KERN HEALTH SYSTEMS

REGULAR MEETING OF THE QI/UM COMMITTEE

Thursday, August 22nd, 2019
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, August 22nd, 2019

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; Paula Zandi; 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

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SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

3) Announcements
4) Closed Session
5) CMO Report

CA-6) QI/UM Committee Summary of Proceedings May 23rd, 2019 – RECEIVE AND FILE

7) Physician's Advisory Committee (PAC) Summary of Proceedings 2nd Quarter – APPROVE
   - April 2019
   - May 2019
   - June 2019

CA-8) Pharmacy TAR Log Statistics 2nd Quarter 2019 – RECEIVE AND FILE
   - April 2019
   - May 2019
   - June 2019

9) QI Focus Review Report 2nd Quarter 2019 – APPROVE
   - Critical Elements Monitoring
   - IHEBA Monitoring
   - IHA Monitoring

10) QI Site Review Summary Report 2nd Quarter 2019 – APPROVE
11) QI SHA Monitoring Report 2nd Quarter 2019 – APPROVE

Kaiser Reports

CA-12) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**
   - Kaiser 2018 QI Program Evaluation
   - Kaiser 2019 QI Work Plan
   - Kaiser 2019 QI Program Description
   - Kaiser 2018 UM Program Evaluation
   - Kaiser 2019 UM Work Plan
   - Kaiser 2019 UM Program Description

VSP Reports

13) VSP Reports
- Medical Data Collection Summary Report 2019– APPROVE
- VSP DER Effectiveness Report – APPROVE

Member Services

14) Grievance Operational Board Update - APPROVE
- 2nd Quarter 2019

15) Grievance Summary Reports – APPROVE
- 2nd Quarter 2019

CA-16) Call Center Report – RECEIVE AND FILE
- 2nd Quarter 2019

Provider Relations

17) Re-credentialing Report 2nd Quarter 2019 – APPROVE

CA-18) Board Approved New Contracts – RECEIVE AND FILE
- Effective May, 1st, 2019
- Effective June 1st, 2019
- Effective July 1st, 2019

CA-19) Board Approved Providers Reports – RECEIVE AND FILE
- Effective May, 1st, 2019
- Effective June 1st, 2019
- Effective July 1st, 2019

CA-20) Provider Relations Network Review Report 2nd Quarter 2019– RECEIVE AND FILE

Disease Management

21) Disease Management 2nd Quarter 2019 Report – APPROVE

Policies and Procedures

22) QI/UM Policies and Procedures – APPROVE
- 2.26 I Hospital Re - Admissions - Quality of Care Issues
- 2.26 I Hospital Re - Admissions - Attachment A

Health Education Reports

23) Health Education Activity Report 2nd Quarter 2019 – APPROVE

QI Department Reports

24) KHS 2018 QI Program Evaluation – APPROVE
25) KHS 2019 QI Program Description – APPROVE
26) KHS 2019 QI Work Plan – APPROVE

UM Department Reports

27) Combined UM Reporting 2nd Quarter 2019 – APPROVE
28) KHS 2018 UM Program Evaluation - APPROVE
29) KHS 2019 UM Program Description - APPROVE

ADJOURN TO THURSDAY, November 14th , 2019 AT 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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SUMMARY OF PROCEEDINGS

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

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

Regular Meeting
Thursday, May 23, 2019
7:00 A.M.

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Members Present: Satya Arya, MD; Danielle C Colayco, PharmD, MS; Felicia Crawford, RN; Allen Kennedy; Philipp Melendez, MD; Chan Park, MD; Maridette Schloe MS, LSSBB; Paula Zandi,Martha Tasinga, MD, CMO

Members Absent: Jennifer Ansolabehere, PHN

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

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COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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3) Announcements – **Dr. Martha Tasinga introduced Jane Daughenbaugh, our new Director of Quality Improvement to the committee.**

4) Closed Session – **N/A**

5) CMO Report – **Dr. Martha Tasinga gave overview of the new HEDIS Quality Measure Requirements from DHCS to the committee:**

- **For HEDIS reporting year 2020, Governor Newsom has proposed changes to the required measures for all Medical plans. In addition to adding new measures, plans will now be held to the 50th percentile for all measures. KHS is currently performing at that level for some of the measures but not all.**
- **KHS failed to meet the MPL for Asthma Medication Ratio (AMR) measure yet again. The plan anticipates a CAP from the state this year and is already working on establishing an asthma compliance program.**

CA-6) QI/UM Committee Summary of Proceedings February 21st, 2019 – RECEIVED AND FILED
Melendez-Crawford: All Ayes

7) Physician's Advisory Committee (PAC) Summary of Proceedings 1st Quarter – APPROVED

- February 2019
- March 2019

Melendez-Arya: All Ayes

CA-8) Pharmacy TAR Log Statistics 1st Quarter 2019 – RECEIVED AND FILED

Melendez-Kennedy: All Ayes

- January 2019
- February 2019
- March 2019

9) QI Focus Review Report 1st Quarter 2019 – APPROVED

Kennedy-Arya: All Ayes

- Critical Elements Monitoring
- IHEBA Monitoring
- IHA Monitoring

CA-10) QI Site Review Summary Report 1st Quarter 2019 – RECEIVED AND FILED

Melendez-Kennedy: All Ayes

CA-11) QI SHA Monitoring Report 1st Quarter 2019 – RECEIVED AND FILED

Melendez-Kennedy: All Ayes

Kaiser Reports

CA-12) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**

- KFHC APL Grievance Report-4th Quarter 2018 – RECEIVED AND FILED
- KFHC APL Grievance Report-1st Quarter 2019 – RECEIVED AND FILED
- KFHC UM DME Authorization Denial Report 4th Quarter 2018– RECEIVED AND FILED
- KFHC Volumes Report 4rd Quarter 2018 – RECEIVED AND FILED
- KFHC Volumes Report 1st Quarter 2019 – RECEIVED AND FILED

Melendez-Kennedy: All Ayes

VSP Reports

13) VSP Reports

- Medical Data Collection Summary Report 2019– APPROVED
- VSP DER Effectiveness Report – APPROVED

Melendez-Arya: All Ayes

Member Services

14) Grievance Operational Board Update - APPROVED

- 1st Quarter 2019

Melendez-Arya: All Ayes

15) Grievance Summary Reports – APPROVED

- 1st Quarter 2019

Melendez-Arya: All Ayes

CA-16) Call Center Report – RECEIVED AND FILED
- 1st Quarter 2019

Melendez-Arya: All Ayes

Provider Relations

CA-17) Re-credentialing Report 1st Quarter 2019 – RECEIVED AND FILED

Melendez-Kennedy: All Ayes

CA-18) Board Approved New Contracts – RECEIVED AND FILED
- Effective March 1,2019
- Effective April 1, 2019

Melendez-Kennedy: All Ayes

CA-19) Board Approved Providers Reports – RECEIVED AND FILED
- Effective March 1,2019
- Effective April 1, 2019

Melendez-Kennedy: All Ayes

CA-20) Provider Relations Network Review Report 1st Quarter 2019– RECEIVED AND FILED

Melendez-Kennedy: All Ayes

Disease Management

21) Disease Management 1st Quarter 2019 Report – APPROVED

Melendez-Arya: All Ayes

- **Michael Pitts, Director of Case Management and Disease Management gave committee an overview on the DPP Program.**

- **Program Duration: 26 Group Sessions over 12 Months.**
- **Goal is to lose at least 5% weight and maintain 150 minutes of activity per week.**
- **Follow CDC approved Curriculum.**
- **Sessions 1 – 16: Meet Once a Week for Four Months.**
- **Sessions 17 – 20: Meet Every Other Week for Two Months.**
- **Sessions 21 – 26: Meet Once a Month for Four Months.**
- **Classes held at KFHC Truxtun location: 5701 Truxtun Ave, Suite 201, Bakersfield, CA 93309**
- **Each Group Session one (1) Hour Duration.**
- **Classes commenced on Monday, March 4, 2019.**
- **Both English and Spanish sessions offered.**
- **English: Monday 10 a.m. - 11 a.m. and Wednesday 3 p.m. – 4 p.m.**
- **Spanish: Monday 3 p.m. – 4 p.m. and Wednesday 10 a.m. – 11 a.m.**
- **54 members originally enrolled in program**
- **As of 4/22/19, current active member participation after 8 sessions is 32.**

Policies and Procedures

CA-22) QI/UM Policies and Procedures – APPROVED

- 3.02-P Major Organ Transplant
- 3.03-P Kern Regional Center Services
- 3.05-I Preventative Medical Care
- 3.13-P EPSDT Services and Targeted Case Management
- 3.16-P California Children Services
- 3.21-P Family Planning and Services and Abortion
- 3.22-P Referral and Authorization Process
- 3.24-P Pregnancy and Maternity Care
- 3.72-I Behavioral Health Therapy
- 3.90-I Diabetes Prevention Program

Melendez-Kennedy: All Ayes

Health Education Reports

23) Health Education Activity Report 1st Quarter 2019 – RECEIVED AND FILED

Melendez-Kennedy: All Ayes

- **Distributed Summer Member Newsletter as handout. Includes various articles including a diabetes risk assessment quiz to encourage discussions with PCP.**
- **Eliza outreach pilot exceeded goals. 43% of target population reached and 55% of this group were transferred to a KHS representative.**
- **2019 School Wellness Grant and Internship Programs are open. Will announce grant awards next month.**
- **Health Education Referrals on the Provider Portal went live on 5/2019. Providers are encouraged to use this to request education and outreach services for KFHC members.**

UM Department Reports

24) Combined UM Reporting 1st Quarter 2019 – APPROVED

Melendez-Arya: All Ayes

Health Services overview and update for Q1 2019 given by Shannon Miller, Director of Utilization Management:

- **The 2019 membership enrollment remained stable at 252,000 members. Program evaluation including additional benefit coverage and broadening interdisciplinary collaboration to support our members will continue through 2019.**

Some current upcoming projects or efforts In Utilization Management are:

- **Maternal Depression Screening as part of focus on Maternal Mental Health starting 7/1/19.**
- **Conducting Kaiser Delegated Oversight Audit in May 2019.**

- **Continued transition to Jiva (medical management platform) with our HHP module being targeted for 7/1/19 implementation.**
- **DMHC Medical Audit in August 2019.**
- **Continue to work on new programs for medical respite and working with Housing Collaborative for homeless members.**

Meeting adjourned by Dr. Martha Tasinga, M.D., C.M.O. @ 8:11 A.M.
to Thursday, August 22, 2019

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE MEETING

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

Wednesday, April 3, 2019

7:00 A.M.

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COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D., Ph.D; David Hair, M.D., Ashok Parmar, M.D., Raju Patel, M.D., Jacqueline Paul-Gordon, M.D., Martha Tasinga, M.D., C.M.O.

Members Absent: Angela Egbikuadje, PD.MS, Miguel Lascano, M.D.

Meeting called to order at 7:05 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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STAFF RECOMMENDATION SHOWN IN CAPS

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CA-3) Minutes for KHS Physician Advisory Committee meeting on March 6, 2019 – APPROVED
Paul Gordon-Parmar: All Ayes

ADJOURNED TO CLOSED SESSION @ 7:08 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.**

- **Midlevel discussion amongst committee.**

- **Page 2 – Comprehensive review on new applicant (E.B.M.D.) was conducted. Provider has a Court Order by the Superior Court, County of Riverside, indicating provider is not to engage in solo-practice, billing limitations including a billing monitor. Dr. Tasinga discussed with the committee the current investigation being conducted by Federal authorities on the medical group this provider is joining. Recommendation to defer action on new applicant (E.B.M.D.) and refer to Legal Counsel for review.**

- **Page 3 – Provider PRV010279: Dr. Tasinga asked committee for their insight and recommendation. Members discussed providers case settlements and nature of the complications. After further discussion, motion was made, seconded and carried to modified approval of new**

applicant PRV010279 for 1 year due to significant malpractice history and allowing the opportunity for UM/QI to report any quality issues during the 1st year of network participation.

- **Page 4 – Provider PRV008374: Dr. Tasinga reviewed with committee nature of case settlements for new applicant PRV008374. Provider's clinical restrictions were based on provider performing cardiothoracic and cardiovascular surgeries greater than 10 –years ago. Provider is only being credentialed for the level of residency in General Surgery for KHS network participation. Committee all agreed.**

- **Credentialing & Recredentialing, New Contracts –**
  Paul Gordon-Hair – All Ayes

- **CORRECTIVE ACTION PLAN - PRV001174 – Multiple Grievances found in favor of the enrollee due to In-office Wait time. Yolanda presented the KHS Provider Corrective Action Plan for PRV001174. Provider has exceeded the accessible standards of P&P 4.30, Section 3.8 regarding Office Wait Time. Corrective Action Plan was implemented requiring this provider to reduce the number of grievances for in-office wait time for 6-months-time period to zero.**
  INFORMATIONAL ONLY / CAP RECEIVED AND REVIEWED - NO ACTION REQUIRED AT THIS TIME.

COMMITTEE RECONVENED TO OPEN SESSION @ 7:36 A.M.

5) Review new Policy 3.90-P Diabetes Prevention Program – APPROVED
Hair-Amin: All Ayes

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 7:55 A.M.
TO WEDNESDAY, MAY 1, 2019 AT 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE MEETING

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

Wednesday, May 1, 2019

7:00 A.M.

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COMMITTEE RECONVENED

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

Members Absent: None

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

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CA-3) Minutes for KHS Physician Advisory Committee meeting on April 3, 2019 – APPROVED
Parmar-Amin: All Ayes

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

CLOSED SESSION

3) Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) – **BY A VOTE OF 8-0, THE COMMITTEE APPROVED PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING AND RECREDENTIALING.**

- **PRV000252 – (Recredentialing) – Yolanda Herrera, Credentialing Supervisor, reviewed with the committee the provider's explanation surrounding the malpractice case and clinical privilege revocation from SJCH, to which the provider declined to proceed with a hearing, and subsequently resigned at the advisement of his attorney. The provider contends that he was not the on-call physician of record and that there were many inconsistency with the other physicians involved. Committee member thoroughly discussed case and asked if there was any pending investigation, which there are none and the Medical Board of California did not find reason to investigate this case.**

- **PRV004723 – Yolanda provided case summary details related to this providers malpractice settlement to the committee. Dr. Tasinga stated the doctor was looked at as negligent, since the patient ended up as paraplegic. Yolanda informed the committee that there is no current investigation with the Medical Board of California.**

- **PRV000324 (L.S.) – Yolanda provided case summary details related to this providers malpractice settlement to the committee. Response from provider's attorney was received and reviewed. Per Dr. Tasinga, she indicated the allegations were over 2-yrs ago, and the provider's only involvement was in regard to a single chest x-ray.**

  Cred/Recred: Approved by Amin-Lascano

COMMITTEE RECONVENED TO OPEN SESSION @ 7:29 A.M.

5) DHCS Requirements and Updates – DISCUSSION

Dr. Tasinga spoke to committee regarding:

- **HEDIS Asthma measure - Plan continues with maintaining consistent member compliance with controller versus rescue inhaler ratio.**
- **Governor updates - Plan for Pharmacy benefit for MCO to be moved to FFS MCAL for State versus plan oversight.**
- **Mental health support - Pregnant members are often reluctant to receive MH services during pregnancy; many times members are misinformed about medication safety during pregnancy. Stronger community collaboration is needed to foster broader reach of education, screenings, and earlier treatment.**
- **Pregnant women depression screening/postpartum depression - DHCS regulatory mandate 07/01/19 for Health plan case management and screenings for pregnant members.**

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 7:57 A.M.
TO WEDNESDAY, JUNE 5, 2019 AT 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE MEETING

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

Wednesday, June 5, 2019
7:00 A.M.

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COMMITTEE TO RECONVENE

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

Members Absent: Angela Egbikuadje, PD.MS, Ph.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]) **NO ONE HEARD.**

CA-3) Minutes for KHS Physician Advisory Committee meeting on May 1, 2019 – APPROVED
Amin-Parmar: 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 5-0, THE COMMITTEE APPROVED PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING AND RECREDENTIALING.**

- **Recredentialing #5 – Dr. Parmar excused himself at 7:23 AM and returned at 7:26 AM so that the committee could perform comprehensive review on one of his staff physicians.**

- **Of note; Jake and Yolanda will verify the grievance numbers for Recredentialing # 7 and # 8, which appear to be high for the individual practitioner. It was recommended these numbers be validated to exclude grievances that are against the facility and/or staff.**

- **Comprehensive review on new applicant (E.B.M.D.) – Yolanda provided the summary prepared by the attorney which described the legal precedents that confirm the practitioner's acknowledgement of signing a Felony Plea Form on May 5, 2017. The plea deal indicates he entered a guilty plea relating to violations and felony charges under Penal Code section 549 and 186.11 (a)(2).**

Practitioner is scheduled for sentencing on 06/21/2019. After extensive discussion, Dr. Tasinga requested the opportunity to discuss the summary and course of actions available to KHS with our attorney first. If was advised that should not be part of the process and that the committee members would need to vote on a recommendation.

- **Dr. Amin made a motion that committee wait until court decision is made and bring back to PAC August 7, 2019. Dr. Parmar seconded.**

COMMITTEE RECONVENED TO OPEN SESSION @ 7:55 A.M.

5) Review new Policy 3.72-P Behavioral Health Therapy and Behavioral Intervention – APPROVED
Hair-Amin: All Ayes

6) Review VSP Medical Data Collection Summary Report – APPROVED
Amin-Parmar: All Ayes

7) New HEDIS Quality Measure Requirements from DHCS – DISCUSSION
This item was held. Committee members were asked to bring their input on this subject to a future meeting.

MEETING ADJOURNED BY MARTHA TASINGA, M.D., C.M.O. @ 8:12 A.M.
TO WEDNESDAY, AUGUST 7, 2019 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	**2019**
Month Audited	**April**
Total TAR's for the month	**3373**
	100%
APPROVED TAR'S	
Timeliness - Reviewed & Returned in 1 busines day	**74/74**
Date Stamped	**74/74**
Fax copy attached	**74/74**
Decision marked	**74/74**
DENIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**61/61**
Initally Denied - Signed by Medical Director and/or Pharmacist	**61/61**
Letter sent within time frame	**61/61**
Date Stamped	**61/61**
Fax copy attached	**61/61**
Decision marked	**61/61**
Correct form letter, per current policies used	**61/61**
MODIFIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**0**
Date Stamped	**0**
Fax copy attached	**0**
Decision marked	**0**
Correct form letter, per current policies used	**0**
DUPLICATE TAR'S	
Timeliness - Reviewd & Returned in 1 business day	**17/17**
Date Stamped	**17/17**
Fax copy attached	**17/17**

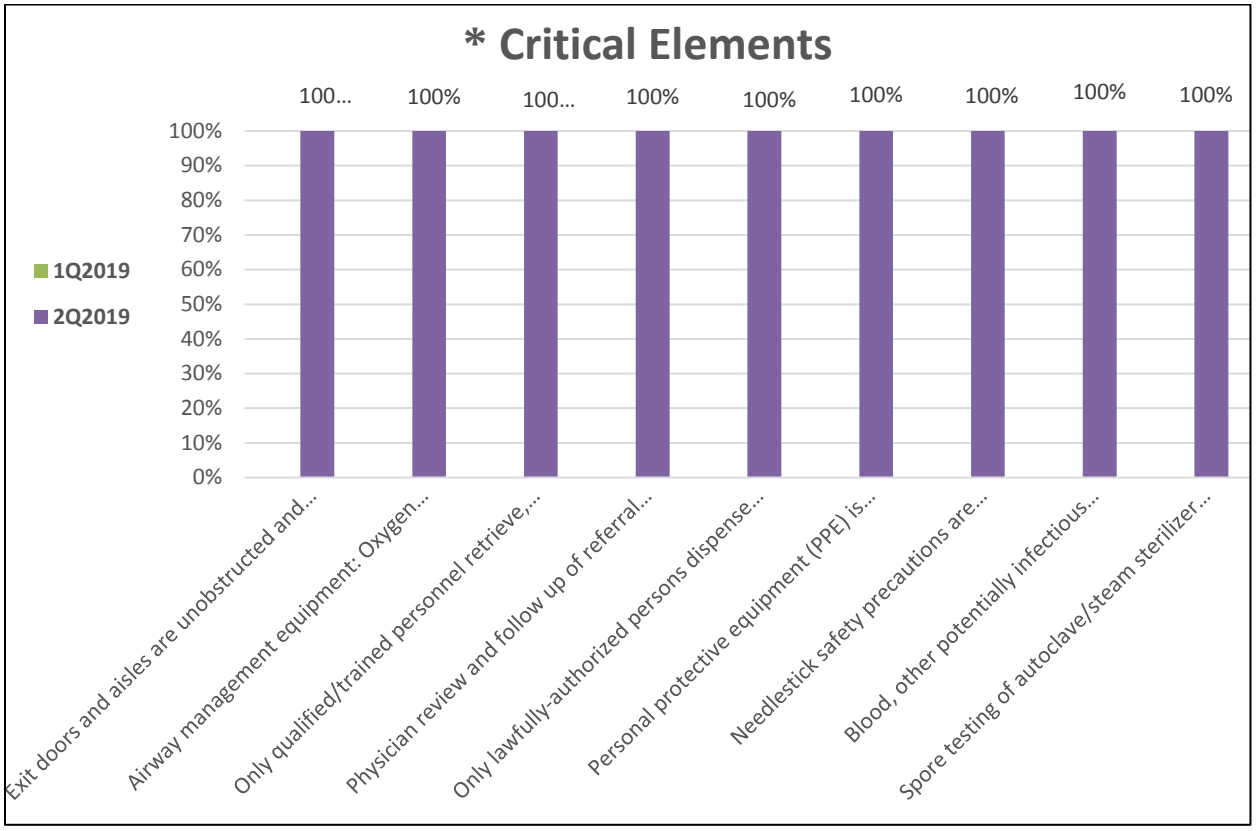
Quarter/Year of Audit	**2019**
Month Audited	**May**
Total TAR's for the month	**3661**
	100%
APPROVED TAR'S	
Timeliness - Reviewed & Returned in 1 busines day	**87/87**
Date Stamped	**87/87**
Fax copy attached	**87/87**
Decision marked	**87/87**
DENIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**51/51**
Initally Denied - Signed by Medical Director and/or Pharmacist	**51/51**
Letter sent within time frame	**51/51**
Date Stamped	**51/51**
Fax copy attached	**51/51**
Decision marked	**51/51**
Correct form letter, per current policies used	**51/51**
MODIFIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**0**
Date Stamped	**0**
Fax copy attached	**0**
Decision marked	**0**
Correct form letter, per current policies used	**0**
DUPLICATE TAR'S	
Timeliness - Reviewd & Returned in 1 business day	**15/15**
Date Stamped	**15/15**
Fax copy attached	**15/15**

Quarter/Year of Audit	**2019**
Month Audited	**June**
Total TAR's for the month	**3419**
	100%
APPROVED TAR'S	
Timeliness - Reviewed & Returned in 1 busines day	**67/67**
Date Stamped	**67/67**
Fax copy attached	**67/67**
Decision marked	**67/67**
DENIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**75/75**
Initally Denied - Signed by Medical Director and/or Pharmacist	**75/75**
Letter sent within time frame	**75/75**
Date Stamped	**75/75**
Fax copy attached	**75/75**
Decision marked	**75/75**
Correct form letter, per current policies used	**75/75**
MODIFIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**0**
Date Stamped	**0**
Fax copy attached	**0**
Decision marked	**0**
Correct form letter, per current policies used	**0**
DUPLICATE TAR'S	
Timeliness - Reviewd & Returned in 1 business day	**8/8**
Date Stamped	**8/8**
Fax copy attached	**8/8**

Kern Health Systems
Focus Review Summary Report
Q2 2019

Critical Elements (CE) Description: KHS is responsible for systematic monitoring of all PCP and OB/GYN 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 survey or monitoring visit. The PCP and/or site contact are required to correct 100% of the survey deficiencies regardless of the survey score.

All providers evaluated over the last 4 Quarters scored 100% in all areas with one exception. The one area with an opportunity for improvement was in the 4th Quarter of 2018. It was related to airway management equipment being appropriate and present on the site. A Corrective Action Plan (CAP) was issued and the deficiencies were corrected.



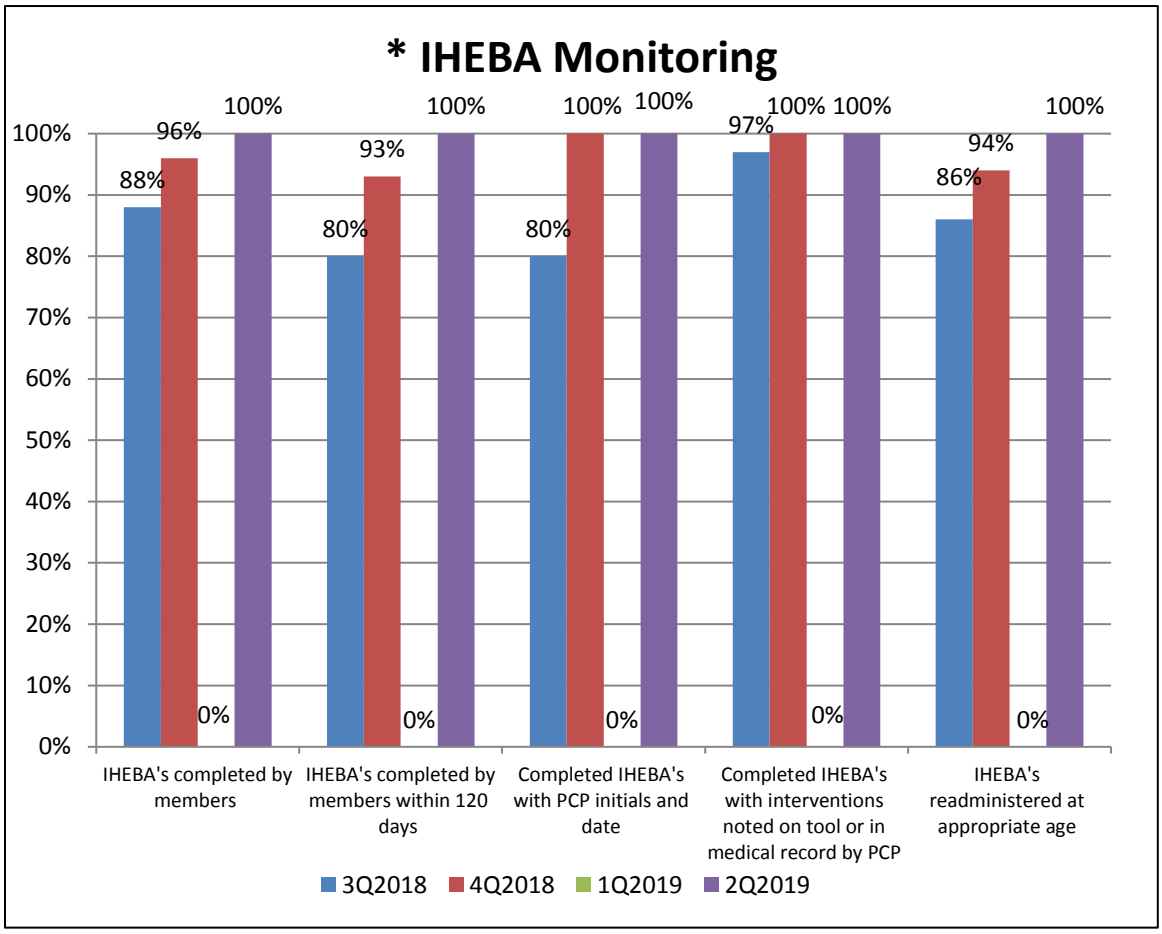
* **Note:** There is no data for the 1st Quarter of 2019 due to HEDIS Review Activity.

Critical Elements Results: Due to the HEDIS audit, Focus Reviews were not performed in the1st Quarter of 2019. However, when Focus Review site visits resumed again in the 2nd Quarter of 2019, five (5) providers were audited. All five (5) providers scored 100% in all areas of the Critical Elements portion of the review.

There are nine critical survey elements related to the potential for adverse effect on patient health or safety which 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 review or monitoring visit must be corrected by the provider within 10 business days of the survey date. Sites found deficient in any critical element during a Focus Review are required to correct 100% of the survey deficiencies, regardless of survey score. Critical elements include the following nine criteria:

- Exit doors and aisles are unobstructed and egress (escape) accessible.
- Airway management equipment, appropriate to practice and populations served, are present on site.
- Only qualified/trained personnel retrieve, prepare or administer medications.
- Office practice procedures are utilized on-site that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results.
- Only lawfully-authorized persons dispense drugs to patients.
- Personal protective equipment (PPE) is readily available for staff use.
- Needle stick safety precautions are practiced on-site.
- 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.
- Spore testing of autoclave/steam sterilizer is completed (at least monthly, with documented results).

Individual Health Education Behavioral Assessment (IHEBA) Description: The 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. The minimum performance level (MPL) is 80%.



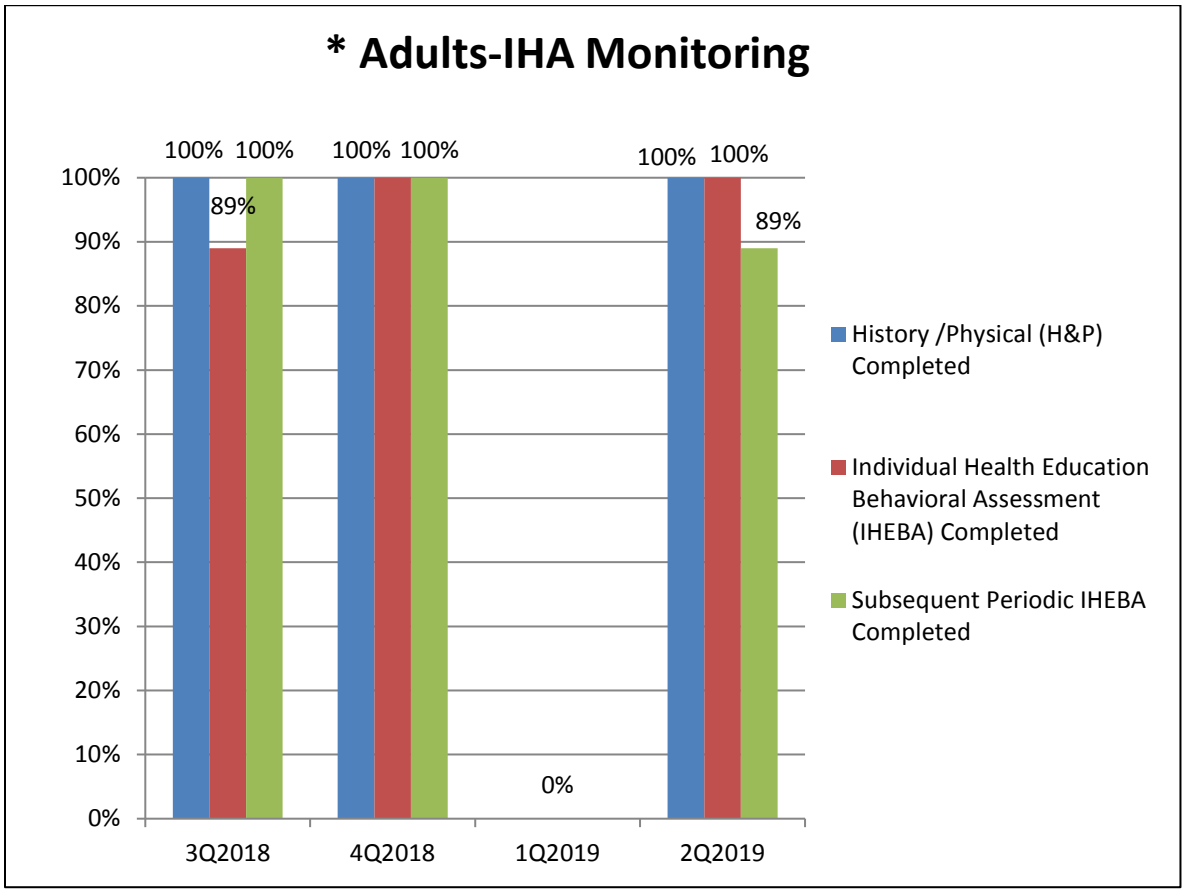
* **Note:** There is no data for the 1st Quarter of 2019 due to HEDIS Review Activity.

IHEBA Results: No IHEBA records were reviewed in the 1st Quarter of 2019 due to HEDIS, but in the 2nd Quarter of 2019, thirteen (13) records were audited from five (5) different providers. The five providers surveyed scored 100% in all areas. This shows progress from the 4th Quarter of 2018 where the areas for improvement noted were:

- IHEBA's Completed by Members
- Member completion of IHEBAs within 120 days
- IHEBA's re-administered at appropriate age

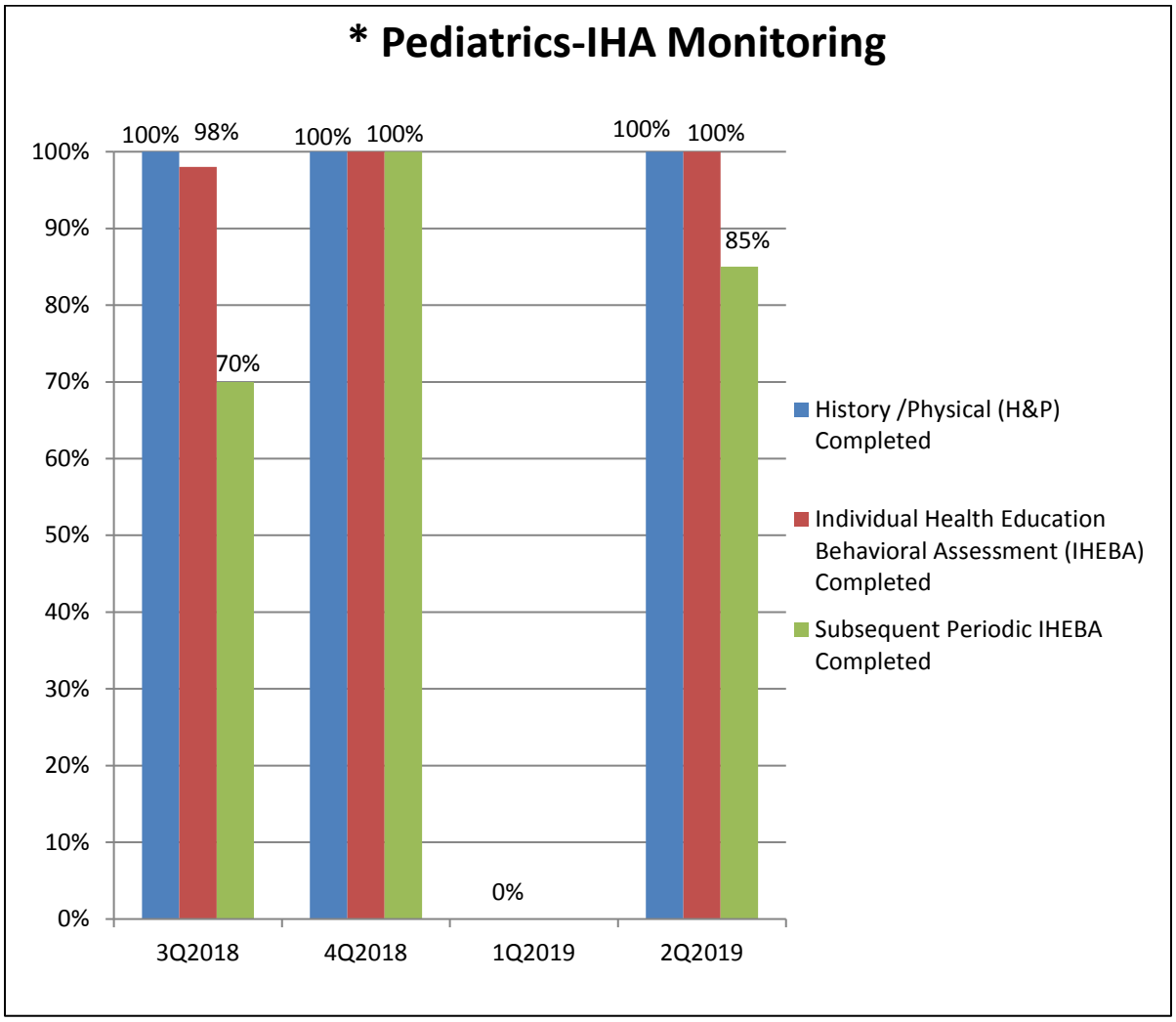
Corrective Action Plans (CAPS) were issued and the deficiencies were corrected.

