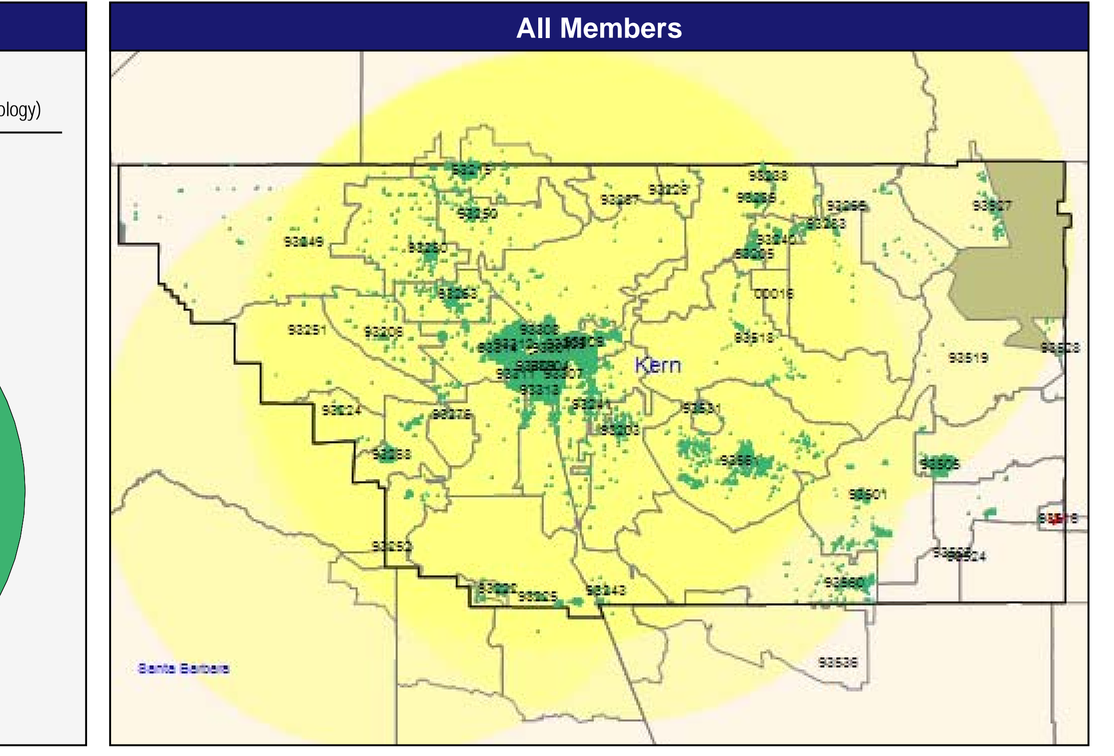
Overall Access[1]

243,028 Members
13 providers at 10 locations (Kern Family Health Care - Endocrinology)

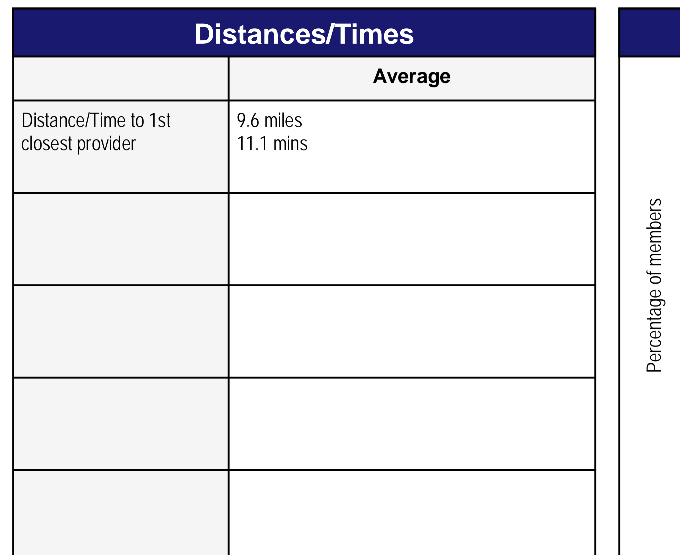
- 242,640 (99.8%) Members with access
- 388 (0.2%) Members without access
- 0 (0.0%) Members excluded



All Members



Distances/Times



	Average
Distance/Time to 1st closest provider	9.6 miles 11.1 mins

© 2018 Quest Analytics, LLC.

Access Standard Comparison

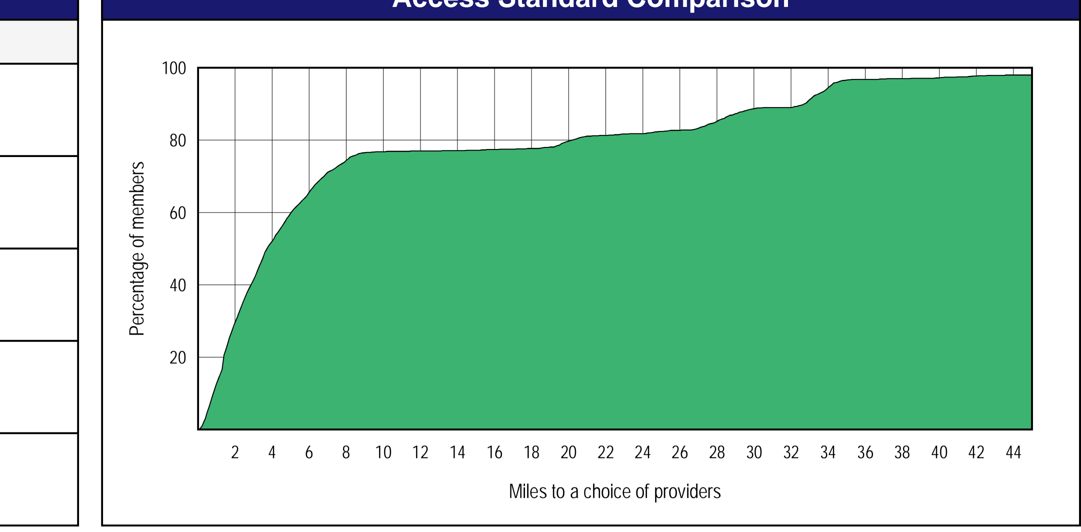


Exhibit B-4

Kern Family Health Care - ENT

Access Analysis
- Kern Family Health Care - ENT

Member / Provider Groups
- Kern Family Health Care - All Enrollees
  - Kern Family Health Care - ENT

Access Map
Member locations
- With access
- Without access

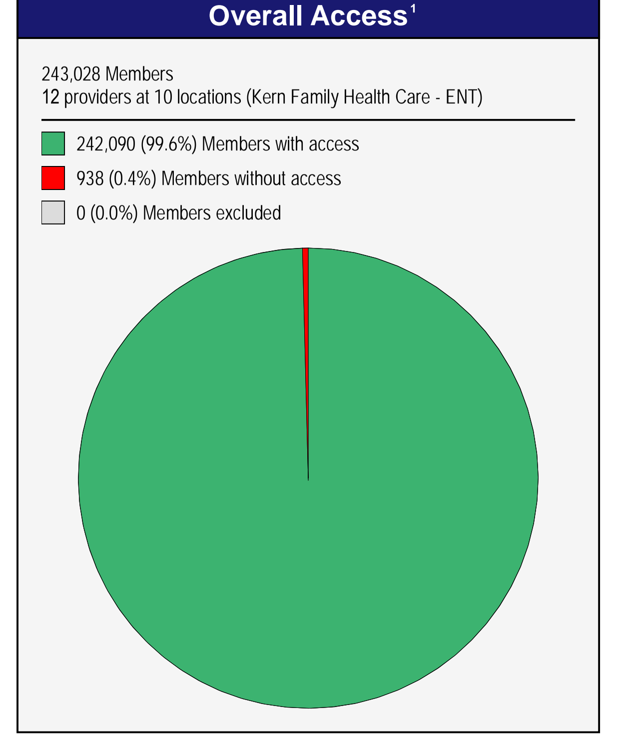
Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest

[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:
1 (Kern Family Health Care - ENT) provider in 45 miles or 75 minutes

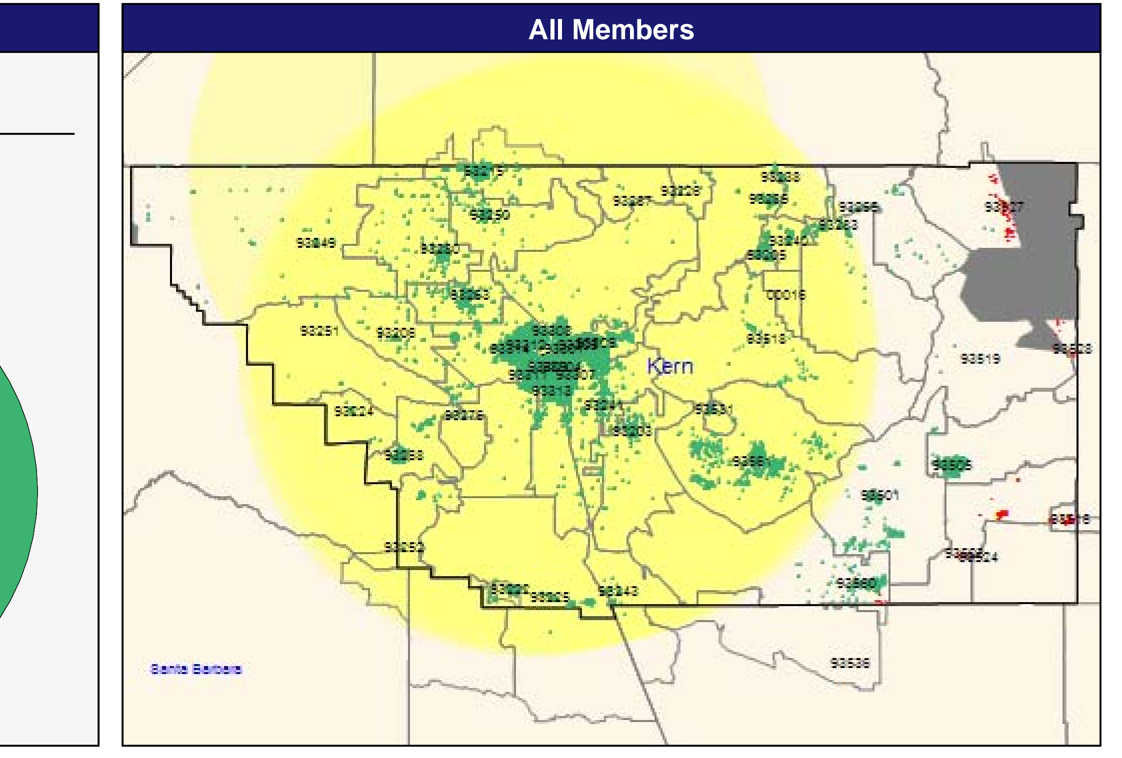
Overall Access[1]

243,028 Members
12 providers at 10 locations (Kern Family Health Care - ENT)

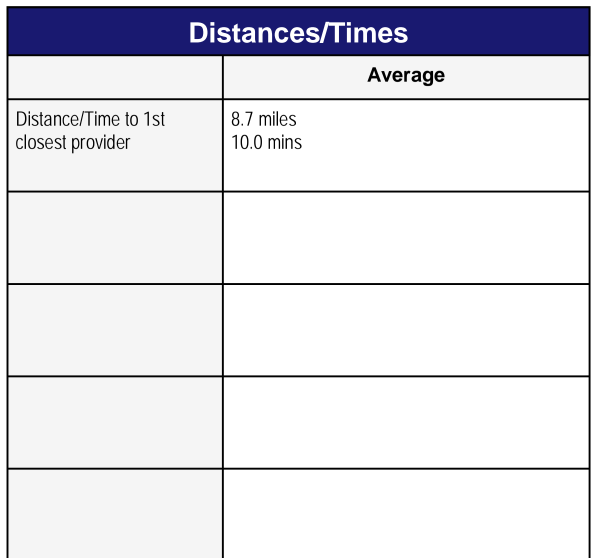
- 242,090 (99.6%) Members with access
- 938 (0.4%) Members without access
- 0 (0.0%) Members excluded



All Members

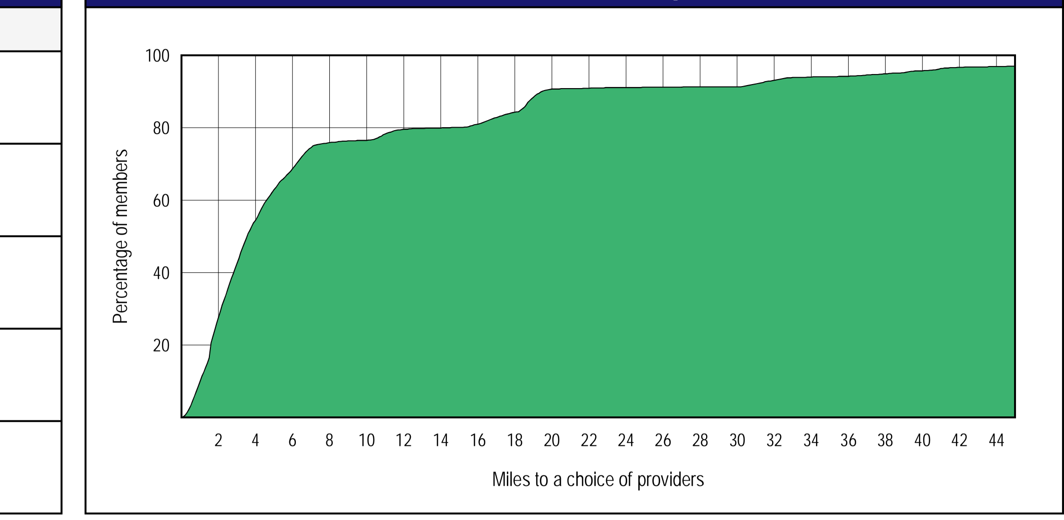


Distances/Times



	Average
Distance/Time to 1st closest provider	8.7 miles 10.0 mins

Access Standard Comparison



© 2018 Quest Analytics, LLC.

Exhibit B-4

Kern Family Health Care - Gastroenteroloy

Access Analysis

Kern Family Health Care - Gastroenterology

Member / Provider Groups

Kern Family Health Care - All Enrollees

Kern Family Health Care - Gastroenterology

Access Map

Member locations

- With access
- Without access

Comparison Graph

Percent of members with access to a choice of providers over miles

- 1st closest

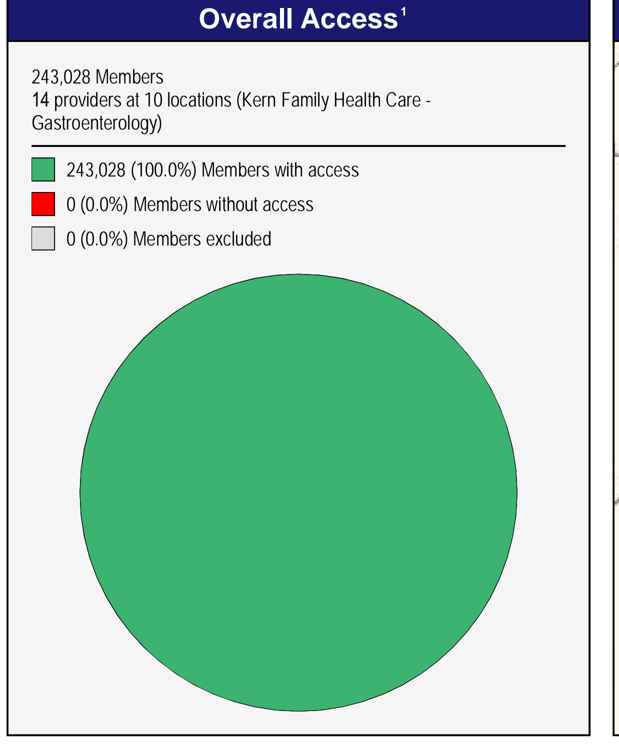
[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:

1 (Kern Family Health Care - Gastroenterology) provider in 45 miles or 75 minutes

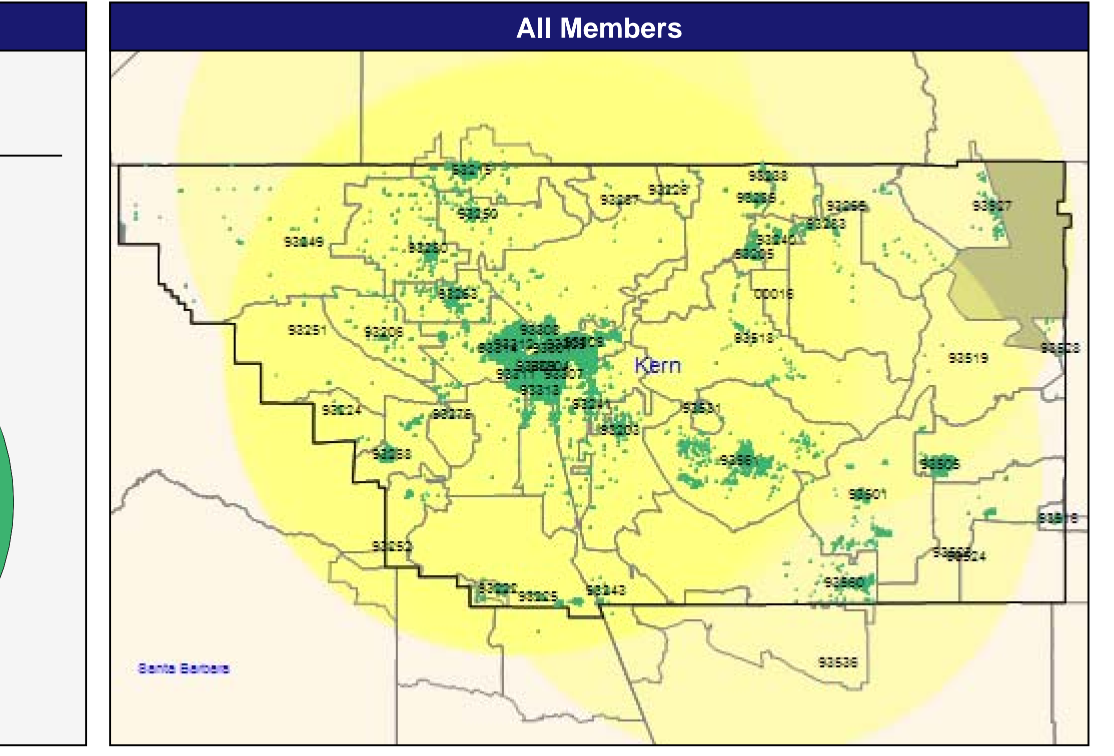
Overall Access[1]

243,028 Members
14 providers at 10 locations (Kern Family Health Care - Gastroenterology)

- 243,028 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded



All Members



Distances/Times

	Average
Distance/Time to 1st closest provider	6.9 miles 8.2 mins

© 2018 Quest Analytics, LLC.

Access Standard Comparison

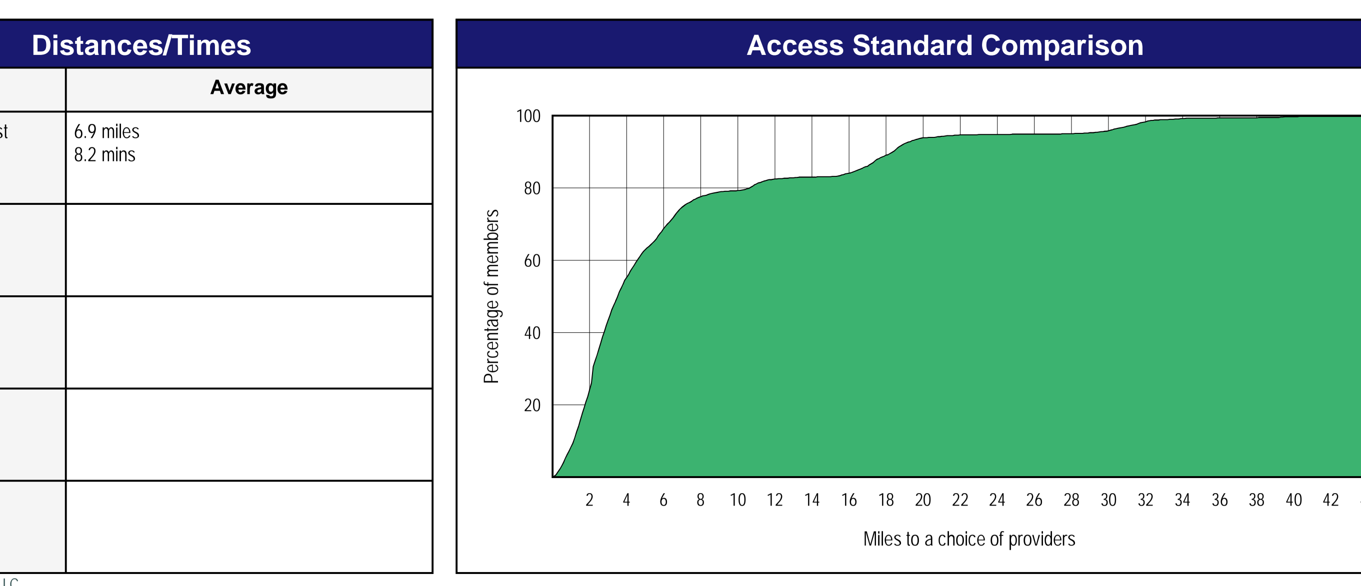


Exhibit B-4

Kern Family Health Care - General Surgery

Access Analysis
- Kern Family Health Care - General Surgery

Member / Provider Groups
- Kern Family Health Care - All Enrollees
  - Kern Family Health Care - General Surgery

Access Map
Member locations
- ◆ With access
- ● Without access

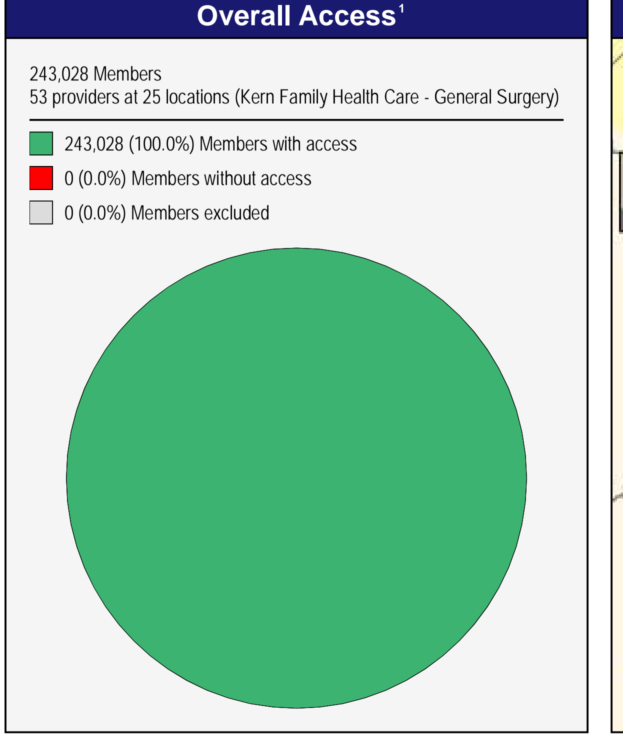
Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest

[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:
1 (Kern Family Health Care - General Surgery) provider in 45 miles or 75 minutes

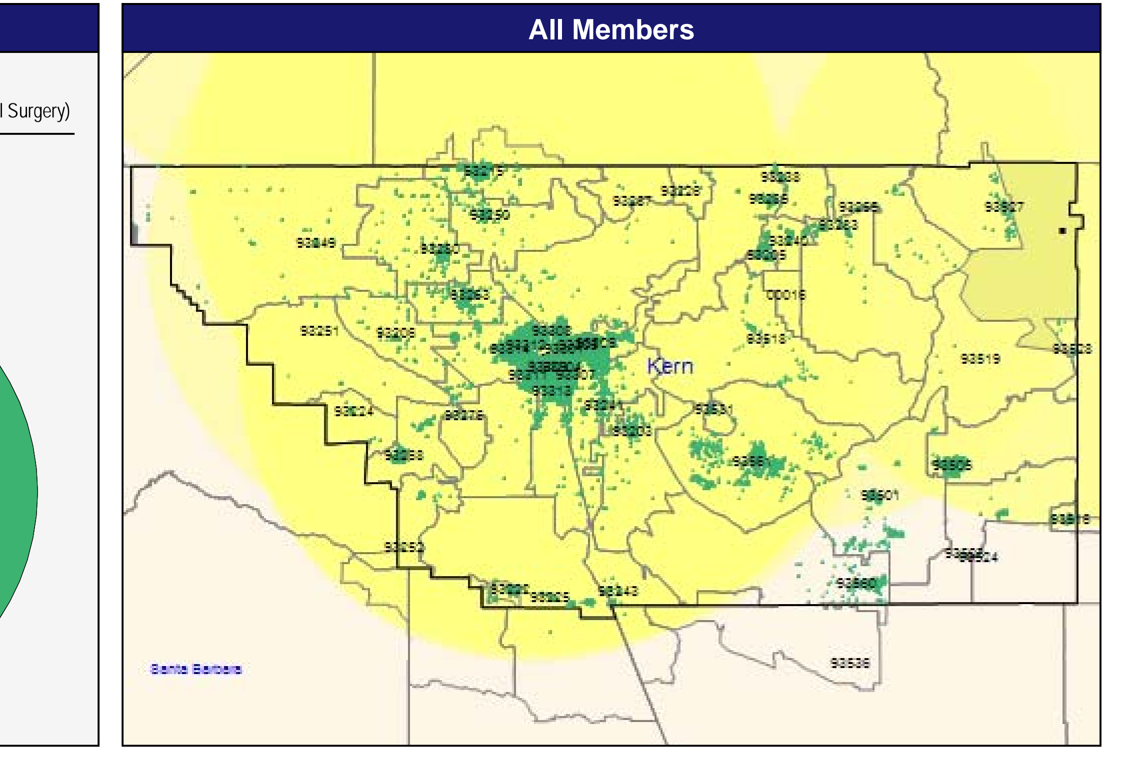
Overall Access[1]

243,028 Members
53 providers at 25 locations (Kern Family Health Care - General Surgery)

- 243,028 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded



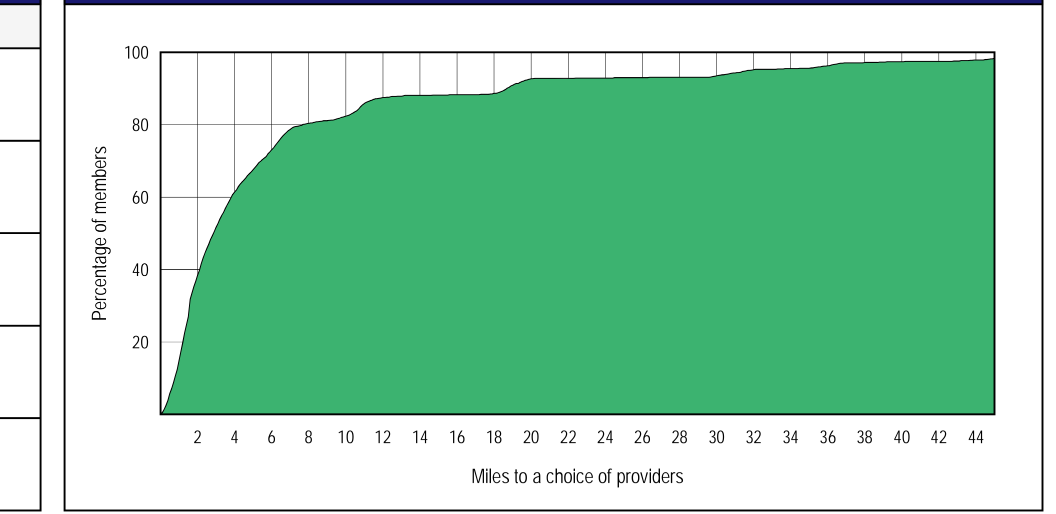
All Members



Distances/Times

	Average
Distance/Time to 1st closest provider	6.6 miles 7.7 mins

Access Standard Comparison



© 2018 Quest Analytics, LLC.

Exhibit B-4

Kern Family Health Care - Hematology

Access Analysis

Kern Family Health Care - Hematology

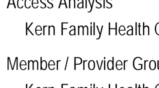
Member / Provider Groups

Kern Family Health Care - All Enrollees

Kern Family Health Care - Hematology

Access Map

Member locations



With access

Without access

Comparison Graph

Percent of members with access to a choice of providers over miles

1st closest

[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:

1 (Kern Family Health Care - Hematology) provider in 45 miles or 75 minutes

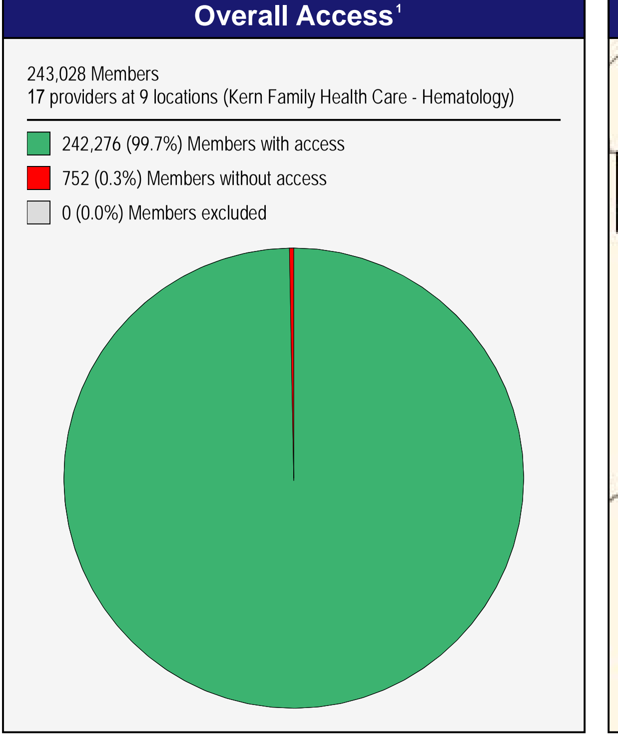
Overall Access[1]

243,028 Members
17 providers at 9 locations (Kern Family Health Care - Hematology)

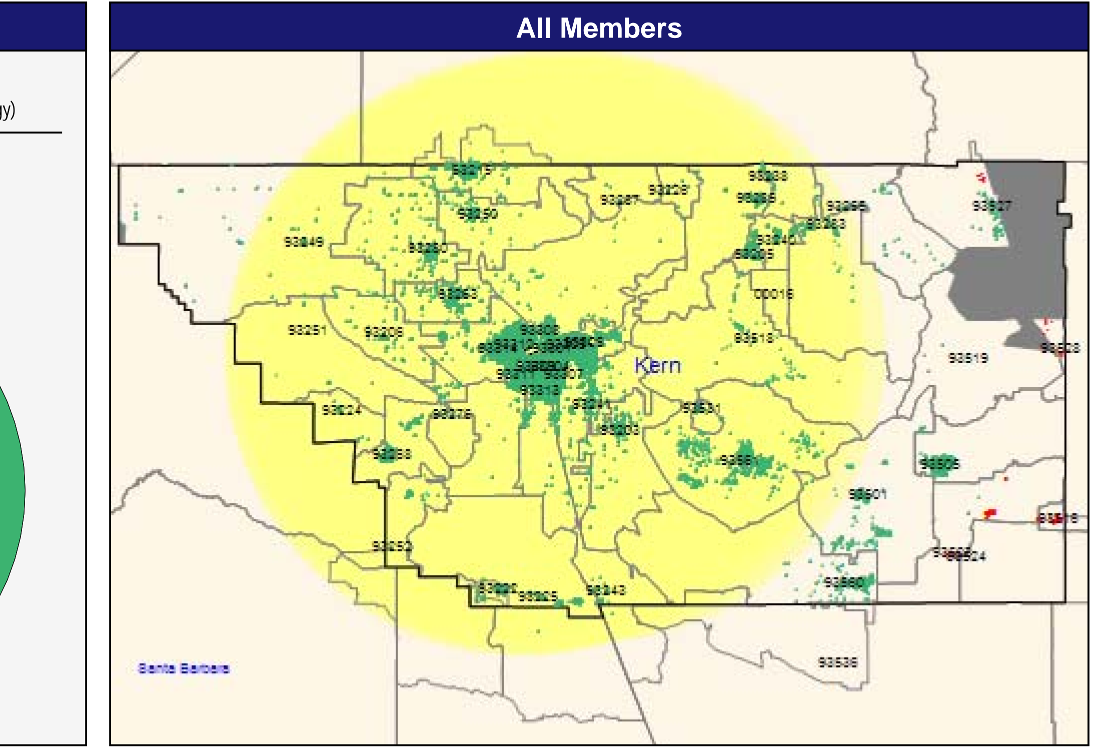
242,276 (99.7%) Members with access

752 (0.3%) Members without access

0 (0.0%) Members excluded



All Members



Distances/Times

	Average
Distance/Time to 1st closest provider	11.6 miles 13.2 mins

© 2018 Quest Analytics, LLC.

Access Standard Comparison

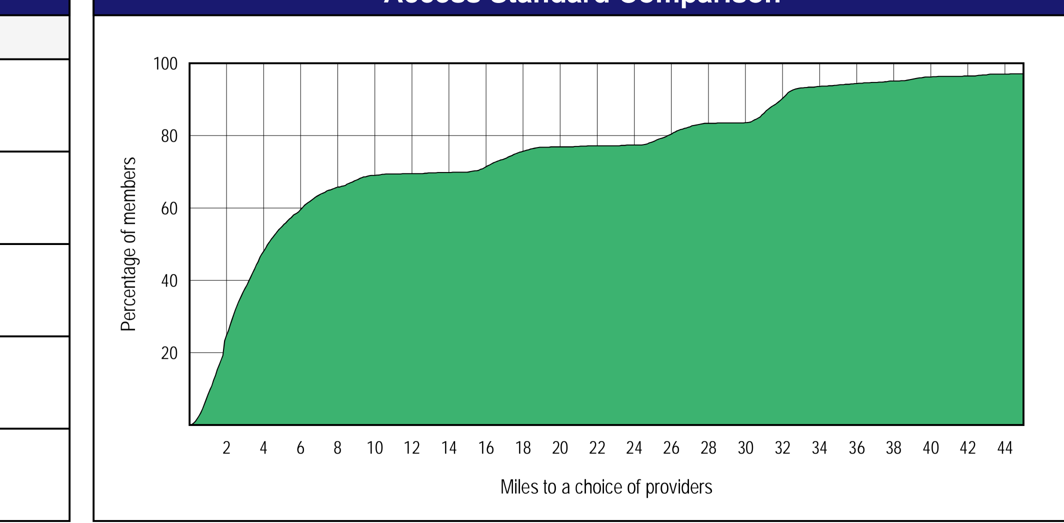


Exhibit B-4

Kern Family Health Care - Infectious Disease

Access Analysis

Kern Family Health Care - Infectious Diseases

Member / Provider Groups

Kern Family Health Care - All Enrollees

Kern Family Health Care - Infectious Diseases

Access Map

Member locations

- With access
- Without access

Comparison Graph

Percent of members with access to a choice of providers over miles

- 1st closest

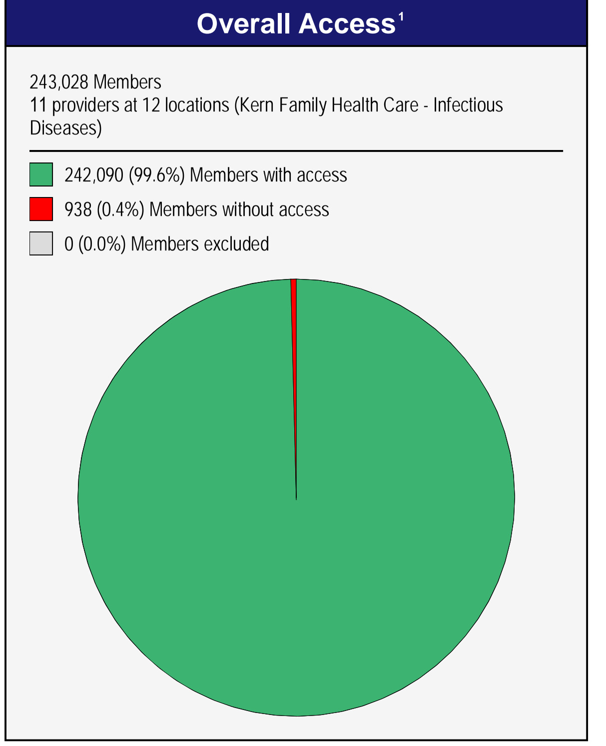
[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:

1 (Kern Family Health Care - Infectious Diseases) provider in 45 miles or 75 minutes

Overall Access[1]

243,028 Members
11 providers at 12 locations (Kern Family Health Care - Infectious Diseases)

- 242,090 (99.6%) Members with access
- 938 (0.4%) Members without access
- 0 (0.0%) Members excluded



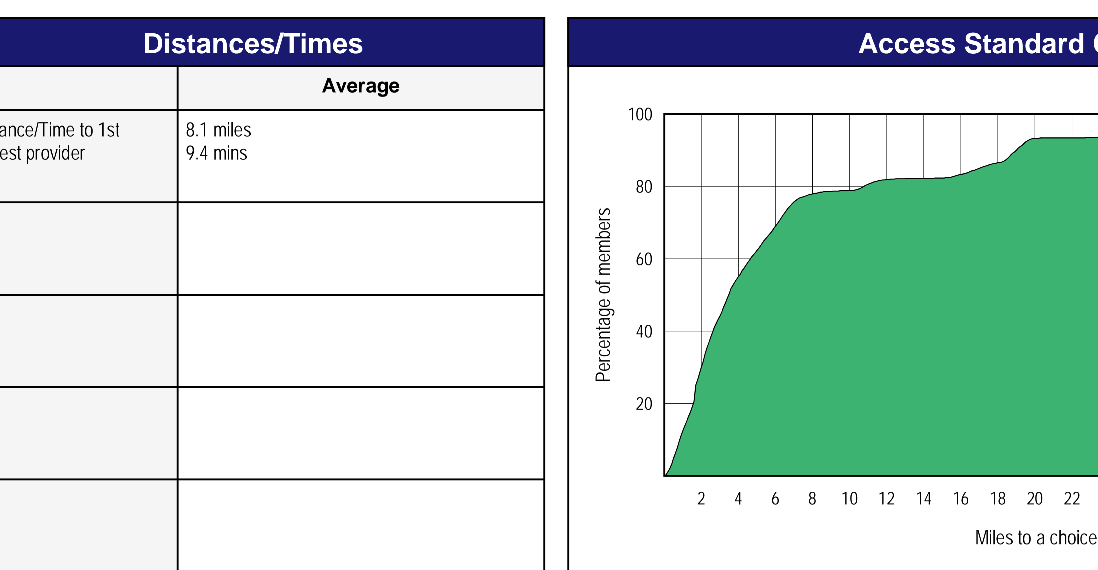
All Members

Kern
Santa Barbara

Distances/Times

	Average
Distance/Time to 1st closest provider	8.1 miles 9.4 mins

Access Standard Comparison



© 2018 Quest Analytics, LLC.

Exhibit B-4

Kern Family Health Care - Nephrology

Access Analysis
- Kern Family Health Care - Nephrology

Member / Provider Groups
- Kern Family Health Care - All Enrollees
  - Kern Family Health Care - Nephrology

Access Map

Member locations
- With access
- Without access

Comparison Graph

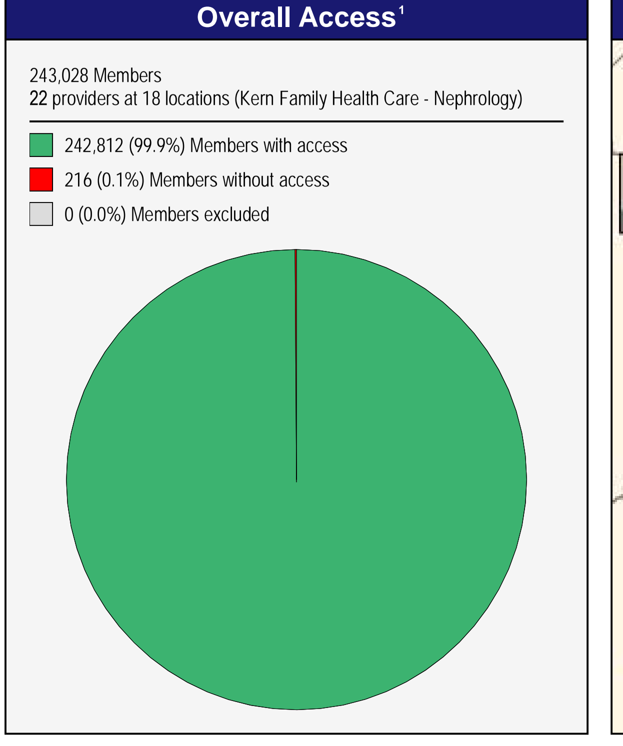
Percent of members with access to a choice of providers over miles
- 1st closest

[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:
1 (Kern Family Health Care - Nephrology) provider in 45 miles or 75 minutes

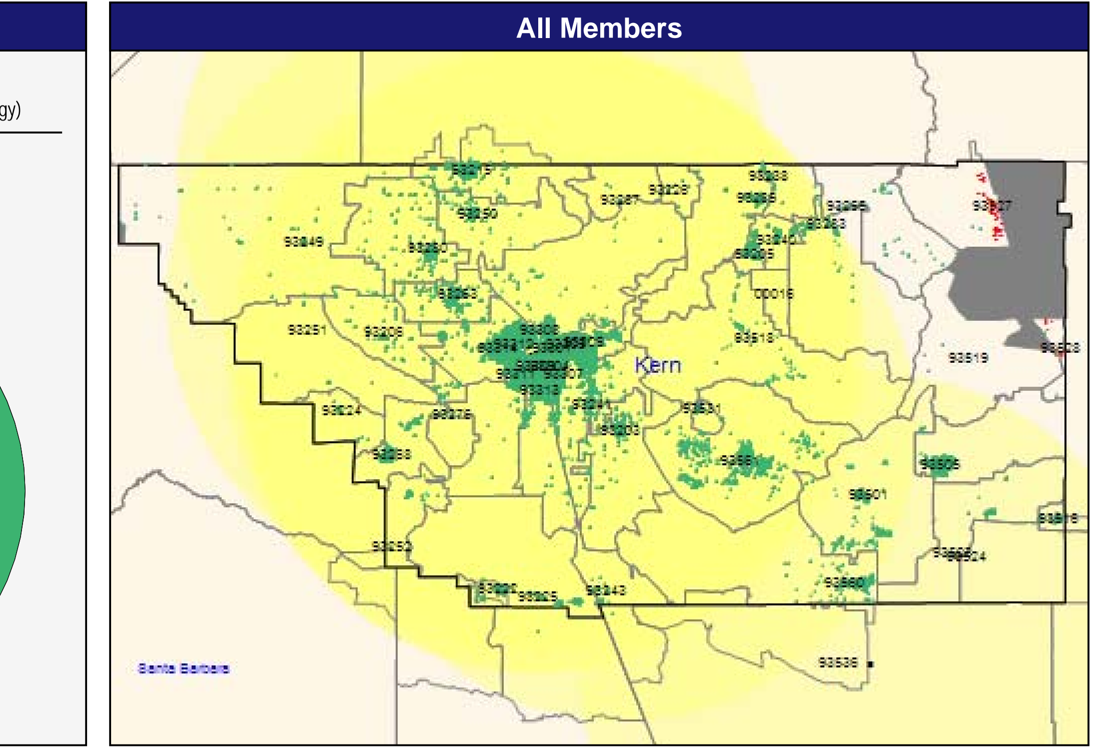
Overall Access[1]

243,028 Members
22 providers at 18 locations (Kern Family Health Care - Nephrology)

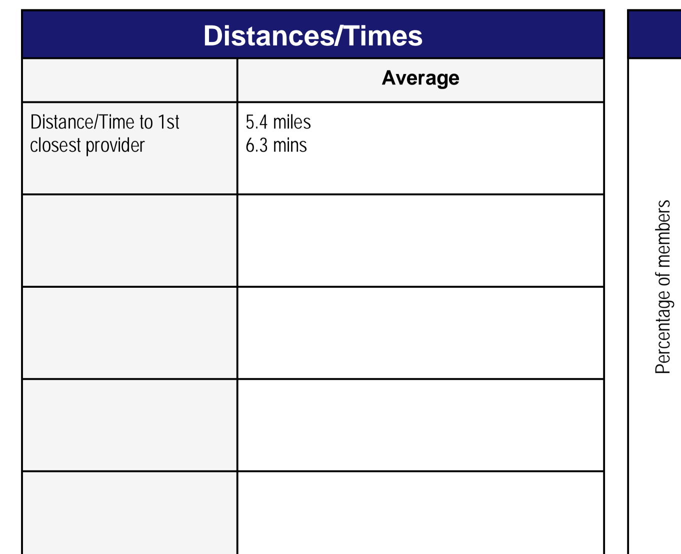
- 242,812 (99.9%) Members with access
- 216 (0.1%) Members without access
- 0 (0.0%) Members excluded



All Members

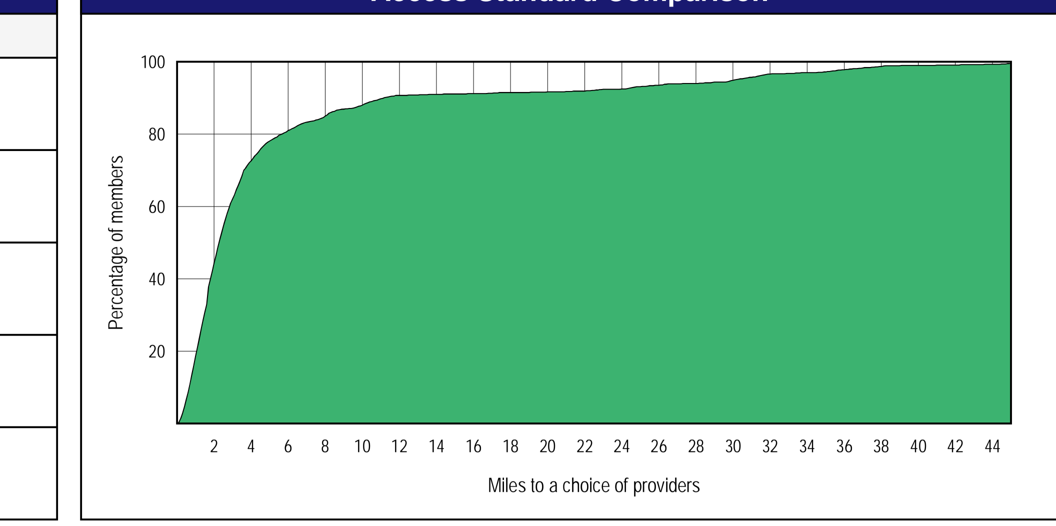


Distances/Times



	Average
Distance/Time to 1st closest provider	5.4 miles 6.3 mins

Access Standard Comparison



© 2018 Quest Analytics, LLC.

Exhibit B-4

Kern Family Health Care - Neurology

Access Analysis
- Kern Family Health Care - Neurology

Member / Provider Groups
- Kern Family Health Care - All Enrollees
  - Kern Family Health Care - Neurology

Access Map
Member locations
- ◆ With access
- ● Without access

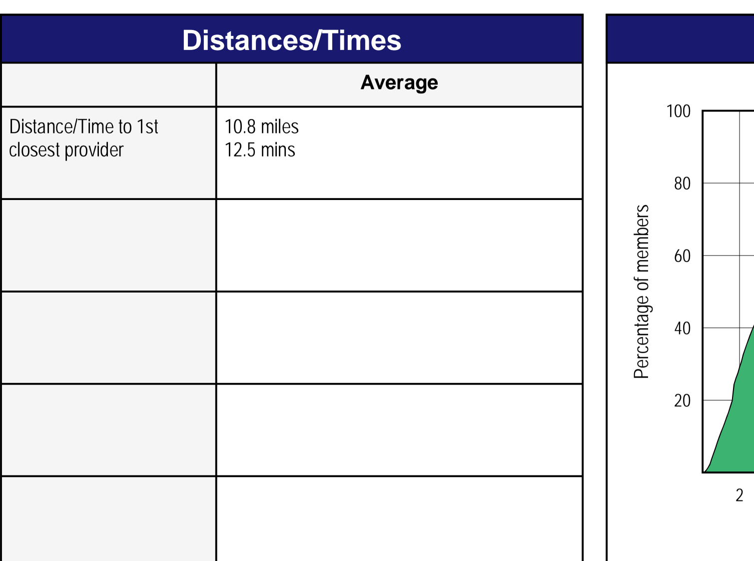
Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest

[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:
1 (Kern Family Health Care - Neurology) provider in 45 miles or 75 minutes

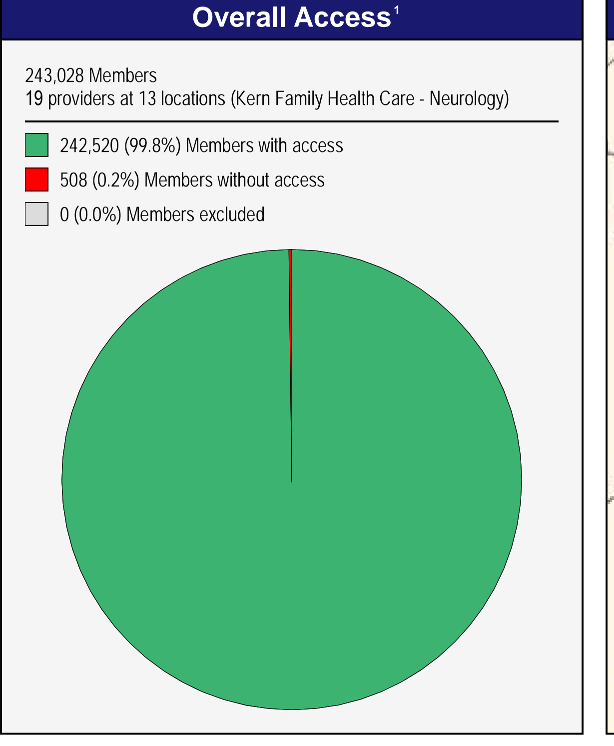
Overall Access[1]

243,028 Members
19 providers at 13 locations (Kern Family Health Care - Neurology)

- 242,520 (99.8%) Members with access
- 508 (0.2%) Members without access
- 0 (0.0%) Members excluded



All Members



Distances/Times

	Average
Distance/Time to 1st closest provider	10.8 miles 12.5 mins

Access Standard Comparison

Percentage of members: 20, 40, 60, 80, 100

Miles to a choice of providers: 2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 26, 28, 30, 32, 34, 36, 38, 40, 42, 44

© 2018 Quest Analytics, LLC.

Exhibit B-4

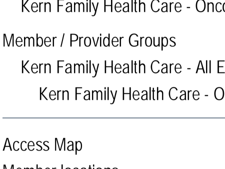
Kern Family Health Care - Oncology

Access Analysis
- Kern Family Health Care - Oncology

Member / Provider Groups
- Kern Family Health Care - All Enrollees
  - Kern Family Health Care - Oncology

Access Map

Member locations



- With access
- Without access

Comparison Graph

Percent of members with access to a choice of providers over miles

- 1st closest

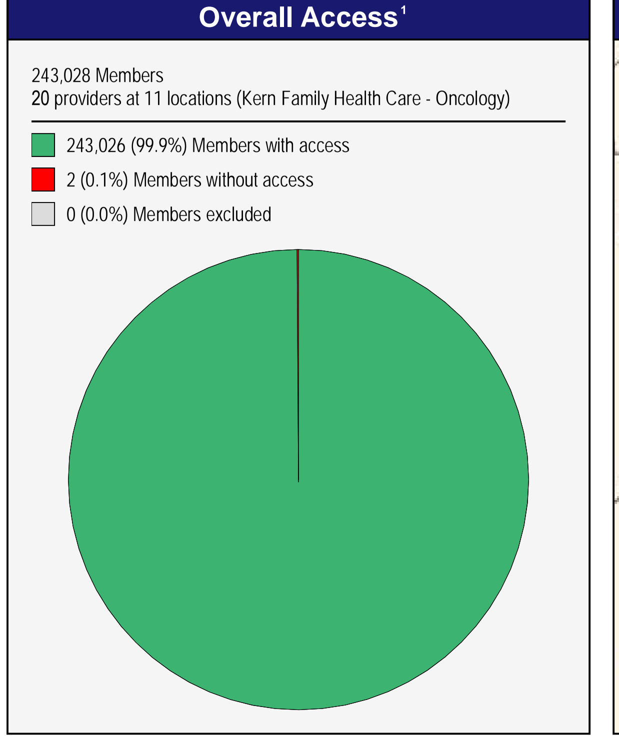
[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:

1 (Kern Family Health Care - Oncology) provider in 45 miles or 75 minutes

Overall Access[1]

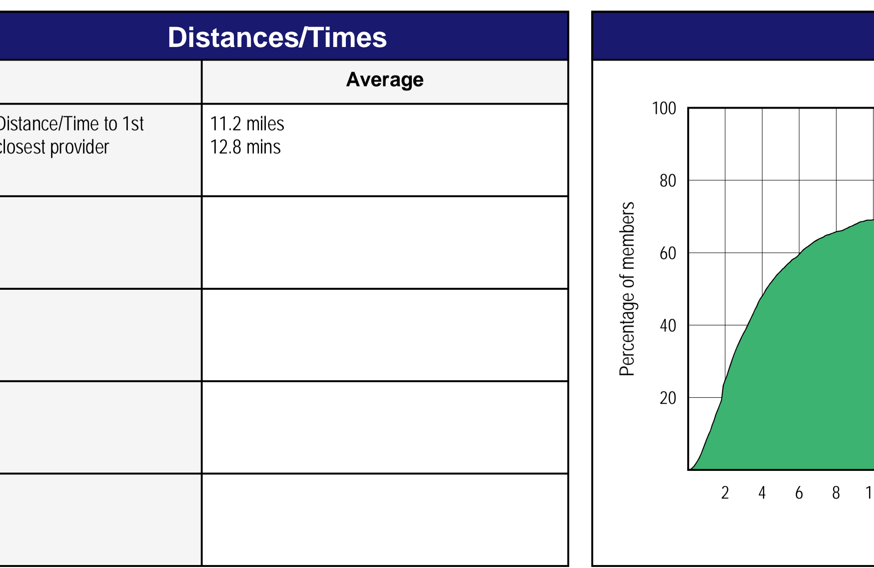
243,028 Members
20 providers at 11 locations (Kern Family Health Care - Oncology)

- 243,026 (99.9%) Members with access
- 2 (0.1%) Members without access
- 0 (0.0%) Members excluded



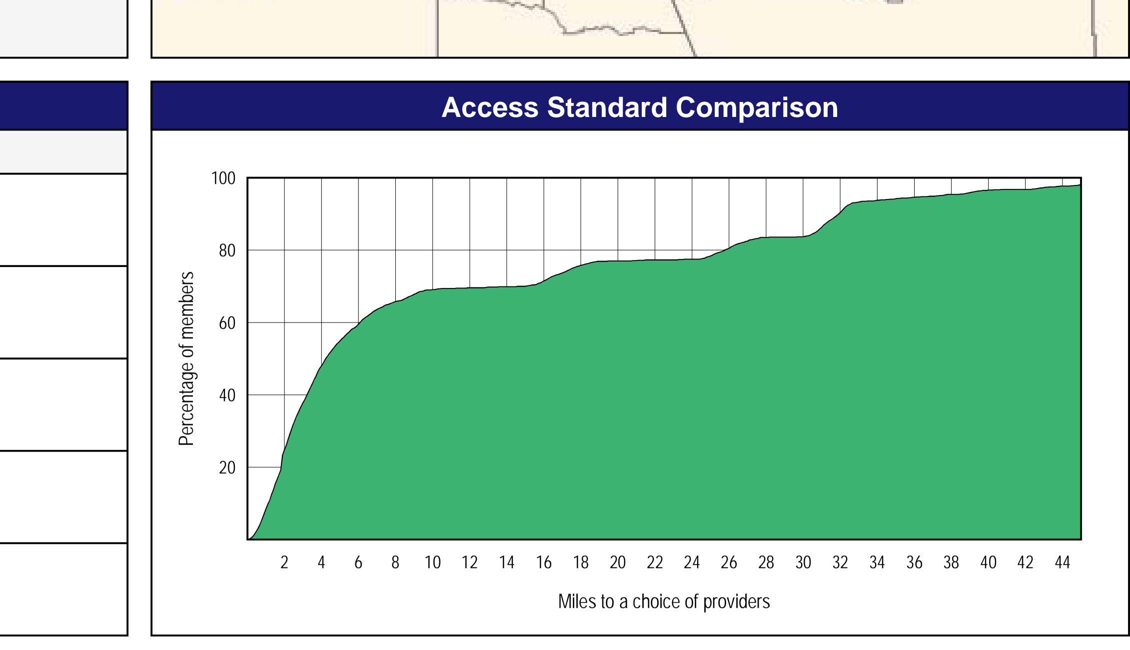
All Members

Distances/Times



	Average
Distance/Time to 1st closest provider	11.2 miles 12.8 mins

Access Standard Comparison



© 2018 Quest Analytics, LLC.

Exhibit B-4

Kern Family Health Care - Ophthalmology

Access Analysis
- Kern Family Health Care - Ophthalmology

Member / Provider Groups
- Kern Family Health Care - All Enrollees
  - Kern Family Health Care - Ophthalmology

Access Map

Member locations
- With access
- Without access

Comparison Graph

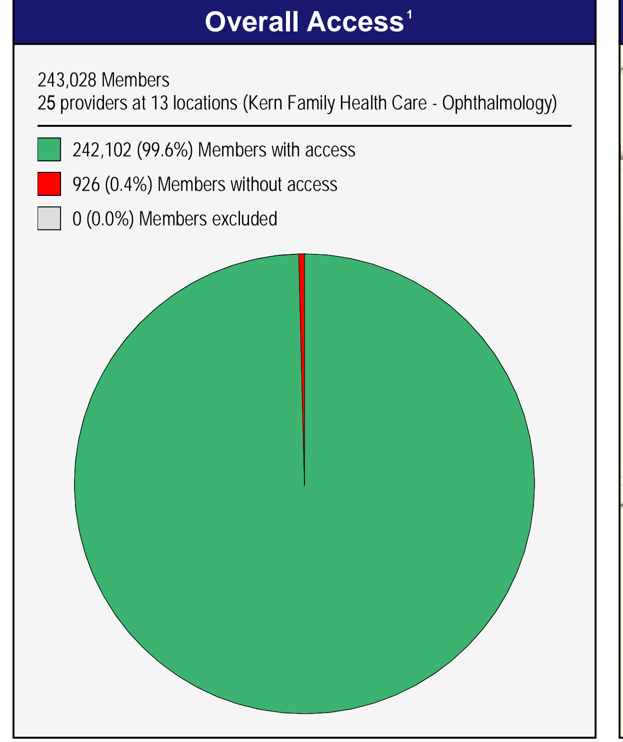
Percent of members with access to a choice of providers over miles
- 1st closest

[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:
1 (Kern Family Health Care - Ophthalmology) provider in 45 miles or 75 minutes

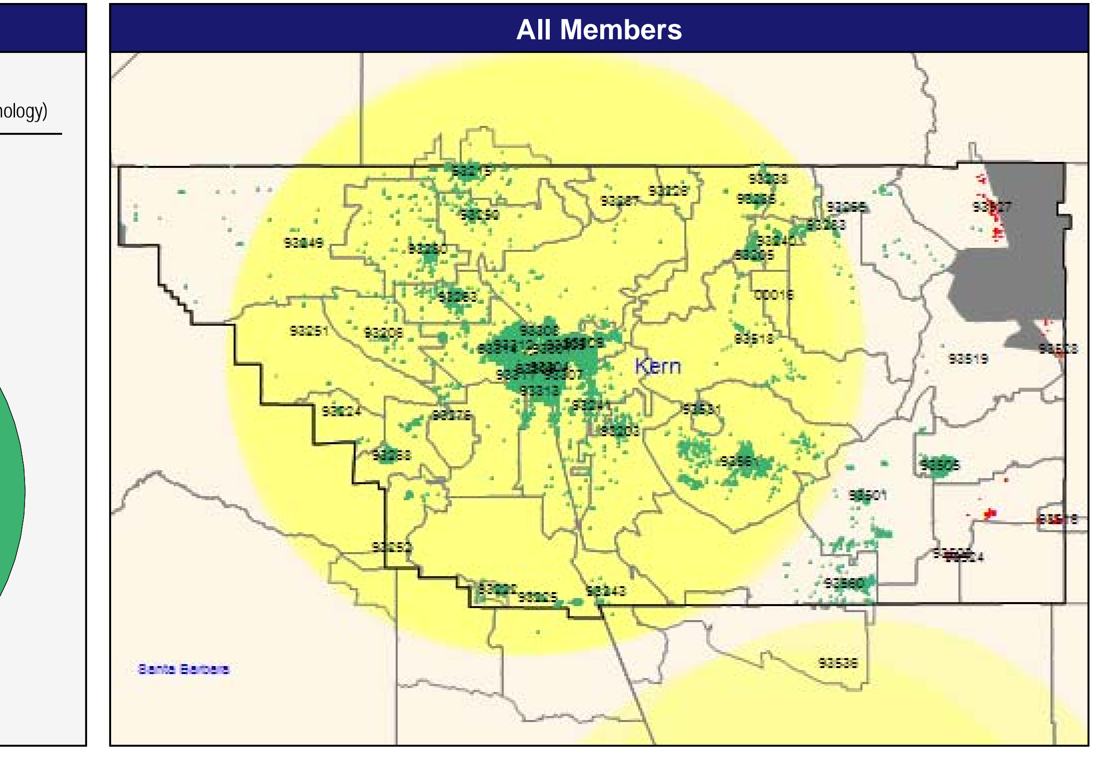
Overall Access[1]

243,028 Members
25 providers at 13 locations (Kern Family Health Care - Ophthalmology)

- 242,102 (99.6%) Members with access
- 926 (0.4%) Members without access
- 0 (0.0%) Members excluded



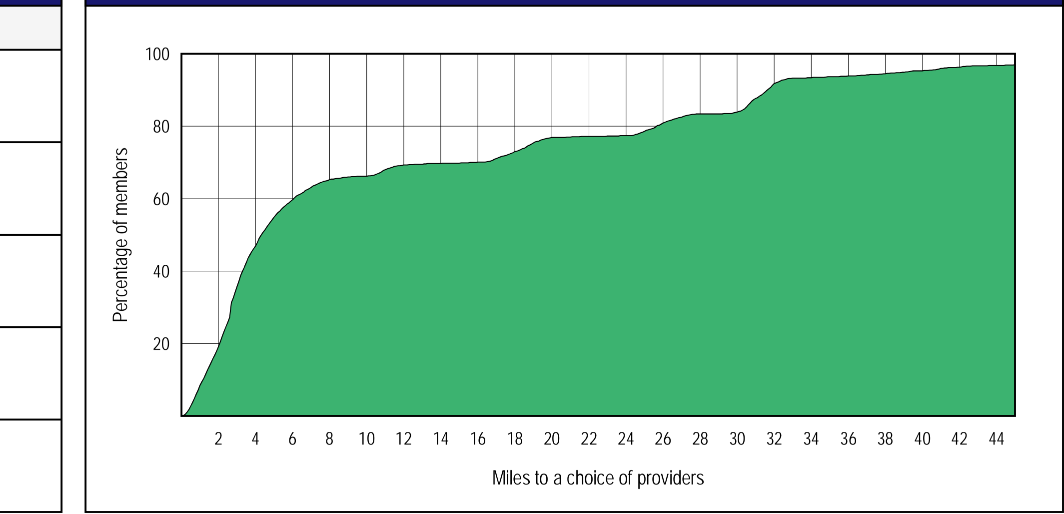
All Members



Distances/Times

	Average
Distance/Time to 1st closest provider	11.8 miles 13.6 mins

Access Standard Comparison



© 2018 Quest Analytics, LLC.