Initial Health Assessment (IHA) Description: An IHA must be provided to each member within 120 days of enrollment. As PCP's receive their assigned members, the practitioner's office contacts the member to schedule an IHA to be performed within the 120 day time limit. If the practitioner is unable to contact the member, he/she contacts the KHS Member Services Department for assistance. Contact attempts and results are documented by both the PCP and Member Services staff. The MPL is 80% for this measure, and IHAs are performed on both adult and child members.



* **Note:** There is no data for the 1st Quarter of 2019 due to HEDIS Review Activity.

Adult IHA Results: No IHA records were reviewed in the 1st Quarter of 2019 because of HEDIS. All 3 elements of the adult IHAs were in compliance in the 2nd Quarter of 2019. There were five (5) providers evaluated and seven (7) adult IHA records reviewed. The providers scored 100% in 2 out of 3 areas. The area of improvement noted was completion of the Subsequent Periodic IHEBA according to age.



***Note:** There is no data for the 1st Quarter of 2019 due to HEDIS Review Activity.

Pediatric IHA Results: In the 1st Quarter of 2019 no Pediatric records for focus reviews were evaluated because of HEDIS. However, in 2nd Quarter 2019 there were five (5) providers evaluated and sixteen (16) pediatric records reviewed. The five (5) providers surveyed scored 100% in 2 out of 3 categories. The area most in need of improvement this quarter, and over the last 4 quarters, was completion of the Subsequent Periodic IHEBA.

Kern Health Systems
Facility Site Review Summaries
Full Site Review-Site and Medical Record Review Report
Q2 2019

Full Site Review (FSR) and Medical Record Review (MRR) Description:

Certified Site Reviewers perform a Facility Site Review on all contracted primary care provider sites (including OB/GYNs and pediatricians) as well as providers who serve a high volume of SPD beneficiaries. Per APL 14-005, certified site reviewers complete FSRs and MRRs for providers credentialed per DHCS and MMCD contractual and policy requirements.

An Initial Full Site Review (IFSR) is completed as part of the credentialing process on new providers at sites that have not previously been reviewed before being added to the KHS provider network. An IFSR is also completed when an existing KHS provider moves to a new site location. Approximately 3 months after the completion of an IFSR, an Initial Medical Record Review (IMRR) is conducted on sites other than Urgent Care (UC) Facilities. A passing FSR score is considered "current" if it is dated within the last three (3) years.

Subsequent Periodic Full Site Reviews (PFSRs) are conducted as part of the re-credentialing process for providers three (3) years after completion of the IFSR and every three (3) years thereafter.

Scoring and Corrective Action Plans

Provider sites that receive a FSR or MRR score with an Exempted Pass (90% or above, without deficiencies in critical elements) are not required to complete a corrective action plan (CAP). All sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements) are required to complete a CAP addressing each of the noted deficiencies. The compliance level categories for both the FSR and MRR are as listed below:

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

Corrective Action Plans (CAPs)

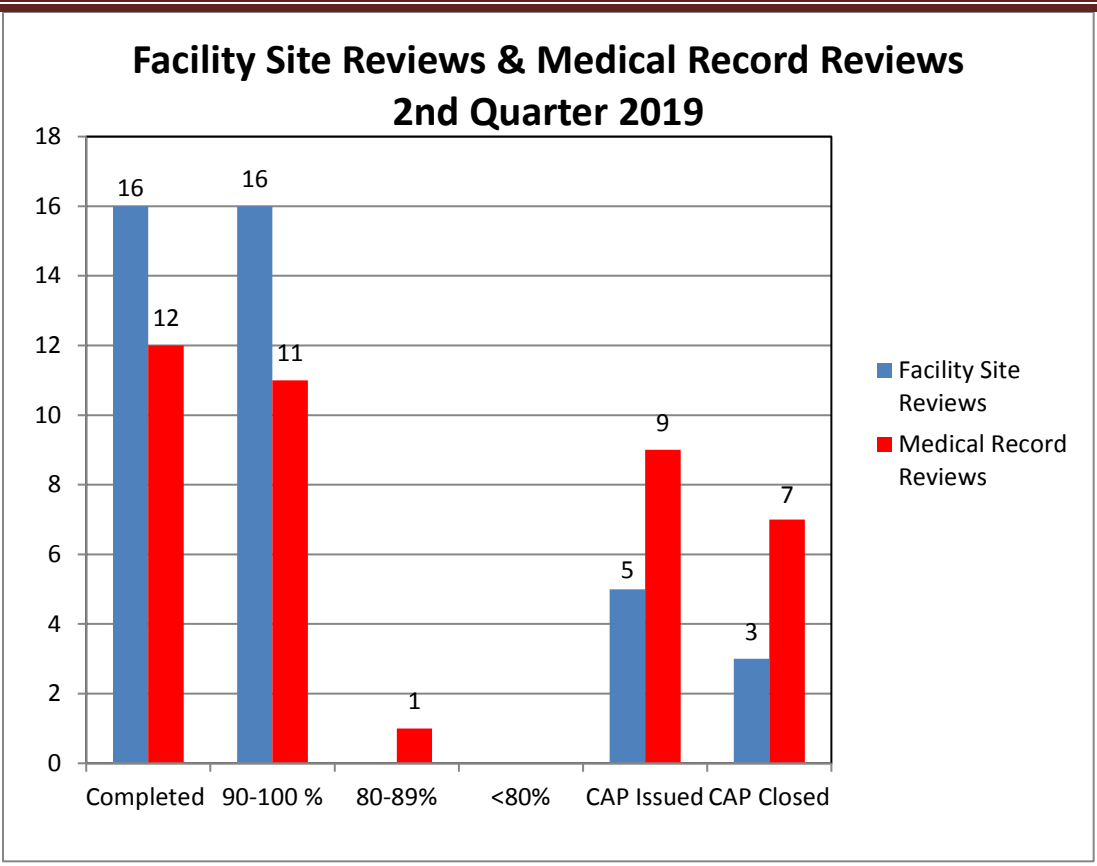
A CAP is issued when an initial, periodic, or focus review has deficiencies identified. DHCS requires follow up at 10 days for failure of any critical element, follow up for other failed elements at 45 days, and if not corrected by the 45 day follow up, at 90 days after a CAP has been issued. The majority of CAPs issued are corrected and completed within the 45 Day follow up period. Providers are encouraged to speak with us if they have questions or

encounter issues with CAP completion. QI nurses provide education and support during the CAP resolution process.

Critical Elements

There are nine critical elements related to the potential for adverse effect on patient health or safety and include the following:

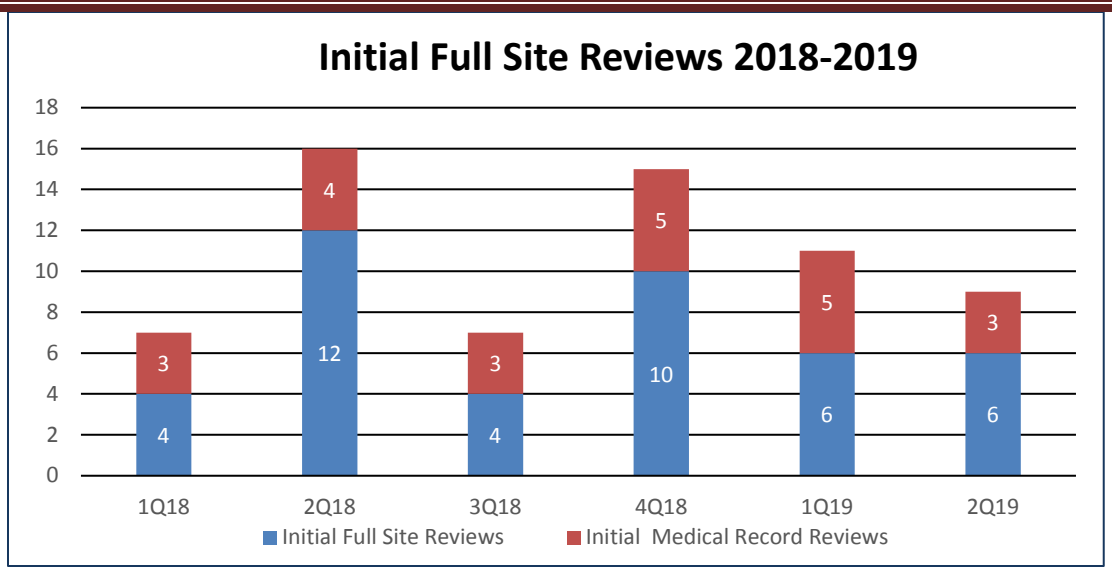
- Exit doors and aisles are unobstructed and egress (escape) accessible.
- Airway management equipment, appropriate to practice and populations served, are present on site.
- Only qualified/trained personnel retrieve, prepare or administer medications.
- Office practice procedures are utilized on-site that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results.
- Only lawfully-authorized persons dispense drugs to patients.
- Personal protective equipment (PPE) is readily available for staff use.
- Needle stick safety precautions are practiced on-site.
- 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.
- Spore testing of autoclave/steam sterilizer is completed (at least monthly, with documented results).



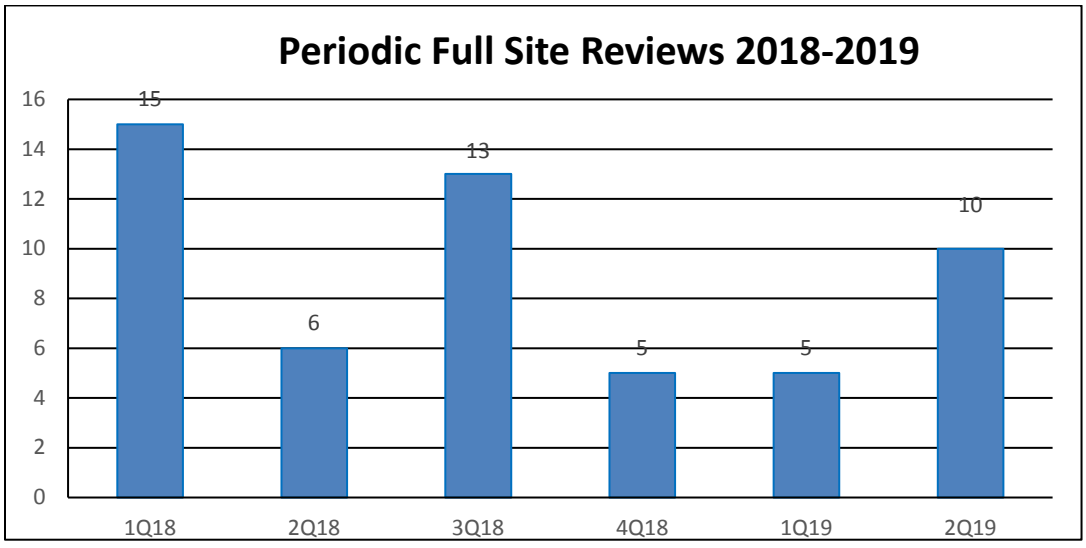
<u>Facility Site Review and Medical Record Review Results</u>:
A total of sixteen (16) Site Reviews were completed in the 2nd Quarter of 2019. Out of the sixteen (16) completed, six (6) were Initial Reviews and ten (10) were Periodic Reviews.

A total of twelve (12) Medical Record Reviews were completed in the 2nd Quarter of 2019. Three (3) were Initial Medical Record Reviews, and nine (9) were Periodic Medical Record Reviews.

There were five (5) Facility Site Review CAPs issued and nine (9) Medical Record Review CAPs issued. Three (3) Full Site Review CAPs were closed, and seven (7) Medical Record Review CAPs were closed.

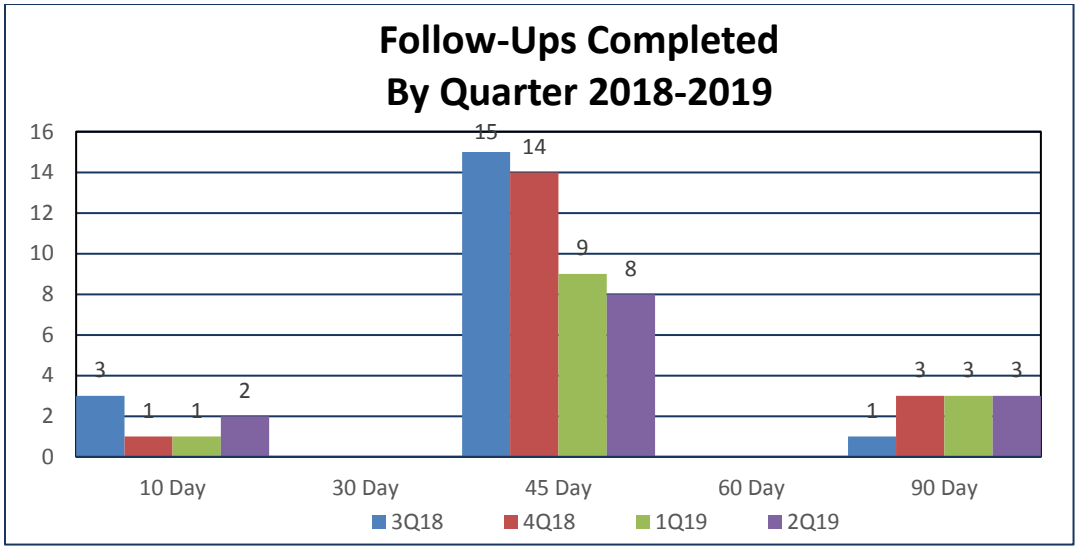


Initial Full Site Reviews
An Initial Full Site Review is required to be completed and the provider must pass before they can be contracted as a KHS Provider. No trends are identified, and this chart simply reflects the volume of new providers in KHS's Network.

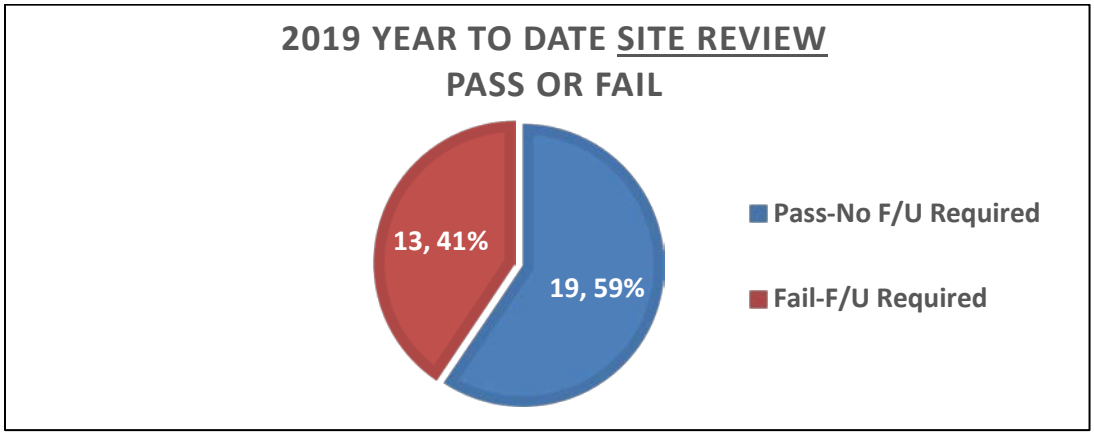


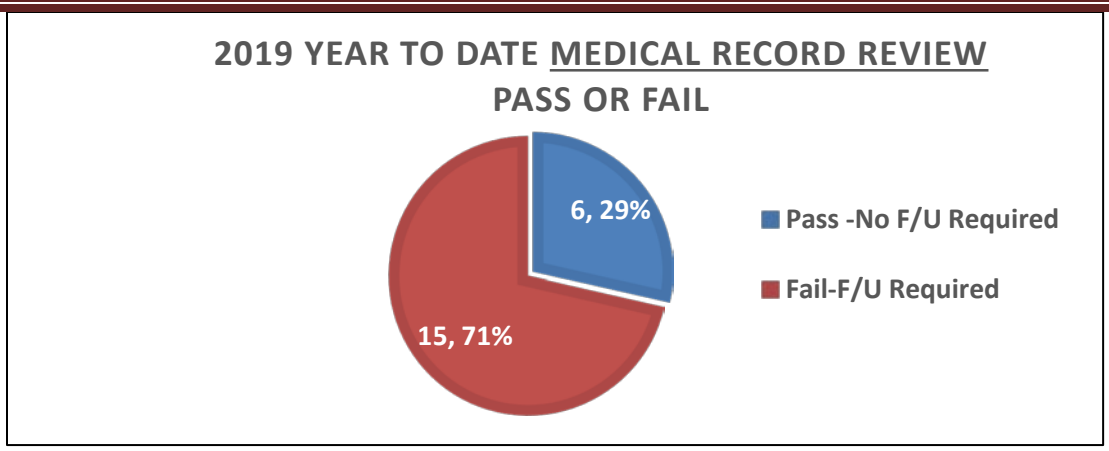
Periodic Full Site Reviews
Periodic Full Site Reviews are required every 3 years. This chart simply reflects the number of Periodic Full Site Reviews that were due and completed for each quarter. The due date for Periodic FSRs is

based on the last Initial or Periodic FSR that was completed. The volume of Periodic Reviews is not controlled by KHS. It is based on the frequency dictated by DHCS.



Facility Site Review and Focus Review Corrective Action Plans (CAPs):
In the 2nd Quarter of 2019 there were two (2) 10 Day Follow-ups, eight (8) 45 Day Follow-ups, and three (3) 90 Day Follow-ups completed.





Year to Date (YTD) Initial and Periodic FSR Pass or Fail Rate:
In 2019 YTD 67% of the Initial and Periodic site reviews performed passed on the first visit and 33% required follow-up. There are typically more follow-ups required for Medical Record Reviews. 29% of the Medical Records Reviews performed to date passed on the first visit and 71% required additional follow-up.

Top 3 Facility Site Review Critical Element Deficiencies

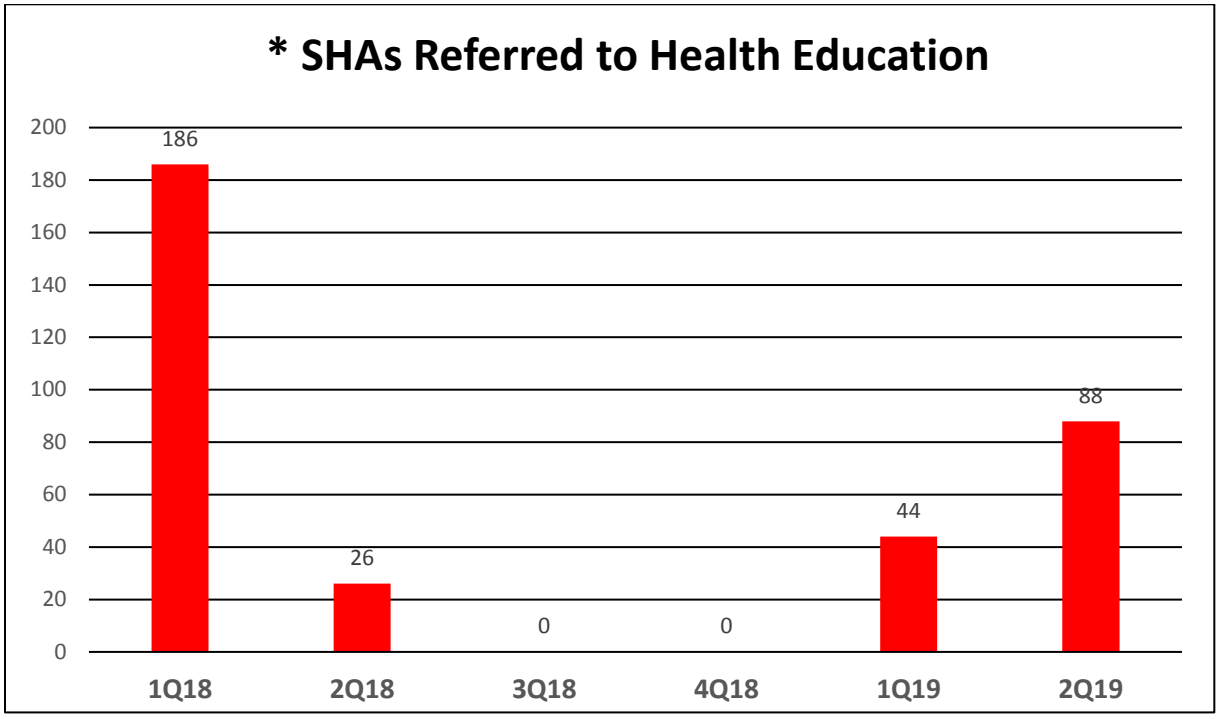
1. Checking of medication expiration dates
2. Compliance with annual training required for providers and staff
3. Compliance with spore testing for infection control purposes

Top 3 Medical Record Review Deficiencies

1. Outreach efforts for missed appointments
2. Timely immunizations for children
3. Timely completion of Staying Healthy Assessments

Kern Health Systems
Staying Healthy Assessments Monitoring
Q2 2019

Staying Healthy Assessment (SHA) Description: KHS works to identify members with unmet health needs. During the course of HEDIS audits, QI nurses identify members with positive SHA results in their medical record indicative of an unmet health need. These positive SHAs are shared with the Health Education (HE) Department to evaluate clinical follow-up and provide them with education. The QI department gathers the SHAs identified as part of their HEDIS file review. The number of SHAs collected and referred to HE is listed below. There is a variance from quarter to quarter depending on the number of HEDIS records reviewed. When HEDIS reviews are not occurring no SHAs are gathered.



* **Note**: During the 3rd and 4th quarters of 2018 HEDIS reviews were not conducted, and no SHAs were gathered.

SHA Monitoring Results

During routine audits of medical records, QI RNs validate that an SHA was completed yearly. During Q1 of 2018 there were 186 positive SHAs sent to Health Education. This increase was related to the number of records reviewed for HEDIS. In Q2 of 2018 there was a decrease with only 26 SHAs submitted at the end of HEDIS. There were no SHA's were referred to HE in Q3 and Q4 of 2018 since HEDIS reviews did not occur during those time frames. Tracking of SHAs resumed when HEDIS season began again with 44 SHA's submitted in Q1 of 2019 and 88 SHA's submitted in Q2 of 2019.

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Kaiser Reports

CA-12) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**

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Medical Data Collection Summary Report

Period Covered: July, 2018 through June, 2019
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:	25,253	
Diabetes?:	1,279	5.1%
Diabetic Retinopathy:	136	.5%
Glaucoma:	187	.7%
Hypertension:	1003	4.0%
High Cholesterol	377	1.5%
Macular Degeneration:	28	.1%

Estimated Number of Cases

Total Members:	247,377	
Diabetes?:	5,476	2.2%
Diabetic Retinopathy:	483	.2%
Glaucoma:	917	.4%
Hypertension:	24,095	9.7%
High Cholesterol	37,077	15.0%
Macular Degeneration:	296	.1%

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

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
2018	August	4,743	190	178	368
	September	557	27	26	53
	October	598	22	23	45
	November	770	41	41	82
	December	853	52	64	116
2019	January	8,557	327	259	586
	February	8,910	412	140	552
	March	265	24	1	25
	April	1,012	39	0	39
	May	553	14	0	14
	June	729	5	0	5
Totals		**27,547**	**1,153**	**732**	**1,885**

LTM Effectiveness* : 7 %

12-Month Effectiveness (Jan 2018 - Dec 2018) : 9 %

* This figure does not include an estimate of those patients who will return within 90 or 180 days.
It solely calculates based upon the patients who have returned to date for letters sent within the last twelve months.

Grievance Report

- The DMHC requires KHS Management report/review quarterly grievances with the KHS Board of Directors.

Category	Q2 2019	Trend	Issue	Q1 2019	Q4 2018	Q3 2018
Access to Care	32		Appointment Availability	41	32	59
Coverage Dispute	9		Authorizations and Pharmacy	14	12	21
Medical Necessity	244		Questioning denial of service	228	240	267
Other Issues	13		Miscellaneous	9	10	7
Quality of Care	26		Questioning services provided. All cases forwarded to Quality Dept.	29	22	30
Quality of Service	1		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	6	3	2
Total Grievances	325			327	319	386

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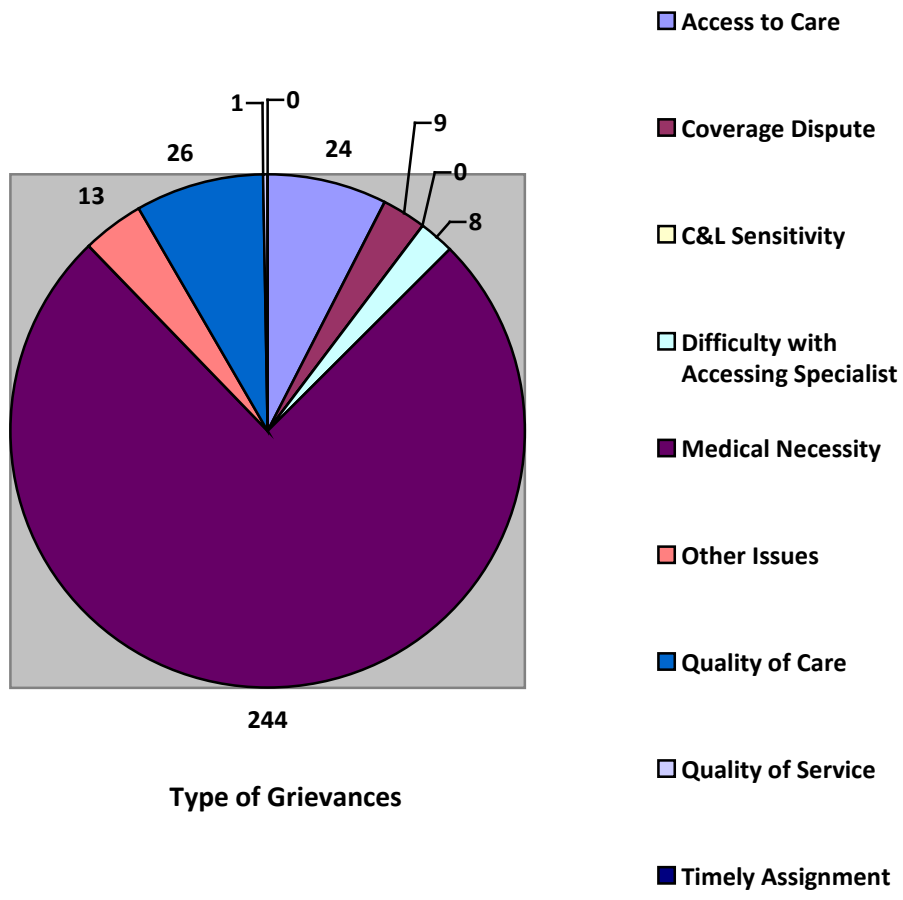
Additional Insights-Grievance Detail

Issue	2nd Quarter Grievances	Upheld Plan Decision	Overturned Ruled for Member	Still Under Review
Access to Care (PCP)	24	19	5	0
Coverage Dispute	9	8	0	1
Specialist Access	8	5	3	0
Medical Necessity	244	184	60	0
Other Issues	13	13	0	0
Quality of Care	26	14	12	0
Quality of Service	1	1	0	0
Total	325	244	80	1

2nd Quarter 2019 Grievance Summary

Issue	Number	In Favor of Health Plan	In favor of Enrollee	Still under review
Access to care	24	19	5	0
Coverage dispute	9	9	0	0
Cultural and Linguistic Sensitivity	0	0	0	0
Difficulty with accessing specialists	8	5	3	0
Medical necessity	244	184	60	0
Other issues	13	13	0	0
Quality of care	26	14	12	0
Quality of service	1	1	0	0
Timely assignment to provider	0	0	0	0



Type of Grievances

Grievances per 1,000 Members = 1.25

During the second quarter of 2019, there were three hundred and twenty five grievances received. Eighty cases were closed in favor of the Enrollee; two hundred and forty five cases were closed in favor of the Plan. Three hundred and twenty four cases closed within thirty days, and one case was pended as additional information was required. Ninety eight cases were received from SPD (Seniors and Persons with Disabilities) members. One hundred and forty one cases were received from Medi-Cal Expansion members.

2nd Quarter 2019 Grievance Summary

Access to Care

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

Fifteen members complained about the lack of available appointments with their Primary Care Provider (PCP). Eleven of the cases closed in favor of the Plan after the responses indicated the office provided appropriate access to care based on the Access to Care Standards for PCP appointments. Four of the cases closed in favor of the Enrollee after the response 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. Seven 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 as a walk-in, which are not held to Access to Care standards. One case closed in favor of the Enrollee after the response indicated the member was not seen within the appropriate wait time for an appointment.

One member complained about the telephone access with their Primary Care Provider (PCP) appointment. This case closed in favor of the Plan after the response indicated the member was provided with the appropriate telephone access.

Coverage Dispute

There were nine 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:

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

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

Cultural and Linguistic Sensitivity

There were no grievances pertaining to Cultural and Linguistic Sensitivity.

Difficulty with Accessing a Specialist

There were eight grievances pertaining to Difficulty Accessing a Specialist. Five cases closed in favor of the Plan. Three cases 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 response indicated the office many not have provided appropriate access to care based on the Access to Care Standards for specialty appointments.

Two members complained about the wait time to be seen for a specialist appointment. One case closed in favor of the Plan after the responses indicated the member was seen within the appropriate wait time for an appointment. One case closed in favor of the Enrollee after the response indicated the member may not have been seen within the appropriate wait time for an appointment.

Four members complained about telephone access with a specialist's office. Three cases closed in favor of the Plan after the response indicated the member was provided with the appropriate telephone access. One case closed in favor of the Enrollee after the response indicated the office may not have provided appropriate telephone access.

Medical Necessity

There were two hundred and forty four grievances pertaining to Medical Necessity. One hundred and eighty four of the cases were closed in favor of the Plan. Sixty of the cases closed in favor of the Enrollee. The following is a summary of these issues.

One hundred and ninety seven members complained about the denial or modification of a referral authorization request. One hundred and thirty nine 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. Five out of the one hundred and thirty nine upheld cases were modified. Fifty eight cases were closed in favor of the Enrollee as it was determined medical necessity was met and the denials were overturned.

Forty seven members complained about the denial or modification of a TAR. Forty five 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. Two cases were closed in favor of the Enrollee as it was determined medical necessity was met and the denials were overturned.

Other Issues

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

One member complained they felt discriminated against by the staff in a provider's office due to them placing her on hold and how far out they scheduled her appointment. This case closed in favor of the Plan after the response from the provider indicated the member received the appropriate services and was not discriminated against.
One member complained that they felt discriminated against by a provider for refusing to see or treat her when not feeling well. This case closed in favor of the Plan after the

response from the provider indicated the reason member was not seen was because she did not have an appointment scheduled.

One member's mother complained that they felt discriminated against by a provider for not accepting member as a patient due to medical conditions. This case closed in favor of the Plan after the response from the provider indicated the provider was not taking new patients at this time.

One member complained that that they felt a specialist was racist towards them because of the language they spoke and because the provider did not provide the treatment they felt they needed. This case closed in favor of the Plan after the response from the provider indicated the provider used a translator during the appointment and recommended member be referred to a different specialist who could assist her better with her medical condition.

One member complained they paid out of pocket for durable medical equipment (DME) at a provider's office after staff told them the Plan would cover it. This case closed in favor of the Plan after the response from the provider acknowledged they never told member it would be covered and the member chose to pay. Member was provided emergency claim forms to submit receipts for review of reimbursement.

One member's mother complained that they felt member was discriminated against by the staff and providers with a hospital for suggesting she take member to an out of area hospital if services are needed in the future. This case closed in favor of the Plan after the response from the hospital indicated member's care was transferred to a children's hospital after no progress was made locally.

One member complained that they felt discriminated against by the staff and providers with a hospital because she felt they discharged her without treating her. This case closed in favor of the Plan after the response from the hospital indicated member was treated but did not agree with the treatment plan and left the hospital after verbal discharge was given.

One member complained that they felt discriminated against by the staff of a provider's office due to the color of her skin. This case closed in favor of the Plan after the response from the provider indicated the member received the appropriate services and they were not discriminated against.

One member complained that they felt discriminated against by a provider and their staff due to their sexuality. This case closed in favor of the Plan after the response from the provider indicated the member received the appropriate services and they were not discriminated against.

One member complained that a provider gave them the test results of another patient; therefore, a HIPAA violation was present. This case closed in favor of the Plan after the response from the provider indicated the member was not provided with the PHI of another patient. This case was sent to Compliance for further review.

One member appealed the denial of hospice care services with a non-participating provider. This case closed in favor of the Plan after the member was retro-disenrolled

from the plan during the processing of the appeal. Thus making the member no longer eligible with the Plan during the requested dates the authorization was asking services to be covered for.

One member's mother complained that a specialist would not allow her to attend her adult child's medical appointments. This case closed in favor of the Plan after the response from the provider indicated the member agreed that mother did not need to be in the exam room with her during the appointments, after mother had been disruptive.

One member complained that she felt the provider was not treating and diagnosing her in an acceptable time frame. This case closed in favor of the Plan as after the response from the provider indicated member was seen in an appropriate time frame and had future appointments and testing scheduled.

Quality of Care

There were twenty six grievances involving Quality of Care issues. Fourteen cases were closed in favor of the Plan. Twelve cases were closed in favor of the Enrollee. The following is a summary of these issues:

Fifteen members complained about the quality of care received from a Primary Care Provider (PCP). Seven 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. Eight cases closed in favor of the Enrollee after review of all medical documents and written responses received indicated that the care received may have been below standard.

Nine members complained about the quality of care received from a specialty provider. Five cases were closed in favor of the Plan after it was determined that the specialist provided the member with the appropriate care. Four cases closed in favor of the Enrollee after review of all medical documents and written responses received indicated that the care received may have been below standard.

Two members complained about the quality of care received from providers staffed by an urgent care. Both of these cases closed in favor of the Plan after it was determined that the hospital provided the members with the appropriate care

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

Quality of Service

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

One member complained about the service they received from a provider. This case was closed in favor of the Plan after the written response was reviewed and it was determined that the member received the appropriate services.

Timely Assignment to Provider

2nd Quarter 2019 Grievance Summary

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

Kaiser Permanente Grievances

During the second quarter of 2019, there were forty one grievances and appeals received by KFHC members assigned to Kaiser Permanente. Thirty nine cases were closed in favor of the Enrollee. Two cases are still pending closure at the time of this report.

Access to Care

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

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

One member complained about the lack of Primary Care Provider (PCP) availability. This case closed in favor of the Enrollee.

Coverage Dispute

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

Seven members complained about a non-covered or out-of-network service they requested; however, were not being covered. All of the seven cases closed in favor of the Enrollee and services were provided.

Medical Necessity

There were no grievances pertaining to Medical Necessity received this quarter.

Quality of Care

There were no grievances pertaining to quality of care received this quarter.

Quality of Service

There were thirty grievances pertaining to Quality of Service. Twenty eight cases closed in favor of the Enrollee. Two cases are still open pending review. The following is a summary of these issues:

Thirty members complained about the services being inadequate at a facility. Twenty eight cases were closed in favor of the Enrollee. Two cases are still open and pending review.

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	Q2 2019	60251	680	59571	0:00:17	0:07:13	1.1%	87%	Y	Y
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KERN HEALTH SYSTEMS
2nd Quarter 2019
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Report Date: July 9, 2019

Department: Provider Relations

Monitoring Period: April 1, 2019 through June 30, 2019

Population:

Providers	Credentialed	Recredentialed
MD's	60	66
DO's	11	1
AU's	0	0
DC's	1	0
AC's	0	0
PA's	8	10
NP's	17	6
CRNA's	0	0
DPM's	1	0
OD's	3	0
ND's	0	0
RD's	0	0
BCBA's	19	4
Mental Health	6	4
Ocularist	0	0
Ancillary	9	22
OT	0	0
TOTAL	**135**	**113**

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	2	13	15	0
Audiology	0	0	0	0
Autism / Behavioral Analyst	19	4	23	0
Cardiology	0	4	4	0
Chiropractor	1	0	1	0
Colon & Rectal Surgery	0	0	0	0
Critical Care	0	0	0	0
Dermatology	3	3	6	0
Emergency Medicine	0	2	2	0
Endocrinology	1	0	1	0
Family Practice	13	11	24	0
Gastroenterology	0	1	1	0
General Practice	3	2	5	0
General Surgery	9	2	11	0
Genetics	0	0	0	0
Gynecology	0	0	0	0

KERN HEALTH SYSTEMS
2nd Quarter 2019
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Gynecology/Oncology	0	0	0	0
Hematology/Oncology	1	0	1	0
Hospitalist	3	1	4	0
Infectious Disease	0	0	0	0
Internal Medicine	17	14	31	0
Mental Health	6	4	10	0
Mid Wife	0	0	0	0
Naturopathic Medicine	0	0	0	0
Neonatology	0	0	0	0
Nephrology	1	0	1	0
Neurological Surgery	1	2	3	0
Neurology	1	4	5	0
Obstetrics & Gynecology	3	6	9	0
Ocularist	0	0	0	0
Occupational Therapy	0	0	0	0
Ophthalmology	0	1	1	0
Optometry	3	0	3	0
Orthopedic Surgery / Hand Surg	2	1	3	0
Otolaryngology	1	1	2	0
Pain Management	2	0	2	0
Pathology	0	1	1	0
Pediatrics	8	1	9	0
Physical Medicine & Rehab	3	1	4	0
Plastic Sugery	0	2	2	0
Podiatry	1	0	1	0
Psychiatry	2	1	3	0
Pulmonary	0	0	0	0
Radiation Oncology	1	0	1	0
Radiology	23	9	32	0
Registered Dieticians	0	0	0	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	2	1	3	0
KHS Medical Directors	0	0	0	0
TOTAL	**132**	**92**	**224**	**0**

KERN HEALTH SYSTEMS
2nd Quarter 2019
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

ANCILLARY	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Ambulance	0	0	0	0
Cardiac Sonography	0	0	0	0
Comm. Based Adult Services	0	0	0	0
Dialysis Center	0	5	5	0
DME	0	2	2	0
Hearing Aid Dispenser	0	0	0	0
Home Health	0	1	1	0
Home Infusion/Compounding	0	0	0	0
Hospice	0	0	0	0
Hospital	0	2	2	0
Laboratory	1	2	3	0
Lactation Consultant	0	0	0	0
MRI	0	0	0	0
Ocular Prosthetics	0	0	0	0
Pharmacy	3	2	5	0
Pharmacy/DME	3	1	4	0
Physical / Speech Therapy	0	1	1	0
Prosthetics & Orthotics	0	2	2	0
Radiology	0	1	1	0
Skilled Nursing	0	0	0	0
Sleep Lab	0	2	2	0
Surgery Center	0	0	0	0
Transportation	0	1	1	0
Urgent Care	2	0	2	0
TOTAL	**9**	**22**	**31**	**0**

Defer = 0 **Denied = 0**

KERN HEALTH SYSTEMS
2nd Quarter 2019
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

KERN HEALTH SYSTEMS
2nd Quarter 2019
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Kern Health Systems
Board Approved Effective 05/01/19

Legal Name	Specialty	Address	Provider #	Pay to #	Effective
Devika Pharma Inc dba: Arvin Pharmacy	Pharmacy	1241 Bear Mountain Blvd Ste. E Arvin CA 93203	PRV052294	PRV052294	5/1/2019
Teaching Autistic Children Inc dba: Learning Arts	ABA Therapy	5329 Office Center Court Ste. 150 Bakersfield CA 93309	PRV052185	PRV052185	5/1/2019
Eva A. Hammond dba: Ingram's Pharmacy	Pharmacy	1709 27th Street Bakersfield CA 93301	PRV052323	PRV052323	5/1/2019
Michael G. Oefelein MD	Urology	3838 San Dimas Street Ste. B-231 Bakersfield CA 93301	PRV052179	PRV052179	Retro Eff 4/1/2019
Hernake S. Takhar dba: Takhar Eye Care Optometric Center	Optometry *	4725 Panama Lane Ste. D11 Bakersfield CA 93313	PRV052337	PRV052304	5/1/2019
Hemant Dhingra MD dba: The Nephrology Group Inc	Nephrology	3933 Coffee Road Ste. B Bakersfield CA 93308	PRV013885	PRV013885	5/1/2019
St. Therese Medical Group Inc	PCP	511 W. Columbus Ave Ste. Bakersfield CA 93301	PRV000180	PRV000180	5/1/2019
Langlois Medical Corporation dba: Kern Island Pain Medicine	Pain Medicine & Physical Med/Rehab	230 S Montclair Street Ste. 101 Bakersfield CA 93309	PRV014462	PRV014462	5/1/2019
Mohamed M. Hammami MD Inc.	Internal Medicine	511 W. Columbus Ave Ste. Bakersfield CA 93301	PRV052193	PRV052193	5/1/2019
Taoheed Hasan dba: Valley Pharmacy	Pharmacy & DME	1324 West Avenue J Ste. 1 Lancaster CA 93534	PRV052184	PRV052184	5/1/2019

Kern Health Systems
Board Approved Effective 06/01/19

Legal Name DBA Name	Specialty	Provider #	Group #	Address	Contract Effective Date
PAC 05/01/2019					
Kern Psychiatric Health and Wellness Center, Inc	Psychiatry	PRV046499	PRV046499	6313 Schirra Ct Suite 1 Bakersfield CA 93313	**6/1/2019**
Shih Applied Behavior Analysis	ABA Provider	PRV052860	PRV052861	8723 Winlock St Bakersfield CA 93312	**6/1/2019**

Kern Health Systems
Board Approved Effective 07/01/19

Legal Name DBA Name	Specialty	Provider #	Group #	Address	Contract Effective Date
The Baiden Group Inc. dba: Acton Vale Pharmacy	Pharmacy / DME	**PRV053470**	**PRV053470**	3630 Smith Ave Ste. A Acton CA 93510	**7/1/2019**
Biocorp Clinical Lab, Inc.	Clinical Laboratory	**PRV001470**	**PRV001470**	2700 F Street Ste. 240 Bakersfield CA 93301	**7/1/2019**
Burns Prescription Pharmacy dba: Burns Pharmacy	Pharmacy / DME	**PRV050811**	**PRV050811**	866 W. Lancaster Blvd. Lancaster CA 93534	**7/1/2019**
Curex Pharmacy, Inc.	Pharmacy	**PRV053477**	**PRV053477**	3008 Sillect Ave Ste. 180 Bakersfield CA 93308	**Retro-Eff 6/1/2019**

Kern Health Systems
Board Approved Effective 05/01/19

	A	B	C	D	E	F
1	NAME	LEGAL NAME/ADDRESS	SPECIALTY	PROVIDER#	PAY TO PRV #	EFFECTIVE
2	Arvin Pharmacy	Devika Pharma Inc. Dba: Arvin Pharmacy 1241 Bear Mountain Blvd Ste. E Arvin CA 93203	Pharmacy	PRV052294	PRV052294	**Yes** **Eff 5/1/19**
3	Brandon, Willam BCBA	Teaching Autistic Children Inc. Dba: Learning Arts 5329 Office Center Court Ste. 150 Bakersfield CA 93309	Behavior Analyst / Qualified Autism Services Provider	PRV052186	PRV052185	**Yes** **Eff 5/1/19**
4	Ingram's Pharmacy	Eva A. Hammond Dba: Ingram's Pharmacy 1709 27th Street Bakersfield CA 93301	Pharmacy	PRV052323	PRV052323	**Yes** **Eff 5/1/19**
5	Khanna, Apurv MD	Hemant Dhingra, M.D. The Nephrology Group, Inc. 3933 Coffee Road Ste. B Bakersfield CA 93308	Nephrology	PRV048793	PRV013885	**Yes** **Eff 5/1/19**
6	Langlois, Leo MD	Langlois Medical Corporation Dba: Kern Island Pain Medicine 230 S Montclair Street Ste. 101 Bakersfield CA 93309	Pain Medicine & Physical Med/Rehab	PRV006785	PRV014462	**Yes** **Eff 5/1/19**
7	Oefelein, Michael MD	Michael G. Oefelein 3838 San Dimas Street Ste. B-231 Bakersfield CA 93301	Urology	PRV009421	PRV009421	**Yes** **Eff 4/1/19**
8	Takhar, Hernake OD	Hernake S. Takhar Dba: Takhar Eye Care Optometric Center 4725 Panama Lane Ste. D11 Bakersfield CA 93313	Optometry	PRV052337	PRV052304	**Yes** **Eff 5/1/19**
9	Wolde, Tsion Hanna BCBA	Teaching Autistic Children Inc. Dba: Learning Arts 5329 Office Center Court Ste. 150 Bakersfield CA 93309	Behavior Analyst / Qualified Autism Services Provider	PRV052187	PRV052185	**Yes** **Eff 5/1/19**
10	Valley Pharmacy	Valley Pharmacy 1324 West Avenue J Ste. 1 Lancaster CA 93534	Pharmacy & DME	PRV052184	PRV052184	**Yes** **Eff 5/1/19**
11	Chen, Emery MD	Adventist Health Medical Center Tehachapi 105 West E Street Tehachapi CA 93561	General Surgery	PRV010279	ALL SITES	**Yes / Modified to 1-yr** **Eff 5/1/19**
12	Lemus-Rangel, Rafael MD	Adventist Health Medical Center Tehachapi 105 West E Street Tehachapi CA 93561	General Surgery	PRV007697	ALL SITES	**Yes** **Eff 5/1/19**
13	Talwar, Raman MD	Adventist Health Medical Center Tehachapi 105 West E Street Tehachapi CA 93561	General Surgery	PRV008374	ALL SITES	**Yes** **Eff 5/1/19**
14	Accelerated Urgent Care	Emergency Physicians Urgent Care, Inc. Accelerated Urgent Care - Coffee Road * Bakersfield CA 93309	Urgent Care Center	PRV032603	PRV032603	**Yes** **Retro - Eff 1/31/19**
15	Abdelmisseh, Mariam MD	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	Internal Medicine	PRV037177	ALL SITES	**Yes** **Eff 5/1/19**
16	Arbelaez, Janine LMFT	Ridgecrest Regional Hospital RHC - 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	Marriage & Family Therapy	PRV050561	PRV000279 PRV029495	**Yes** **Eff 5/1/19**

Kern Health Systems
Board Approved Effective 05/01/19

	A	B	C	D	E	F
17	Dasu, Vani DO	Regional Anesthesia Associates, Inc. 1700 Mt Vernon Avenue Bakersfield CA 93306	Anesthesiology	PRV011185	PRV037540	**Yes** **Eff 5/1/19**
18	De Freese, Marissa MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	General Surgery / Trauma & Surg Critical Care	PRV049777	ALL SITES	**Yes** **Eff 5/1/19**
19	Feil, Susan NP-C	Kern County Hospital Authority Grow Clinic - 820 34th Street 93301 9330 Stockdale Highway Ste. 400 93311 Bakersfield CA	Internal Medicine	PRV050559	ALL SITES	**Yes** **Eff 5/1/19**
20	Gamino-Buzo, Luis LCSW	Infusion & Clinical Services dba: Premier Health Home Program 5401 White Lane Ste. A Bakersfield CA 93309	Clinical Social Worker	PRV048536	PRV047600	**Yes** **Eff 5/1/19**
21	Givens, Larry MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	Diagnostic Radiology	PRV006106	PRV000324	**Yes** **Eff 5/1/19**
22	Gonzalez, Sarah MD	Kern County Hospital Authority Whole Person-3551 Q Street Ste. 102 93301 1111 Columbus Street 93305 Bakersfield CA	General Practice	PRV037165	ALL SITES	**Yes** **Eff 5/1/19**
23	Helvie, Stephen MD	United Neuroscience, Inc 3838 San Dimas Street Ste. A140 2323 16th Street Ste. 400 Bakersfield CA 93301	Neurology	PRV006139	PRV030840	**Yes** **Eff 5/1/19**
24	Khan, Nadir MD	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	Internal Medicine	PRV037176	ALL SITES	**Yes** **Eff 5/1/19**
25	Kiong, Yi-Tian Timothy MD	Omni Family Health 4900 California Avenue Ste. 100B 4131 Ming Avenue 1701 Stine Road Bakersfield CA 93309	Psychiatry	PRV050563	PRV000019	**Yes** **Eff 5/1/19**
26	Li, Jane OD	Omni Family Health 2101 7th Street - Wasco 93280 525 Roberts Lane Bldg A 93308 4600 Panama Lane Ste. 102B 93313 Bakersfield CA	Optometry	PRV000693	PRV000019	**Yes** **Eff 5/1/19**
27	Limjoco, Bettina MD	Majid Rahimifar, MD, Inc. Dba: Bakersfield Neuroscience & Spine Institute 2601 Oswell Street Ste. 101 Bakersfield CA 93306	Physical Medicine & Rehab	PRV050551	PRV000205	**Yes** **Eff 5/1/19**
28	Mansilungan, Ramon NP-C	Carlos A. Alvarez, MD Inc. 8929 Panama Road Ste. A Lamont CA 93241	Internal Medicine	PRV048662	PRV030784	**Yes** **Eff 5/1/19**
29	McCague, Andrew DO	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	General Surgery / Trauma & Surg Critical Care	PRV032818	ALL SITES	**Yes** **Eff 5/1/19**
30	Montana, Wilbur DO	Comprehensive Blood & Cancer Center 6501 Truxtun Avenue Bakersfield CA 93309	Oncology	PRV051160	PRV013881	**Yes** **Eff 5/1/19**

Kern Health Systems
Board Approved Effective 05/01/19

	A	B	C	D	E	F
31	Moosavi, Leila MD	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	Internal Medicine	PRV047802	ALL SITES	**Yes** **Eff 5/1/19**
32	Nattuzi, Eileen MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	General Surgery / Trauma	PRV049915	ALL SITES	**Yes** **Eff 5/1/19**
33	Patel, Rishi DO	Comprehensive Blood & Cancer Center 6501 Truxtun Avenue Bakersfield CA 93309	Internal Medicine	PRV050565	PRV013881	**Yes** **Eff 5/1/19**
34	Prusse, Annaliese PA-C	Comprehensive Blood & Cancer Center 6501 Truxtun Avenue Bakersfield CA 93309	Dermatology	PRV045849	PRV013881	**Yes** **Eff 5/1/19**
35	Reyes, Robin PA	Comprehensive Blood & Cancer Center 6501 Truxtun Avenue Bakersfield CA 93309	Dermatology	PRV001604	PRV013881	**Yes** **Eff 5/1/19**
36	Sami, Faisal MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	Diagnostic Radiology	PRV052194	PRV000324	**Yes** **Eff 5/1/19**
37	Sandhu, Ahana MD	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	Internal Medicine	PRV037173	ALL SITES	**Yes** **Eff 5/1/19**
38	Salameh, Samir MD	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	Internal Medicine	PRV037175	ALL SITES	**Yes** **Eff 5/1/19**
39	Shoua, Basel MD	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	Internal Medicine	PRV037072	ALL SITES	**Yes** **Eff 5/1/19**
40	Sidhu, Parmeet NP-C	Central California Foundation for Health dba: Delano Women's Medical Clinic 1201 Jefferson Street Delano CA 93215	OB/GYN & Family Practice	PRV051163	PRV005653 DELANO PRV004640 WASCO	**Yes** **Eff 5/1/19**
41	Singh, Kamalneel NP-C	Kern County Hospital Authority Whole Person-3551 Q Street Ste. 102 Bakersfield CA 93301	General Practice	PRV048452	ALL SITES	**Yes** **Eff 5/1/19**
42	Sodhi, Sandeep MD	Telehealthdocs Medical Corporation dba: Telehealthdocs Medical Group *All Locations 2215 Truxtun Avenue Ste. 100 Bakersfield CA 93301	Endocrinology / Metabolism	PRV051161	PRV036952	**Yes** **Eff 5/1/19**
43	Talai-Shahir, Maryam MD	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	Internal Medicine	PRV037993	ALL SITES	**Yes** **Eff 5/1/19**
44	Tidwell, Grace MD	Omni Family Health 2101 7th Street - Wasco CA 93280 21138 Paso Robles Hwy - Lost Hills 93249	Family Practice	PRV051817	PRV000019	**Yes** **Eff 5/1/19**
45	Udofia, Aniebiet-Abasi MD	Adventist Health Medical Center Tehachapi 105 West E Street Tehachapi CA 93561	Orthopedic Surgery / Sports Medicine	PRV050370	ALL SITES	**Yes** **Eff 5/1/19**

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	A	B	C	D	E	F
46	Villanueva, Dina DO	West Side Family Health Care Primary Care 100 E North Street Taft CA 93268	Family Practice	PRV047864	PRV000306	**Yes** **Eff 5/1/19**

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	NAME	LEGAL NAME/ADDRESS	Provider #	Group #	SPECIALTY	CONTRACT STATUS	PAC APPROVED - EFFECTIVE DATE
1	Shih, Lily BCBA	Shih Applied Behavior Analysis 8723 Winlock St Bakersfield CA 93312	PRV052860	PRV052861	Behavior Analyst / Qualified Autism Services Provider	New Contract	Yes Eff 6/1/19
2	Laird, Natasha MD	Ridgecrest Regional Hospital RHC - 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	PRV051162	PRV000279 PRV029495	OB/GYN	Existing	Yes Eff 6/1/19
3	Aboul Hosn, Nader BCBA	California Psychcare, Inc. 624 E Commercy Ave Unit E Palmdale CA 93551	PRV052862	PRV011225	Behavior Analyst / Qualified Autism Services Provider	Existing	Yes Eff 6/1/19
4	Ayala, Stefany BCBA	California Psychcare, Inc. 25134 Rye Canyon Loop Ste. 270 Santa Clarita CA 91355	PRV052864	PRV011225	Behavior Analyst / Qualified Autism Services Provider	Existing	Yes Eff 6/1/19
5	Borst, Richard MD	Centric Health dba: Centric X-Ray 3008 Sillect Ave Ste. 104 Bakersfield CA 93308	PRV040658	PRV000503	Diagnostic Radiology / Vascular & Interventional Radiology	Existing	Yes Eff 6/1/19
6	Bosque, Jose MD	Adventist Health Medical Center Tehachapi 105 West E Street Tehachapi CA 93561	PRV036848	ALL SITES	Orthopedic Surgery / Sports Medicine	Existing	Yes Eff 6/1/19
7	Del Castillo Lemos, Cinthya MD	Ridgecrest Regional Hospital RHC - 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	PRV051159	PRV029495	Pediatrics	Existing	Yes Eff 6/1/19
8	Dulanto, Luigi MD	Clinica Sierra Vista 8787 Hall Rd Lamont CA 93241	PRV049656	PRV000002	Psychiatry	Existing	Yes Eff 6/1/19
9	Eloe, Natalie BCBA	Center for Autism & Related Disorders Inc 5300 Lennox Avenue Ste. 100 Bakersfield CA 93309	PRV052867	PRV032083	Behavior Analyst / Qualified Autism Services Provider	Existing	Yes Eff 6/1/19
10	Galinato, Melvin NP-C	Carlos A. Alvarez, MD Inc. 8929 Panama Rd Ste. A Lamont CA 93241	PRV046215	PRV030784	Internal Medicine	Existing	Yes Eff 6/1/19
11	Garcia-Pacheco, Igor MD	Dignity Health Medical Foundation dba: Dignity Health Medical Group - Bakersfield DHMG-Bakersfield Stockdale Hwy 9500 Stockdale Hwy Ste. 203 Bakersfield CA 93311	PRV003960	PRV012886	Internal Med / Critical Care Med / Hospitalist	Existing	Yes Eff 6/1/19

12	Ghorbanifarajzadeh, Ali DPM	Oak Hills Medical Corporation dba: Heart Vascular & Leg Center-Wound 1408 Commercial Way Ste. A Bakersfield CA 93309	**PRV047248**	**PRV000310**	Podiatry / Foot & Ankle Surgery	Existing	**Yes** **Eff 6/1/19**
13	Gonzalez, Kimberly NP-C	Vanguard Medical Corporation 845 7th St Wasco CA 93280 565 Kern Street Shafter CA 93263	**PRV051806**	**PRV044703**	Family Practice	Existing	**Yes** **Eff 6/1/19**
14	Hanna Al-Kass, Farajallah MD	Oak Hills Medical Corporation 5020 Commerce Dr Bakersfield CA 93309	**PRV052816**	**PRV000310**	Diagnostic Radiology / Vascular & Interventional Radiology	Existing	**Yes** **Eff 6/1/19**
15	Hanrahan, Jeffery MD	Clinica Sierra Vista 815 Dr. Martin Luther King Jr. Blvd Bakersfield CA 93307	**PRV052190**	**PRV000002**	Pediatrics	Existing	**Yes** **Eff 6/1/19**
16	Hawkins, Herminia NP-C	Clinica Sierra Vista 1611 1st St Bakersfield CA 93304	**PRV031073**	**PRV000002**	Family Practice	Existing	**Yes** **Eff 6/1/19**
17	Kaur, Navdeep NP-C	San Joaquin Valley Pulmonary Med Grp 3551 Q St Ste. 100 Bakersfield CA 93301	**PRV052711**	**PRV000354**	Internal Medicine	Existing	**Yes** **Eff 6/1/19**
18	Lee, Alice BCBA	Center for Autism & Related Disorders Inc *All Locations 5300 Lennox Avenue Ste. 100 Bakersfield CA 93309	**PRV052868**	**PRV032083**	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes** **Eff 6/1/19**
19	Lee, Jennifer BCBA	Center for Autism & Related Disorders Inc *All Locations 5300 Lennox Avenue Ste. 100 Bakersfield CA 93309	**PRV052869**	**PRV032083**	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes** **Eff 6/1/19**
20	Lopez Guerrero, Paola BCBA	California Psychcare, Inc. 4500 California Ave Ste. 101 Bakersfield CA 93309	**PRV052870**	**PRV011225**	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes** **Eff 6/1/19**
21	MacPherson, April BCBA	California Psychcare, Inc. 624 E Commercy Ave Unit E Palmdale CA 93551	**PRV042152**	**PRV011225**	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes** **Eff 6/1/19**
22	Ogun, Omolade MD	Universal Urgent Care, PC *All Locations 8325 Brimhall Road Ste. 100 Bakersfield CA 93312	**PRV037071**	**ALL SITES**	Family Practice	Existing	**Yes** **Eff 6/1/19**

23	Pike, Suzanne PhD	Telehealthdocs Medical Corporation dba: Telehealthdocs Medical Group *All Locations 2215 Truxtun Avenue Ste. 100 Bakersfield CA 93301	**PRV052817**	**PRV036952**	Psychology	Existing	**Yes Eff 6/1/19**
24	Powell, Brian DO	Telehealthdocs Medical Corporation dba: Telehealthdocs Medical Group *All Locations 2215 Truxtun Avenue Ste. 100 Bakersfield CA 93301	**PRV052818**	**PRV036952**	Pain Medicine	Existing	**Yes Eff 6/1/19**
25	Rafiq, Rehana MD	Kern County Hospital Authority 6001 Truxtun Ave Ste 210B Bakersfield CA 93309	**PRV034961**	**ALL SITES**	Pediatrics	Existing	**Yes Eff 6/1/19**
26	Recio, Melody NP-C	Bakersfield Pediatrics, A Medical Group *All Locations 300 Old River Rd Ste. 105 Bakersfield CA 93301	**PRV052872**	**PRV000363**	Pediatrics	Existing	**Yes Eff 6/1/19**
27	Romero-Ramon, Maritza BCBA	California Spectrum Services 901 Tower Way Ste. 304 & 306 Bakersfield CA 93309	**PRV052875**	**PRV031975**	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes Eff 6/1/19**
28	Sakowski, Melissa PA-C	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield 9330 Stockdale Hwy Ste. 400 Bakersfield	**PRV048362**	**ALL SITES**	Neurological Surgery	Existing	**Yes Eff 6/1/19**
29	Siriratsivawong, Kris MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	**PRV051366**	**ALL SITES**	General Surgery	Existing	**Yes Eff 6/1/19**
30	Towne, Sasha BCBA	California Psychcare, Inc. 624 E Commercy Ave Unit E Palmdale CA 93551	**PRV052880**	**PRV011225**	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes Eff 6/1/19**
31	Tucker, Kim NP-C	Omni Family Health 161 N Mill St Tehachapi CA 93561	**PRV045335**	**PRV000019**	General Practice & OB/GYN	Existing	**Yes Eff 6/1/19**
32	Webb, Kristin BCBA	California Psychcare, Inc. 4500 California Ave Ste. 101 Bakersfield CA 93309	**PRV052878**	**PRV011225**	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes Eff 6/1/19**
33	Welch, Devin BCBA	California Psychcare, Inc. 624 E Commercy Ave Unit E Palmdale CA 93551	**PRV052881**	**PRV011225**	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes Eff 6/1/19**

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34	Young, John MD	Dignity Health Medical Foundation dba: Dignity Health Medical Group - Bakersfield DHMG-Bakersfield Stockdale Hwy 9500 Stockdale Hwy Ste. 203 Bakersfield CA 93311	**PRV011417**	**PRV012886**	Family Practice	Existing	**Yes** **Eff 6/1/19**

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	NAME	LEGAL NAME/ADDRESS	Provider #	Group #	SPECIALTY	CONTRACT STATUS	PAC APPROVED - EFFECTIVE DATE
1	Acton Vale Pharmacy	The Baiden Group Inc. dba: Acton Vale Pharmacy 3630 Smith Ave Ste. A Acton CA 93510	PRV053470	PRV053470	Pharmacy / DME	New Contract	Yes Eff 7/1/19
2	Biocorp Clinical Lab, Inc.	Biocorp Clinical Lab, Inc. 2700 F Street Ste. 240 Bakersfield CA 93301	PRV001470	PRV001470	Clinical Laboratory	New Contract	Yes Eff 7/1/19
3	Burns Pharmacy	Burns Prescription Pharmacy dba: Burns Pharmacy 866 W. Lancaster Blvd. Lancaster CA 93534	PRV050811	PRV050811	Pharmacy & DME	New Contract	Yes Eff 7/1/19
4	Curex Pharmacy	Curex Pharmacy Inc. 3008 Sillect Ave Ste. 180 Bakersfield CA 93308	PRV053477	PRV053477	Pharmacy	New Contract	Yes Retro - Eff 6/1/19
5	Agrait-Bertan, Edgardo MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV053471	PRV000324	Diagnostic Radiology	Existing	Yes Eff 7/1/19
6	Anderson, Orson MD	Clinica Sierra Vista 6310 Lake Isabella Blvd Lake Isabella CA 93240	PRV000595	PRV000002	Family Practice	Existing	Yes Eff 7/1/19
7	Bennett, Andrew MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV053472	PRV000324	Diagnostic Radiology	Existing	Yes Eff 7/1/19
8	Brown, Mark MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV053473	PRV000324	Diagnostic Radiology	Existing	Yes Eff 7/1/19
9	Dann, Phoebe MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV053474	PRV000324	Diagnostic Radiology	Existing	Yes Eff 7/1/19
10	Gordon, Anthony MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV053475	PRV000324	Diagnostic Radiology	Existing	Yes Eff 7/1/19
11	Hartz, William MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV053476	PRV000324	Diagnostic Radiology	Existing	Yes Eff 7/1/19

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12	Klipper, David DO	Kern Radiology Medical Group *All Locations 2301 Bahamas Dr Bakersfield CA 93309	PRV047313	ALL SITES	Diagnostic Radiology	Existing	**Yes** **Eff 7/1/19**
13	Lee, Jason MD	Coffee Surgery Center dba: All Kids Dental 2525 Eye Street Ste. 100 Bakersfield CA 93301	PRV004437	PRV000369	Anesthesiology	Existing	**Yes** **Retro - Eff 6/6/19** **(Needed for Coverage)**
14	Manjikian, Viken MD	Stockdale Radiology Physician Services *All Locations 4000 Empire Drive Ste. 100 Bakersfield CA 93309	PRV030718	PRV000396	Diagnostic Radiology	Existing	**Yes** **Eff 7/1/19**
15	Altmiller, Sandi PA	Universal Urgent Care, PC *All Locations 8325 Brimhall Road Ste. 100 Bakersfield CA 93312 Additional Affiliations: Ashok Parmar MD, Inc. Ming Primary Care Clinic (PCP) Brimhall Primary Care Center (PCP)	PRV047038	PRV045444 PRV036257 PRV012894	Family Practice	Existing	**Yes** **Eff 7/1/19**
16	Betterman, Mary MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV045828	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 7/1/19**
17	Board, Darren PA-C	Comprehensive Blood & Cancer Center 6501 Truxtun Ave Bakersfield CA 93309	PRV050745	PRV013881	Dermatology	Existing	**Yes** **Eff 8/1/19** **(1yr-Exp)**
18	Bonetti, Renee MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV053478	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 7/1/19**
19	Cook, Taylor PA-C	Grossman Medical Group 420 34th St Bakersfield CA 93301	PRV052468	PRV000405	General Surgery	Existing	**Yes** **Eff 7/1/19**
20	DeLorio, Glori BCBA	California Psychcare, Inc. 624 E Commercy Ave Unit E Palmdale CA 93551	PRV053479	PRV011225	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes** **Eff 7/1/19**
21	Drew, Jack MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV053480	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 7/1/19**
22	Eisenberg, Danny MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV034247	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 7/1/19**

23	Fagan, Royce MD	Hospitalist Medicine Physicians of CA, Inc. Dba: Sound Physicians of California 2615 Chester Avenue Bakersfield CA 93301	PRV007047	PRV014433	Internal Medicine / Hospitalist	Existing	**Yes** **Eff 7/1/19**
24	Foster, Elisa DO	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV002349	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 7/1/19**
25	Galoyo, Rubie NP	Onyinye Okezie, MD 500 Old River Rd Ste. 110 Bakersfield CA 93311	PRV053486	PRV029412	Pediatrics	Existing	**Yes** **Eff 7/1/19**
26	Gendy, Amir MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV051247	ALL SITES	General Surgery / Surgical Critical Care	Existing	**Yes** **Eff 7/1/19**
27	Guiterrez, Brian BCBA	California Psychcare, Inc. 624 E Commercy Ave Unit E Palmdale CA 93551	PRV053487	PRV011225	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes** **Eff 7/1/19**
28	Hawk, Kristina MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV043704	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 7/1/19**
29	Heinlen, Stephanie MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV053481	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 7/1/19**
30	Hill, Samantha LCSW	Omni Family Health *Various Omni Locations 4900 California Ave Ste 100B Bakersfield CA 93309	PRV052512	PRV000019	Social Worker	Existing	**Yes** **Eff 7/1/19**
31	Hoffman, Grant DC	Omni Family Health 912 Fremont St Delano 93215 2101 7th St Wasco 93280	PRV040964	PRV000019	Chiropractor	Existing	**Yes** **Eff 7/1/19**
32	Holland, James LCSW	Omni Family Health 4900 California Ave Ste 100B 1014 Calloway Dr 1701 Stine Rd 4151 Mexicali Dr Bakersfield CA	PRV052510	PRV000019	Social Worker	Existing	**Yes** **Eff 7/1/19**
33	Hughes, Kelly DO	Omni Family Health 161 N Mill St Tehachapi 1133 N Chelsea St Ridgecrest 4900 California Ave Ste. 100B Bakersfield	PRV052191	PRV000019	Pediatrics	Existing	**Yes** **Eff 7/1/19**
34	Jett, Beckie PA	Clinica Sierra Vista 815 Dr. Martin Luther King Jr. Blvd Bakersfield CA 93307	PRV038254	PRV000002	Pediatrics	Existing	**Yes** **Eff 7/1/19**

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35	Jung, Edward MD	Rio Bravo Oncology Inc. 4500 Morning Drive Ste. 105 Bakersfield CA 93306	PRV050762	PRV035588	Radiation Oncolgy	Existing	**Yes** **Eff 7/1/19**
36	Lebovits, Raphael PA-C	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV052192	ALL SITES	Urology	Existing	**Yes** **Eff 7/1/19**
37	Ly, Kelly OD	ACE Eyecare Inc. 1721 Westwind Dr Ste. B Bakersfield CA 93301	PRV053488	PRV041736	Optometry	Existing	**Yes** **Eff 7/1/19**
38	Maliyekkal, Lincy NP-C	San Joaquin Community Hospital Adventist Health Bakesfield - TOC 2819 H St Bakersfield CA 93301	PRV004218	PRV000207	Internal Medicine	Existing	**Yes** **Eff 7/1/19** ***TOC Rates pending entry into QNXT. Effective date may change.**
39	Maloney, Jami LCSW	Ridgecrest Regional Hospital RHC - 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	PRV051970	PRV000279 PRV029495	Social Worker	Existing	**Yes** **Eff 7/1/19**
40	Medley, Mitchell BCBA	Valley Achievement Center (VAC) 7300 Ming Ave Bakersfield CA 93309	PRV053489	PRV014033	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes** **Eff 7/1/19**
41	Otto, Tara MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV053482	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 7/1/19**
42	Pandya, Sangita MD	Universal Urgent Care, PC *All Locations 8325 Brimhall Road Ste. 100 Bakersfield CA 93312	PRV002523	ALL SITES	Family Practice	Existing	**Yes** **Eff 7/1/19**
43	Park, Young In DO	Hospitalist Medicine Physicians of California, Inc. Dba: Sound Physicians of California 2615 Chester Avenue Bakersfield CA 93301	PRV048154	PRV014433	Internal Medicine / Hospitalist	Existing	**Yes** **Eff 7/1/19**
44	Pi, Alexander DO	Hospitalist Medicine Physicians of California, Inc. Dba: Sound Physicians of California 2615 Chester Avenue Bakersfield CA 93301	PRV011179	PRV014433	Internal Medicine / Hospitalist	Existing	**Yes** **Eff 7/1/19**
45	Premier Urgent Care of California	Infusion & Clinical Services Dba: Premier Urgent Care of Central Calif. 901 Olive Drive Bakersfield CA 93308	PRV000404	PRV000404	Urgent Care Center	Existing	**Yes** **Retro - Eff 5/15/19**

46	Ramirez, Jorge MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	**PRV053483**	**PRV000324**	Diagnostic Radiology	Existing	**Yes** **Eff 7/1/19**
47	Ramos, Ariel NP-C	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield 1111 Columbus St Bakersfield	**PRV050863**	**ALL SITES**	Otolaryngology	Existing	**Yes** **Eff 7/1/19**
48	Ring, Natalie BCBA	California Psychcare, Inc. 624 E Commercy Ave Unit E Palmdale CA 93551	**PRV053490**	**PRV011225**	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes** **Eff 7/1/19**
49	Saba, John BCBA	California Psychcare, Inc. 624 E Commercy Ave Unit E Palmdale CA 93551	**PRV053491**	**PRV011225**	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes** **Eff 7/1/19**
50	Shaffner, Angie NP-C	Omni Family Health 3409 Calloway Dr 1014 Calloway Dr 1022 Calloway Dr Bakersfield CA 93312	**PRV051818**	**PRV000019**	Family Practice	Existing	**Yes** **Eff 7/1/19**
51	Sohal, Narinder NP-C	Singh Family Medical Clinic 9900 Stockdale Hwy Ste. 205 Bakersfield CA 93311	**PRV053492**	**PRV000019**	Family Practice	Existing	**Yes** **Eff 7/1/19**
52	Stewart, Margarita NP-C	Clinica Sierra Vista 1611 1st St Bakersfield CA 93304	**PRV052189**	**PRV000002**	Family Practice	Existing	**Yes** **Eff 7/1/19**
53	Sulzer, Jana MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	**PRV053484**	**PRV000324**	Diagnostic Radiology	Existing	**Yes** **Eff 7/1/19**
54	Tank, Jay MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	**PRV053485**	**PRV000324**	Diagnostic Radiology	Existing	**Yes** **Eff 7/1/19**
55	Whitbey, Misty NP-C	Bakersfield Pediatrics, A Medical Group 300 Old River Road Ste. 105 1215 34th Street Bakersfield CA	**PRV053098**	**PRV000363**	Pediatrics	Existing	**Yes** **Eff 7/1/19**

Provider Network Management
Network Review
Quarter 2, 2019

- **After Hours Calls**
- **Appointment Availability Survey**
- **Access Grievance Review** (Q1 2019)
- **Geographic Accessibility**
- **Network Adequacy**

KERN HEALTH SYSTEMS

After Hours Calls

Quarter 2, 2019

AFTER HOURS CALLS SURVEY

Q2, 2019

KERN HEALTH SYSTEMS

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:

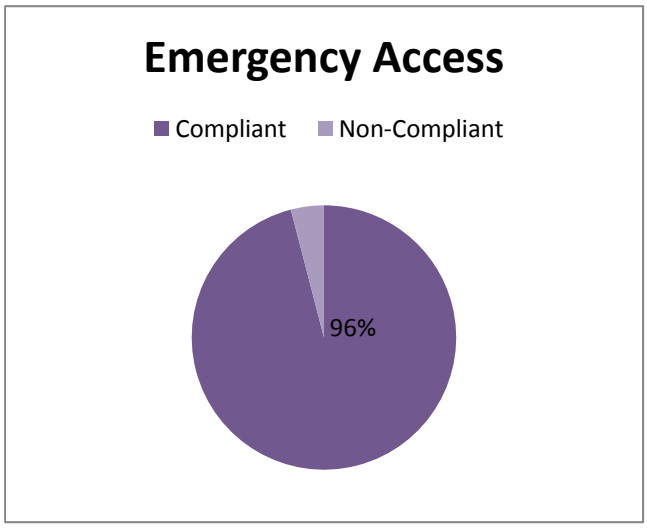
1.) Provider's answering machine or answering service must instruct the member to call 911 if the purpose of the call is a medical emergency.