Exhibit B-4

Kern Family Health Care - Orthopdic Surgery

Access Analysis

Kern Family Health Care - Orthopedic Surgery

Member / Provider Groups

Kern Family Health Care - All Enrollees

Kern Family Health Care - Orthopedic Surgery

Access Map

Member locations

- With access
- Without access

Comparison Graph

Percent of members with access to a choice of providers over miles

- 1st closest

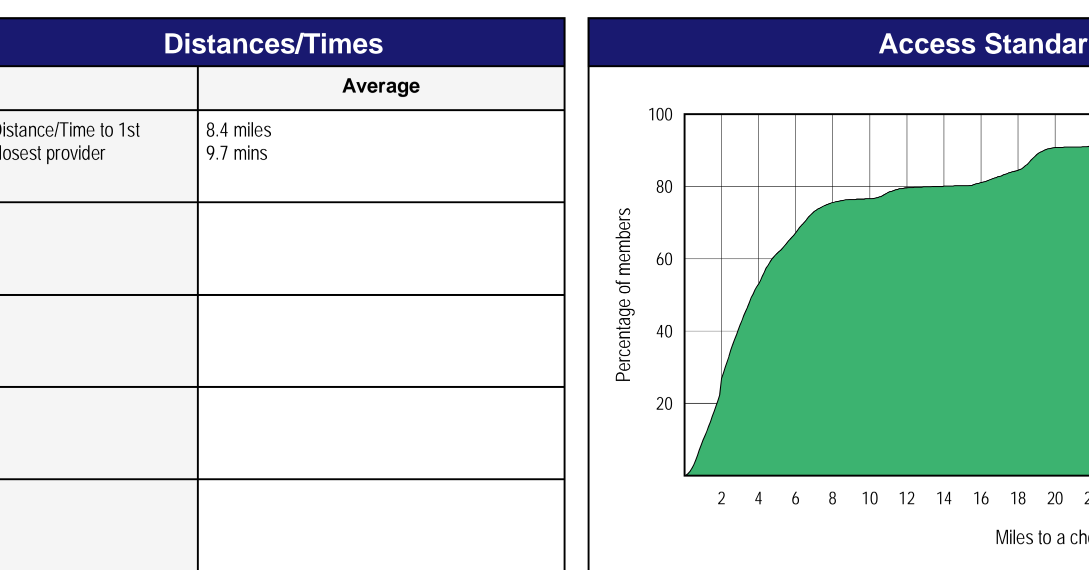
[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:

1 (Kern Family Health Care - Orthopedic Surgery) provider in 45 miles or 75 minutes

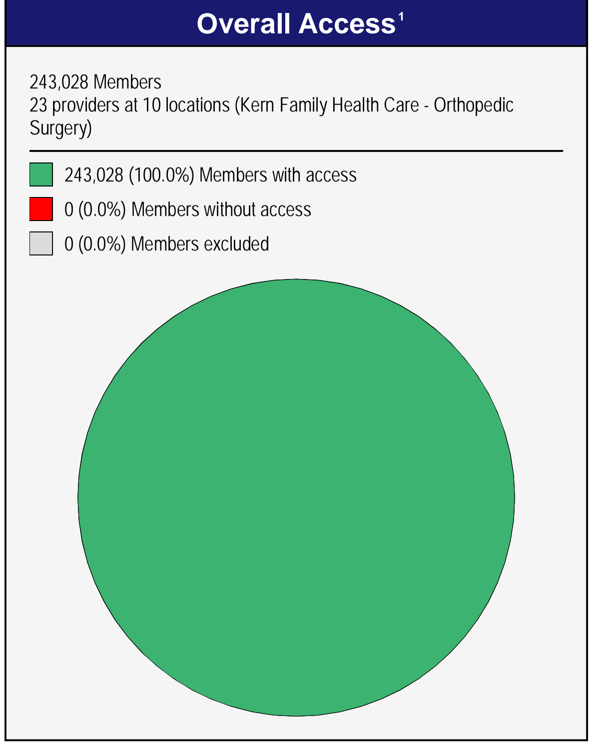
Overall Access[1]

243,028 Members
23 providers at 10 locations (Kern Family Health Care - Orthopedic Surgery)

- 243,028 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded



All Members



Distances/Times

	Average
Distance/Time to 1st closest provider	8.4 miles 9.7 mins

Access Standard Comparison

Percentage of members

Miles to a choice of providers

© 2018 Quest Analytics, LLC.

Exhibit B-4

Kern Family Health Care - Physical Med and Rehab

Access Analysis

Kern Family Health Care - Physical Med and Rehab

Member / Provider Groups

Kern Family Health Care - All Enrollees

Kern Family Health Care - Physical Med and Rehab

Access Map

Member locations

- With access
- Without access

Comparison Graph

Percent of members with access to a choice of providers over miles

- 1st closest

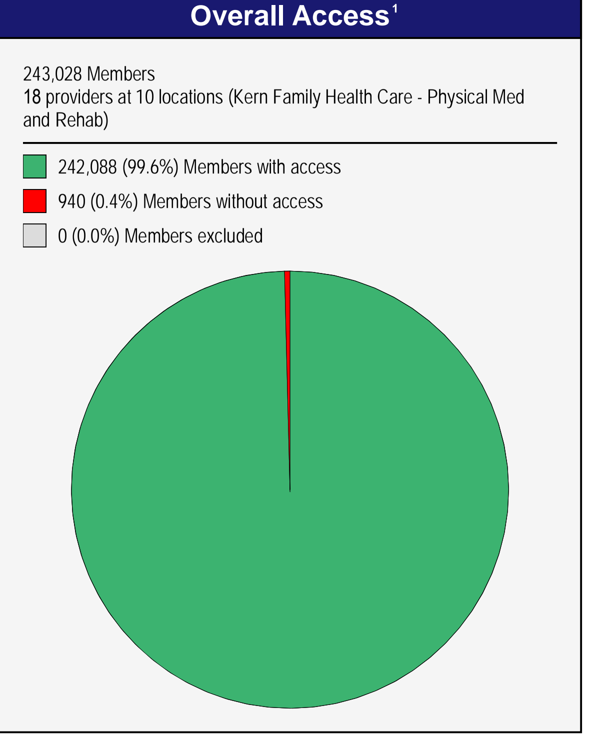
[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:

1 (Kern Family Health Care - Physical Med and Rehab) provider in 45 miles or 75 minutes

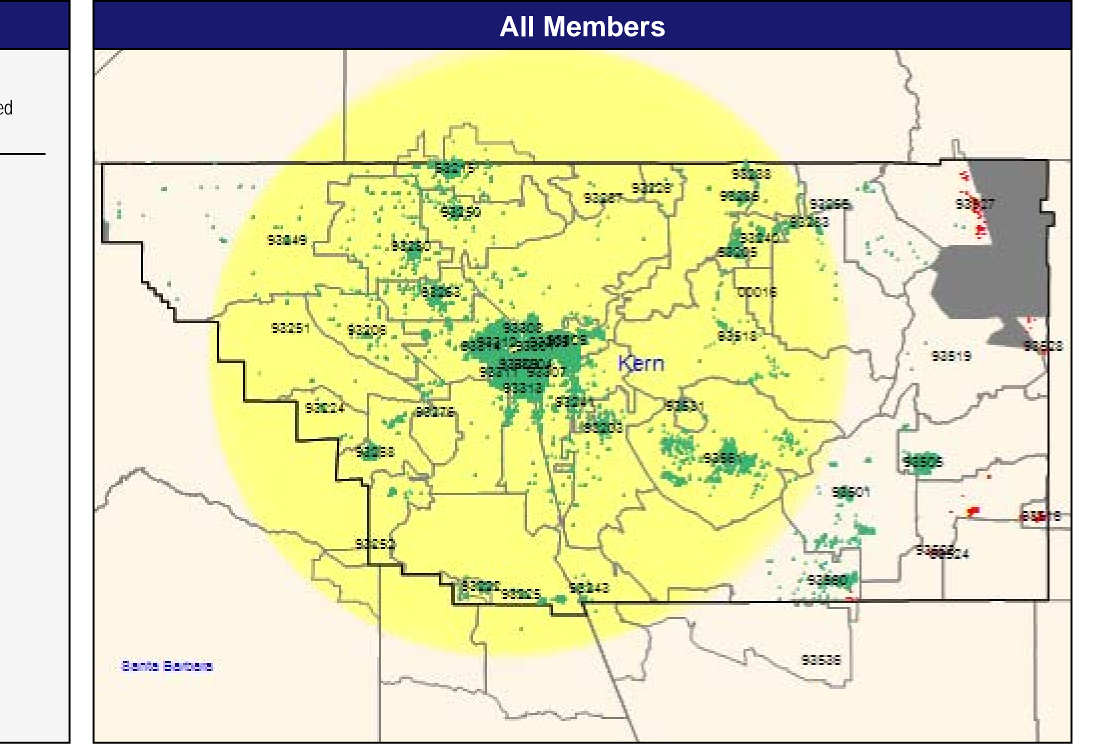
Overall Access[1]

243,028 Members
18 providers at 10 locations (Kern Family Health Care - Physical Med and Rehab)

- 242,088 (99.6%) Members with access
- 940 (0.4%) Members without access
- 0 (0.0%) Members excluded



All Members



Distances/Times

	Average
Distance/Time to 1st closest provider	12.0 miles 13.6 mins

© 2018 Quest Analytics, LLC.

Access Standard Comparison

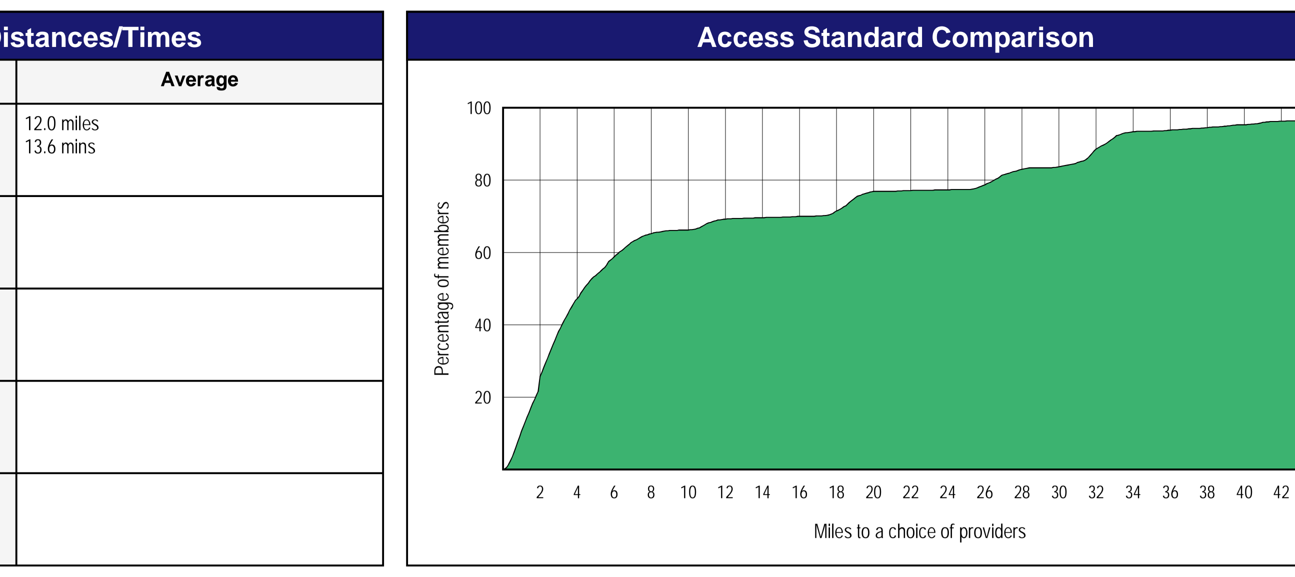


Exhibit B-4

Kern Family Health Care - Psychiatry

Access Analysis
- Kern Family Health Care - Psychiatry

Member / Provider Groups
- Kern Family Health Care - All Enrollees
  - Kern Family Health Care - Psychiatry

Access Map
Member locations
- With access
- Without access

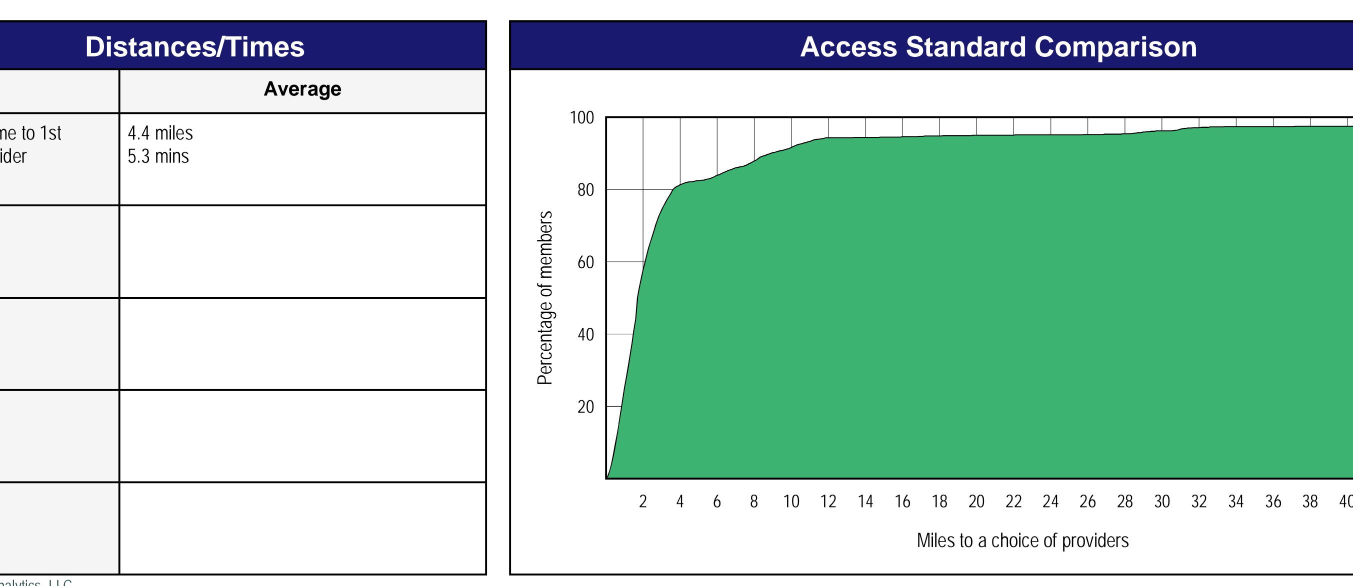
Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest

[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:
1 (Kern Family Health Care - Psychiatry) provider in 45 miles or 75 minutes

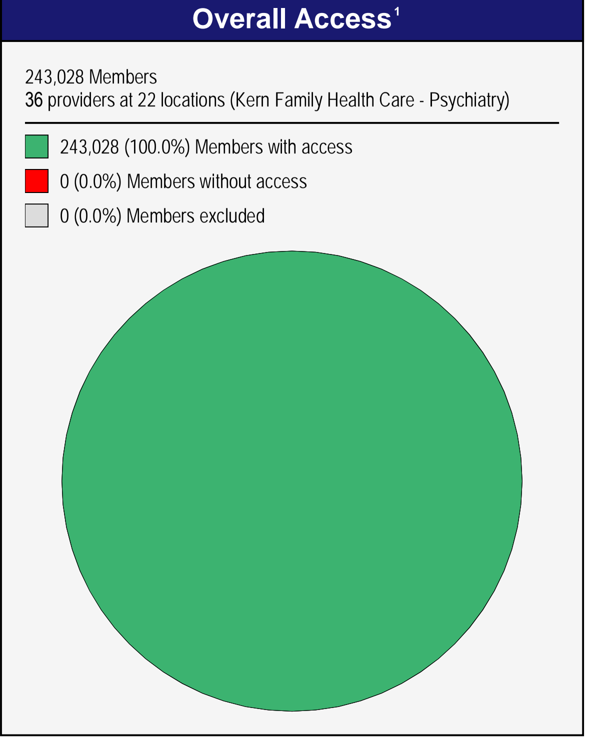
Overall Access[1]

243,028 Members
36 providers at 22 locations (Kern Family Health Care - Psychiatry)

- 243,028 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded



All Members



Distances/Times

	Average
Distance/Time to 1st closest provider	4.4 miles 5.3 mins

Access Standard Comparison

Percentage of members (20–100) vs. Miles to a choice of providers (2–44)

© 2018 Quest Analytics, LLC.

Exhibit B-4

Kern Family Health Care - Pulmonology

Access Analysis
- Kern Family Health Care - Pulmonology

Member / Provider Groups
- Kern Family Health Care - All Enrollees
  - Kern Family Health Care - Pulmonology

Access Map
Member locations
- With access
- Without access

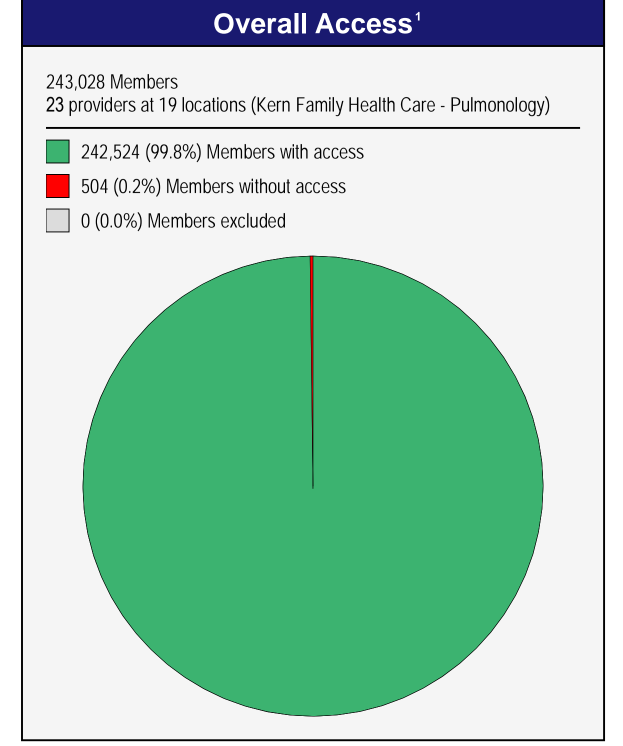
Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest

[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:
1 (Kern Family Health Care - Pulmonology) provider in 45 miles or 75 minutes

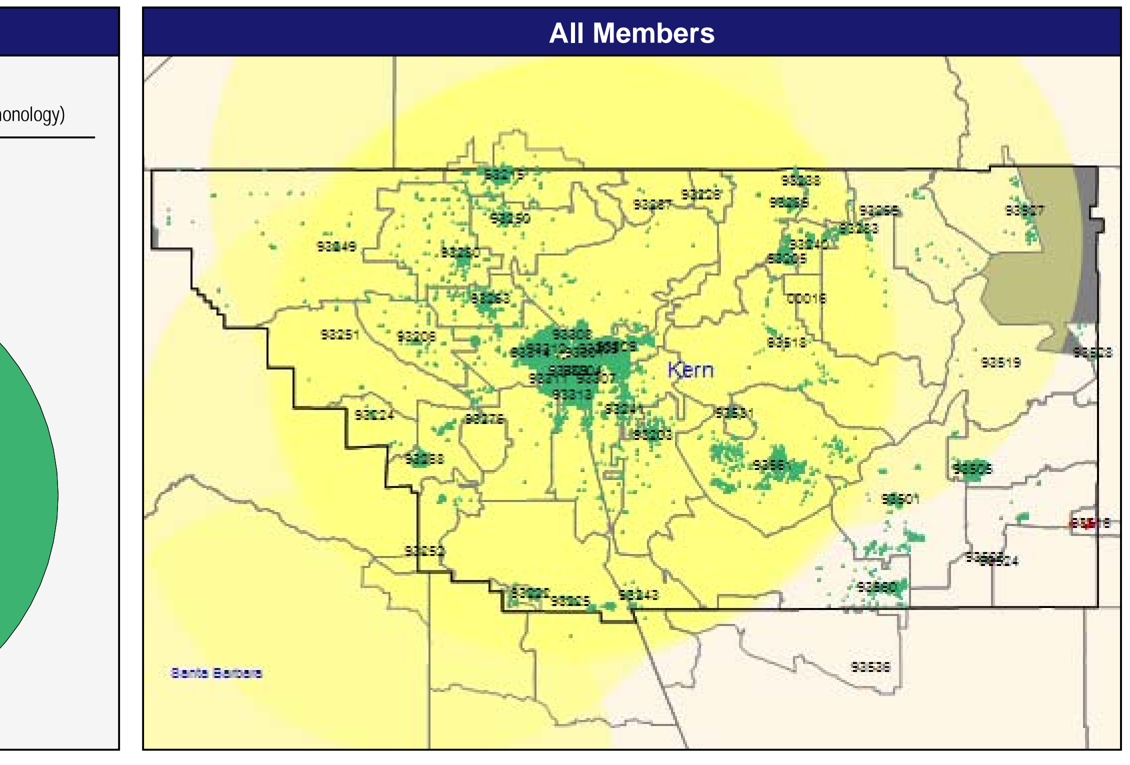
Overall Access[1]

243,028 Members
23 providers at 19 locations (Kern Family Health Care - Pulmonology)

- 242,524 (99.8%) Members with access
- 504 (0.2%) Members without access
- 0 (0.0%) Members excluded



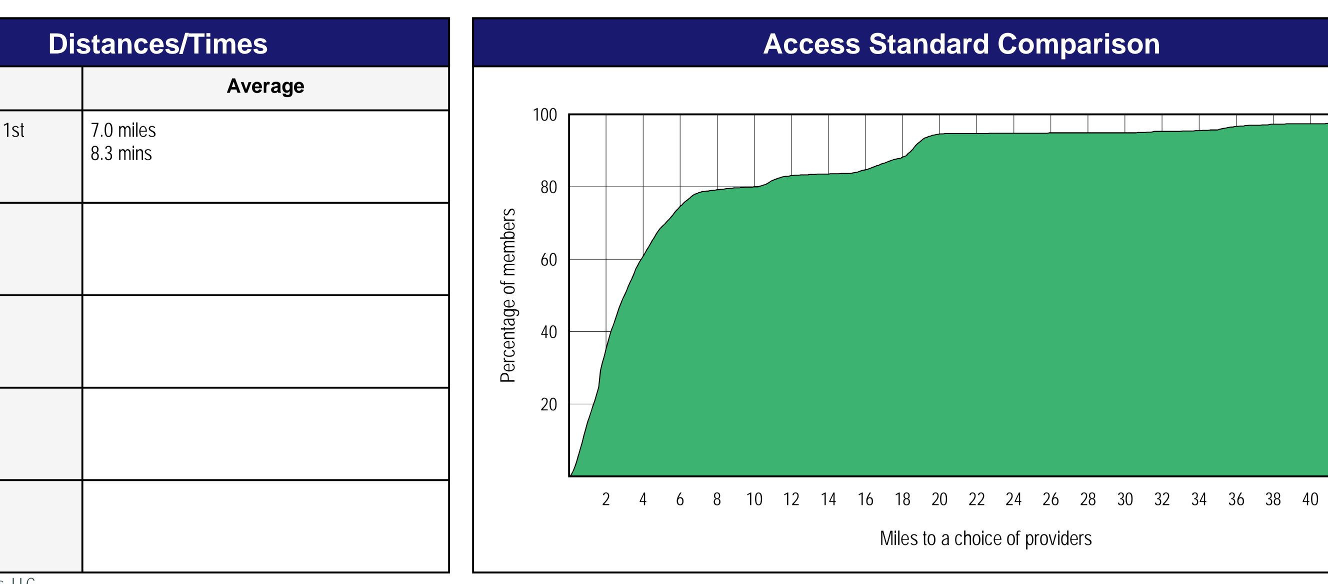
All Members



Distances/Times

	Average
Distance/Time to 1st closest provider	7.0 miles 8.3 mins

Access Standard Comparison



© 2018 Quest Analytics, LLC.

Exhibit B-5

Kern Family Health Care - Primary Care OBGYN

Access Analysis
- Kern Family Health Care - Primary Care OBGYN

Member / Provider Groups
- Kern Family Health Care - All Enrollees
  - Kern Family Health Care - OBGYN Primary Care

Access Map

Member locations
- ◆ With access
- ● Without access

Comparison Graph

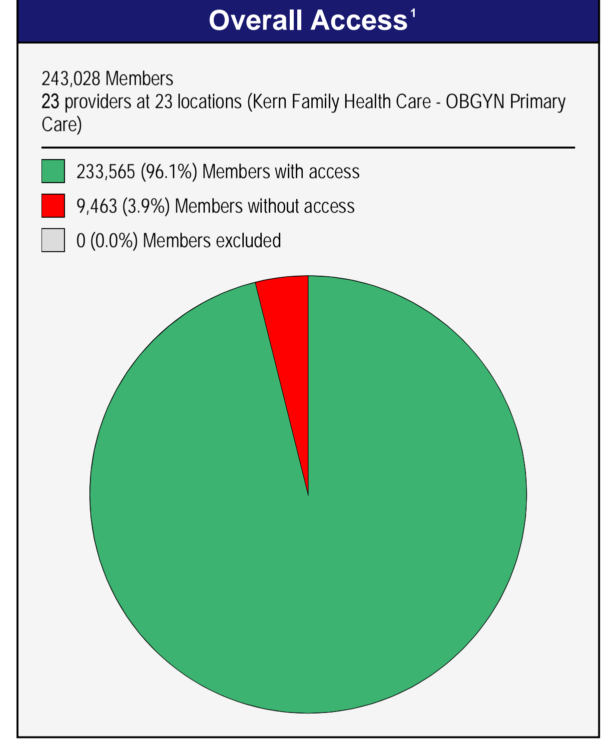
Percent of members with access to a choice of providers over miles
- ■ 1st closest

[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:
1 (Kern Family Health Care - OBGYN Primary Care) provider in 10 miles or 30 minutes

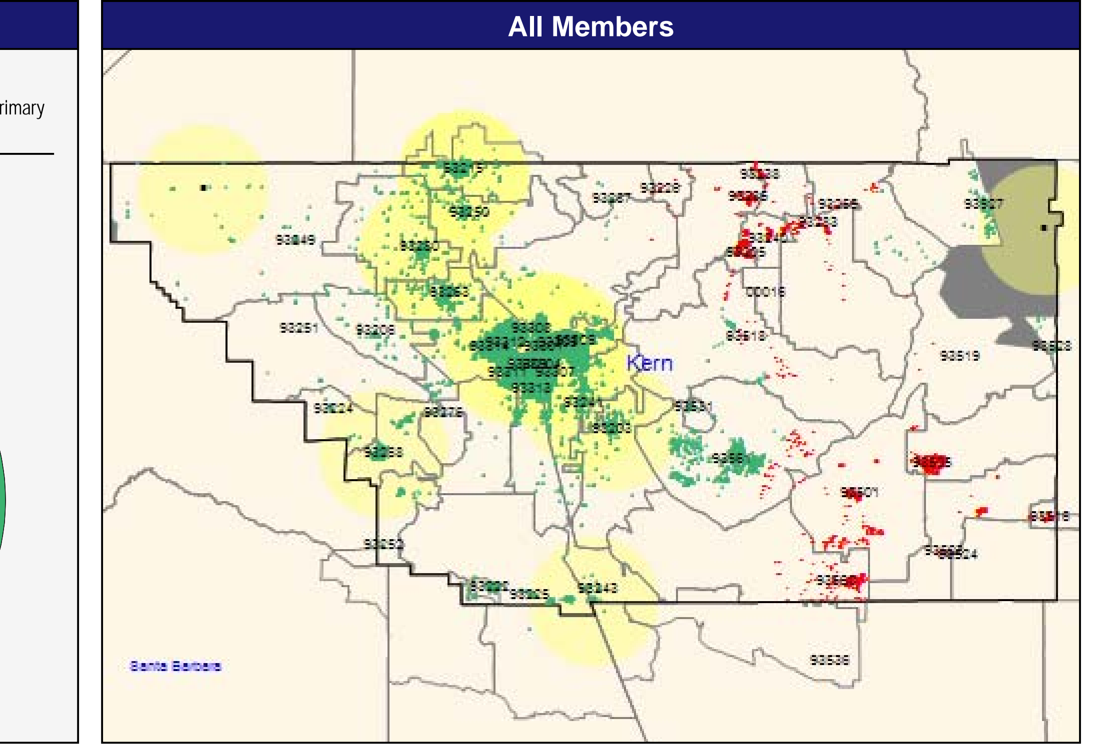
Overall Access[1]

243,028 Members
23 providers at 23 locations (Kern Family Health Care - OBGYN Primary Care)

- 233,565 (96.1%) Members with access
- 9,463 (3.9%) Members without access
- 0 (0.0%) Members excluded



All Members



Distances/Times

	Average
Distance/Time to 1st closest provider	4.3 miles 5.2 mins

© 2018 Quest Analytics, LLC.

Access Standard Comparison

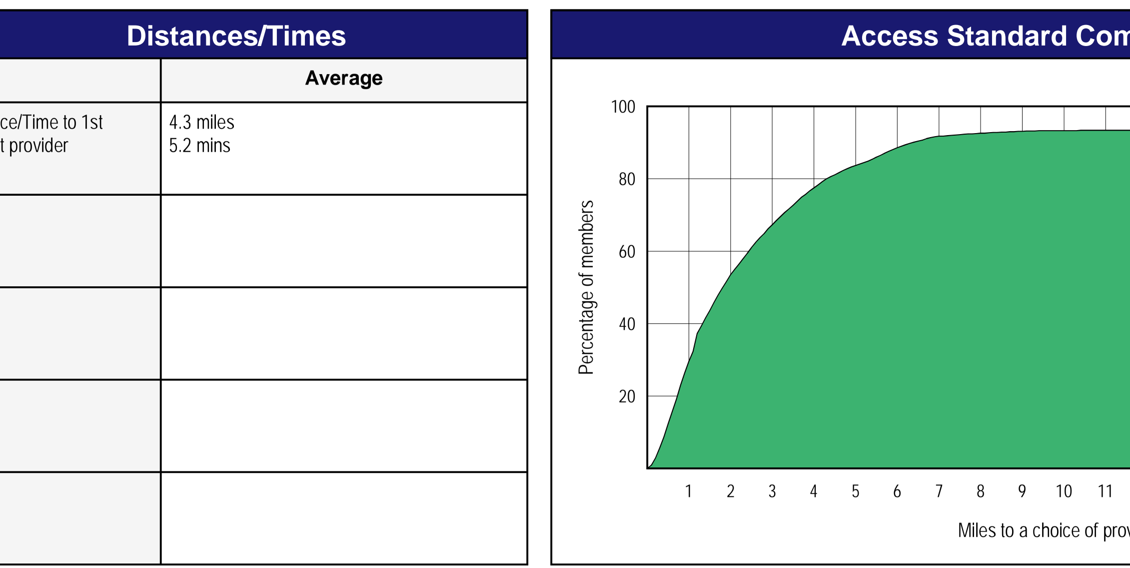


Exhibit B-5

Kern Family Health Care - Specialty Care OBGYN

Access Analysis

Kern Family Health Care - Specialty Care OBGYN

Member / Provider Groups

Kern Family Health Care - All Enrollees

Kern Family Health Care - OBGYN Specialty Care

Access Map

Member locations

- With access
- Without access

Comparison Graph

Percent of members with access to a choice of providers over miles

- 1st closest

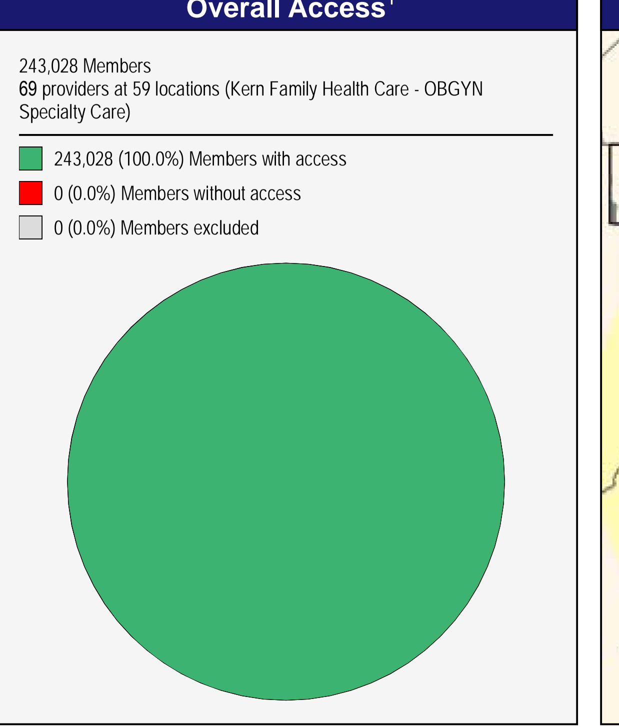
[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:

1 (Kern Family Health Care - OBGYN Specialty Care) provider in 45 miles or 75 minutes

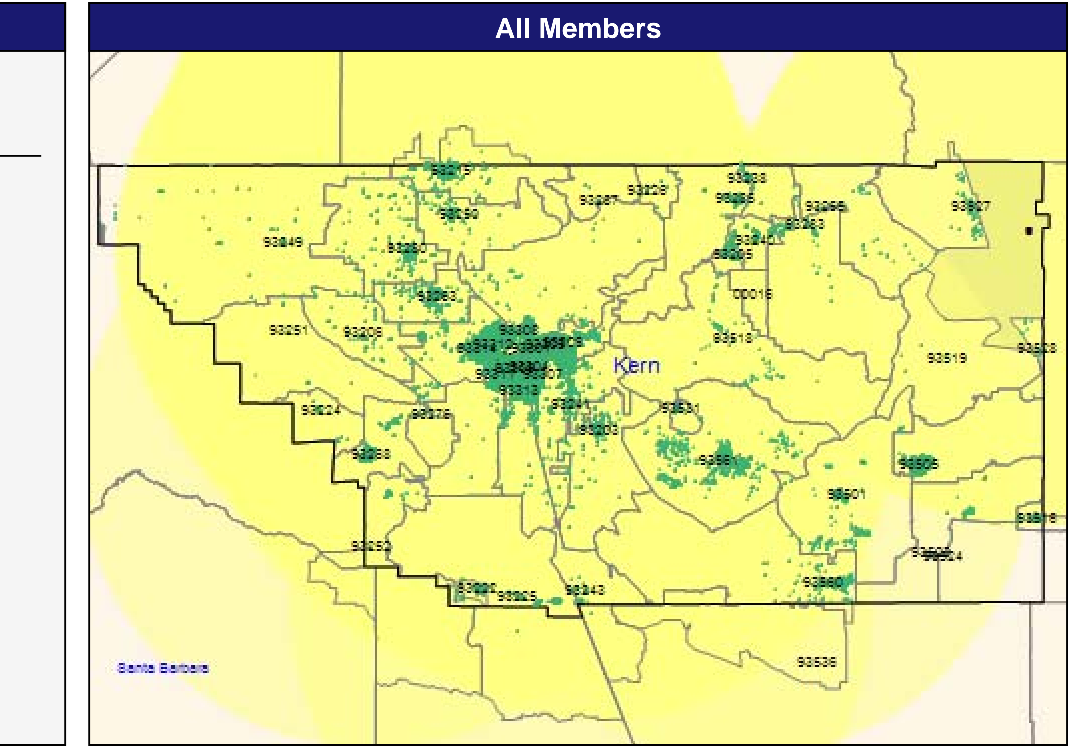
Overall Access[1]

243,028 Members
69 providers at 59 locations (Kern Family Health Care - OBGYN Specialty Care)

- 243,028 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded



All Members



Distances/Times

	Average
Distance/Time to 1st closest provider	2.7 miles 3.2 mins

© 2018 Quest Analytics, LLC.

Access Standard Comparison

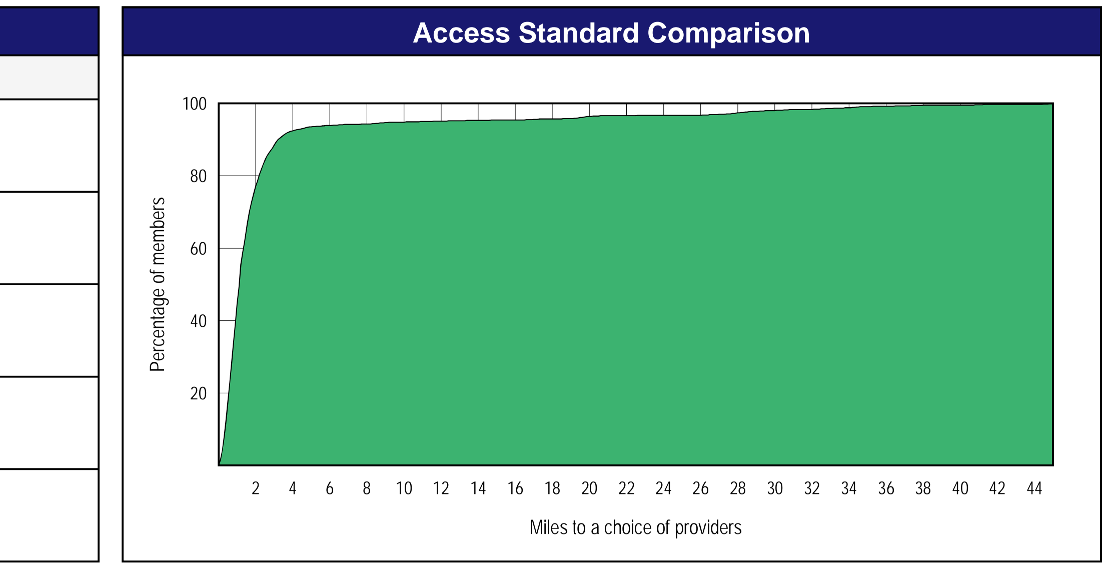


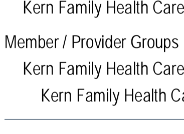
Exhibit B-6

Kern Family Health Care - Hospitals

Access Analysis
- Kern Family Health Care - Hospital

Member / Provider Groups
- Kern Family Health Care - All Enrollees
  - Kern Family Health Care - Hospitals

Access Map
Member locations



- With access
- Without access

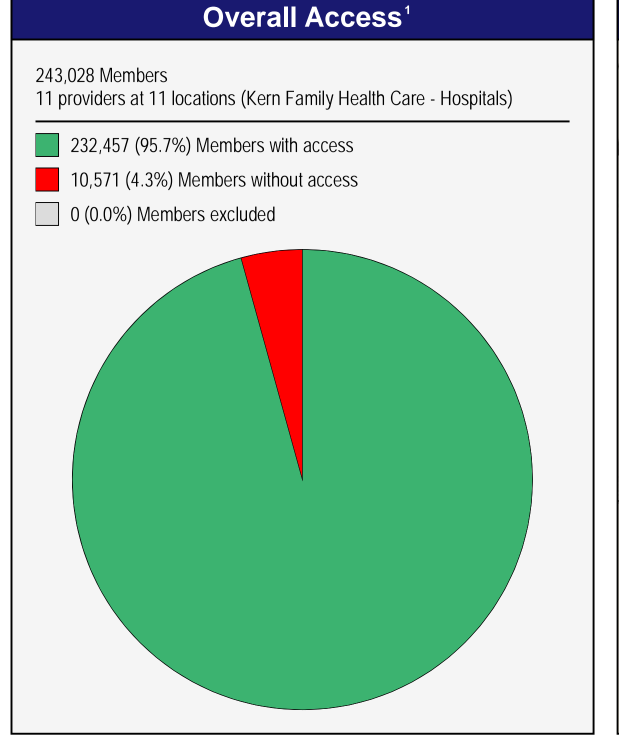
Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest

[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:
1 (Kern Family Health Care - Hospitals) provider in 15 miles or 30 minutes

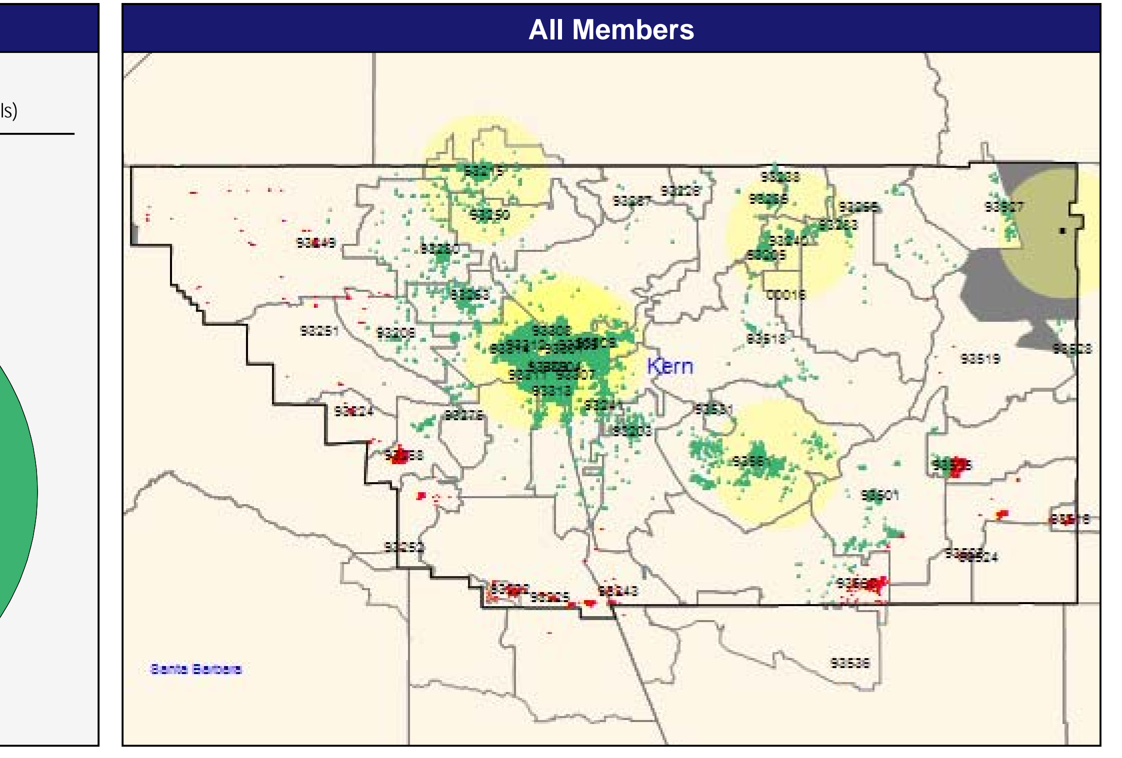
Overall Access[1]

243,028 Members
11 providers at 11 locations (Kern Family Health Care - Hospitals)

- 232,457 (95.7%) Members with access
- 10,571 (4.3%) Members without access
- 0 (0.0%) Members excluded



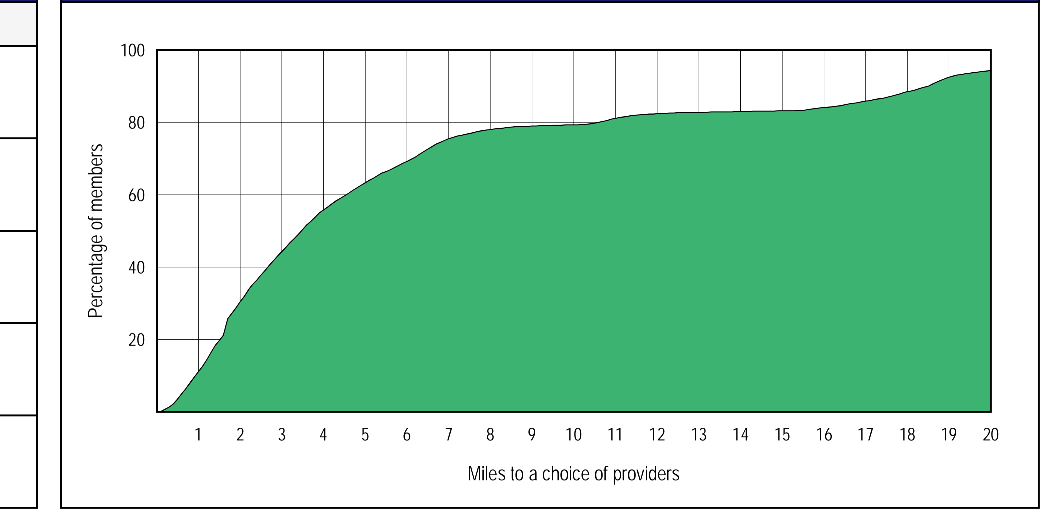
All Members



Distances/Times

	Average
Distance/Time to 1st closest provider	6.7 miles 7.7 mins

Access Standard Comparison



© 2018 Quest Analytics, LLC.

Exhibit B-7

Kern Family Health Care - Mental Health

Access Analysis

Kern Family Health Care - Mental Health

Member / Provider Groups

Kern Family Health Care - All Enrollees

Kern Family Health Care - Mental Health

Access Map

Member locations

- With access
- Without access

Comparison Graph

Percent of members with access to a choice of providers over miles

- 1st closest

[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:

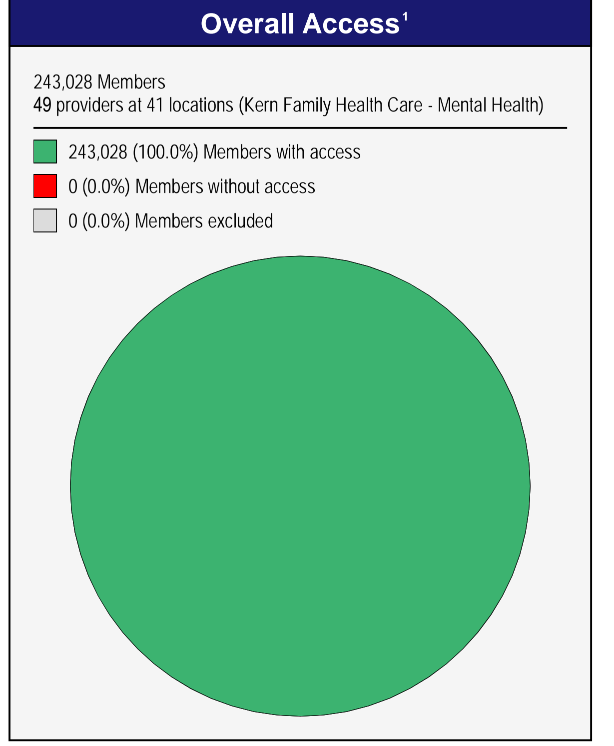
1 (Kern Family Health Care - Mental Health) provider in 45 miles or 75 minutes

Overall Access[1]

243,028 Members
49 providers at 41 locations (Kern Family Health Care - Mental Health)

- 243,028 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

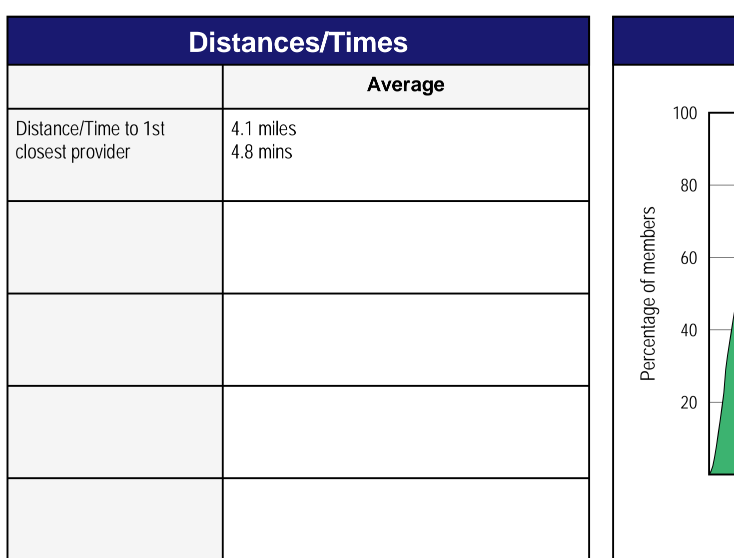
All Members



Distances/Times

	Average
Distance/Time to 1st closest provider	4.1 miles 4.8 mins

Access Standard Comparison



© 2018 Quest Analytics, LLC.

Exhibit B-8

Kern Family Health Care - Pharmacy

Access Analysis
 Kern Family Health Care - Pharmacy

Member / Provider Groups
 Kern Family Health Care - All Enrollees
 Kern Family Health Care - Pharmacy

Access Map
Member locations
- With access
- Without access

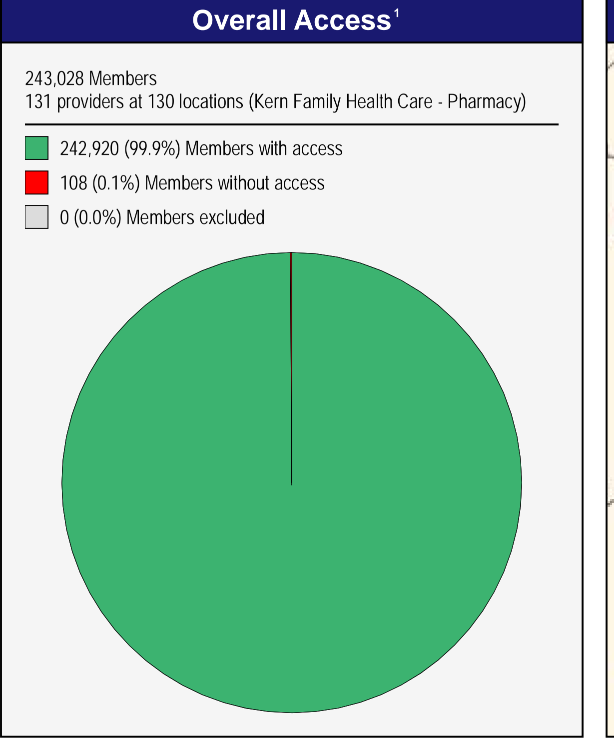
Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest

[1] The Access Standard is defined as (Kern Family Health Care - All Enrollees) members accessing:
 1 (Kern Family Health Care - Pharmacy) provider in 10 miles or 30 minutes

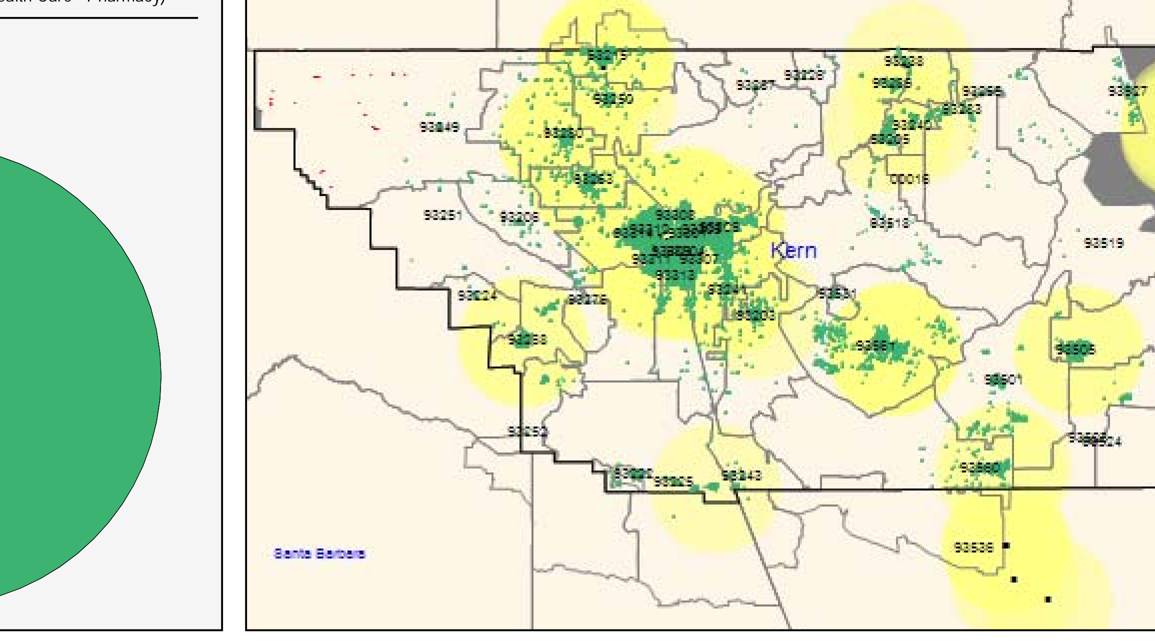
Overall Access[1]

243,028 Members
131 providers at 130 locations (Kern Family Health Care - Pharmacy)

- 242,920 (99.9%) Members with access
- 108 (0.1%) Members without access
- 0 (0.0%) Members excluded



All Members



Distances/Times

	Average
Distance/Time to 1st closest provider	1.4 miles 1.6 mins

Access Standard Comparison

Percentage of members
100
80
60
40
20
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Miles to a choice of providers

© 2018 Quest Analytics, LLC.

ACCESS GRIEVANCE REVIEW

2017 - Quarter 4

Access Grievance Review

Q4, 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 Q4 2017, twenty five (25) grievances were received and reviewed by the KHS grievance committee. In twenty (20) of the cases no issues were identified and were closed in favor of the plan. The remaining five (5) cases, were closed in favor of the enrollee; these cases were forwarded to the Plan's Provider Relations Department for further tracking and trending.

Tracking and Trending

During the Q4 Access Grievance Review meeting, the five (5) cases that were closed in favor of the enrollee were reviewed against all access grievances received in the previous year.

Upon review, it was identified that four (4) of the cases was brought against Plan contracted provider groups who had additional access grievances closed in favor of the enrollee within the past year. KHS outreach to these providers is outlined below.

KHS did not identify any other trends amongst the other provider groups that received access grievances closed in favor of the enrollee in Q4 2017.

KHS Policy/Provider Outreach

The time standards for access to a primary care appointment, specialist appointment, and in-office wait time are outlined in KHS policy 4.30-P *Accessibility Standards.*

As a result of Q4 2017 grievance review, during Q1 2018 the Provider Relations Management team conducted outreach out to one of the providers identified in the Plans tracking and trending; this provider and providers office staff was coached on the Plan's policies and procedures in regards to accessibility standards. The two (2) other provider's identified in the Plan's tracking and trending were contacted via letter. The Plan will continue to monitor providers in future access grievance reviews and will take further action as necessary.

Quarter 4, 2017 (October – December) Access Grievances Review Agenda

Date: 3/30/2018

Discussion:

1. **Review access grievances for Q4 2017**
   - **Identify any trends regarding access**
   - **Conduct file review for grievances closed in favor of the enrollee**

2. **Review Access Grievances for Q4 2017 against last year of annual grievances**
   - **Identify any trends regarding access**

Closed in Favor of the Enrollee	**5**
Access to Care	**4**
Bichai, William MD	1
Kern Pediatrics	1
Kern Medical	1
Clinica Sierra Vista – North of the River	1
Difficulty Accessing Specialist	**1**
Kern Medical	1

Name	Title
James Winfrey	Snr. Provider Network Analyst.
Yolanda Herrera	Cred Coord Lead
Adriana Zavala	[signature]
Melissa Lopez	[signature] Provider Relations Manager

FULL TIME EQUIVALENCY (FTE) & PROVIDER TO ENROLLEE RATIOS

2018 – Quarter 1

FTE & PROVIDER TO ENROLLEE RATIOS

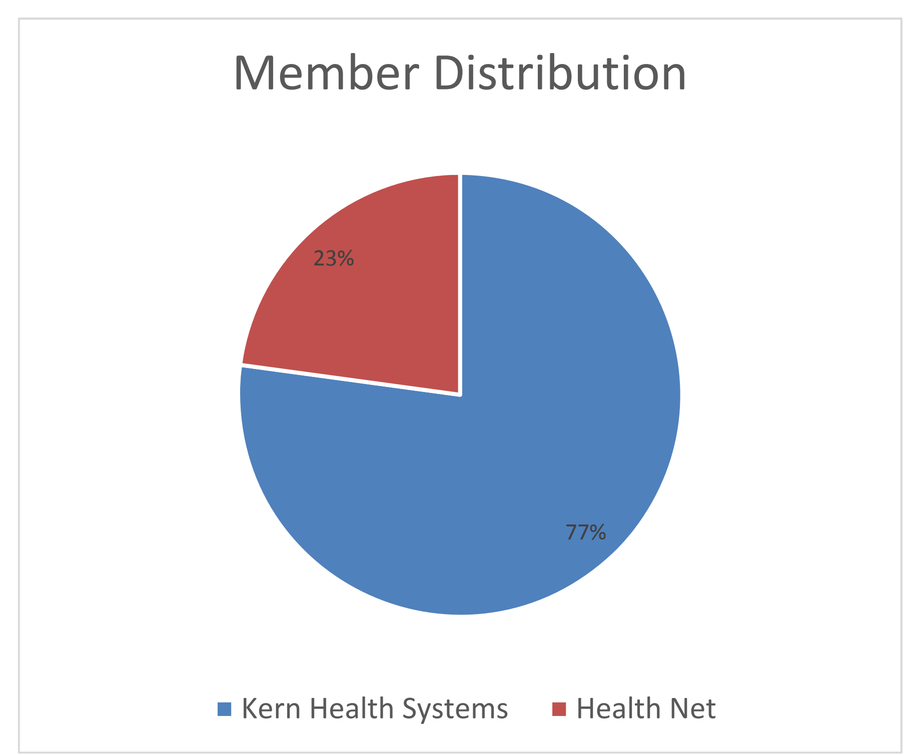
Q1, 2018

Introduction

Per CCR § 1300.67.2, Kern Health Systems shall maintain, "at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and […] approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees." Per KHS policy, 4.30-P *Accessibility Standards,* §4.5 Full-time equivalent (FTE) Provider to Member Ratios, "Full-time equivalency shall be determined by percentage of members assigned to the two Medi-Cal managed care plans in Kern County. For example, if KHS has 80% of the Medi-Cal managed care members in Kern County, the PCP FTE assumption to calculate the PCP to member ratio will be 80% FTE of all PCPs in the network."

Member Distribution

As of Q1 2018, 326,595 Medi-Cal members were distributed amongst the two Kern County Medi-Cal managed care plans (Kern Health Systems, Health Net). Of those members, 251,961 **(77.15%)** were enrolled under Kern Health Systems, and 74,634 **(22.85%)** under Health Net.



FTE & PROVIDER TO ENROLLEE RATIOS

Q1, 2018

Full Time Equivalency Compliance Calculations

Of KHS' 251,961 membership, 8,294 were assigned and managed by Kaiser and did not access services through KHS' network of contracted providers; due to this, Kaiser managed membership is not considered when calculating FTE compliance.

As of Q1 2018, the plan was contracted with 339 Primary Care Providers, a combination of 186 physicians and 153 mid-levels. Based on the FTE calculation process outlined above, with a 77.15% membership distribution amongst Kern Medi-Cal members, KHS maintains a total of 202.51 FTE PCPs. With a member enrollment of 251,961 utilizing KHS contracted providers, KHS currently maintains a ratio of 1 FTE PCP to every 1244.17 members; KHS is compliant with state regulations and Plan policy.

As of Q1 2018, the plan was contracted with 919 Physicians. Based on the FTE calculation process outlined above, with a 77.15% membership distribution amongst Kern Medi-Cal members, KHS a total of 708.99 FTE Physicians. With a total membership assignment of 251,961, KHS currently maintains a ratio of 1 FTE Physician to every 349.32 members; KHS is compliant with state regulations and Plan policy.

KERN HEALTH SYSTEMS
DISEASE MANAGEMENT DEPARTMENT QUARTERLY REPORT

Report Date: April 16, 2018

Reporting Period: January 1, 2018 – March 31, 2018

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:

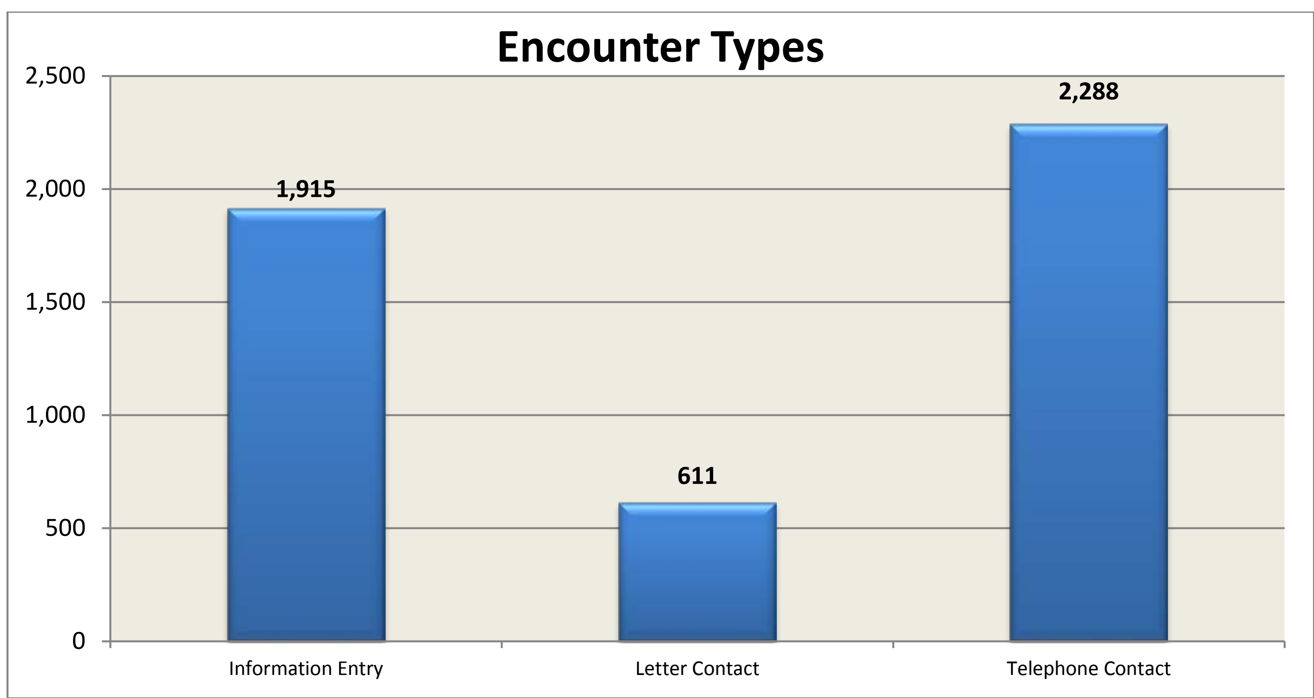
Staff	Caseload
RN 1	25
RN 2	9
RN 3	7
RN 4	16
TOTAL	**57**

DM Program Caseload:

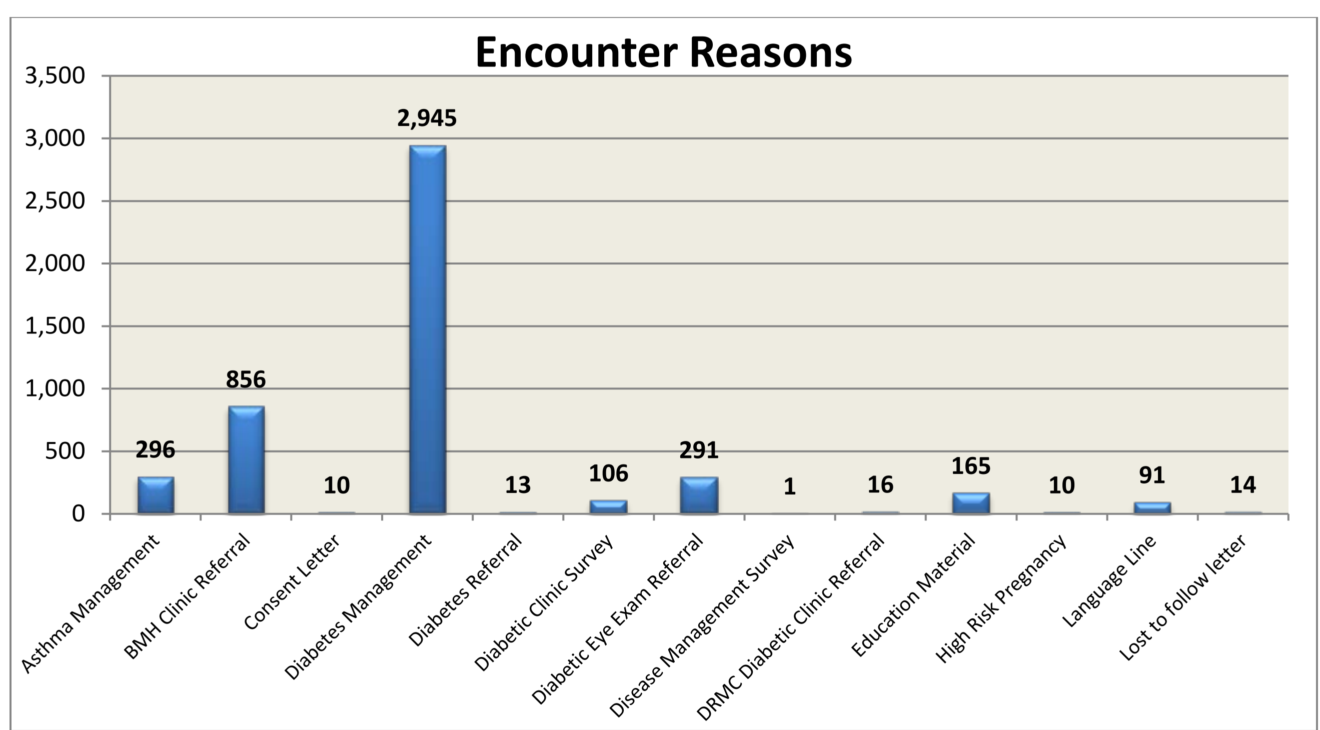
DM Program	Caseload
Asthma	20
Diabetes and Hypertension	37
TOTAL	**57**

Encounters:

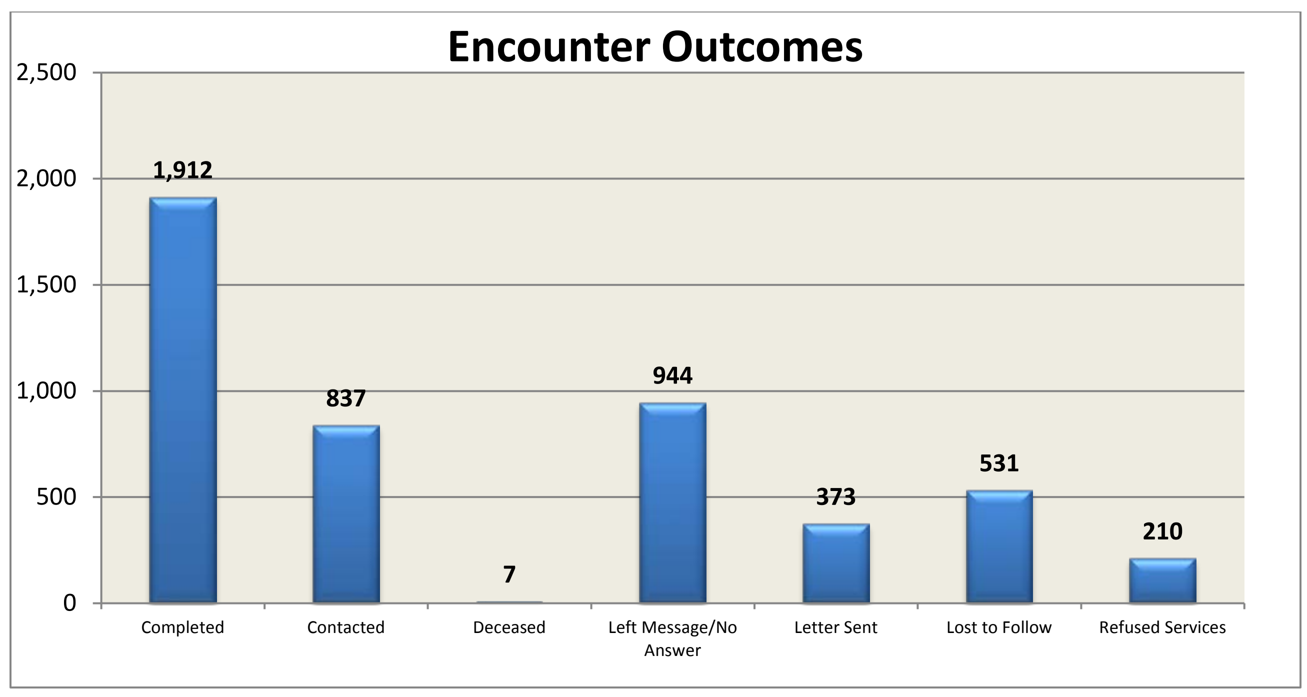
There were a total of 4,814 encounters submitted during this quarter for 1,676 KFHC members and the majority of the encounter types were listed as a Telephone Contact at 48%.



The majority of the encounter reasons at 61% was listed as Diabetes Management.

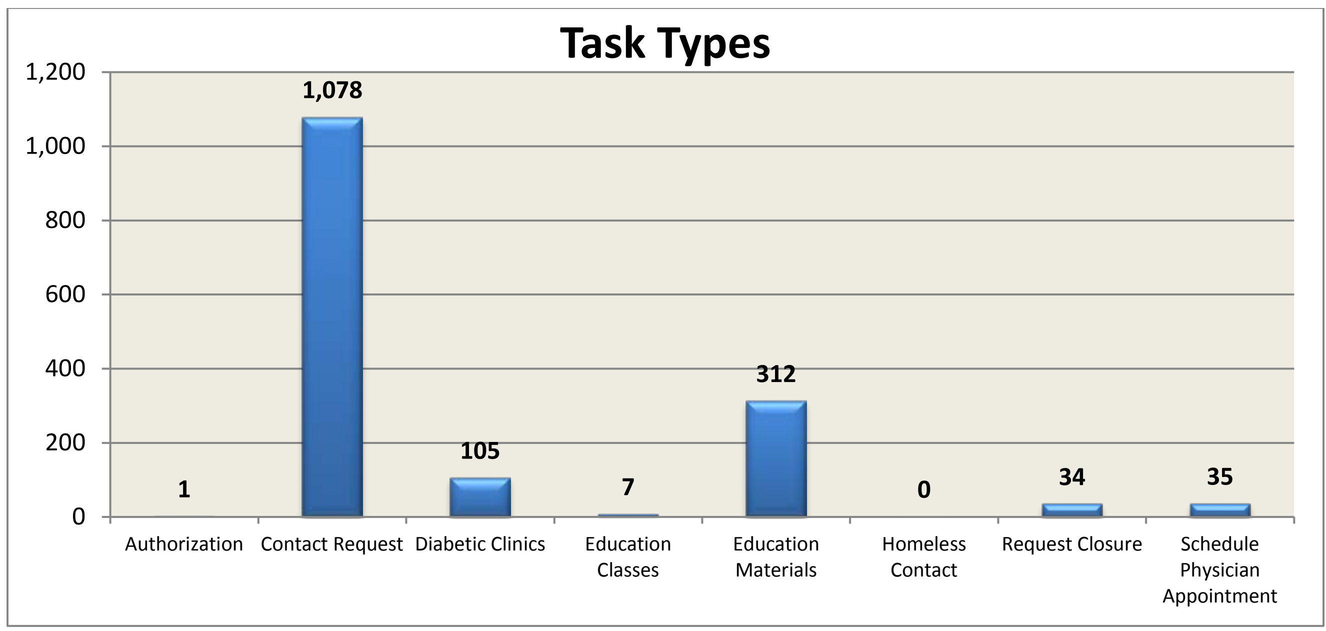


The majority of the encounter outcomes at 40% are listed as completed.

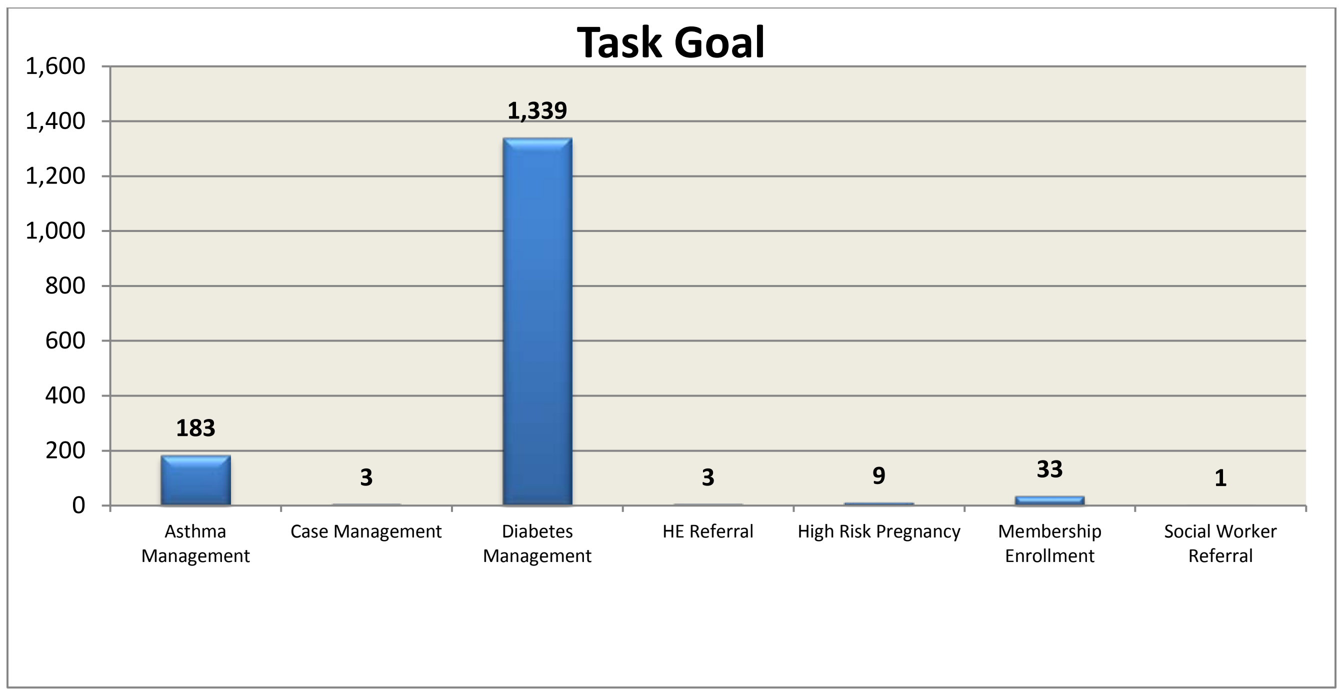


Tasks:

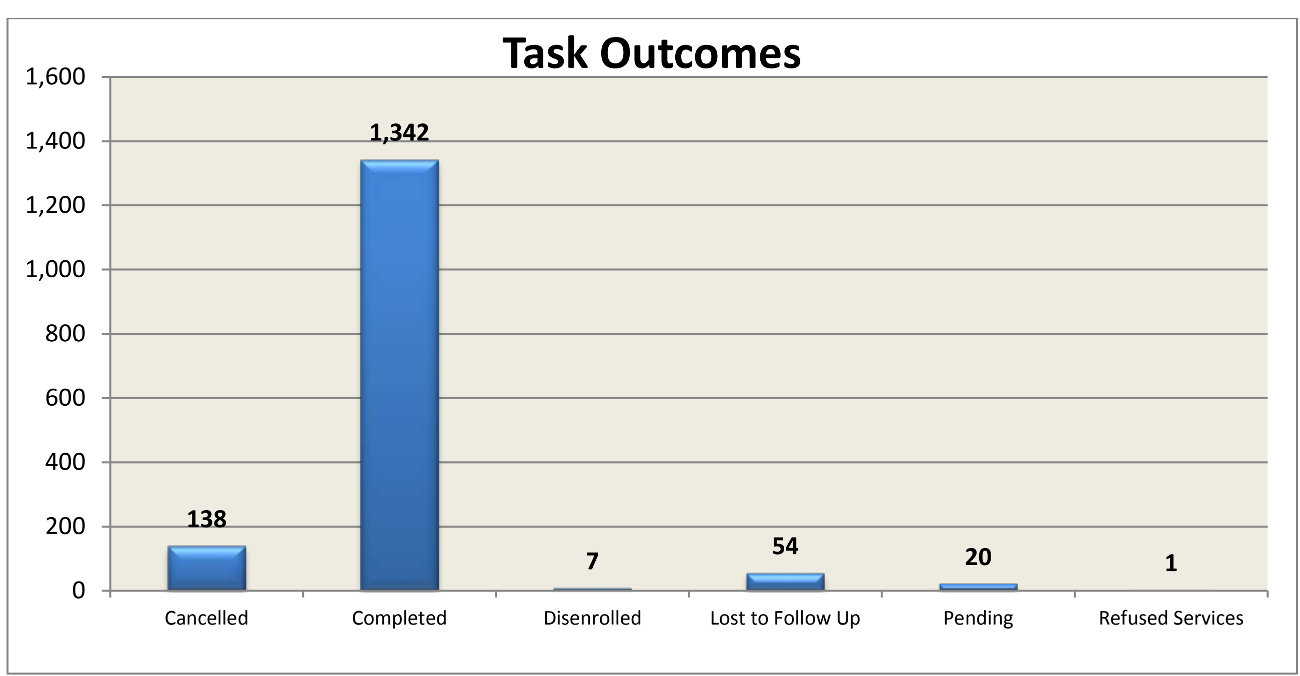
There were a total of 1,540 tasks assigned to the Disease Management department during the quarter for 918 KFHC members. The majority of Task Types were Contact Request at 69%.



The majority of task goals at 85% was listed as Diabetes Management.

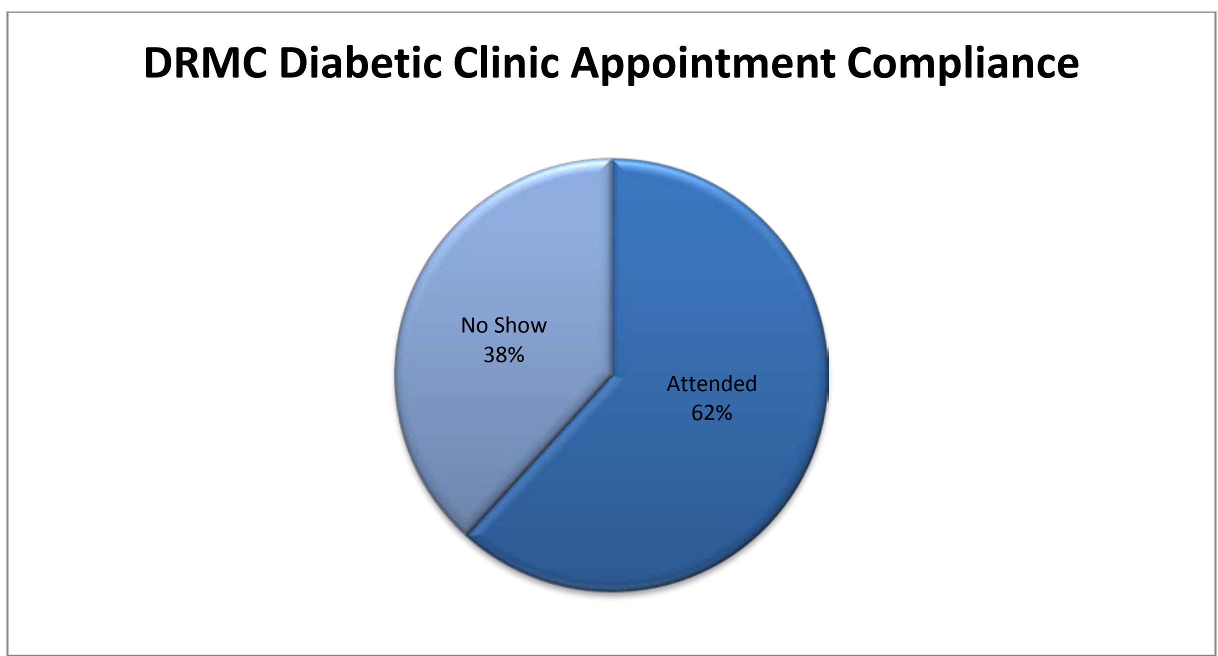


The majority of the task outcomes at 86% are completed.



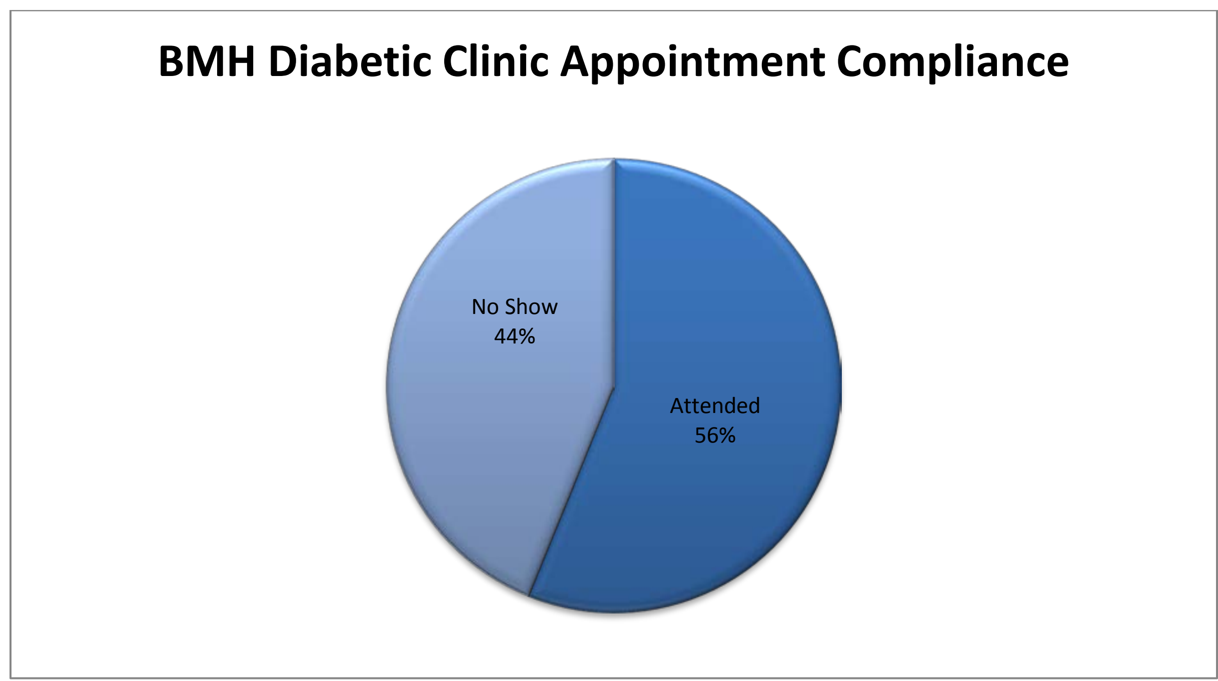
Delano Regional Medical Center (DRMC) Diabetic Clinic

The DRMC Diabetes Clinic ceased operation on February 22, 2018. Appointment compliance for January and February revealed that 62% of members attended their scheduled appointment.



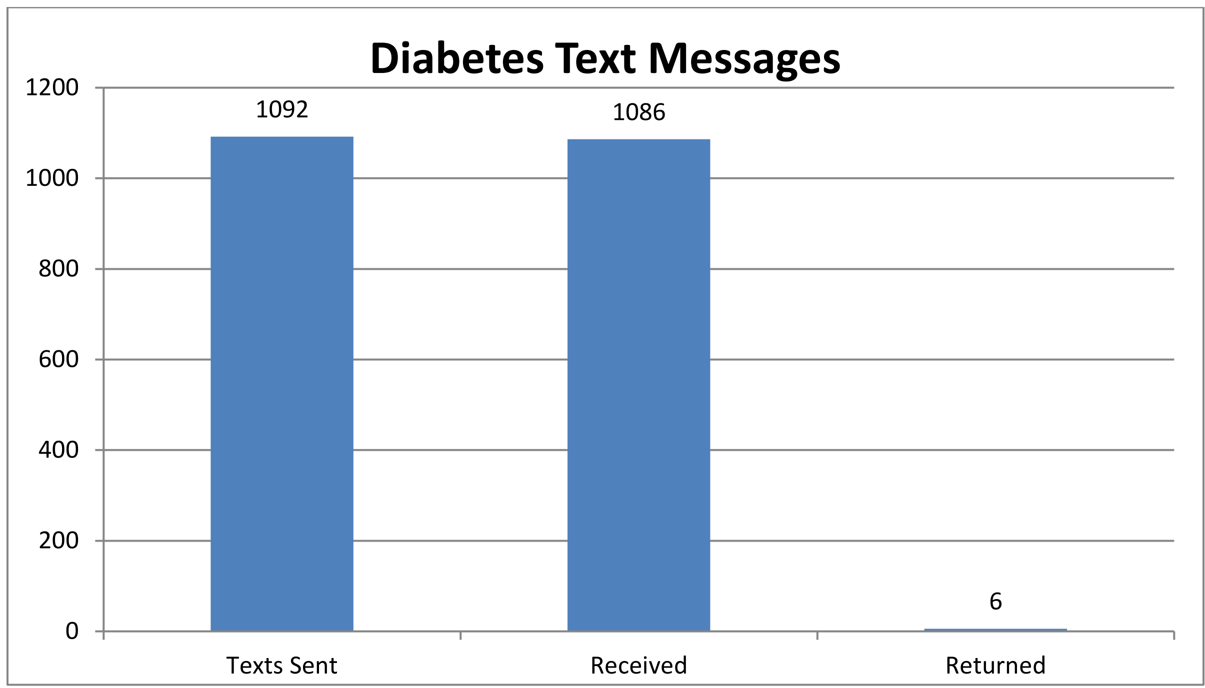
Bakersfield Memorial Hospital (BMH) Diabetic Clinic

Appointment compliance at the BMH Diabetic Clinic revealed 56% of members attended their scheduled appointment.



Diabetes Text Messaging Program

Four diabetes related text messages, totaling 1.092were sent to members during this quarter. 99.5% of those messages were successfully received by the members.



Health Education Policies

Policy No.	Revision No.	Replaces	Changes of Interest to Staff
3.70-I Cultural and Linguistic Services	01/09/2018	2017-11	Policy updated throughout. 1.3 Notice of Non-Discrimination and Language Assistance Services Taglines and 4.8 CommGap are new sections for review.
2.30-I Health Education	12/20/2017	2017-01	Policy revised to meet Readability and Suitability of Written Health Education Materials as requested by DHCS to comply with the requirement of APL 11-018.

Utilization Management Policy

Policy No.	Revision No.	Replaces	Changes of Interest to Staff
2.45-I Delegation of QI, UM Care and Case Management and Pharmacy	12/04/2017	2017-07	Policy revised by Administrative Director of Health Services to comply with Mega Reg.
3.10-P Alcohol and Substance Abuse Treatment	03/19/2018	2017-04	Policy updated to comply MTI 19K for the provision of Alcohol Misuse Screening and Counseling (AMSC).
3.13-P EPSDT Supplemental Services and Targeted Case Management (TCM)	01/11/2018	2016-02	Section 3.0 removed in order to created new policy on same. Request to create new policy from DHCS.
3.14-P Mental Health Services	01/09/2018	2017-04	Major revisions throughout policy provided by Administrative Director of Utilization Management to comply with APL 17-018.
3.23-P Provider Appeals Regarding Authorization	11/27/2017	2009-11	Major revision to comply with APL 17-006. Revised by Administrative Director of Health Services.
3.61-I Comprehensive Case Management and Coordination of Care	11/27/2017	2017-07	Major revisions to policy by Administrative Director of Health Services to comply with Mega reg.
3.69-I Provider Preventable Conditions	03/19/2018	2015-02	Policy revised by Administrative Director of Health Services to comply with APL 17-009.
3.75-I Health Risk Assessment (Previously 2.41-I)	01/19/2018	2011-10	Major revision to policy to comply with APL17-013. Policy re-numbered to fit under direction of UM as requested by Administrative Director of Health Services. Previously 2.41-I Health Risk Assessment.
3.77-I Palliative Care	02/05/2018	New	New policy created to comply with All Plan Letter (APL) 17-015.

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
First Quarter 2018

Report Date: April 10, 2018

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.

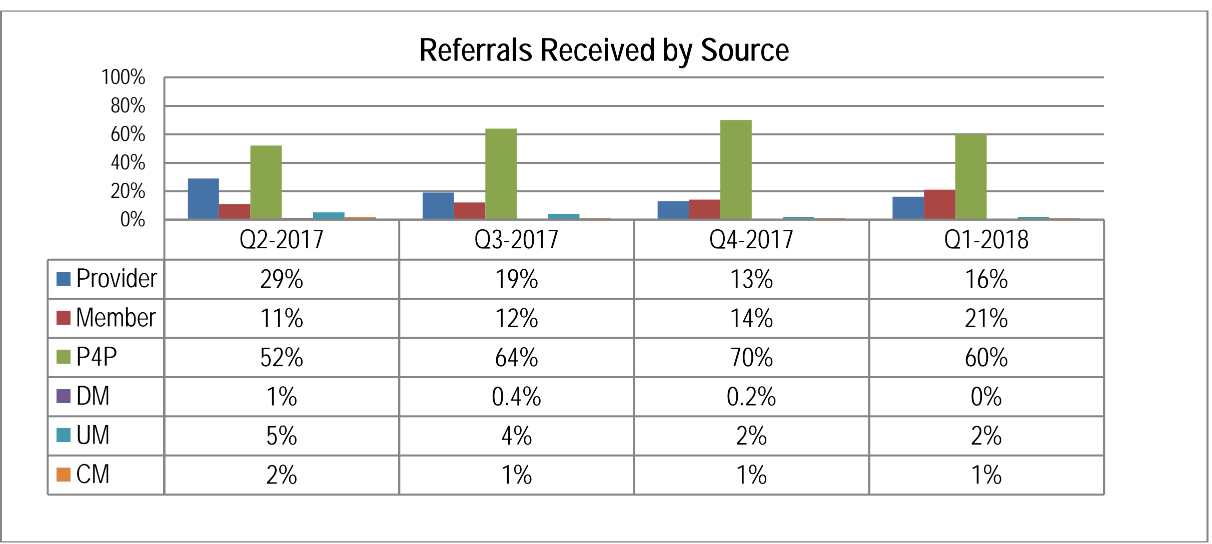
- School Wellness Grant and Internship Programs
- Summer Member Newsletter
- Health Education Member Focus Groups
- Revised Member Incentive Programs
- New KFHC Gardening Workshop

The following pages reflect statistical measurements for the Health Education department detailing the ongoing activity for 1st quarter 2018.

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

REFERRALS FOR HEALTH EDUCATION SERVICES

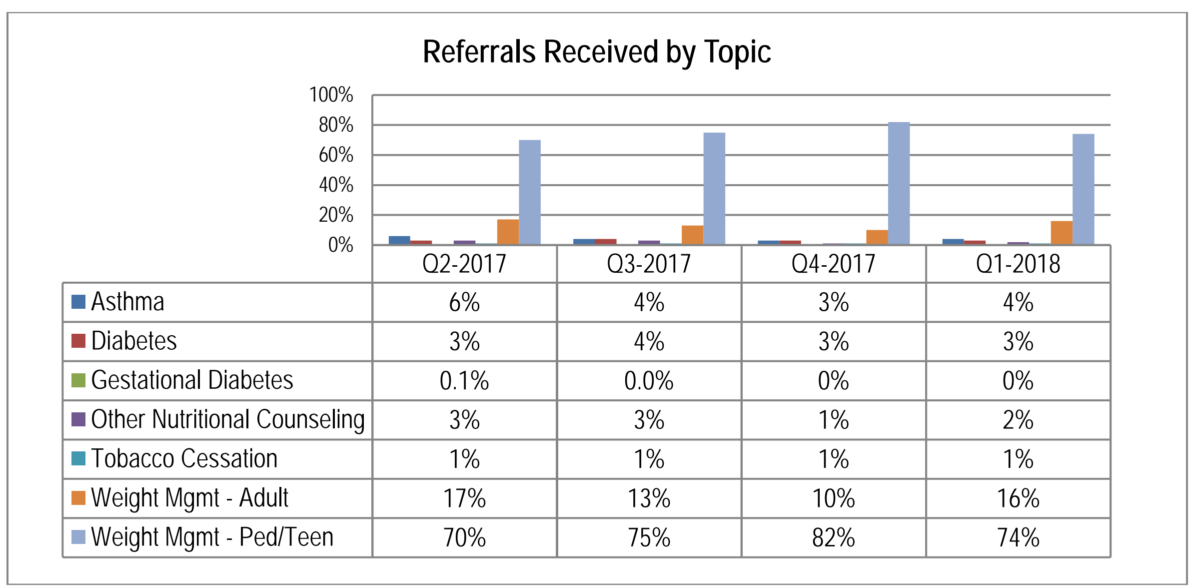
The Health Education Department (HE) receives referrals from various sources. Internal referrals are received from the Kern Health Systems (KHS) Utilization Management Department (UM), the Disease Management Department (DM), Case Management (CM), and the Provider Pay for Performance Program (P4P). Externally,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



	Q2-2017	Q3-2017	Q4-2017	Q1-2018
Provider	29%	19%	13%	16%
Member	11%	12%	14%	21%
P4P	52%	64%	70%	60%
DM	1%	0.4%	0.2%	0%
UM	5%	4%	2%	2%
CM	2%	1%	1%	1%

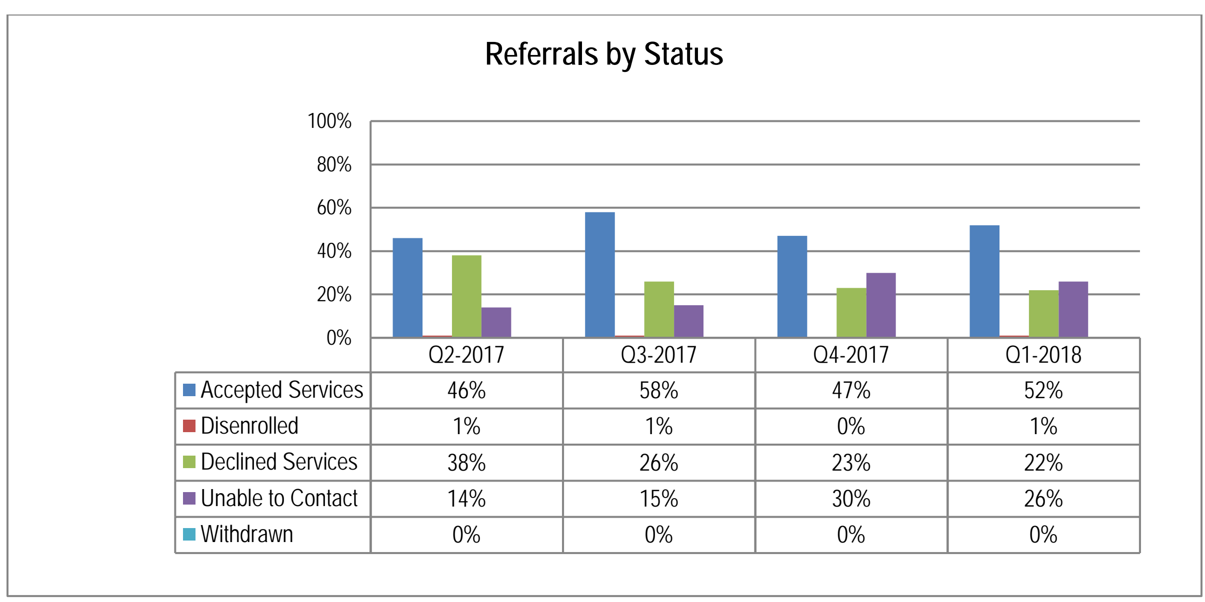
During this quarter, 810 referrals were received which is a 24% decrease in comparison to the previous quarter. This decrease is attributed to a decline in provider requests for health education services.

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
First Quarter 2018



	Q2-2017	Q3-2017	Q4-2017	Q1-2018
Asthma	6%	4%	3%	4%
Diabetes	3%	4%	3%	3%
Gestational Diabetes	0.1%	0.0%	0%	0%
Other Nutritional Counseling	3%	3%	1%	2%
Tobacco Cessation	1%	1%	1%	1%
Weight Mgmt - Adult	17%	13%	10%	16%
Weight Mgmt - Ped/Teen	70%	75%	82%	74%

The HE department receives referrals for various health conditions. Weight management education continues to be the most requested service for members. It accounted for 90% of all referrals received in the 1st Quarter of 2018.



	Q2-2017	Q3-2017	Q4-2017	Q1-2018
Accepted Services	46%	58%	47%	52%
Disenrolled	1%	1%	0%	1%
Declined Services	38%	26%	23%	22%
Unable to Contact	14%	15%	30%	26%
Withdrawn	0%	0%	0%	0%

The rate of members who accepted to receive health education services increased from 47% in the 4th quarter to 52% in the 1st quarter in 2018.

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. Member received previous education.

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
- Intro to Gardening
- Rethink Your Drink

Bakersfield Memorial Hospital (BMH):

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

Community Wellness Program (CWP):

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

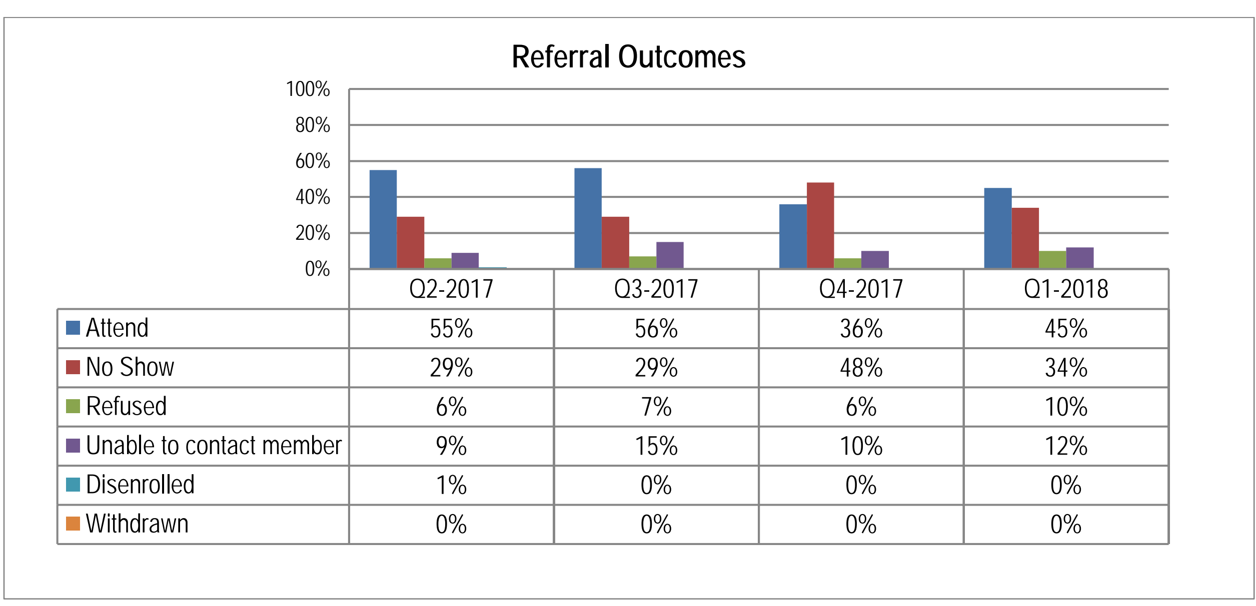
Clinica Sierra Vista (CSV) WIC:

- Diabetes Management Classes
- Heart Healthy Classes

California Smokers' Helpline (CSH):

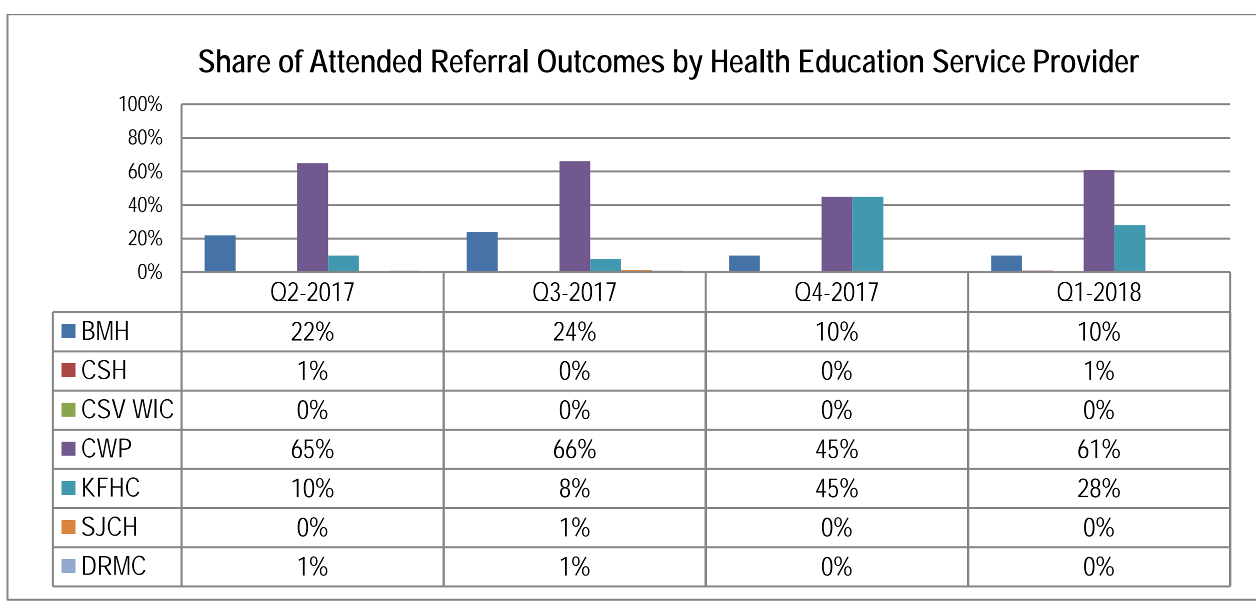
- Telephone Smoking Cessation Counseling

REFERRAL OUTCOMES



	Q2-2017	Q3-2017	Q4-2017	Q1-2018
Attend	55%	56%	36%	45%
No Show	29%	29%	48%	34%
Refused	6%	7%	6%	10%
Unable to contact member	9%	15%	10%	12%
Disenrolled	1%	0%	0%	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 36% to a 45%.

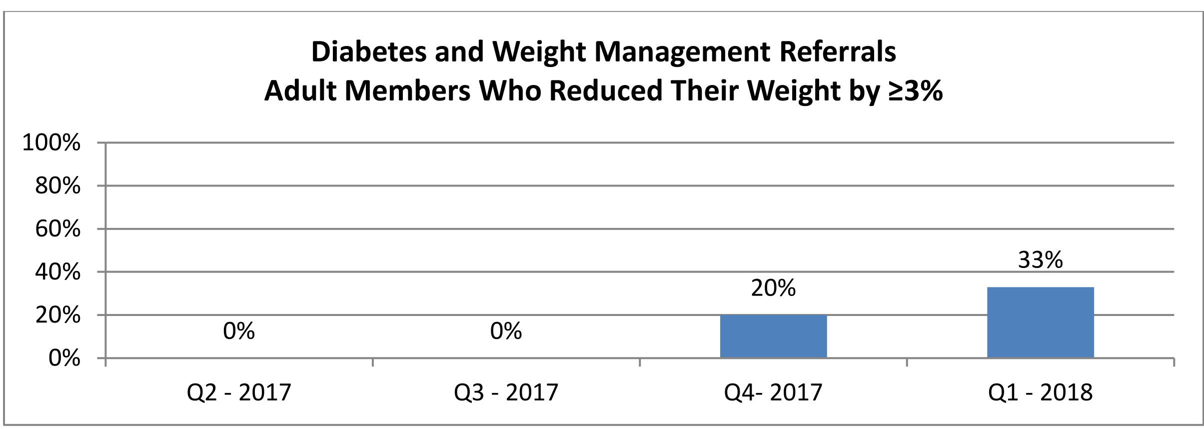


	Q2-2017	Q3-2017	Q4-2017	Q1-2018
BMH	22%	24%	10%	10%
CSH	1%	0%	0%	1%
CSV WIC	0%	0%	0%	0%
CWP	65%	66%	45%	61%
KFHC	10%	8%	45%	28%
SJCH	0%	1%	0%	0%
DRMC	1%	1%	0%	0%

Services through CWP continue to account for the largest share of referral outcomes. This quarter CWP showed an increase from 45% in 4th quarter to a 61% in the 1st quarter of 2018.

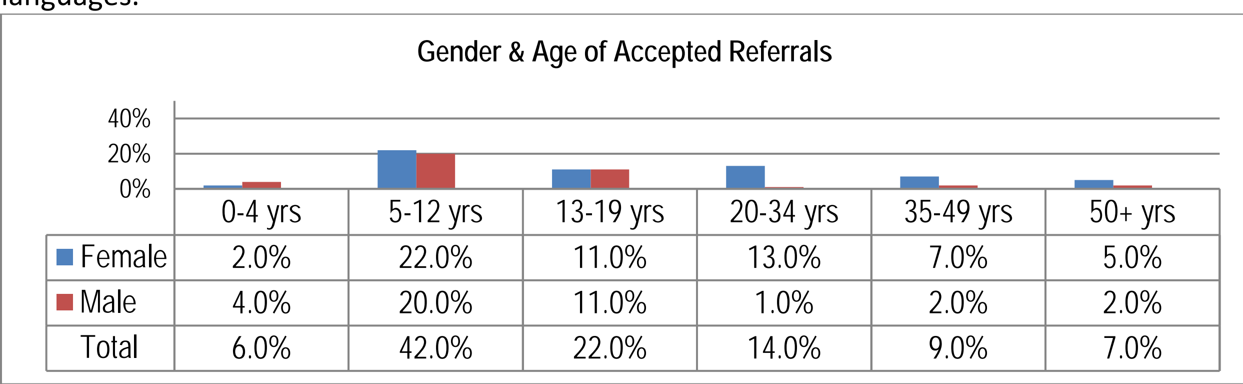
Effectiveness of Health Education Services

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 was in the process of revising the evaluation metrics for its health education services which resulted in no follow up calls performed until December 2017. Follow up call findings revealed 33% of members had reduced their weight by 3% or greater during this quarter.



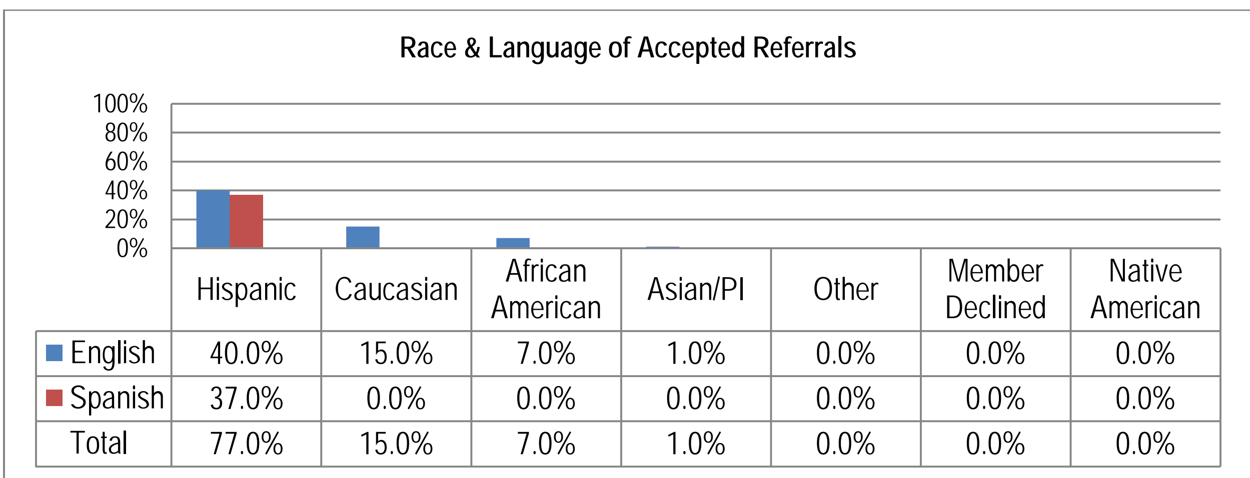
Demographics of Members Served

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	2.0%	22.0%	11.0%	13.0%	7.0%	5.0%
Male	4.0%	20.0%	11.0%	1.0%	2.0%	2.0%
Total	6.0%	42.0%	22.0%	14.0%	9.0%	7.0%

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	Native American
English	40.0%	15.0%	7.0%	1.0%	0.0%	0.0%	0.0%
Spanish	37.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	77.0%	15.0%	7.0%	1.0%	0.0%	0.0%	0.0%

A breakdown of member classifications by race and language preferences revealed that 40% of members who accepted services are Hispanic and prefer to speak English.

Referrals Accepted by Top Bakersfield Zip Codes

Q2-2017	Q3-2017	Q4-2017	Q1-2018
93307	93307	93307	93307
93306	93306	93306	93306
93305	93304	93305	93304
93304	93301	93304	93305
93308	93305	93309	93309

KHS serves members in the Kern County area. During this quarter, 73% 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

Q2 - 2017	Q3-2017	Q4-2017	Q1-2018
Delano	Delano	Delano	Delano
Shafter	Wasco	Lamont	Wasco
Wasco	Shafter	Shafter	Shafter
McFarland	Taft	Arvin	Arvin
Arvin	McFarland	McFarland	Lamont
Taft		Wasco	McFarland

Additionally, 27% 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

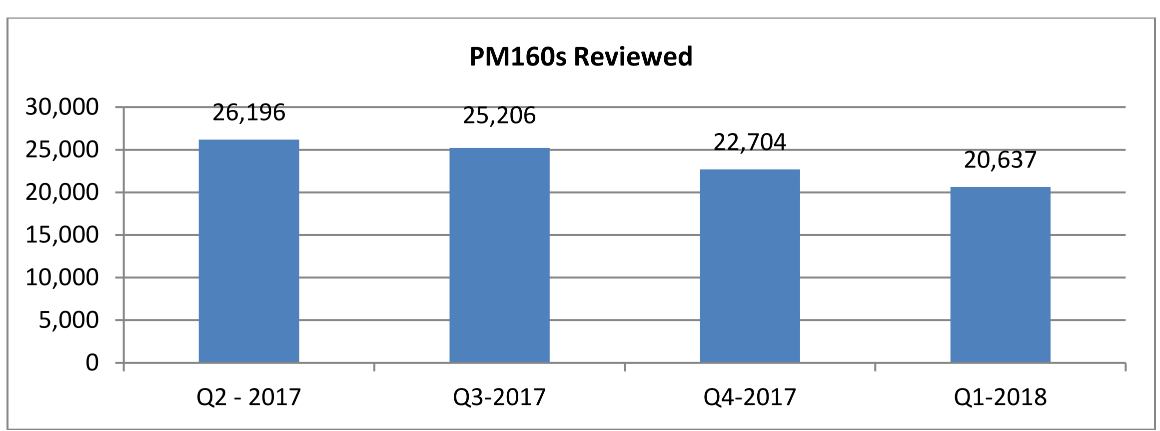
In addition to referrals, the HE department mails out a variety of educational material in an effort to assist members with gaining knowledge on their specific diagnosis or health concern. During this quarter, the HE department mailed 3,178 educational packets to members on the following health topics:

Educational Mailings

	Q2-2017	Q3-2017	Q4-2017	Q1-2018
Anemia	1	0	0	0
Asthma	52	36	31	19
High Cholesterol	8	4	6	4
Diabetes	33	25	15	15
Gestational Diabetes	0	1	0	2
High Blood Pressure	28	19	20	14
Nutrition	0	0	0	0
COPD	1	0	0	0
Postpartum Care	300	953	408	14
Prenatal Care	73	241	254	8
Smoking Cessation	18	22	10,199	68
Weight Management	1497	1472	893	674
Postpartum Incentive	0	0	275	275
WIC	**0**	**0**	**2473**	**2360**
Total	**2011**	**2773**	**14,574**	**3,178**

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 103 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	
Q4-2017	Q1-2018
Spanish	Spanish
Arabic	Arabic
Cambodian	Cantonese
	Punjabi

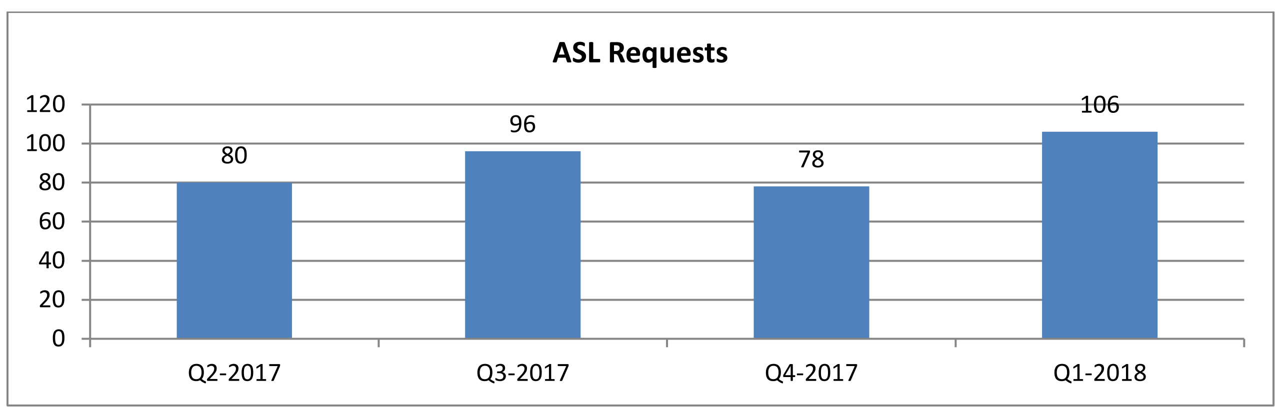
Telephonic Interpreter Requests

During this quarter, there were 533 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			
Q2 - 2017	**Q3-2017**	**Q4-2017**	**Q1-2018**
Spanish	Spanish	Spanish	Spanish
Punjabi	Punjabi	Punjabi	Punjabi
Arabic	Arabic	Arabic	Arabic
Tagalog	Tagalog	Tagalog	Tagalog
Mandarin	Vietnamese	Vietnamese	Vietnamese

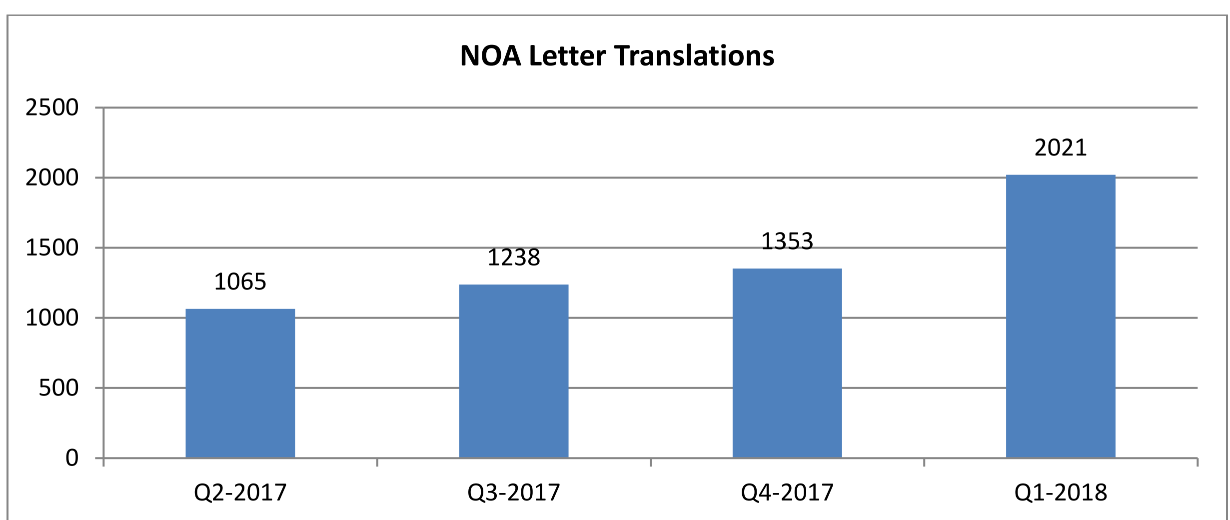
American Sign Language (ASL) Requests

During this quarter, there were a total of 106 requests received for an American Sign Language interpreter, which was a decrease in comparison to the previous quarter.



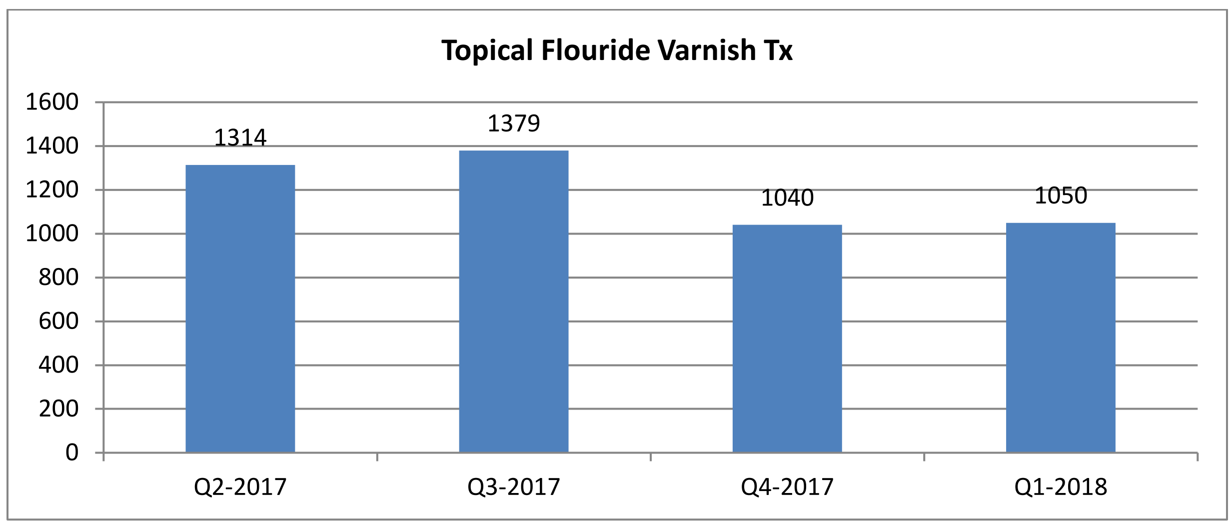
DOCUMENT TRANSLATIONS

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, 2,021 Notice of Action letters were translated into Spanish for the UM and Pharmacy departments.



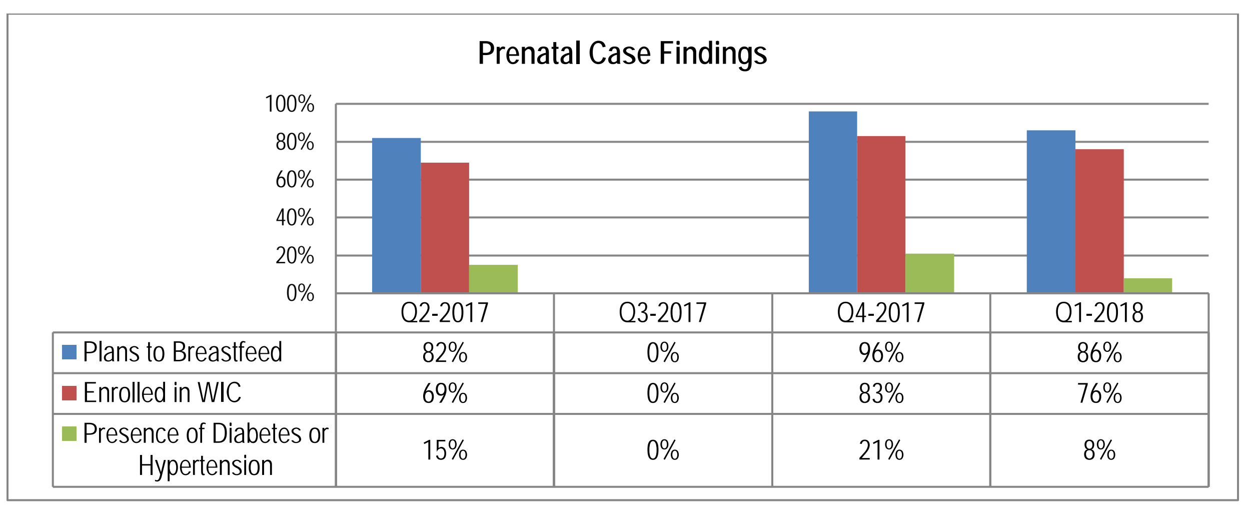
TOPICAL FLUORIDE VARNISH TREATMENTS

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.

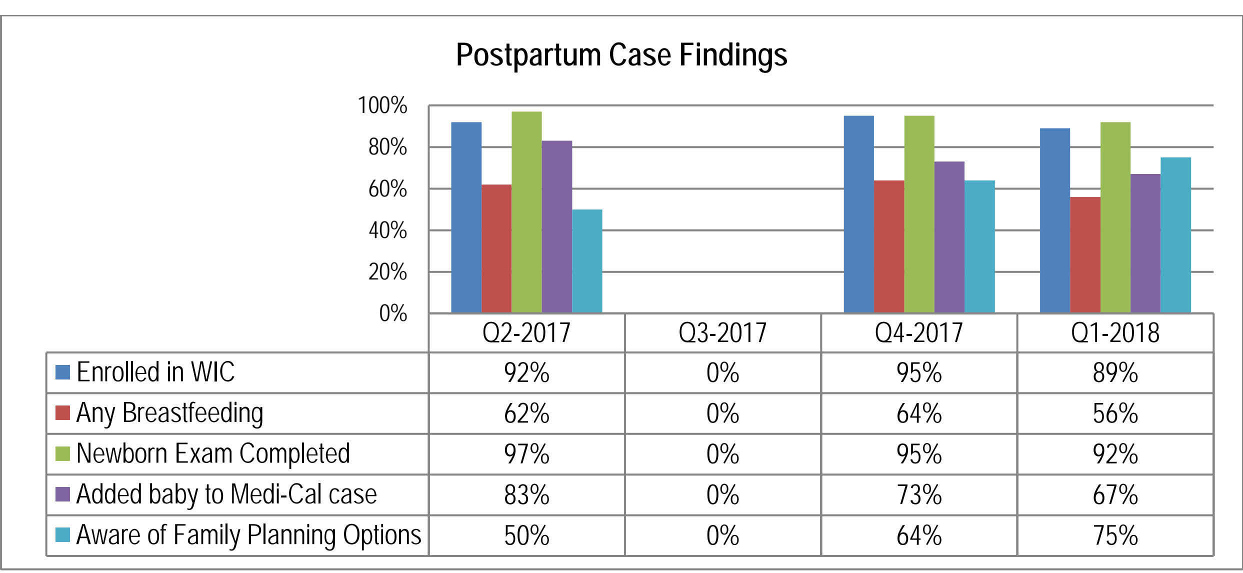


OB CASE MANAGEMENT PROJECT

The HE department performs outreach education calls to all members identified as being pregnant in the 1st trimester, a pregnant teen (under age 18), or postpartum due to a c-section or teen pregnancy delivery. During the 1st quarter, 37 pregnant and 36 postpartum members were successfully reached and provided education.