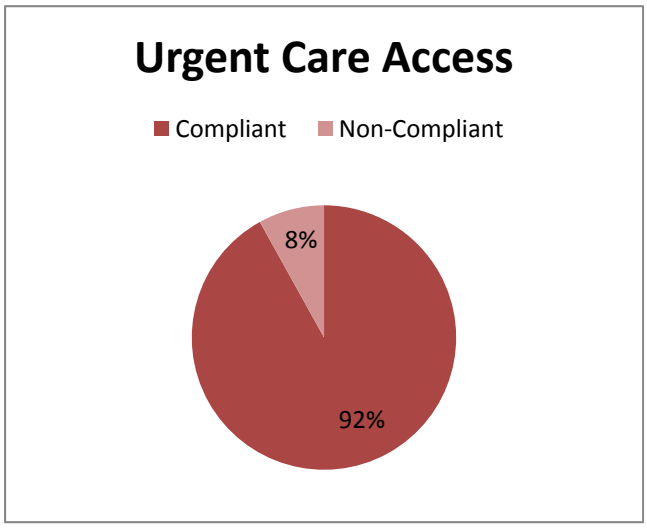
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

An initial survey is conducted by Health Dialog and then forwarded to the Plan's Provider Network Analysts who make additional calls each quarter based on the results received from the survey vendor. Results are to be reported to the KHS QI/UM Committees and to Executive Staff.

Results

124 provider offices were contacted during Q2 2019. Of those offices, 119 were compliant with the Emergency Access Standards and 114 were compliant with the Urgent Care Access Standards.





AFTER HOURS CALLS SURVEY

Q2, 2019

Trending / Follow –Up / Outreach

The Plan reviewed results against past quarters. The Plan identified five (5) provider groups that were out of compliance for a second quarter in a row. It appears that Plan outreach and education based on 1st quarter's results may have taken place concurrent with the Plan's survey vendor conducting the 2nd quarter afterhours calls – which could be one potential reason for multiple providers remaining out of compliance. The Plan's Provider Network Management department will conduct outreach and education to all providers identified to inform them of survey results and provide additional coaching on the Plan's after-hours access standards.

KERN HEALTH SYSTEMS

Appointment Availability Survey

Quarter 2, 2019

Provider Network Management

Appointment Availability Survey

Q2, 2019

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; compliance is determined using the methodology utilized by the DHCS during the 2017 Medical Audit in which they conducted a similar appointment availability survey. Results are to be reported to the KHS QI/UM Committees and to Executive Staff.

KHS also utilizes these quarterly calls to monitor contracted provider's **Phone Answering Timeliness.** KHS *Policy 4.30-P Accessibility Standards,* requires "contracted providers must answer or design phone systems that answer phone calls within six rings." In conducting the quarterly appointment availability, KHS staff count the rings prior to a provider answering to gauge compliance.

Appointment Availability Survey Results

A random sample of 15 primary care provider offices and 15 specialist offices were contacted during Q2 2019. Of the primary care providers surveyed, the plan compiled the wait time (in days) to determine the Plan's average wait time for a primary care appointment; for Q2 2019 the Plan's average wait time for a primary care appointment was **4.4 days**, and was found to be in-compliance with the 10 business day standard. Of the specialist providers surveyed, the plan compiled the wait time (in days) to determine the Plan's average wait time for a specialist appointment; for Q2 2019 the Plan's average wait time for a specialist appointment was **11.5 days**, and was found to be in-compliance with the 15 business day standard.

Phone Answering Timeliness Results

Utilizing the methodology outlined above, KHS conducts a phone answering timeliness survey in conjunction with the appointment availability survey. During Q2 2019, all calls were answered within six rings or less, with an average **1.8 rings** before a call was answered.

KERN HEALTH SYSTEMS

Access Grievance Review

Quarter 1, 2019

Provider Network Management

Access Grievance Review

Q1, 2019

Introduction and KHS Policy

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".

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.*

During Q1 2019, forty (40) access-related grievances were received and reviewed by the KHS grievance committee. In twenty-eight (28) of the cases, no issues were identified and were closed in favor of the plan. The remaining **twelve (12) 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, Trending, and Provider Outreach

During the Q1 2019 Access Grievance Review meeting the twelve (12) cases that were closed in favor of the enrollee were reviewed against all access grievances received in the previous year.

Of the twelve (12) cases reviewed, eight (8) grievances were classified as "Difficulty Accessing a Specialist"; three (3) of the grievances were for in-office wait time, four (4) were for appointment availability, and one (1) for phone access. Upon review of these grievances against grievances received in the previous year, the Plan did not identify any trends, in neither specialty type, nor provider.

The remaining four (4) cases reviewed were classified as "Access to Care"; two (2) of the grievances were for in-office wait time, and two (2) were for appointment availability. Upon review of these grievances against grievances received in the previous year, the Plan did not identify any trends.

Corrective Action Plan Monitoring

The Plan currently has an ongoing Corrective Action Plan (CAP) for a provider who had previously received multiple access grievances, found in favor of the enrollee, for in-office wait time. That provider did not receive any access grievances, found in favor of the enrollee, for in-office wait time during Q4 2018 or Q1 2019, fulfilling the remediation activity outlined in the CAP. At this time, the Plan is considering this CAP met but will continue to monitor this provider's access grievances through this quarterly review.

KERN HEALTH SYSTEMS

Quarter 1, 2019 Access Grievances Review Agenda
Date: 8/13/19

Discussion:

1. **Review access grievances for Q1, 2019**
   - **Identify any trends regarding access**
   - **Conduct file review for grievances closed in favor of the enrollee**

2. **Review Access Grievances for Q1, 2019 against last year of annual grievances**
   - **Identify any trends regarding access**

Name	Title	Date
James Winfrey	Sr PR Analyst	8/13/19
Yolanda Herrera	Credentialing Supervisor	8/13/19
Melissa Lopez	PR Manager	8/13/2019

KERN HEALTH SYSTEMS

Geographic Accessibility

Quarter 2, 2019

Provider Network Management

Geographic Accessibility

Q2, 2019

KERN HEALTH SYSTEMS

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.

For all geographic areas in which the Plan does not currently meet the regulatory accessibility standard, The Plan monitors and maintains an alternative access standard that has been reviewed and approved by the DMHC or DHCS.

DHCS Annual Network Certification - 2019

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

As a part of the Annual Network Certification requirement outlined in APL 18-005 and 19-002, the Plan was required to submit geographic access analysis outlining compliance with the above-listed standards. For all zip codes in which the Plan was not compliant with the above standard, the Plan was able to submit alternative access standards to ensure compliance.

The Plan currently maintains a subcontract with Kaiser Permanente (KP) to provide services to a subset of KHS enrollees; DHCS Network Certification required KP contracted providers to be included in the geographic analysis conducted by the Plan. In reviewing the two plans combined provider data, KHS found that KP providers practice in the same geographic areas as KHS providers, and did not cause substantial change to KHS' compliance with geographic accessibility standards.

Geographic Accessibility

Q2, 2019

The Plan completed required network certification reporting in Q1 2019, including the submission of alternative access standard requests based on the results of the Plan's geographic accessibility analysis. During Q2 2019, the DHCS completed its review of the Plan's alternative access standard requests – of the 65 standard requests reviewed, 31 were approved, 31 were granted partial approval, and 3 were denied. In analyzing the DHCS' alternative access standard determinations, the Plan found the majority of the partial approvals/denials were due to the DHCS locating an out-of-network, out-of-service-area provider closer to the member than the Plan's in-network, in-service-area provider. The Plan is currently working with the DHCS in an effort to resolve the determinations that received partial approval/denial.

During Q2 2019, the Plan reviewed the geographic analysis conducted during Q1 2019 against changes within the provider network during Q2 2019, and did not find any substantial changes that would affect the plan's current geographic accessibility.

KERN HEALTH SYSTEMS

Network Adequacy

Quarter 2, 2019

Provider Network Management

Network Adequacy

Q2, 2019

KERN HEALTH SYSTEMS

Introduction

Per CCR § 1300.67.2, Kern Health Systems (KHS) shall maintain, "at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and […] approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees."

During Q3/Q4 2018, KHS, in conjunction with guidance from the Department of Managed Health Care (DMHC), developed and adopted an updated methodology for determining full-time equivalency for contracted providers. KHS memorialized this methodology in Policy 4.30-P *Accessibility Standards;* this policy was submitted to the DMHC and received approval on 12/14/2018.

Per KHS policy, 4.30-P *Accessibility Standards, §4.5 Full-time equivalent (FTE) Provider to Member Ratios,* "Full-time equivalency shall be determined via an annual survey of KHS' contracted providers to determine the percentage of time allocated to Plan's beneficiaries. The results of the survey will be used to calculate an average FTE percentage which will be applied to the Plan's network of providers when calculating the physician-to-enrollee compliance ratios. The methodology for the survey, results of the survey, and network capacity review of above ratios, will be reported annually to the KHS QI/UM Committee. Due to a maximum member assignment of 1,000 Mid-level providers serving in the Primary Care capacity will be counted as .5 of a PCP FTE, prior to percentage calculation."

Survey Methodology and Results

In 2018, KHS contracted with SPH Analytics to conduct our annual Provider Satisfaction Survey; as a part of that survey, responding providers were asked, "*What portion of your managed care volume is represented by Kern Health Systems?"* Outreach for the survey was placed to every contracted provider within the Plan's network. Responses received, and FTE calculations based on those responses, do not account for providers who refuse to participate in the survey. KHS used the responses collected from Primary Care Providers to calculate the FTE for Primary Care Providers, and used the responses collected from Primary Care Providers and Specialists to calculate the FTE for Physicians.

KHS utilized SPH Analytics, an NCQA certified survey vendor, to conduct the survey for 2018. SPH's methodology involved two waves of mail and Internet, with a third wave of phone follow up to administer the survey; for 2018, the provider survey was conducted from June to August.

Based on the results of 2018 survey, KHS calculated a network-wide FTE of **49.08% for Primary Care Providers** and **40.23% for Physicians.**

Network Adequacy

Q2, 2019

Full Time Equivalency Compliance Calculations

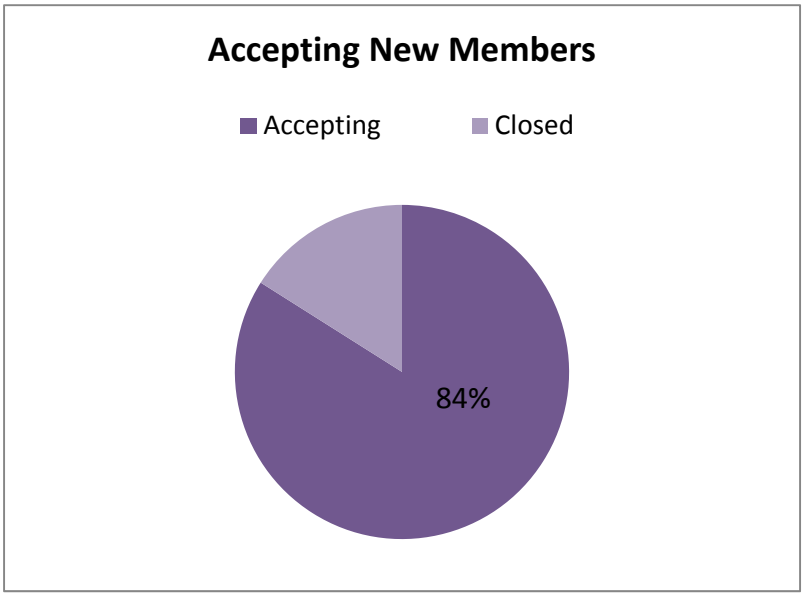
Of KHS' 256,422 membership at time of review, 8,705 were assigned and managed by Kaiser and did not access services through KHS' network of contracted providers; due to this, Kaiser managed membership is not considered when calculating FTE compliance.

As of the end of Q2 2019, the plan was contracted with 387 Primary Care Providers, a combination of 211 physicians and 176 mid-levels. Based on the FTE calculation process outlined above, with a 49.08% PCP FTE, KHS maintains a total of **146.75 FTE PCPs**. With a membership enrollment of 247,717 utilizing KHS contracted PCPs, KHS currently maintains a ratio of **1 FTE PCP to every 1688.03 members**; KHS is compliant with state regulations and Plan policy.

As of the end of Q2 2019, the plan was contracted with 1051 Physicians. Based on the FTE calculation process outlined above, with a 40.23% Physician FTE, KHS a total of **422.79 FTE Physicians**. With a total membership enrollment of 247,717 utilizing KHS contracted Physicians, KHS currently maintains a ratio of **1 FTE Physician to every 585.91 members**; KHS is compliant with state regulations and Plan policy.

Accepting New Members

In addition to the Full Time Equivalency Compliance review conducted above, the Plan monitors adequacy of its Primary Care Network by reviewing the count/percentage of Primary Care Providers (PCP) who are accepting new members. At the end of Q2 2019 the plan maintained a network of 387 Primary Care Providers, a combination of 211 physicians and 176 mid-levels. At the time of this review, 325 Primary Care Providers were accepting new members at a minimum of one Plan-contracted location, a combination of 166 physicians and 159 mid-levels. **The Plan calculated that 84% of the network of Primary Care Providers is currently accepting new members at a minimum of one location**. The Plan will continue to monitor this percentage quarterly to ensure it maintains an adequate network of Primary Care Providers.

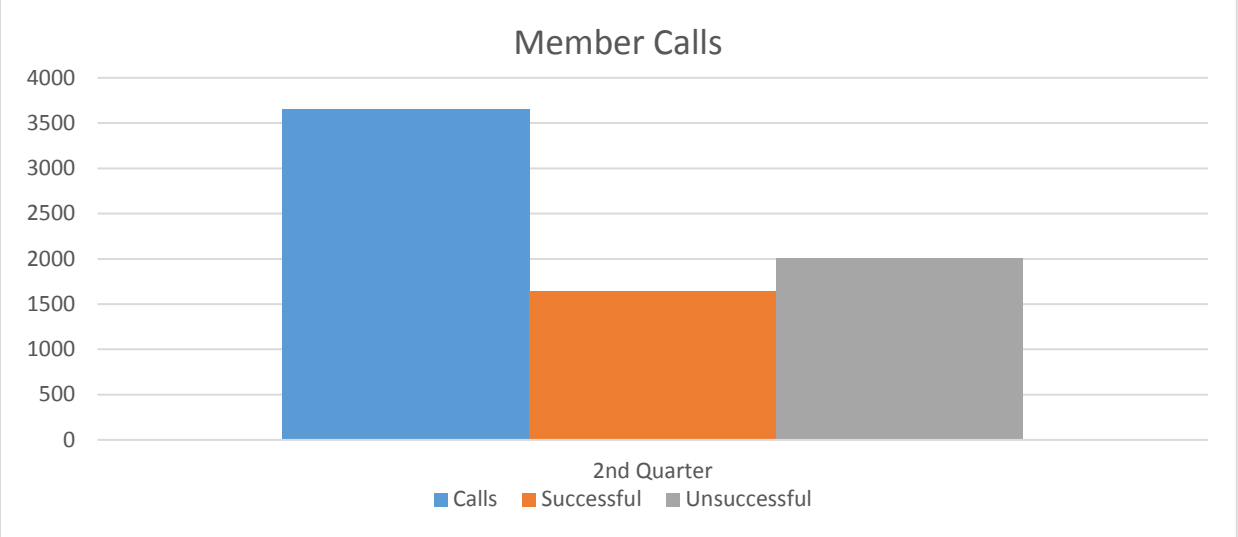


Disease Management Quarterly Report

2ND Quarter, 2019

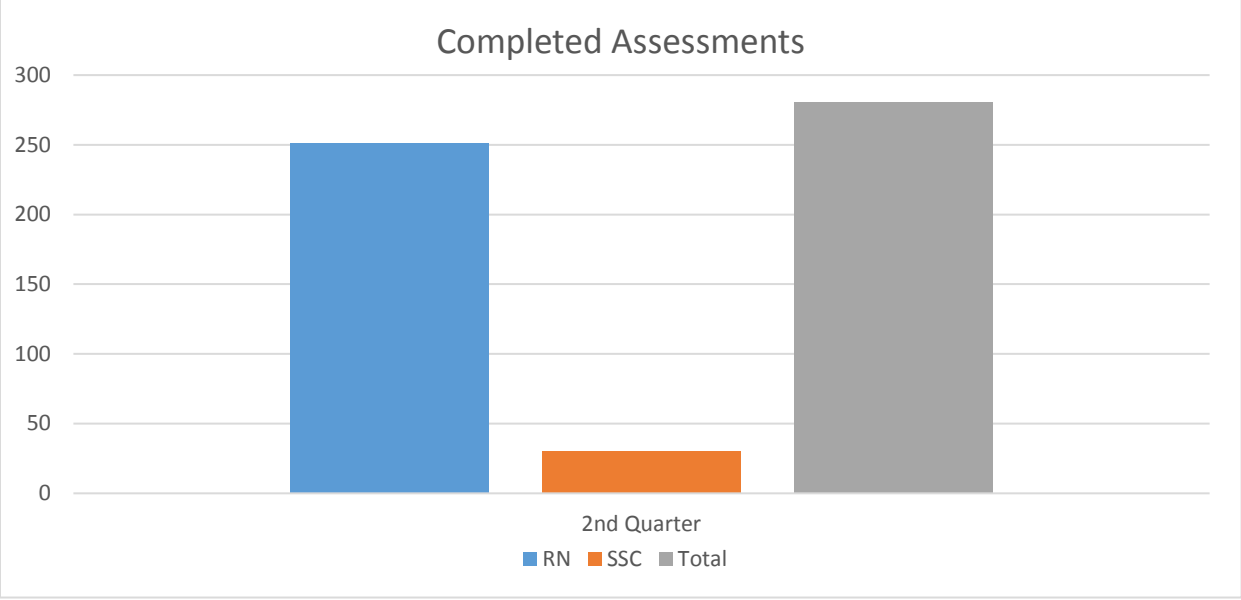
Telephone Calls: A total of 3,654 calls were made by the DM staff during the 2nd Quarter, 2019.

Member Calls Attempted	Successful Calls	Unsuccessful Calls	Total Member Calls	% Contacted
RN	856	1,582	2,438	35%
SSC	789	427	1,216	65%
Total	**1,645**	**2.009**	**3,654**	**45%**



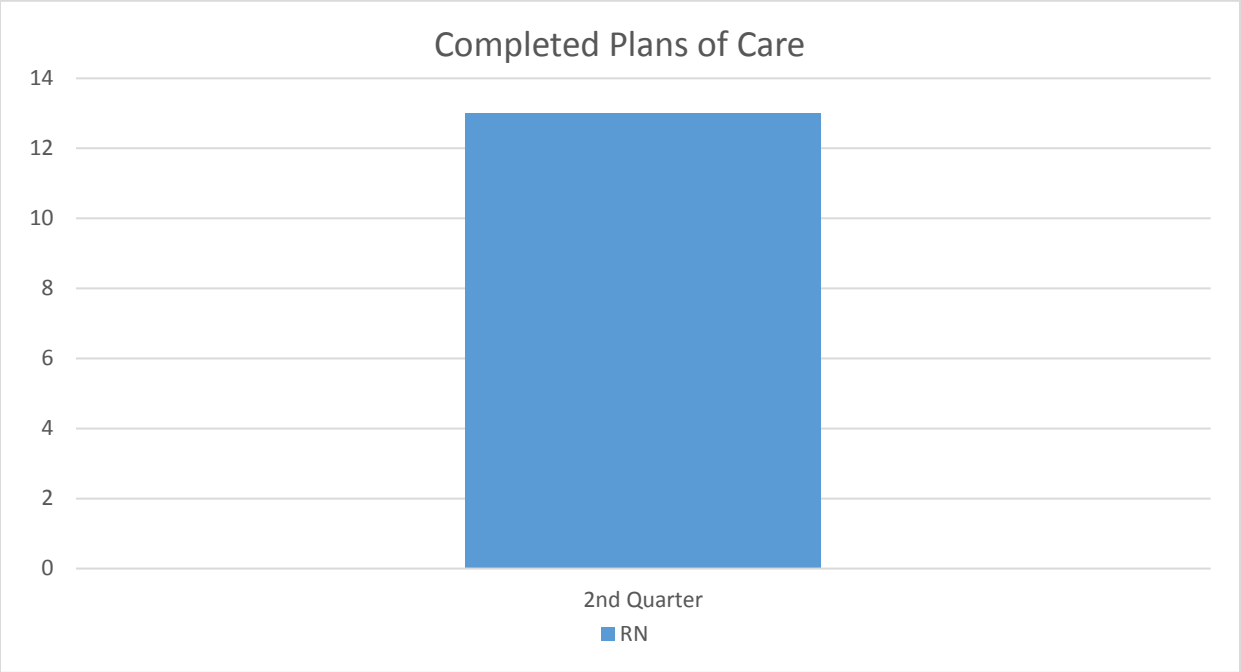
New Assessments Completed.

RN	SSC	Total
251	30	281



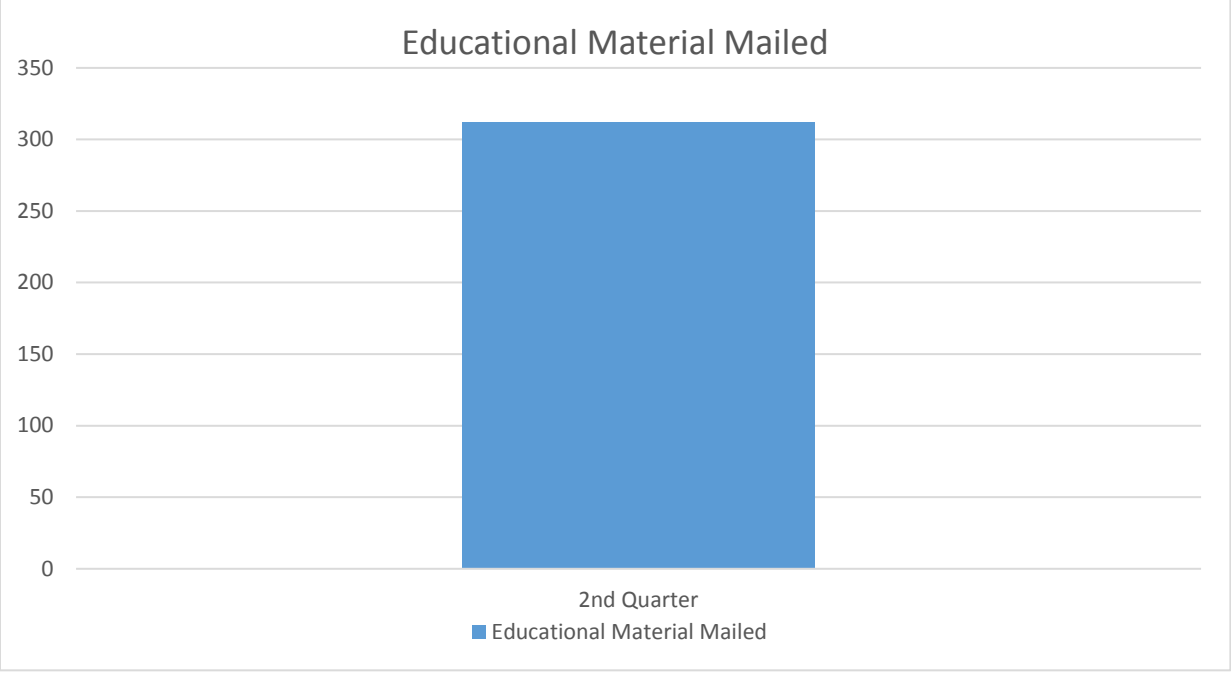
Plans of Care Completed & Closed.

RN
13



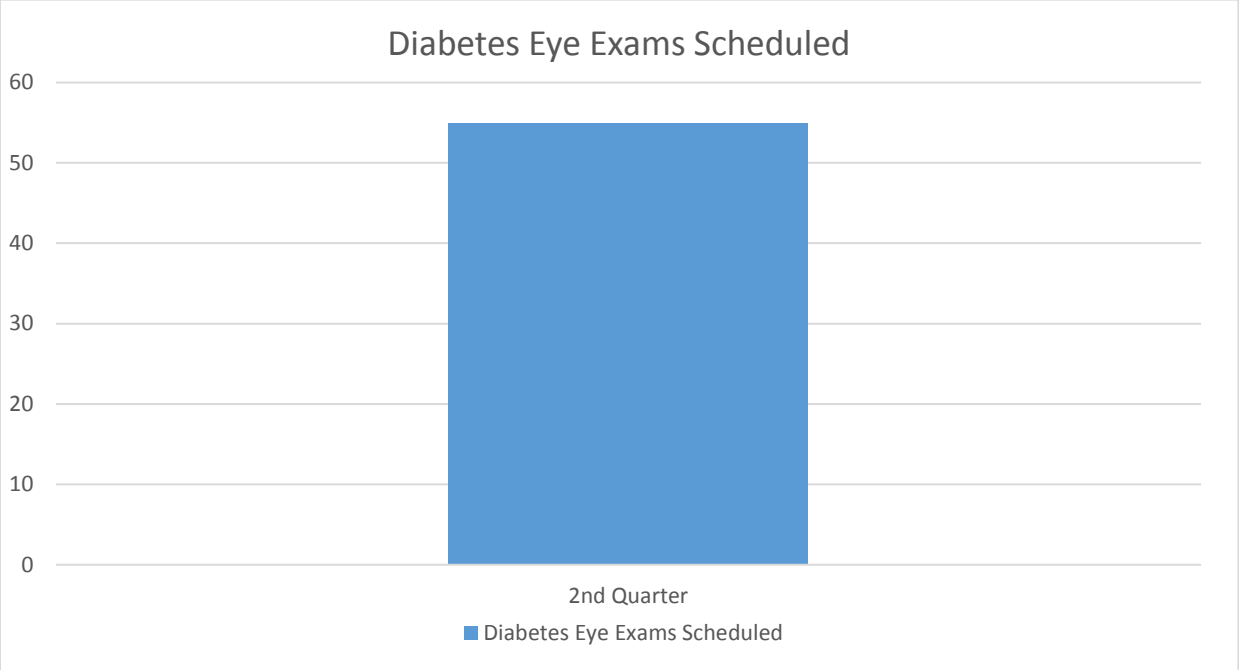
Educational Material Mailed.

312



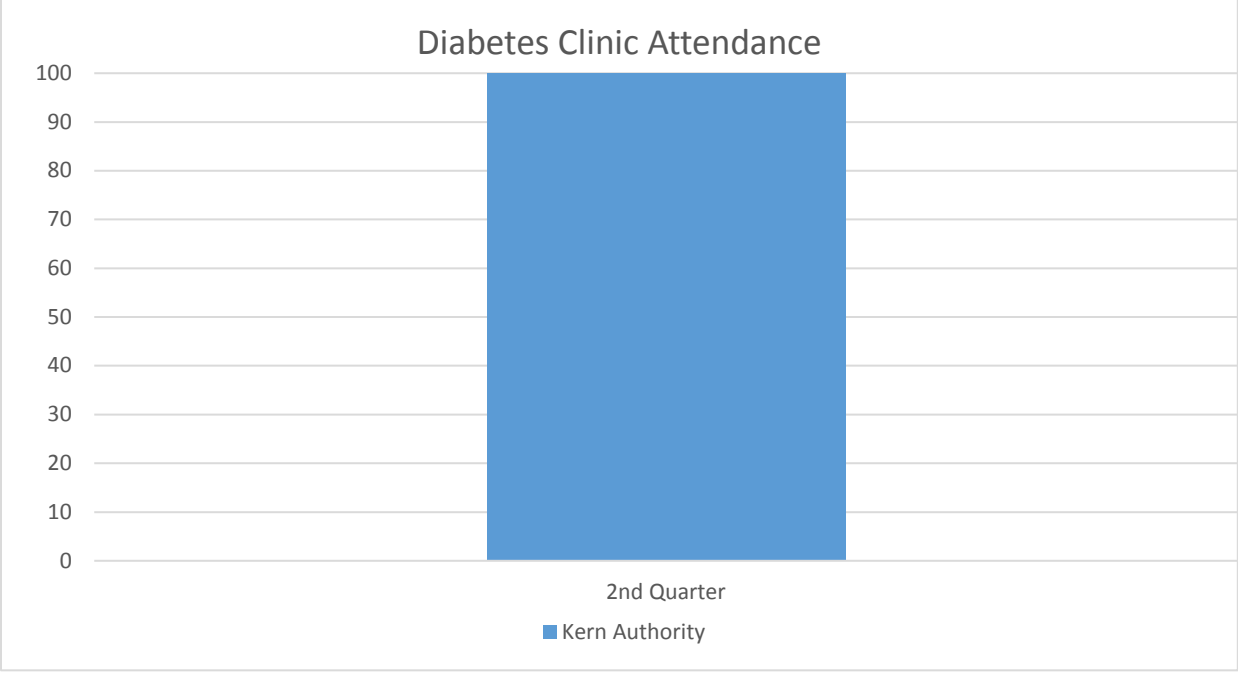
Diabetes Eye Exams Scheduled.

55



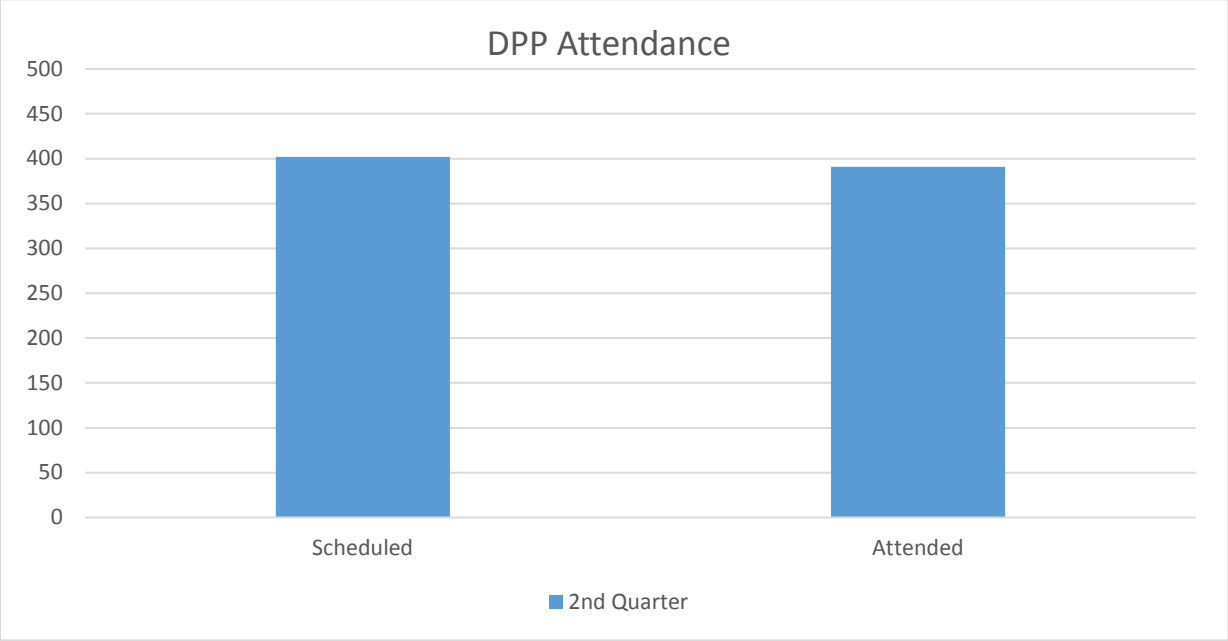
Diabetes Clinic Attendance.