	Q2-2017	Q3-2017	Q4-2017	Q1-2018
Plans to Breastfeed	82%	0%	96%	86%
Enrolled in WIC	69%	0%	83%	76%
Presence of Diabetes or Hypertension	15%	0%	21%	8%



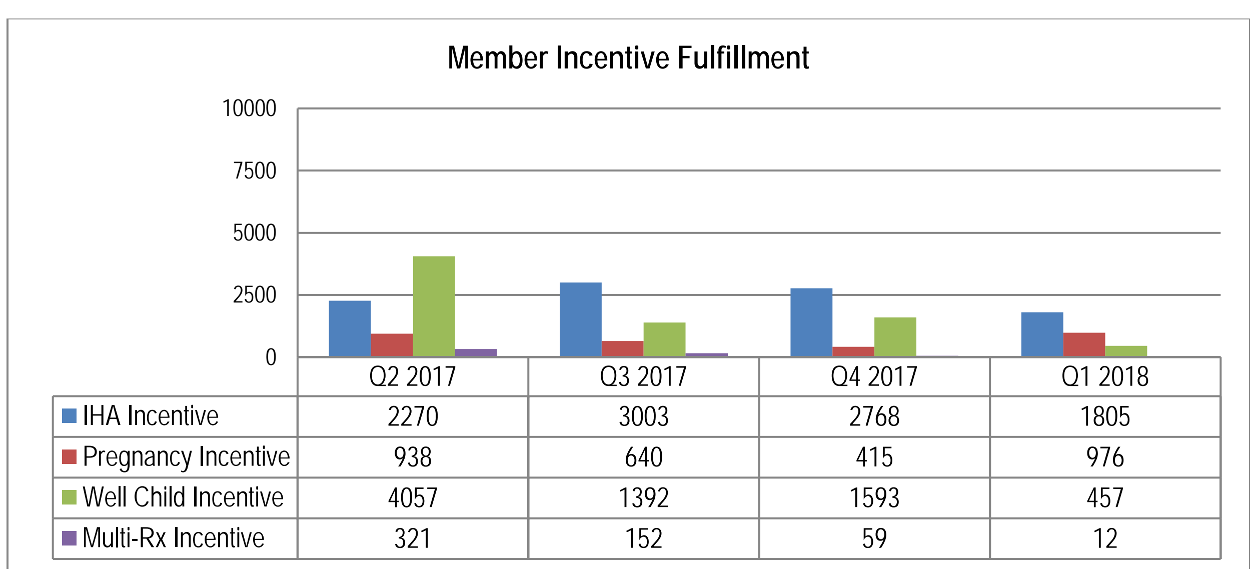
	Q2-2017	Q3-2017	Q4-2017	Q1-2018
Enrolled in WIC	92%	0%	95%	89%
Any Breastfeeding	62%	0%	64%	56%
Newborn Exam Completed	97%	0%	95%	92%
Added baby to Medi-Cal case	83%	0%	73%	67%
Aware of Family Planning Options	50%	0%	64%	75%

MEMBER WELLNESS AND CHRONIC CONDITION BASED INCENTIVES

During the 1st quarter of 2018, KHS continued to offer 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	Q4 2017	Q1 2018
IHA Incentive	2270	3003	2768	1805
Pregnancy Incentive	938	640	415	976
Well Child Incentive	4057	1392	1593	457
Multi-Rx Incentive	321	152	59	12

1. QI ACTIVITIES

According to the Medi-Cal Managed Care Division (MMCD) APL 17-014 all Medi-Cal managed care health plans are contractually required to report an annual performance measurements results, participate in a consumer satisfaction survey when indicated (usually required every three years), and conduct ongoing quality improvement projects (PIPs).

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS):

HEDIS 2017 is the latest completed edition of the Healthcare Effectiveness Data and Information Set, a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS has been developed and maintained by the National Committee for Quality Assurance (NCQA), a private not-for-profit organization dedicated to improving health care quality, since the early 1990s.

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

The previous calendar year is the standard measurement year for HEDIS data. Therefore, the HEDIS 2017 results shown in this report are based on 2016 data, with a few exceptions, which are noted in the descriptions of the measures. HEDIS 2017 results can be found in Appendix A. APL 17-014, which also states that for each measure that does not meet the established MPL or is reported as “No Report” (NR), the health plan must submit an Improvement Plan (IP) within 60 days of being notified by DHCS of the measures for which IPs are required. KHS submitted IPs for the AAB and CCS measures for HEDIS 2017 and submitted PIPs for the CIS-Combo 3 and the MMA measures. All were accepted by DHCS, and the PIP brought our rates above MPL. All three improvement projects were closed.

Following HEDIS 2017, DHCS and their California EQRO, HSAG required a Disparities PIP and a second PIP of our choosing. For the disparities PIP KHS chose Improving Immunization Rates in African-American Children at Age Two. The second PIP was Decreasing

Imaging Studies in Members with Uncomplicated Low Back Pain, the only measure KHS scored less than the MPL. This combined the IP and PIP process into one submission.

CONSUMER STATISFACTION SURVEYS (CAHPS):

Per MMCD APL 17-014 the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for both adults and children was administered by the EQRO in 2017. DHCS provided the "sample frame" member information for contracted health plans to the EQRO. No CAHPS surveys will be required in 2017 or 2018.

PROCESS IMPROVEMENT PROJECTS (PIPs):

QIPs were retired per APL 14-024 and replaced with PIPs. Each PIP runs approximately 18 months. KHS's PIPs for 2017, Immunizations for Children Two Years of Age based on HEDIS measure use CIS-Combo3, and The Use of Controller Medication in Persons with Asthma based on the MMA measure. These PIPs followed the PDSA format formalized into five modules. KHS has submitted all Modules on time.

Immunizations for Children Two Years of Age – This PIP chose a high volume, poor performing (based on claims data) provider to partner with us on this 18 month project. During this project, three interventions were trialed. The first intervention, using Modifier 25 to change a sick visit to a well visit so immunizations can be given was successful and spread to other organizations. The second intervention, monthly visits/meetings with the provider partner gave us the opportunity to review the records of the children under 2 to identify opportunities for improvement. Chart abstraction by an RN showed this office's performance as 95% instead of the 36% shown by claims and CAIR data. The third intervention, entering immunization information into CAIR was initially accepted by the provider but despite assurances, the office manager was unwilling to change internal processes to implement this change.

For the second PIP, The Use of Controller Medication in Persons with Asthma, KHS partnered with a FQHC clinic to which a high number of diabetics were assigned. The QI department reached out to the members assigned there to invite them to our educational sessions. The vast majority of these members could not be reached and this intervention ended. Further data analysis showed that these members more frequently attended a different clinic than the one where they were assigned. A cluster was found at an alternate clinic so this is where the second intervention was focused. The second intervention was to increase referrals

to KHS's Asthma education. Even after internal barriers were overcome, referrals remained low as did attendance at the educational sessions. This PIP closed without improving Asthma controller medication usage.

2. FACILITY SITE REVIEWS AND COLLABORATION

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

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

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

3. MONITORING AND FOCUS REVIEWS

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

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

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

QI PROGRAM OVERVIEW

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
Oversight of all delegated QI functions for the following services: • Kaiser • VSP	Met	8/25/2017	QI and UM evaluations, programs and workplans for Kaiser and VSP went to the May 25th, 2017 QI/UM committee.	Complete for 2017
QI Policies and Procedures	Met	Ongoing	1. QI Policies and Procedures are updated annually as well as reviewed periodically in order to comply with any new regulatory requirements. 2. Each policy and procedure is reviewed against the DHCS contract and regulatory requirements and revised as needed to ensure compliance. 3. Revisions to current QI policies and procedures have been taken to the QI/UM committee 4. Delegated credentialing tools provided and policy review done with Provider Relations Department and UM	Complete for 2017
Audits				
P4P	Met	9/30/2017	P4P – The ongoing P4P audit was performed to evaluate the use of Provider portal to capture IHA, Prenatal and BMI percentile/Weight counselling. Providers who scored 100% in 4 sequential audits were assessed, and those who retained 100% were removed from the denominator and will be	Complete for 2017. Project complete

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			assessed yearly. A random sample of the remaining providers' were audited and results were shared with the CMO and Director of PR. Due to the new provider and member portals, P4P will no longer be submitted this way and the P4P audits will not continue in 2018	
ER prescription audit	Met	9/30/2017	Compliance Rx – QI performed quarterly audits for Compliance to evaluate if a sufficient amount of medications were given to members who accessed ER and were given a prescription to fill on discharge. Results were given to Compliance	Complete for 2017
Site review timeliness audit	Met	9/30/2017	Site Review Timeliness – A quarterly retrospective audit was performed to ensure that Site and Medical Record reviews were done on time. All site reviews and follow-up in this time period were timely.	Complete for 2017
Clinical Guidelines	Met	9/30/2017	The PAC reviewed and completed the following Clinical Guidelines and related policies: 1. Venous Ablation 2. Ambulatory Hysterectomy Procedures	Complete for 2017
Staying Healthy Assessment	Met	9/30/2017	715 positive Staying Healthy Assessments (SHAs) were identified through P4P and HEDIS chart review. These were forwarded to Health Education in collaboration with them.	Complete for 2017
30 day readmission	Met	Ongoing	The QI department continues to look for opportunities for improvement in members who are readmitted within 30 days of discharge. This organization-wide focus has brought the following changes: • Increases Social Workers presence in the CM Department. • Transition of Care program is ongoing, identifying members at risk of readmission and linking them to appropriate services including medication reconciliation and a Discharge Clinic	Complete for 2017

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			• Health Homes were established, and there are three open at this time. • A Respite Care program was developed to help provide home care for the discharged homeless.	
Notifications (Death, General)	Met	Ongoing	The QI department continues to look for opportunities for improvement through the Notification process. Concurrent and retrospective reviews have identified internal opportunities for improvement. All notifications are tracked and trended, and information is shared with the Chief Medical Officer during the re-credentialing process. This process has been digitalized with electronic forms now being sent through work items.	Complete for 2017
Grievances	Met	Ongoing	The QI department continues to look for opportunities for improvement through the Grievance process. Retrospective reviews have identified external opportunities for improvement. All quality related grievances are tracked and trended, and information is shared with Chief Medical Officer during the re-credentialing process. Two trending reports were generated in 2017	Complete for 2017
Resources				
• Director of Quality Improvement	Not Met	TBD	This position remained vacant all year and is no longer posted	unknown
• QI supervisor	Met	9/30/2017	The department's QI supervisor provides oversight of all QI activities, reporting to the Administrative Director Health Services and the CMO	Complete for 2017
• QI RN II	Met	9/30/2017	The department currently has three RN II positions. Each position is filled by a senior RN in the department. The positions are:	Complete for 2017

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			• Master Trainer • HEDIS RN • Clinical Liaison	
• QI RN I	Met	9/30/2017	The QI department is at full staff. QI RN I = 4 FTEs	Complete for 2017
• QI Coordinator	Met	9/30/2017	This position was budgeted since 2015 to insource HEDIS Medical Record retrieval and has been very successful	Complete for 2017
• QI Assistant	Met	9/30/2017	This is the second position budgeted since 2015 to insource HEDIS Medical Record retrieval. This position also is responsible for the Member Incentive.	Complete for 2017
• Business Analyst	Met	9/30/2017	This position is responsible for providing an advanced role in the analysis of health care information as it relates to HEDIS and the QI department. This position will be transitioned to a QI Operations Analyst in 2018	Complete for 2017
• QI Technician and Trainer	New	9/30/2017	This is a new position to provide reporting support to the QI department. The previous SSC was promoted to a new position, QI Technician and Trainer. In this role she will continue her focus on reporting actionable data, streamlining current processes, developing new processes, and training staff.	Complete for 2017
• Senior Support Clerk	Met	9/30/2017	QI has one SSC who support the clerical needs of the department.	Complete for 2017
QI Projects				
QI site automation	Met	12/1/2017	The first phase of QI Site Review automation is complete with Attachments A, B and C available electronically. DHCS and Health Net reporting is automated. Phase 2 will begin in 2018	Complete for 2017
Modifier 25 education	Met	9/30/2017	Data analysis of performance in the pediatric HEDIS measures showed that many young members only saw their PCP for	Complete for 2017

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			injury or illness. In order to capture immunizations and more extensive assessments, educational material was developed to help providers and offices convert applicable sick visit to well visits with modifier 25. This would allow provider payment for immunization and other preventive care done during a sick visit. The provider portal was adapted to show each unmet HEDIS/P4P measure on the eligibility screen which the office staff can print and flag for the provider. This intervention was part of the CIS PIP and increased immunization rates. It was also rated highly in provider satisfaction. This education will be ongoing through 2018	
Telephone Reminder Calls		12/31/2017	75,077 automated reminder calls were sent to members in August, September and November 2017. Topics included: • Yearly childhood wellness exam • Asthma medication • Women's preventive health screenings (PAPs and Mammos) • Immunizations for children and adolescents • Diabetes care	Completed for 2017
Member Education Material	Met	12/31/2017	The HEDIS team, acting on provider request, obtained educational material for providers on the following topics: • HPV • Diet and Exercise for children • Avoidance of antibiotics for acute bronchitis These materials were provided to 59 poor performing offices and clinics.	Completed
Proactive Letters	Met	12/31/2017	In 2017 QI sent 25,256 letters to members whom, based on claims data, had not completed their preventive health testing. On 9/8/2017, 15,000 reminders were sent to women	Completed

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			to have Cervical Cancer Screening (CCS) performed. 10,256 members with diabetes were reminded to have their A1c, BP and kidney function checked and eye exams performed. Due to changes in regulations, this intervention will not be continued in 2018	
Member Incentive	Met	12/31/2017	To motivate young members and their families to see their PCP for well-visits, a member incentive was trialed in November 2014. This 'Wellness Rewards Program' offered 2 movie tickets for each child who had a well-visit through the end of 2014. The head of household's name was put in a monthly raffle for the chance to win one of ten $25.00 gift certificates. The trial was a success, and the incentive became an ongoing event. The 2017 member incentive, targeting members ages 12 months to 19 years of age, was started 7/15/2017. 29,889 letters were mailed to households of 45,848 pediatric members notifying them of the opportunity to receive two movie tickets and be involved in a monthly raffle for one of twenty-five 10.00 gift certificates. 2,747 letters came back undeliverable. At the end of 2017, 1009 members had responded to the member incentive and had a PCP visit. Due to changing regulations this member incentive will be transitioned to the member portal in 2018.	Complete.
Committees				
Quality Improvement/Utilization Management Committee (QI/UMC)	Met	Quarterly - ongoing	1. Reports to the Board of Directors and retains oversight of the QI Program with direction from the Medical Director. 2. The QI/UMC promulgates the quality improvement process to participating groups and physicians, practitioner/providers, subcommittees, and internal KHS	Complete for 2017

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			functional areas with oversight by the Chief Medical Officer. 3. Committee also performs oversight of UM activities conducted by KHS to maintain high quality health care and effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services. 4. All ten (10) positions are filled; four (4) QI/UMC meetings were held in the reporting period with attendance as follows: (see attendance table below)	
	Met	9/30/2017	1. Practitioner attendance and participation in the QI/UM Committee or subcommittees is required. 2. The participating practitioners represent a broad spectrum of specialties and participate in clinical QI and UM activities, guideline development, peer review committees and clinically related task forces. 3. The extent of participation must be relevant to the QI activities undertaken by KHS.	Complete for 2017
	Met	9/30/2017	1. Practitioner participation and attendance for this reporting period continue to result in improved communication.	Complete for 2017

QI/UM Committee Members	Role	Attended
Dr Tasinga/designee	CMO	2/2 (Dr Harris, AMD)
Bruce Taylor DO	Family Practitioner #1	1
Chan Park MD	Family Practitioner #2	3
Satya Ayra, ND	Specialist #1	4
Philipp Melendez MD (candidate)	Specialist #2	2
Maridette Schole MS, LSSBB	FQHC Provider	4
Danielle Colayco PharmC, MS	Pharmacy Provider	4
Jennifer Ansolabehere, PHN	Public Health	2
Felicia Crawford RN	Home Health/Hospice Provider	2
Allen Kennedy	DME Provider	3

<table>
<tr><th>Goal</th><th>Metrics</th><th>Target Completion</th><th>Action Steps and Monitoring</th><th>Results</th></tr>
<tr><td></td><td></td><td></td><td>2. Participating practitioners who are involved in the QI Program also serve as a communications conduit to the practitioner community.
3. These practitioners help educate participating practitioners and providers about the principles of QI and UM, it’s specific quality activities and the results of these activities</td><td></td></tr>
<tr><td>Physician Advisory Committee (PAC)</td><td>Met</td><td>9/30/2017</td><td>1. Serves as advisor to the Board of Directors on health care issues, peer review, provider discipline, and credentialing/recredentialing decisions.
2. This committee meets on a monthly basis and is responsible for reviewing practitioner/provider grievances and/or appeals, practitioner/provider quality issues, and other peer review matters as directed by the KHS Medical Director.
3. The PAC has a total of eight (8) voting committee positions.</td><td>Complete for 2017</td></tr>
<tr><td></td><td>Met</td><td>9/30/2017</td><td>Ten (10) PAC meetings were held during the reporting period with attendance as follows:
<table>
<tr><th>PAC Committee Members</th><th>Role</th><th>Attended</th></tr>
<tr><td>Dr Tasinga/designee</td><td>CMO</td><td>10</td></tr>
<tr><td>Hasmukh Amin, MD</td><td>Pediatrician</td><td>8</td></tr>
<tr><td>Angela Egbikuadje, PD, MS, PHD</td><td>Clinical Psychologist</td><td>7</td></tr>
<tr><td>David Hair MD</td><td>Eye Specialist</td><td>8</td></tr>
<tr><td>Miguel Lascano MD</td><td>OB/GYN</td><td>8</td></tr>
<tr><td>Ashok Parmar MD</td><td>Pain Medicine</td><td>8</td></tr>
<tr><td>Raju Patel MD</td><td>Family Practitioner</td><td>8</td></tr>
<tr><td>Jacqueline Paul-Gordon MD</td><td>Family Practitioner</td><td>9</td></tr>
</table></td><td>Complete for 2017</td></tr>
<tr><td></td><td>Met</td><td>9/30/2017</td><td>The PAC reviewed and approved the following Clinical Guidelines and related policies:
1. KHS Policy 13.07-P Administration of Vaccines by Pharmacist
2. Modified Checklist for Autism in Toddlers (M-CHAT)</td><td>Complete for 2017</td></tr>
</table>

<table>
<tr><th>Goal</th><th>Metrics</th><th>Target Completion</th><th>Action Steps and Monitoring</th><th>Results</th></tr>
<tr><td></td><td></td><td></td><td>3. KHS Policy 3.17-P Sexually Transmitted Disease (STD) Treatment
4. Venous Ablation Criteria
5. Policy 3.10-P Alcohol and Substance Abuse Treatment
6. Policy 3.73-I Medical Decision Making</td><td></td></tr>
<tr><td>Pharmacy and Therapeutics Committee (P&T)</td><td>Met</td><td>9/30/2017</td><td>1. Serves to objectively appraise, evaluate, and select pharmaceutical products for formulary addition or deletion.
2. This is an ongoing process to ensure the optimal use of therapeutic agents.
3. P&T meet quarterly to review products to evaluate efficacy, safety, ease of use and cost.
4. Medications are evaluated on their clinical use and develop policies for managing drug use and administration.</td><td>Complete for 2017</td></tr>
<tr><td></td><td>Met</td><td>9/30/2017</td><td>Four (4) P&T meetings were held during the reporting period with attendance as follows:
<table>
<tr><th>P&T Committee Members</th><th>Role</th><th>Attended</th></tr>
<tr><td>Dr Tasinga/designee</td><td>CMO/Chair</td><td>3</td></tr>
<tr><td>Allison Bell, PharmD</td><td>Retail pharmacy – independent</td><td>4</td></tr>
<tr><td>Dilbaugh Gehlawat, MS</td><td>Pediatrician</td><td>4</td></tr>
<tr><td>Paul J Herndon, PharmD</td><td>Retail pharmacy – chain</td><td>1</td></tr>
<tr><td>Kimberly Hoffmann, PharmD</td><td>Board Member – Rx representative</td><td>4</td></tr>
<tr><td>Jeremiah (Jay) Josen, PharmD</td><td>Pharmacy – specialty practice</td><td>4</td></tr>
<tr><td>Sam Ratnayake, MD</td><td>Internal Medicine</td><td>2</td></tr>
<tr><td>Sarabheet Singh MD</td><td>General Practice</td><td>3</td></tr>
<tr><td>Vasanthi Srinivas MD</td><td>OB/GYN</td><td>4</td></tr>
<tr><td>Bruce Wearda, RPh</td><td>KHS Director of Pharmacy/Alt Chair</td><td>4</td></tr>
</table></td><td>Complete for 2017</td></tr>
<tr><td>Public Policy/Community Advisory Committee (PP/CAC)</td><td>Met</td><td>9/30/2017</td><td>1. PP/CAC provides a mechanism or structured input from KHS members and community representatives regarding how KHS operations impact the delivery of care.
2. The PP/CAC is supported by the Board of Directors to provide input in the development of public policy activities for KHS.</td><td>Complete for 2017</td></tr>
</table>

<table>
<tr><th>Goal</th><th>Metrics</th><th>Target Completion</th><th>Action Steps and Monitoring</th><th>Results</th></tr>
<tr><td></td><td></td><td></td><td>3. The committee meets every four months and provides recommendations and reports findings to the Board of Directors.</td><td></td></tr>
<tr><td></td><td>Met</td><td>9/30/2017</td><td>PP/CAC has twelve (12) committee positions. Eight (8) of the twelve (12) positions were filled; Four (4) PP/CAC meetings were held in the reporting period with attendance as follows:
<table>
<tr><th>CAC/PP Committee Members</th><th>Role</th><th>Attended</th></tr>
<tr><td>Louie Iturriria</td><td>Chair</td><td>4</td></tr>
<tr><td>Basulto, Beatriz</td><td>Member</td><td>4</td></tr>
<tr><td>Hernandez-Colin, Santa Cecilia</td><td>Member</td><td>3</td></tr>
<tr><td>Albert, Jenny</td><td>Member</td><td>0</td></tr>
<tr><td>Hefner, Janet</td><td>Children's Health Initiative of KC /CHW</td><td>4</td></tr>
<tr><td>Wood-Slayton, Jennifer</td><td>Lamont Family Resource Center</td><td>2</td></tr>
<tr><td>Vega, Juan</td><td>KC Department of Public Health</td><td>3</td></tr>
<tr><td>Townsend, Pam</td><td>KC Department of Human Services</td><td>4</td></tr>
<tr><td>Andrea Gomez</td><td>Member</td><td>2</td></tr>
</table></td><td>Complete for 2017</td></tr>
<tr><td colspan="5">Regulatory Compliance</td></tr>
<tr><td>DHCS audit</td><td>Met</td><td>8/29-9/9/2017</td><td>DHCS performed a general audit. There were no findings related to QI</td><td>Complete for 2017</td></tr>
<tr><td>HEDIS 2017</td><td>Partially Met</td><td>6/30/2017</td><td>On 6/15/2017, all elements of HEDIS 2017 were complete and approved by HSAG and NCQA accepted our submission. We did not meet the Low Back Pain measures, and in lieu of an Improvement Plan, DHCS allowed us to choose this topic as our second PIP which will continue through 2019</td><td>Complete for 2017</td></tr>
<tr><td>AAB IP</td><td>Met</td><td>12/31/2017</td><td>In HEDIS 2016, KHS did not meet the MPL for the AAB measures. Interventions to raise the rates included:
• Evaluation of data showed Urgent Care Centers being the highest volume prescribers for antibiotics for members with bronchitis
• AAB posters explaining why antibiotics are not helpful when someone has bronchitis were placed in UCC waiting areas</td><td>Complete for 2017</td></tr>
</table>

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			• Peer to peer education where our Associate Medical Director met with providers • Member outreach with call, pre-test, mailing of AAB magnet and post-test KHS met the MPL in HEDIS 2017 and this IP is closed	

CCS IP	Met	12/31/2017	In HEDIS 2016, KHS did not meet the MPL for the CCS measures. Interventions to raise the rates included:
			• Worked with high volume provider to have:
			  o Patient navigators contact those with unmet needs
			  o Open a clinic that provides women's preventive care services
			  o Provide data to provider for them to evaluate their performance
			• Sent proactive letters to those without cervical cancer screening in the past two years.
			KHS met the MPL in HEDIS 2017 and this IP is closed
				Complete for 2017

PIPs				
CIS-Combo 3	Met	7/31/2017	The CIS-Combo 3 PIP was completed and accepted by HSAG. KHS submitted a poster to the DHCS conference on our lessons learned.	Completed for 2017
MMA	Met	7/31/2017	The MMA as our second PIP was completed and accepted by HSAG.	Completed for 2017
Disparities - CIS	New	7/31/2019	Although KHS met MPL in the CIS measure, we did not meet the state average. In order to improve our rate, this measure was chosen as our Disparities PIP. A high volume provider has agreed to partner with us. Modules 1 and 2 have been submitted.	Ongoing

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
Low Back Pain	New	7/31/2019	KHS did not meet MPL in the LBP measure in HEDIS 2017. In order to improve rates, this measure was chosen as our PIP. A high volume provider has agreed to partner with us. Modules 1 and 2 have been submitted.	Ongoing
Site Reviews				
• Initial	Met	9/30/2017	25 Initial site reviews were completed with PERS (Attachment C). All subsequent medical record reviews were complete. All CAPS and required follow-up visits were completed and closed.	Completed for 2017
• Full	Met	9/30/2017	31 Full Site and Medical Record reviews were completed. PERS (Attachment C) were reviewed and completed if needed. All CAPS and required follow-up visits were completed and closed.	Completed for 2017
• Focused	Met	9/30/2015	38 Focused (Periodic) reviews were completed. All CAPS and required follow-up visits were completed and closed.	Completed for 2017
• Pending F/U	Met	9/30/2017	There are no pending follow-up visits. All CAPS and required follow-up visits were completed and closed.	Completed for 2017

KERN HEALTH SYSTEMS

2018

Quality Improvement Program Description

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

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

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

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

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

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

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

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

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

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

5. Providing monitoring and oversight of delegated activities.

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

7. Promoting an awareness and commitment in the health care community toward quality improvement in health care, safety and service. Continuously identifying opportunities for improvement in care processes, organizations or structures that can improve safety and delivery of health care to members. Providing appropriate evaluation of professional services and medical decision making and to identify opportunities for professional performance improvement.

8. Reviewing member concerns regarding quality of care issues that are identified from grievances or from the Public Policy/Community Advisory Committee (PP/CAC).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. **QI/UM Committee (QI/UMC):** The QI/UMC reports to the Board of Directors and retains oversight of the QI Program with direction from the CMO. The QI/UMC develops and enforces the quality improvement process with respect to contracting providers, subcommittees and internal KHS functional areas with oversight by the CMO. This committee also performs oversight of UM activities conducted by KHS to maintain quality health care and effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

xvi. Provide oversight for the KHS UM Program
xvii. Provide oversight for KHS credentialing
xviii. Provide oversight of the Health Education Department
xix. Assist in the development of clinical practice and preventive care health guidelines

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

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

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

i. 1 KHS Chief Medical Officer or designee (Chairperson)
ii. 2 Participating Primary Care Physician
iii. 2 Participating Specialty Physicians

iv. 1 Participating Home Health Representative
v. 1 Participating Pharmacist
vi. 1 Kern County Public Health Officer or Rep.
vii. 2 Other Participating Ancillary Representatives
viii. 1 Administrative Director Health Services,
ix. 1 Supervisor QI,
x. 1 Director Health Education, Cultural and Linguistics
xi. Staff (Committee staff support)

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

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

2. Physician Advisory Committee (PAC):

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

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

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

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

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

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

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

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

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

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

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

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

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

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

i. Objectively appraise, evaluate and select pharmaceutical products for formulary addition or deletion. This is an ongoing process to ensure the optimal use of therapeutic agents. Products are evaluated based on efficacy, safety, ease of use and cost;
ii. Evaluate the clinical use of medications and develop policies for managing drug use and administration;
iii. Monitor for quality issues regarding appropriate drug use for KHS and members. This includes Drug Utilization Review (DUR) and Drug Use Evaluation (DUE) programs;
iv. Provide recommendations regarding protocols and procedures for the use of non-formulary medications;
v. Provide recommendations regarding educational materials and programs about drug products and their use to contracting providers;
vi. Recommend disease state management or treatment guidelines for specific diseases or medical or behavioral health conditions. These guidelines are a recommended series of actions, including drug therapies, concerning specific clinical conditions;
vii. Monitor and assess contracting pharmacy activities as needed through review of audits and pharmacy profiling.

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

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

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

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

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

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

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

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

i. 1 Ex-officio Non-Voting Member: KHS Director of Marketing and Member Services (Chairperson)
ii. 5 subscribers/members
iii. 2 Community Representatives
iv. 2 Participating Health Care Practitioner
v. 1 Kern County Health Officer or Representative
vi. 1 Director, Kern County Department of Human Services or Representative

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

5. **Grievance Review Team (GRT)**

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

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

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

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

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

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

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

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

   The CMO reports to the CEO and communicates directly with the Board of Directors as necessary. The CMO supervises the following Medical Services departments and related staff: Quality Improvement, Utilization Management, Pharmacy, Health Education and Disease Management. The CMO also supervises all QI activities performed by the Quality Improvement Department. The CMO devotes the majority of his time to quality improvement activities. The duties of the position include: providing direction for all medical aspects of KHS, preparation, implementation and oversight of the QI Program, medical services management, resolution of medical disputes and grievances; and medical oversight on provider selection, provider coordination, and peer review. Principal accountabilities include: developing and implementing medical policy for utilization and QI functions, reviewing current medical practices so that that medical protocols and medical personnel of KHS follow rules of conduct, assigned members are provided healthcare services and medical attention at all locations, and medical care rendered by providers meets applicable professional standards for acceptable medical care and quality. These standards should equal or exceed the standards for medical practice developed by KHS and approved by the California Department of Health Care Services (DHCS) or the California Department of Managed Health Care (DMHC).

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

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

3. **Administrative Director of Health Services (the "Director")** - The Director must possess a valid Registered Nurse (RN) license issued by the State of California, five years of experience in an acute health care facility and 15 years

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

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

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

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

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

ii. QI Registered Nurses – The QI nurses possess a valid California Registered Nursing license and three years registered nurse experience in an acute health care setting preferably in emergency, critical and/or general medical-surgical care. The QI nurses assist in the implementation of the QI Program and Work Plan through the quality monitoring process. Staffing will consist of an adequate number of QI nurses with the required qualifications to complete the full spectrum of responsibilities

for the QI Program development and implementation. Additionally, the QI nurses teach contracting providers DHCS MMCD standards and KHS policies and procedures to assist them in maintaining compliance.

iii. QI Coordinator – The QI Coordinator is a graduate from a licensed Medical Assistant training institution with 4 years experience in a provider office setting. The QI Coordinator manages the HEDIS process including but not limited to producing and validating the chase list, producing fax lists, collecting data and reporting essential elements of the HEDIS process.

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

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

vi. QI Business Analyst – graduated from an accredited college or university with a Bachelor's degree in Business Administration and two years of paid experience in report generation, analysis and result documentation. Experience may be substituted for education on a year for year basis. Experience preferred in health care industry, desirable in the MediCare or MediCaid environment. Experience in Business Objects Reporting and HEDIS reporting. Assists in running queries and reports using business supplied reporting tools. Analysis of reporting results and data mining of query information is a critical component of this position. Assist in business process improvement and streamlining workflows. This position will be transitioned to an Operations Analyst in 2018

VIII. Program Information – KHS utilizes information provided through the Information Technology (IT), Operations and Provider Relations departments. Information includes claims and UM data, encounter and enrollment data, and grievance and appeal information. The KHS QI Department identifies data sources, develops studies and provides statistical analysis of results.

IX. Work Plan – The annual QI Work Plan is designed to target specific QI activities, projects and tasks to be completed during the coming year and monitoring and investigation of previously identified issues. A focal activity for the Work Plan is the

annual evaluation of the QI Program, including accomplishments and impact on members. Evaluation and planning the QI Program is done in conjunction with other departments and organizational leadership. High volume, high risk or problem prone processes are prioritized.

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

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

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

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

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

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

ii. **PCP After-Hours Access** – KHS contracts with an after-hours triage service to facilitate after-hours member access to care. The Administrative Director Health Services reviews monthly reports for timeliness, triage response and availability of contracting providers. Results of the access studies are shared with contracting providers, QI/UMC, Board of Directors and DHCS.

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

For 2018, the accountability sets are:

Measure	Measure Type Methodology	SPD** Stratification Required	Auto Assignment Algorithm ****
All-Cause Readmissions	Administrative (non-NCQA), defined by ACR collaborative	Yes	No
Ambulatory Care: • Outpatient visits • Emergency Department visits **(Children)***** • Emergency Department visits **(Adults)** • Emergency Department visits **(Total)**	Administrative	Yes	No
Annual Monitoring for Patients on Persistent Medications (2 indicators): • ACE inhibitors or ARBs • Diuretics	Administrative	Yes	No
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Administrative	No	No
Breast Cancer Screening	Administrative	No	No
Cervical Cancer Screening	Hybrid	No	Yes
Childhood Immunization Status – Combo 3	Hybrid	No	Yes
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
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**
Controlling High Blood Pressure < 140/90 mm Hg (except < 150/90 mm Hg for ages 60-85 without diabetes)	Hybrid	No	Yes
Immunizations for Adolescents (meningococcal, Tdap, HPV)	Hybrid	No	No

2018 Accountability Set (con't)

Measure	Measure Type Methodology	SPD** Stratification Required	Auto Assignment Algorithm ****
Asthma Medication Ratio	Administrative	No	No
Prenatal & Postpartum Care (2 indicators): • Timeliness of Prenatal Care • Postpartum Care	Hybrid	No	Yes, for *Prenatal only*
• Depression Screening and Follow-Up for Adolescents and Adults	Electronic Clinical Data Systems (ECDS)	No	No
Use of Imaging Studies for Low Back Pain	Administrative	No	No
Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents • Counseling for nutrition • Counseling for physical activity	Hybrid	No	No
Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life	Hybrid	No	Yes

Further details on KHS HEDIS studies can be found in the HEDIS technical specifications published by NCQA and in KHS internal policies. KHS's 2017 rates can be found in Appendix A.

KHS is contractually required to meet or exceed the DHCS established Minimum Performance Level (MPL) for each required HEDIS measure. For any measure that does not meet the established MPL, or is reported as a "No Report" (NR) due to an audit failure, an Improvement Plan (IP) is contractually required to be submitted within 60 days of being notified by DHCS of the measures for which IPs are required. The CAP measures are excluded from Improvement Plans

3. **Performance Improvement Projects (PIPs)** – KHS is mandated to participate in two (2) PIPs. The first one was approved by DHCS and HSAG and will mirror the CIS-Combo in it's focus on decreasing disparities. The second PIP is improving the care of members with Low Back Pain.

4. In 2016, the CAHPS **Member Satisfaction Survey** – was performed according to NCQA's HEDIS® methodology. The HEDIS® specifications require health plans to utilize the Consumer Assessment of Health Plans (CAHPS®) Survey, and to administer the survey through a third party, NCQA-certified data collection vendor. HSAG will not administer the survey in 2018.

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

   - Health Plan Rating
   - Health Care Received Rating
   - Specialist Rating

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

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

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

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

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

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

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

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

HEDIS measures developed by NCQA. HEDIS reports are produced annually and have been incorporated into QI assessments and evaluations.

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

9. **Health Education** – KHS actively works to improve the health of members in order to prevent or delay the progression of chronic conditions. Those with or at risk of chronic conditions are identified through claims encounter data, new member outreach calls, external and internal referrals, and other reporting measures. Members are notified of the KHS health education programs for diabetes, asthma, nutrition counseling, weight management, and tobacco cessation through targeted mailings, outreach phone calls, the KHS website, member portal, automated IVR messages and community events and presentations

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

    Each disease management program contains well-formulated activities that address the continuum of care. The effectiveness of activities is evaluated using quantitative measures and appropriate data. Contracting providers are involved in disease management development. KHS has developed and implemented disease management system to address asthma and diabetes.

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

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

    Complex Case Management is the systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management. Basic Case

Management means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered basic case management services.

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

13. **Health Homes** Kern Health Systems have implemented Health Homes in Kern County to address the needs of our high risk chronically ill members. Eligible members are contacted by the Health Home Department at KHS (Kern Care) and given the opportunity to enroll in one of the voluntary Health Homes where they are met by a multidisciplinary team who works with each member to design a personalized health plan, assist them in reaching health goals and linking them to community services they may need. The Kern Care Department assists our members by providing an overview of the program, scheduling their initial appointment, offer transportation if needed and initiate their journey in achieving better health.

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

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

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

    Greivances that are closed in favor of the member or closed with a quality of care issue identified are forwarded to the QI department for further review and action. At minimum, all cases are tracked and the data provided to the CMO or designee during the provider credentialing/re-credentialing process. Other actions may include request(s) for a plan of correction for issues or concerns identified during review.

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

        i. **Drug Utilization Review** – KHS performs drug utilization reviews to provide oversight of prescribed medications. DUR is a structured, ongoing program that evaluates, analyzes, and

interprets drug usage against predetermined standards and undertakes actions to elicit improvements and measure the results. The objectives of DUR are to improve the quality of patient care by assuring safe and effective drug use while concurrently managing the total cost of care.

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

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

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

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

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

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

XI. KHS Providers: KHS contracts with physicians and other types of health care providers. Provider Relations conducts a quarterly assessment of the adequacy of contracting providers. All PCPs and specialists must meet KHS credentialing and recredentialing

standards. Contracting providers must meet KHS requirements for access and availability. Members may select their PCPs based on cultural needs and preferences. The Provider Directory lists additional languages spoken by PCPs or their office staff.

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

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

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

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

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

XV. **Members Right to Confidentiality:** KHS retains oversight for provider confidentiality

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

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

XVII. Provider Participation:

1. **Provider Information** – KHS informs contracting providers through its Provider bulletins, letters and memorandums, distribution of updates to the Provider Policy and Procedure Manual, and training sessions.
2. **Provider Cooperation** – KHS requires that contracting providers and hospitals cooperate with QI Program studies, audits, monitoring and quality related activities. Requirements for cooperation are included in provider and hospital contract language that describe contractual agreements for access to information.

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

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

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

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

3. Hospital contracts include provisions for the following:

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

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

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

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

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

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

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

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

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

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

2. Credentialing information.

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

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

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

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

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

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

____

KHS Board of Directors (Chair) Date

____

Chief Executive Officer Date

____

Chairman QI/UMC Date

Appendix A

HEDIS 2017
Hybrid Measures

Measure		2017 Rate
CCS	Cervical Cancer Screening	57.91
CIS-3	CIS – Combo 3	64.72
CDC-E	Eye Exam (Retinal) Performed	48.01
CDC-HT	HbA1c Testing	84.24
CDC-H9 *	HbA1c Poor Control (>9.0%)	45.83
CDC-H8	HbA1c Control (<8.0%)	45.83
CDC-N	Medical Attn. for Nephropathy	88.95
CDC-BP	Blood Pressure Control <140/90	63.04
CBP	Controlling High Blood Pressure	54.99
IMA-1	Immunizations for Adolescents	21.41
PPC-Pre	Timeliness of Prenatal Care	75.43
PPC-Pst	Postpartum Care	63.75
WCC-BMI	BMI percentile	57.91
WCC-N	Counseling for Nutrition	51.82
WCC-PA	Counseling for Phys Activity	70.07
W-34	Well-Child Visits	57.91

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

Administrative Measures

Measure		2017 Rate
AAB**	Avoidance of Antibiotic Treatment	29.47
AMR	Asthma Medication Ratio	48.38
BCS	Breast Cancer Screening	50.48
CAP-1224	12-24 Months	89.65
CAP-256	25 Months – 6 Years	80.61
CAP-711	7-11 Years	81.49
CAP-1219	12-19 Years	80.21
CDF	Screening for Clinical Depression	9.29
LBP	Use of Imaging for Low Back Pain	66.25
MPM-ACE	ACE inhibitors or ARBs	88.40
MPM-Dig	Digoxin	46.27
MPM-Diu	Diuretics	87.61

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

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

KERN HEALTH SYSTEMS
2018 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNT ABILITY	STATUS
I. QUALITY MANAGEMENT AND IMPROVEMENTS				
A. Annual Review/Approval of QI Program Documents				
1. Approval QI Evaluation	Approval of 2018 QI Program Evaluation	05/24/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	QI/UMC Agenda May 2018
2. Review/Update and Approval of QI Program Description	Approval of 2018 QI Program Description	05/24/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	QI/UMC Agenda May 2018
3. Review/Update and Approval of QI Work Plan	Approval of 2018 QI Work Plan	05/24/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	QI/UMC Agenda May 2018
B. Analysis of Member Demographics and Morbidities Data	Previous year end data and ongoing risk stratification for CM and DM targetted interventions	ongoing	Chief Information Officer, Administrative Director Health Services, Director Health Education, Cultural and Linquistic Services	Ongoing 2018
C. Clinical - Focused Studies				
1. State Required				
a. IP - LBP	regulatory requirement due to HEDIS scores below MPL - see PIP below	6/30/2019	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing through July 2019
b. IP - CCS	regulatory requirement due to HEDIS scores above MPL but below state average - see PIP below	6/30/2019	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing through July 2019
c. Disparitites CIS PIP	18 month quality improvement project led by HSAG	6/30/2019	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing through July 2019
d. LBP PIP	18 month quality improvement project led by HSAG	6/30/2019	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing through July 2019
2. Health Plan Required	TBD based on opportunities for improvement	Ongoing 2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2018
D. 2018 HEDIS Monitoring (Medi-cal) / Quality Measurements				
1. The Roadmap	Report to State EQRO Auditor - HSAG	01/29/2018	QI/Claims/PR/IT	Submitted
2. Childhood Immunization Status	Report annually to QI/UM Committee/Board of Directors (BOD)/DHCS	08/27/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
3. Well Child Visits 3rd, 4th, 5th, and 6th years of life	Report annually to QI/UM Committee/BOD/DHCS	08/27/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
4. Prenatal and Postpartum Care	Report annually to QI/UM Committee/BOD/DHCS	08/27/2018	Director of QI, Health Education and Disease Management / IT	In Progress
5. Comprehensive Diabetes Care	Report annually to QI/UM Committee/BOD/DHCS	08/27/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
6. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Report annually to QI/UM Committee/BOD/DHCS	08/27/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
7. Annual Monitoring for Patients on Persistent Medications	Report annually to QI/UM Committee/BOD/DHCS	08/27/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
8. Cervical Cancer Screening	Report annually to QI/UM Committee/BOD/DHCS	08/27/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
9. Children's and Adolescent's Access to PCPs	Report annually to QI/UM Committee/BOD/DHCS	08/27/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
10. Ambulatory Care	Report annually to QI/UM Committee/BOD/DHCS	08/27/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
11. Immunizations in Adolescents	Report annually to QI/UM Committee/BOD/DHCS	08/27/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
12. Use of Imaging Studies for Low Back Pain	Report annually to QI/UM Committee/BOD/DHCS	08/27/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
13. Controlling High Blood Pressure	Report annually to QI/UM Committee/BOD/DHCS	08/27/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
14. Asthma Medication Ratio	Report annually to QI/UM Committee/BOD/DHCS	08/27/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
15. Weight Assessment & Counseling for Nutrition & Physical Activity for Children and Adolescents	Report annually to QI/UM Committee/BOD/DHCS	08/27/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
16. All Cause ReadITsions	Report annually to QI/UM Committee/BOD/DHCS	08/27/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNT ABILITY	STATUS
17. Breast Cancer Screening	Report annually to QI/UM Committee/BOD/DHCS	08/27/2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	In Progress
F. Other On-going Monitoring				
1. 30 day re-admissions	In annual report 2018 QI Plan Evaluation to QI/UMC & BOD	Annually	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2018
2. Unanticipated Deaths	In annual report in 2018 QI Plan Evaluation to QI/UMC & BOD	Annually	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	2018
3. Untoward Events/PPC 3. Focused Reviews	In annual report in 2018 QI Plan Evaluation to QI/UMC & BOD	Annually	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	2018
a. Referral Process	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2018
b. IHEBA - Staying Healthy Assessment	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2018
c. Initial Health Assessment (IHA)	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2018
d. Kern Regional Center/Early Start Program	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2018
e. California Children's Service (CCS)	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2018
f. Critical elements	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2018
g. Diabetes Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ending 12/31/2018
h. Asthma Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ending 12/31/2018
i. Maternity Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2018
G. Safety of Clinical Care				
1. Autoclave	Credentialing/Recredentialing/As necessary	Facility Site Rev/Focus Review	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2018
2. Bio-hazardous waste	Credentialing/Recredentialing/As necessary	Facility Site Rev/Focus Review	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2018
3. Infection Control	Credentialing/Recredentialing/As necessary	Facility Site Rev/Focus Review	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2018
4. Facility Site Review (FSR) DHS Database	FSR database of completed site reviews	Jan / July 2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2018
5. Focused Reviews - Critical Elements	Physician Site Monitoring / Quarterly Reporting	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing 2018
I. Availability				
1. Primary Care Practitioners				
a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Annually	Director of Provider Relations, Director AIS	In Progress
b. Geographic Standard - *Health Education Cultural and Linguistics Needs Assessment*	Measure and Report to DHS every three years	2021	Chief Medical Officer (CMO) / Administrative Director Health Services/ Director Health Education, Cultural and Linquistic Services	Next Needs Assessment due 2021
2. Speciality Practitioners				
a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Annually	Director of Provider Relations, Director AIS	Ongoing 2018
b. Geographic Standard	Measure and Report	Annually	Director of Provider Relations, Director AIS	N/A
J. Access				
1. Primary Care Appointments				
a. Preventive Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Director of Provider Relations, Director AIS	Ongoing 2018
b. Routine Primary Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Director of Provider Relations, Director AIS	Ongoing 2018
c. Urgent Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Director of Provider Relations, Director AIS	Ongoing 2018
e. After-hours Care Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Director of Provider Relations, Director AIS	Ongoing 2018
2. Telephone access to Member Services				

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNT ABILITY	STATUS
a. Abandonment rate	Measure/Report to QI/UM Committee Quarterly	Annually	Director of Provider Relations, Director AIS	Ongoing 2018
b. Speed of answer	Measure/Report to QI/UM Committee Quarterly	Annually	Director of Provider Relations, Director AIS	Ongoing 2018
3. Mental Health Appointment	Annual MOU Meetings/Grievances	As necessary	Utilization Management/Grievance Review Team	Ongoing 207
a. Life-threatening Emegency Standard (immediate care)	Report as necessary to QI/UM Committee	As necessary	Director of Provider Relations, Director AIS	Ongoing 2018
b. Non-life-threatening Emergency Standard	Report as necessary to QI/UM Committee	As necessary	Director of Provider Relations, Director AIS	Ongoing 2018
c. Urgent needs Standard	Report as necessary to QI/UM Committee	As necessary	Director of Provider Relations, Director AIS	Ongoing 2018
d. Routine office visit Standard (visit within 10 working days)	Report as necessary to QI/UM Committee	As necessary	Director of Provider Relations, Director AIS	Ongoing 2018
e. Telephone access to screening and triage Standard	Report as necessary to QI/UM Committee	As necessary	Director of Provider Relations, Director AIS	Ongoing 2018
1) Caller reaches non-recorded voice			Director of Provider Relations, Director AIS	
2) Abandonment rate			Director of Provider Relations, Director AIS	
K. Encounters, Complaints, Grievances and Appeals Data Analysis	Report aggregate data quarterly to QI/UM Committee	Quarterly	Director of Member Services	Ongoing 2018
L. CAHPS Survey	State administered N/A	TBD	State Administered/CIO/Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	TBD
1. Results reported to QI/UMC	Report to QI/UMC when applicable	TBD	State Administered/CIO/Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	TBD
2. Results reported to practitioners and providers	Report in Provider Newsletter/Bulletin when applicable	TBD	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI, Director of Provider Relations	TBD
M. Disease Management System				
1. Asthma	Measure and Report to QI/UM Committee	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ending 12/31/2018
2. Diabetes with Hypertension comorbidity	Measure and Report to QI/UM Committee	Quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ending 12/31/2018
3. Staying Healthy Assessments (IHEBA)	Measure and Report to QI/UM Committee	Quarterly	Chief Medical Officer (CMO), Administrative Director Health Services, Director Health Education, Cultural and Linquistic Services, Supervisor QI	Beginning 1/1/2018
N. Clinical Practice Guidelines	Report to QI/UM Committee	Annually	CMO	As appropriate
1. Annual Measurement of Performance of at least two (2) aspects of three (3) Clinical Pactice Guidelines	To be determined	Annually	Chief Medical Officer (CMO) / Administrative Director Health Services/ Manager UM	As appropriate
a. To be determined	Measure, analyze and report	Annually	Chief Medical Officer (CMO) / Administrative Director Health Services/ Manager UM	As appropriate
b. To be determined	Measure, analyze and report	Annually	Chief Medical Officer (CMO) / Administrative Director Health Services/ Manager UM	As appropriate
c. Mental Health Guidelines	Annual MOU Meetings	Annually	Chief Medical Officer (CMO) / Administrative Director Health Services/ Manager UM	As appropriate
2. Develop New Guidelines	Develop, approve and implement	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	2018 Guidelines:
a. To be determined	Reported to QI/UM Committee from PAC	To be determined	Medical Director or designee	As appropriate
O. Continuity of Care Monitoring	Monitored through Grievances, FSR/Peer Review, HEDIS	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	As appropriate
1. Primary Care Practitioner (PCP)	Monitored through Grievances, FSR/Peer Review, HEDIS	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing
2. PCP & Mental Health	Monitored through Grievances, Peer Review, HEDIS	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services	Ongoing
3. Specialist	Monitored through Grievances, Peer Review, HEDIS	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services	Ongoing
P. Cultural and Linguistic Services Report (HFP)	To meet needs of limited English proficient applicants and subscribers - to address types of services	Annually	Director Disease Management, Cultural and Linquistic Services	4Q 2018
R. Delegation of QI Activities	QI/UM delegation to Kaiser and VSP includes ongoing reporting of Grievances, QI Program, Evaluation and Workplan	2Q 2018	Director of Provider Relations	2Q 2018

KERN HEALTH SYSTEMS
2018 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNT ABILITY	STATUS
S. Annual Review of QI Policies and Procedures	Submit to QI/UMC and DHCS	Annually and as necessary	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI/Director AIS	Ongoing
T. QI/UM Committee				
1. Reports and agenda items	Gathered from pertinent departments	Quarterly or more often if nec	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing
2. Minutes	Attached to next meetings agenda and sent to BoD	Quarterly or more often if nec	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing
3. Form 700	Send to all committee members yearly	Initial / Yearly December	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing
4. PO's and Check Requests	Fill out for each member attending meeting	Feb /May Aug/Nov	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI / Accounting	Ongoing
II. UTILIZATION MANAGEMENT - See UM WorkPlan				
A. Annual Review/Approval of UM Program Documents	Program Description 2018	05/24/2018	Administrative Director of Health Services	QI/UMC May 2018 Agenda
III. CREDENTIALING AND RECREDENTIALING				
A. Initial Credentialing Site Visit & Medical Record	Upon Credentialing/Quarterly FSR Summary	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing
B. Organization Providers Quality Assessment	Data Reviews are received from QI/UM/AIS/MS for any opportunities form improvement identified. QI Department quality reviews of readmisions within 30 days, member deaths and notifications. See 1F	At least quarterly	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing
1. Hospitals	Tracking Grievances, Notifications, Deaths and QI issues	Ongoing	Director of Provider Relations	Ongoing
2. SNF's	Tracking Grievances, Notifications, Deaths and QI issues	Ongoing	Director of Provider Relations	Ongoing
3. Home Health Agencies	Tracking Grievances, Notifications, Deaths and QI issues	Ongoing	Director of Provider Relations	Ongoing
4. Free-Standing Surgery Centers	Tracking Grievances, Notifications, Deaths and QI issues	Ongoing	Director of Provider Relations	Ongoing
5. Impatient MH/SA Facilities	Tracking Grievances, Notifications, Deaths and QI issues	Ongoing	Director of Provider Relations	Ongoing
6. Residential MH/SA Facilities	Tracking Grievances, Notifications, Deaths and QI issues	Ongoing	Director of Provider Relations	Ongoing
7. Ambulatory MH/SA Facilities	Tracking Grievances, Notifications, Deaths and QI issues	Ongoing	Director of Provider Relations	Ongoing
C. Ongoing Monitoring of Sanctions and Complaints	Ongoing; time sensitive; sanctions; grievance process	Ongoing	Director of Provider Relations/AIS	Ongoing
D. Credentialing / Recredentialing File Audit	Ongoing KHS/AIS random audits	Ongoing	Director of Provider Relations	Ongoing
E. Delegated Credentialing	Delegation will be for hospital based practitioners if hospital is JCI accredited	Annually / as necessary	Director of Provider Relations	Ongoing
F. Annual Review of Credentialing/Recredentialing Policies and Procedures	Ongoing	Annually / as necessary	Director of Provider Relations	Ongoing
IV. MEMBER RIGHTS AND RESPONSIBILITIES				
A. Statement of Members' Rights and Responsibilities	Review, annually / revise as necessary	Annually / as necessary	Director of Member Services	Ongoing
B. Distribution of Rights Statement to Members & Practitioners	As necessary	Annually / as necessary	Director of Member Services	2018
C. Complaints and Appeals	Aggregate/analyze/report to QI/UM Committee Quarterly	Quarterly	Director of Member Services	In progress
D. Grievance Report (HFP)	Report number and types of benefit grievances for previous calendar year - geographic region, ethnicity, gender and primary language	Quarterly	Director of Member Services	Ongoing
E. Annual Analysis of Privacy and Confidentiality Policies	Review annually / Revise as needed	Ongoing	Director AIS	Ongoing
F. Marketing Information	Focus Groups, Public Policy/Community Advisory Committee	Ongoing	Director of Marketing	Focus groups will be continued in 2018
G. Delegation of Members' Rights and Responsibilities Activities	Non-delegated. Grievance committee	N/A	Grievance Committee	Ongoing
H. Annual Review of Member Rights Policies and Procedures	Non-delegated	N/A	Grievance Committee	Ongoing
V. PREVENTIVE HEALTH SERVICES				
A. Adoption of Preventive Health Guidelines	As necessary	2018	CMO and PAC	Ongoing
B. Annual Distribution of Preventive Health Guidelines to Practitoners	As necessary	2018	Director Provider Relations	Ongoing
C. Annual Analysis of Member Demographics to Identify High Risk Population	Annually and as needed	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services/ Director Health Education, Cultural and Linguistic Services	In progress

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNT ABILITY	STATUS
D. Health Promotion for Members and Wellness Program	Ongoing through PSA, traditional and social media including FaceBook, twitter, Text Messaging program, Healthy Eating and Active Lifestyle Class, You-tube cooking classes, Member newsletters,	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services/ Director Health Education, Cultural and Linguistic Services	Ongoing
V. PREVENTIVE HEALTH SERVICES				
E. Delegation of Preventive Health Activities	Non-delegated	N/A	QI/UM Committee	N/A
F. Annual Review of Preventive Health Policies and Procedures	Annually / revise as necessary	2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Director Health Education, Cultural and Linguistic Services	Ongoing
VI. MEDICAL RECORDS				
A. Review of Medical Record Documentation Standards	Annually / revise as necessary	2018	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI	Ongoing
B. Distribution of Standards to New Providers	Ongoing / as necessary	Ongoing	Director of Provider Relations	Ongoing
C. Audit of Medical Records Documentation	Refer to Credentialing/Recredentialing	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI / Director of Provider Relations	Ongoing
D. Annual Review of Policies and Procedures	Annually / revise as necessary	Ongoing	Chief Medical Officer (CMO) / Administrative Director Health Services/ Supervisor QI / Director of AIS	Ongoing

2018 HEDIS Rate Tracking

As of 2018-4-27 Final

Note: These are preliminary rates awaiting Over-read and HSAG validation.

Hybrid Measures

Measure	Current 2018 Rate	2018 MPL	2018 HPL	2017 KHS Rate	Current Vs. 2018 MPL	Current Vs. 2018 HPL	Current Vs. 2017 KHS
Cervical Cancer Screening	58.39	51.82	70.80	58.39	6.57	-12.41	0.00
CIS – Combo 3	68.86	65.25	79.32	64.96	3.61	-10.46	3.90
Eye Exam (Retinal) Performed	58.94	47.57	68.33	48.19	11.37	-9.39	10.75
HbA1c Testing	89.60	84.25	92.82	84.49	5.35	-3.22	5.11
HbA1c Poor Control (>9.0%)	30.66	48.57	29.07	39.60	17.91	-1.59	8.94
HbA1c Control (<8.0%)	58.21	41.94	59.12	51.09	16.27	-0.91	7.12
Medical Attn. for Nephropathy	92.88	88.56	93.27	88.87	4.32	-0.39	4.01
Blood Pressure Control <140/90	69.89	52.70	75.91	63.87	17.19	-6.02	6.02
Controlling High Blood Pressure	58.39	47.69	71.69	57.91	10.70	-13.30	0.48
Immunizations for Adolescents (Combo 2)	36.74	15.87	30.39	21.65	20.87	6.35	15.09
Timeliness of Prenatal Care	82.48	77.66	91.67	75.43	4.82	-9.19	7.05
Postpartum Care	66.67	59.59	73.67	63.50	7.08	-7.00	3.17
Counseling for Nutrition	63.02	58.56	82.53	67.40	4.46	-19.51	-4.38
Counseling for Phys Activity	57.91	49.06	75.40	61.56	8.85	-17.49	-3.65
Well-Child Visits	66.67	66.18	82.77	69.83	0.49	-16.10	-3.16

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

Administrative Measures

Measure	Current 2018 Rate	2018 MPL	2018 HPL	2017 KHS Rate	Current Vs. 2018 MPL	Current Vs. 2017 HPL	Current Vs. 2017 KHS
Avoidance of Antibiotic Treatment	27.63	24.91	39.53	29.47	2.72	-11.90	-1.84
Asthma Medication Ratio	49.80	55.33	72.38	48.38	-5.53	-22.58	N/A
Breast Cancer Screening	55.98	52.70	70.29	50.48	3.28	-14.31	N/A
12-24 Months	89.69	93.27	97.89	89.65	-3.58	-8.20	0.04
25 Months – 6 Years	81.42	84.94	93.16	80.61	-3.52	-11.74	0.81
7-11 Years	80.88	87.58	96.09	81.49	-6.70	-15.21	-0.61
12-19 Years	78.84	85.65	94.72	80.21	-6.81	-15.88	-1.37
Depression Screening and Follow-Up for Adolescents and Adults	0.00	N/A	N/A	N/A	N/A	N/A	N/A
Use of Imaging for Low Back Pain	71.59	66.23	78.29	66.25	5.36	-6.70	5.34
ACE inhibitors or ARBs	90.19	85.93	92.79	88.40	4.26	-2.60	1.79
Diuretics	89.79	85.52	92.47	87.61	4.27	-2.68	2.18

** Rate for these measures derived by an inverse calculation. The number of required numerators must decrease by the number shown.

Note: For measures shaded in gray, DHCS is not holding MCPs accountable to meet the MPLs for HEDIS 2018 (measurement year 2017).

2017 Utilization Management Program Evaluation

Executive Summary : Kern Health Systems (KHS) Utilization Management (UM) Program is designed to manage the use of limited resources to maximize the effectiveness of the care provided to Kern Health Systems members. It is designed to promote equitable, safe and consistent UM decision- making and coordination of care. The Medi-Cal (MCAL) beneficiary eligible residents have chosen Kern Family Health Care as their managed care plan due to the exceptional quality of care and service provided to the members.- UM Management, in coordination with Human Resource and the Executive team, continue to develop alternative methods to attract and retain qualified RN candidates. Ensuring KHS members are provided high quality, cost effective care in an appropriate setting while maintaining compliance with the Department of Health Care Services and the Department of Managed Health Care are goals that are foremost for the Utilization Management Department. The UM Program includes prior authorization, concurrent review, retrospective review and case management components, depending upon the type of service and the identified member's clinical condition. Systems have been established to facilitate the monitoring of the referral process and the evaluation of those processes in collaboration with KHS delegates and the Chief Medical Officer and /or their designee(s), to promote timely services for members. Conducting an annual evaluation of the effectiveness of the UM Program allows an organization to determine how well it has deployed its resources in the recent past to improve the quality and safety of clinical care and the quality of service provided to its membership. Where the evaluation shows that the program has not met its goals, the organization recommends appropriate changes incorporated into the subsequent annual UM Program Descriptions. KHS experienced unprecedented growth as a result of the Affordable Care Act. With this growth came increasing medical complexity as the addition of the new aid categories and expanded eligibility that primarily consisted of adults. The Statement of Work is as follows:

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	☐ Leadership Support ☐ Mentoring	Met/Not Met	Year End 2017	1. Managerial training is provided to all onboarding of new management staff as well as ongoing opportunities for current levels of management, including Clinical and Non-Clinical staff in UM.	☐ Goal met
UM	☐ Staff Realignment of Health Service Departments	Met/Not Met	Year End 2017	1. Revised organizational structure chart conducted ad hoc 2. Developed, transitioned and implemented chart. 3. Created new job descriptions reviewed and approved by Human Resources. 4. Staffing ratios provided.	☐ Goal met ☐ Cross training for inpatient and outpatient
UM	☐ Update UM Program Description ☐ Completion of 2018 Annual UM Program Evaluation ☐ Development and implementation of 2018 UM Program Description	Met/Not Met	Year End 2017	1. Review, and revise the annual UM Program Description, Program Plan, and Evaluation including Medical and Behavioral Health. 2. Acquire approval of 2017 UM Program Description and the 2017 UM Program Evaluation from the appropriate utilization and quality committees within 12 months of the prior year approval. 3. Evaluate the adequacy of resources, committee structure, practitioner participation and leadership involvement in the UM Program to restructure or change the UM program for the subsequent year as necessary.	☐ Goal met ☐ All documents reviewed, revised, and approved in 2017 ☐ Annual UM Program Evaluation was completed and approved ☐ UM Program Description was reviewed, revised and approved
UM	☐ Resources for growth and development	Met/Not Met	Year End 2017	1. Case Management Society of America – standards of practice provided to the Case Management staff. 2. Organizational Membership recommended for the team that allows for Director, Managers, and Supervisors to both access volumes of educational and training materials as well as allowing for annual conference attendance for leadership team. 3. Local Community Resources information provided. 4. Case Management, MCG Evidence Based Clinical Guidelines, Inpatient Concurrent Review Documentation, Ethics Training – resources on all these provided to team.	☐ Goal met

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	☐ Oversight of all delegated UM functions for the following services: Kaiser VSP Health Dialog	Met	Year End 2017	1. Evaluate effectiveness of the UM program for policy adherence to include compliance with state, federal, and NCQA standards. 2. Approve 2017 UM program evaluation for delegated services delegated services . 4. Submit delegated UM program information for approval at all applicable UM and Quality Committees	☐ Goal met ☐ Next Steps: o Continue quarterly review of delegated services UM reports, annual audit of Policy and Procedures, collaborations annual denial file review. Ad hoc review as identified. o Report delegated services findings to KHS PAC and UM/QI Committees.
UM	☐ Remote workforce support	Met	Year End 2017	1. VPN/RDP connectivity supports remote workforce in local acute hospitals. 2. On call after hours support for care coordination	☐ Goal met
UM	☐ Provide UM Training Programs	Met	Year End 2017	1. Review, revise, and implement UM Training Program for UM stakeholders as applicable for ongoing process improvements. This includes inpatient, outpatient, CCS (Peds), Call tracking, QNXT and Jiva processes.	☐ Goal met ☐ Next Steps: o Continue to update and provide training as needed o Training is based on Regulatory standards and changes o Training needs are identified through a Needs Assessment Trainings included rounds training tools, discharge planning tools, documentation recommendations and ethics training tools.
UM	☐ Review of 2017 Behavioral Health and Non- Behavioral Health UM criteria used for authorization decisions ☐ BH UM criteria revision approvals at Quality Committee and Executive Resource Committee	Met/Not Met	Year End 2017	1. UM Criteria used for Behavioral Health and Non- Behavioral Health authorization decisions reflect updates based on evidence based medicine, DHCS APL notifications, current medical literature, EOC, and formulary changes 2. Policy recommendations related to APL language or DHCS/DMHC guidance applied to policy and procedures. Transition of all BHT services from Regional Center to Kern Health Systems.	☐ Goal met ☐ All criteria were reviewed by PAC committee, CMO and designees, and staff at various times throughout the year ☐ Next Steps: o Continue annual review, update and approval of UM Criteria for 2017
UM	☐ Periodic reports to Quality Committee and Executive Committee	Met/Not Met	Year End 2017	1. Establish effective lines of communication regarding UM processes, new programs and issues/concerns: a) Executive Committee b) Physicians Advisory Committee c) UM/QI Committee d) Public Policy Committee e) Pharmacy and Therapeutics Committee f) Grievance Committee 2. Oversee the development, implementation and completion of corrective action plans (CAPS) related to regulatory survey findings.	☐ Goal met ☐ Periodic reporting is ongoing and completed to provide an update on UM processes, new programs and various UM related issues and/or concerns ☐ Determines necessity of implementing corrective action plans ☐ Next Steps: o Continue to review, revise and approve Utilization management policies and procedures. Ongoing and ad hoc report to committees

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	☐ Periodic reports to the Pharmacy and Therapeutics Committee	Met/Not Met	Year End 2017	1. Review, Revise and approve pharmaceutical management policies and procedures at least annually, update them as new pharmaceutical resource management information become available and provide them to practitioners 2. Review of formulary at least annually and make revisions based on provider/commmittee input	☐ Goal met ☐ Completed ☐ Documentation of work completed to review and approved the 2017 pharmaceutical management policies and procedures ☐ Next steps: o Continue to review, revise and approve pharmaceutical management policies and procedures.
UM	☐ Timely and complete notification of denials of care	Met/Not Met	Year End 2017	1. Monitor, analyze and evaluate denial notices for compliance with federal, state, contractual requirements 2. Based on results of the analysis and evaluation: review, revise, approve and implement UM policies and procedures as needed as well as review stafffing ratios to support compliance. **UM - Referral Notification Compliance** 120.0% 100.0% 80.0% 60.0% 40.0% 20.0% 0.0% |	4Q/16	1Q/17	2Q/17	3Q/17	4Q/17
Member Notification	94.7%	96.0%	97.0%	97.0%	91.0%
Provider Notification	89.4%	91.0%	89.0%	89.0%	90.0%
Criteria Included	96.4%	89.0%	89.0%	89.0%	80.0%
MD Signature Included	97.7%	96.0%	93.0%	92.0%	96.0%		☐ Goal Not Met -expectation is to remain consistent at 90% or greater. JIVA implementation impacted notificaiton related to new platform functionality and user learning curve ☐ Staff re-education/training on JIVA system and criteria attachment ongoing as warranted
UM	☐ Member Satisfaction with UM processes completion and analysis ☐ Physician satisfaction with UM programs; i.e. communication, access, authorization process	Met/Not Met	Year End 2017	1. Annually survey satisfaction with the UM process: Collect and analyze data on member and practitioner satisfaction to identify improvement opportunities and take action designed to improve member and practitioner satisfaction a. Report the annual survey results and opportunities to improve are approved by the appropriate UM and Quality Committees 2. Develop and Implement Corrective Action Plans (CAP) as needed based on results	☐ Goal Met Physician Satisfaction Survey completed in 2017 ☐ Favorable feedback received from various areas in assisting to provide quality patient care ☐ Results remained stable from past years, no significant changes
UM	Health Services P&Ps	Met/Not Met	Year End 2017	1. UM, DM, CM policies and procedures reviewed. Revisions to current UM and QI policies and procedures provided to PAC and QI/UM committee. 2. Delegated services to VSP, Health Dialog, and Kaiser	o Goal Met
UM	Interrater reliability audits	Met/Not Met	Year End 2017	1. Interrater reliability audits completed bi-annually with minimum 80% passing for all clinical staff and Medical Directors who render decision outcomes completed to support consistent application of medical necessity in the decision making process.	o Goal Met

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Emergency Room (ER) Utilization	Met/Not Met	Year End 2017	1. ER intensive case management follow up for the top 50 ER utilizers by KHS MSW 2. Regular monthly report and ongoing program 3. Partnerships with community entities to support efforts for educational suupport and coordination of care.	o Goal Met o Redirection to appropriate level of care-Urgent Care versus PCP
UM	UM Health Services Program Administrator (additional duties)	Met/Not Met	Year End 2017	Medication Therapy Managment, DME effectiveness, Synagis, Hepatitis C, BHT reporting, Diabetic clinics, Palliative, and community outreach completed. 2. UM Health Services Program Administrator partners with UM Business Analyst to develop more system driven outcomes reporting for new programs and expanded benefits. Respite, Pulmonary Rehab added as KHS benefit not reimbursed by DHCS but deemed critical to health outcomes for vulnerable populations. 3. Medical Loss Ratio project to optimize cost savings and improve delivery of care as defined in Triple Aim	o Goal Met
UM	DHCS/DMHC Audit	Met/Not Met	Year End 2017	DHCS completed a medical audit in August 2017. UM had 0 findings in the audit	o Goal Met
UM	Systems Review	Met/Not Met	Year End 2017	1. Systems review by component completed. 2. Clinical criteria, predictive modeling, care plans, workflows and educational tools integrated within the system. 3. JIVA Medical Management System implemented 11/2017 for UM component	o Goal Met
UM	Quarterly State Reports Submission	Met/Not Met	Year End 2017	Quarterly report and mailing- a) Out of Network; b) CBAS; c) Mental Health; e) BHT; f) Dental Anesthesia Delegated Kaiser reporting required for all reports listed to DHCS	o Goal Met

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
DHCS	Quality Improvement/Utilization Management Committee (QI/UMC)	Met/Not Met	Year End 2017	1. Reports to the Board of Directors and retains oversight of the UM Program with direction from the Chief Medical Officer or their designee. 2. The QI/UMC promulgates the quality improvement process to participating groups and physicians, practitioner/providers, subcommittees, and internal KHS functional areas with oversight by the Chief Medical Officer. 3. Committee also performs oversight of UM activities conducted by KHS to maintain high quality health care and effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services. 4.Practitioner attendance and participation in the QI/UM Committee or subcommittees is required. 5. The participating practitioners represents a broad spectrum of specialties and participate in clinical QI and UM activities, guideline development, peer review committees and clinically related task forces. 6. The extent of participation must be relevant to the QI activities undertaken by KHS.	o Goal Met
DHCS	Quality Improvement/Utilization Management Committee (QI/UMC)	Met/Not Met	Year End 2017	Ten (10) of the ten (10) positions were filled; Four (4) QI/UMC meetings were held in the reporting period with attendance Role: Attended CMO: 2/2 Family Practitioner #1: 1 Family Practitioner #2: 3 Specialist #1: 4 Specialist #2: 2 FQHC Provider: 4 Pharmacy Provider: 4 KC Department of Public Health: 2 Home Health/Hospice Provider: 2 DME Provider: 3	o Goal Met
DHCS	Physician Advisory Committee (PAC)	Met/Not Met	Year End 2017	1. Serves as advisor to the Board of Directors on health care issues, peer review, provider discipline, criteria and policy recommendtions and develoment, and credentialing/recredentialing decisions. 2. This committee meets on a monthly basis and is responsible for reviewing practitioner/provider grievances and/or appeals, practitioner/provider quality issues, clinical criteria and guidelines, and other peer review matters as directed by the KHS Medical Director. 3. The PAC has a total of eight (8) voting committee positions.	o Goal Met

<table>
<tr><th>Required By</th><th>Goals</th><th>Metrics</th><th>Target Completion Date</th><th>Action Steps & Monitoring</th><th>Results</th></tr>
<tr><td>DHCS</td><td>Physician Advisory Committee (PAC)</td><td>Met/Not Met</td><td>Year End 2017</td><td>Ten (10) PAC meetings were held during the reporting period with attendance as follows:
<table>
<tr><th>Role</th><th>Attended</th></tr>
<tr><td>CMO</td><td>10</td></tr>
<tr><td>Pediatrician</td><td>8</td></tr>
<tr><td>Clinical Psychologist</td><td>7</td></tr>
<tr><td>Eye Specialist</td><td>8</td></tr>
<tr><td>OB/GYN</td><td>8</td></tr>
<tr><td>Pain Medicine</td><td>8</td></tr>
<tr><td>Family Practitioner</td><td>8</td></tr>
<tr><td>Family Practitioner</td><td>9</td></tr>
</table></td><td>o Goal Met</td></tr>
<tr><td>DHCS</td><td>Pharmacy and Therapeutics Committee (P&T)</td><td>Met/Not Met</td><td>Year End 2017</td><td>1. Serves to objectively appraise, evaluate and select pharmaceutical products for formulary addition or deletion.
2. Ongoing process to ensure the optimal use of therapeutic agents.
3. P&T meet quarterly to review products to evaluate efficacy, safety, ease of use and cost.
4. Medications are evaluated on their clinical use and develop policies for managing drug use and administration.</td><td>o Goal Met</td></tr>
<tr><td>DHCS</td><td>Pharmacy and Therapeutics Committee (P&T)</td><td>Met/Not Met</td><td>Year End 2017</td><td>The Pharmacy and Therapeutics Committee has a total of (10) committee positions as follows:
<table>
<tr><th>Role</th><th>Attended</th></tr>
<tr><td>CMO/Chair</td><td>3</td></tr>
<tr><td>Retail pharmacy -independent</td><td>4</td></tr>
<tr><td>Pediatrician</td><td>4</td></tr>
<tr><td>Retail pharmacy - chain</td><td>1</td></tr>
<tr><td>Board Member —RX representative</td><td>4</td></tr>
<tr><td>Pharmacy-specialty practice</td><td>5</td></tr>
<tr><td>Internal Med</td><td>2</td></tr>
<tr><td>General Practice</td><td>3</td></tr>
<tr><td>OB/GYN</td><td>4</td></tr>
<tr><td>KHS Director of Pharmacy/Alt Chair</td><td>5</td></tr>
</table></td><td>o Goal Met</td></tr>
<tr><td>DHCS</td><td>Public Policy/Community Advisory Committee (PP/CAC)</td><td>Met/Not Met</td><td>Year End 2017</td><td>1. Provides a mechanism or structured input from KHS members and community representatives regarding how KHS operations impact the delivery of care.
2. The PP/CAC is supported by the Board of Directors to provide input in the development of public policy activities for KHS.
3. The committee meets quarterly and provides recommendations and reports findings to the Board of Directors.</td><td>o Goal Met</td></tr>
</table>

<table>
<tr><th>Required By</th><th>Goals</th><th>Metrics</th><th>Target Completion Date</th><th>Action Steps & Monitoring</th><th>Results</th></tr>
<tr><td>DHCS</td><td>Public Policy/Community Advisory Committee (PP/CAC)</td><td>Met/Not Met</td><td>Year End 2017</td><td>PP/CAC has twelve (12) committee positions.
Nine (9) of the twelve (12) positions were filled; Four (4) PP/CAC meetings were held in the reporting period with attendance as follows:
<table>
<tr><th>Role</th><th>Attended</th></tr>
<tr><td>Chair</td><td>4</td></tr>
<tr><td>Member</td><td>4</td></tr>
<tr><td>Member</td><td>3</td></tr>
<tr><td>Member</td><td>0</td></tr>
<tr><td>Children's Health Initiative of KC /CHW</td><td>4</td></tr>
<tr><td>Lamont Family Resource Center</td><td>2</td></tr>
<tr><td>KC Department of Public Health</td><td>3</td></tr>
<tr><td>KC Department of Human Services</td><td>4</td></tr>
<tr><td>Member</td><td>2</td></tr>
</table></td><td>o Goal Met</td></tr>
<tr><td>UM</td><td>Utilization Management Process

Policy/Procedure Revision/Development and Implementation</td><td>Met/Not Met</td><td>Year End 2017</td><td>1. UM Policies and Procedures are reviewed at least annually and updated at a minimum every 2-3 years. Revisions are performed periodically in order to comply with any new regulatory requirements.
2. Each policy and procedure is reviewed against the DHCS contract and regulatory requirements and revised as needed to ensure compliance.
3. A review of UM policies and procedures are performed as well as the creation of new policies in direct relation to the addition of the Mental and Behavioral health benefits, Chiropractic, Tobacco Cessation, Mental Health Parity, Continuity of Care, Palliative, Transgender, and others to meet the reporting and medical identification requirements set forth by the Department of Health Care Services (DHCS). Mega Regs and contract update necessitated multiple policy updates for 2017.</td><td>o Goal Met</td></tr>
</table>

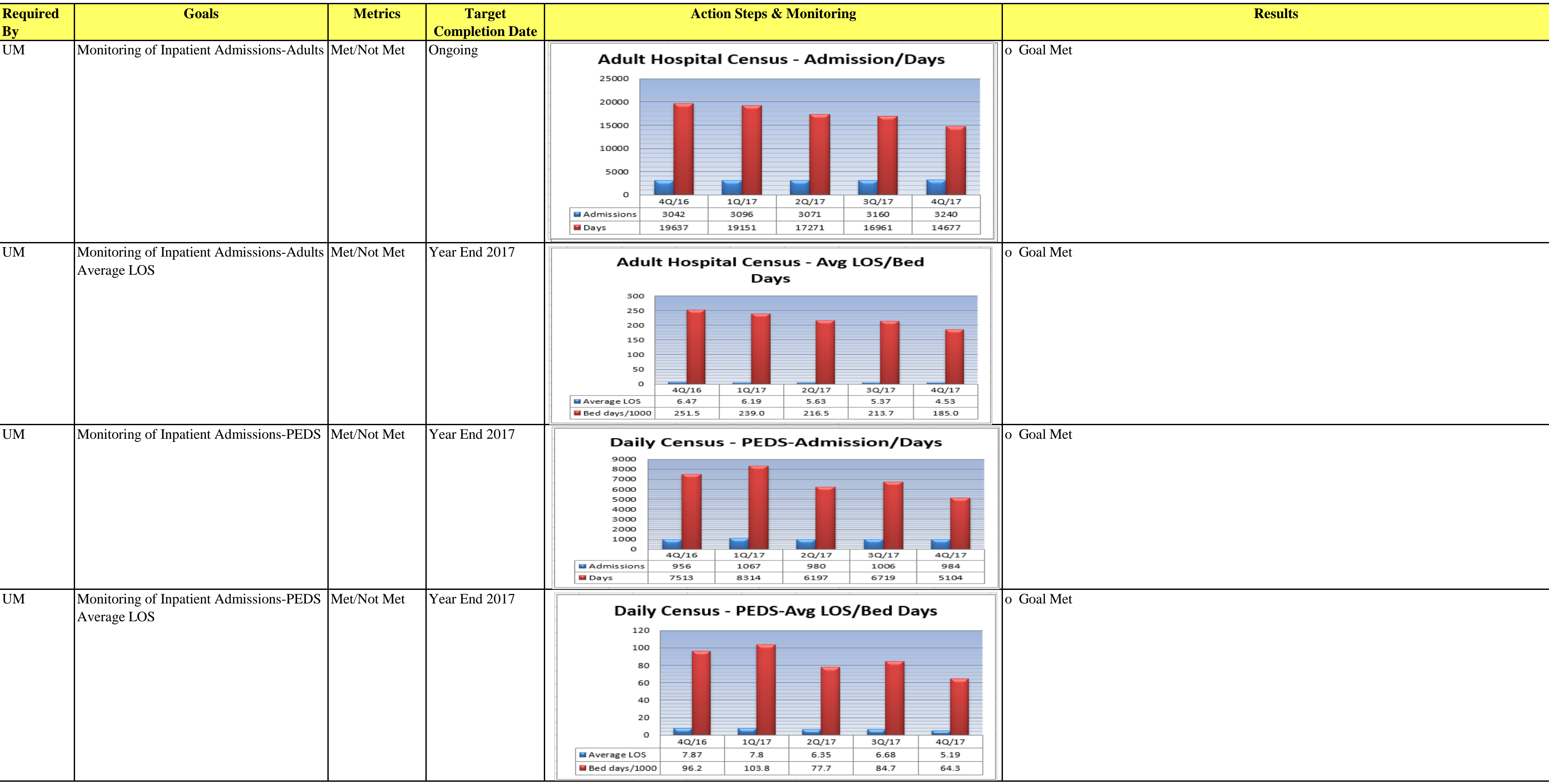
Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Revisions in Criteria and/or Approach to UM Activities	Met/Not Met	Year End 2017	1. Milliman Care Guidelines (MCG), an evidence based web criteria utilized by KHS, are updated annually by MCG. MCG provides KHS UM with training and documentation of changes that have occurred. 2. The Clinical Intake Coordinators and Chief Medical Officer, and Medical Directors utilize MCG, Medi-Cal Guidelines, DHCS and DMHC contract language, and KHS Internal Guidelines to determine if a referral reviewed for medical necessity should be denied, modified and deferred. 3. MCG Inter-Reviewer Reliability is performed bi-annually to promote consistency of the application of guideline utilization by all clinical UM staff 4. Presently there are 60+ internally created medical guidelines referenced by the staff for decision making. 5. Internal guidelines based on Medi-Cal and other evidence based sources were drafted in 2017 by the Administrative Director of Health Services and approved for implementation by the KHS Chief Medical Officer for presentation to the PAC and QI/UM Committees to provide additional support in the decision making process.	o Goal Met
UM	Monitoring UM Decision Turn-Around Times, Volume, and Denial Rates	Met/Not Met	Year End 2017	1. Timeliness of UM Decisions are monitored on a daily basis through activity reports produced the UM Auditor through the Business Intelligence reporting program, Business Objects. 2. The UM Management staff is able to identify the number of referrals each Clinical Intake Coordinator are required to complete within the state mandated five-day turnaround time. 3. A formal timeliness report is provided by the Administrative Director of Health Services on a quarterly basis to the QI/UM Committee.	o Goal Met for monitoring/oversight

<table>
<tr><th>Required By</th><th>Goals</th><th>Metrics</th><th>Target Completion Date</th><th>Action Steps & Monitoring</th><th>Results</th></tr>
<tr><td>UM</td><td>Timeliness of Decision Trending</td><td>Met/Not Met</td><td>Year End 2017</td><td>Quarterly audits are conducted to ensure compliance with regulatory requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.
Urgent: Response back to Provider in 3 business days
Routine: Response back to Provider in 5 business day

UM - Timeliness of Decision
<table>
<tr><th></th><th>4Q/16</th><th>1Q/17</th><th>2Q/17</th><th>3Q/17</th><th>4Q/17</th></tr>
<tr><td>Urgent Compliance %</td><td>98.7%</td><td>98.9%</td><td>99.6%</td><td>99.1%</td><td>93.4%</td></tr>
<tr><td>Routine Compliance %</td><td>98.8%</td><td>99.8%</td><td>99.8%</td><td>99.4%</td><td>94.5%</td></tr>
</table>
- Member Nonfiction: 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</td><td>o Goal Met in Q1 thru Q3->98% .
o Goal not met in Q4. New JIVA Medical management platform implemention impacted notification related to platform functionality and user learning curve
☐ Staff re-education/training/monitoring on JIVA system and compliance ongoing as warranted to maintain compliance.</td></tr>
<tr><td>UM</td><td>Timeliness of Decision Trending</td><td>Met/Not Met</td><td>Year End 2017</td><td>UM - Referral Notification Compliance
<table>
<tr><th></th><th>4Q/16</th><th>1Q/17</th><th>2Q/17</th><th>3Q/17</th><th>4Q/17</th></tr>
<tr><td>Member Notification</td><td>94.7%</td><td>96.0%</td><td>97.0%</td><td>97.0%</td><td>91.0%</td></tr>
<tr><td>Provider Notification</td><td>89.4%</td><td>91.0%</td><td>89.0%</td><td>89.0%</td><td>90.0%</td></tr>
<tr><td>Criteria Included</td><td>96.4%</td><td>89.0%</td><td>89.0%</td><td>89.0%</td><td>80.0%</td></tr>
<tr><td>MD Signature Included</td><td>97.7%</td><td>96.0%</td><td>93.0%</td><td>92.0%</td><td>96.0%</td></tr>
</table></td><td>o Goal Not Met->98%. Referral volume (10,000 per week/ 25,00 per month) and staffing restraints hindered notifications.
O Staff re-education/training/monitoring on JIVA system and compliance ongoing as warranted to maintain compliance.</td></tr>
</table>

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Referral Count	Met/Not Met	Year End 2017	**Total Referrals Received** Total Referrals: 4Q/2016 25270; 1Q/2017 35221; 2Q/2017 30419; 3Q/2017 29910; 4Q/2017 26499	o Goal Met
UM	Denial % - Adults	Met/Not Met	Year End 2017	**Denial % - Adults** Denial %: 4Q/16 7.9%; 1Q/17 6.7%; 2Q/17 9.4%; 3Q/17 8.5%; 4Q/17 2.2%	o Goal Met overall <10% by recommended industry standard (CCS, other carve out services removed)
UM	Approved/Denied Adult Referral Count	Met/Not Met	Year End 2017	**Approved/Denied - Adults** Approvals: 4Q/16 19637; 1Q/17 17868; 2Q/17 15644; 3Q/17 15526; 4Q/17 14332 Denied: 4Q/16 1551; 1Q/17 1283; 2Q/17 1627; 3Q/17 1435; 4Q/17 317	o Goal Met
UM	Denial % - Peds	Met/Not Met	Year End 2017	**Denial % - PEDS** Denial %: 4Q/16 43.8%; 1Q/17 50.6%; 2Q/17 52.6%; 3Q/17 48.9%; 4Q/17 64.4% CCS Denial %: 4Q/16 39.2%; 1Q/17 44.6%; 2Q/17 50.3%; 3Q/17 43.7%; 4Q/17 48.5%	o Goal Met

<table>
<tr><th>Required By</th><th>Goals</th><th>Metrics</th><th>Target Completion Date</th><th>Action Steps & Monitoring</th><th>Results</th></tr>
<tr><td>UM</td><td>Approved/Denied Peds Referral Count</td><td>Met/Not Met</td><td>Year End 2017</td><td>
Approved/Denied - PEDS
<table>
<tr><th></th><th>4Q/16</th><th>1Q/17</th><th>2Q/17</th><th>3Q/17</th><th>4Q/17</th></tr>
<tr><td>Approvals</td><td>4220</td><td>4108</td><td>2939</td><td>3435</td><td>1775</td></tr>
<tr><td>Denied</td><td>3293</td><td>4206</td><td>3258</td><td>3284</td><td>3288</td></tr>
</table>
</td><td>o Goal Met</td></tr>
<tr><td>UM</td><td>Monitoring of Emergency Services --Health Dialog</td><td>Met/Not Met</td><td>Year End 2017</td><td>
1. Health Dialog provides after-hours call and triage services to provide after hours medical triage, eligibility information, and determine appropriate place of service disposition.
2. Health Dialog provides monthly summary reports which are reviewed to monitor trends and reports to the Executive Staff to determine if additional steps are needed to educate the providers and members in efforts to decrease ER usage and increase the member's ability to seek care of their assigned PCP office.
<table>
<tr><th>Member's Initial Intended Treatment Plan</th><th>Number of Symptom Check Calls</th><th>Recommended for Redirection</th><th>Successfully Redirected to Appropriate Care</th></tr>
<tr><td>Call 911</td><td>35</td><td>18</td><td>61.1%</td></tr>
<tr><td>Emergency Room</td><td>859</td><td>461</td><td>55.1%</td></tr>
<tr><td>Urgent Care</td><td>545</td><td>160</td><td>75.0%</td></tr>
<tr><td>Call Provider or Office Visit</td><td>522</td><td>284</td><td>57.0%</td></tr>
<tr><td>Home Treatment</td><td>597</td><td>491</td><td>74.9%</td></tr>
</table>
</td><td>o Goal Met</td></tr>
<tr><td>UM</td><td>Monitoring of Inpatient Admissions</td><td>Met/Not Met</td><td>Ongoing</td><td>
1. Daily census and rounding reports were expanded in the Business Intelligence to identify all reported hospital and other facility admissions.
2. These reports are reviewed daily by the UM Management team to assess inpatient volume and determine length of stay appropriateness as documented by the UM Inpatient team.
3. These reports have been refined to provide financial obligations on a daily basis as well as detailed information on discharges, real time level of care and anticipated bed days.
4. Business decisions can be formulated based on details contained in the reports.
</td><td>o Goal Met</td></tr>
</table>



Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Monitoring of Inpatient Admissions-Adults	Met/Not Met	Ongoing	Adult Hospital Census - Admission/Days	o Goal Met
UM	Monitoring of Inpatient Admissions-Adults Average LOS	Met/Not Met	Year End 2017	Adult Hospital Census - Avg LOS/Bed Days	o Goal Met
UM	Monitoring of Inpatient Admissions-PEDS	Met/Not Met	Year End 2017	Daily Census - PEDS-Admission/Days	o Goal Met
UM	Monitoring of Inpatient Admissions-PEDS Average LOS	Met/Not Met	Year End 2017	Daily Census - PEDS-Avg LOS/Bed Days	o Goal Met

Adult Hospital Census - Admission/Days

	4Q/16	1Q/17	2Q/17	3Q/17	4Q/17
Admissions	3042	3096	3071	3160	3240
Days	19637	19151	17271	16961	14677

Adult Hospital Census - Avg LOS/Bed Days

	4Q/16	1Q/17	2Q/17	3Q/17	4Q/17
Average LOS	6.47	6.19	5.63	5.37	4.53
Bed days/1000	251.5	239.0	216.5	213.7	185.0

Daily Census - PEDS-Admission/Days

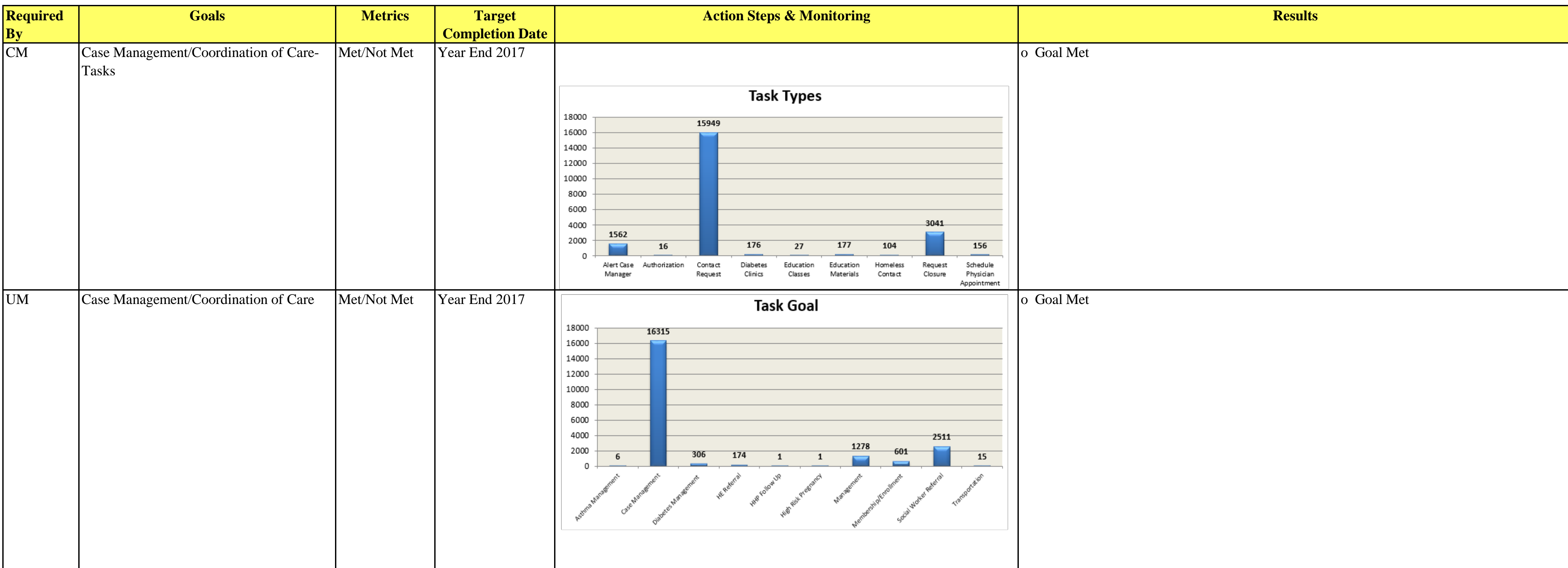
	4Q/16	1Q/17	2Q/17	3Q/17	4Q/17
Admissions	956	1067	980	1006	984
Days	7513	8314	6197	6719	5104

Daily Census - PEDS-Avg LOS/Bed Days

	4Q/16	1Q/17	2Q/17	3Q/17	4Q/17
Average LOS	7.87	7.8	6.35	6.68	5.19
Bed days/1000	96.2	103.8	77.7	84.7	64.3

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Transition of Care Program-30 day Readmissions	Met/Not Met	Year End 2017	Tracking and trending continues as a collaborative effort between UM and QI for 30 readmissions. Care/Case management perform outreach for post discharge members for care coordination and resources allocation. Post Discharge clinics were created to enhance immediate access to either members PCP or specialized clinic to perform medication reconciliation, DME procurement, and promote medical and behavioral condition stabilization.	o Goal Met
UM	Transition of Care Program-Medication Reconciliation with Pharmacist Education and intervention	Met/Not Met	Year End 2017	2017 MTM MEMBER BY MONTH 350 300 250 200 150 100 50 0 January February March April May June July August September October November December Total 251 241 264 194 327 283 251 304 289 316 164 155	o Goal Met
UM	Transition of Care Program-Post Discharge Clinic-Education and intervention	Met/Not Met	Year End 2017	The Transitional Care Model (TCM) is an evidence-based solution to these challenges. The TCM has consistently demonstrated improved quality and cost outcomes for high-risk, cognitively intact and impaired older adults when compared to standard care in: reductions in preventable hospital readmissions for both primary and co-existing health conditions; improvements in health outcomes; enhanced patient experience with care; and a reduction in total health care costs. Collaborative care is the cornerstone of the TCM model. Collaborating partner's staff will form the interdisciplinary clinic that provides biopsychosocial and diagnostic screenings and evaluations, medication management, care management, treatment planning and intervention services, as well as general medical services for the identified population. The main goals of integration include: • Foster cross-system linkages and partnerships; • Quality and value based system of care; • Create robust inpatient discharge coordination and develop cross-system transfer of care protocols; • Expand strategy and education opportunities; • Improve patient experience and quality outcomes; and • Implement model of care that is sustainable and cost effective.	o Goal Met

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
CM	Case Management/Coordination of Care-Member Risk	Met/Not Met	Year End 2017	During the year of 2017, There were a total of 2, 243 Members that were managed by the CM staff department. The majority of the members at 58 % are high risk. 37% were Low Risk and 58% were High Risk. **Member Risk** LOW 24% HIGH 76%	o Goal Met
CM	Case Management/Coordination of Care-Encounter	Met/Not Met	Year End 2017	**Encounter Types** BMH SW ER Connect: 2148 Centric SW: 915 Information Entry: 33593 Letter Contact: 9049 Link to Encounter: 18786 Remote Nurse: 6 Telephone Contact: 28118	o Goal Met



Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
CM	Case Management/Coordination of Care-Tasks	Met/Not Met	Year End 2017		o Goal Met
UM	Case Management/Coordination of Care	Met/Not Met	Year End 2017		o Goal Met

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Monitoring Under-utilization	Met/Not Met	Year End 2017	1. The UM department mails correspondence notifications to both the practitioners and members of any carved-out services that are provided outside of KHS benefit coverage for Coordination of care. 2. The KHS QI Department continues to assist the UM department in monitoring and tracking specialty referrals. 3. Referrals for various educational programs, including smoking cessation, obesity, prenatal care, asthma, high blood pressure and diabetes are forwarded to QI/Health Education to assist UM in promoting the member's health through education and facilitating services with community based programs and other contracted service providers. 4. The Prior Authorization (PA) lists' goal is to facilitate timely access of services to members while eliminating barriers to the provider and enhance the provider experience. 5. PA information is communicated to the providers via a quarterly bulletin, as well as posted on the KHS internet site and provider portal. Various departments review trends to determine which services can be included for inclusion in a future PA listing. 6. Audits are conducted to review for under utilization of services that no longer require prior authorization to identify aberrant provider behavior or performed focused reviews on outlier activity and communicate with providers how to become more aligned with the positive trending.	o Goal Met

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Process for Monitoring Over-utilization	Met/Not Met	Year End 2017	1. Triage provided by Health Dialog for KFHC member's to receive services in the emergency room and urgent care center are reviewed retrospectively for appropriateness of the triage. On a monthly basis, the UM MSW receives a report that identifies members with multiple ER and/or UC usage for review and follow-up. 2. This helps to identify PCP access issues, members needing guidance on medical services, needs for disease management, and inappropriate behavior of members seeking controlled drugs. Finding solution to ER Overutilization is a major focus for KHS and will continue to be included in the business's ongoing Projects plan. 3. Specialty referrals for the members are reviewed concurrently by the RN Case Managers. The medical necessity for the referral is considered as well as determining the appropriateness of locally provided care versus out of area tertiary facility treatment. 4. Durable medical equipment continues to be tracked for duplication and rental items are monitored for the appropriateness of continued use. Careful review of any DME requests and documentation of the dates of the covered services are performed by the UM Clinical Intake Coordinators and UM Nurse's when processing referrals. 5. If it is determined that the member no longer meets the requirements for the previously approved DME equipment, a termination letter is drafted after review of the documentation by the Chief Medical Officer or designee.	o Goal Met

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Process for Monitoring Over-utilization (continued)	Met/Not Met	Year End 2017	6. KHS contracts with a consultant who performs in home evaluations to determine the appropriate equipment and recommend additional functional devices as needed to improve member's mobility and independence. 7. The admission and continued stay of KHS members in an acute or rehabilitation facility are concurrently reviewed for the severity of illness and the intensity of service. Levels of Care are monitored closely to ensure the member receives care in the appropriate setting for promotion of wellbeing and recovery. 8. If ongoing hospitalization is no longer deemed medical necessary, communication between the facility and KHS are initiated to inform of intent to deny for inappropriate setting for care required. 9. Analysis of Primary Care and Specialty physician referral trends are reviewed to determine if requests are appropriate and if aberrancies noted, staff will initiate appropriate through coordination with Provider Relations Department. 10. Providers area contacted directly to begin dialogue and request clarifications to referral requests and provide additional education through criteria and policy and procedure review to increase compliance and reduce unnecessary referral requests and processing.	o Goal Met
UM	CCS Collaboration	Met/Not Met	Year End 2017	Ongoing supportive and collaborative partnership with county CCS. KHS worked with CCS to identify transportation duplication among KHS membership	o Goal Met
UM	Patient Centered Medical Home Program	Met/Not Met	Year End 2017	Three (3) Patient Centered Medical/Behavioral health Home models implemented in 2017 within contracted Provider Network to provide holistic whole person medical, social, and Behavioral health services to members in a new care delivery model.	o Goal Met Heatlh Home Program team in place and expansion beyond current models with expansion of additional HHP with FQHC and other community/individual partners.
UM	Point of Service UM/CM/DM	Met/Not Met	Year End 2017	Product expansion with current Evidence based criteria vendor MCG to include Care Web QI to allow for point of service authorization for providers via portal entry; promote consistent application of guidelines; increase reporting capabilities in the goal of operational efficiency with one system versus multiple internal workflows.	o Goal Met MCG CWQI incorporated into the Medical Management Implementation JIVA UM platform November 2017. MCG Point of Service module will be added in July 2018

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Physician Profiling	Met/Not Met	Year End 2017	Track and trend physician pattern of Utilization to address outliers in the deviation from standard of care in a goal towards value based purchasing alternative payment methodologies. Areas of focus include Inpatient, Oupatient, ER utilization, Pharmacy, Specialty referral and DME/ancillary utilization, etc. that allows for drill down to costs, utilization, and comparison among peers. The tool is used as an eductional component to the contracted provider network to foster appropriate utilziation, reduce costs, that in turn improve health and consistency among the community providers.	o Goal Met 2D profiling will be used by Medical Mgmt and Executives for physician trending and educational opportunities conducted by KHS clinical staff.

KERN FAMILY HEALTH CARE
UTILIZATION MANAGEMENT
2018 PROGRAM DESCRIPTION

Introduction

Kern Health Systems (KHS), d.b.a. Kern Family Health Care (KFHC), is the Local Initiative for the arrangement of medical and behavioral health care for Medi-Cal enrollees in Kern County. The Kern County Board of Supervisors established KHS in 1993. The Board of Supervisors appoints a Board of Directors, who serves as the governing body for KHS.

The purpose of the Utilization Management (UM) Program is to provide members with comprehensive health care and health education, within available resources, and to achieve the optimum level of quality health care in a cost-effective manner. Coordination with various internal departments such as Case Management, Pharmacy, Disease Management, Transitional Care, Health Homes, and Health Education, and partnering with our contracted and community entities assists KHS with the provision of a holistic and patient centered approach to providing health care to our membership. Success of the UM Program begins with positive patient-practitioner relationships and depends, not on the portioning of services, but on the management and delivery of medically necessary, cost-effective health care designed to achieve optimal health status.

In order to ensure efficiency and continuity in this program, policies and procedures have been developed to define major functions and accountabilities. All activities described in the UM Program are conducted with oversight by the Quality Improvement/Utilization Management (QI/UM) Committee.

Most requests for routine, non-emergent medical care (unless otherwise specified) are authorized prospectively by the UM department for Kern Family Health Care (KFHC) members. Prior authorization is required for specific identified services in order for that care to be covered by Kern Health Systems (KHS). Authorization may also be obtained verbally from the KHS Chief Medical Officer or their designee(s) or a UM Nurse or Clinical Intake Coordinator. Exceptions to the requirement for prior authorizations include but are not limited to: Primary Care Provider Services, specific OB/GYN services, Abortion Services, Hospice Care, Transportation, Treatment for Sexually Transmitted Diseases, HIV Services, Family Planning Services, Maternity Care, Vision, Sensitive Services, Emergent/Urgent Care, and other procedures as identified.

The UM department nursing staff function primarily as Clinical Intake Coordinators evaluating utilization of services, while providing ongoing monitoring of patient care for quality and continuity in collaboration with the QI department. Authority to accomplish this is delegated to UM department staff by the KHS Chief Medical Officer, or designee (Medical Director or the Associate Medical Director). Essential to this process and success is strong support and understanding of the UM Program by the KHS Chief Medical Officer, Medical Director(s), and

DRAFT

Board of Directors. The KHS Utilization Management Program Description is a written description of the overall scope and responsibilities of the UM Program. The UM Program clinical team actively monitors, evaluates, and takes effective action to address any needed improvements in the quality, appropriateness, safety and/or outcomes of covered health care services delivered by all contracting providers rendering services to members. This is done through the development and maintenance of an interactive health care system that includes the following elements:

- The development and implementation of a structure for the assessment, measurement and problem resolution of the medical , behavioral health, social, and vision needs of the members;
- To provide the process and structure for monitoring contracted providers referral patterns;
- To provide oversight and direction for processes affecting the delivery of covered health care to members, either directly or indirectly;
- To ensure that members have access to covered health care in accordance with state legal standards;
- To monitor and improve the quality and safety of clinical care for covered services for members.

Purpose

The UM Program is comprised of various systems and processes which interface with other departments and administrative systems in the delivery of quality and value enhanced care. The link between UM and other administrative systems must be collaborative in order to deliver quality care and have effective resource management.

- Provide the coordination of medically necessary services to all KFHC eligible members as defined by contractual obligations under the Department of Health Care Services, Department of Managed Care, and the regulations outlined in our Knox-Keene license in the State of California; and KHS Policy and Procedures;
- Monitor appropriateness of medical care and related services delivered to KFHC members;
- Provide systematic monitoring of the delivery of medical care and related services in a timely, effective, efficient manner consistent with the delivery of high quality and value enhanced care;
- Continually monitor, evaluate and optimize health care resource utilization and medical outcomes;
- Monitor utilization practice patterns of practitioners and provider organizations;
- Identify the need for case management through the referral/authorization review process;
- Foster Transitional Care to enhance the continuum of care;
- Develop programs that address specific needs of the KHS population;
- Educate members, practitioners and provider organizations of objectives for providing high quality and value enhanced managed health care; and

DRAFT

- Identify potential quality of care issues.

Objectives

The KHS UM Program develops, implements, continuously updates, and annually improves a UM program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services.
The UM program includes:

- Qualified clinical staff responsible for the UM program;
- Separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management concerns. The provision for a second opinion from a qualified health professional is provided at no cost to the Member;
- Established criteria for approving, modifying, deferring, delaying, or denying requested services.

The KHS UM Program utilizes nationally recognized evaluation criteria and standards in making decisions to approve, modify, defer, or deny services. The KHS UM Program will also review and present internally generated and other outside criterions the QI/UM Committee for direction in the development and/or adoption of specific criteria to be utilized by the KHS UM staff.

When making medical-necessity decisions, UM staff obtains relevant clinical information to finalize UM decisions. Clinical information is provided to the Chief Medical Officer or their designee to support the decision-making process. Examples of clinical information include the following:

- History and physicals
- Progress notes
- Health Risk Assessments
- Risk Stratification
- Diagnostic results, such as laboratory results, or x-rays
- Specialty Consultation reports
- Pharmacy profiles
- Telehealth communications
- Hospital records
- Physical/Occupational therapy notes
- Behavioral Health/Mental Health
- Telephonic and fax reviews from inpatient facilities

DRAFT

The KHS UM Program verifies that its pre-authorization, concurrent reviews, and retrospective review procedures, meet the following minimum requirements:

- Qualified health care professionals supervise review decisions, and a qualified physician will make the determination to deny any services based on medical necessity;
- Annual competency evaluation (at a minimum) for all clinical staff assigned to medical necessity determinations;
- There are a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed and updated;
- Reasons for decisions are clearly documented and communicated to the provider and member.

The KHS UM Program utilizes several approved sources to determine benefit coverage and to make decisions based on medical necessity. Many decisions are outlined in state regulatory guidelines and law. In addition, clinical guidelines are available as a guide for medical-necessity decisions. Medical judgment regarding the particular patient is also considered when making decisions. Regulations and guidelines include but not limited to:

Regulations

- California Code of Regulations Title 22
- California Code of Regulations Title 28
- California Code of Regulations Title 42
- California Health and Safety Code §§1363.5; 1367.01; 1371.4; 1374.16
- MCG Hearst Health Network
- UpToDate
- Lippincott Care Plan Guidelines
- Medi-Cal /Medicare Guidelines
- KHS Internally generated Medical Criteria
- DHCS/DMHC Guidelines
- All Plan Letters (APL)

Scope

Kern Health Systems Utilization Management Program provides comprehensive health care services. The scope of covered services defined by the UM Program includes:

- Prior authorizations/referral management
- Primary and Specialty Care
- Tertiary referral coordination
- Behavioral/Mental Health management
- Autism Spectrum Disorder Management
- Concurrent review

DRAFT

- Retrospective review
- Continuity of Care
- Recommendations for policy decisions
- Guidance of studies and improvement activities
- Complex/Targeted Case management
- Medication Therapy Management
- Transitional Care
- Community Based Adult Services
- Respite Care (DHCS approved KHS benefit enhancement)
- Pulmonary Rehabilitation(DHCS approved KHS benefit enhancement)
- Maternity Care
- Gender Dysphoria
- Acupuncture
- Chiropractic
- Genetics
- Major Organ Transplants (kidney, cornea)
- Discharge planning/Rehabilitation Services
- Prescription Drug Program in coordination with the Director of Pharmacy
- Out-of-area Case management
- Emergency service management
- Emergent/Non-emergent Medical Transportation
- Ancillary service management
- Home Health
- Cardiac Rehabilitation (new 2018)
- Hospice Services
- Palliative Care
- Diagnostic Services; including laboratory, radiology, and genetic counseling
- Inpatient certification
- Skilled Nursing and Long Term Care
- Denial/appeals management
- Utilization data management
- Social Services (i.e. tracking of appropriate usage of services, mental health service assistance, social services assistance
- After Hours Nurse Triage Services
- Recommendations for any additional needed actions

The UM Program addresses the technical, professional and clinical aspects of patient care, which includes but is not limited to:

- Indication for services (medical necessity)
- Fraud, waste, and abuse monitoring
- Efficient ordering practices

DRAFT

- Appropriate level(s) of hospital care
- Appropriate and efficient use of resources
- Effective coordination and communication
- Reduction in the duplication of services
- Timeliness and access to care
- Valid data management to include the following data sources:
  - Claims and encounter submission
  - Medical Records
  - Medical Utilization data
  - Pharmacy Utilization data
  - Predictive Modeler data
- Identification of potential quality of care issues

Collaboration of Services

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

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

KHS is required to provide beneficiaries with the completion of certain covered services that the beneficiary was receiving from a non-participating provider or from a terminated provider, subject to certain conditions. The beneficiaries must be given the option to continue treatment for up to 12 months.

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

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

DRAFT

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

In addition, KHS UM staff also coordinates Autism Spectrum Disorder (ASD) services with Kern Regional Center (KRC) through a Memorandum of Understanding. This coordination is essential in order to provide members with uninterrupted medical services as they transition between the systems of care.
The UM Nurse and Clinical Intake Coordinator also coordinates Specialty children's services with California Children's Services (CCS) through a Memorandum of Understanding. This coordination is essential in order to provide members with uninterrupted medical services as they transition between the systems of care.

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

Member health education and disease management is an important component in member Case Management. Improvement of the member's health is a collaborative effort between the member, KHS Health Education, UM Nurse and Clinical Intake Coordinator, Community partnerships and the member's practitioner.

Authority and Responsibility

KHS Board of Directors

The Board of Directors for KHS assigns the responsibility to lead, direct, and monitor the activities of the UM and QI Programs to the QI/UM Committee. The QI/UM Committee is responsible for the ongoing development, implementation, and evaluation of the UM and QI Programs. All the activities described in this document are conducted under the oversight of the QI/UM Committee.

<u>Structure</u>

1 Board Chair

DRAFT

1 Rural PCP Representative
1 Urban PCP Representative
1 Safety Net Provider Representative
1 Hospital Representative
1 Pharmacist Representative
2 1st District Community Representative
2 2nd District Community Representative
2 3rd District Community Representative
2 4th District Community Representatives
2 5th District Community Representatives

The Board is directly involved with the UM process in the following ways:

- Approve and support the UM Program direction, evaluate effectiveness and resource allocation. Support takes the form of establishing policies needed to implement the plan;
- Appoint individual and/or departments within the KHS organization to provide oversight of the UM Program;
- Approve policies and procedures needed to maintain the UM Program;
- Receive and review periodic summary reports on quality and safety of clinical care and quality of service, and make decisions regarding corrective actions that require the Board's level of intervention;
- Receive, review, and make final decisions on issues involving provider credentialing and recredentialing recommendations from the Physician Advisory Committee (PAC);
- Receive reports representing actions taken and improvements made by the QI/UMC, at a minimum on a quarterly basis;
- Evaluate and approve the UM Program Description annually;
- Evaluate and approve the UM Program Evaluation annually, providing recommendations as appropriate and track findings.

Monitor the following activities delegated to the KHS Chief Medical Officer or designee:

- Oversight of the UM Program
- Chairperson of the QI/UM Committee
- Chairperson of associated subcommittees
- Supervision of Health Services staff to include UM, QI, Pharmacy, Health Homes, Health Ed, Case Management, and Disease Management;
- Oversight and coordination of Continuity of Care activities for members;
- Proactive incorporation of quality outcomes into operational policies and procedures;
- Oversight of all committee reporting activities so as to link information.

The Board of Directors delegate's responsibility for monitoring the quality of health care delivered to members to the Chief Medical Officer or designee, and the QI/UMC with

DRAFT

administrative processes and direction for the overall UM Program initiated through the Chief Medical Officer.

Chief Medical Officer (CMO) Responsibilities:

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

- Application of the UM Program, by KHS staff and contracting providers;
- Participation in provider quality activities, as necessary;
- Monitoring and oversight of provider QI and UM programs, activities and processes including policies;
- Oversight of KHS delegated credentialing and recredentialing activities;
- Retrospective review of KHS credentialed providers for potential or suspected deficiencies related to quality of care;
- Final authority and oversight of KHS non-delegated credentialing and recredentialing activities;
- Monitoring and oversight of any delegated UM activities;
- Supervision of Health Services staff involved in the UM Program, including: Administrative Director of Health Services, Director of Pharmacy, and other related staff;
- Supervision of all Utilization Management activities performed by the UM Department;
- Monitoring that covered medical care provided meets industry and community standards for acceptable medical care;
- Contributor in the development of medical criteria for necessity determinations;
- Actively participating in the functioning of the plan grievance procedures;
- Resolving grievances related to medical quality of care.

DRAFT

Medical Director and/or Associate Medical Director(s):

The Medical Director and/or Associate Medical Director(s) support the Chief Medical Officer with projects as assigned and serves the role of Chief Medical Officer in the CMO's absence or when the CMO's position is not filled. KHS may have one or more Associate Medical Directors performing the functions of the Medical Director when the Medical Director position is not filled. The Medical Director and or Associate Medical Director provide oversight for the following including:

- Serve as a member of the following committees of the KHS Board of Directors: Physician Advisory Committee; Grievance; Pharmacy & Therapeutics Committee; Quality Improvement and Utilization Management Committees (Serve as Chairperson of these committees as delegated by CMO). Attend committee meetings as scheduled.

- Participates in carrying out the organization's mission, goals, objectives, and continuous quality improvement of KHS;
- Represents KHS in the medical community and in general community public relations;
- Participates in the implementation of the KHS Credentialing Program;
- Identify fraud, waste, and abuse through multi-disciplinary internal staff participation;
- Obtains support of the medical community for QI, UM, DM, HE, and CM programs;
- Directly communicates with primary care physicians and other referring physicians in order to resolve referral issues, research treatment protocols, solicit advice on problem cases, and to assist in development of referral criteria and practice guidelines;
- Supports, communicates, and collaborates with KHS Clinical Intake Coordinators and UM Nurses in order to resolve case management and referral issues;
- Implements the Disease Management and Quality Improvement Program(s).

Program Structure

Committees

Quality Improvement/Utilization Management (QI/UM) Committee

The QI/UM Committee reports to the Board of Directors and retains oversight of the UM Program with direction from the CMO or designee. The QI/UM Committee performs oversight of UM activities conducted by KHS to maintain quality health care and effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services. This committee also develops and enforces the quality improvement process with respect to contracting providers, subcommittees and internal KHS functional areas with oversight by the CMO.

Key Responsibilities

- Assure that practitioner/provider organizations participate in specific QI/UM activities as assigned;
- Oversee the effectiveness of UM activities within KHS (internal and external);
- Review, investigate and make recommendations to the appropriate individual or department regarding utilization issues affecting member care; or, in the case of review of individual practitioners/provider organizations performance, refer such review/investigation to the CMO /Physician Advisory Committee (PAC) Corrective Action Plans (CAP);
- Promote communication of UM activities across KHS and to practitioner/provider organizations;
- Maintain processes to promote confidentiality of the UM Program information as well as avoidance of conflict of interest on the part of practitioner reviewers;
- Identify methods to increase the quality of health care and service for members;

DRAFT

- Design and accomplish UM Program objectives, goals and strategies;
- Recommend policy direction;
- Review and evaluate results of UM activities at least annually and revise as necessary;
- Institute needed actions and ensure follow-up;
- Develop and assign responsibility for achieving goals;
- Monitor clinical safety;
- Ensuring access to quality care;
- Oversee the identification of trends and patterns of care;
- Monitor grievances and appeals for clinical issues;
- Develop and monitor Corrective Action Plan (CAP) performance;
- Report progress in attaining goals to the Board of Directors;
- Ensure incorporation of findings based on member and provider input/issues into KHS policies and procedures;
- Provide oversight for the KHS UM Program;
- Provide oversight for KHS credentialing;
- Assist in the development of clinical practice guidelines.

Structure

1	KHS Chief Medical Officer(Chairperson), or designee
2	Participating Primary Care Physician-Family Practitioner and Pediatrician
2	Participating Specialty Physicians-OB/GYN and ENT
1	Participating Home Health Representative
1	Kern County Public Health Officer or designee
1	Participating FQHC Provider
2	Other Participating Ancillary Representatives
1	Participating Hospital Representative

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

Meeting Schedule

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

DRAFT

Physician Advisory Committee (PAC)

Key Responsibilities

- Serve as advisor to the Board of Directors on health care issues, peer review and provider discipline. Review and comment on Credentialing/Recredentialing Policies and Procedures;
- Review and comment on other issues such as grievances and/or appeals, provider quality issues, and other peer review matters as directed by the KHS Chief Medical Officer or designee or as requested by the Board of Directors;
- Perform assigned functions under the Credentialing policies and procedures, the QI program, the UM program, the complaint/grievance process, and the practitioner/provider organizations appeal process;
- Serve as the committee for clinical quality review of contracting providers;
- Evaluate, assess and make decisions regarding contracting provider issues, grievances and clinical quality of care issues referred by the KHS CMO or designee and develop and recommend actions plans as required;
- Review provider qualifications, including adverse findings and recommend to the Board of Directors approval or denial of participation with initial credentialing and every three years in conjunction with recredentialing. When indicated, the time frame form credentialing/recredentialing may be shortened. Report Board action regarding credentialing/recredentialing to the QI/UMC at least quarterly;
- Review contracting providers referred by the KHS CMO or designee due to grievance and/or complaint trend review, other quality indicators or other information related to contracting provider quality of care or qualifications;
- Review, analyze and recommend any changes to the KHS Credentialing and Recredentialing program policies and procedures on an annual basis or as deemed necessary;
- Monitor any delegated credentialing/recredentialing process, facility review and outcomes for all delegated actions related to providers;
- Review and distribute preventive care guidelines for members, including infants, children, adults, elderly, Seniors and Persons with Disabilities, and perinatal patients;
- Base preventive care and disease management guidelines on scientific evidence or appropriately established authority;
- Develop, review and distribute disease management and behavioral health guidelines for selected diagnosis and treatments administered to members;
- Periodically review and update preventive care and clinical practice guidelines as presented by the CMO or designee;
- Review and assess new medical technologies and new applications of existing technologies for potential addition as covered benefits for members;
- Assess standards of health care as applied to members and providers, assist with development of indicators for studies and review guidelines that are promulgated to contracting providers;

DRAFT

- Develop internally criteria utilized through application of evidence based benchmarks; and
- Assess industry and technology trends with updates to KHS standards as indicated.

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

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

The PAC reviews and comments upon pertinent KHS standards and guidelines with updates as needed. The PAC evaluates improvements in practice patterns of contracting providers and the development of local care standards. Development of educational programs includes input from the PAC. The PAC also reviews and comments on other issues as requested by the Board of Directors.

Structure

1	KHS Chief Medical Officer(Chairperson) or designee
2	General/Family Practitioners
1	General Internist
1	Pediatrician
1	Obstetrician/Gynecologist
1	Non-invasive Specialist
1	Invasive Specialist
1	Practitioner at Large

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

Meeting Schedule
The PAC meets monthly or more frequently if necessary.

Reporting Relationship
- The PAC reports recommendations to the QI/UM Committee quarterly
- The QI/UM Committee reports PAC recommendations to the Board of Directors quarterly through the Chief Medical Officer or their designee.

DRAFT

Pharmacy and Therapeutics Committee (P&T)

Key Responsibilities

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

Membership

1	KHS Chief Medical Officer (Chairperson) or designee
1	KHS Director of Pharmacy (Alternate Chairperson)
1	KHS Board Member
1	Retail/Independent Pharmacist
1	Retail Chain Pharmacist
1	Specialty Practice Pharmacist
1	Pediatrician
1	Internist
1	PCP/General Practice Medical Doctor
1	OB/GYN Practitioner

Meeting Schedule

DRAFT

The P&T meets quarterly with additional meetings as necessary

Reporting Relationship

Reports to the QI/UM Committee quarterly

Public Policy/Community Advisory Committee (PP/CAC)

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

The functions of the PP/CAC are as follows:

- Culturally appropriate service or program design;
- Priorities for health education and outreach program;
- Member satisfaction survey results;
- Findings of health education and cultural and linguistic Group Needs Assessment;
- Plan marketing materials and campaigns;
- Communication of needs for provider network development and assessment;
- Community resources and information;
- Periodically review the KHS grievance processes;
- Report program data related to Case Management and Disease Management
- Review changes in policy or procedure that affects public policy;
- Advise on educational and operational issues affecting members who speak a primary language other than English;
- Advise on cultural and linguistic issues.

The PP/CAC is delegated by the Board of Directors to provide input in the development of public policy activities for KHS. The committee makes recommendations and reports findings to the Board of Directors.

Appointed members include:

1 Ex-officio Non-Voting Member: KHS Director of Marketing and Public Affairs (Chairperson)
5 KHS Subscribers/Enrollees
2 Community Representatives
2 Participating Health Care Practitioner
1 Kern County Health Officer or Representative
1 Director, Kern County Department of Human Services or Representative

The PP/CAC meets at least quarterly with additional meetings as necessary.

DRAFT

Grievance Review Team (GRT)

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

Key Responsibilities

- Ensure that KHS' policies and procedures are applied in a fair and equitable manner;
- Hear submitted grievances in a timely manner and recommend action to resolve the grievance as appropriate within the stipulated time-frame;
- Review and evaluate KHS' practices and procedures that consistently produce dissatisfaction, and recommend, when appropriate, modification to such practices and procedures;
- Participate in the Independent Medical Review process as warranted;
- Provide detailed explanation for decisions to both member and provider;
- Participate in the State Fair Hearing process as warranted to resolve grievances;
- Provide prompt and accurate information to the member detailing the resolution outcome of the grievance.

Structure

1	KHS Chief Medical Officer (Chairperson) or designee
1	KHS Director of Compliance and Regulatory Affairs
1	KHS Director of Provider Relations
1	KHS Chief Operations Officer
1	KHS Grievance Coordinator (Staff)
1	KHS Quality Improvement, Health Education and Disease Management representative(s), or designee(s)
1	KHS Director of Pharmacy
1	KHS Administrative Director of Health Services, or designee
1	KHS Director of Member Services

Meeting Schedule Grievance Review Team meets on a weekly basis or sooner if necessary.

Program Staff Responsibilities

Chief Executive Officer (CEO)

Appointed by the Board of Directors, the CEO has the overall responsibility for KHS management and viability. Responsibilities include:

DRAFT

- Lead KHS mission, vision and direction, organization and operation;
- Developing strategies for each department including the QI Program; Human Resources direction and position appointments;
- Fiscal efficiency;
- Public relations;
- Governmental and Community liaison;
- Contract approval.

The CEO directly supervises the Chief Operating Officer (COO), Chief Financial Officer (CFO), Chief Medical Officer (CMO), Chief Information Officer (CIO), and the Director of Governmental Affairs and Business Development (PMO). The PAC reports to the CEO and contributes information regarding provider issues. The CEO interacts with the Chief Medical Officer regarding ongoing QI/UM Program activities, progress towards goals, and identified health care problems or quality issues requiring corrective action.

Chief Medical Officer (CMO)

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

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

The duties of the position include but not limited to:

- Provide direction for all medical aspects of KHS, preparation, implementation and oversight of the UM Program, medical services management, resolution of medical disputes and grievances;
- Medical oversight on provider selection, provider coordination, and peer review;
- Principal accountabilities include development and implementation of medical policy for utilization and QI functions, reviewing current medical practices so that that medical protocols and medical personnel of KHS follow rules of conduct;
- Assigned members are provided healthcare services and medical attention at all locations, and medical care rendered by providers meets applicable professional standards for acceptable medical care and quality.
- Ensure that medical decisions are rendered by qualified medical personnel;
- Are not influenced by fiscal or administrative management considerations;

DRAFT

- Ensure that the medical care provided meets the current standards for acceptable care;
- Ensure that medical protocols and rules of conduct for practitioner or plan medical personnel are followed;

These standards should equal or exceed the standards for medical practice developed by KHS and approved by the California Department of Health Care Services (DHCS) or the California Department of Managed Health Care (DMHC).