Kern Authority
259



Diabetes Prevention Program: At the end of the 2nd Quarter, 27 members remain enrolled in the program.

Sessions Scheduled to Attend	Actual Sessions Attended
402	391



KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Hospital Re-admissions – Identification of Potential Quality of Care Issues				POLICY #: 2.26-I	
DEPARTMENT: ~~Utilization Management - Health Education and Disease Management~~Quality Improvement					
Effective Date: 10/1999	Review/Revised Date: ~~07/27//2015~~	DMHC	X	PAC	X
		DHCS	X	QI/UM COMMITTEE	X
		BOD	X	FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Martha Tasinga, M.D.
Chief Medical Officer

_____ Date _____
Deborah Murr, R.N.
~~Administrative~~ Senior Director of Health Services

_____ Date _____
Jane Daughenbaugh, R.N.
Director of Quality Improvement

POLICY:

~~To further patient safety and to identify opportunities for improvement, it is the policy of~~ Kern Health Systems (KHS) ~~to~~ will evaluate ~~all~~ hospital re-admissions that occur within 30 days of the first hospital discharge to identify any trends in quality of care issues~~.~~

~~It is understood that n~~Not all re-admissions within thirty (30) days are due to Quality of Care Issues. ~~however~~The following mechanisms will be used to ensure~~, in order to ensure~~ appropriate evaluation occurs ~~the following processes are in place~~ to identify quality of care concerns and opportunities ~~to~~ for improvement ~~the~~ in care ~~we provide~~provided:

1. ~~All diagnosis codes are evaluated for readmission within 30 days.~~A sampling of 50 re-

admissions per quarter will be selected for review and case selection will represent a comprehensive view of the entire pool of 30 day re-admissions (e.g. male versus female, hospital, geographic area, age, diagnosis, etc.).

2. The Business Intelligence team produces a monthly report of all 30-day Re-admissions that is used for case review selection. Case selection may be focused depending on identified trending patterns. ~~All admissions are evaluated through concurrent review by inpatient nurse review case managers for quality of care concerns~~.

~~2.~~3. If at any time there are 100 or more 30 day readmission reviews awaiting review for potential quality of care identification, the QI team will narrow the pool to 50 re-admissions for each quarter based on the method described in section 1 above.

4. ~~Potential quality of care concerns are forwarded to the QI Supervisor or designee for evaluation through the 'Notification Process'~~Cases selected for review are evaluated for a potential quality of care concern by a QI RN.

5. After the RN completes their review, it is sent to a medical director or their designee for final determination of whether a potential quality of care concern exists and identification of follow up actions needed.

6. An aggregate report of 30 day re-admissions to evaluate trending will be presented to the QI-UM Committee for review and recommended actions.

7. Re-admissions excluded from review for a potential quality of care concern include:
    a. Re-admissions that are only an observation stay and do not involve actual hospital admission
    b. Scheduled re-admission as part of a planned course of treatment
    c. Transfers to another hospital with no break between discharge and admission between hospitals.
    ~~a.~~d. Patients scheduled or anticipated for readmission (e.g. patient being scheduled for and returning to the hospital for further treatment of a disease, illness or injury).

PROCEDURES:

1.0 INITIAL EVALUATION OF RE-ADMISSIONS

8. ~~Once a r~~Hospital re-admissions occurring within 30 days from the date of discharge for a previous hospital stay are ~~-~~evaluated to identify any potential quality of care issue (PQI). Cases selected for review are entered into the Health Services care management system's 30 Day Re-admission Review module and a QI RN initiates the process for evaluating if a potential quality of care concern is present. If additional medical records are needed, the RN advises~~d~~ the QI Senior Support Clerk who submits the request to the facility. The RN completes the process for potential quality of care concerns. (See Policy and Procedure 5.01-I, KHS Member Grievance and Appeal System, and APL 17-006, Grievance and Appeal Requirements).

~~If any of the questions on the worksheet are checked in the 'YES" column, the case is excluded from the 30 day readmission chart review.~~ If a potential quality of care issue ~~was~~ is identified, a notification form ~~will be~~is completed, sent to the designated QI RN and QI Director and ~~a formal review will be initiated~~process for PQIs is initiated.

A report of all 30 day re-admissions is run from KHS' Business Intelligence team. On a quarterly basis, the QI-UM Committee reviews re-admissions in aggregate to identify any trending patterns. Categories reviewed include but are not limited to the following categories:

- Male

- Female
- Ages 0 – 12
- Ages 13 – 17
- Ages 18 – 64
- Ages 65 and over
- Hospital
- Diagnosis
- Geographic area
- Provider

The ~~Supervisor of~~ QI Director or their designee ~~will~~ screens all cases initiated by UM to ensure that each is appropriate for review within the readmission process and with consideration of exclusions listed in the Policy section item 7~~above~~. ~~Screening exclusion criteria include:~~

~~The patient was scheduled for the second readmission. An example of this would be the patient being scheduled for and returning to the hospital for further treatment of a disease, illness or injury.~~

~~The patient did not return home between admissions. For example, if a patient was discharged to a rehabilitation or skilled nursing facility at the first admission and then readmitted from that facility.~~

~~A. The patient did not participate in discharge planning due to elopement or leaving against medical advice (AMA) during the first admission so that plan of care was disrupted.~~

~~Current or recent enrollment in the Outpatient Care Management Program to assist high-risk and problem prone members meet their discharge plans~~

Cases that do not pass the screening process may be reviewed for other quality of care related concerns (example: death)

2.0 REVIEW OF MEDICAL RECORDS

~~Once the Supervisor of QI or designee has verified that the case is appropriate for 30-day readmission review, the Senior Support Clerk (SSC) will verify that the information on the form is correct and then enter the existing information in Sharepoint. Once the case has been opened in Sharepoint, the SSC~~ After the initial screening is completed, the QI RN will notify the SCC if additional medical records are needed. The SCC ~~will order~~faxes a request for the inpatient and outpatient records ~~from each admission~~to the provider designated by the reviewing QI nurse. Once the records have arrived, the SSC ~~will document~~ uploads the ~~activity~~ documents into the care management system and ~~place the chart in the~~ puts the episode to the 30 day re-admissions ~~review~~ queue.

A QI Nurse reviews the ~~medical records~~documents and summarizes the member's care and any potential quality of care ~~problems or~~ concerns that occurred ~~during each hospitalization and discharge~~related to the re-admission. The summary should include a synopsis of the ~~patient's medical and surgical~~clinical ~~history including possible predisposing factors/risks~~facts supporting their quality of care concern. Once the summary is complete, the QI Nurse~~,~~ ~~notes~~ documents the information in the episode in the care management system~~Sharepoint and assigns the case to the SSC~~. ~~The SSC documents the reassignment in Sharepoint and~~ The

nurse immediately ~~forwards the record~~assigns the episode to the QI Medical Director ~~or designee responsible for Quality Improvement~~ or their physician designee to determine whether a Quality of Care Issue actually exists and to take action. The QI Medical Director or their physician designee reviews the records for internal or external quality of care issues and opportunities for improvement. The ~~SSC~~ QI nurse works with the QI Medical Director or their physician designee ~~to prioritize record review~~for any follow up actions requested. ~~Should~~Follow up action may include both internal and external opportunities for improvement. ~~be found~~Internal issues~~, the case~~ will be discussed with the relevant department(s) ~~to examine and refine~~and a mitigation plan developed as appropriate. The QI nurse and QI Medical Director or their physician designee will coordinate for external quality of care issues to identify who will communicate with the external provider and the necessary follow up actions.

~~The Medical Director or designee reviews the records for internal or external quality of care issues and opportunities for improvement. Should internal opportunities for improvement be found, the case will be discussed with the relevant departments to examine and refine~~

~~processes of care.~~ Where indicated a referral to KHS's other medical management programs such as ~~, QI,~~ UM, CM and DM ~~assistance~~ will be ~~requested in~~made to ~~managing~~manage complex or challenging ~~cases~~member issues. ~~Consideration will be given to following the patient through concurrent review, transition of care or care management programs~~.

~~If needed, the~~The QI Medical Director or their physician designee may draft a letter requesting further information and/or clarification regarding the issue in question. If a quality of care issue is identified, the Medical Director or designee ~~—~~will inform the involved facility's ~~Quality Improvement~~QI Department or the responsible provider of the findings. ~~.~~ ~~—~~Not all identified quality of care issues will require a corrective action plan but all will be tracked for re-credentialing purposes.

3.0 CLOSING CASE

Based on the outcome of the review, the case may be closed with a Severity Level of

- Level 0 = No Quality of Care Concern
  - Follow-up = Track and Trend and/or Provider Education
- Level 1 = Potential for Harm
  - Follow-up = Track and trend the particular area of concern for the specific provider and the Medical Director or their designee may provide additional actions that are individualized to the specific case or provider
- Level 2 = Actual Harm
  - Follow-up = Corrective Action Plan plus direction from Medical Director or their designee which is individualized to the specific case or provider
- Level 3 = Actual Morbidity or Mortality Failure
  - Follow-up = Corrective Action Plan plus direction from Medical Director or their designee which is individualized to the specific case or provider

~~.~~ Copies of all written correspondence and pertinent documents are filed in the appropriate, secured Quality Improvement files within the medical management system. ~~.~~

4.0 TRACKING AND TRENDING

Tracking and trending is performed to identify opportunities for improvement that may not be initially evident by chart review. This is done to identify any persistent patterns of concerns

and opportunities for improvement. ~~–~~

The Medical Director requesting tracking and trending identifies and documents the specific areas for focus and the period of time to conduct tracking and trending. All cases selected for tracking and trending are logged by the QI SSC ~~to the~~into Jiva. All notifications that are identified as a PQI for tracking and trending are monitored, at a minimum, on a monthly basis. A report is run within the first week following the report month for all active track and trend cases. New PQI activity is summarized by the QI RN and presented to the Medical Director for review and direction. ~~quality improvement database~~. ~~The SSC enters details of the case in the tracking and trending database and includes any action deemed necessary by the Medical Director or designee.~~After reviewing the active track and trending cases, the Medical Director makes a decision to:

- Stop tracking and trending and close the case due to no quality of care issue identified
- Stop tracking and trending and close the case due to the identified quality of care issue has been corrected
- Continue tracking and trending with the same focus and for the original period of time identified
- Continue tracking and trending with modification of the focus and for the original period of time identified
- Continue tracking and trending with the same focus, but for a different time period
- Continue tracking and trending with a modification of the focus and a different time period.
- ~~Stop tracking and trending and move to Corrective Action Plan~~

Any trends identified will be discussed with the Medical Director or designee ~~for possible referral to the Physician Advisory Committee and their action~~to evaluate if the PQI leveling and follow up action need to be adjusted. Physician specific trends will be reported to Provider Relations ~~to include~~for inclusion in the ~~credentialing/~~recredentialing process.

~~The Medical Director or designee and others identifies those members included in the concurrent review database. Examples include members with a high volume of admissions or members with complicated physical or social needs.~~

ATTACHMENTS:

- Attachment A – Readmission Review Worksheet (revised)
- ~~Attachment B – Chart Review Process Flowchart (new)~~

REFERENCE:

Policy 5.01, KHS Member Grievance and Appeal System
APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights"
~~Attachements~~Attachments
Title 22, CCR, Section 53858(e)(2)

Revision 2019-08: ~~PAC approved~~PAC approved 8/7/2019. Policy updated to define PQI levels, follow up actions, and process for tracking and trending ~~–b~~by Director of QI.. Removed attachment B, workflow diagram.
Revision 2015-05: PAC approved 6/3/2015. Policy updated to include new processes such as the Transition of Care Program and Outpatient Care Management. Attachment A revised. Attachment B added.
Revision 2013-08: Policy reviewed by Director of Quality Improvement, Health Education and Disease Management.

No revision need, titles updated.
Revision 2009-04: Routine review provided by QI Department. **Revision 2005-03:** Revised to comply with DHS 2005 Contract. Effective Date 01/01/01: Changes requested by QI.

KERN HEALTH SYSTEMS
QUALITY IMPROVEMENT DEPARTMENT

READMISSION REVIEW WORKSHEET
READMISSION FOR SAME OR RELATED CONDITIONS WITHIN 30 DAYS OF DISCHARGE

Today's Date: _____

Member Name: _____ KHS ID: _____

DOB: _____ Age: _____ Date of Review: _____

Admission #1 (Prior Admit): Auth ID: _____

Admission Date: _____ Discharge Date: _____

Facility: _____ Physician: _____

Admitting Dx: _____ Discharge Dx: _____

Admission #2 (Current Admit) Auth ID: _____

Admission Date: _____ Discharge Date: _____

Facility: _____ Physician: _____

Admitting Dx: _____ Discharge Dx: _____

Exclusion Instructions: Review the patient's records and answer each question with a check mark in the appropriate **YES/NO** column. A **YES** in any column indicates that this case does not meet the criteria for readmission review and should be excluded from this sample.

Exclusion Questionnaire	**YES**	**NO**
1) ~~Did the patient elope from the first admission?~~		
2) Was the patient placed under observation status versus actual admission for either stay		
3) Was the second admission scheduled?		
4) Was the patient transferred from another facility as part of the original admission?		
a) Was this patient discharged directly to this facility at first discharge?		
b) Did the patient remain institutionalized the entire period between admissions?		
5) ~~Has this patient been enrolled in the Case Management program?~~		

If excluded, include additional medical/social history as needed then sign and date below.

Signature: Date:

Exclusion from the readmission review does not exclude this member or this hospitalization from other reviews. If a quality of care issue is suspected, please complete the green Notification Form and submit it to Quality Improvement along with a copy of this form and related records.

☐ Potential Quality of Care Issue ☐ No Quality of Care Issue ☐ Unknown

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Second Quarter 2019

Report Date: August 9, 2019

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.

- Fall/Winter Member Newsletter
- 2019 School Wellness Grant Program & Internship
- Asthma Impact Model Pilot with Central California Asthma Collaborative
- Member Engagement Pregnancy Project

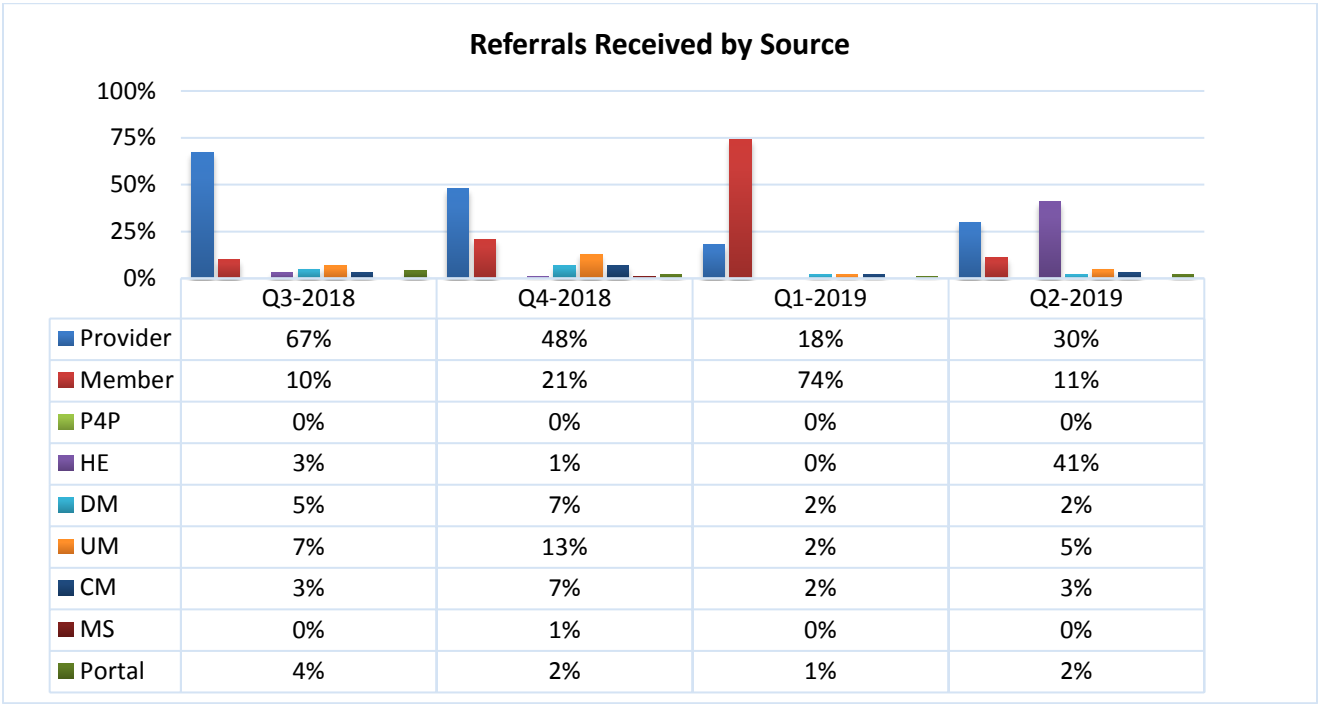
The following pages reflect statistical measurements for the Health Education department detailing the ongoing activity for the 2nd quarter 2019.

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

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Second Quarter 2019

REFERRALS FOR HEALTH EDUCATION SERVICES

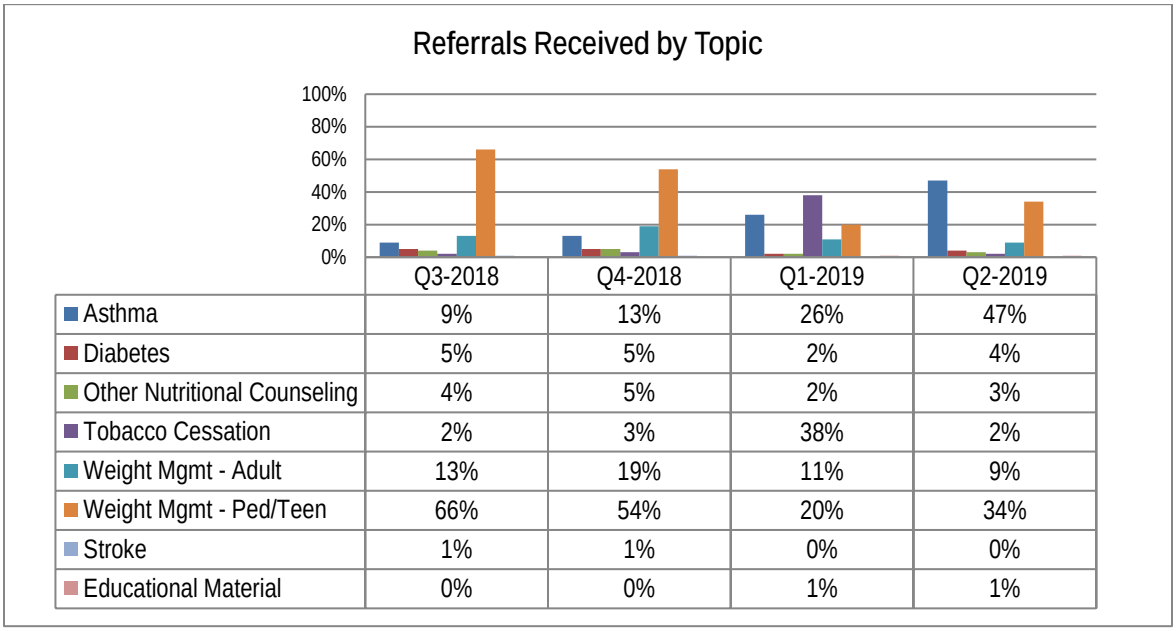
The Health Education Department (HE) receives referrals from various sources. Internal referrals are received from the Kern Health Systems (KHS) Utilization Management (UM), Disease Management (DM), Case Management (CM), Member Services (MS), and Member Portal. Externally, KHS providers submit referrals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



	Q3-2018	Q4-2018	Q1-2019	Q2-2019
Provider	67%	48%	18%	30%
Member	10%	21%	74%	11%
P4P	0%	0%	0%	0%
HE	3%	1%	0%	41%
DM	5%	7%	2%	2%
UM	7%	13%	2%	5%
CM	3%	7%	2%	3%
MS	0%	1%	0%	0%
Portal	4%	2%	1%	2%

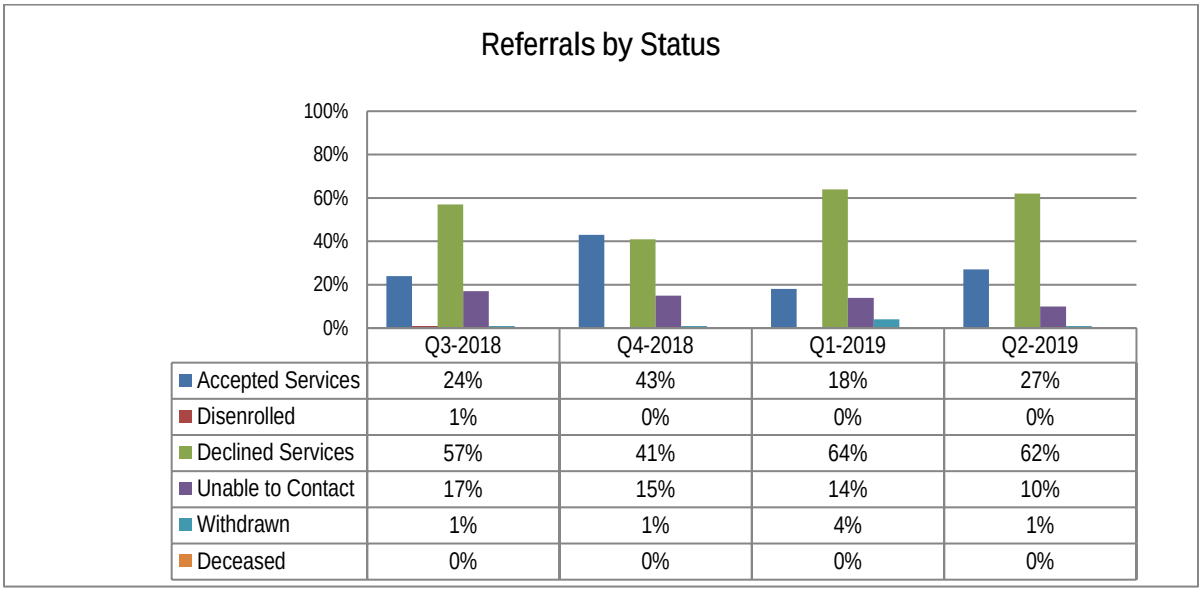
During this quarter, 964 referrals were received which is a 44% decrease in comparison to the previous quarter. This is attributed to the end of the Eliza Outreach and Engagement Pilot.

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Second Quarter 2019



	Q3-2018	Q4-2018	Q1-2019	Q2-2019
Asthma	9%	13%	26%	47%
Diabetes	5%	5%	2%	4%
Other Nutritional Counseling	4%	5%	2%	3%
Tobacco Cessation	2%	3%	38%	2%
Weight Mgmt - Adult	13%	19%	11%	9%
Weight Mgmt - Ped/Teen	66%	54%	20%	34%
Stroke	1%	1%	0%	0%
Educational Material	0%	0%	1%	1%

The HE department receives referrals for various health conditions. This quarter, referrals for asthma education almost doubled due to targeted outreach calls performed by the HE department. Weight management referrals also increased to 43% during the 2nd Quarter of 2019.



	Q3-2018	Q4-2018	Q1-2019	Q2-2019
Accepted Services	24%	43%	18%	27%
Disenrolled	1%	0%	0%	0%
Declined Services	57%	41%	64%	62%
Unable to Contact	17%	15%	14%	10%
Withdrawn	1%	1%	4%	1%
Deceased	0%	0%	0%	0%

The rate of members who accepted to receive health education services increased from 18% in the 1st quarter to 27% in the 2ndquarter of 2019.

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
  - Intro to Gardening
  - Rethink Your Drink
  - Funxercise
  - Healthy Cooking
- Breathe Well Asthma Workshop

Bakersfield Memorial Hospital (BMH):

- Diabetes Management Classes (English only)
- Heart Healthy Classes
- Individual Nutrition Counseling

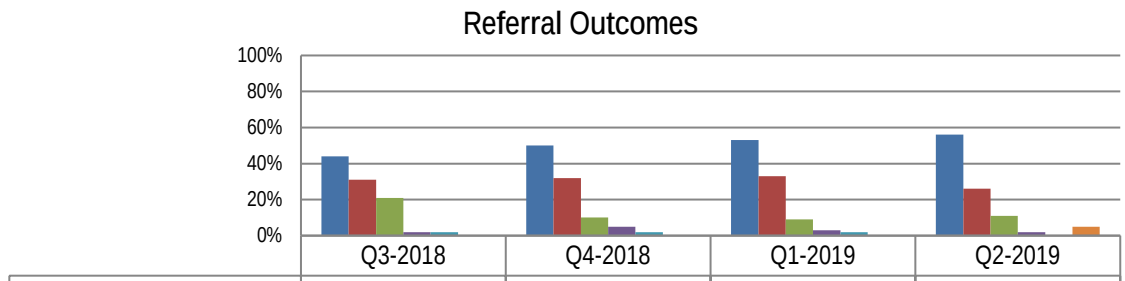
Clinica Sierra Vista (CSV) WIC:

- Diabetes Management Classes
- Heart Healthy Classes

California Smokers' Helpline (CSH):

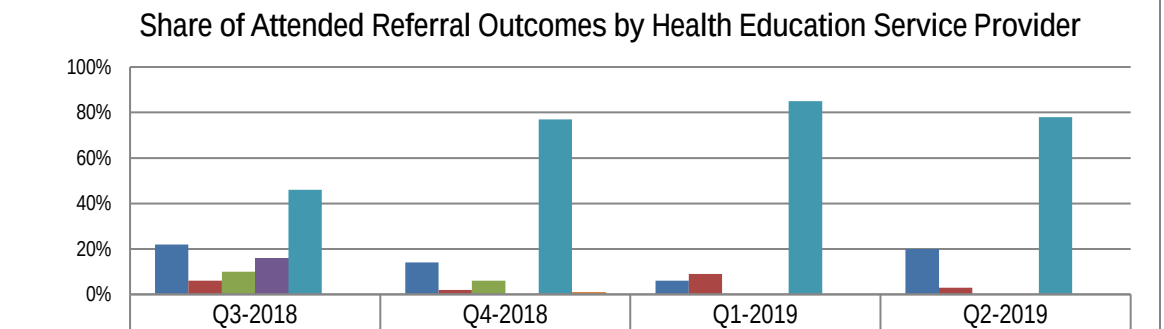
- Telephone Smoking Cessation Counseling

REFERRAL OUTCOMES



	Q3-2018	Q4-2018	Q1-2019	Q2-2019
Attend	44%	50%	53%	56%
No Show	31%	32%	33%	26%
Refused	21%	10%	9%	11%
Unable to contact member	2%	5%	3%	2%
Disenrolled	2%	2%	2%	0%
Withdrawn	0%	0%	0%	5%

During this quarter, the rate of members who received health education services out of all members who accepted services increased from 53% to 56%.

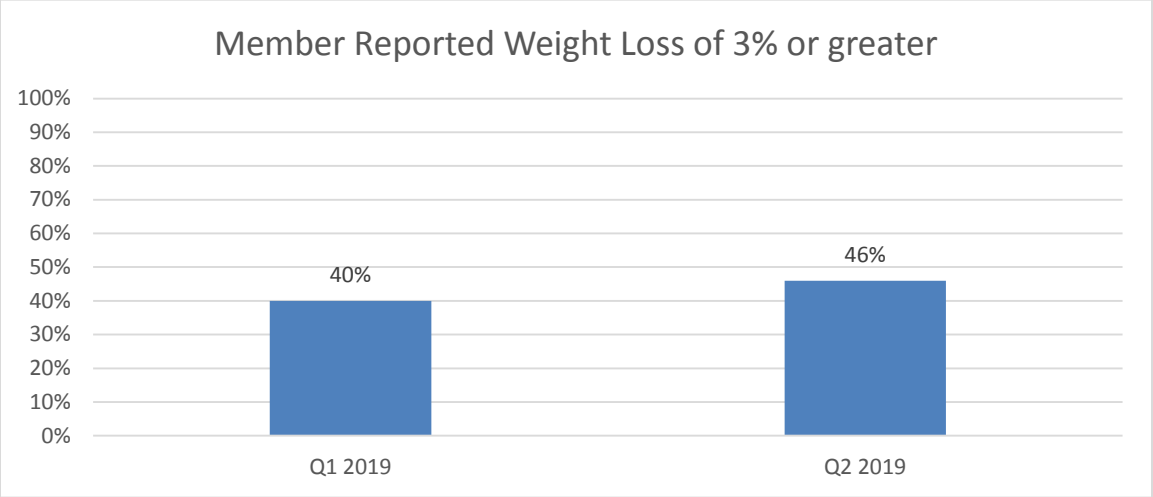


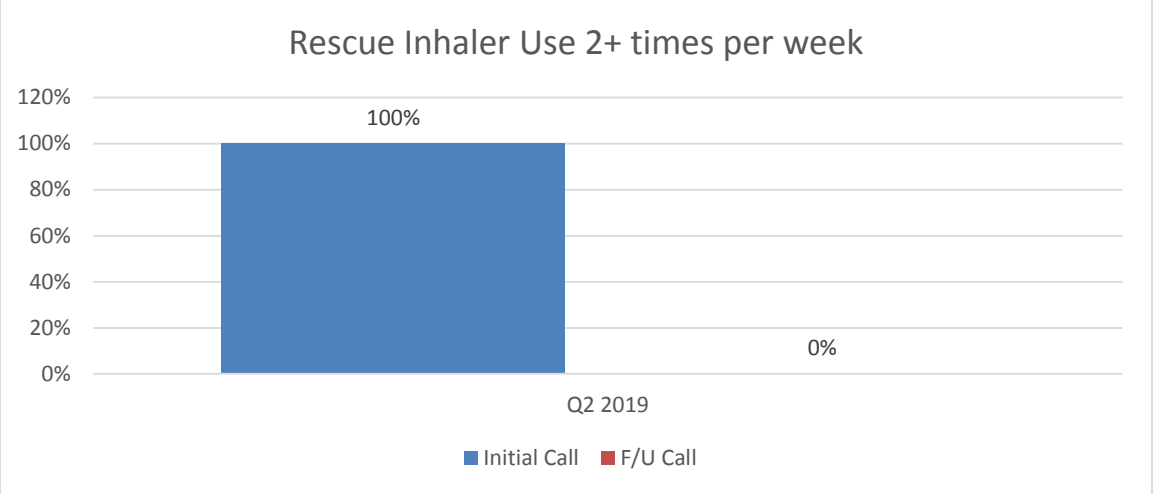
	Q3-2018	Q4-2018	Q1-2019	Q2-2019
BMH	22%	14%	6%	20%
CSH	6%	2%	9%	3%
CSV WIC	10%	6%	0%	0%
CWP	16%	0%	0%	0%
KFHC	46%	77%	85%	78%
SJCH	0%	1%	0%	0%

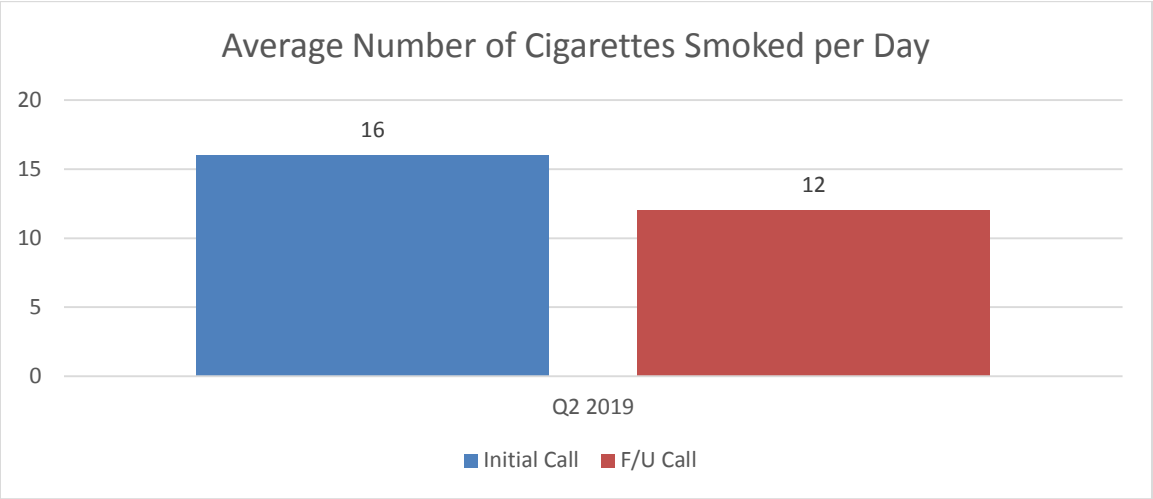
Services through KFHC demonstrates to be one of the largest share of referral outcomes. This quarter KFHC showed a decrease from 85% in the 1st quarter to 78% in the 2nd quarter of 2019.

Effectiveness of Health Education Services

To evaluate the effectiveness of the health education services provided to members, a 3-month follow up call was conducted on members who received services during the prior quarter. Of the 35 members who participated in the 3 month follow up call, 25 received weight management education, 2 received asthma education and 5 received tobacco cessation education. All findings are based on self-reported data from the member.

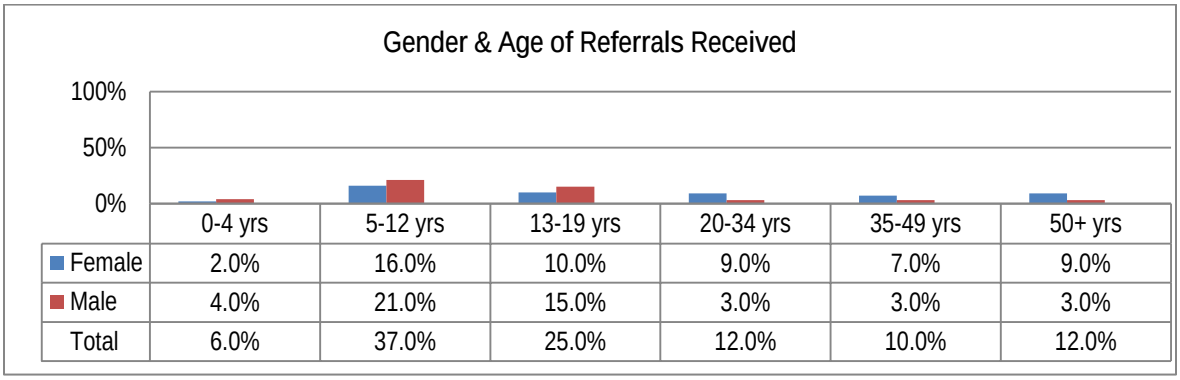






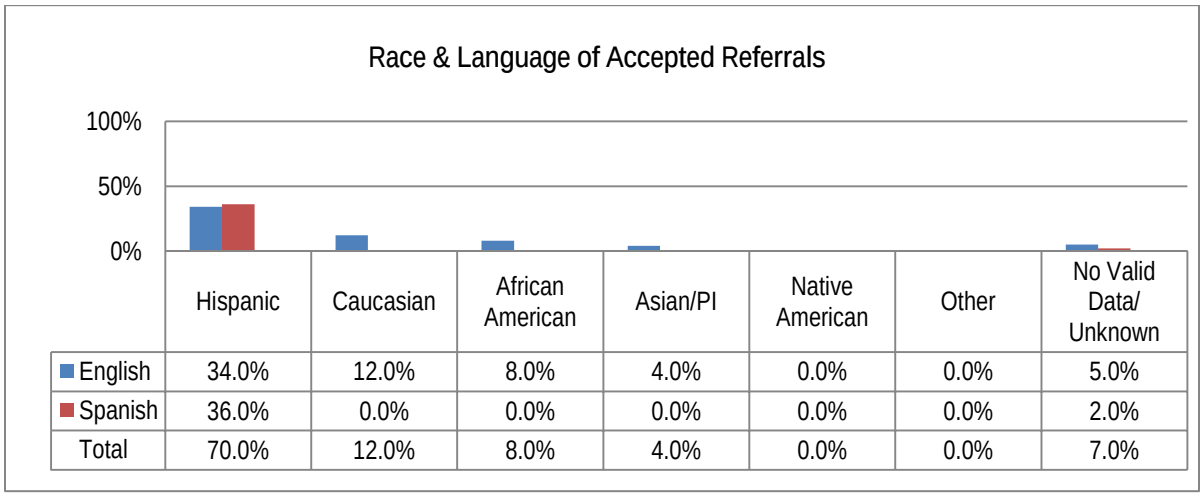
Demographics of Members

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%	16.0%	10.0%	9.0%	7.0%	9.0%
Male	4.0%	21.0%	15.0%	3.0%	3.0%	3.0%
Total	6.0%	37.0%	25.0%	12.0%	10.0%	12.0%

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



	Hispanic	Caucasian	African American	Asian/PI	Native American	Other	No Valid Data/ Unknown
English	34.0%	12.0%	8.0%	4.0%	0.0%	0.0%	5.0%
Spanish	36.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.0%
Total	70.0%	12.0%	8.0%	4.0%	0.0%	0.0%	7.0%

A breakdown of member classifications by race and language preferences revealed that 70% of members who accepted services are Hispanic and the majority preferred to speak Spanish.