Medical Director and /or Associate Medical Director

- Develop and implements medical policy;
- Resolve grievances related to medical quality of care and service;
- Actively participate in the functioning of KHS' grievance procedures and implementation of the plan Quality Improvement Program;
- Provide direction and oversight to administration of the QI, UM and Credentialing Programs;
- Detect and correct inadequate practitioners/provider organizations performance within responsibility level Supports the CMO with projects as assigned;
- Participates in carrying out the organization's mission, goals, objectives, and continuous quality improvement of KHS
- Is responsible for monitoring and controlling the appropriate utilization of health care services in order to achieve high quality outcomes in the most cost effective manner
- Participates in carrying out the organization's mission, goals, objectives, and continuous quality improvement of KHS
- Is responsible for monitoring and controlling the appropriate utilization of health care services in order to achieve high quality outcomes in the most cost effective manner
- Directly communicates with primary care physicians and other referring physicians in order to resolve referral issues, research treatment protocols, solicit advice on problem cases, and to assist in development of referral criteria and practice guidelines; and
- Supports, communicates, and collaborates with KHS case managers in order to resolve case management and referral issues.

Administrative Director of Health Services
Under administrative direction of the Chief Medical Officer (CMO) this position is responsible for overseeing the activities of the Health Services Department in support of the company's strategic plan; establishing the strategic vision, and the attendant policies and procedures, initiatives, and functions. The Health Services Department includes: Utilization Management, Case Management and Quality Improvement.

Position requires a licensure to practice as a Registered Nurse in the State of California. Qualifications for the Director of Health Services include two years of management level

DRAFT

experience in utilization management in managed care environment AND one year of experience as a utilization review or medical (physical medicine) nurse OR four years of experience as a utilization review or medical (physical medicine) nurse AND two years of supervisory experience; OR any equivalent combination of experience. A Bachelor's degree in Nursing is desirable.

The Administrative Director of Health Services will provide direct clinical support to the UM Nurse and Clinical Intake Coordinators, Health Services Manager, Health Services Program Administrator, Operational Analyst, and the UM Clinical Inpatient and Outpatient Nurse Supervisor(s), ensuring that the appropriate level of member care is being provided through referral processing.

The Administrative Director is responsible for overseeing the development of quality improvement strategies for the enterprise and clinical program development for population-based clinical quality measures. Directs the development of the clinical quality plan and the integration of quality into the overall business process. Responsible for overseeing the Case Management, Utilization Management, and Quality Improvement programs to ensure that all activities are relevant and meeting the needs of the population served.

Evaluates industry best practices, medical research, and other resources to develop clinical programs and tools which facilitate and support quality, cost-effective care. Develops and implements an annual plan detailing the strategies, programs, and tools to be implemented. Assures compliance with QI and UM work plans. When necessary assures compliance with NCQA standards.

Provides oversight to assure accurate and complete quantitative analysis of clinical data and presentation of results of data analysis. Tracks Health Services Program performance and results. Works with both internal and external customers to promote understanding of health services activities and objectives and to prioritize projects according to corporate goals, monitoring of case management activity and accuracy of decision making is reported to the executive team.

Ongoing development and monitoring of activities related to identification and tracking of members needing disease management, case management, behavioral health or autism services, tracking of inpatient members including authorizations of level of care, appropriateness of admissions to non-par facilities and timely transfer to participating facilities are critical to the effectiveness of the UM program.

- Establish, initiate, evaluate, assess, and coordinate processes in the areas of Utilization Management;
- Oversees all activities of department and aids the CMO and appropriate corporate staff in formulating and administering organizational and departmental initiatives;

DRAFT

- Meets regularly with Finance Department to review trends in medical costs and to determine areas of focus;
- Reviews analyses of activities, costs, operations and forecast data to determine departmental progress towards stated goals and objectives;
- Administer and ensure compliance with the National Committee on Quality Assurance (NCQA) standards as determined for accreditation of the health plan;
- Participate in, attend and plan/coordinate staff, departmental, committee, sub-committee, community, State and other activities, meetings and seminars;
- Participate in provider education and contracting as necessary;
- Leads and participates in cross functional teams which design and implement new case management programs and quality interventions to improve health outcomes;
- Leads teams of clinicians charged with promoting effective use of resources.
- Ensures adherence to all contract and regulatory requirements;
- Develops short and long term objectives and monitors processes and procedures to ensure consistency and compliance;
- Manages budget and special projects; and
- Develops and implements process and program redesigns.

<u>Deputy Director of Health Services</u>
Under the direction of the KHS Administrative Director of Health Services, the Deputy Director of Health Services will oversee and participate in activities related to Utilization Management (UM) for the organization and membership by monitoring, assessing and improving performance in ambulatory and inpatient health care delivery or health care related services. The Deputy Director will assist in the implementation of the KHS Utilization Management Program Plan and Evaluation and communicate with contract providers regarding required studies and participation. Related duties will include ongoing data collection, medical record reviews, report writing, and collaboration and coordination with other KHS departments, as well as outside agencies.

This position is responsible for collaborative oversight of the Utilization Management functions for KHS. The Deputy Director will also be responsible for overseeing the production, analysis, and dissemination of contractually mandated reports. This position will assist in ensuring compliance with Medi-Cal contractual stipulations for Utilization programs. In collaboration with the Administrative Director of Health Services, will make an effective contribution to KHS's business planning and fiscal processes and will remain clear about departmental objectives and resource requirements. In addition, this position will reinforce a shared sense of purpose throughout the organization and serve as a mentoring role that strongly encourages the growth of team members. Ensuring professional development goals are incorporated into team members' annual performance objectives, and regular reviews progress towards attaining them is paramount to this role.

- Maintains delegated responsibility in coordination with the Administrative Director of Health Services for activities within the Utilization and Case Management departments;

DRAFT

- Responsible for the collaborative oversight of the Disease Management and Health Education Program(s) with the Manager of Health Education and Disease Management;
- Shares in direction and supervision for ongoing and new projects for the UM program with the Administrative Director of Health Services;
- Oversees quality of care investigations and reporting;
- Works closely with the Case Management Supervisor to facilitate needs for members identified as High Risk or requiring coordination of services;
- Assist the UM clinical staff in the review of claims for the accuracy and appropriateness of billed charges;
- Ensure coordination of medically necessary services within the plan and with community;
- Coordinates UM activities and data collection between KHS departments and KHS contracted providers;
- Assists with interviews, selects, trains, develops and evaluates subordinate staff; provides input to HR regarding disciplinary issues, as necessary;
- Serves as resource to the Quality Improvement and Utilization Management Committee, the Physician Advisory Committee and other committees, as appropriate;
- Works in a coordinated effort with the UM Health Services Manager and Program Administrator to ensure the smooth and efficient operations of the outpatient processes;
- Serves as a clinical liaison with contracted facilities and providers and participates in Joint Operations meetings to improve patient care and ensure access standards; Coordinates and conducts in-depth chart analysis, data collection, and report preparation;
- Summarizes information collected for identification of patterns, trends, and individual cases requiring intensive review;
- In coordination with the UM Auditor, perform periodic audits of the Clinical Intake Coordinators and Social Workers of outpatient clinical decisions for appropriateness and accuracy of documentation and summarize and report the results of the audit; and
- Implements and facilitate internal audit studies and work groups for continuous improvement within the organization.

DRAFT

Health Services Manager

The Health Services Manager reports to the Administrative Director of Health Services and is responsible for the daily management, evaluation and operations of the health services administrative processes, provide supervisory support to Utilization Management (UM) staff and assist with defining and creation of reports in collaboration with the UM Senior Auditor/Analyst, UM Analyst/Trainer, and Health Services Program Administrator.
This position will work with the administrative support staff to promote the delivery of quality health care to Kern Health System (KHS) members through comprehensive case management, compliance with KHS policies and procedures, and maintenance of a positive and safe work environment leading to maximum departmental efficiency, accuracy, and quality.

- Supervise the functions and activities of the clerical support staff;
- Monitors and reports production and quality of work by clinical and clerical staff;

- Works with clerical staff to achieve production, timeliness, and quality of work;
- Participate with Inter-departmental process improvement teams and planned quality management;
- Assist with development and formalization of departmental budget;
- Assist with development and updating of UM criteria, guidelines, and policies;
- Responsible for payroll activities, including approval of time cards, for all clerical hourly staff in the UM;
- Monitor UM processes for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes;
- Train staff, as appropriate, regarding use of the MHC systems as it relates to the UM and Pharmacy processes;
- Generates reports for CMO and Administrative Director of Health Services to support business decisions;
- Research and analyze qualitative and quantitative data, prepare statistical reports, and submit final report to the state contract manager in conjunction with KHS departmental Analyst(s) and Health Services Program Administrator;
- Works in collaboration with the Health Services Program Administrator to develop and facilitate new program processes and guidelines under the supervision of the Administrative Director of Health Services.

<u>UM Outpatient Clinical Supervisor</u>

The UM Outpatient Clinical Supervisor reports to the Administrative Director of Health Services and is responsible for supervising the functions and activities for clinical level positions associated with Outpatient Medical, Behavioral, Mental Health, and Social Services within the UM Department. The UM Outpatient Clinical Supervisor will work in a coordinated effort with the Health Services Manager to ensure smooth, efficient and productive operations within the UM Department, as directed by the Administrative Director of Health Services. This position will work closely with the KHS Chief Medical Officer and Medical Director(s) in the smooth and efficient operation of the referral and inpatient clinical decision making process.

- Educate and develop UM nursing staff regarding organizational policies, procedures and UM decision making skills;
- Monitor the UM process for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes;
- Participation on inter-departmental process improvement teams and KHS quality management;
- Monitor UM nursing staff referral and documentation for accuracy and appropriateness;
- Coordinate training of staff within the Interrater Reliability Review Tool to all clinical staff, including CMO and Medical Directors to facilitate consistent decisions based on evidence based guidelines;

DRAFT

- Supervise the appropriate case management in compliance with UM guidelines and KHS Policy and Procedures;
- Monitors and reports production and quality of work by outpatient clinical staff;
- Works with staff to achieve production, timeliness, accuracy, and quality of work;
- Summarize and prepare necessary production reports for management;
- Perform periodically scheduled audits of outpatient clinical decisions for appropriateness and accuracy of documentation;
- Serves as a clinical liaison with contracted facilities and providers and participates in Joint Operations meetings to improve patient care and ensure access standards;
- Ensure coordination of medically necessary services within the plan and with community;
- Remain current with Department of Health Care Services and Department of Managed Care policy implementation or revisions;
- Act as clinical liaison with Member Services, Claims, MIS, and Provider Relations on referral data entry functions.

UM Inpatient Clinical Supervisor

The UM Inpatient Clinical Supervisor reports to the Administrative Director of Health Services and is responsible for supervising the functions and activities for clinical level positions associated with Inpatient Medical, Mental, Behavioral, and Social Services within the UM Department. The UM Inpatient Clinical Supervisor will work in a coordinated effort with the Health Services Manager to ensure smooth, efficient and productive operations within the UM Department, as directed by the Administrative Director of Health Services. This position will work closely with the KHS Chief Medical Officer and Medical Director(s) in the smooth and efficient operation of the referral and inpatient clinical decision making process.

- Educate and develop UM nursing staff regarding organizational policies, procedures and UM decision making skills;
- Monitor the UM process for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes;
- Participation on inter-departmental process improvement teams and KHS quality management;
- Monitor UM nursing staff referral and documentation for accuracy and appropriateness;
- Coordinate training of staff within the Interrater Reliability Review Tool to all clinical staff, including CMO and Medical Directors to facilitate consistent decisions based on evidence based guidelines;
- Supervise the appropriate case management in compliance with UM guidelines and KHS Policy and Procedures;
- Monitors and reports production and quality of work by inpatient clinical staff;
- Reviews decisions regarding hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership as related to coordination of services upon discharge;

DRAFT

- Assists with coordinating discharge planning activities with facility discharge planners;
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan e.g. CCS, Mental Health, Long Term Care, State Waiver Programs.
- Works closely with the Transitional Care team to facilitate needs for members identified as High Risk or requiring coordination of services;
- Assist the UM clinical staff in the review of claims for the accuracy and appropriateness of billed charges;
- In coordination with the UM Clinical Auditor, perform periodic audits of the UM Nurse RN and Social Workers of inpatient clinical decisions for appropriateness and accuracy of documentation and summarize and report the results of the audit;
- Works with staff to achieve production, timeliness, accuracy, and quality of work;
- Summarize and prepare necessary production reports for management;
- Perform periodically scheduled audits of inpatient clinical decisions for appropriateness and accuracy of documentation;
- Serves as a clinical liaison with contracted facilities and providers and participates in Joint Operations meetings to improve patient care and ensure access standards;
- Ensure coordination of medically necessary services within the plan and with community;
- Remain current with Department of Health Care Services and Department of Managed Care policy implementation or revisions;
- Act as clinical liaison with Member Services, Claims, MIS, and Provider Relations on referral data entry functions.

<u>Health Services Program Administrator</u>

The Program Administrator is responsible for oversight, coordination, planning, management, execution, and finalization of Business related programs that require Business resources. The Program Administrator will be required to conduct program analysis, comprehend technical requirements, define plans for execution, coordinate technical resources assigned to tasks or programs, create program tracking reports, and accurately report to all levels of management on a program(s) status. This position requires the ability to maintain an interdependent relationship with providers, staff and members by providing administrative support on sponsored projects.

- Consult with medical, business, and community groups to discuss service problems, respond to community needs, coordinate activities and plans, and promote programs;
- In a liaison role, assist in the design, review and testing of system generated processes used within KHS;

DRAFT

- Works closely with the MIS Department as needed to ensure proper processing of internal data processing technology, government regulations, health insurance changes and financing options;
- Interviews department personnel, researches existing procedures and requirements in sufficient detail to yield statistics concerning volumes, timing, personnel requirements and representative transactions; analyzes and documents study findings; coordinate the system design between all users and data processing; designates controls and audit trails; writes program specifications; conducts user education
- Review and analyze facility activities and data to aid planning and cash and risk management and to improve service utilization;
- Act as a program management resource for Health Services on projects as assigned and may have to establish objectives and evaluative or operational criteria;
- Evaluate KHS Health Services preparedness recommend/suggest change in integrated health care delivery systems, such as work restructuring, technological innovations, and shifts in the focus of care;
- Participate in the preparation of business plans, analyses, financial projections, and programmatic and operational reports; work with internal teams to develop and implement strategic initiatives for any issues that may require root cause analysis evaluation(s);
- Demonstrate an analytical aptitude to learn and understand business segment processes, including understanding issues of data integrity, security and confidentiality according to the Health Insurance Portability and Accountability Act (HIPAA).

Operational Analyst

This position is responsible for providing an advanced role in the analysis of health care information as it relates to multiple disciplines for functional departments within the organization. The Operational Analyst (OA) position is a resource with an ability in providing experience within integrated reporting, data analytics, process improvement, departmental metrics, and data integrity based on the collection, association, review, and the interpretation of data and operational processes. The OA will provide the skills necessary for report writing and presentation, and performs detailed business analytics that contribute to and support the company's dashboard reporting efforts.

The Operational Analyst is responsible for eliciting and projecting the actual needs of stakeholders, not simply their expressed desires, through an experienced methodical analytic process and seasoned ability to expose data reporting requirements. The position plays a central and critical role in aligning the needs of multiple business units with capabilities delivered by Information Technology and other operational departments, and will lead or facilitate complex analytical discussions between all groups.

DRAFT

Some of the key fundamental goals and objectives of the incumbent include but are not limited to:

- Providing professional skills to mentor and assist team members in the most complicated analytics and report writing;
- Perform complex analytics in support of the overall achievement of strategic goals set out by the Board of Directors and Chief Executive Officer;
- Identify and address operational issues as to why a certain behavior or outcomes are exhibited in a department's data metrics;
- Function as the Departmental Subject Matter Expert (SME) for project requirement definition and communication;
- Ability to analyze and answer difficult operational questions under the direction of the Chief Medical Officer to provide validity as to why a certain measured artifact exists in data and brings meaningful context with a clear presentation to all levels of management.

UM Nurse and Clinical Intake Coordinators (RN /LVN)

Under the direction of the Kern Health Systems (KHS) Chief Medical Officer or designee and Administrative Director of Health Services, the UM Nurse and Clinical Intake Coordinators will promote coordination and continuity of care and quality management in both the inpatient and ambulatory care settings by the review of referrals and authorization of payment for specialty care and ancillary services. The review will evaluate the appropriateness of care using established criteria and Plan benefit guidelines. Review will be conducted on a prospective, concurrent, and retrospective basis. The UM Nurse and Clinical Intake Coordinators manages the required caseload on a monthly basis.

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

DRAFT

UM Clinical Auditor/Trainer (RN)

- Train other UM clinical licensed staff as appropriate regarding use of the all platforms and core adjudication system as it relates to the UM process;
- Develop and implement staff training for new and existing employees along with internal findings.
- Responsible for written and verbal communication with contract providers and internal KHS staff to promote timely coordination of care and dissemination of KHS policies and procedures.
- Assist the UM clinical staff in the review of claims and disputes for the accuracy and appropriateness of billed charges;
- In coordination with the UM Senior Auditor/Analyst, perform spot audits of performance of UM Clinical Intake Coordinators and Social Workers and summarize and report the results of the audit to UM Management for process improvement;
- Perform periodic spot audits of inpatient and outpatient clinical decisions for appropriateness and accuracy of documentation; Assists in data collection and compilation, of various committee and quarterly reports; and
- Summarize and prepare necessary production reports for management.

Claims and Disputes Review Nurse (RN)

Under the direction of the Administrative Director of Health Services and in coordination with the Kern Health Systems (KHS) Chief Medical Officer or designee, the Medical Claims Review RN will be responsible for retroactive review of medical service claims and disputes for payment and medical necessity following accurate contract and non-contract guidelines for both Inpatient and Outpatient services. The review will evaluate the appropriateness of care using established criteria and Plan benefit guidelines.

- Reports, track and documents all claims and disputes review activity in appropriate programs such as QNXT, as well as specially developed internal logs for tracking and trending purposes;
- Perform retro review and approval of specialty and ancillary services referrals using established criteria for purposes of payment;
- Perform retro review and approval of hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership;
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan e.g. CCS, Long Term Care, State Waiver Programs.

UM Social Worker (MSW)/Licensed Clinical Social Worker (LCSW)

DRAFT

The Master of Social Worker or Licensed Clinical Social Worker primary duties are to identify and assist members that are displaying a complex variety of social and or emotional needs and usage of services reflective of abuse, lack of compliance to medical or pharmaceutical instructions, or self-destructive habits. The MSW or LSCW coordinates with these members and the member's PCP in an effort to provide better medical management and to track and gauge the effectiveness of that effort.

- ♦ Responsible for the promotion of coordination, continuity of care and quality improvement in both the inpatient and ambulatory care settings;
- ♦ Assists the members with psychosocial and discharge planning needs as well as community resources;
- ♦ Performs reviews available reports for frequent usages of services and inappropriate usage of services by members;
- ♦ Identifies environmental impediments to client or patient progress through both personal or telephonic interviews and review of medical records;
- ♦ Investigates suspected child/elder abuse or neglect cases and notify authorized protective agencies when necessary.
- ♦ Refers member to community resources to assist in recovery from mental or physical illness and to provide access to services such as financial assistance, legal aid, housing, or education.
- ♦ Advocates for members to resolve crises and demonstrate proficiency in de-escalation and interventional techniques
- ♦ Provides assistance and education to members as appropriate and in coordination with disease management, works to improve member participation in regular testing and screening along with follow-up visits to their PCP;
- ♦ Works collaboratively with the Care Management team to assist with identified social issues;
- ♦ Provide guidance and recommendations for the Behavioral and Mental Health Benefits, including Autism Spectrum Disorders.

UM Analyst/Trainer

The purpose of this position is to provide support to the UM Management team for report generation, data collection for providing to the UM Clinical Auditor for review. Based on feedback from the UM Auditor, management and clinical staff, assist in training criteria for staff improvement along with providing one-on-one training to improve staff efficiencies.

- ♦ Performs utilization management activities related to data collection, data review and report preparation per KHS Utilization Management Program;
- ♦ Assists in the reporting of DHCS and DMHC required reports and Utilization Management's quality studies in order to meet State contractual requirements.
- ♦ Develop and implement staff training for new and existing employees along with internal findings as it relates to the duties of Utilization Management.

UM Senior Auditor/Analyst

DRAFT

This position provides the vital link between inpatient and outpatient as it relates to case managing members moving from hospital to home care. This position will ensure that processes are in place and followed in support of all members seeking care. This is a proactive audit of UM processes as they are in motion to catch and prevent errors. This position will link the social worker, case managers and medical directors in direct support of members under case management.

- Performs audit of staff referral processing as it relates to compliance, accuracy and performance levels;
- Reviews available reports and data to analyze the accuracy of staff performance as it relates to timeliness of referral processing, accuracy of data entry and appropriateness of decisions;
- Prepares State mandated report requirements as scheduled by the DHCS for management review and approvals;
- Reviews post-activity audit findings to UM Management to insure compliance and to review where further training opportunity exist.

UM Non-Clinical Intake Coordinators (NCIC)

The Non-Clinical Intake Coordinators support the Clinical Intake Coordinator staff in the processing of Health Plan referrals for medical services, behavioral health, mental health, palliative, durable medical equipment, and specialty care. This position will provide the UM Department with administrative support in the implementation of the authorization process to ensure accuracy of service determinations, limitations of Health Plan coverage, and timeliness in the communication and decision-making process. This position will play a key role as provider and member liaison to the KHS UM process.

- Support licensed UM staff in the processing of KHS referrals for specialty care and services;
- Provide technical support in the form of call screening, authorization and precertification data entry, documentation, and member and practitioner liaison to the KHS UM process;
- Act as liaison to KHS members, community providers, and employees to the UM clinical staff;
- Assigns diagnostic and procedural codes using ICD-10, and CPT coding classification system for service requests. Requests input from the Clinical Intake Staff when needing direction or clinical expertise; Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan (e.g. CCS, Long Term Care, and State Waiver Programs);
- Perform referral screening for Prior Authorization, requested procedure criteria and preparatory review for Nurse review and validation;
- Support licensed staff in review, validation and initial data entry of referrals and inpatient processing; and
- Provide clerical support in data entry, letter generation and closeout of Referral and Inpatient processes.

DRAFT

- Provides clerical support to the UM Staff in the form of faxing, filing, mail processing, referral retrieving, and telephone screening in addition to staff assignment of incoming referral authorization requests from providers via the fax or electronic online authorization platform for review via the electronic workflow process.

UM Case Management Manager

Responsible for oversight of Complex Case management (CCM) activities specific to the Seniors and Persons with Disabilities (SPDs) and High Risk Medi-Cal populations.

- Maintains overall responsibility for staff coverage and assignments related to case management activities;
- Provides direction and acts as resource to Case Management staff in terms of contract and benefit clarifications;
- Ensures all programs are compliant with state and federal requirements and works to implement modifications as necessary;
- Establish and meet appropriate benchmarks for department performance;
- Responsible for achieving KHS department initiative for medical cost management;
- Works closely with the leadership of KHS to assure communication and operational integration within the Plan;
- Key clinical and operational liaison for Health Homes, Transitional Care Clinics, and Emergency Room Avoidance programs, and others as defined;
- Responsible for data reporting and operational metrics;
- Collaborates with internal department managers and directors in the planning, development and coordination of department specific and cross - functional initiatives as needed;
- Collaborates with key external provider partners in the planning, development and coordination of initiatives as needed;
- Participates as a member of the KHS management team;
- Key clinical and operational liaison for any subcontracted vendor services related to case management activities;
- Assist with the effective implementation of new programs, i.e. specialty clinics, homeless collaborative, and health home member engagement and reporting; and
- Keeps KHS Finance Department continually informed of trends, high cost cases and possible reinsurance cases.

UM Case Manager (RN)

The UM Case Manager, RN is responsible for providing complex case management (CCM) Complex case management within KHS as identified through predictive modeling tool and ad hoc review to provide coordination of care and services for members who need help navigating the healthcare system to facilitate the appropriate delivery of care and services. These services are provided utilizing available resources across a continuum of care and in collaboration with members, caregivers, medical home providers, and ancillary health care providers. Assessments,

DRAFT

including care plan creation and educational support to both the member and the provider network are critical to ensuring the continuum of care associated with all aspects of benefit coverage. Identification of homelessness and the provision of resources to improve health outcomes are a major focus.

UM Case Management Assistant

The UM Case Management Assistant supports the clinical Case Management staff in all activities related to case management and care coordination within the department. The Case Management Assistant will help members navigate the healthcare system and obtain the best care in the most appropriate setting. Appointment reminder calls, pharmaceutical utilization review, and transportation coordination are critical to member's access to medically necessary services.

Director of Pharmacy

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

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

- Participates and serves as the Chairperson on the Pharmacy & Therapeutics Committee;
- Offers direction for the Committee for continued development of the Formulary;
- Assists providers and members with issues concerning pharmaceuticals;
- Review of Treatment Authorization Request (TAR) for approval or denial;
- Encodes TAR information in Pharmacy Benefit Manager desktop system;
- Develops and maintains printed Formulary for providers;
- Contributes information on Formulary for provider newsletters;
- Accountability for maintaining drug expenditure within an established pharmacy budget;
- Creation of clinically efficacious and cost-effective management programs;
- Development, implementation, and monitoring of clinical strategies to improve quality of care for members as well as provide clinical consultative services to contracting providers and KHS staff as necessary to support clinical programs;
- Oversight of clinical programs with supervision of the Pharmaceutical Program prior authorization process enabling open lines of communication with pharmacy providers on issues related to the KHS Formulary, pharmacy policies and procedures;

DRAFT

- Oversight and management of all clinically related activities with the KHS Pharmacy benefits staff.

Pharmacist

This position is responsible for executing the adherence of the Formulary and associated activities regarding pharmaceuticals for a Knox-Keene licensed health maintenance organization (HMO). Development and maintenance of protocols for disease state management that involves pharmaceuticals while serving as a liaison with pharmaceutical vendor representatives and other vendor representatives regarding pharmaceutical issues is critical to ensure appropriate medication decision making.

Pharmacy Technician

Support the KHS Director of Pharmacy in pharmacy activities related to the review, authorization and TAR preparation. These activities are under the direction of the Director of Pharmacy The Pharmacy Technician assists the Director of Pharmacy and, as necessary, communicates follow-up to members, perform data entry, record keeping, data collection, filing, chart audits, collaboration with other departments at KHS and interaction with regulatory and contracted agencies. The Pharmacy Technician has a current CA Technician license or Certified Pharmacy Technician certificate with at least three years of pharmacy technician experience.

Pharmacy Senior Support Clerk

Assists in the coordination of Pharmacy activities related to data collection, data review, data entry, and report preparation.

UM Department Orientation/Onboarding

Upon completion of the company orientation provided by Human Resources, all new employees assigned to UM are greeted by the Health Services Manager or designee who then provides initial department orientation. For clerical level staff, the UM Analyst/ Trainer will begin the training process dependent on the role the employee is moving into. For clinical staff (nurses) the UM Clinical Auditor/Trainer works collaboratively with the Outpatient and Inpatient Clinical Supervisor(s) to complete the orientation process which include introductions to policy and procedures, guidelines and information pertaining to the role of Clinical Intake Coordinator or UM Nurse. Initial training on referral or inpatient processing is cooperative and slowly migrated to allow the new employee autonomy into their role based on their level of understanding and competence demonstrated for the process.

Ongoing Training

KHS provides and encourages ongoing staff training. Areas of opportunity includes: seminars, conferences, workshops, training by KHS Health Education department, and specialty specific

DRAFT

training by contracted practitioners and provider organizations. The role of UM Analyst /Trainer and UM Clinical Auditor/Trainer receives direction on the training needs of specific staff members from the Health Services Management leaders where areas of improvement regarding error rates indicate the need for additional training of staff member(s).

KHS UM Management staff evaluates competency of the clinical decision making staff via the use of the MCG IRR training module for Medical Directors and Clinical Intake Coordinators and UM Nurse staff. The UM Clinical Supervisor(s) selects specific topics of interest to push out to the various Clinical Intake Coordinators and UM Nurse staff for completion. The IRR training module records the completion for each user, along with the test results. Successful completion is required as a fulfillment of the clinical staff outlined job duties bi-annually.

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

Components of the UM Program

The referral and authorization process conforms to the requirements outlined in the following statutory, regulatory, and contractual sources:

- Code of Federal Regulations Title 42 §§431.211; 431.213; and 431.214
- California Health and Safety Code §§1363.5; 1367.01; 1371.4; 1374.16
- California Code of Regulations Title 28 §1300.70(b) and (c)
- California Code of Regulations Title 22 §§51014.1; 51014.2; and 53894
- 2018 DHCS Contract Exhibit
- DHCS MMCD Letters
- DHCA APL
- Knox Keene License
- CMS Federal Regulations

DRAFT

Pre-authorization

With the exception of specific OB/GYN, Abortion Services, treatment for Sexually Transmitted Disease, HIV services, Sensitive services, Family Planning Services, Maternity Care, Transportation, Vision, Emergent/Urgent care, and Mental Health, PCP services from a KHS contract PCP, and services listed outside of the Prior Authorization List, most non-urgent specialty care must be pre-authorized by KHS in accordance with KHS referral policy and procedures. There are excluded specialties that require prior authorization to ensure timely access, completion of conservative treatment regimens, and utilization data for staffing model

decisions. Requests for services are submitted either by fax or electronic online submission to KHS for review and processing.

For those services requiring pre-authorization, only KHS UM Clinical Staff and/or KHS Chief Medical Officer or designee(s), including the Physician Advisory Panel staff, may give authorization for payment by KHS. Denials, delays/extended delay, modifications, and terminations are performed in accordance with the Knox Keene license and DHCS contract. KHS utilized both internal MD staff as well as contracted vendor(s), DME Consulting and AMR, for medical necessity reviews for additional guidance and evidence based scholarly references to ensure appropriate medical decision making.

Independent Medical Review

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

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

Referral Management

Referral management is designed to determine medical necessity utilizing established criteria based on an assessment of the member's clinical condition, diagnosis and requested treatment plan. Each case is evaluated individually and sound medical criteria applied as appropriate. Contract providers are obligated to utilize health care services for members provided by KHS network providers, and/or providers approved through the Utilization Management Letter of Agreement process, unless medical necessity or emergency dictates otherwise. KHS utilizes a member centric platform, JIVA system by Zeomega, to house all clinical information for each

DRAFT

member. The goal is to have all health services departments implemented on the platform before end of 2018.

Concurrent Review

Concurrent review is the process of continual reassessment of the medical necessity and appropriateness of acute inpatient care during a hospital admission in order to justify the continued level of care. The concurrent review process is conducted by California licensed Registered Nurses by review of the member's medial record, reviewing the hospital's case management notes, dialoguing with the attending physician and other members of the health care team, and speaking with the patient and/or family or significant other, as needed. Various hospitalist contracted providers support medical oversight at the local inpatient facilities. Through the hospitalist program, the UM Nurse can authorize referral requests on behalf of KHS for member discharge planning during non-business hours. Each referral authorization is faxed to KHS and processed by internal UM staff the next business day. All other hospitals not listed above are case managed directly by KHS UM Nurses.

Additionally, KHS Facility Based UM Nurses perform concurrent inpatient review for members in both acute and post acute local and out of area facilities. The purpose of the services was to provide real time record review and promote early discharge planning as well as assist with decreasing length of stay and facilitate services requested during the hospital admission. Members are also triaged in the ER to assist in decreasing unnecessary admissions through prompt recognition of services needed prior to receiving a retro notification from the hospital regarding an admission.

Retrospective Review

For those services requiring prior authorization, retrospective review for payment of claims is initiated when no prior authorization was obtained by the practitioner or provider organization. Retrospective review is also initiated for services performed by a non-contracted provider. Members, practitioners, and provider organizations are notified by mail/online of the UM/ claims decision.

Discharge Planning

UM Nurse staff and/or the UM Social Worker will assess member's post hospital continuing care needs and will collaborate with the provider organization's discharge planning staff to make arrangements for placement, DME, Home Health, specialist follow-up visits, and any other services pertinent to the member's recovery. Provision and coordination for immediate post discharge care through Respite, Acute/Pulmonary/Cardiac Rehabilitation, and Post Discharge Clinics are designed to address potentially avoidable readmission, recidivism, and improve health through member empowerment and early intervention.

DRAFT

Case Management

Case Management (CM) in the UM department is a diverse system of care coordination. Members with catastrophic illnesses are case managed by the UM Case Managers. This coordination of the member's care enables the case manager to assess individual need, identify and plan resources, monitor, track, and evaluate the care being provided. Case management for the member may be short term or ongoing based on their individual needs. CM coordinates all medically necessary services with the Care Management staff within QI to ensure that all appropriate services are reviewed and any identified barriers to care are removed.

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

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

- Promotion and support of the Medical Home as the source of the member's primary healthcare and source of specialty referrals, and enhancing this with the necessary social, care management and medical support to facilitate comprehensive patient-centered planning
- Identification and elimination of potential barriers to seeking and receiving appropriate care within their designated medical home (e.g., housing, transportation, child care, nutrition, mental and behavioral health needs, identification of culturally competent providers and appropriate access, discharge and transitional care planning, health education, etc.)

  Potential assessment and education modules may include:

  1. Social needs
  2. Medical and/or behavioral health home
  3. Appointment attendance
  4. Urgent symptom management
  5. Medication and treatment adherence

DRAFT

6. Behavioral risk
7. Condition-specific self-management

As a result of this assessment, the Case Manager will:

- Contact the Primary Care Physician as needed to identify areas where he/she would like assistance (e.g., improving medication compliance)
- Identify communication preferences when more than one provider is involved in the medical care (e.g., does the PCP prefer all coordination go through his/her office or should the disease manager reach out to the specialist as appropriate?)
- Determine the type and frequency of information the PCP wants going forward
- Develop the person-centered care plan in conjunction with the PCP using predictive modeling risk scores with clinical based rules and medical management platforms (e.g., Milliman Care Guidelines, KHS internal criteria, etc.)

The following processes and activities are in place for Case Management/Coordination of Care as part of the Transition of Care Program:

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

The Complex Case Management Group consists of members identified through a Predictive Modeler identifying high risk scores above 0. 5 combined with risk of an inpatient admission within 6 months. These members are stratified into the Complex Group monthly and are discharged by Disenrollment, Death, stratification or other criteria established by the Case Closure Policy, such as achievement of documented targeted outcomes, member opting out of the program, the member is unable to be located, or determination by the case manager that he/she is no longer able to provide appropriate case management services (i.e. due to member non-compliance, non-adherence to the plan of care). This last reason for case closure involves discussion and decision making between the Case Manager and the Medical Director.

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

The following processes and activities are in place for Case Management (CM)/Coordination of Care:

DRAFT

- Collaborate with PCPs for basic CM services
- Arrange and track referrals to specialists
- Track referrals and coordination of car for carved out and other out-of-network services and providers
- Identify community resources and refer members
- Offer health education services
- Emergency room avoidance program
- Homeless identification and care coordination
- Implement continuous quality improvement activities
- Post discharge and Transitional Care clinic

Denial Process

All recommended denials are reviewed by the CMO or designee(s), with the exception of administrative denials that are not based on medical necessity and performed by the UM RN Clinical Intake Coordinators/UM Nurse. Services denied, delayed/extended delay, terminated, or modified based on medical necessity may be eligible for an Independent Medical Review. The referring practitioner, provider and member are notified of the denial through a Notice of Action (NOA) letter, translated in both English and Spanish.

Appeal Process

KFHC members are notified in writing of his/her right to appeal through the Member Grievance Process. The notice includes member's right to request a State Fair Hearing, member's right to represent himself/herself at the State Fair Hearing or to be represented by legal counsel, friend, or other spokesperson, the name, address, and phone number of KHS, toll free number for obtaining information on legal service organizations for representation, and the right to request an Independent Medical Review.

Practitioners/providers may submit a written appeal for referrals that have been denied on the member behalf with a member's consent. KHS has established a fast, fair and cost-effective appeal resolution mechanism to process and resolve practitioner/provider prior auth appeals. A practitioner or provider appeal is defined as "A contracted or non-contracted practitioner's or providers written notice to KHS seeking resolution of a denial of service referral request." The appeal must contain the practitioner/provider name, tax identification number, contact information, and a clear explanation of the issue and the practitioner/provider's position thereon." Additional medical information pertinent to the appeal should be included at that time. All appeals must be submitted to KHS within 60 calendar days of the date of KHS action, or in the case of inaction, 365 calendar days after the time for action has expired.

DRAFT

Mental Health Services

KHS responsibilities are limited to mild to moderate mental health conditions rendered in the outpatient setting. Psychotropic drug therapy remains carved out and provided under the Fee for Service MCAL payment structure. Referrals for behavioral health services may be generated by the practitioner, KHS UM Social Workers, KHS' 24-hour contracted advice and triage nurses, school systems, employers, family, or the member.

Members needing immediate crisis intervention may self-refer to the Emergency Room or to the Kern County Behavioral and Recovery Services' Crisis Stabilization Unit. This information is provided to the members through the member handbook, and periodically, through the member newsletter. Mental Health Services for Medi-Cal participants are a covered benefit as described under the Kern Health Systems Health Plan in the contract with the Department of Health Care Services (DHCS).

KHS administers the behavioral health care benefit in addition to contracting with the Kern Behavioral Health and Recovery Services (KBHRS) and other provider groups for their covered services through a Memorandum of Understanding (MOU). Behavioral health care quality issues are assessed through review of member grievances, member satisfaction study results, interactions with members, and quarterly meetings with KBHRS. KHS UM staff is available to assist KBHRS with complex cases and facilitate coordination and continuity of care between providers.

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

Behavioral Health Therapy (BHT) and Behavioral Intervention Services (BIS)

Autism Spectrum Disorder (ASD) encompasses several conditions that were previously diagnosed separately: autistic disorder, pervasive development disorder not otherwise specified (PDD-NOS) and Asperger syndrome. Transition of eligible members who were currently receiving ABA treatment from the local Regional Center originally transitioned to coverage under KFHC in 2016. For those Kern Family Health Care members not currently receiving ABA treatment from the local Regional Center, Primary Care Providers or other specialists can submit a prior authorization request for the comprehensive diagnostic evaluation by a psychiatrist, psychologist, or neurologist. Upon completion of the Comprehensive diagnostic evaluation that results in a diagnosis of a qualifying ASD, ABA services will be reviewed in the usual manner as any other medical or behavioral service request to KFHC. Effective July 2017, KHS will expand

coverage of the BHT benefit to include non-ASD diagnosis and provide Continuity of Care for the defined members; similarly to the first transition.

Respite/Recuperative Care

The purpose of Respite/Recuperative Care is to reduce the costs of unnecessary hospital utilization and repeated costly emergency room visits for homeless individuals and other individuals who are hard to place post discharge.

Respite/ Recuperative Care includes post-hospitalization services to individuals who are at risk of homelessness or lack a physical address at the time of discharge from an acute care, inpatient facility. Typically, patients will stay in Recuperative Care from five (5) to sixty (60) days is dependent on each individual's recovery and personal needs. This model is based on the following parameters:

- Intensive Case Management
- Substance Use Disorder
- Resource linkage
- Self care and independent living

Patient Centered Medical Home

The Health Homes Program (HHP) is an option afforded to states under Section 2703 of the Affordable Care Act. It allows states to create Medicaid Health Homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by beneficiaries with chronic conditions.

The HHP will be structured as a health home network with entities functioning as a team to provide whole-person care coordination as outlined by the Department of Health Care Services. These include but not limited to:

• *Improve care coordination*. A primary function of the HHP is to provide increased care coordination for individuals with chronic conditions. This increased care coordination will be provided through HHP Services, which include homelessness, physical and behavioral health, and care coordination.

• *Integrate palliative care into primary care delivery.* To strengthen the foundation for palliative care delivery, palliative care will be included in an HHP member's needs assessment. Care coordinators may also emphasize the importance of using advanced directives and Physician Orders for Life-Sustaining Treatment (POLST) forms.

• *Strengthen community linkages within health homes.* Linkages to housing and social services are critical to providing comprehensive care coordination in HHP. Requirements for strong linkages to, and assistance and follow-up with, community resources will ensure that these

DRAFT

resources are available to HHP members. In addition to linking and coordinating available social services, the multi-disciplinary care team will also encourage HHP members to participate in evidence-based prevention programs such as diabetes management and smoking cessation, and other available programs that are documented to use best practices and have positive outcomes. Information about the availability of these programs will be provided to the member.

• *Strengthen team-based care, including use of community health workers/promotores/other frontline workers.* HHPs will be required to have team-based care, including community health workers where appropriate. Because of the linkages to housing and other social services, and potential outreach activities, community health workers will have a role in providing HHP services.

• Improve the health outcomes of people with high-risk chronic diseases.

To date, KHS has fully implemented four (4) HHP facilities in collaboration with our FQHC and Public hospitals. Four additional locations are in progress with an anticipated implementation of late 2018.

<u>Transitional Care Program</u>

The Transitional Care Model (TCM) is an evidence-based solution to these challenges. The TCM has consistently demonstrated improved quality and cost outcomes for high-risk, cognitively intact and impaired older adults when compared to standard care in: reductions in preventable hospital readmissions for both primary and co-existing health conditions; improvements in health outcomes; enhanced patient experience with care; and a reduction in total health care costs.

- *Avoidance of hospital readmissions for primary and complicating conditions***.** TCM has resulted in fewer hospital readmissions for patients. Additionally, among those patients who are rehospitalized, the time between their discharge and readmission is longer and the number of days spent in the hospital is generally shorter than expected.

- *Improvements in health outcomes after hospital discharge.* Patients who received TCM have reported improvements in physical health, functional status and quality of life.

- *Enhancement in patient and family caregiver experience with care.* Overall patient satisfaction is increased among patients receiving TCM. In ongoing studies, TCM also aims to lessen the burden among family members by reducing the demands of caregiving and improving family functioning.

Collaborative care is the cornerstone of the TCM model. Collaborating partner's staff will form the interdisciplinary clinic that provides biopsychosocial and diagnostic screenings and evaluations, medication management, care management, treatment planning and intervention services, as well as general medical services for the identified population. The main goals of integration include:

- Foster cross-system linkages and partnerships;

DRAFT

- Quality and value based system of care;
- Create robust inpatient discharge coordination and develop cross-system transfer of care protocols;
- Expand strategy and education opportunities;
- Improve patient experience and quality outcomes; and
- Implement model of care that is sustainable and cost effective

Medical Necessity Review Criteria

During the review/case management process, KHS UM department staff uses criteria to assist in the clinical appropriateness determination. The criteria used include, but are not limited to:

- ♦ Milliman Care Guidelines (MCG)– Updated annually by vendor in 1st Quarter
- ♦ Medi-Cal Criteria – Updated by the Department of Health Services, current year at their discretion
- ♦ Medicare Criteria – Updated by the Center of Medicare Services, current year at their discretion
- ♦ Internally generated Medical Criteria derived from evidence based medical references and reviewed annually for revisions or appropriateness based on MCAL guidelines.
- ♦ Up to Date- evidence-based physician-authored clinical decision support resource which clinicians utilize to determine point-of-care decisions, including a collection of medical and patient information, access to Lexi-comp drug monographs and drug-to-drug, drug-to-herb and herb-to-herb interactions information, and a number of medical calculators.
- ♦ All Plan Letter (APL) guidance as received from DHCS/DMHC

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

Review criteria are communicated to practitioners when KHS UM modify, delay, or deny referrals for services requested. The practitioners are notified during their office In-service/onboarding by the Provider Relations department and through KHS practitioner newsletters/bulletins of the availability of KHS referral criteria.

The KHS Chief Medical Officer or their designee(s) are responsible for ensuring medical decisions are rendered by qualified medical personnel and that the medical care provided meets the standards for acceptable medical care, as well as ensuring that medical protocols and rules of conduct for plan medical personnel are followed.

KHS maintains the organizational and administrative capacity to provide services to our members.

DRAFT

All medical decisions are rendered by the qualified Chief Medical Officer, or Medical Director(s), unhindered by fiscal and administrative management considerations. In addition, any decision based on medical necessity or otherwise, shall be reviewed by a different Medical Director, or Physician Reviewer, who did not take part in any prior decision making processes.

Ensuring Appropriate Utilization

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

- The UM department monitors underutilization of specialty referrals through collaboration with the QI department. The KHS QI department assist the UM department in monitoring and tracking of referrals to the specialist. The UM department also sends correspondence notifying the practitioners and members of the carved-out services and a reminder to see their primary care provider for all other health care services not addressed by the carved-out specialty care provider.
- Over-utilization of services is monitored through several functions. Reports are provided and reviewed to analyze unfulfilled authorizations and determine interventions to ameliorate any identified adverse trends.
- Suspected or identified Fraud, waste, and abuse is reported to the Compliance department for investigation to determine if additional actions are required.

The KHS contracted 24 hour Nurse Advice and triage call center reports to KHS the utilization of Urgent Care Centers and Emergency Rooms at scheduled intervals. The report is reviewed for trending of ER and Urgent Care usage based on total usage compared against deferment back to the PCP and Home/Self Help care. Monthly touchpoints are scheduled to address any issues or trends identified. Actions plans are developed if utilization patterns raise concerns for escalation.

Hospitalizations are concurrently reviewed for appropriate length of stay and discussed during daily rounding meetings with the KHS CMO (or designee) if medical necessity cannot be established. Concurrent reviews are performed collaboratively with KHS contracted hospitalist groups and/or providers and KHS RN staff to determine medical necessity of admission, length of stay, and post discharge dispositions.

Request for prior authorization or the continuations of previously authorized services are tracked for duplication and appropriateness of continued use. Coordination of the member's health care as part of the targeted case management process serves to determine the medical necessity of diagnostic and treatment services recommended but may be covered services through Kern County Public Health, Kern Regional Center, Kern Behavioral and Recovery Service, California Children Services (CCS), or various community programs and resources.

DRAFT

Evaluation of New Medical Technologies

KHS evaluates a variety of web-based interactive applications for future consideration of medical technologies adoption. KHS MIS department develops and implements new technologies as they emerge to provide efficient methods of tracking member activity and report generation. UM clinical staff have direct access to various websites for review and reference for discussions on innovative methods not currently in use by KHS that may be implemented in the delivery of healthcare to KHS members. New technologies are vetted with MCAL guidelines for coverage, then forwarded to the PAC and QI/UM committees before board approval.

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

- Proposed procedure/treatment/medication device
- Length of time the treating practitioner has been performing the procedure/treatment
- Number of cases the practitioner has performed
- Privileging or certification requirements to perform this procedure
- Outcome review: mortality during a global period, one year out and five years out; other known complications, actual and anticipated
- Identification of other treatment modalities available
- Consideration as to whether Medicare/Medi-Cal approves the service/procedure
- Whether the medication/procedure is FDA approved
- Literature search findings
- Input from network Specialist

The CMO, or designee, or the Director of Pharmacy, consults specialists, market colleagues, the Physicians Advisory Committee (PAC) and/or the Pharmacy and Therapeutics Committee (P&T) as needed to assist in making coverage determinations and/or recommendations.

Telemedicine

Telemedicine and other remote capability is a growing trend in the evaluation of a member's health. Telemedicine allows for HIPAA compliant medical information to be exchanged from one site to another via electronic communications to improve the member's clinical health status through the use of two way video, email, smart phones, wireless tools and other forms of telecommunications technology. No prior authorization is required for telemedicine consultations and limited to those KHS contracted providers who have demonstrated adequate office space, availability of a patient navigator, and suitable telemedicine equipment to connect with a remote medical group. This allows KHS additional options to serve members in rural areas to improve specialty access and reduce wait times.

Provider and Member Satisfaction

Satisfaction Surveys are conducted annually by the KHS Member Services and Provider Relations Department with results shared with the Executive leadership as well as the various KHS departments. Any unsatisfactory areas of the UM process is re-evaluated by the KHS Chief

DRAFT

Medical Officer or designee and the Administrative Director of Health Services to identify specific areas requiring a need for process improvement.

KHS contracts with physicians and other types of health care providers. Provider Relations conducts assessments of the network adequacy of contracting providers. All PCPs and specialists must meet KHS credentialing and recredentialing standards. Contracting providers must meet KHS requirements for access and availability. Members may select their PCPs based on cultural needs and preferences. The Provider Directory lists additional languages spoken by PCPs or their office staff and includes other information related to disability accommodations and hours of operation. The Provider Directory is 274 compliant with DHCS requirements.

Emergency Services

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

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

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

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

Pharmaceutical Management

KHS maintains a Formulary for the purpose of delineating specific prescribed treatments that are felt to be the most therapeutically efficacious and cost effective. The Board of Directors is ultimately responsible for supervising the Formulary Process. This responsibility is delegated, with certain restrictions, to the Pharmacy and Therapeutics Committee (P&TC). The P&TC is responsible for reviewing specific medications and treatments for possible inclusion in or deletion from the Formulary and to review all therapeutic categories every two years. Pharmacy benefits are executed via the Pharmacy Benefits Manager (PBM), known as DST Health. The PBM contract is managed by the Director of Pharmacy.

DRAFT

Delegation of UM Activities

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. KHS tracks and processes all KHS member's UM activity internally with the exception of Kaiser members whose UM functions are delegated as part of a two-way agreement under contractual requirement with DHCS.

KHS contracts with a third party vendor to provided 24/7, weekend and holiday triage services for all KHS members. The vendor provides not only triage services but also a member initiated Health Library to promote education on a varying number of topics. Reports are generated monthly to monitor their activities as well as identify member patterns during execution of after hour services.

Vision Care is delegated to a 3rd party vendor and capitated for all vision services. Reports are generated monthly to monitor their activities as well as identify utilization patterns.

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

Medical Reviews and Audits by Regulatory Agencies

KHS' Director of Compliance and Regulatory Affairs, in collaboration with the Administrative Director of Health Services and other departmental leadership, manages KHS medical reviews and medical audits by regulatory agencies. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QI/UM Program. CAPs for medical matters are approved and monitored by the QI/UMC.

Integration of Study Outcomes with KHS Operational Policies and Procedures

KHS assesses study outcomes over time and, as a result of key quality issue identification and problem resolution, develops changes in strategic plans and operational policies and procedures. Study outcomes are assessed and changes may be incorporated into the KHS strategic plan and

DRAFT

operational policies and procedures to address those outcomes and incorporate ongoing quality issue solutions into organizational operations.

Statement of Conflict of Interest

UM decision-making is based on established criteria, appropriateness of care and service, and existence of coverage. KHS does not provide financial incentive for practitioners or other individuals conducting utilization review for denials of services or coverage. All committee members are required to sign a conflict of interest statement. Committee members cannot vote on matters where they have an interest and must be recuse until the issue has been resolved.

Statement of Confidentiality

The UM department handles all patient identifiable information used in clinical review, care, and service in a privileged and proprietary manner. The QI/UM Committee develops and implements confidentiality policies and procedures and reviews practices regarding the collection, use, and disclosure of medical information. KHS retains oversight for provider confidentiality procedures. KHS has established and distributed confidentiality standards to contracting providers in the KHS Provider Policy and Procedure Manual. All provider contracts include the provision to safeguard the confidentiality of member medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and federal laws. As a condition of participation with KHS, all contracting providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of members to their practitioners. KHS monitors contracting providers for compliance with KHS confidentiality standards during provider facility and medical records reviews and through the Grievance Process. All members, participating KHS staff and guests of the QI/UMC and subcommittees are required to sign the Committee Attendance Record, including a statement regarding confidentiality and conflict of interest. All KHS employees are required to sign a confidentiality agreement upon hiring. The confidentiality agreements are maintained in the practitioner or employee files, as appropriate. All peer review records, proceedings, reports and member records are maintained in a confidential manner in accordance with state and federal confidentiality laws.

Annual Program Evaluation

On an annual basis KHS evaluates and revises as necessary, the UM Program Description and Evaluation. The Chief Medical Officer, with assistance from the Administrative Director of Health Services; Director of Health Education and Cultural and Linguistics, Disease Management Supervisor; Director of Pharmacy; and Manager of Case Management, documents a yearly summary of all completed and ongoing QI Program activities with documentation of evidence of improved health care or deficiencies, status of studies initiated, or completed, timelines, methodologies used, and follow-up mechanisms. A written evaluation of the UM Program is prepared and reported to the QI/UM Committee and Board of Directors annually.

DRAFT

The Board of Directors is responsible for the direction of the UM Program and actively evaluates the annual plan to determine areas for improvement. Board of Director comments, actions and responsible parties assigned to changes are documented in the minutes. The status of delegated follow-up activities is presented in subsequent Board meetings. A summary of UM activities and progress toward meeting UM goals is available to members and contracting providers upon request.

____

KHS Board of Directors (Chair)   Date

____

Chief Executive Officer   Date

____

Chairman QI/UMC   Date

DRAFT

Health Services Overview

The 2018 membership enrollment remained stable at 248,000 in Q1 2018. Additional benefit coverage and broadening interdisciplinary collaboration to support the membership growth will continue through 2018.

- Phase 2 Medical Management Platform-Case and Disease Management and Health Education-in production beginning Q2 2018
- Prior auth Appeals/QI/Health Homes modules in JIVA
- Point of Service MCG Interactive medical criteria with providers
- Palliative Care-new benefit 1/1/2018
- Behavioral Health Therapy- Autism-expansion of eligibility 7/2018
- Cardiac Rehabilitation-new benefit

The following pages reflect statistical measurements for Utilization Management, Case Management and Disease Management detailing the ongoing compliance activity for the 1st Quarter 2018.

Respectfully submitted,

Deborah (Murr RN)

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

Utilization Management Reporting

Timeliness of Decision Trending

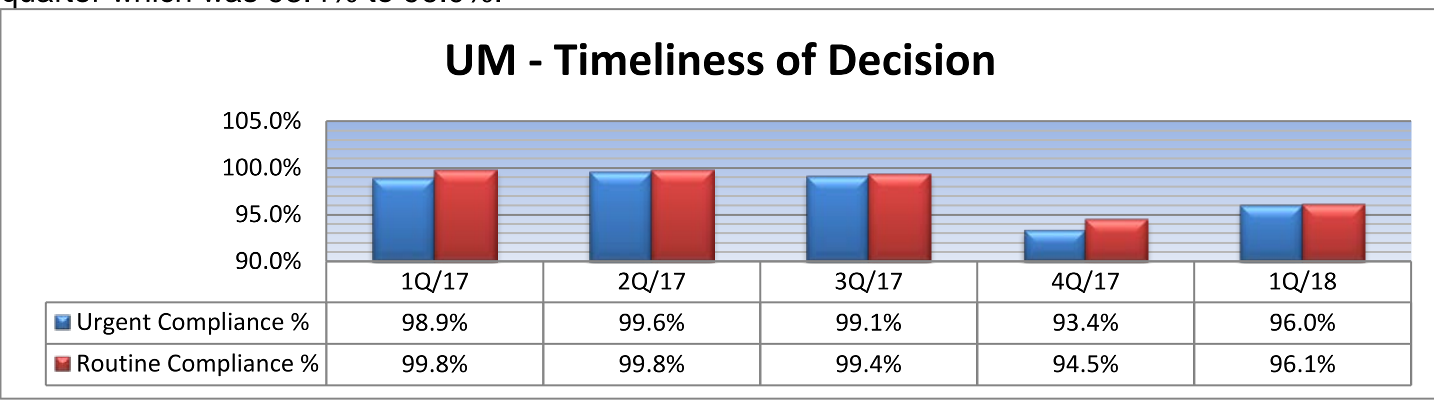
Summary:
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

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.

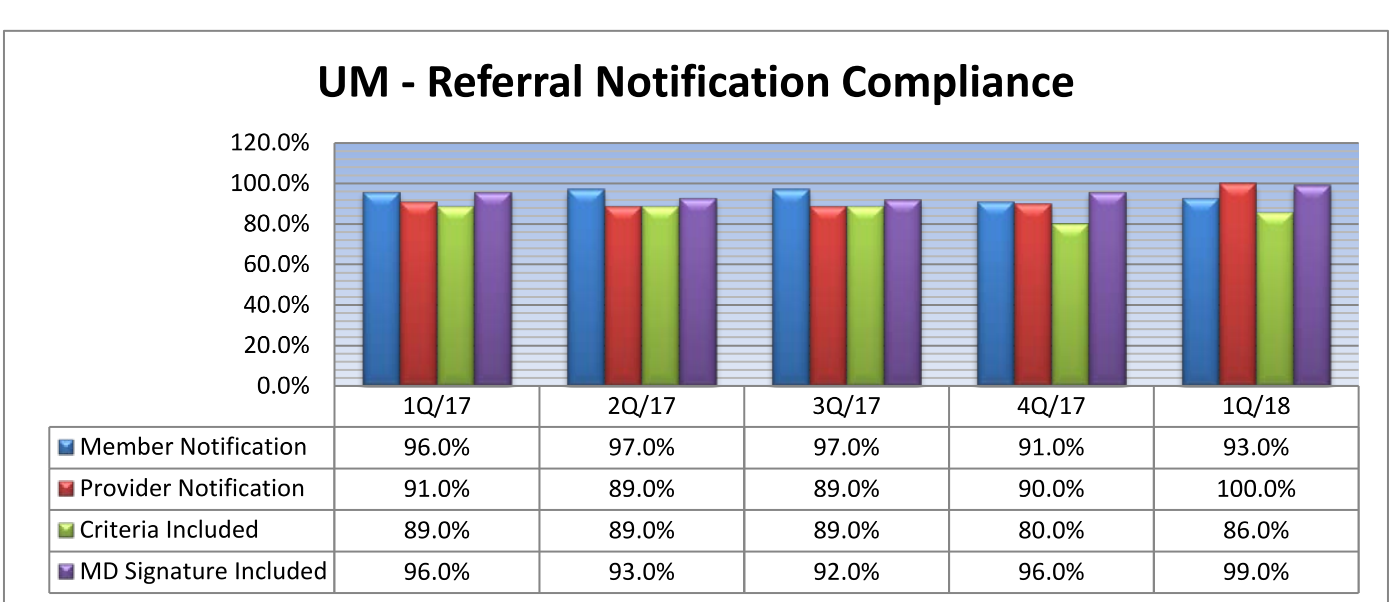
Urgent: Response back to Provider in 3 business days
Routine: Response back to Provider in 5 business day

There were 26,468 referrals processed in the 1st quarter 2018 of which 2,244 referrals were reviewed for timeliness of decision. In comparison to the 4th quarters processing time, the routine referrals increased from the 4th quarter which was 94.5% to 96.1% and urgent referrals increased from the 4th quarter which was 93.4% to 96.0%.



	1Q/17	2Q/17	3Q/17	4Q/17	1Q/18
Urgent Compliance %	98.9%	99.6%	99.1%	93.4%	96.0%
Routine Compliance %	99.8%	99.8%	99.4%	94.5%	96.1%

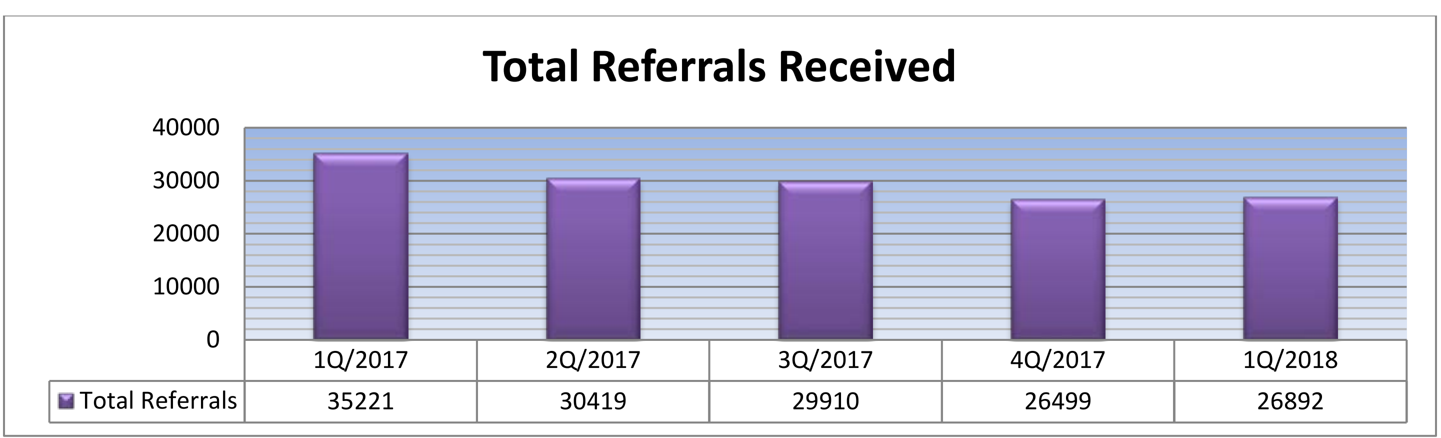
Audit Criteria:
- Member Nofication: Letter of referral decision sent to member within 24 hours
- Provider Notification: Referral is faxed back to the provider with 24 hours of decision
- Criteria Included: Criteria provided to provider on denial reason
- MD Signature: MD Signature included all referrals/NOA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



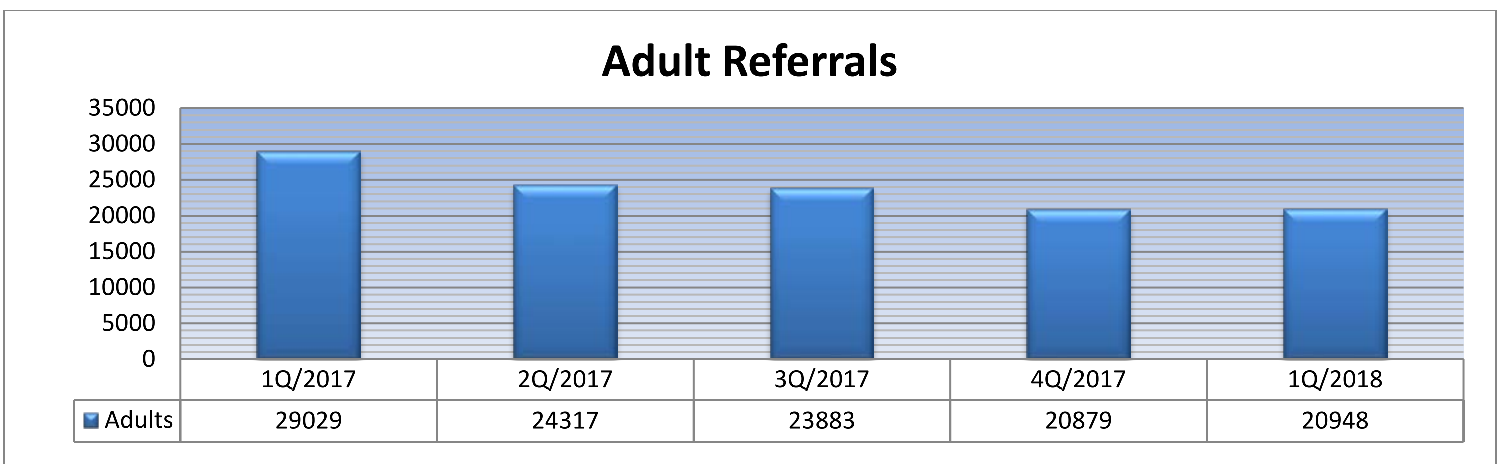
	1Q/17	2Q/17	3Q/17	4Q/17	1Q/18
Member Notification	96.0%	97.0%	97.0%	91.0%	93.0%
Provider Notification	91.0%	89.0%	89.0%	90.0%	100.0%
Criteria Included	89.0%	89.0%	89.0%	80.0%	86.0%
MD Signature Included	96.0%	93.0%	92.0%	96.0%	99.0%

Summary: Overall compliance rate from the 1st Qtr of 2018 is 95% which increased from the 4th Qtr which was 89.3%.