Referrals Accepted by Top Bakersfield Zip Codes			
Q3-2018	**Q4-2018**	**Q1-2019**	**Q2-2019**
93306	93307	93307	93307
93307	93306	93306	93306
93305	93304	93304	93305
93304	93305	93308	93304
93309	93313	93305	93308

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			
Q3-2018	**Q4-2018**	**Q1-2019**	**Q2-2019**
Delano	Arvin	Delano	Delano
Arvin	Lamont	Arvin	Wasco
Lamont	Shafter	Lamont	Lamont
Shafter	Delano	Wasco	McFarland
California City	Wasco	Shafter	Shafter
		Tehachapi	Arvin

Additionally, 27% of the members who accepted services reside in the outlying areas of Kern County and the highest concentration of members reside 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 1,367 educational packets to members on the following health topics:

Educational Mailings				
	Q3-2018	**Q4-2018**	**Q1-2019**	**Q2-2019**
Anemia	0	0	1	1
Asthma	25	97	453	427
High Cholesterol	15	21	23	11
Diabetes	92	75	56	53
Gestational Diabetes	0	1	0	5
High Blood Pressure	14	41	29	4
COPD	1	0	0	0
Postpartum Care	36	80	46	471
Prenatal Care	10	18	56	145
Smoking Cessation	136	17,500	252	13
Weight Management	57	675	713	173
WIC	2444	1270	821	64
Total	**2,832**	**19,778**	**2,450**	**1,367**

INTERPRETER REQUESTS

Face-to-Face Interpreter Requests

During this quarter, there were 226 requests for face-to-face interpreting services received. KHS employs qualified staff interpreters in Spanish and contracts with the interpreting vendor, CommGap. The majority of these requests were for a Spanish interpreter.

Top Languages Requested			
Q3-2018	**Q4-2018**	**Q1-2019**	**Q2-2019**
Spanish	Spanish	Spanish	Spanish
Cantonese	Punjabi	Vietnamese	Cantonese
Vietnamese	Cantonese	Arabic	Punjabi
Punjabi	Vietnamese	Cantonese	English
	Arabic	Punjabi	Arabic
		Mandarin	

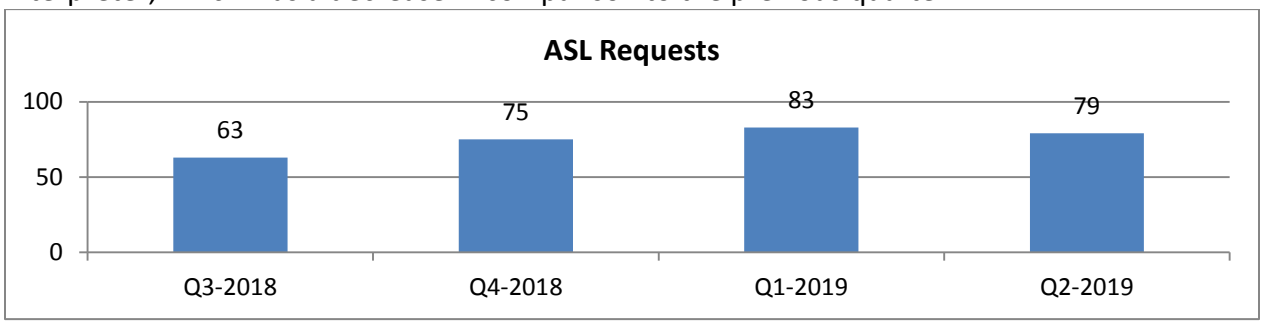
Telephonic Interpreter Requests

During this quarter, there were 883 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			
Q3-2018	**Q4-2018**	**Q1-2019**	**Q2-2019**
Spanish	Spanish	Spanish	Spanish
Punjabi	Punjabi	Punjabi	Punjabi
Arabic	Arabic	Arabic	Arabic
Tagalog	Tagalog	Tagalog	Tagalog
Vietnamese	Vietnamese	Vietnamese	Mandarin

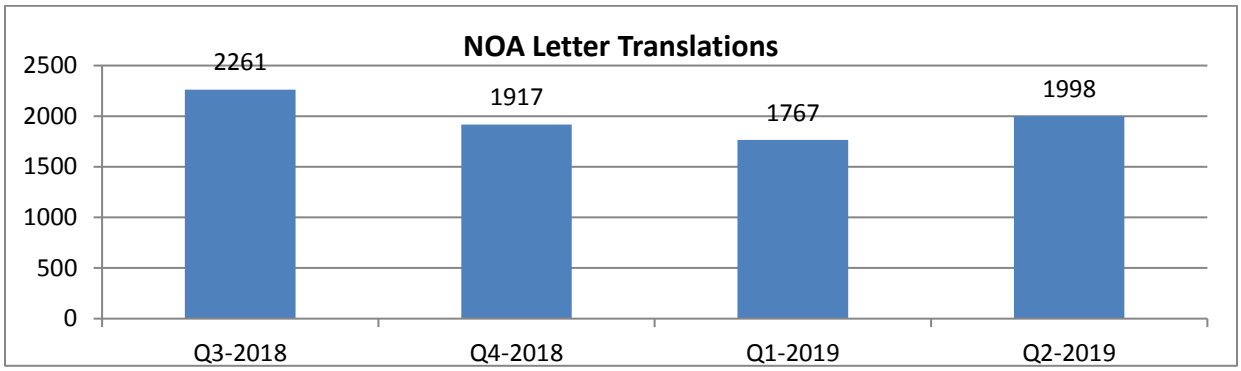
American Sign Language (ASL) Requests

During this quarter, there were a total of 79 requests received for an American Sign Language interpreter, which was a decrease in comparison to the previous quarter.



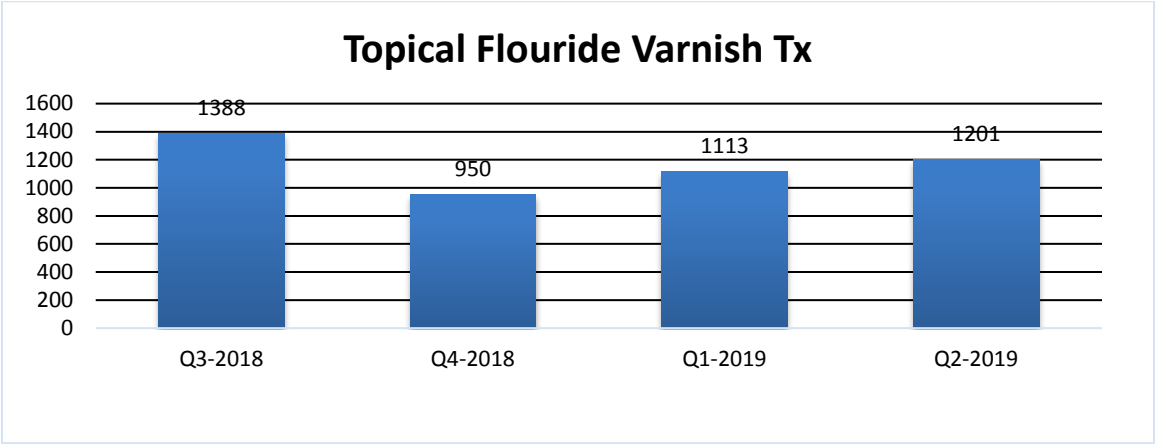
DOCUMENT TRANSLATIONS

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, 1,998 Notice of Action letters were translated into Spanish for the UM and Pharmacy departments.



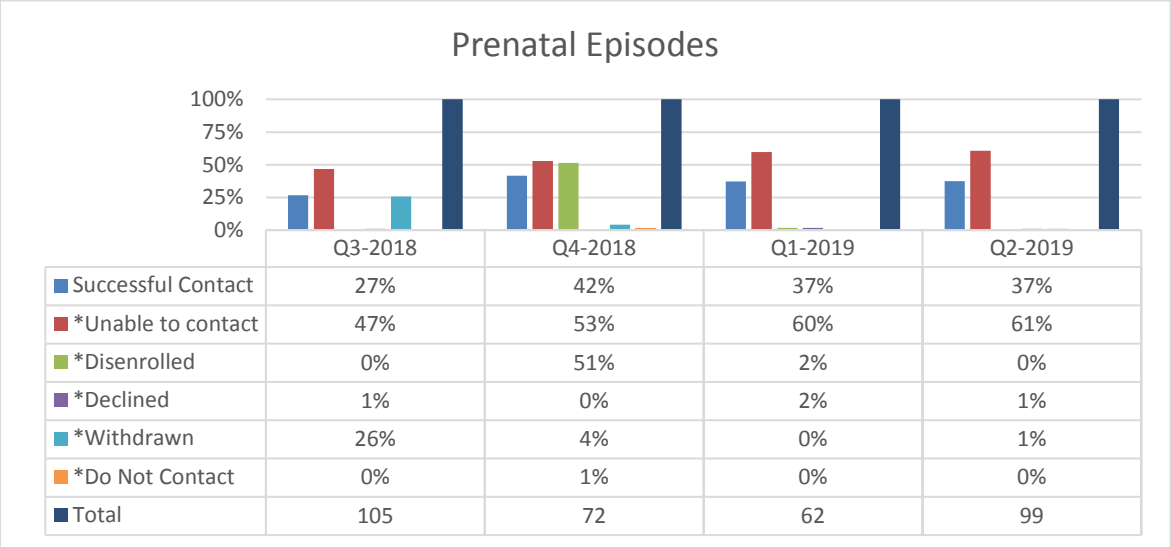
TOPICAL FLUORIDE VARNISH TREATMENTS

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.



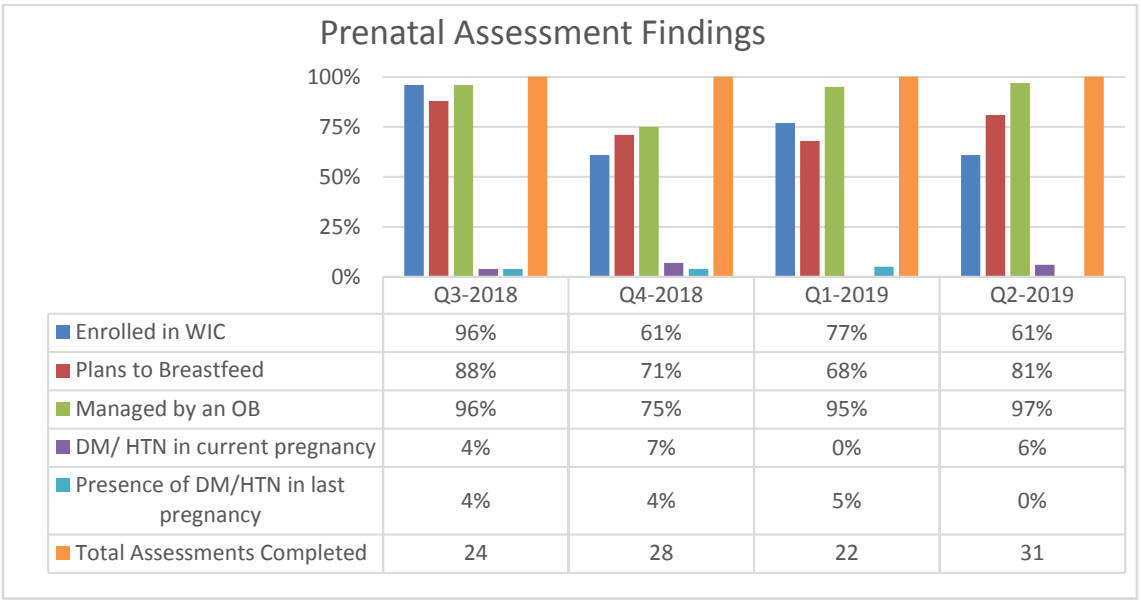
PERINATAL OUTREACH AND EDUCATION

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.



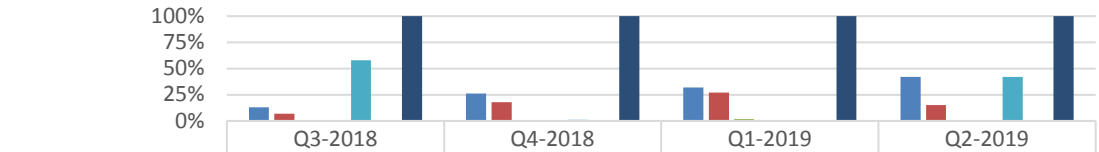
	Q3-2018	Q4-2018	Q1-2019	Q2-2019
Successful Contact	27%	42%	37%	37%
*Unable to contact	47%	53%	60%	61%
*Disenrolled	0%	51%	2%	0%
*Declined	1%	0%	2%	1%
*Withdrawn	26%	4%	0%	1%
*Do Not Contact	0%	1%	0%	0%
Total	105	72	62	99

During the 2nd quarter, 99 episodes for pregnant members were created and 37% were successfully contacted.



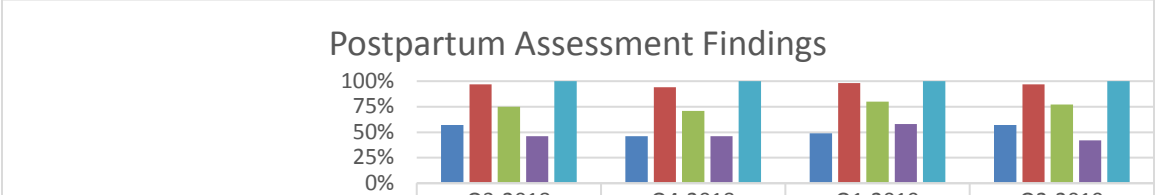
	Q3-2018	Q4-2018	Q1-2019	Q2-2019
Enrolled in WIC	96%	61%	77%	61%
Plans to Breastfeed	88%	71%	68%	81%
Managed by an OB	96%	75%	95%	97%
DM/ HTN in current pregnancy	4%	7%	0%	6%
Presence of DM/HTN in last pregnancy	4%	4%	5%	0%
Total Assessments Completed	24	28	22	31

The total prenatal assessments completed increased from 22 in the 1st quarter of 2019 to 31 in the 2nd quarter of 2019.



	Q3-2018	Q4-2018	Q1-2019	Q2-2019
Successful Contact	13%	26%	32%	42%
*Unable to contact	7%	18%	27%	15%
*Disenrolled	0%	0%	1%	0%
*Decline	0%	0%	0%	0%
*Withdrawn	58%	1%	0%	42%
*Do Not Contact	0%	0%	0%	0%
Total	416	58	76	474

During the 2nd quarter, 474 postpartum members were created and 42% were successfully contacted.



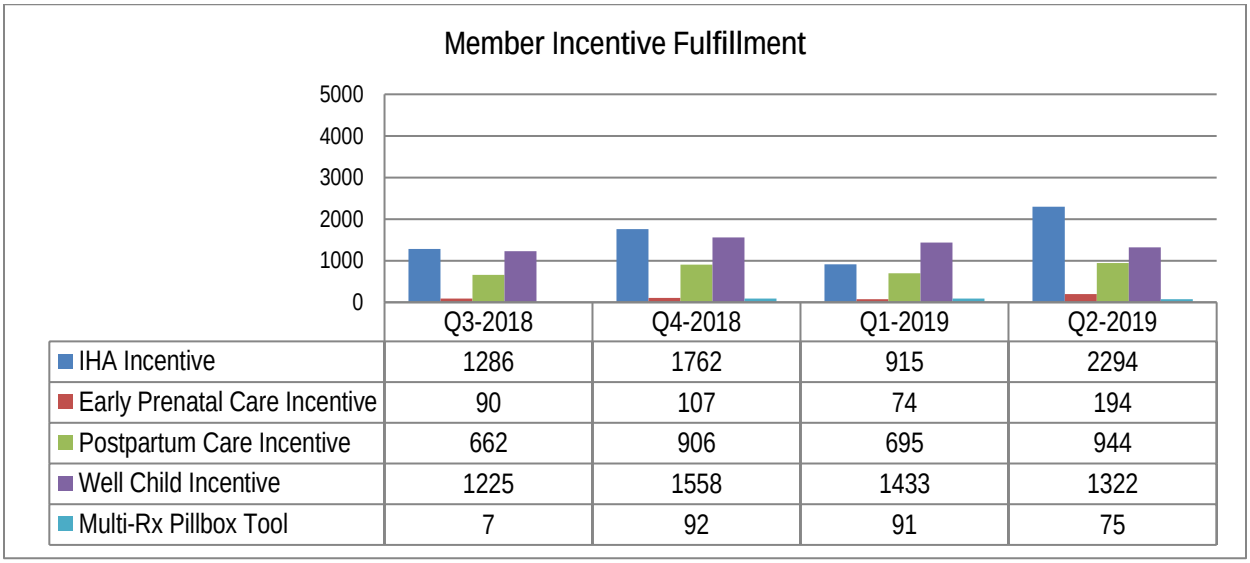
	Q3-2018	Q4-2018	Q1-2019	Q2-2019
Currently Brestfeeding	57%	46%	49%	57%
Newborn saw a doctor after leaving hospital	97%	94%	98%	97%
Newborn added to Medi-Cal case	75%	71%	80%	77%
Aware of Family Planning /Birth Control Options	46%	46%	58%	42%
Total Assessments Completed	65	28	45	188

Postpartum assessments completed increased from 45 assessments in the 1st quarter of 2019 to 188 assessment completed in the 2nd quarter of 2019.

MEMBER WELLNESS BASED INCENTIVES AND CHRONIC CONDITION TOOLS

During the 2nd quarter of 2019, KHS continued to offer wellness based incentives and one chronic condition tools for members. In January 2019, the IHA incentive was changed to a gift card instead of a first aid kit based on member feedback regarding the incentive. This incentive program was also expanded to provide one incentive per eligible member instead of per household.

- **Initial Health Assessment (IHA)** – newly enrolled members who complete the IHA visit within 120 days of enrollment are mailed a $10 gift card.
- **Early Prenatal Care** – pregnant members who complete prenatal care during the 1st trimester will receive a $30 gift card.
- **Postpartum Care** – members who complete the postpartum visit within 21-56 days following delivery will receive an additional $30 gift card.
- **Well Child** – members ages 12 -23 months who complete a well child visit are mailed a $25 gift card.
- **Multi-Medication** – members on multiple medications and would benefit from a pill box. KHS disease and case management departments identify and mail this tool to members.



	Q3-2018	Q4-2018	Q1-2019	Q2-2019
IHA Incentive	1286	1762	915	2294
Early Prenatal Care Incentive	90	107	74	194
Postpartum Care Incentive	662	906	695	944
Well Child Incentive	1225	1558	1433	1322
Multi-Rx Pillbox Tool	7	92	91	75

Kern Health Systems
Quality Improvement Program Evaluation
Reporting Period: January 1, 2018 – December 31, 2018

1. QI ACTIVITIES

According to the California Department of Health Care Services (DHCS) All Plan Letter (APL) 17-014, Quality and Performance Improvement Requirements, 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 by DHCS and conduct ongoing quality improvement projects (PIPs).

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS):

HEDIS 2018 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 1990.

All Medi-Cal managed care health plans must submit annual report scores for the required External Accountability Set (EAS) performance measures. 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 2018 results shown in this report are based on 2017 data, with a few exceptions, which are noted in the descriptions of the measures. HEDIS 2018 results can be found in Appendix A. APL 17-014 states that for each measure below the established Minimum Performance Level (MPL) or 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 one IP for the AMR, Asthma Medication Ration, measure for HEDIS 2018 and is working on two PIPs that were approved by DHCS in 2017. One is for Increasing Appropriate Use of Imaging Studies for Uncomplicated Low Back Pain and the other is for Improving Immunization Compliance Among African American Children. The AAB measure, Avoidance of Antibiotic Treatment, was higher than the MPL and the AMR measure, Asthma Medication Ratio, continued to fall below the MPL. An Improvement project was submitted to DHCS is underway.

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 2018. The next survey is scheduled for 2019.

PROCESS IMPROVEMENT PROJECTS (PIPs):

Each PIP runs approximately 18 months. KHS's PIPs for 2018 are Increasing Appropriate Use of Imaging Studies for Uncomplicated Low Back Pain and Improving Immunization Compliance Among African American Children. These PIPs followed the PDSA format formalized into five modules. KHS has submitted all Modules on time.

Increasing Appropriate Use of Imaging Studies for Uncomplicated Low Back Pain (LBP) – In HEDIS 2017, Kern Health System's LBP measure fell below MPL with a rate of 66.25%. Historical data showed a gradual decline in rate over the last 3 years. This PIP is focused on decreasing the number of members who receive imaging studies (plain x-rays, CT scans or MRI's) within 28 days of initial diagnosis of uncomplicated low back pain. Interventions included:

- Introduce the concept of HEDIS and measuring best practice to providers
- Place a poster with LBP guidelines in Urgent Cares exam rooms. Provider can use the poster to educate members requesting an x-ray.
- Develop LBP screening tool to provide a guideline in management of LBP
- Have providers educate members on LBP disease process and treatment management options
- Provider to offer other options for pain control such as warm pack application, physical therapy, yoga, tai chi, and rest.

For the second PIP, Improving Immunization Compliance among African American Children, KHS partnered with a FQHC clinic to identify and remove barriers for getting timely vaccines among the African American population. The intent is to improve health outcomes related to preventable diseases and improve the HEDIS CIS measure. Interventions for this PIP included providing growth charts during the post-partum visit and immunization outreach by KHS QI staff. This PIP is continuing in 2019.

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 DHCS certified Master Trainer 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 Memorandum of Understanding (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 for conducting this review 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 nine critical elements are as follows:

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. Needle stick 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 collection, processing, storage, transport or shipping; and
9. Spore testing of autoclave/steam sterilizer is completed (at least monthly), unless otherwise stated in the manufacturers guidelines, with documented results.

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	8/31/2019	QI and UM evaluations, programs and work plans for Kaiser and VSP will be presented to the Physician Advisory Committee on August 7, 2019 and to the QI-UM Committee on August 22, 2019	Complete for 2018
QI Policies and Procedures	Not Met	Ongoing	1. QI Policies and Procedures are updated every 3 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 5. One policy, 2.26-I Hospital Re-admissions - Quality of Care Issues 2015-05, was not updated within 3 years and will be updated in 2019.	Not Complete for 2018
Audits				

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
Site review timeliness audit	Met	12/1/2018	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 2018
			1.	
Staying Healthy Assessment	Met	12/1/2018	212 positive Staying Healthy Assessments (SHAs) were identified through and HEDIS chart review. These were forwarded to Health Education in collaboration with them.	Complete for 2018
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: • 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. • Health Homes continues to expand. There are currently 6 number of Community-Based Care Management Entities (CB-CMEs). . •	Complete for 2018
Notifications (Death, General)	Met	Ongoing	The QI department continues to look for opportunities for improvement through the Notification process. 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 2018
Grievances	Met	Ongoing	The QI department continues to look for opportunities for improvement through the Grievance process. Retrospective	Complete for 2018

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			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.	
Resources				
• Director of Quality Improvement	Not Met	2019	Recruitment efforts will be re-started next year.	Not Met for 2018
• QI supervisor	Met	12/1/2018	The department's QI supervisor position was eliminated in the 4th quarter	Complete for 2018
• QI RN II	Met	12/1/2018	The department currently has one RN II position and that is filled by a senior RN who is a Master Trainer for Facility Site Reviews. One RN I position serves as the lead HEDIS RN. •	Complete for 2018
• QI RN I	Met	12/1/2018	The QI department is at full staff. QI RN I = 5 FTEs	Complete for 2018
• QI Coordinator	Met	12/1/2018	This position was budgeted since 2015 to insource HEDIS Medical Record retrieval and has been very successful	Complete for 2018
• QI Assistant	Met	12/1/2019	This position assists with HEDIS Medical Record retrieval and is responsible for the Member Incentive.	Complete for 2018
• Operational Analyst	Met	12/1/2018	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 was transitioned from a QI Business Analyst in 2018.	Complete for 2018
• QI Technician and Trainer	Met	12/1/2018	This position provides reporting support to the QI department and focuses on reporting actionable data, streamlining current processes, developing new processes, and training staff.	Complete for 2018

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
• Senior Support Clerk	Met	12/1/2018	QI has one SSC who support the clerical needs of the department.	Complete for 2018
QI Projects				
QI site automation	Met	12/1/2018	The first phase of QI Site Review automation was completed with Facility Site Review Form Attachments A, B and C available electronically. DHCS and Health Net reporting is automated. Phase 2 included automation of the Corrective Action Plan forms and Focus Review forms and began in w 2018 and will continue in 0219.	Complete for 2018
			•	
Member Education Material	Met	12/31/2018	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 4,452 educational documents were distributed to 67 provider offices and clinics.	Completed
Member Incentive	Met	12/31/2018	To motivate young members and their families to see their PCP for well-visits, a member incentive was offered for 2 movie tickets for each child who had a well-visit through the end of 2018. 391 letters were sent to parents of children who qualified. 43 parents responded back and received the incentive reward. .	Complete.
Committees				

<table>
<tr><th>Goal</th><th>Metrics</th><th>Target Completion</th><th>Action Steps and Monitoring</th><th>Results</th></tr>
<tr><td>Quality Improvement/Utilization Management Committee (QI/UMC)</td><td>Met</td><td>Quarterly - ongoing</td><td>1. Reports to the Board of Directors and retains oversight of the QI Program with direction from the Medical Director.
2. The QI/UMC promulgates the quality improvement process to participating groups and physicians, practitioner/providers, subcommittees, and internal KHS functional areas with oversight by the Chief Medical Officer.
3. Committee also performs oversight of UM activities conducted by KHS to maintain high quality health care and effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services.
4. Ten (10) of the eleven (11) positions are filled; four (4) QI/UMC meetings were held in the reporting period with attendance as follows:

<table>
<tr><th>QI/UM Committee Members</th><th>Attended</th></tr>
<tr><td>CMO</td><td>4 meetings</td></tr>
<tr><td>Family Practitioner</td><td>3 meetings</td></tr>
<tr><td>Family Practitioner</td><td>3 meetings</td></tr>
<tr><td>ENT Specialist</td><td>4 meetings</td></tr>
<tr><td>2nd Specialist</td><td>Open Position</td></tr>
<tr><td>FQHC Provider</td><td>4 meetings</td></tr>
<tr><td>Pharmacy Provider</td><td>3 meetings</td></tr>
<tr><td>Public Health Department</td><td>1 meeting</td></tr>
<tr><td>Home Health/Hospice Provider</td><td>2 meetings</td></tr>
<tr><td>DME Provider</td><td>4 meetings</td></tr>
</table>
</td><td>Complete for 2018</td></tr>
</table>

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
	Met	12/31/2018	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 2018
	Met	12/31/2018	1. Practitioner participation and attendance for this reporting period continue to result in improved communication. 2. Participating practitioners involved in the QI Program serve as a communication representation for the practitioner community. 3. These practitioners provide input and support toward educating participating providers about the principles of QI, and specific quality activities.	Complete for 2018
Physician Advisory Committee (PAC)	Met	12/31/2018	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.	Complete for 2018

<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>Met</td><td>12/31/2018</td><td>Ten (10) PAC meetings were held during the reporting period with attendance as follows:

<table><tr><th>Physician Advisory Committee Members</th><th>Attended</th></tr><tr><td>CMO</td><td>10 meetings</td></tr><tr><td>Pediatrician</td><td>5 meetings</td></tr><tr><td>Clinical Psychologist</td><td>10 meetings</td></tr><tr><td>Eye Specialist</td><td>10 meetings</td></tr><tr><td>OB/GYN Provider</td><td>6 meetings</td></tr><tr><td>Pain Medicine Provider</td><td>9 meetings</td></tr><tr><td>Family Practitioner</td><td>9 meetings</td></tr><tr><td>Family Practitioner</td><td>8 meetings</td></tr></table></td><td>Complete for 2018</td></tr>
<tr><td></td><td></td><td></td><td>1.</td><td></td></tr>
<tr><td>Pharmacy and Therapeutics Committee (P&T)</td><td>Met</td><td>12/31/2018</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 2018</td></tr>
<tr><td></td><td>Met</td><td>12/31/2018</td><td>Four (4) P&T meetings were held during the reporting period with attendance as follows:

<table><tr><th>Pharmacy & Therapeutics Committee Members</th><th>Atte</th></tr></table></td><td>Complete for 2018</td></tr>
</table>

<table>
<tr><th>Goal</th><th>Metrics</th><th>Target Completion</th><th>Action Steps and Monitoring</th><th>Results</th></tr>
<tr><td></td><td></td><td></td><td>
<table>
<tr><td>CMO</td><td>4 meetings</td></tr>
<tr><td>Retail Pharmacy/Independent</td><td>2 meetings</td></tr>
<tr><td>Pediatrician</td><td>4 meetings</td></tr>
<tr><td>Retail Pharmacy/Chain</td><td>4 meetings</td></tr>
<tr><td>Board Member/Rx Representative</td><td>4 meetings</td></tr>
<tr><td>Pharmacy/Specialty Practice</td><td>Open Position</td></tr>
<tr><td>Pharmacy/Geriatric Specialist</td><td>4 meetings</td></tr>
<tr><td>Internal Medicine</td><td>2 meetings</td></tr>
<tr><td>Cardiologist</td><td>2 meetings</td></tr>
<tr><td>General Practice/Geriatrics</td><td>Open Position</td></tr>
<tr><td>KHS Pharmacy Director/Alternate Chairperson</td><td>4 meetings</td></tr>
</table>
</td><td></td></tr>
<tr><td>Public Policy/Community Advisory Committee (PP/CAC)</td><td>Met</td><td>12/31/2018</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.
3. The committee meets every four months and provides recommendations and reports findings to the Board of Directors.</td><td>Complete for 2018</td></tr>
<tr><td></td><td>Met</td><td>12/31/2018</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>Public Policy Committee Members</th><th>Attended</th></tr>
<tr><td>Chair</td><td>4</td></tr>
<tr><td>KHS Member</td><td>3</td></tr>
<tr><td>KHS Member</td><td>3</td></tr>
<tr><td>KHS Member</td><td>0</td></tr>
</table>
</td><td>Complete for 2018</td></tr>
</table>

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			Community Representative 3 Community Representative 3 Kern County Department of Public Health 3 Kern County Department of Human Services 3	
Regulatory Compliance				
DHCS audit	Met	8/14/2018 – 8/17/2018	DHCS performed their annual managed care plan audit. There were no findings related to QI	Complete for 2018
HEDIS 2017	Partially Met	7/6/2018	On 7/6/2018, all elements of HEDIS 2018 were complete and approved by HSAG and NCQA accepted our submission. We did not meet the Asthma Medication Ratio measure and an Improvement Project was implemented and accepted by DHCS.	Complete for 2018
Improvement Plans (IPs)				
Asthma Medication Ratio	Met	6/30/2019	An interactive voice response program (IVR) was implemented to perform outreach to select members to contact, engage and provide education in support of appropriate use of controller and rescue medications for their asthma. The second intervention was submitted to DHCS and accepted. This IP has been closed	Ongoing
Performance Improvement Projects (PIPs)				
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	9/30/2019	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	12/31/2018	28 Initial site reviews were completed with Physical Accessibility Review Survey (PARS) (DHCS Attachment C). All subsequent medical record reviews were complete. All CAPS and required follow-up visits were completed and closed.	Completed for 2018
• Full	Met	12/31/2018	74 Full Site and Medical Record reviews were completed. PARS (Attachment C) were reviewed and completed if needed. All CAPS and required follow-up visits were completed and closed.	Completed for 2018
• Focused	Met	12/31/2018	44 Focused (Periodic) reviews were completed. All CAPS and required follow-up visits were completed and closed.	Completed for 2018
• Pending F/U	Met	12/31/2018	There are no pending follow-up visits. All CAPS and required follow-up visits were completed and closed.	Completed for 2018

Attachment A
2017 Measurement Year and 2018 Report Year
EAS/HEDIS Results

Measure		Current 2018 Rate	2018 MPL	2018 HPL	2017 KHS Rate	Current Vs. 2018 MPL	Current Vs. 2018 HPL	Current Vs. 2017 KHS
CCS	Cervical Cancer Screening	58.39	51.82	70.80	58.39	6.57	-12.41	0.00
CIS-3	CIS – Combo 3	68.86	65.25	79.32	64.96	3.61	-10.46	3.90
CDC-E	Eye Exam (Retinal) Performed	58.94	47.57	68.33	48.19	11.37	-9.39	10.75
CDC-HT	HbA1c Testing	89.60	84.25	92.82	84.49	5.35	-3.22	5.11
CDC-H9 *	HbA1c Poor Control (>9.0%)	30.66	48.57	29.07	39.60	17.91	-1.59	8.94
CDC-H8	HbA1c Control (<8.0%)	58.21	41.94	59.12	51.09	16.27	-0.91	7.12
CDC-N	Medical Attn. for Nephropathy	92.88	88.56	93.27	88.87	4.32	-0.39	4.01
CDC-BP	Blood Pressure Control <140/90	69.89	52.70	75.91	63.87	17.19	-6.02	6.02
CBP	Controlling High Blood Pressure	58.39	47.69	71.69	57.91	10.70	-13.30	0.48
IMA-2	Immunizations for Adolescents (Combo 2)	36.74	15.87	30.39	21.65	20.87	6.35	15.09
PPC-Pre	Timeliness of Prenatal Care	82.48	77.66	91.67	75.43	4.82	-9.19	7.05
PPC-Pst	Postpartum Care	66.67	59.59	73.67	63.50	7.08	-7.00	3.17
WCC-N	Counseling for Nutrition	63.02	58.56	82.53	67.40	4.46	-19.51	-4.38
WCC-PA	Counseling for Phys Activity	57.91	49.06	75.40	61.56	8.85	-17.49	-3.65
W-34	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.*

Measure		Current 2018 Rate	2018 MPL	2018 HPL	2017 KHS Rate	Current Vs. 2018 MPL	Current Vs. 2017 HPL	Current Vs. 2017 KHS
AAB**	Avoidance of Antibiotic Treatment	27.63	24.91	39.53	29.47	2.72	-11.90	-1.84
AMR	Asthma Medication Ratio	49.80	55.33	72.38	48.38	-5.53	-22.58	N/A
BCS	Breast Cancer Screening	55.98	52.70	70.29	50.48	3.28	-14.31	N/A
CAP-1224	12-24 Months	89.69	93.27	97.89	89.65	-3.58	-8.20	0.04
CAP-256	25 Months – 6 Years	81.42	84.94	93.16	80.61	-3.52	-11.74	0.81
CAP-711	7-11 Years	80.88	87.58	96.09	81.49	-6.70	-15.21	-0.61
CAP-1219	12-19 Years	78.84	85.65	94.72	80.21	-6.81	-15.88	-1.37
DSF	Depression Screening and Follow-Up for Adolescents and Adults	0.00	N/A	N/A	N/A	N/A	N/A	N/A
LBP**	Use of Imaging for Low Back Pain	71.59	66.23	78.29	66.25	5.36	-6.70	5.34
MPM-ACE	ACE inhibitors or ARBs	90.19	85.93	92.79	88.40	4.26	-2.60	1.79
MPM-Diu	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 2019 (measurement year 2018).