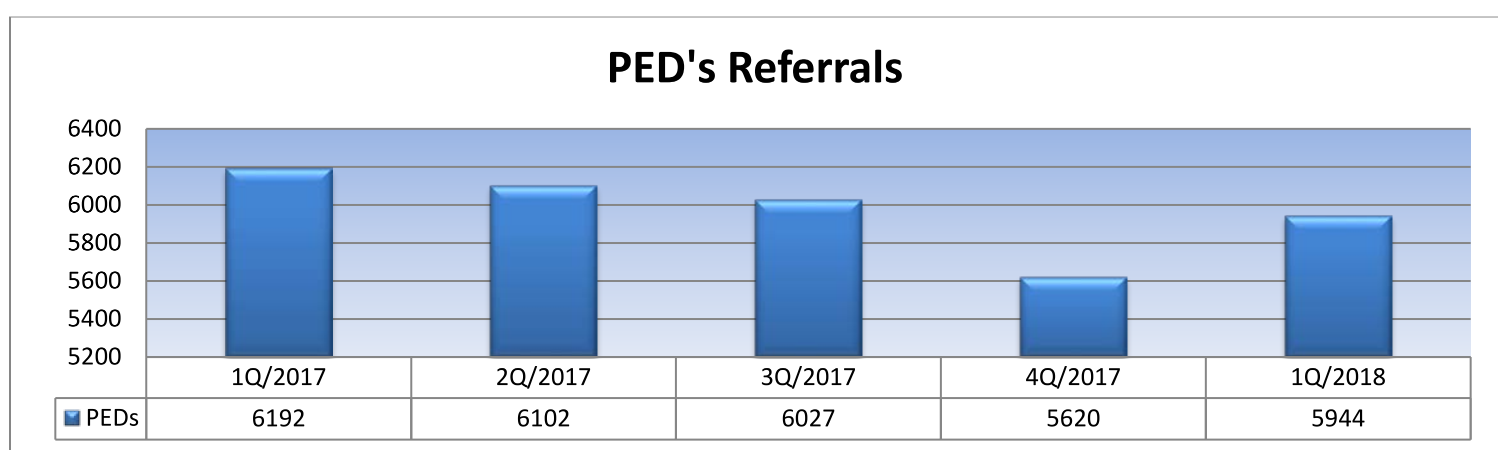
Outpatient Referral Statistics



	1Q/2017	2Q/2017	3Q/2017	4Q/2017	1Q/2018
Total Referrals	35221	30419	29910	26499	26892



	1Q/2017	2Q/2017	3Q/2017	4Q/2017	1Q/2018
Adults	29029	24317	23883	20879	20948



	1Q/2017	2Q/2017	3Q/2017	4Q/2017	1Q/2018
PEDs	6192	6102	6027	5620	5944

KHS Monthly Inpatient and LOS Report

Report captures how many members were inpatient during reporting month, excluding CCS denials

Dates of Discharge Between : 01/01/2018-03/31/2018

	20 and Under	Over 20	Totals
Total Inpatient:	1143	4809	**5952**
Total LOS:	2979	18746	**21725**
Average LOS:	2.6	3.9	**3.7**

PAR Facilities	Admits	LOS	Average LOS
Totals :	5615	20048	3.6
Adult Inpatient	3,710	13909	3.7
Adult Observation	637	1927	3.0
Adult Rehab/SNF	0	1319	8.3
Pediatric Inpatient	1110	2893	2.6
Pediatric Rehab/SNF	0	0	0.0

NPAR Facilities	Admits	LOS	Average LOS
Totals :	337	1677	5.0
Adult Inpatient	266	1304	4.9
Adult Observation	11	20	1.8
Adult Rehab/SNF	27	267	9.9
Pediatric Inpatient	33	86	2.6
Pediatric Rehab/SNF	0	0	0.0

Activity by Facility	Total Inpatient	Total LOS	Average LOS
ADVENTIST HEALTH BAKERSFIELD	995	3644	3.7
ALAMEDA HEALTH SYSTEM	4	10	2.5
ANTELOPE VALLEY HOSP	87	312	3.6
ARROWHEAD REG MED CTR	3	5	1.7
BAKERSFIELD HEART HOSPITAL	144	632	4.4
BAKERSFIELD MEMORIAL HOSPITAL	1542	5131	3.3
BARLOW RESPIRATORY HOSP	2	4	2.0
BARSTOW COMM HOSPITA	2	4	2.0
BELLAGIO IN THE DESERT	15	138	9.2
BEVERLY HOSPITAL	2	6	3.0
CAPRI IN THE DESERT	3	8	2.7
CENTERPOINT MEDICAL CENTER	2	0	0.0
CHILDRENS HOSPITAL OF LOS ANGE	45	156	3.5
CHILDRENS HOSPITAL OF ORANGE C	6	10	1.7
CLINICA SIERRA VISTA	2	6	3.0
CLOVIS COMMUNTIY MEDICAL CENTE	2	18	9.0
COUNTY OF SAN JOAQUIN	1	3	3.0
DEANCO HEALTHCARE LLC	2	10	5.0
DELANO REGIONAL MEDICAL CENTER	212	554	2.6
DESERT REGIONAL MEDICAL CENTER	1	6	6.0
DESERT VALLEY HOSPITAL INC	2	10	5.0
DOCTORS MEDICAL CENTER	2	8	4.0
EVERGREEN AT ARVIN HEALTHCARE	4	75	18.8
EVERLASTING HEALTHCARE	2	22	11.0
FENTON VILLA	2	8	4.0
FLAGSTAFF MEDICAL CENTER	2	6	3.0
FRESNO COMMUNITY HOSPITAL AND	15	40	2.7
GGNSC SHAFTER LP	6	42	7.0
GLENDALE ADVENTIST MEDCIAL GRO	2	4	2.0
GOLDEN LIVING CENTER - BAKERSF	8	64	8.0

GOOD SAMARITAN HOSPITAL	130	528	4.1
GOOD SAMARITAN HOSPITAL, L.P.	2	6	3.0
HARBOR - UCLA MED FOUNDATION	2	6	3.0
HEALTHSOUTH BAKERSFIELD REHABI	43	318	7.4
HEIGHT STREET SKILLED CARE	1	2	2.0
HENRY MAYO NEWHALL MEMORIAL HO	9	18	2.0
HILLCREST HOSP CLARE	2	0	0.0
HOFFMANN HOSPICE OF THE VALLEY	3	10	3.3
HOLLYWOOD PRESBYTERIAN MEDICAL	2	6	3.0
KAISER FOUNDATION HOS PLS	2	4	2.0
KAWEAH DELTA DIST HO	7	27	3.9
KECK HOSPITAL OF USC	6	28	4.7
KECK HOSPITAL OF USC	42	222	5.3
KERN COUNTY MEDICAL AUTHORITY	6	14	2.3
KERN COUNTY MEDICAL AUTHORITY	1050	3347	3.2
KERN MEDICAL CENTER	7	25	3.6
KERN MEDICAL CTR OH	2	2	1.0
KERN VALLEY HEALTHCARE DISTRIC	34	113	3.3
KINGMAN REGIONAL MEDICAL	2	4	2.0
LAC HARBOR UCLA MEDICAL	2	38	19.0
LAC USC MEDICAL CENTER	2	4	2.0
LACO OV-UCLA MED CTR	2	12	6.0
LAC-USC MEDICAL CTR	6	90	15.0
LANCASTER HOSPITAL CORPORATION	20	100	5.0
LIFEHOUSE BAKERSFIELD OPERATIO	1	21	21.0
LIFEHOUSE HEALTH SERVICES	6	21	3.5
LOMA LINDA UNIVERSITY CHILDREN	2	2	1.0
LOMA LINDA UNIVERSITY MEDICAL	6	40	6.7
LOMPOC VALLEY MEDICAL CENTER	2	6	3.0
MARTIN LUTHER KING, JR COMMUNI	1	2	2.0
MEMORIAL HOSPITAL OF GARDENA	2	2	1.0
MERCY HOSPITAL	951	3100	3.3
MERCY SAN JUAN HOSPITAL	2	4	2.0

MILLS PENINSULA MEDICAL CENTER	2	2	1.0
NATIVIDAD MEDICAL CENTER	3	12	4.0
OAK FENCE SENIOR LIVING, LLC	1	2	2.0
OCONNOR HOSPITAL	1	2	2.0
ORANGE COAST MEMORIAL MEDICAL	2	6	3.0
PACIFICA HOSPITAL OF THE VALLE	1	1	1.0
PARKVIEW JULIAN CONVALESCENT H	8	71	8.9
PIONEERS M HEALTH DIST HOSPITA	2	4	2.0
POMONA VALLEY HOSPITAL	1	2	2.0
PRIME HEALTHCARE SERVICES RENO	2	4	2.0
PRIME HEALTHCARE SERVICES, INC	4	34	8.5
PROCARE HOSPICE	1	0	0.0
PROVIDENCE ALASKA MEDICAL CENT	2	14	7.0
PROVIDENCE SAINT JOSEPH MEDICA	2	6	3.0
RADY CHILDRENS HOSPITAL	2	4	2.0
REGENTS OF THE UNIV OF CALIFOR	14	102	7.3
REGIONAL MEDICAL CENTER	2	6	3.0
REHOBOTH MCKINLEY CHRISTIAN HE	2	2	1.0
RIDGECREST REGIONAL HOSPITAL	10	28	2.8
RIVERSIDE COMMUNITY HOSPITAL	6	50	8.3
ROSE DESERT CONGREGATE CARE IN	8	66	8.3
SAINT AGNES MEDICAL CENTER	3	9	3.0
SAN ANTONIO COMM HOSP	2	2	1.0
SAN MARINO IN THE DESERT	3	34	11.3
SANTA BARBARA COTTAGE HOSPITAL	2	4	2.0
SANTA ROSA MEMORIAL HOSPITAL	2	20	10.0
SCRIPPS MEMORIAL HOSPITAL	2	24	12.0
SIERRA VIEW MEDICAL CENTER	4	4	1.0
SIERRA VISTA REGIONAL MEDICAL	2	10	5.0
SIMI VALLEY HOSPITAL	2	38	19.0
SORRENTO IN THE DESERT	14	92	6.6
SOUTHERN CALIFORNIA SPECIALITY	4	50	12.5
SOUTHERN MONO HEALTHCARE DISTR	1	2	2.0

ST FRANCIS MEDICAL CENTER	2	8	4.0
ST MARY MEDICAL CENTER	2	8	4.0
ST. JOHN'S PLEASANT VALLEY HOS	2	56	28.0
ST. ROSE DOMINICAN HOSPITAL	2	4	2.0
STANFORD MEDICAL	4	26	6.5
STR LP	7	109	15.6
SUTTER DAVIS	2	8	4.0
SUTTER GEN HOSPITAL	2	32	16.0
TOLUCA CONGREGATE LIVING	2	29	14.5
UCI MEDICAL CENTER	6	26	4.3
UCLA MEDICAL CENTER	55	256	4.7
UCSD MEDICAL CENTER	8	64	8.0
UNITED CARE FACILITIES	36	392	10.9
UNIVERSITY OF CALIFORNIA DAVIS	4	16	4.0
USC NORRIS CANCERHOSPITAL	6	122	20.3
USC VERDUGO HILLS HOSPITAL	2	2	1.0
VALLEY CHILDRENS HOSPITAL	146	443	3.0
VALLEY CHILDREN'S HOSPITAL	42	142	3.4
VALLEY CONVALESCENT HOSPITAL	1	0	0.0
VENTURA COUNTY MEDICAL CENTER	2	0	0.0
VFP HOMES	1	4	4.0
WESTERN ARIZONA REGIONAL MEDIC	2	4	2.0
WHITE MEMORIAL MEDICAL CENTER	2	6	3.0

KHS Monthly Inpatient and LOS Report

Report captures how many members were inpatient at a rehab or skilled nursing facility during reporting month,

Dates of Discharge Between : 01/01/2018-03/31/2018

Total Inpatient:	187
Total LOS:	1622
Average LOS:	8.7

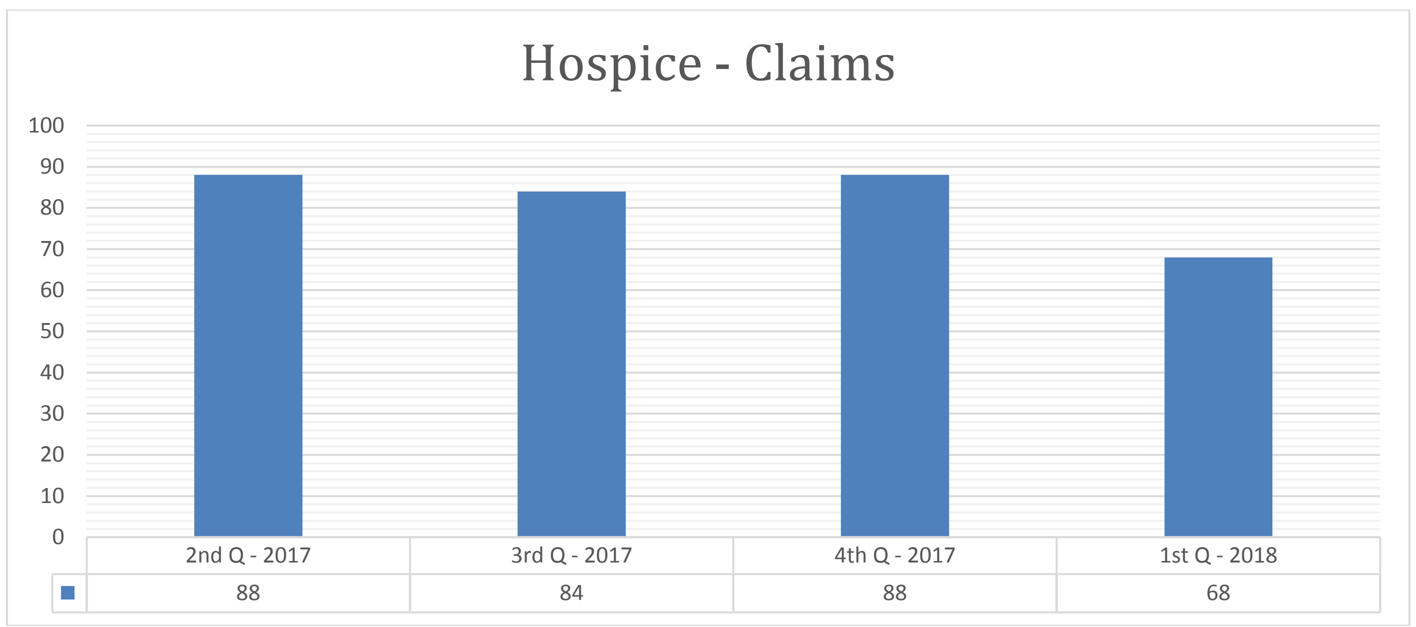
PAR Facilities	Admits	LOS	Average LOS
Totals :	161	1357	161.0
Adult Rehab	44	332	7.5
Adult SNF	117	1025	8.8
Pediatric Rehab	0	0	0.0
Pediatric SNF	0	0	0.0

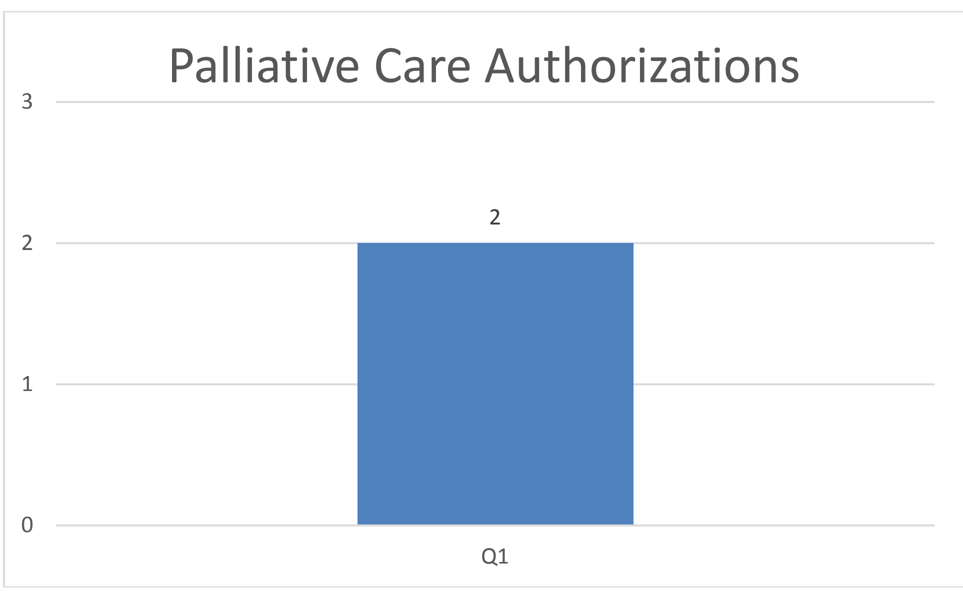
NPAR Facilities	Admits	LOS	Average LOS
Totals :	1	265	26.0
Adult Rehab	2	5	2.5
Adult SNF	24	260	10.8
Pediatric Rehab	0	0	0.0
Pediatric SNF	0	0	0.0

Activity by Facility	Total Inpatient	Total LOS	Average LOS
BELLAGIO IN THE DESERT	13	115	8.8
CAPRI IN THE DESERT	3	8	2.7
CLINICA SIERRA VISTA	2	6	3.0
EVERGREEN AT ARVIN HEALTHCARE	3	46	15.3
EVERLASTING HEALTHCARE	2	22	11.0
GGNSC SHAFTER LP	4	31	7.8
GOLDEN LIVING CENTER - BAKERSF	7	54	7.7
HEALTHSOUTH BAKERSFIELD REHABI	40	281	7.0
HEIGHT STREET SKILLED CARE	1	2	2.0
HOFFMANN HOSPICE OF THE VALLEY	3	10	3.3

KERN COUNTY MEDICAL AUTHORITY	1	9	9.0
LIFEHOUSE BAKERSFIELD OPERATIO	1	21	21.0
LIFEHOUSE HEALTH SERVICES	4	20	5.0
LOMA LINDA UNIVERSITY MEDICAL	1	1	1.0
MERCY HOSPITAL	2	9	4.5
NATIVIDAD MEDICAL CENTER	1	4	4.0
OAK FENCE SENIOR LIVING, LLC	1	2	2.0
PACIFICA HOSPITAL OF THE VALLE	1	1	1.0
PARKVIEW JULIAN CONVALESCENT H	6	60	10.0
PROCARE HOSPICE	1	0	0.0
ROSE DESERT CONGREGATE CARE IN	6	48	8.0
SAN MARINO IN THE DESERT	2	26	13.0
SORRENTO IN THE DESERT	14	91	6.5
SOUTHERN CALIFORNIA SPECIALITY	2	25	12.5
STR LP	7	109	15.6
TOLUCA CONGREGATE LIVING	2	29	14.5
UNITED CARE FACILITIES	34	375	11.0
VALLEY CONVALESCENT HOSPITAL	1	0	0.0
VFP HOMES	1	4	4.0

Hospice Claims has decreased in the 1st Quarter 2018.

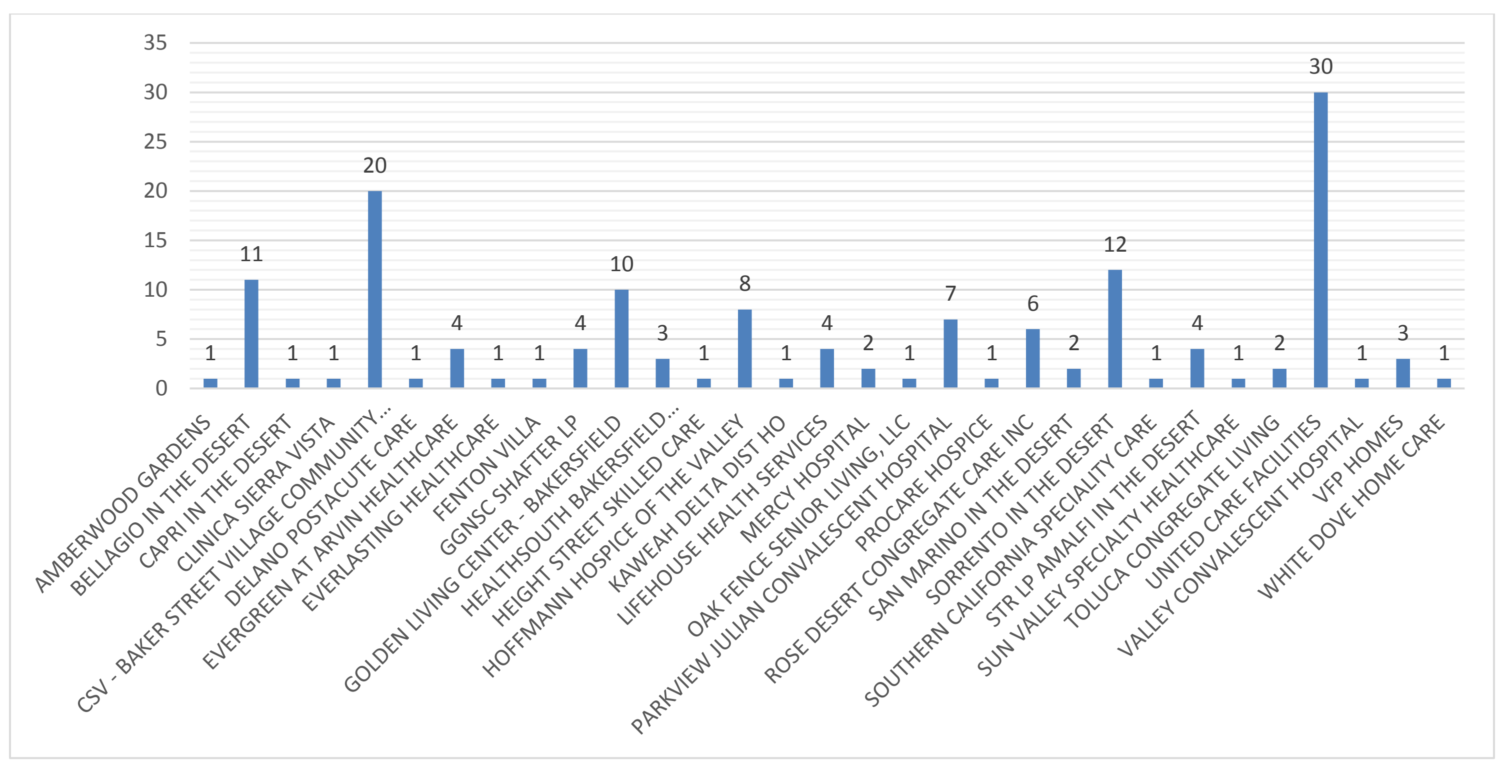




Nursing Facility Services Report

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

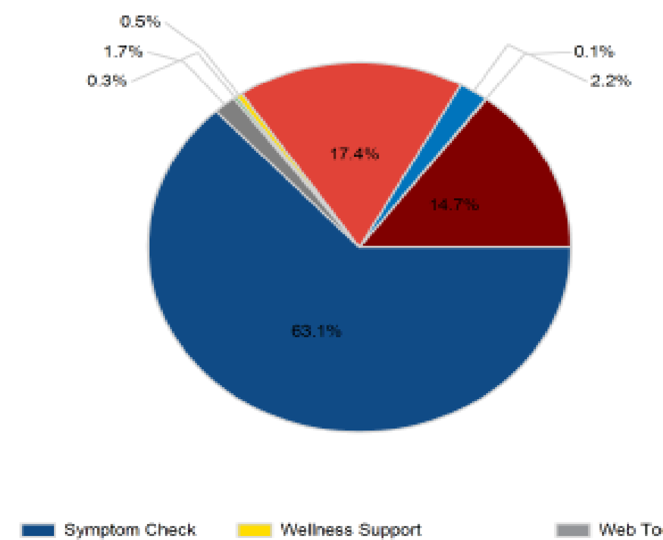
Summary: Summary: During the 1st quarter 2018, there were 175 referrals for Nursing Facility Services. The average length of stay was 26 days for these members. During the 4th quarter there was only 1 denial of the 132 referrals.



Health Dialog Report

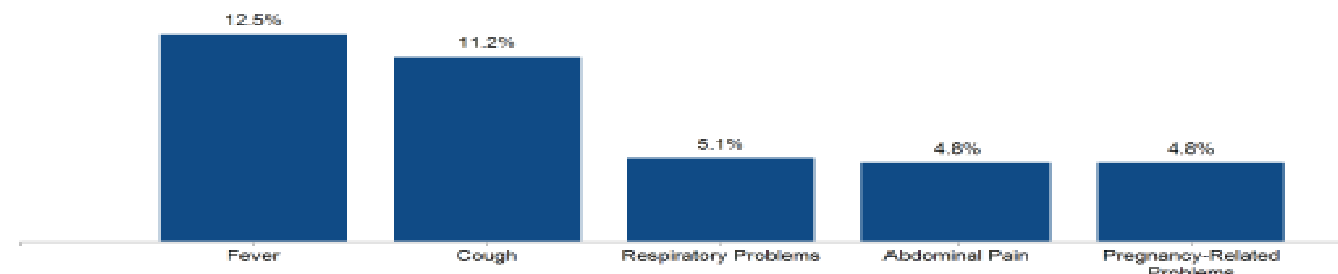
January:

Member Inbound Call Reasons (Rolling Twelve Months)

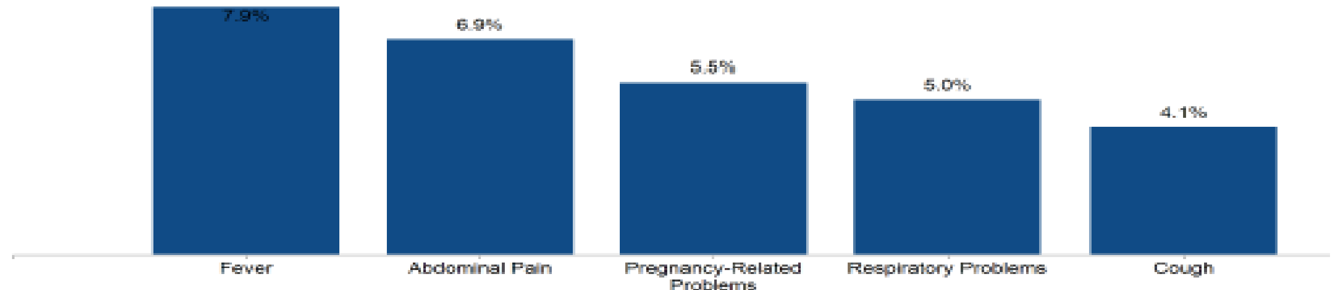


REASON	NUMBER
Symptom Check	3,280
Condition Support	90
Decision Support	13
Wellness Support	25
Health Plan	902
Mailing or Message Follow Up	115
Web Tools	4
Other	766

Most Frequent Symptoms - Inbound Symptom Check Calls (Jan-2018)

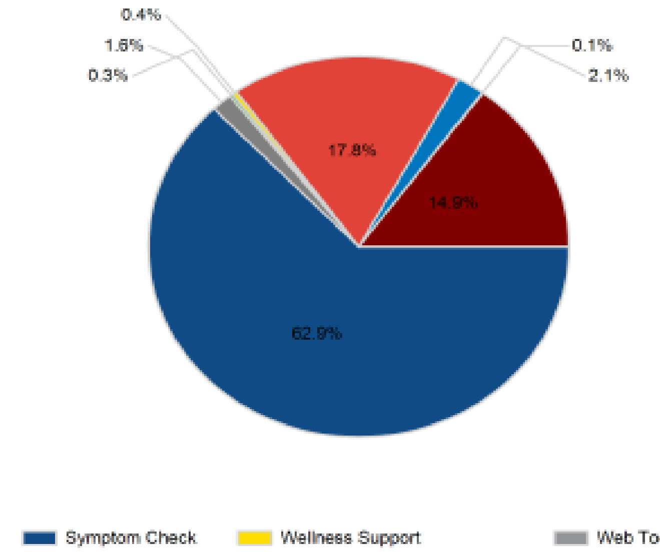


Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



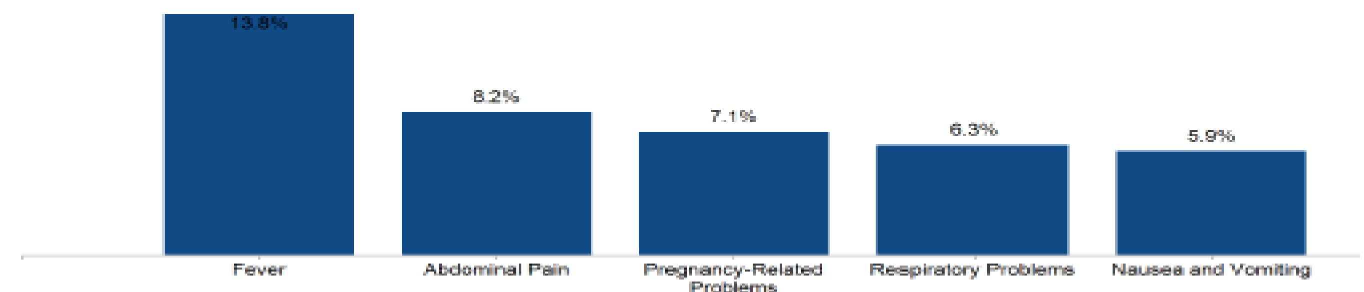
February:

Member Inbound Call Reasons (Rolling Twelve Months)

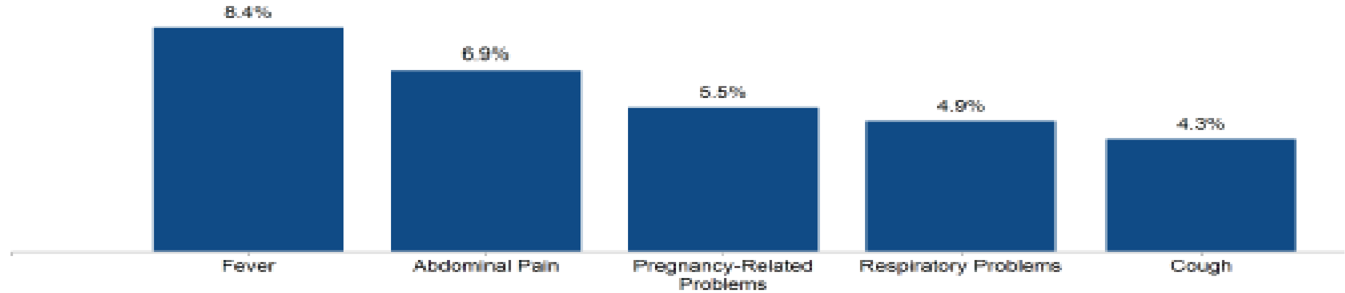


REASON	NUMBER
Symptom Check	3,237
Condition Support	83
Decision Support	13
Wellness Support	19
Health Plan	914
Mailing or Message Follow Up	108
Web Tools	4
Other	769

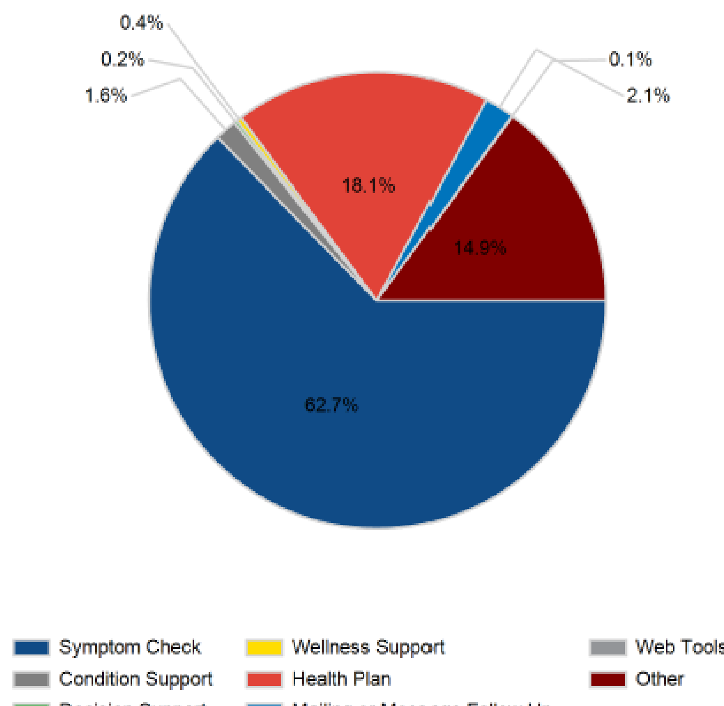
Most Frequent Symptoms - Inbound Symptom Check Calls (Feb-2018)



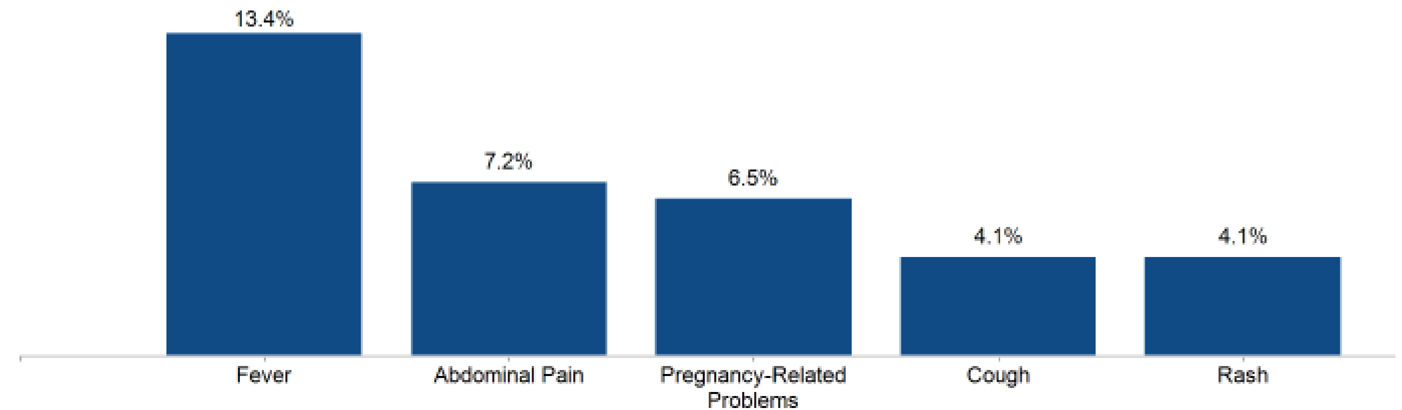
Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)

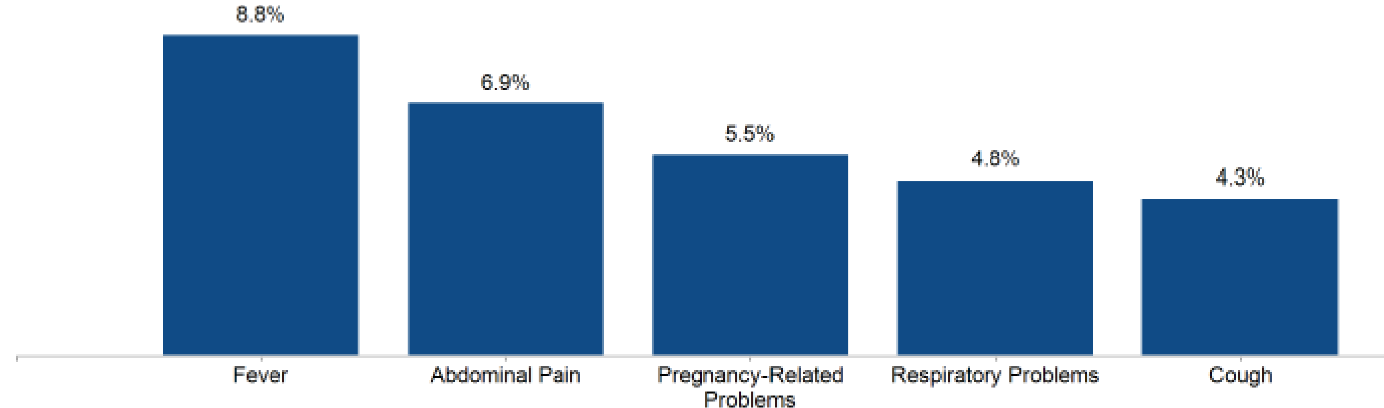


March

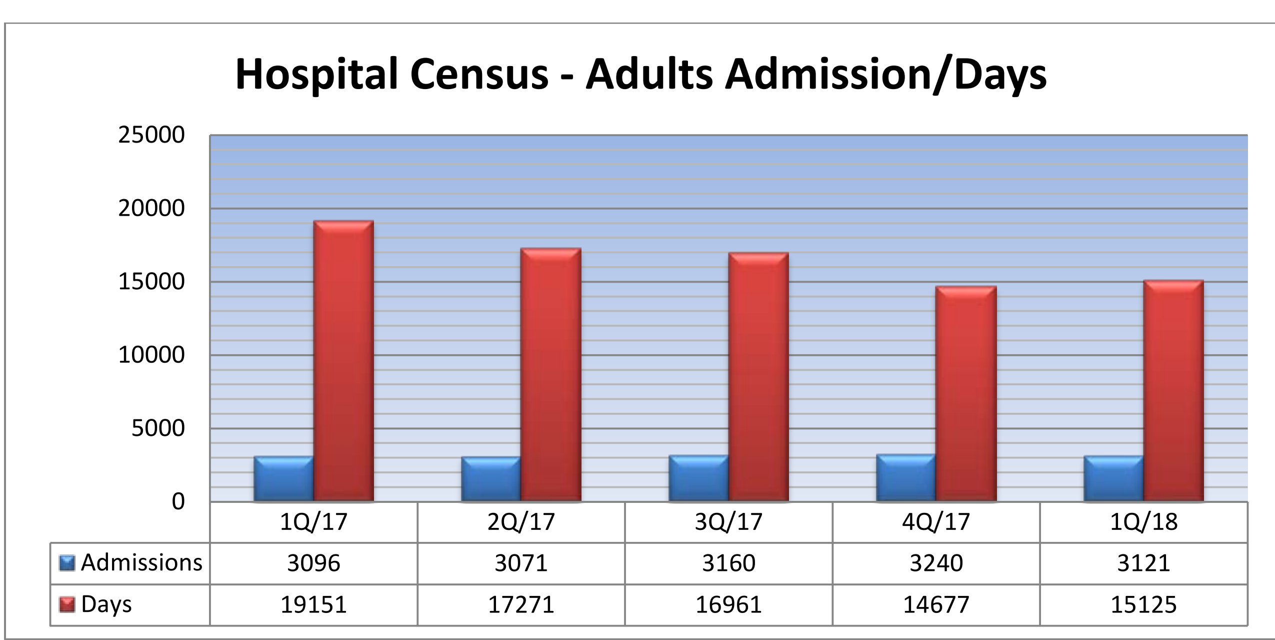


REASON	NUMBER
Symptom Check	3,233
Condition Support	80
Decision Support	12
Wellness Support	19
Health Plan	932
Mailing or Message Follow Up	109
Web Tools	3
Other	771

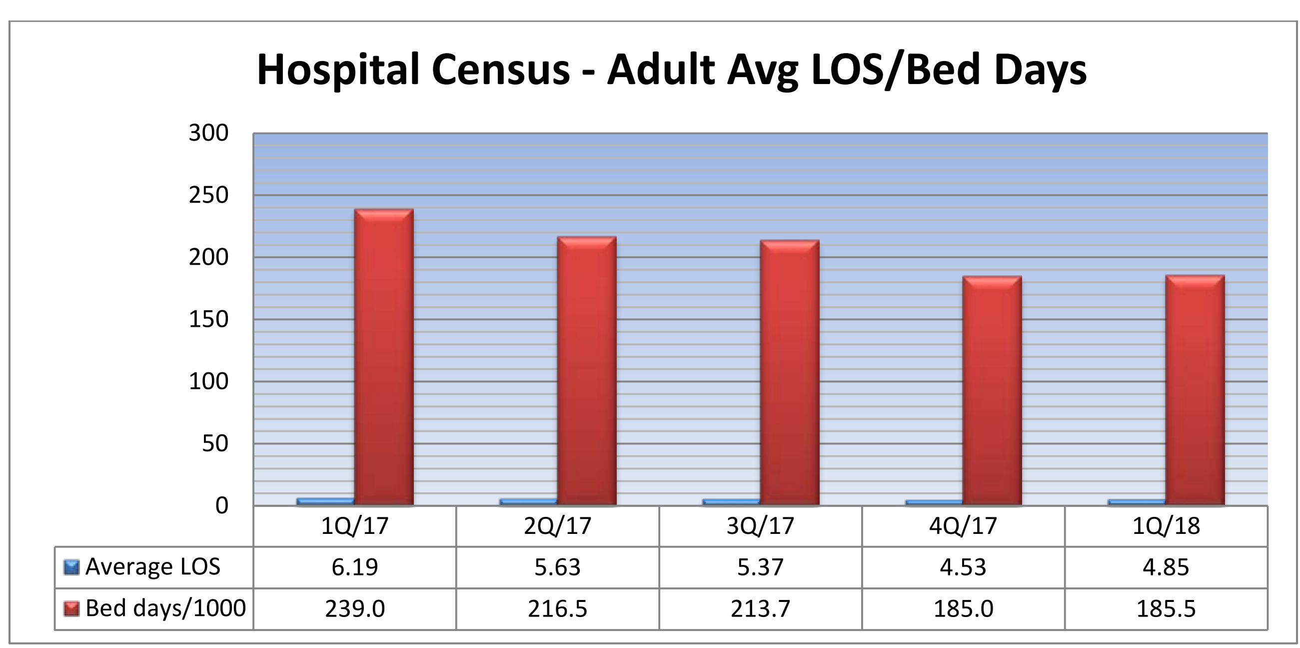

Most Frequent Symptoms - Inbound Symptom Check Calls (Mar-2018)
13.4%
7.2%
6.5%
4.1%
4.1%
Fever
Abdominal Pain
Pregnancy-Related Problems
Cough
Rash


Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)
8.8%
6.9%
5.5%
4.8%
4.3%
Fever
Abdominal Pain
Pregnancy-Related Problems
Respiratory Problems
Cough

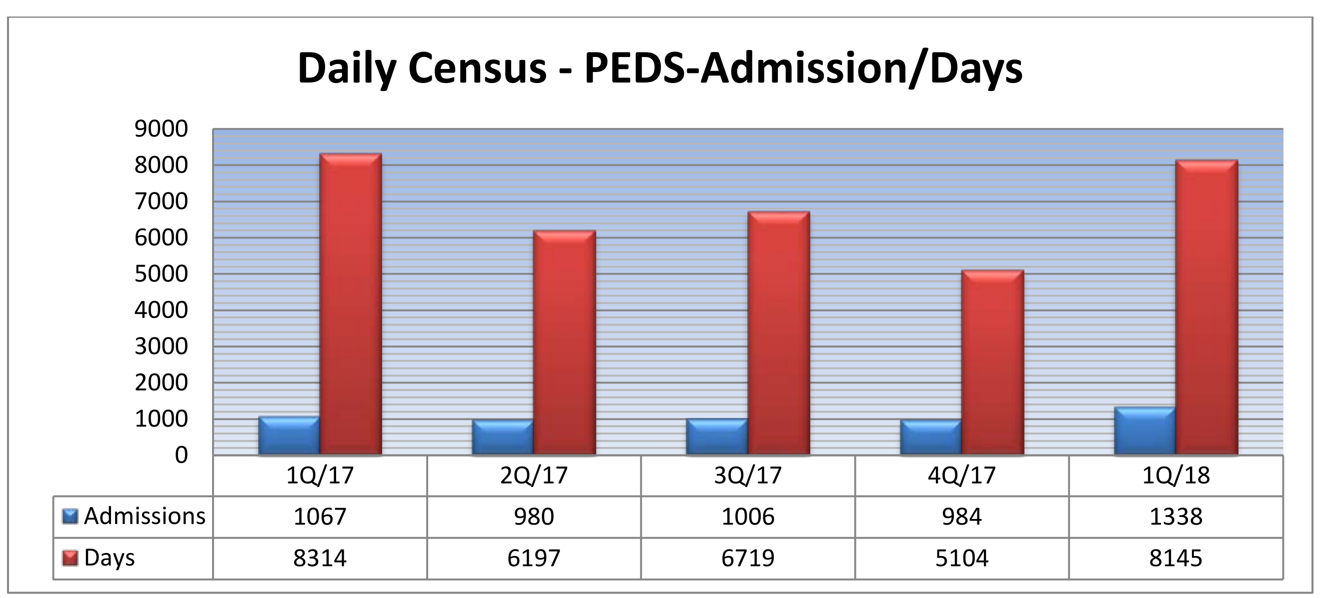
Inpatient 1st Quarter Trending



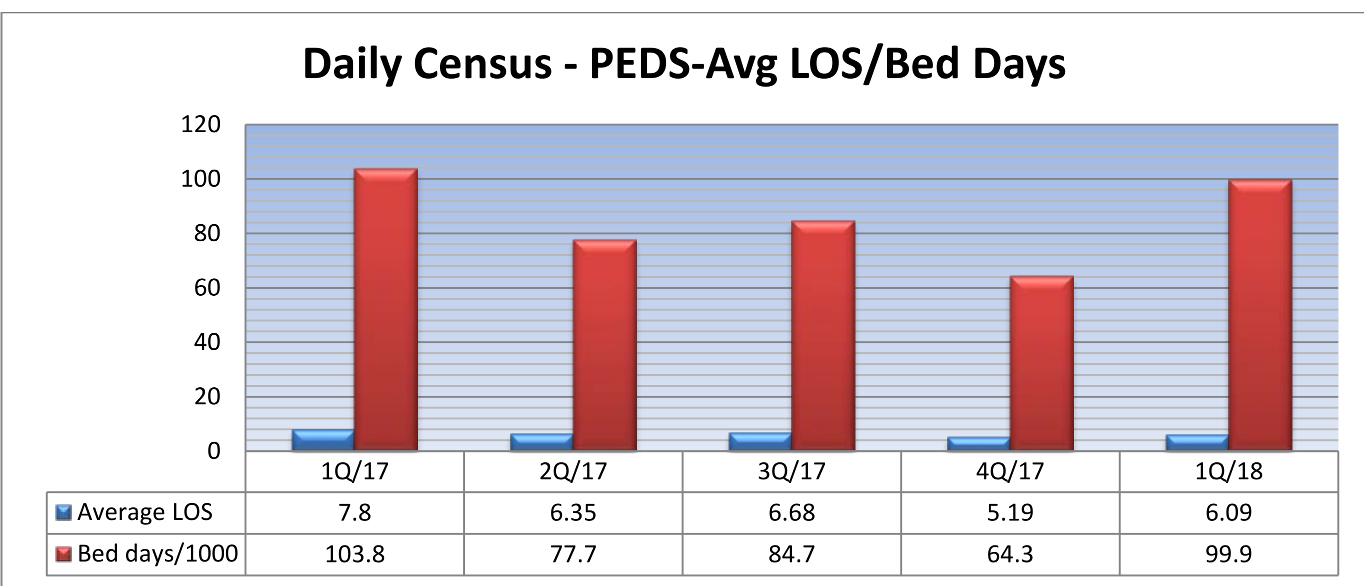
	1Q/17	2Q/17	3Q/17	4Q/17	1Q/18
Admissions	3096	3071	3160	3240	3121
Days	19151	17271	16961	14677	15125



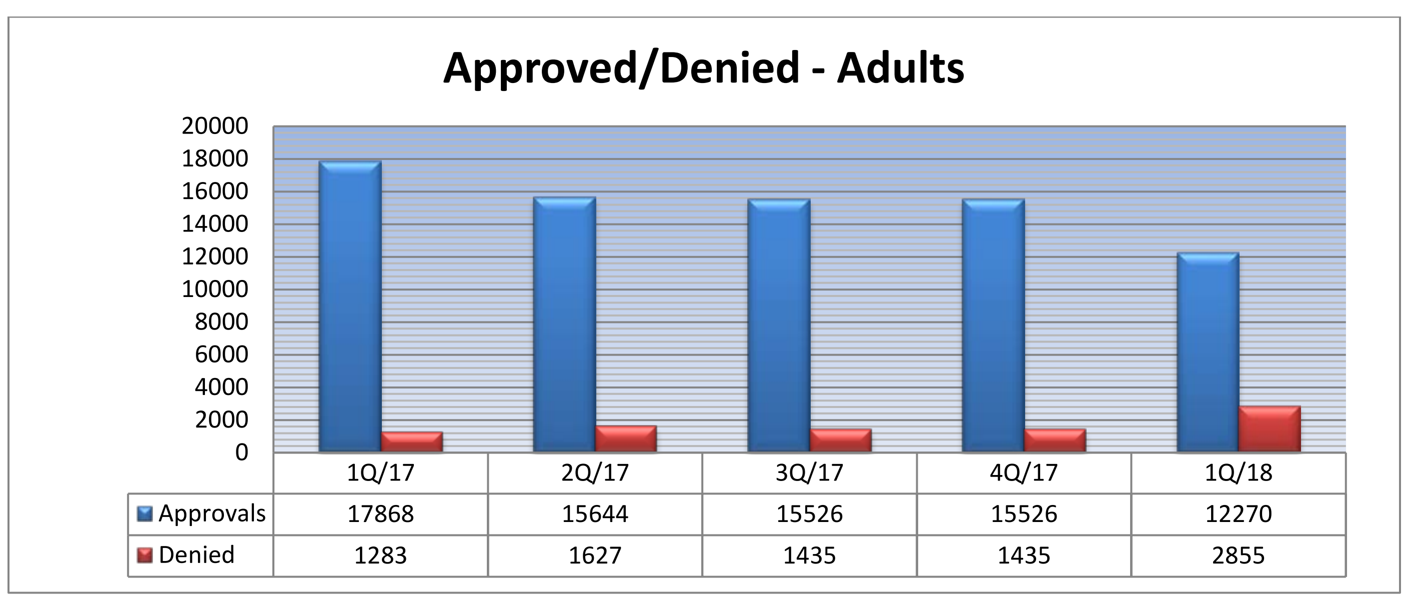
	1Q/17	2Q/17	3Q/17	4Q/17	1Q/18
Average LOS	6.19	5.63	5.37	4.53	4.85
Bed days/1000	239.0	216.5	213.7	185.0	185.5



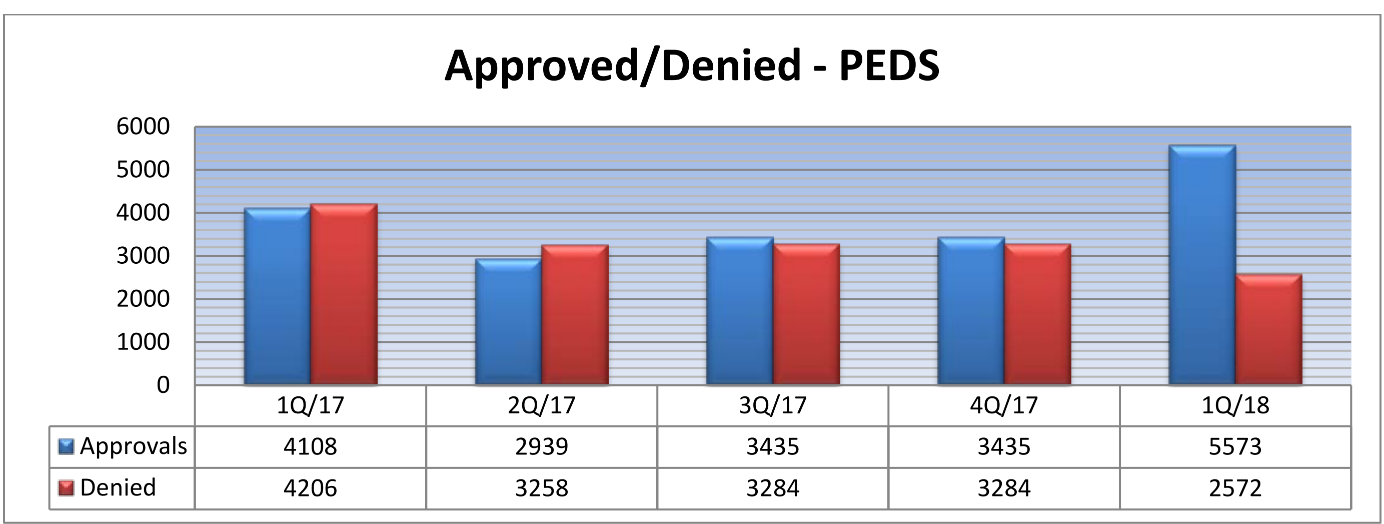
	1Q/17	2Q/17	3Q/17	4Q/17	1Q/18
Admissions	1067	980	1006	984	1338
Days	8314	6197	6719	5104	8145



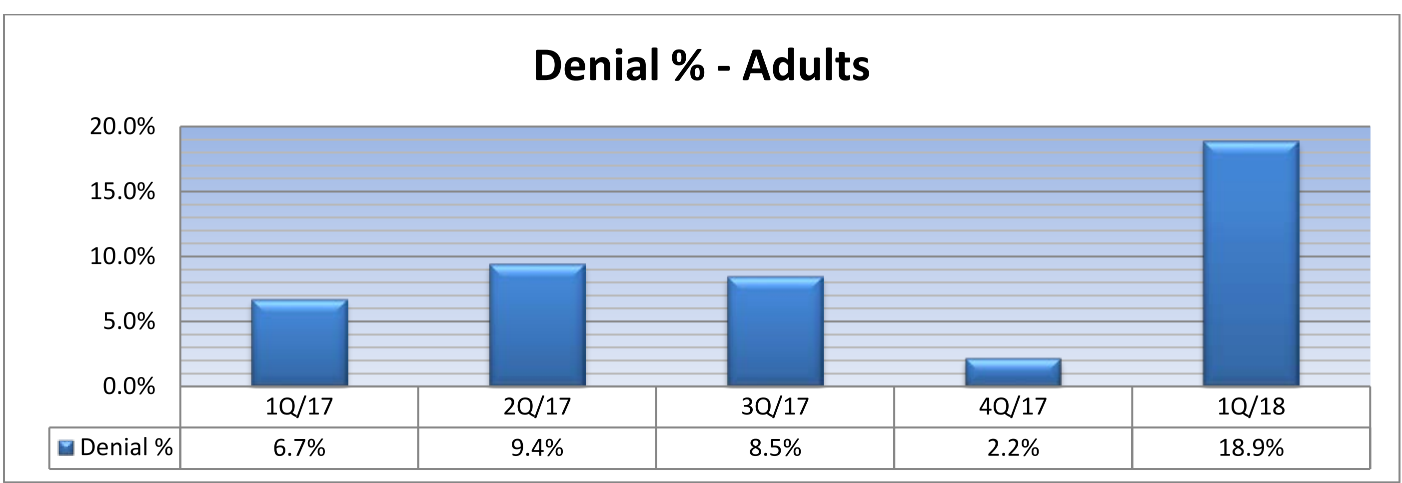
	1Q/17	2Q/17	3Q/17	4Q/17	1Q/18
Average LOS	7.8	6.35	6.68	5.19	6.09
Bed days/1000	103.8	77.7	84.7	64.3	99.9



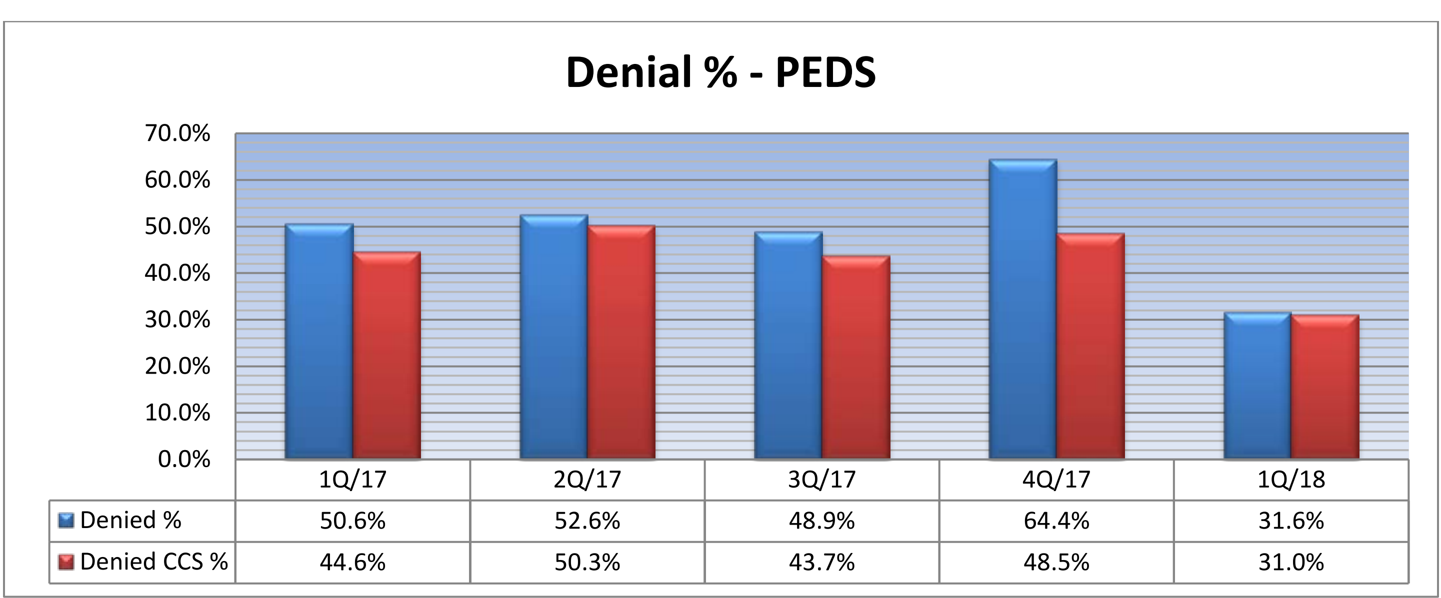
	1Q/17	2Q/17	3Q/17	4Q/17	1Q/18
Approvals	17868	15644	15526	15526	12270
Denied	1283	1627	1435	1435	2855



	1Q/17	2Q/17	3Q/17	4Q/17	1Q/18
Approvals	4108	2939	3435	3435	5573
Denied	4206	3258	3284	3284	2572



	1Q/17	2Q/17	3Q/17	4Q/17	1Q/18
Denial %	6.7%	9.4%	8.5%	2.2%	18.9%



	1Q/17	2Q/17	3Q/17	4Q/17	1Q/18
Denied %	50.6%	52.6%	48.9%	64.4%	31.6%
Denied CCS %	44.6%	50.3%	43.7%	48.5%	31.0%

Continuity of Care

Total Referral – 17

Total Approval – 16

Total Denial - 1

Total SPD COC -3

UM Provider Disputes

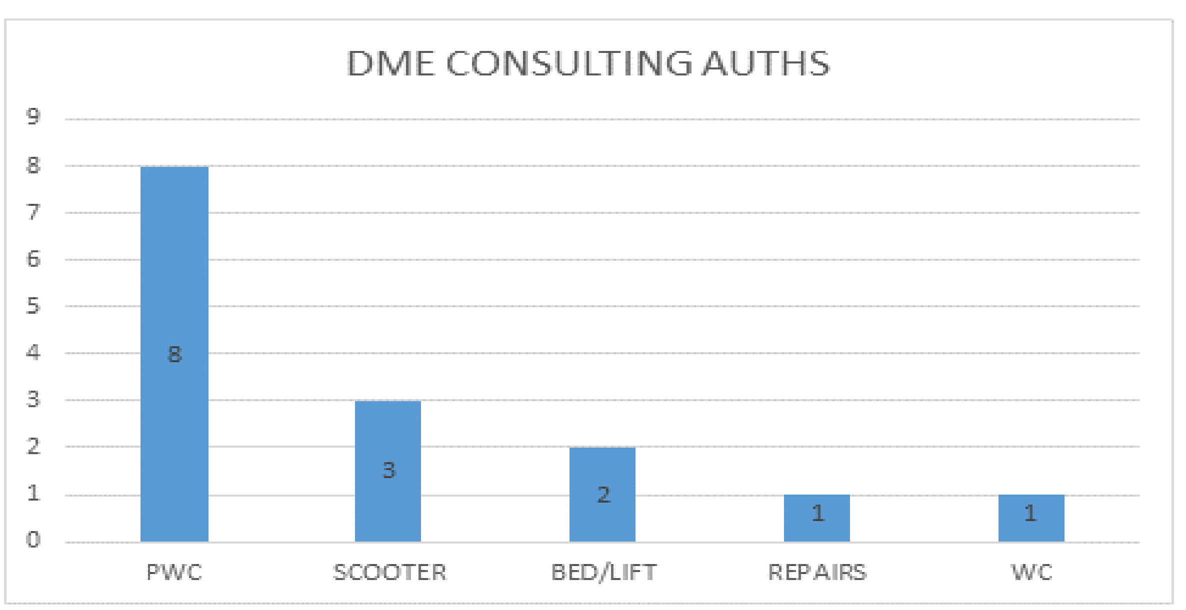
Total Disputes – 18

Favor of Provider -5

Favor of Plan – 4

Pending – 9

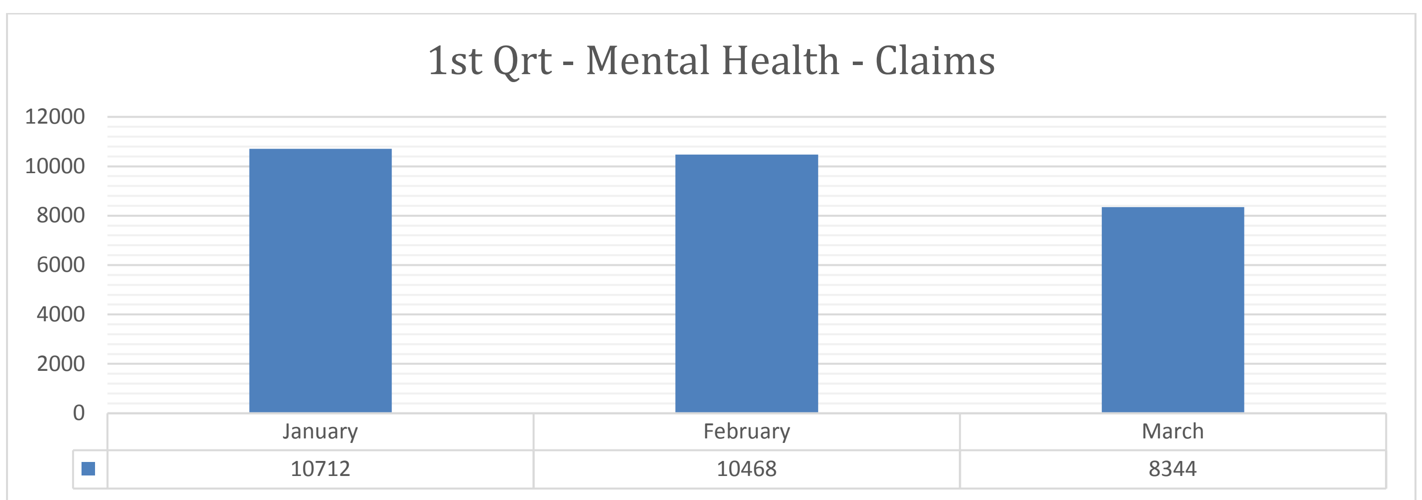
DME Consulting



Autism Reporting

UNIQUE CASES		Mild	Moderate	Severe	Total	Undetermined
MEMBER COUNT	128	16	46	7	69	59
Severity %		23.19%	66.67%	10.14%	1	
SEVERITY	JAN	FEB	MAR	TOTAL		
MILD	3	7	6	16		
MODERATE	4	15	25	44		
SEVERE	1	3	3	7		
Approved FBA	32	32	30	94		
Approved Treatment	37	26	35	98		
PENDING DX	39	12	9	60		
	JAN	FEB	MAR	TOTAL		
AGE 7 OR LESS	25	23	21	69		
AGE 8 OR GREATER	22	14	22	58		
TOTAL	39	37	43	119		
% < 7	64.10%	62.16%	48.84%	57.98%		
% > 8	56.41%	37.84%	51.16%	48.74%		

Mental Health



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
2017	April	155	16	7	23
	May	105	10	9	19
	June	516	26	13	39
	July	99	15	2	17
	August	348	34	3	37
	September	101	9	0	9
	October	374	8	1	9
	November	641	48	25	73
	December	10,512	314	45	359
2018	January	740	21	0	21
	February	0	0	0	0
	March	0	0	0	0
Totals		**13,591**	**501**	**105**	**606**

LTM Effectiveness* : 4 %

12-Month Effectiveness (Oct 2016 - Sep 2017) : 8 %

Reported Cases

	Members	
Received Eye Exam:	20,012	
Diabetes?:	1,015	5.1%
Diabetic Retinopathy:	124	.6%
Glaucoma:	178	.9%
Hypertension:	808	4.0%
High Cholesterol	233	1.2%
Macular Degeneration:	40	.2%

Estimated Number of Cases

Total Members:	242,919	
Diabetes?:	5,568	2.3%
Diabetic Retinopathy:	477	.2%
Glaucoma:	926	.4%
Hypertension:	24,284	10.0%
High Cholesterol	36,691	15.1%
Macular Degeneration:	298	.1%

CASE MANAGEMENT DEPARTMENT MONTHLY REPORT

Report Date: April 6th, 2018

Reporting Period: January 31st, 2018 – March 31st, 2018

CASE MANAGEMENT DEPARTMENT OVERVIEW:

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

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

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

- Promotion and support of the Medical Home as the source of the member's primary healthcare and source of specialty referrals, and enhancing this with the necessary social, care management and medical support to facilitate comprehensive patient-centered planning
- Identification and elimination of potential barriers to seeking and receiving appropriate care within their designated medical home (e.g., housing, transportation, child care, nutrition, mental and behavioral health needs, identification of culturally competent providers and appropriate access, discharge and transitional care planning, health education, etc.)
    - Potential assessment and education modules may include:
        1. Social needs
        2. Medical and/or behavioral health home
        3. Appointment attendance
        4. Urgent symptom management
        5. Medication and treatment adherence
        6. Behavioral risk
        7. Condition-specific self-management

As a result of this assessment, the Case Manager will:

- Contact the Primary Care Physician as needed to identify areas where he/she would like assistance (e.g., improving medication compliance)
- Identify communication preferences when more than one provider is involved in the medical care (e.g., does the PCP prefer all coordination go through his/her office or should the disease manager reach out to the specialist as appropriate?)
- Determine the type and frequency of information the PCP wants going forward
- Develop the person-centered care plan in conjunction with the PCP using predictive modeling risk scores with clinical based rules and medical management platforms (e.g., Milliman Care Guidelines, KHS internal criteria, etc.)