KERN HEALTH SYSTEMS

2019

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 (QI) Program is designed to objectively monitor, systematically evaluate and effectively improve the health and care of those being served. KHS' Quality Improvement Department manages the Program and oversees activities undertaken by KHS to achieve improved health of the covered population. All contracting providers of KHS will participate in the Quality Improvement (QI) program.

II. **Purpose:** Kern Health Systems (KHS), d.b.a. Kern Family Health Care (KFHC), is the Local Initiative managing the medical and mild to moderate behavioral health care for Medi-Cal enrollees in Kern County. Specialty mental health care and substance use disorder benefits are carved out from KHS' Medi-Cal plan and covered by Kern County Behavioral Health and Recovery Services 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 members.
2. To provide a process and structure for quality improvement by contracting providers.
3. To provide oversight and direction of processes affecting the quality of covered health care services delivered to members, either directly or indirectly.
4. To ensure that members have access to covered health care in accordance with federal and state regulations, and our contractual obligations with the California Department of Health Care Services (DHCS).
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, community partners and regulatory agencies. An evaluation of program objectives and progress is performed by the QI Department 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 members by identifying potential areas for improvement in the health care delivery system.

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 through maintenance of standards of practice and credentialing and recredentialing. This applies to services rendered by medical, behavioral health and pharmacy providers.

4. Establishing and promoting open communication between KHS and contracting providers in 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 and trending 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 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 federal and state regulatory requirements for licensure.

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/UM Committee 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), promotion of safe clinical practices and enhancement of services 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/UM Committee.

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 Behavioral

Health and Recovery Services 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 a program to the QI/UM Committee. The QI/UM Committee is responsible for the ongoing development, implementation and evaluation of the QI program. All the activities described in this document are conducted under the auspices of the QI/UM Committee. 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/UM Committee, 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/UM Committee
        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/UM Committee 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/UM Committee and Subcommittees, provides direction for internal and external QI Program functions, and supervision of 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 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: of the Senior Director of Health Services, QI Director, Director of Health Education and Cultural & Linguistics Services, Case Management Director, UM Director, Pharmacy Director, and other related staff
   i. Supervision of all Quality Improvement Activities performed by the QI Department
   j. Monitoring that covered medical and behavioral health 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 **(s): The Medical Director** supports 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 (s) report 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/UM Committee 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/UM Committee, 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/UM Committee 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/UM Committee 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/UM Committee 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/UM Committee 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/UM Committee, with subsequent review of audit results, corrective action and reassessment. A yearly comprehensive plan of studies to be performed is developed by the CMO, Senior Director of Health Services, QI Director, Director of Health Education and Cultural & Linguistics Services, Case Management Director (includes Disease Management) and the QI/UM Committee, including studies that address the health care and demographics of members.

b. **Function -** The following elements define the functions of the QI/UM Committee 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/UM Committee in monitoring and oversight of utilization management related to QI:

i. 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.
ii. 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.
iii. Evaluate results of member and provider satisfaction surveys that relate to satisfaction with the UM process and report results to the QI/UM Committee. Identified sources of dissatisfaction require CAPs and are monitored through the QI/UMC.
iv. Identify potential quality issues and report them to the QI Department for investigation
v.
vi.
vii. 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.
viii. 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 FQHC Provider
v. 1 Pharmacy Provider
vi. 1 Kern County Public Health Officer or Representative
vii. 2 Other Participating Ancillary Representatives
viii. 1 Senior Director of Health Services
ix. 1 Home Health/Hospice Provider
x. 1 DME Provider

xi. 1 QI Director,
xii. 1 Director of Health Education and Cultural & Linguistics Services
xiii. Staff (Committee staff support)

The QI/UM Committee 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/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.

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/UM Committee 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/UM Committee 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/UM Committee and Board of Directors on a regular basis. The committee is composed of:

i. KHS Chief Medical Officer (Chairperson)

ii. 2 Family Practice Providers

iii.

iv. 1 Pediatrician
v. 1 Obstetrician/Gynecologist
vi. 1 Eye Specialist
vii. 1 Pain Medicine Provider
viii. 1 Clinical Psychologist
ix.

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/UM Committee 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/UM Committee 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/Rx Representative
iv. 1 Retail/Independent Pharmacist
v. 1 Retail/Chain Pharmacist
vi. 1 Specialty Practice Pharmacist
vii. 1 General Practice/Cardiology Provider
viii. 1 Pediatrician
ix. 1 Internist
x. 1 Obstetrician/Gynecologist

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 Health Care Practitioners
v. 1 Kern County Public 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 Quality Improvement Director or designee
viii. 1 KHS Senior 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 Medical Officer, 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/UM Committee 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. **QI Director** - The Director must possess a valid Registered Nurse (RN) license issued by the State of California and completion of a Master's Degree in Nursing (MSN) or healthcare field from an accredited college or university. A minimum of five years of experience in an health maintenance organization (HMO) and a minimum of 3 years staff and program management experience. The QI 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 QI Director dedicates 100% of his/her time to the Quality Improvement Department and reports to the Senior Director of Health Services. The QI 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 QI Director monitors the review and resolution of medically related grievances with the CMO, and evaluates the effectiveness of QI systems.

The QI 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 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.

ii. 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.

iii. 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.

iv. 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.

v. 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/UM Committee 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/UM Committee, 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 Senior 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/UM Committee, 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.

   In 2019, DHCS disseminated a new set of measures and guidelines that Medi-Cal Managed Care Plans (MCPs) will be held accountable to meet the minimum performance level (MPL). This new set of measures is called the Managed Care Accountablitity Set (MCAS) and replaces the current External Accountability Set (EAS). The minimum performance level has also changed from the 25th percentile to the 50th percentile. For 2019, the MCAS measures include the following:

Measure #	Measure Name	Admin, Hybrid, Unknown	Denominator	Numerator	Major exclusions	Held to MPL?
1	Plan All-Cause Readmissions	Admin	Expected Readmissions, age 18-64, risk adjusted	Observed Readmissions (risk adjusted)		Y
2	Adolescent Well-Care Visits	Hybrid	Age 12-21	At least one well child visit in the measurement year		Y
3	Adult Body Mass Index Assessment	Hybrid	Age 18-74 with office visit	BMI calculated or plotted once in measurement year or prior year	Pregnancy	Y
4	Antidepressant Medication Management – Acute Phase Treatment	Admin	18 years of age and older, with dx major depression, on antidepressant	Percentage remaining on antidepressant for 12 weeks	Inpatient psych, Outpatient mental health center, ECT, TCMS	Y
5	Antidepressant Medication Management – Continuation Phase Treatment	Admin	19 years of age and older, with dx major depression, on antidepressant	Percentage remaining on antidepressant for 6 months	Inpatient psych, Outpatient mental health center, ECT, TCMS	Y
6	Asthma Medication Ratio**	Admin	Aged 5-64 with persistent asthma	Controller/Total asthma medication 0.5 or greater	COPD, Pulmonary fibrosis, respiratory failure	Y
7	Breast Cancer screening	Admin	Women aged 50-74	Mammogram within 27 months of end of measurement period	LTC/SNF, 66 or older with frailty	Y

Measure #	Measure Name	Admin, Hybrid, Unknown	Denominator	Numerator	Major exclusions	Held to MPL?
8	Cervical Cancer Screening	Hybrid	Women aged 21-64	21-64: cervical cytology within 3 years; 30-64: cervical cytology/high risk HPV every 5 years	Absence of cervix	Y
9	Childhood Immunization Status – Combo 10	Hybrid	Children 2 years of age	24 required vaccines received (10 types of vaccines) by second birthday	Specified medical contraindications to vaccination	Y
10	Chlamydia Screening in Women Ages 16 – 24**	Admin	Women aged 16-24 identified as sexually active	Chlamydia test in the past year	Pregnancy	Y
11	Comprehensive Diabetes Care HbA1c Testing	Hybrid	Age 18-75 with DM type 1 or 5	HbA1c test in the measurement year	GDM only	Y
12	HbA1c Poor Control (>9.0%)	Hybrid	Age 18-75 with DM type 1 or 4	Most recent HbA1c result either absent or >9.0 in measurement year	GDM only	Y
13	Controlling High Blood Pressure <140/90 mm Hg	Hybrid	members 18-85 years of age with Dx HTN	BP <140/90 (both must be below on last BP of year that qualifies	Home BP cuff not electronically connected. Inpatient BP measures	Y
14	Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV)	Hybrid	13 year olds	4 specified shots by 13th birthday	Medical contraindications, hospice	Y

Measure #	Measure Name	Admin, Hybrid, Unknown	Denominator	Numerator	Major exclusions	Held to MPL?
15	Prenatal & Postpartum Care – Timeliness of Prenatal Care	Hybrid	Live births Nov 6 to Nov 6	Start care in 1st trimester		Y
16	Prenatal & Postpartum Care – Postpartum Care	Hybrid	Live births Nov 6 to Nov 5	through 2019: one visit between 2156 days; starting 2020: two visits, one before 21 days, the other 21 to 84 days		Y
17	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents: Body Mass Index Assessment for Children/Adolescents	Hybrid	3-17 years old with outpatient visit with PCP or OB/GYN	BMI percentile calculated or plotted once in measurement year		Y
18	Well-Child Visits in the First 15 months of Life – Six or More Well Child Visits	Hybrid	Children who turned 15 months old in year	Number of well-child visits (6 or more is target		Y
19	Well-Child Visits in the 3rd 4th 5th & 6th Years of Life	Hybrid	Children 3-6 years old	One or more well-child visits in past year		Y
20	Ambulatory Care: Emergency Department (ED) Visits	Admin	All Medi-Cal members	Number of ED visits per day per unique member	Mental Health or Chemical Dependency	N

Measure #	Measure Name	Admin, Hybrid, Unknown	Denominator	Numerator	Major exclusions	Held to MPL?
21	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications – Initiation Phase	Admin	Aged 6-12 years with initial Dx ADHD and prescribed ADHC medication for at least 210 days (5 months)	Visit with prescriber within 30 days	Inpatient mental health or SUD	N
22	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications – Continuation and Maintenance Phase	Admin	Aged 6-12 years with initial Dx ADHD and prescribed ADHC medication	Two or more visits 30-270 days after starting medications	Inpatient mental health or SUD	N
23	Children & Adolescents' Access to Primary Care Practitioners: 12-24 Months	Admin	Age 12 - 24 months	Children 12 - 24 months who had a visit with a PCP during the measurement year		N
24	Children & Adolescents' Access to Primary Care Practitioners: 25 months - 6 yrs.	Admin	Age 25 months - 6 years	Children 25 months to 6 years age who had a visit with a PCP during the measurement year		N
25	Children & Adolescents' Access to Primary Care Practitioners: 7 - 11 yrs.	Admin	Age 7 - 11 years	Children 7 - 11 years age who had a visit with a PCP during the measuremen		N

Measure #	Measure Name	Admin, Hybrid, Unknown	Denominator	Numerator	Major exclusions	Held to MPL?
				t year		
26	Children & Adolescents' Access to Primary Care Practitioners: 12 - 19 yrs.	Admin	Age 12 - 19 years	Children 12 - 19 years age who had a visit with a PCP during the measurement year		N
27	Contraceptive Care age 15-20	Admin (State)	Women aged 15-20 at risk of unplanned pregnancy	1. "Most effective or moderately effective" contraceptive method, or 2. LARC provided in the measurement year		N
28	Contraceptive Care age 21-44	Admin (State)	Women aged 21-44 at risk of unplanned pregnancy	1. "Most effective or moderately effective" contraceptive method, or 2. LARC provided in the measurement period		N
29	Contraceptive Care: Postpartum Women Ages 15-20**: • Most or moderately effective contraception – 3	Admin (State)	Women age 15-20 who had a live birth	Contraceptive Care: Postpartum Women Ages 15-20**: • Most or moderately effective		N

Measure #	Measure Name	Admin, Hybrid, Unknown	Denominator	Numerator	Major exclusions	Held to MPL?
	days			contraceptio n – 3 days		
30	Contraceptive Care: Postpartum Women Ages 15-20**: • LARC – 3 days	Admin (State)	Women age 15-20 who had a live birth	Contracepti ve Care: Postpartum Women Ages 15-20**: • LARC – 3 days		N
31	Contraceptive Care: Postpartum Women Ages 21-44**: • Most or moderately effective contraception – 3 days	Admin (State)	Women age 21-44 who had a live birth	Contracepti ve Care: Postpartum Women Ages 21-44**: • Most or moderately effective contraceptio n – 3 days		N
32	Contraceptive Care: Postpartum Women Ages 21-44**: • LARC – 3 days	Admin (State)	Women age 21-44 who had a live birth	Contracepti ve Care: Postpartum Women Ages 21-44**: • LARC – 3 days		N
33	Developmental Screening	Admin	Children turning 1,2, or 3 in measurement year	96110 billed in the 12 months prior to birthday		N

Measure #	Measure Name	Admin, Hybrid, Unknown	Denominator	Numerator	Major exclusions	Held to MPL?
34	HIV Viral Load Suppression	Admin	18 years and older with medical visit in year with PCP or HIV/ID specialist with dx code of HIV	Viral load in measurement period of less than 200 copies per ml		N
35	Annual Monitoring for Patients on Persistent Medications: ACE inhibitors or ARBs	Admin	Members who received at least 180 days of ACE inhibitors or ARBs during the measurement year	At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year.	Members who had an inpatient encounter or nonacute inpatient encounter during the measurement year	N
36	Annual Monitoring for Patients on Persistent Medications: Diuretics	Admin	Members who received at least 180 days of diuretics during the measurement year	At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year.		N
37	Concurrent Use of Opioids and Benzodiazepines	Admin	All members over 18 years old	Concurrent use of benzodiazepines and opioids	Cancer, hospice	N
38	Use of Opioids at High Dosage in Persons Without Cancer	Admin	Members aged 18 years and older	Members 18 years and older who received prescriptions for opioids with an average daily dosage greater than or equal to	Members with a cancer diagnosis or in hospice	N

Measure #	Measure Name	Admin, Hybrid, Unknown	Denominator	Numerator	Major exclusions	Held to MPL?
				90 morphine milligram equivalents over a period of 90 days or more.		
39	Screening for Depression and Follow-Up Plan: Age 12 and Older**	EHR	Members aged 12 and older	Percentage of members age 12 years and older screened for depression on the date of the encounter using an age appropriate, standardized depression screening tool, and, if positive, a follow-up plan is documented on the date of the positive screen.	Member has an active diagnosis of depression or bipolar disorder	N
* Stratified by Seniors and Persons with Disabilities (SPD).						
** Measure is part of both the CMS Adult and Child Core Sets. Though MCPs will report the "Total" rate, data will be collected stratified by the child and adult age groups.						
^ MCPs held to the MPL on the total rate only.						
Total Number of Measures = 39 (13 Hybrid + 26 Administrative).						

Further details on KHS HEDIS studies can be found in the HEDIS technical specifications published by NCQA and in KHS internal policies. KHS's 2018 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 that is reported as a "No Report" (NR) due to an audit failure, an Improvement Plan (IP) is contractually required to be submitted within 60 days of being notified 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. For 2018-2019, KHS has chosen the following PIP topics:
   - Disparities in Childhood Immunizations: Improving Immunization Compliance Among African American Children
   - Treatment of Low Back Pain: Increasing Appropriate Use of Imaging Studies for Uncomplicated Low Back Pain

   One of the 2019–2021 PIPs will target a health disparity as outlined in DHCS' Health Equity PIP Topic Proposal Form. The second PIP topic will be related to an area in need of improvement related to child and adolescent health. Specific topics for the two PIPs will be submitted by the endo of July of this year for approval by DHCS and based on our latest HEDIS results.

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 administer the survey in 2019.

   Survey results are shared with DHCS, NCQA, the KHS Board of Directors and QI/UM Committee. 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 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/UM Committee 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/UM Committee. The QI/UM Committee 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. **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.

Grievances 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 site 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.

      In 2019, DHCS has distributed draft versions of new Site Review (DHCS Attachment A) and Medical Record Review

(DHCS Attachment B) forms and associated guidelines. It is aniticipated that final versions of the forms and guidelines will be distributed by DHCS in October. KHS will work on implementing the new requirements as direction from DHCS is provided. Implementation includes updating internal processes, securing appropriate tools for automation of documentation and reports, KHS staff education and KHS provider network education.

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.

10. **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 QI Director, Pharmacy Director, Director of Health Education and Cultural & Linguistics Services, Director of Marketing, Director of 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/UM Committee for comment, suggested program adjustments and revision of procedures or guidelines, as necessary. Also included is a Work Plan for the coming year. The Work Plan includes studies, surveys and audits to be performed, compliance submissions, reports to be generated, and quality activities projected for completion.

The yearly 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/UM Committee 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/UM COMMITTEE 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 Permanente – 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 QI Director, 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 activities 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 Senior Director of Health Services and QI Director 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/UM Committee.

_____

KHS Board of Directors (Chair) Date

_____

Chief Executive Officer Date

_____

Chairman QI/UM COMMITTEE Date

Appendix A

HEDIS 2017
Hybrid Measures

Measure		2017 Rate
CCS	Cervical Cancer Screening	60.34
CIS-3	CIS – Combo 3	65.45
CDC-E	Eye Exam (Retinal) Performed	56.88
CDC-HT	HbA1c Testing	89.13
CDC-H9 *	HbA1c Poor Control (>9.0%)	33.15
CDC-H8	HbA1c Control (<8.0%)	55.43
CDC-N	Medical Attn. for Nephropathy	92.93
CDC-BP	Blood Pressure Control <140/90	65.58
CBP	Controlling High Blood Pressure	54.26
IMA-1	Immunizations for Adolescents	40.63
PPC-Pre	Timeliness of Prenatal Care	81.27
PPC-Pst	Postpartum Care	67.64
WCC-N	Counseling for Nutrition	70.56
WCC-PA	Counseling for Phys Activity	65.21
W-34	Well-Child Visits	63.99

***** 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	31.33
AMR	Asthma Medication Ratio	21.49
BCS	Breast Cancer Screening	56.57
CAP-1224	12-24 Months	89.62
CAP-256	25 Months – 6 Years	80.28
CAP-711	7-11 Years	79.90
CAP-1219	12-19 Years	78.35
DSF	Depression Screening and Follow-Up for Adolescents and Adults	0.00
LBP	Use of Imaging for Low Back Pain	73.33
MPM-ACE	ACE inhibitors or ARBs	89.71
MPM-Diu	Diuretics	90.50

****** 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
2019 Quality Improvement Work plan

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
I. QUALITY MANAGEMENT AND IMPROVEMENTS					
A. Annual Review/Approval of QI Program (QIP) Documents					
1. Approval QI Evaluation	Approval of 2019 QI Program Evaluation	8/31/2019	Chief Medical Officer (CMO) / QI Director		QI/UMC Agenda Aug 2019
2. Review/Update and Approval of QI Program Description	Approval of 2019 QI Program Description	8/31/2019	Chief Medical Officer (CMO) / QI Director		QI/UMC Agenda Aug 2019
3. Review/Update and Approval of QI Work Plan	Approval of 2019 QI Work Plan	8/31/2019	Chief Medical Officer (CMO) / QI Director		QI/UMC Agenda Aug 2019
B. Clinical - Focused Studies					
1. State Required					
a. IP - AMR	Regulatory requirement due to HEDIS scores below MPL	6/30/2019	Chief Medical Officer (CMO) / QI Director		Ongoing through June 2019
b. Disparities CIS PIP - Improving Immunization Compliance Among African American Children	18 month quality improvement project led by HSAG	9/30/2019	Chief Medical Officer (CMO) / QI Director		Ongoing through July 2021
c. LBP PIP - Increasing Appropriate Use of Imaging Studies for Uncomplicated Low Back Pain	18 month quality improvement project led by HSAG	7/31/2021	Chief Medical Officer (CMO) / QI Director		Ongoing through July 2021
d. Submit Topics to DHCS for 2019 - 2021 PIPs					
- Health Disparity topic	18 month quality improvement project led by HSAG	9/30/2021	Chief Medical Officer (CMO) / QI Director		Ongoing through September 2021
- Child and Adolescent Health Disparity	18 month quality improvement project led by HSAG	9/30/2021	Chief Medical Officer (CMO) / QI Director		Ongoing through September 2021
C. 2019 HEDIS Monitoring (Medi-cal) / Quality Measurements					
1. The Roadmap	Report to State EQRO Auditor - HSAG	1/31/2019	QI/Claims/PR/IT		Submitted
2. Childhood Immunization Status	Report annually to QI/UM Committee/Board of Directors (BOD)/DHCS	9/30/2019	Chief Medical Officer (CMO) / QI Director		In Progress
3. Well Child Visits 3rd, 4th, 5th, and 6th years of life	Report annually to QI/UM Committee/BOD/DHCS	9/30/2019	Chief Medical Officer (CMO) / QI Director		In Progress
4. Prenatal and Postpartum Care	Report annually to QI/UM Committee/BOD/DHCS	9/30/2019	Chief Medical Officer (CMO) / QI Director		In Progress
5. Comprehensive Diabetes Care	Report annually to QI/UM Committee/BOD/DHCS	9/30/2019	Chief Medical Officer (CMO) / QI Director		In Progress
6. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Report annually to QI/UM Committee/BOD/DHCS	9/30/2019	Chief Medical Officer (CMO) / QI Director		In Progress
7. Annual Monitoring for Patients on Persistent Medications	Report annually to QI/UM Committee/BOD/DHCS	9/30/2019	Chief Medical Officer (CMO) / QI Director		In Progress
8. Cervical Cancer Screening	Report annually to QI/UM Committee/BOD/DHCS	9/30/2019	Chief Medical Officer (CMO) / QI Director		In Progress
9. Children's and Adolescent's Access to PCPs	Report annually to QI/UM Committee/BOD/DHCS	9/30/2019	Chief Medical Officer (CMO) / QI Director		In Progress
10. Ambulatory Care	Report annually to QI/UM Committee/BOD/DHCS	9/30/2019	Chief Medical Officer (CMO) / QI Director		In Progress
11. Immunizations in Adolescents	Report annually to QI/UM Committee/BOD/DHCS	9/30/2019	Chief Medical Officer (CMO) / QI Director		In Progress
12. Use of Imaging Studies for Low Back Pain	Report annually to QI/UM Committee/BOD/DHCS	9/30/2019	Chief Medical Officer (CMO) / QI Director		In Progress
13. Controlling High Blood Pressure	Report annually to QI/UM Committee/BOD/DHCS	9/30/2019	Chief Medical Officer (CMO) / QI Director		In Progress
14. Asthma Medication Ratio	Report annually to QI/UM Committee/BOD/DHCS	9/30/2019	Chief Medical Officer (CMO) / QI Director		In Progress
15. Weight Assessment & Counseling for Nutrition & Physical Activity for Children and Adolescents	Report annually to QI/UM Committee/BOD/DHCS	9/30/2019	Chief Medical Officer (CMO) / QI Director		In Progress
16. All Cause Readmissions	Report annually to QI/UM Committee/BOD/DHCS	9/30/2019	Chief Medical Officer (CMO) / QI Director		In Progress
17. Breast Cancer Screening	Report annually to QI/UM Committee/BOD/DHCS	9/30/2019	Chief Medical Officer (CMO) / QI Director		In Progress
18. Implement New Managed Care Accountability Set (MCAS) measures and minimum performance level for measurement year 2019	New requirements received from DHCS for new measurements that will replace existing EAS measures and a new minimum performance level	11/1/2019	QI Director/ IT Director		In Progress
- Configure HEDIS software for new measures (Cotiviti)	Vendor, Cotiviti, to have all new measure configured, tested and changes approved by NCQA	11/1/2019	QI Director/ IT Director		In Progress
- Configure KHS data and reports for new measures	KHS to modify data receipt, storage and reports to meet new DHCS MCAS specifications	11/1/2019	QI Director/ IT Director		In Progress
- Educate providers on new measures	KHS to educate providers on new requirements for MCAS	11/1/2019	Chief Medical Officer (CMO)/ QI Director/ PR Director		In Progress
- Educate KHS Staff on new measures	KHS to educate internal staff on new requirements for MCAS	11/1/2019	Chief Medical Officer (CMO)/ QI Director		In Progress
D. Other On-going Monitoring					
1. 30 day re-admissions	In annual 2019 QI Plan Evaluation to QI/UMC & BOD	Annually	Chief Medical Officer (CMO) / QI Director		Ongoing 2019
2. Unanticipated Deaths	In annual 2019 QI Plan Evaluation to QI/UMC & BOD	Annually	Chief Medical Officer (CMO) / QI Director		Ongoing 2019
3. Untoward Events/PPC	In annual 2019 QI Plan Evaluation to QI/UMC & BOD	Annually	Chief Medical Officer (CMO) / QI Director		Ongoing 2019
4. Facility Site Reviews (FSR)					
a. Referral Process	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Senior Director Health Services/ Director QI		Ongoing 2019
b. IHEBA - Staying Healthy Assessment	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Senior Director Health Services/ Director QI		Ongoing 2019
c. Initial Health Assessment (IHA)	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Senior Director Health Services/ Director QI		Ongoing 2019
d. Critical elements	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Senior Director Health Services/ Director QI		Ongoing 2019

KERN HEALTH SYSTEMS
2019 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
e. Diabetes Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Senior Director Health Services/ Director QI		Ongoing 2019
f. Asthma Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Senior Director Health Services/ Director QI		Ongoing 2019
g. Maternity Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Senior Director Health Services/ Director QI		Ongoing 2019
5. 2020 Facility Site Review - DHCS Form & Process Changes					
a. Implement Form Changes	Identify and implement process for documenting each type of FSR using the new forms finalized by DHCS	Dependent on final delivery of forms and guidelines from DHCS	QI Director / PR Director		Ongoing 2019
b. Implement Reporting Changes	Identify changes to existing FSR reports and new reports needed based on the new, finalized FSR guidelines from DHCS	Dependent on final delivery of forms and guidelines from DHCS	QI Director / PR Director		Ongoing 2019
c. Educate Staff on New Forms & Requirements	Develop and deliver educational information for KHS staff on the changes to the forms and FSR requirements	Dependent on final delivery of forms and guidelines from DHCS	QI Director / PR Director		Ongoing 2019
d. Educate Providers on New Requirements	Develop and deliver educational information for network providers on the new FSR requirements by DHCS	Dependent on final delivery of forms and guidelines from DHCS	QI Director / PR Director		Ongoing 2019
E. Safety of Clinical Care					
1. Autoclave	Credentialing/Recredentialing/As necessary	Facility Site Rev/Focus Review	Chief Medical Officer (CMO) / QI Director		Ongoing 2019
2. Bio-hazardous waste	Credentialing/Recredentialing/As necessary	Facility Site Rev/Focus Review	Chief Medical Officer (CMO) / QI Director		Ongoing 2019
3. Infection Control	Credentialing/Recredentialing/As necessary	Facility Site Rev/Focus Review	Chief Medical Officer (CMO) / QI Director		Ongoing 2019
4. Facility Site Review (FSR) DHS Database	FSR database of completed site reviews	12/1/2019	Chief Medical Officer (CMO) / QI Director		Ongoing 2019
5. Focused Reviews - Critical Elements	Physician Site Monitoring / Quarterly Reporting	Quarterly	Chief Medical Officer (CMO) / QI Director		Ongoing 2019
F. Availability					
1. Primary Care Practitioners					
a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Annually	Director of Provider Relations, Director Compliance		Ongoing 2019
2. Specialty Practitioners					
a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Annually	Director of Provider Relations, Director Compliance		Ongoing 2019
b. Geographic Standard	Measure and Report	Annually	Director of Provider Relations, Director Compliance		Ongoing 2019
G. Access					
1. Primary Care Appointments					
a. Preventive Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Director of Provider Relations, Director Compliance		Ongoing 2019
b. Routine Primary Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Director of Provider Relations, Director Compliance		Ongoing 2019
c. Urgent Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Director of Provider Relations, Director Compliance		Ongoing 2019
e. After-hours Care Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Director of Provider Relations, Director Compliance		Ongoing 2019
2. Telephone access to Member Services					
a. Abandonment rate	Measure/Report to QI/UM Committee Quarterly	Quarterly	Director of Provider Relations, Director Compliance		Ongoing 2019
b. Speed of answer	Measure/Report to QI/UM Committee Quarterly	Quarterly	Director of Provider Relations, Director Compliance		Ongoing 2019
3. Mental Health Appointment	Quarterly MOU Meetings/Grievances	As necessary	Director of UM; Director of CM		Ongoing 2019
a. Life-threatening Emergency Standard (immediate care)	Report as necessary to QI/UM Committee	As necessary	Director of Provider Relations, Director Compliance		Ongoing 2019
b. Non-life-threatening Emergency Standard	Report as necessary to QI/UM Committee	As necessary	Director of Provider Relations, Director Compliance		Ongoing 2019
c. Urgent needs Standard	Report as necessary to QI/UM Committee	As necessary	Director of Provider Relations, Director Compliance		Ongoing 2019
d. Routine office visit Standard (visit within 10 working days)	Report as necessary to QI/UM Committee	As necessary	Director of Provider Relations, Director Compliance		Ongoing 2019
e. Telephone access to screening and triage Standard	Report as necessary to QI/UM Committee	As necessary	Director of Provider Relations, Director Compliance		Ongoing 2019
- Caller reaches non-recorded voice			Director of Provider Relations, Director Compliance		Ongoing 2019
- Abandonment rate			Director of Provider Relations, Director Compliance		Ongoing 2019
H. Encounters, Complaints, Grievances and Appeals Data Analysis	Report aggregate data quarterly to QI/UM Committee	Quarterly	Director of Member Services		Ongoing 2019
I. CAHPS Survey	State administered survey every 5 years - DHCS reduce the frequency but has not done so yet	2021	State Administered/CIO/Chief Medical Officer (CMO) / QI Director		To be done in 2021
1. Results reported to QI/UMC	Report to QI/UMC (date depends on when results received from the State)	2021	State Administered/CIO/Chief Medical Officer (CMO) / QI Director		To be done in 2021
2. Results reported to practitioners and providers	Report to QI/UMC (date depends on when results received from the State)	2021	State Administered/CIO/Chief Medical Officer (CMO) / QI Director		To be done in 2021
J. Continuity of Care Monitoring	Monitored through Grievances, FSR/Peer Review, HEDIS	Ongoing	Chief Medical Officer (CMO) / QI Director		Ongoing
1. Primary Care Practitioner (PCP)	Monitored through Grievances, FSR/Peer Review, HEDIS	Ongoing	Chief Medical Officer (CMO) / QI Director		Ongoing
2. PCP & Mental Health	Monitored through Grievances, Peer Review, HEDIS	Ongoing	Chief Medical Officer (CMO) / QI Director		Ongoing
3. Specialist	Monitored through Grievances, Peer Review, HEDIS	Ongoing	Chief Medical Officer (CMO) / QI Director		Ongoing
K. Delegation of QI Activities	QI/UM delegation to Kaiser and VSP includes ongoing reporting of Grievances, QI Program, Evaluation and Work plan	2Q 2019	QI Director		2Q 2019
L. Annual Review of QI Policies and Procedures	Submit to QI/UMC and DHCS	Annually and as necessary	Chief Medical Officer (CMO) / QI Director/Director Compliance		Ongoing
M. QI/UM Committee					

KERN HEALTH SYSTEMS
2019 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
1. Reports and agenda items	Gathered from pertinent departments	Quarterly	Chief Medical Officer (CMO) / Senior Director Health Services/ QI Director		Ongoing
2. Minutes	Attached to next meetings agenda and sent to BoD	Quarterly	Chief Medical Officer (CMO) / Senior Director Health Services		Ongoing
3. Form 700 (Statement of Economic Interests)	Send to all committee members yearly	Initial / Yearly December	Chief Medical Officer (CMO) / Senior Director Health Services		Ongoing
4. PO's and Check Requests	Fill out for each member attending meeting	Quarterly	Chief Medical Officer (CMO) / Senior Director Health Services		Ongoing
II. UTILIZATION MANAGEMENT - See UM Work Plan					
A. Annual Review/Approval of UM Program Documents	Program Description 2019	8/31/2019	Chief Medical Officer (CMO) / Senior Director Health Services/ QI Director		QI/UMC August 2019 Agenda
	Evaluation 2018	8/15/2019			QI/UMC August 2019 Agenda
III. CREDENTIALING AND RECREDENTIALING					
A. Initial Credentialing Site Visit & Medical Record	Upon Credentialing/Quarterly FSR Summary	Ongoing	Chief Medical Officer (CMO) / Senior Director Health Services/ Director QI		Ongoing
B. Organization Providers Quality Assessment	Data Reviews are received from QI/UM/Compliance/MS for any opportunities form improvement identified. QI Department quality reviews of readmissions withing30 days, member deaths and notifications. See 1F	At least quarterly	Chief Medical Officer (CMO) / Senior Director Health Services/ Director 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/Compliance		Ongoing
D. Credentialing / Recredentialing File Audit	Ongoing KHS/Compliance random audits	Ongoing	Director of Provider Relations		Ongoing
E. Delegated Credentialing	Delegation will be for hospital based practitioners if hospital is JCI accredited	Annually / as necessary	Director of Provider Relations		Ongoing
F. Annual Review of Credentialing/Recredentialing Policies and Proc	Ongoing	Annually / as necessary	Director of Provider Relations		Ongoing
IV. MEMBER RIGHTS AND RESPONSIBILITIES					
A. Statement of Members' Rights and Responsibilities	Review, annually / revise as necessary	Annually / as necessary	Director of Member Services		Ongoing
B. Distribution of Rights Statement to Members & Practitioners	As necessary	Annually / as necessary	Director of Member Services		2019
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 Compliance		Ongoing
F. Marketing Information	Focus Groups, Public Policy/Community Advisory Committee	Ongoing	Director of Marketing		Focus groups will be continued in 2019
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
VI. MEDICAL RECORDS					
A. Review of Medical Record Documentation Standards	Annually / revise as necessary	2019	Chief Medical Officer (CMO) / Senior Director Health Services/ Director 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) / Senior Director Health Services/ Director QI / Director of Provider Relations		Ongoing
D. Annual Review of Policies and Procedures	Annually and as necessary	Ongoing	Chief Medical Officer (CMO) / QI Director		Ongoing

Why are these greyed out?