The following processes and activities are in place for Case Management/Coordination of Care:

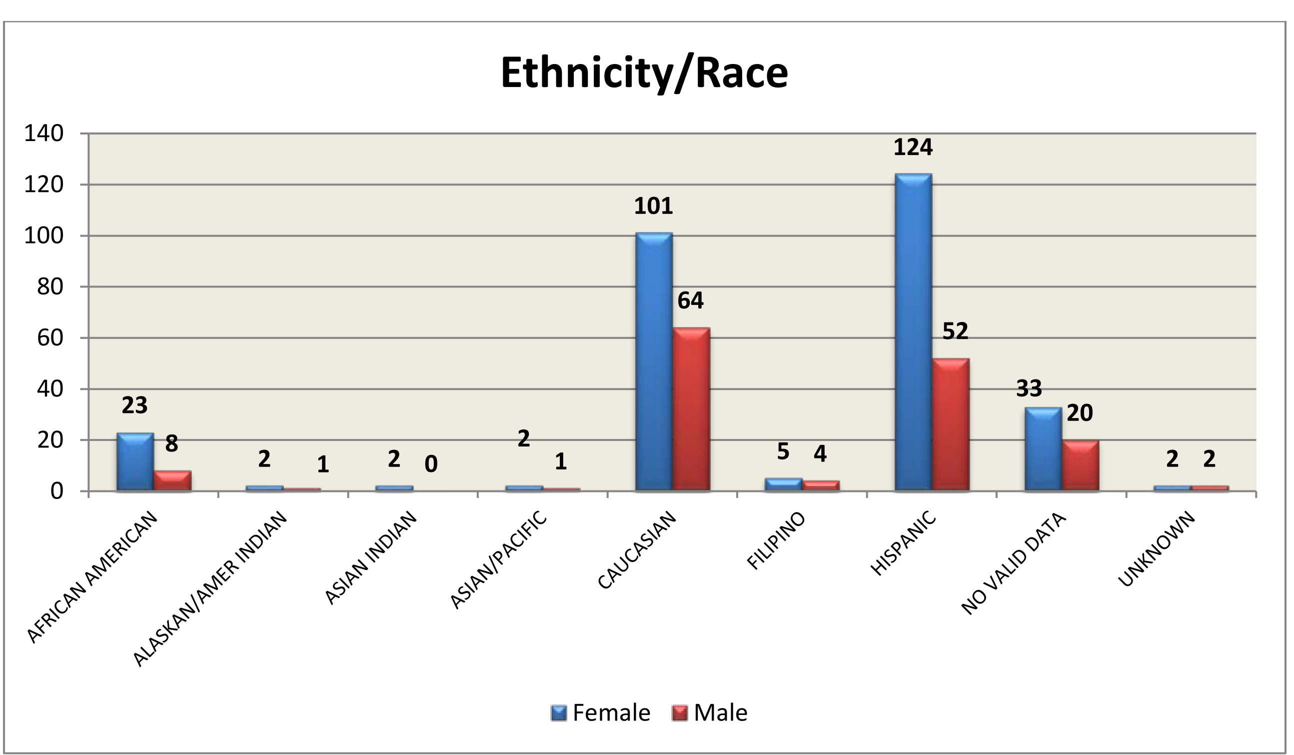
- Collaborate with PCPs for basic CM services
- Arrange and track referrals to specialists
- Track referrals and coordination of car for carved out and other out-of-network services and providers
- Identify community resources and refer members
- Offer health education services
- Implement continuous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

Case Management Team Staffing:

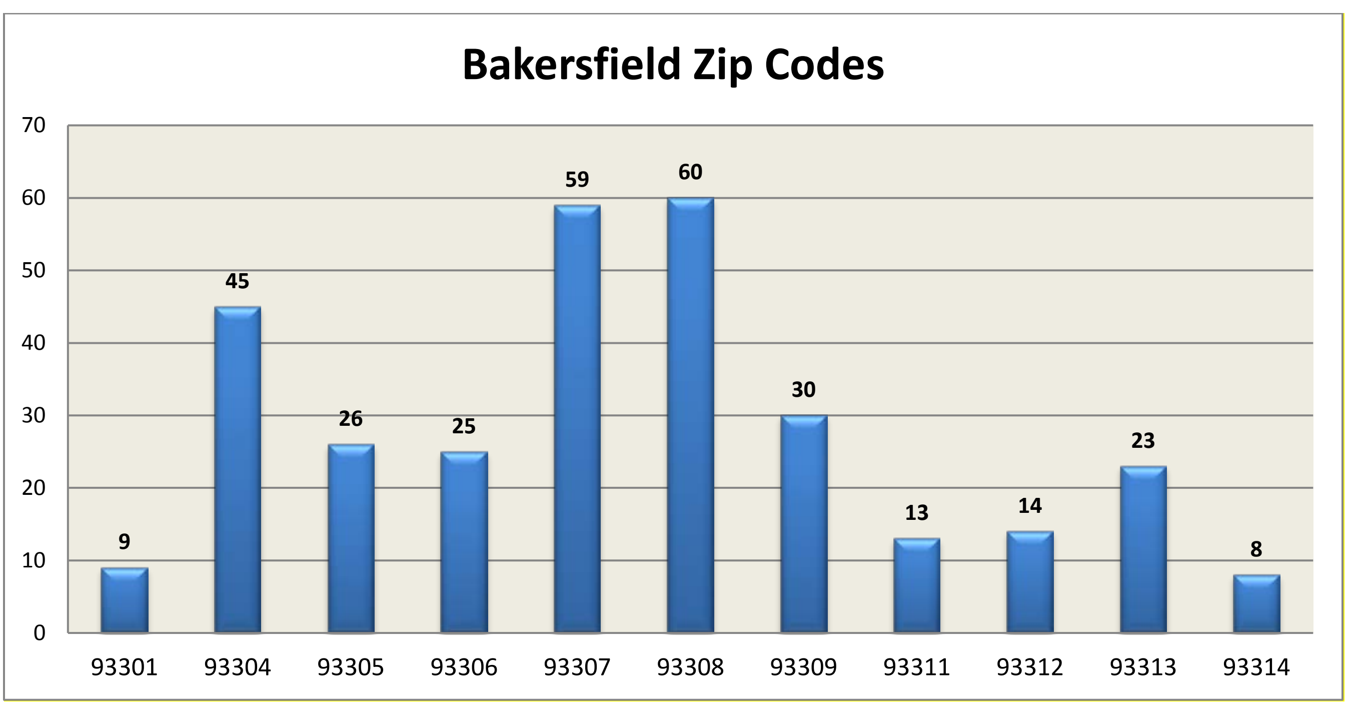
January – March 2018 Case Management Staffing:

Position	Quantity
Case Management RN	7
Case Management CMA's	6
Case Management MSW	6
Case Management Sr. Analyst and Trainer	1

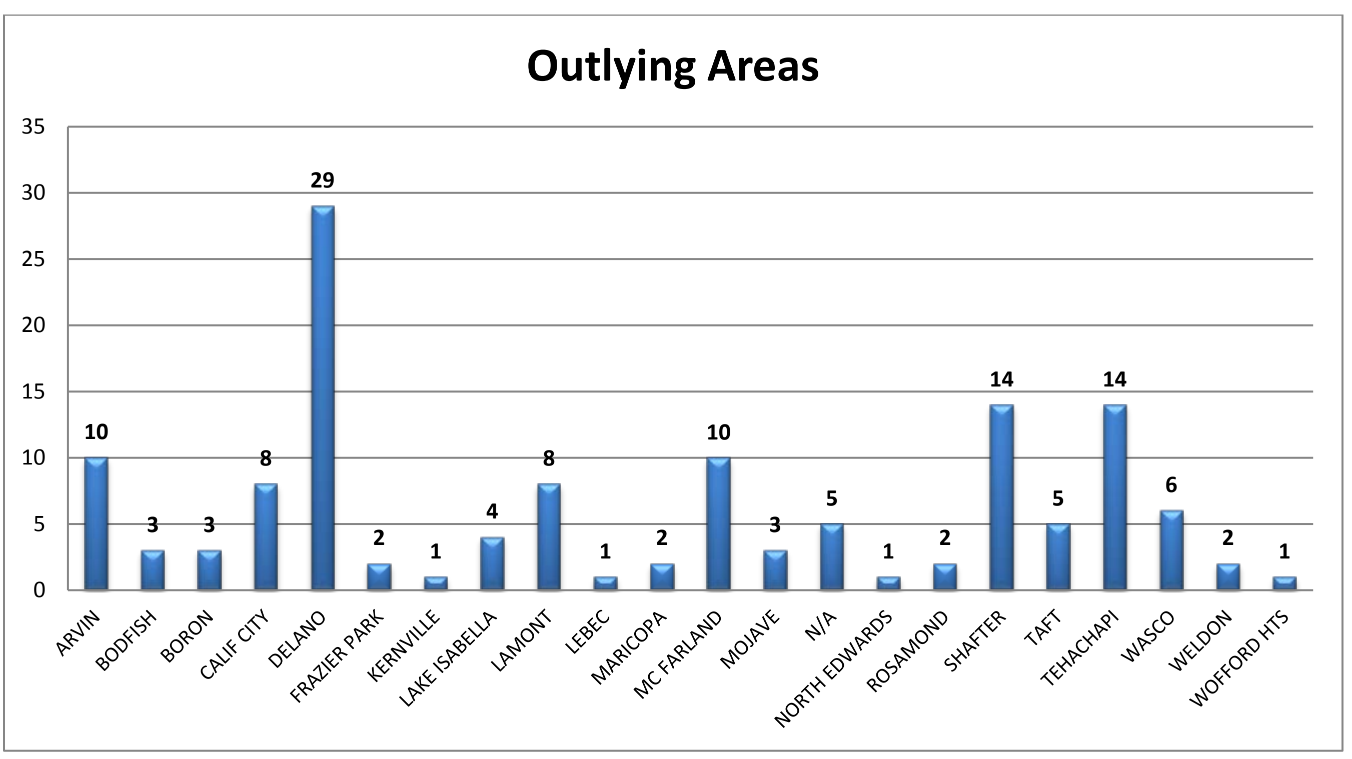
During this 1st Quarter 2018, there were a total of 646 KFHC members that were managed by the CM staff department. Majority of the members managed during the 1st Quarter 2018 were female at 66%. The majority of the members managed this quarter at 40% are Hispanic.



The majority of the members that were managed during the 1st Quarter 2018 reside in Bakersfield at 70%. Of the members from Bakersfield, the majority at 19% reside in the 93308 zip code.

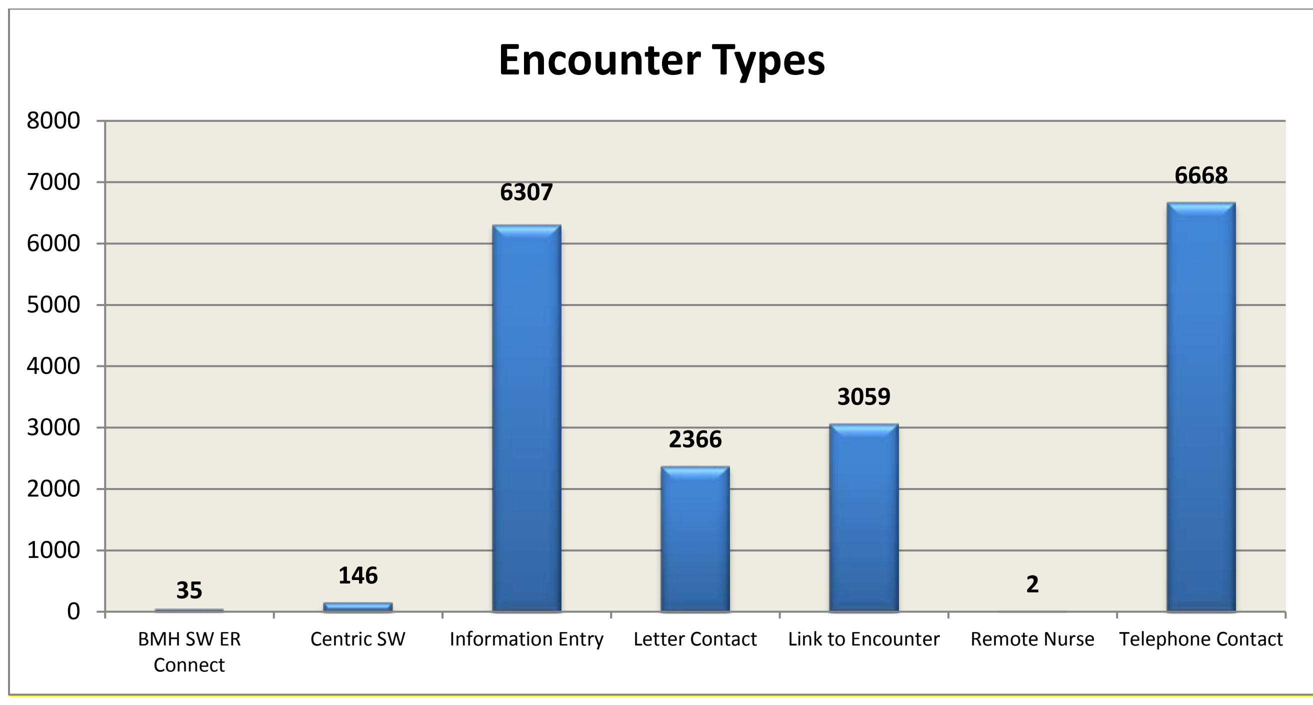


Of the outlying areas, majority of the members at 22% reside in Delano.

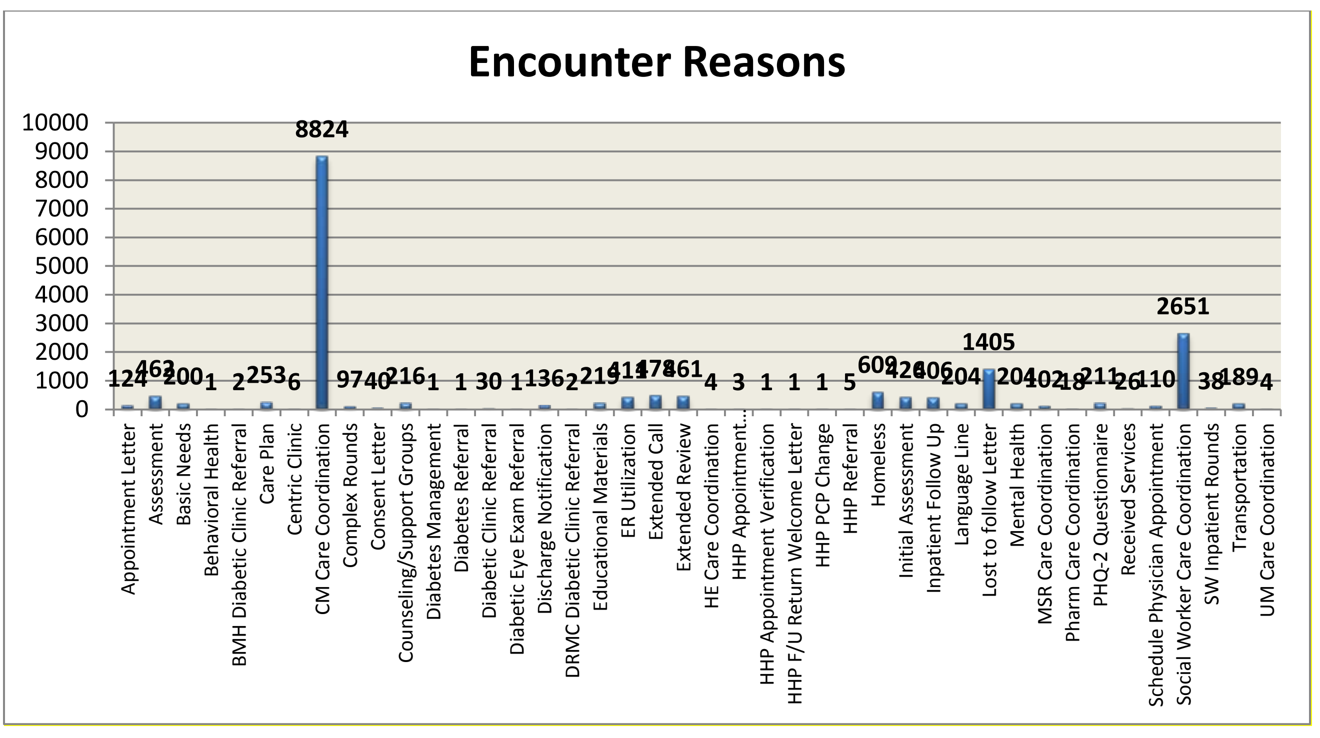


Encounters:

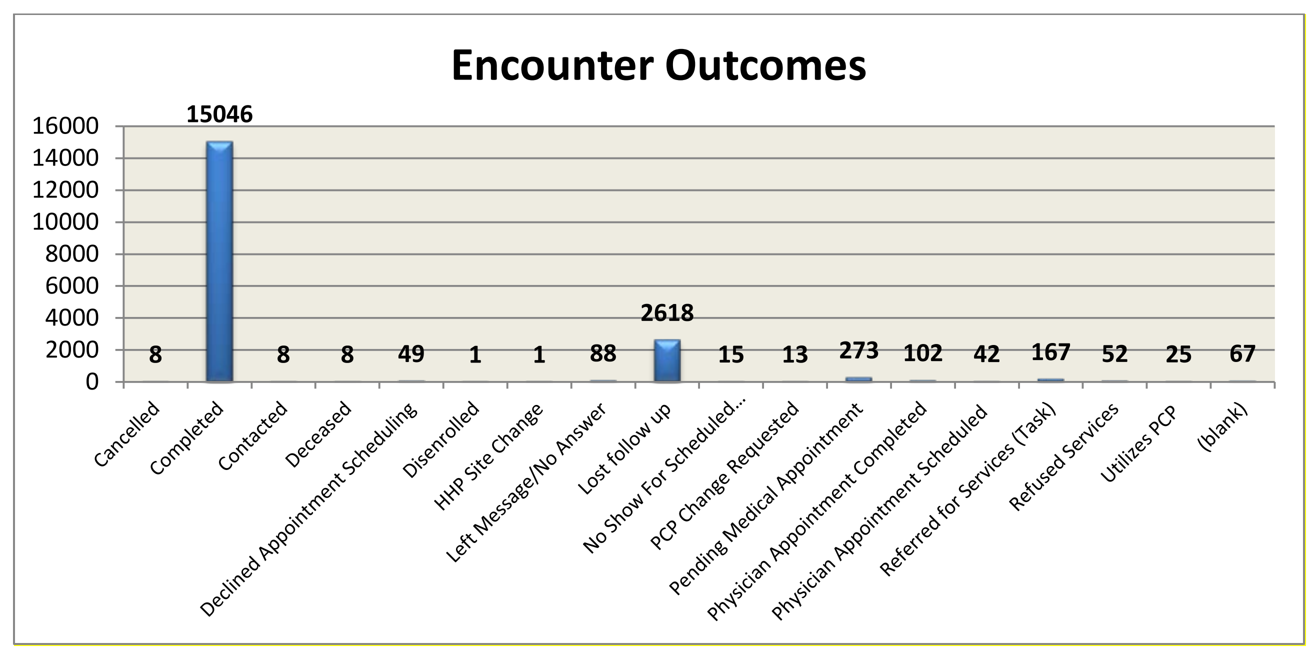
There were a total of 18,583 encounters submitted during the 1st Quarter for 646 KFHC members and the majority of the encounter types were listed as Telephone Contact at 36%.



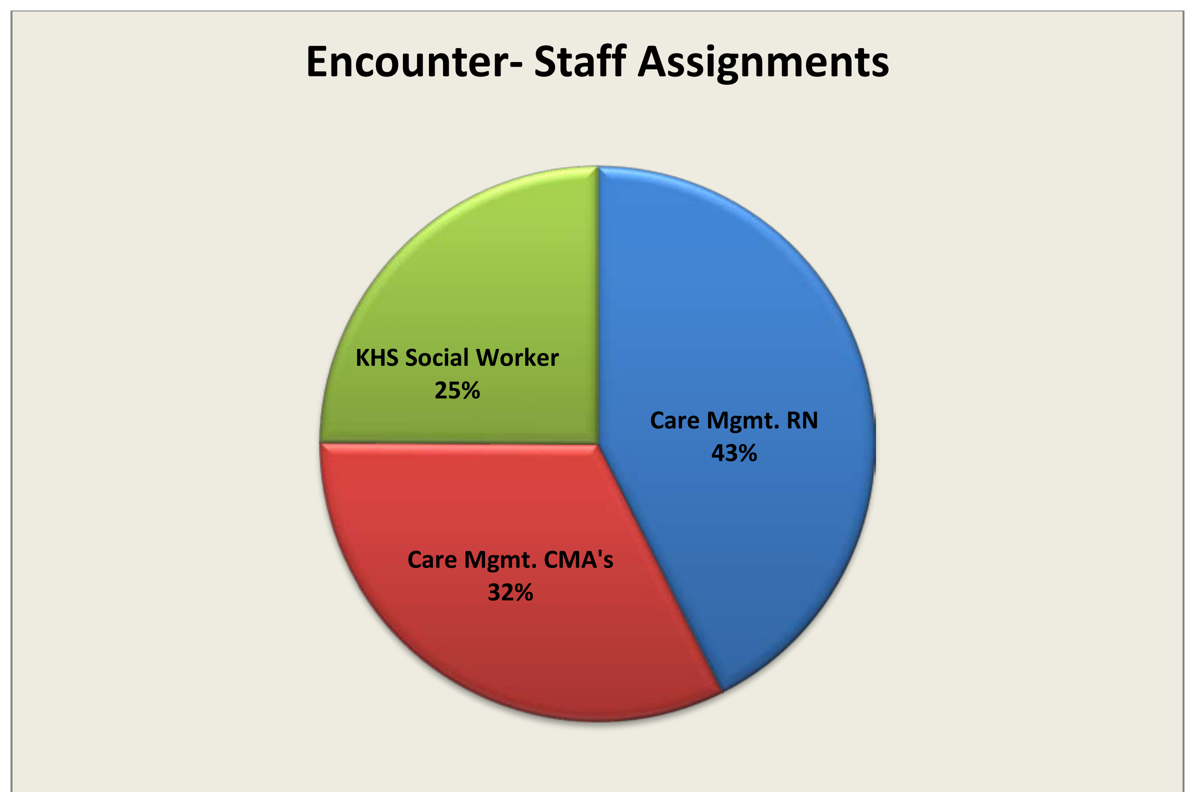
Majority of the encounter reasons at 48% was listed as CM Care Coordination.



Majority of the encounter outcomes at 81% are listed as Completed.

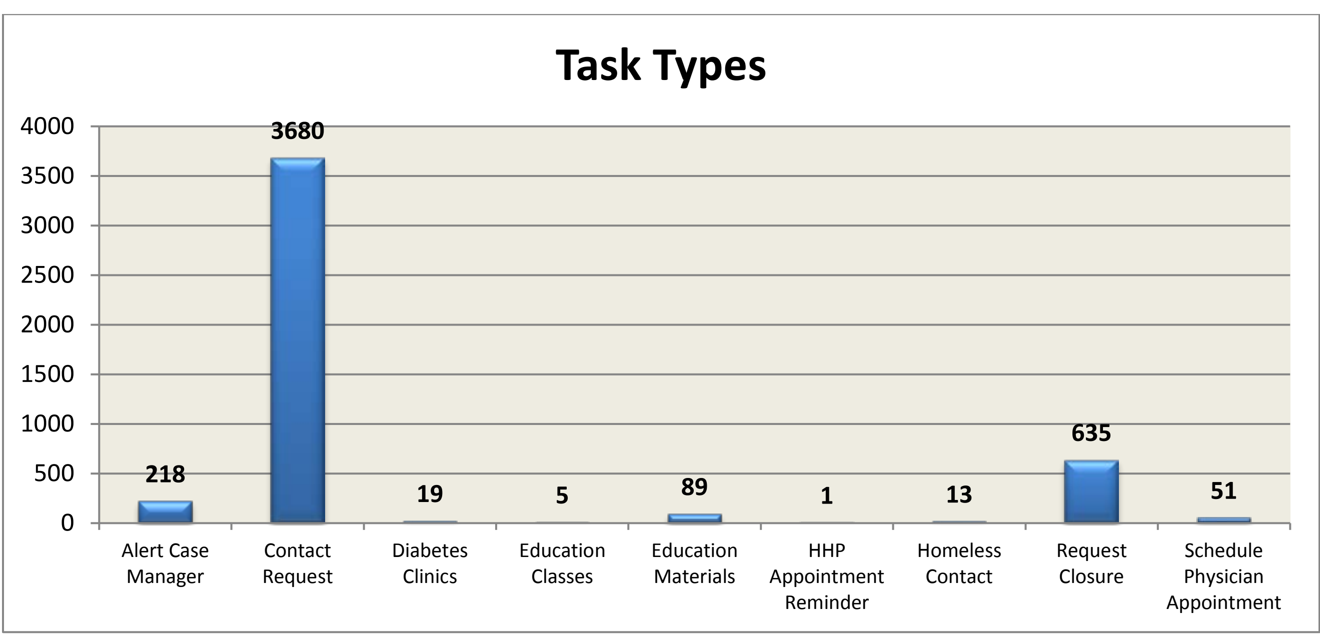


Majority of the encounters were completed by the Care Management RN's at 43%.

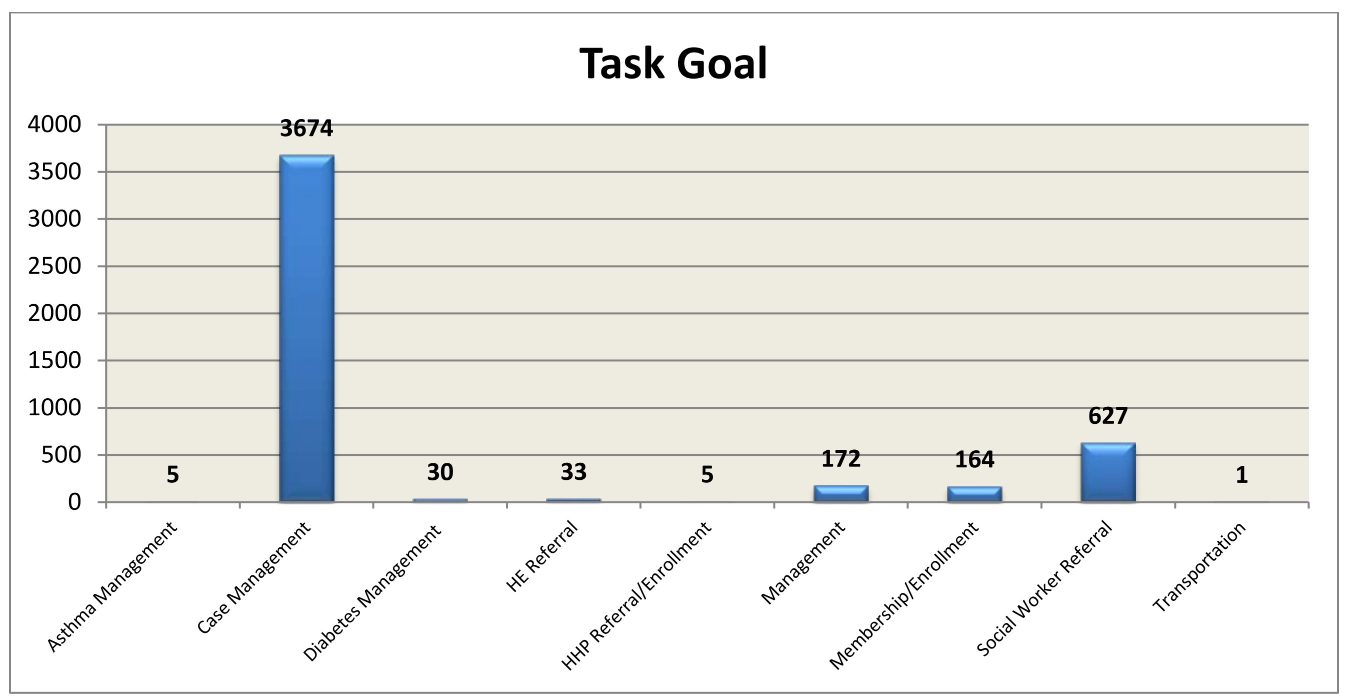


Tasks:

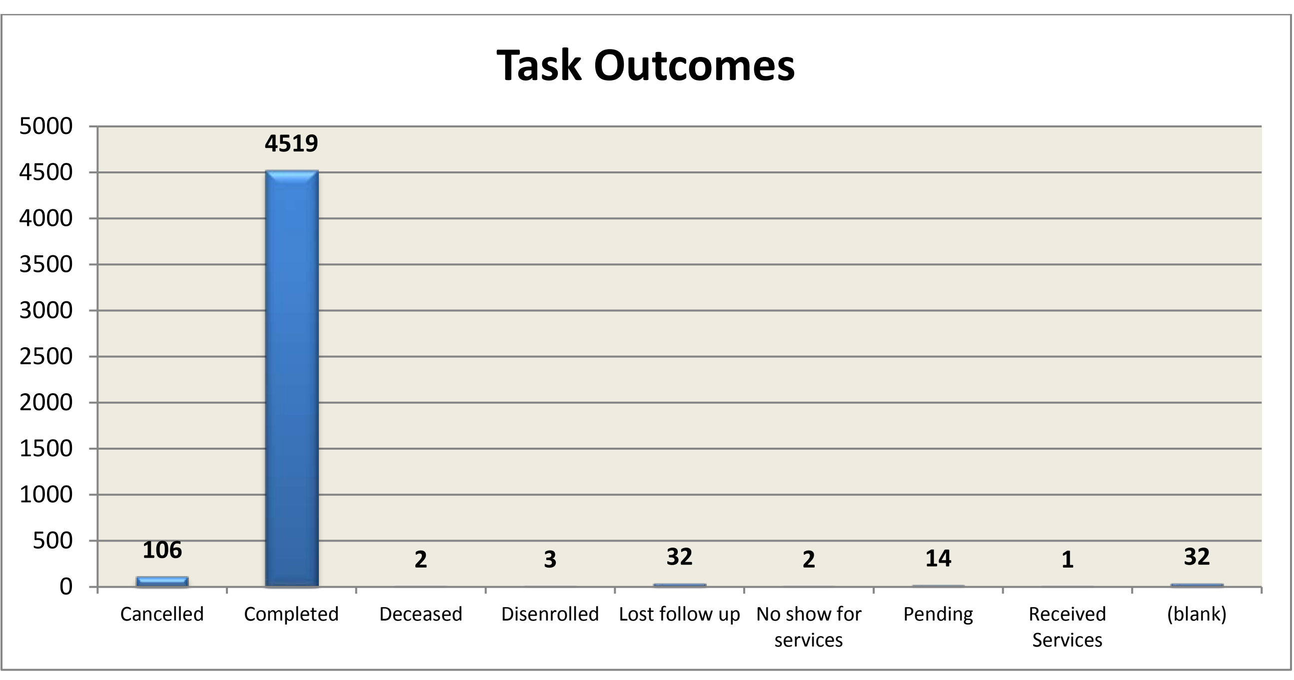
There were a total of 4,711 tasks submitted during the 1st Quarter for 646 KFHC members. The majority of Task Types were Contact Request at 78%.



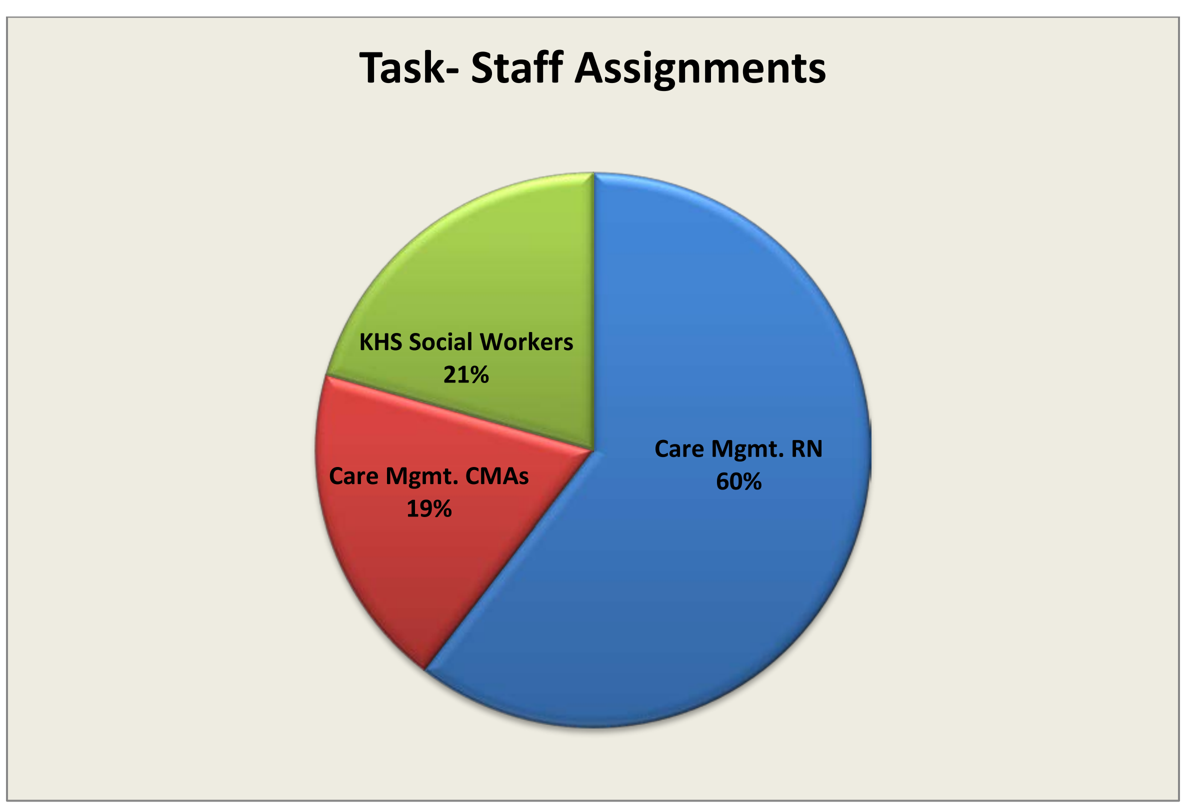
Majority of task goals during the 1st Quarter at 78% were listed as Case Management.



Majority of the task outcomes at 96% are completed.



Majority of the tasks were assigned by the Case Management RN' at 60%.



Seniors and Persons with Disabilities (SPDs):

There were a total of 308 SPD members that were enrolled during the 1st Quarter 2018, according to the high risk stratification report.

There are a total of 13,313 SPD members to date.

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 1st Quarter.

KERN HEALTH SYSTEMS
DISEASE MANAGEMENT DEPARTMENT QUARTERLY REPORT

Reporting Period: January 1, 2018 – March 31, 2018

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:

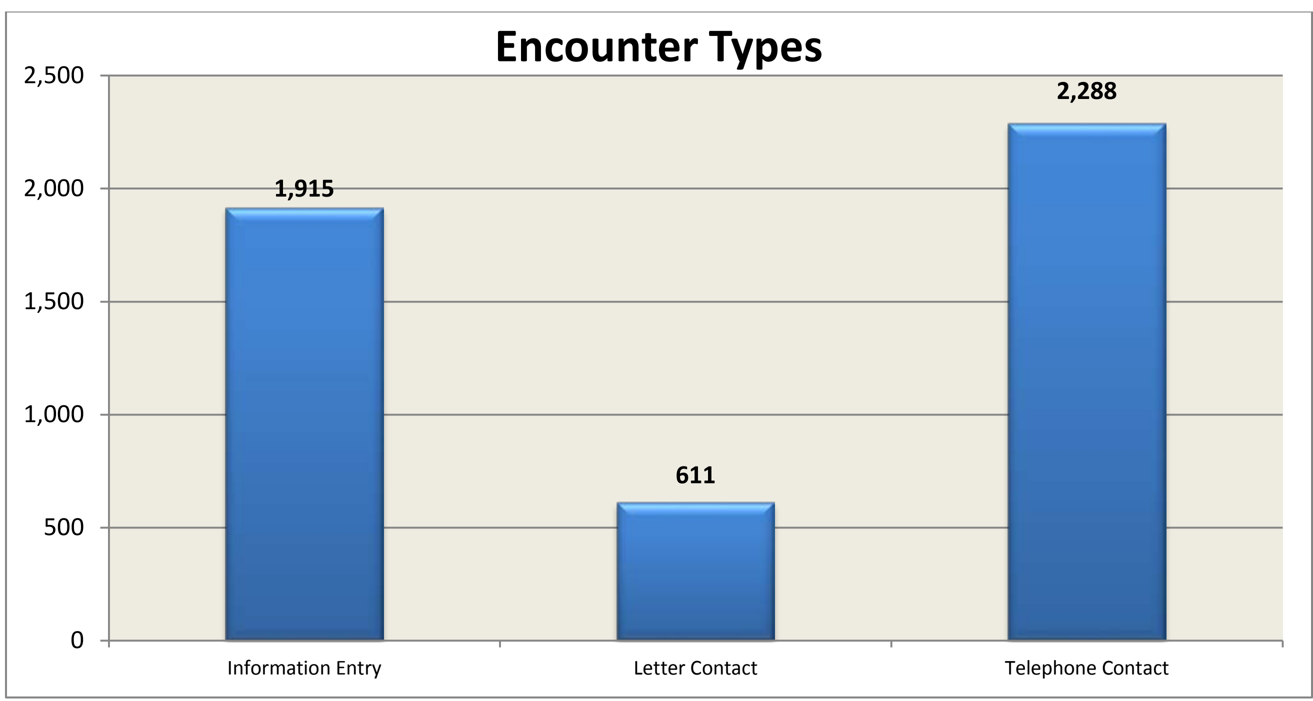
Staff	Caseload
RN 1	25
RN 2	9
RN 3	7
RN 4	16
TOTAL	**57**

DM Program Caseload:

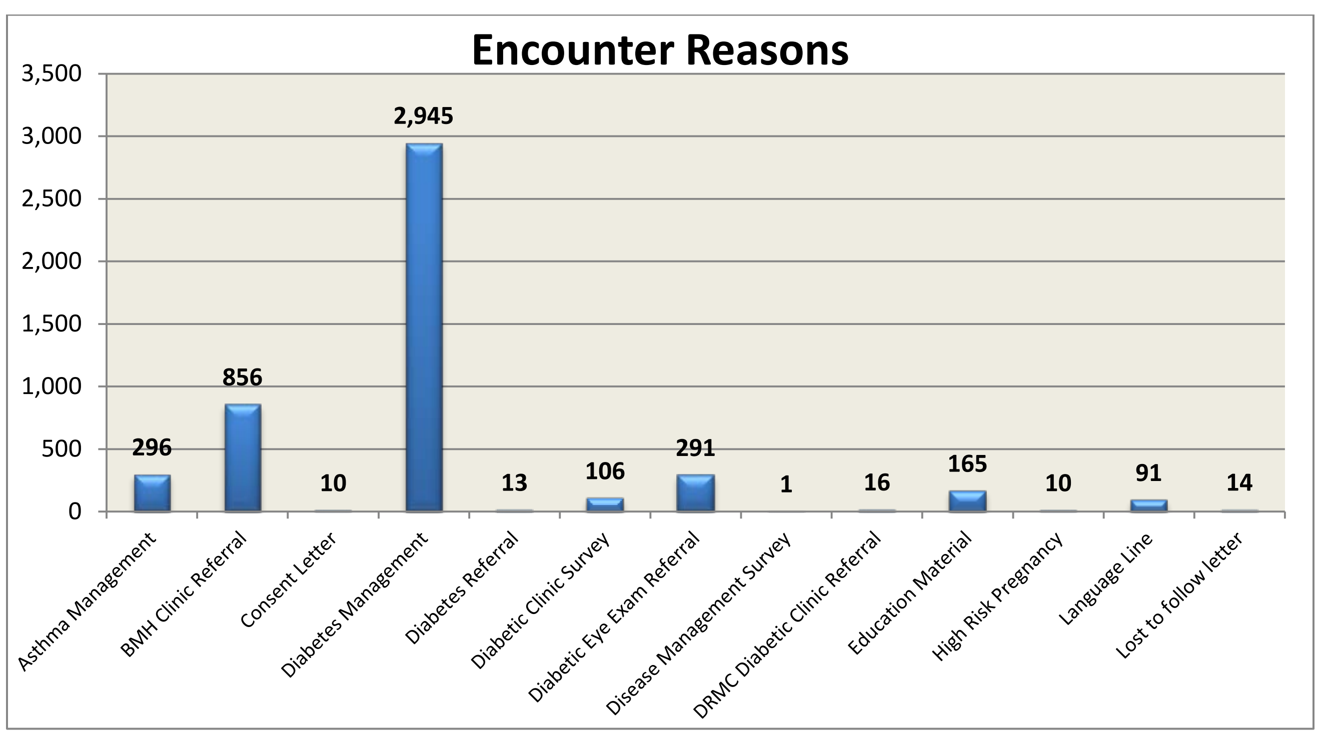
DM Program	Caseload
Asthma	20
Diabetes and Hypertension	37
TOTAL	**57**

Encounters:

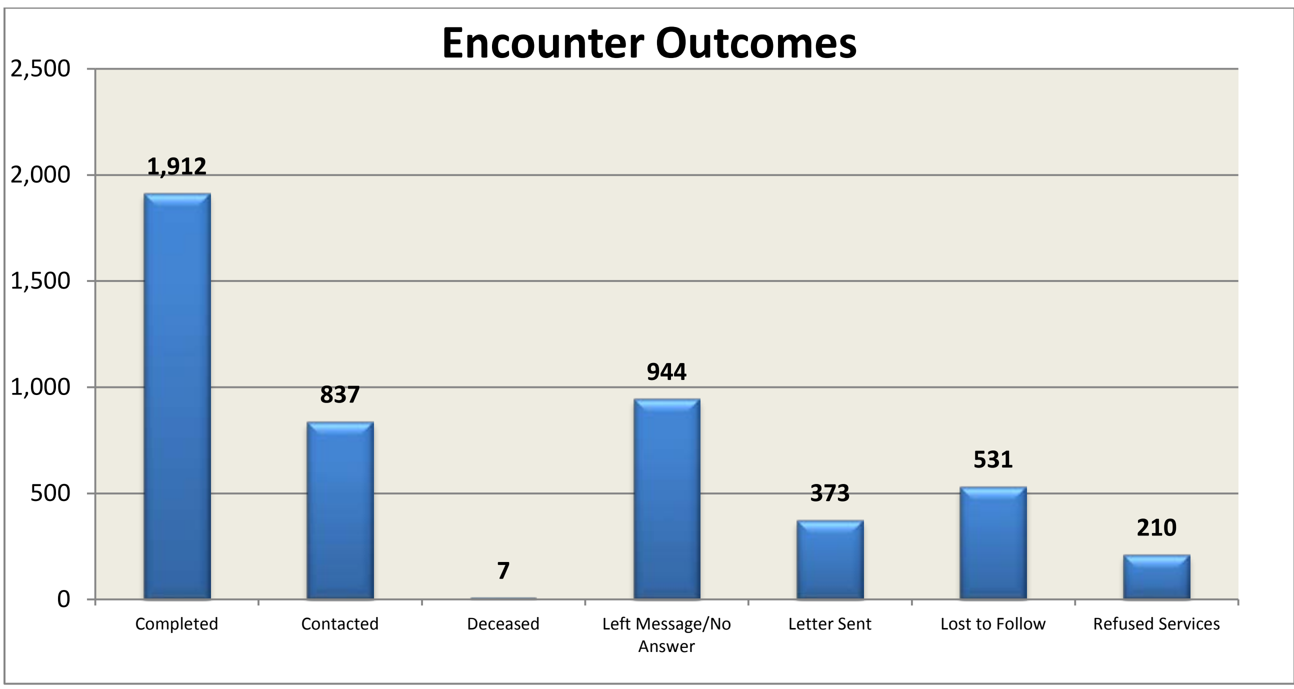
There were a total of 4,814 encounters submitted during this quarter for 1,676 KFHC members and the majority of the encounter types were listed as a Telephone Contact at 48%.



The majority of the encounter reasons at 61% was listed as Diabetes Management.

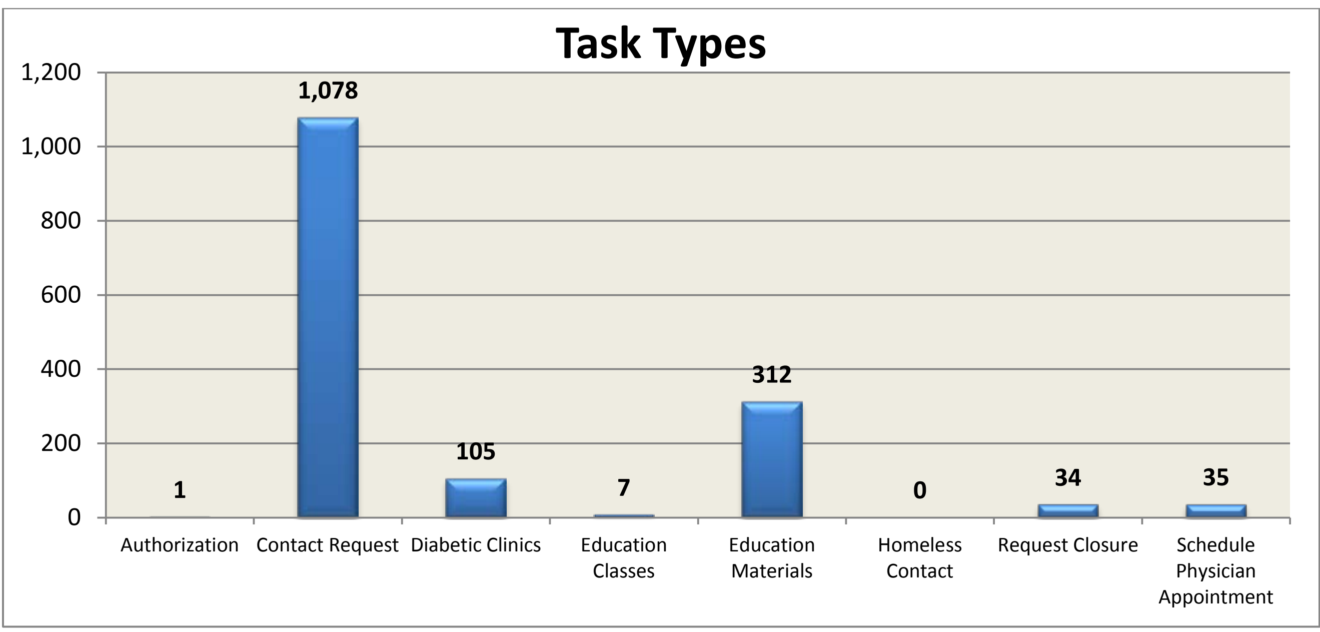

Encounter Reasons
3,500
3,000
2,500
2,000
1,500
1,000
500
0
296
856
10
2,945
13
106
291
1
16
165
10
91
14
Asthma Management
BMH Clinic Referral
Consent Letter
Diabetes Management
Diabetes Referral
Diabetic Clinic Survey
Diabetic Eye Exam Referral
Disease Management Survey
DRMC Diabetic Clinic Referral
Education Material
High Risk Pregnancy
Language Line
Lost to follow letter

The majority of the encounter outcomes at 40% are listed as completed.



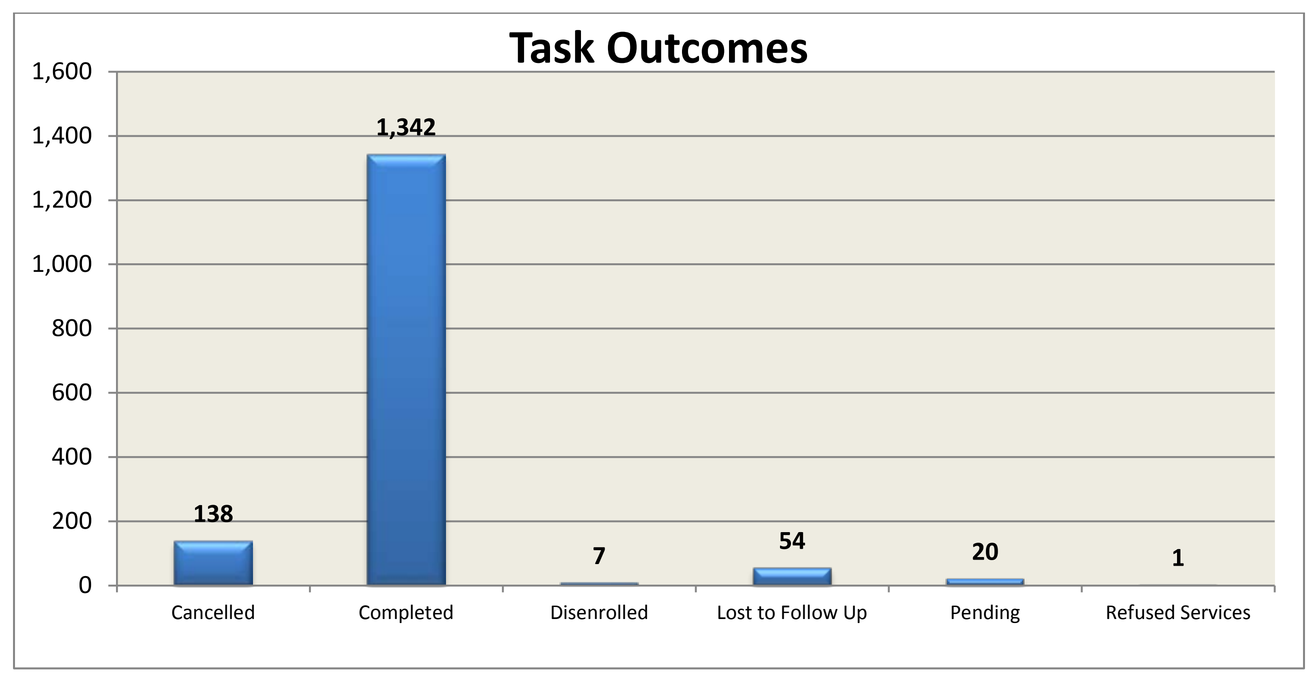
Tasks:

There were a total of 1,540 tasks assigned to the Disease Management department during the quarter for 918 KFHC members. The majority of Task Types were Contact Request at 69%.



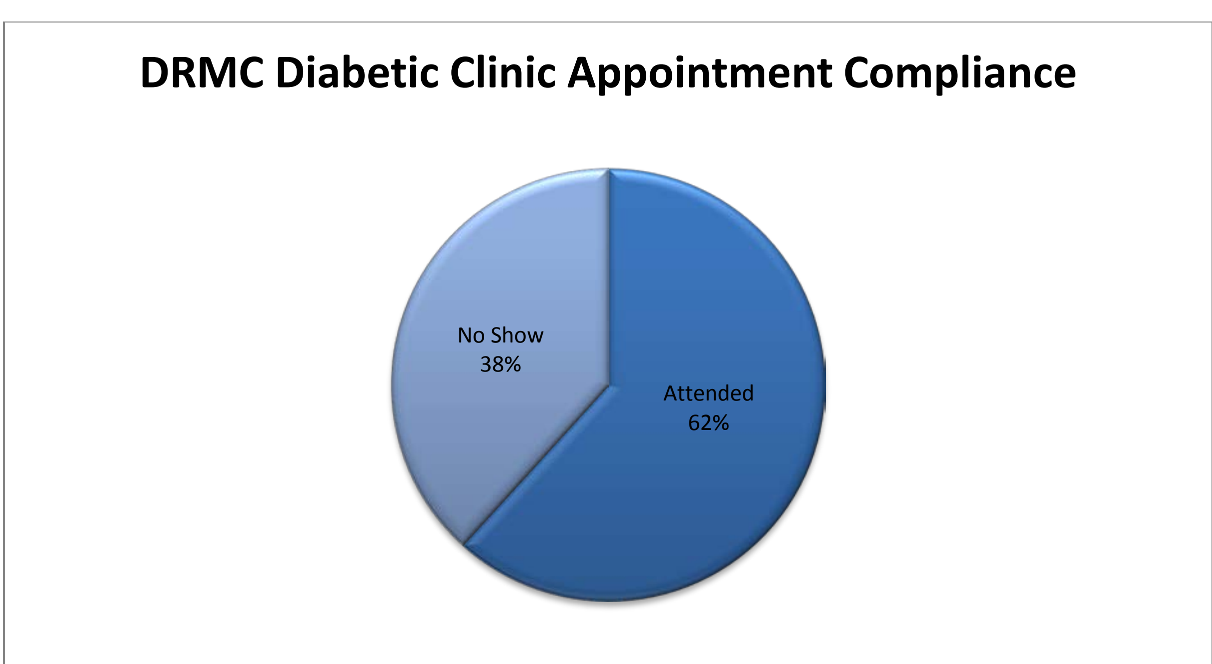
The majority of task goals at 85% was listed as Diabetes Management.

The majority of the task outcomes at 86% are completed.



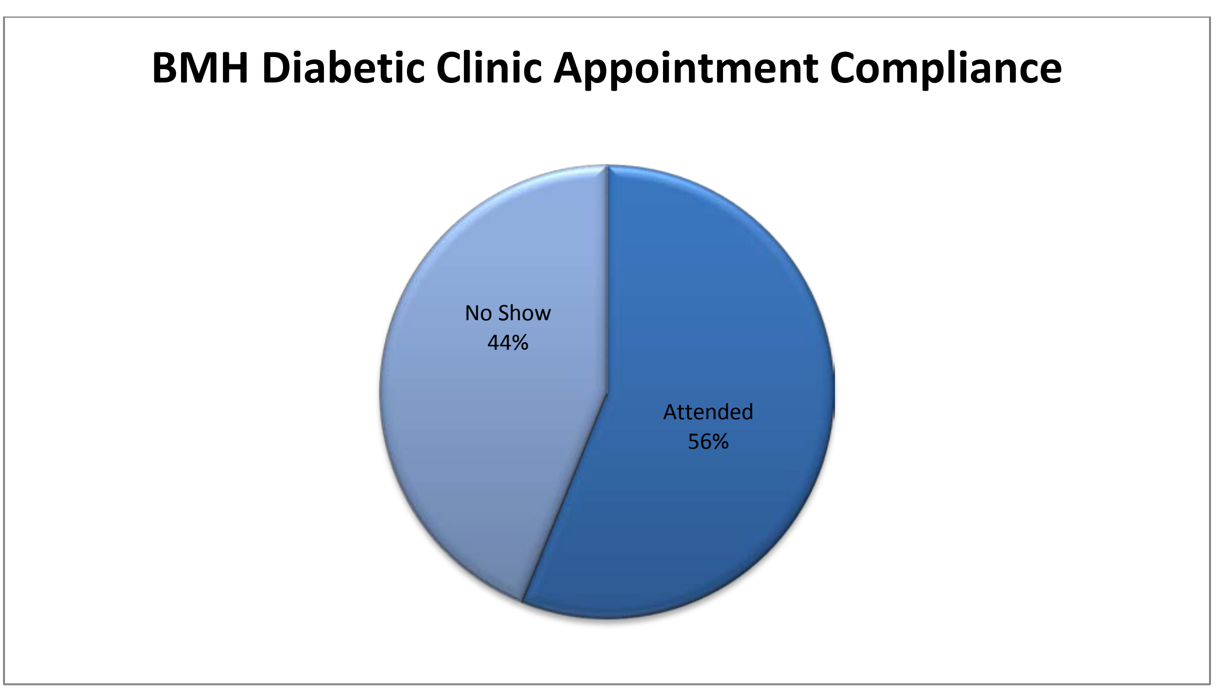
Delano Regional Medical Center (DRMC) Diabetic Clinic

The DRMC Diabetes Clinic ceased operation on February 22, 2018. Appointment compliance for January and February revealed that 62% of members attended their scheduled appointment.



Bakersfield Memorial Hospital (BMH) Diabetic Clinic

Appointment compliance at the BMH Diabetic Clinic revealed 56% of members attended their scheduled appointment.



Diabetes Text Messaging Program

Four diabetes related text messages, totaling 1.092were sent to members during this quarter. 99.5% of those messages were successfully received by the members.