Health Services Quarterly Committee Reporting- Reporting Period April 1, 2019 to June 30, 2019

Health Services Overview

The 2019 membership enrollment remained stable at 255,000 in Q2 2019. Additional benefit coverage and broadening interdisciplinary collaboration to support the membership growth will continue through 2019.

- Maternal Depression Screening 7/1/2019
- New MCAS (HEDIS) measures for 2020
- New Facility Site Review (FSR) and Medical Record Review (MRR) for 2020
- Housing Collaborative Case Management Services contract
- Respite Alternative
- DMHC/DHCS Medical Audit August 2019

The following pages reflect statistical measurements for Utilization Management, Case Management and Disease Management detailing the ongoing compliance activity for the 2nd Quarter 2019.

Respectfully submitted,

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

Utilization Management Reporting

Timeliness of Decision Trending

Summary:

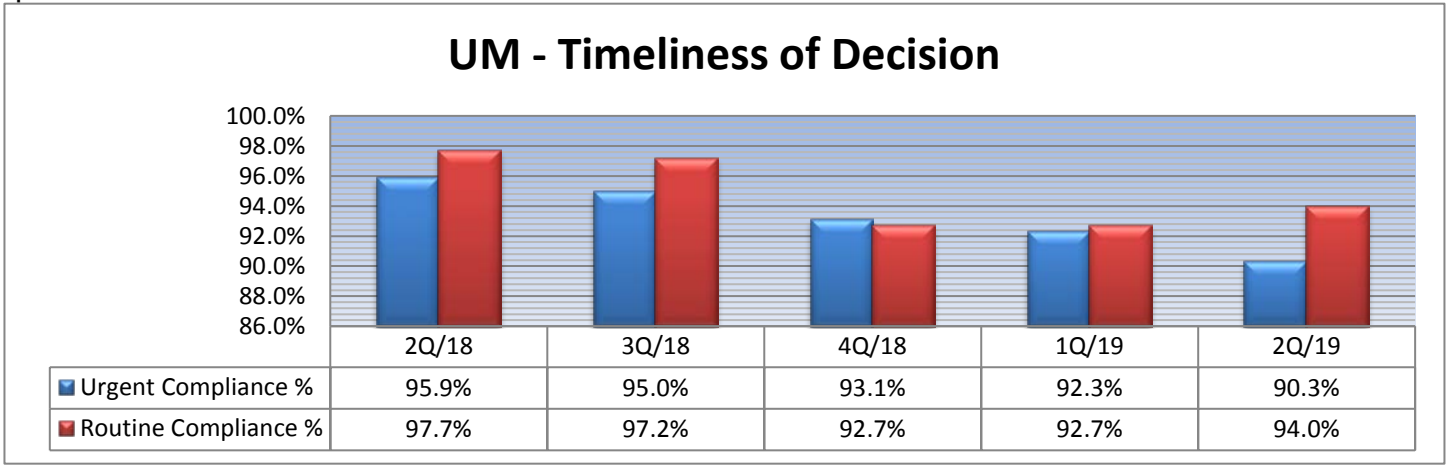
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

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

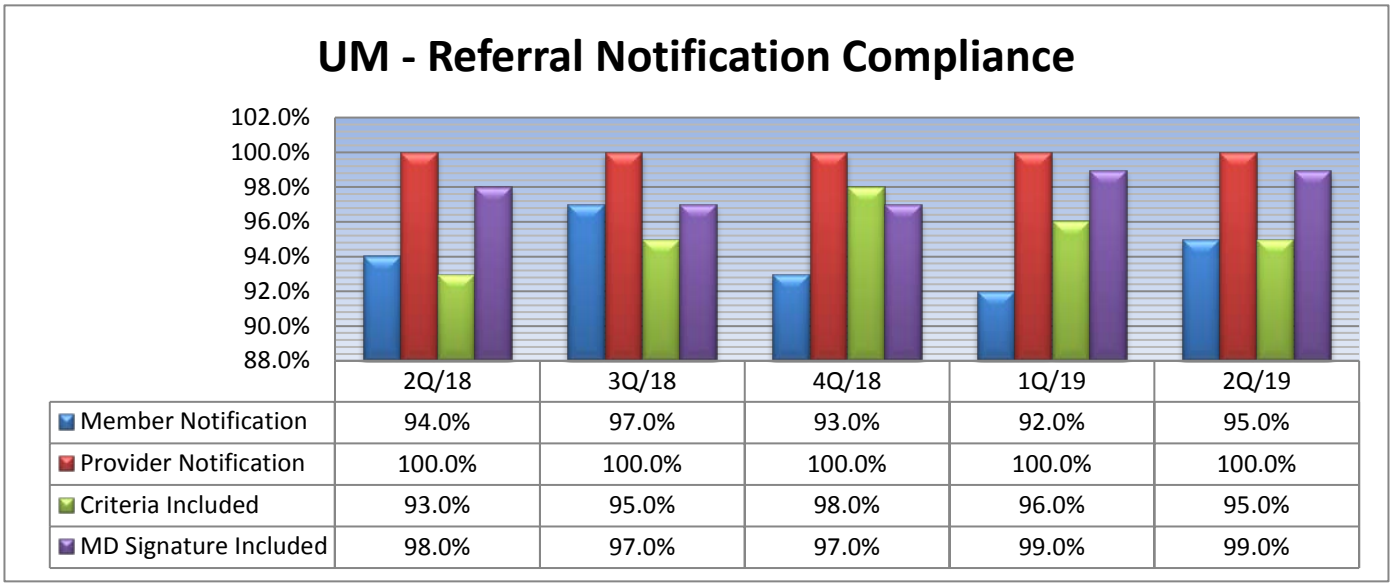
There were 49,547 referrals processed in the 2nd quarter 2019 of which 4,517 referrals were reviewed for timeliness of decision. In comparison to the 1st quarter's processing time, routine referrals increased from the 1st quarter which was 92.7% and urgent referrals decreased from the 1st quarter which was 92.3% to 90.3%.



	2Q/18	3Q/18	4Q/18	1Q/19	2Q/19
Urgent Compliance %	95.9%	95.0%	93.1%	92.3%	90.3%
Routine Compliance %	97.7%	97.2%	92.7%	92.7%	94.0%

Audit Criteria:

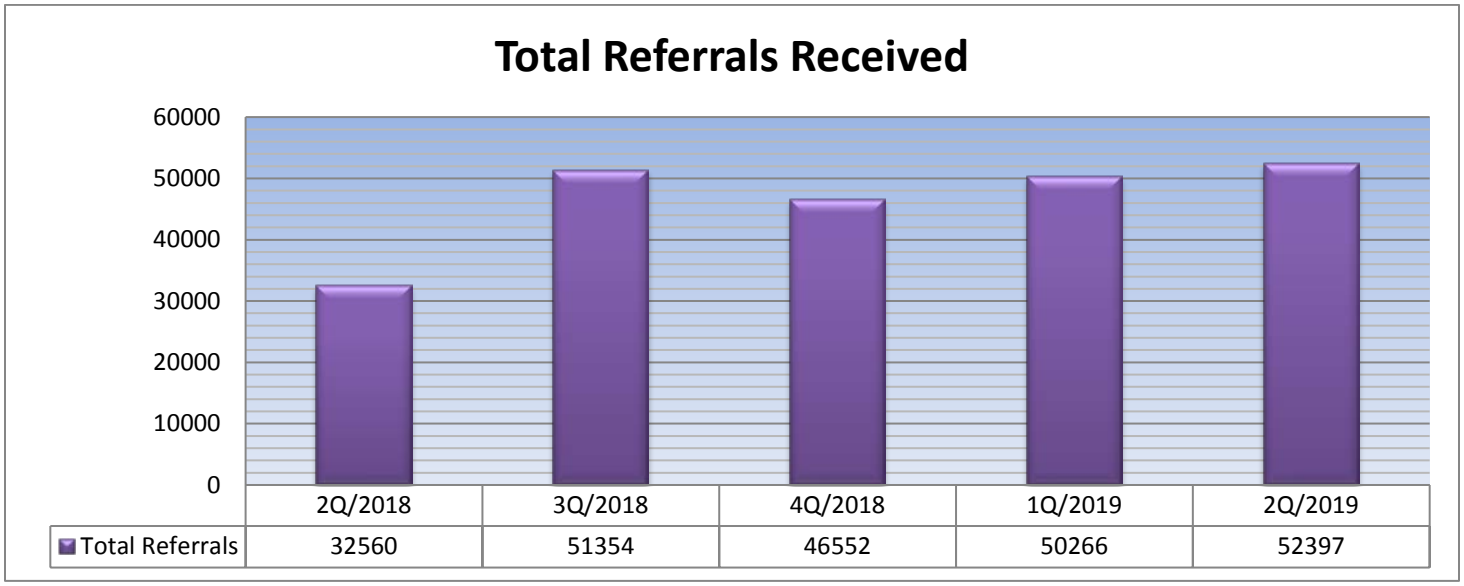
- Member Nofication: Letter of referral decision sent to member within 24 hours
- Provider Notification: Referral is faxed back to the provider with 24 hours of decision
- Criteria Included: Criteria provided to provider on denial reason
- MD Signature: MD Signature included all referrals/NOA letters upon denial

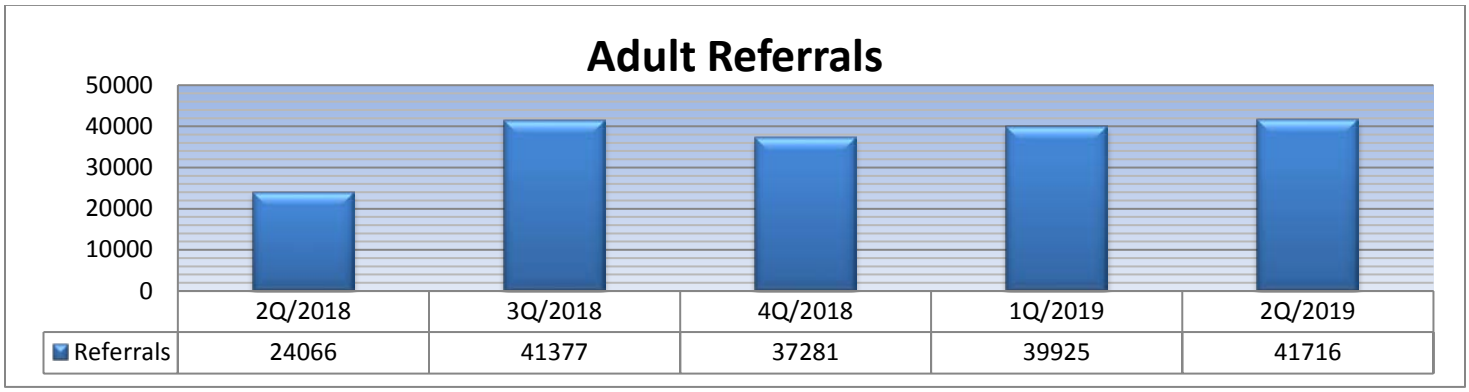


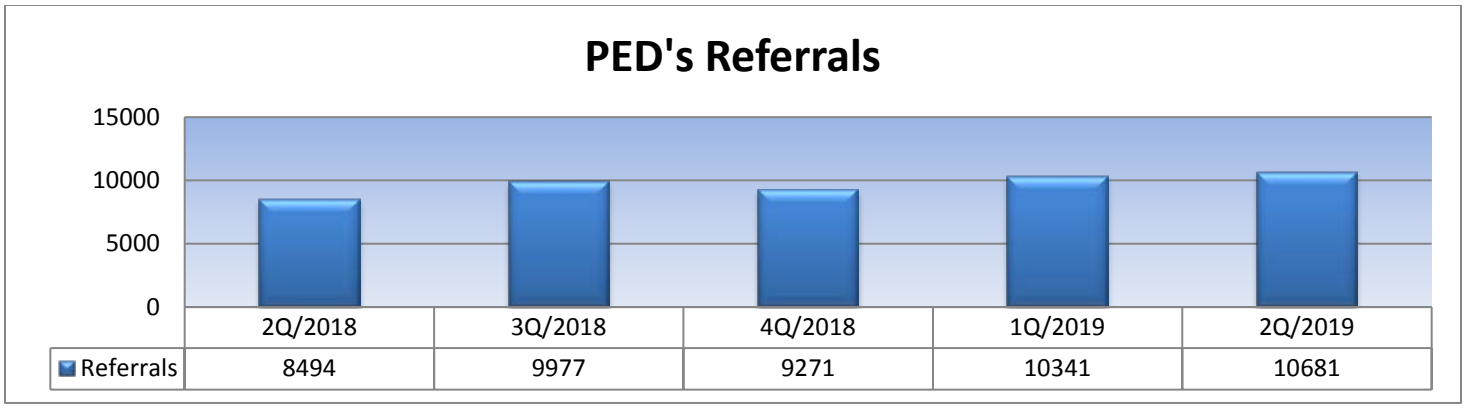
	2Q/18	3Q/18	4Q/18	1Q/19	2Q/19
Member Notification	94.0%	97.0%	93.0%	92.0%	95.0%
Provider Notification	100.0%	100.0%	100.0%	100.0%	100.0%
Criteria Included	93.0%	95.0%	98.0%	96.0%	95.0%
MD Signature Included	98.0%	97.0%	97.0%	99.0%	99.0%

Summary: Overall compliance rate from the 2nd Qtr of 2019 is 97%, no changes from the 1st Qtr which was 97%.

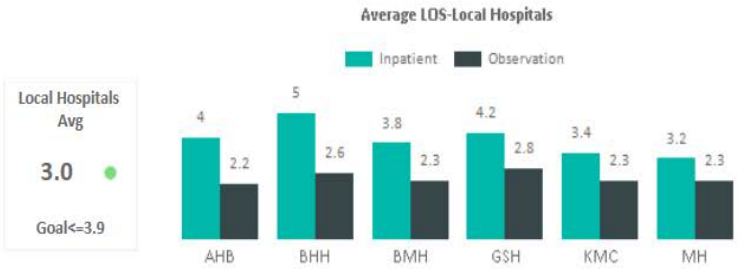
Outpatient Referral Statistics

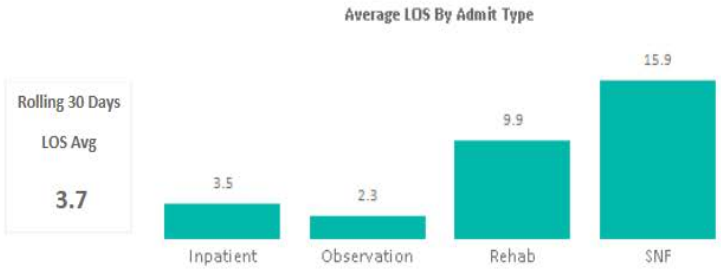






KHS 2nd Quarter Inpatient and LOS Report





Participating Providers		
Provider Name	**Count**	**LOS**
ADVENTIST HEALTH BAKERSFIELD	488	3.7
ADVENTIST HEALTH COMMUNITY CAR	5	2.6
ADVENTIST HEALTH MEDICAL CENTE	29	2.24
ANTELOPE VALLEY HOSPITAL	2	7.5
BAKERSFIELD HEART HOSPITAL	71	4.92
BAKERSFIELD MEMORIAL HOSPITAL	607	3.19
BELLAGIO IN THE DESERT	1	14
DELANO REGIONAL MEDICAL CENTER	71	3.03
GGNSC SHAFTER LP	2	31
GILLI	1	4
GOOD SAMARITAN HOSPITAL	83	4.19
HOFFMANN HOSPICE OF THE VALLEY	5	14.6
KECK HOSPITAL OF USC	81	4.23
KERN COUNTY MEDICAL AUTHORITY	451	2.77
KERN MEDICAL CENTER	1	1
KERN VALLEY HEALTHCARE DIST RH	1	3
KERN VALLEY HEALTHCARE DISTRIC	18	2.67
MERCY HOSPITAL	421	2.82
NAPOLI IN THE DESERT	2	8
RIDGECREST REGIONAL HOSPITAL	2	2.5
SANTA MONICA UCLA MC AND ORTHO	3	5.67
UCLA MEDICAL CENTER	17	4.94
USC NORRIS CANCERHOSPITAL	3	12.67
Total	**2369**	**3.33**

Non Participating Providers		
Provider Name	**Count**	**LOS**
ADVENTIST HEALTH MEDICAL CENTE	2	1
ALHAMBRA HOSPITAL	1	1
ALVARADO HOSP. LLC	1	1
ANTELOPE VALLEY HOSPITAL	45	4.62
BARSTOW COMM HOSPITAL	3	6.67
CALIFORNIA PACIFIC MEDICAL CEN	1	5
CEDARS-SINAI	2	2.5
CENTINELA HOSPITAL MEDICAL GRO	1	2
CITRUS VALLEY HEALTH PARTNERS	1	27
CITY OF HOPE NATIONAL MEDICAL	1	56
DESERT VALLEY HOSPITAL INC	1	14
ENCINO HOSPITAL	1	1
EVERGREEN AT ARVIN HEALTHCARE	1	14
FLAGSTAFF MEDICAL CENTER	1	3
FRENCH HOSPITAL MEDICAL CNTR	1	4
FRESNO COMMUNITY HOSPITAL AND	16	4.31
GLENDALE ADVENTIST	3	5.67
GOOD SAMARITAN HOSPITAL	1	3
HEIGHT STREET SKILLED CARE	1	7
HENRY MAYO NEWHALL	5	3
HOAG MEMORIAL HOSPITAL	1	8
JFK MEMORIAL HOSPITAL	2	4.5
JOHN MUIR MED CENTER	1	4
KAWEAH DELTA MEDICAL CENTER	4	2
KINDRED HOSPITAL	2	19.5
KINDRED HOSPITAL SAN GABRIEL	3	9.67
KINGMAN REGIONAL MEDICAL	1	5
KND DEVELOPEMENT	1	22
LAC USC MEDICAL CENTER	7	9.86
LAC/USC MEDICAL CENTER	8	3.38
LACO OV-UCLA MED CTR	1	4
LAKEWOOD REGIONAL	1	2
LANCASTER HOSPITAL CORPORATION	9	5.33
LOMA LINDA UNIVERSITY MEDICAL	4	14
LONGS PEAK HOSPITAL	1	2
LOS ROBLES HOSPITAL & MC	4	6.5
MARIAN REGIONAL MEDICAL CENTER	2	1.5
MARICOPA INTEGRATED HEALTH	2	3.5

MARSHALL HOSPITAL	1	2
MEMORIAL HOSPITAL OF GARDENA	1	2
MERCY GENERAL HOSPITAL	1	6
MERCY HEALTH MEDICAL CENTER	1	4
MOUNTAINVIEW HOSPITAL	1	1
NORTHWEST TEXAS HEALTHCARE SYS	2	2.5
OU MEDICAL CENTER	2	3
PACIFICA HOSPITAL OF THE VALLE	1	2
PROVIDENCE HEALTH	1	1
PROVIDENCE LITTLE COMPANY	1	4
QUEEN OF THE VALLEY MEDICAL CE	1	13
REDWOOD MEMORIAL HOSPITAL	1	12
REGIONAL MEDICAL CENTER	1	4
RIVERSIDE COMMUNITY HOSPITAL	2	9
RIVERSIDE COUNTY REGIONAL	1	3
SAINT AGNES MEDICAL CENTER	2	7.5
SAINT FRANCIS HOSPITAL, INC.	1	1
SAINT THOMAS MIDTOWN HOSPITAL	1	1
SAN ANTONIO REGIONAL	1	2
SANTA BARBARA COTTAGE HOSPITAL	1	2
SCRIPPS MERCY	1	3
SHARP MEMORIAL REHABILITATION	1	1
SIERRA VIEW DISTRICT HOSPITAL	3	2.67
SIERRA VISTA REGIONAL MEDICAL	2	1
ST FRANCIS MEDICAL CENTER	1	2
ST JOHNS REGIONAL MEDICAL CENT	2	2
ST MARY MEDICAL	1	1
ST MARY MEDICAL CENTER	2	3
ST. JOSEPH HOSP-ORANGE	1	1
STANFORD MEDICAL CENTER	1	6
SUNRISE HOSPITAL AND MEDICAL	1	2
UCSF MEDICAL CENTER	2	24.5
UPMC PASSAVANT	3	5
VALLEY PRESBYTERIAN HOSPITAL	1	9
VENTURA COUNTY MEDICAL CENTER	1	11
Total	**190**	**5.61**

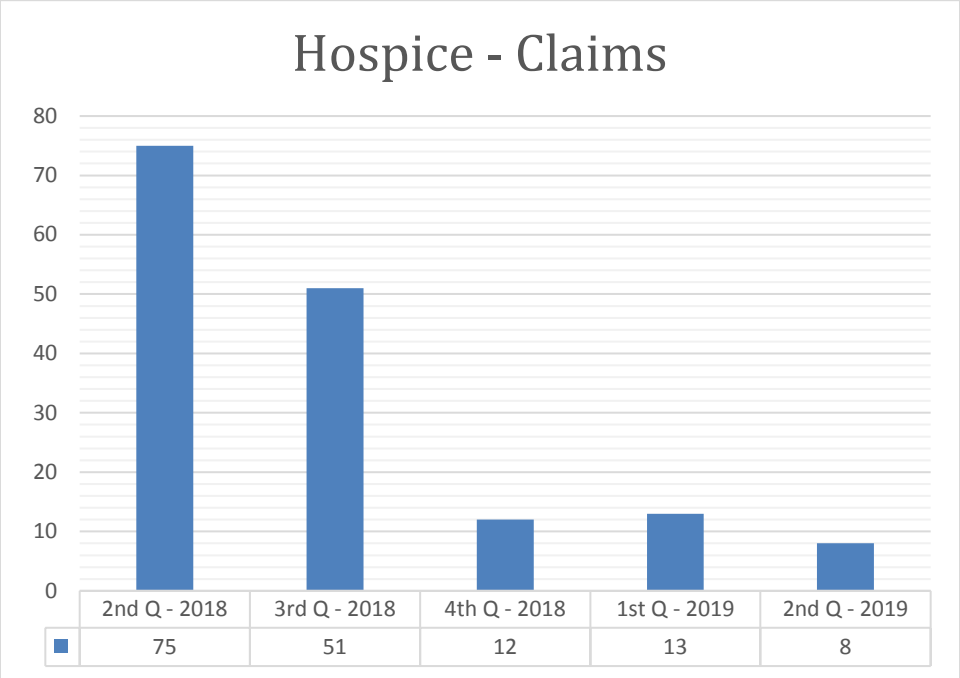
Rehab

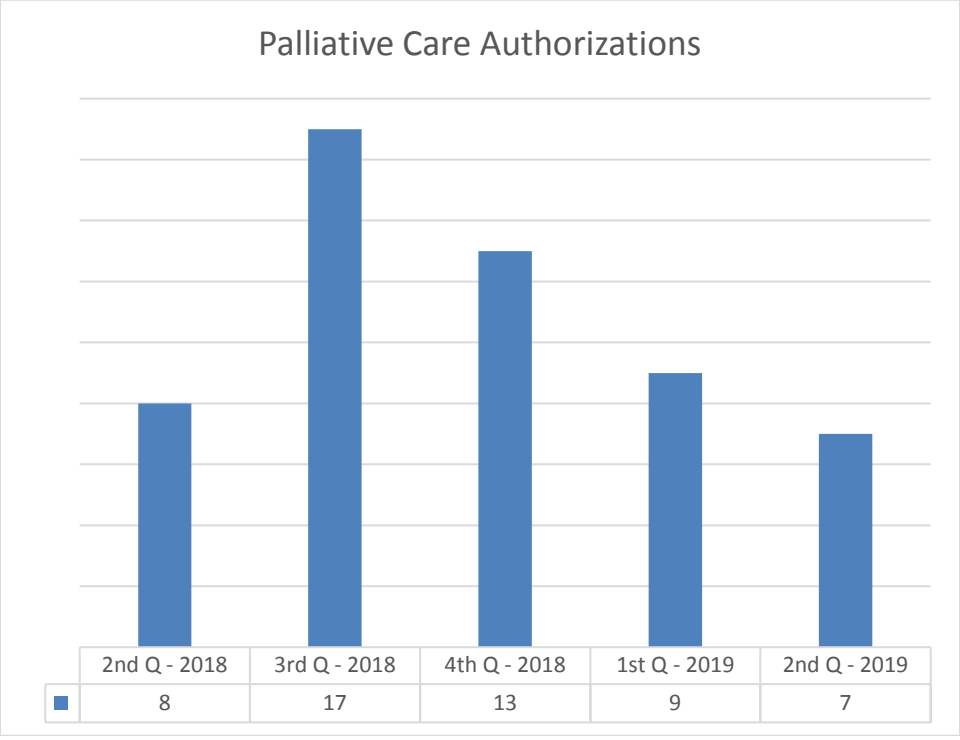
Participating Providers		
Provider Name	**Count**	**LOS**
ENCOMPASS HEATH REHABILITATION	36	9.86
Total	**36**	**9.86**

SNF

Participating Providers		
Provider Name	**Count**	**LOS**
BELLAGIO IN THE DESERT	8	10.63
CAPRI IN THE DESERT	7	12.29
EVERLASTING HEALTHCARE	1	46
GGNSC SHAFTER LP	12	13.17
GOLDEN LIVING CENTER	6	9.17
HOFFMANN HOSPICE OF THE VALLEY	10	4.4
NAPOLI IN THE DESERT	5	19
PARKVIEW JULIAN	3	18.33
THE REHABILITATION CENTER	1	11
UNITED CARE FACILITIES	68	17.87
VFP HOMES	3	23.33
Total	**124**	**15.48**

Non Participating Providers		
Provider Name	**Count**	**LOS**
DELANO REGIONAL MEDICAL CENTER	2	23
EVERGREEN AT ARVIN HEALTHCARE	7	17.86
GGNSC DEDHAM LLC	1	17
HEIGHT STREET SKILLED CARE	3	9.33
KINGSTON HEALTHCARE CENTER	8	18.38
PACIFICA HOSPITAL OF THE VALLE	3	24
Total	**24**	**18.13**

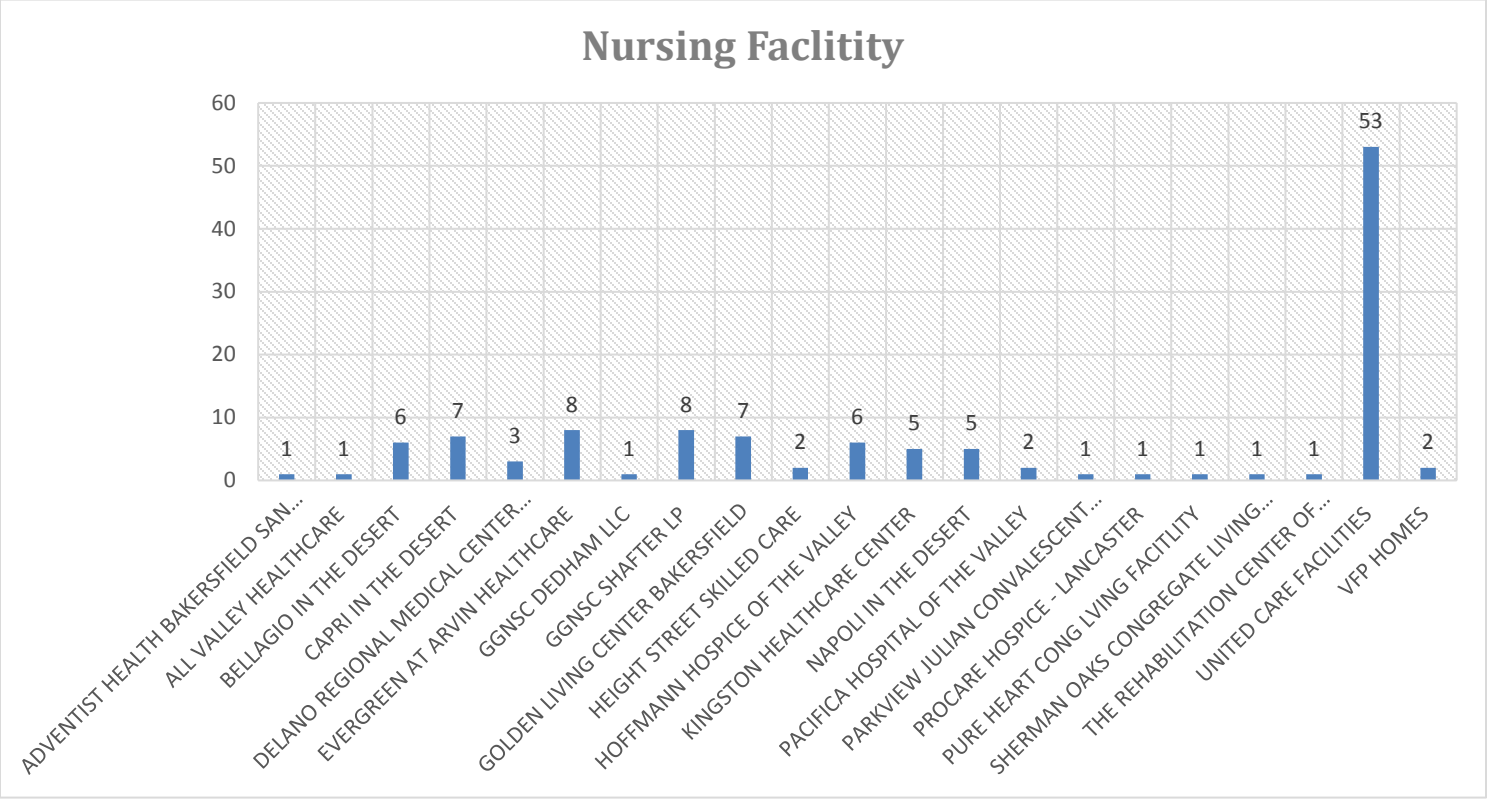

Hospice - Claims
80
70
60
50
40
30
20
10
0
2nd Q - 2018
3rd Q - 2018
4th Q - 2018
1st Q - 2019
2nd Q - 2019
75
51
12
13
8


Palliative Care Authorizations
2nd Q - 2018
3rd Q - 2018
4th Q - 2018
1st Q - 2019
2nd Q - 2019
8
17
13
9
7

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.

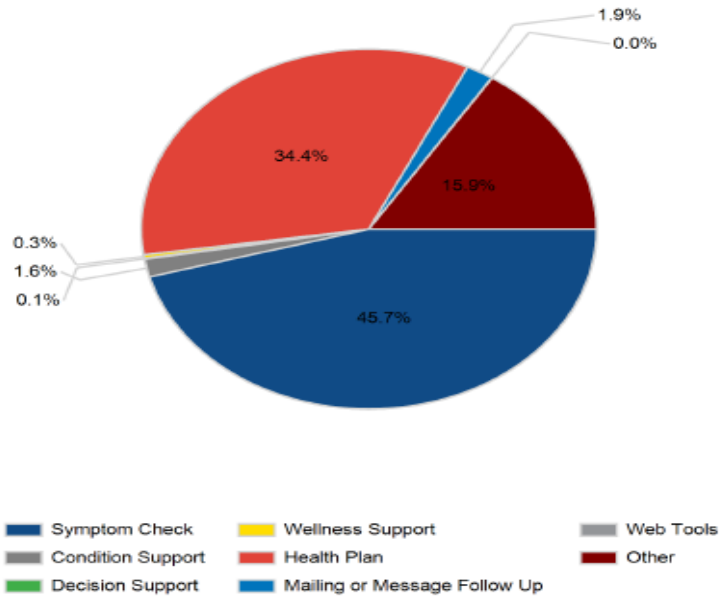
Summary: Summary: During the 2nd quarter 2019, there were 161 referrals for Nursing Facility Services. The average length of stay was 22.5 days for these members. During the 1st quarter there was only 2 denials of the 144 referrals.



Health Dialog Report

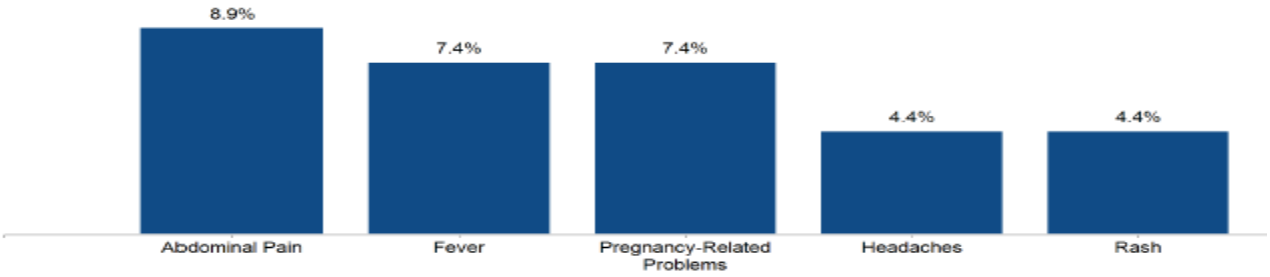
April:

Member Inbound Call Reasons (Rolling Twelve Months)

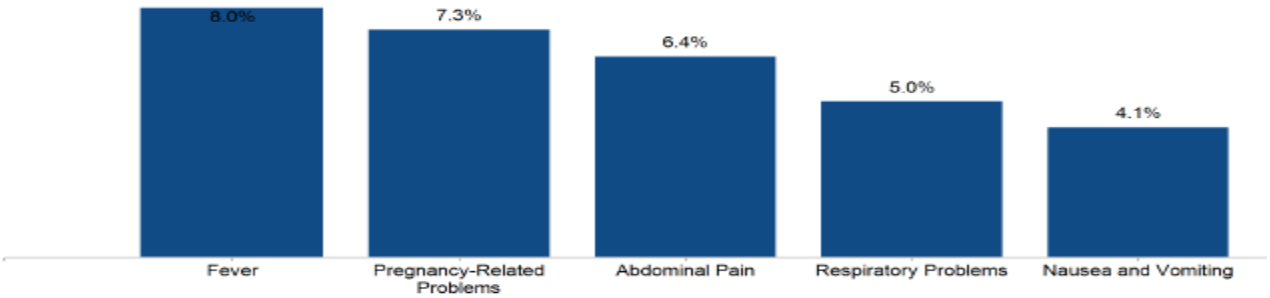


REASON	NUMBER
Symptom Check	2,660
Condition Support	93
Decision Support	5
Wellness Support	18
Health Plan	2,003
Mailing or Message Follow Up	113
Web Tools	2
Other	924

Most Frequent Symptoms - Inbound Symptom Check Calls (Apr-2019)

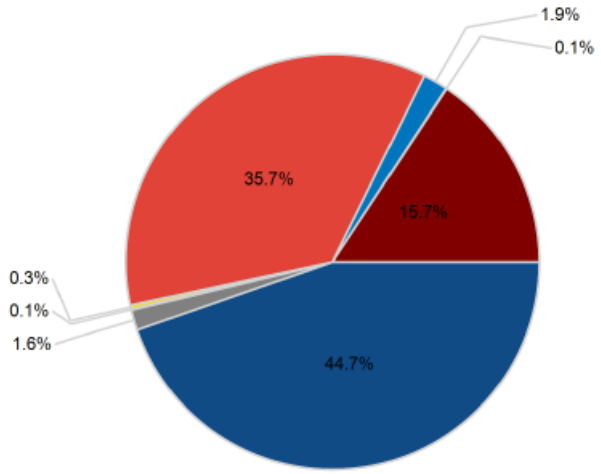


Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



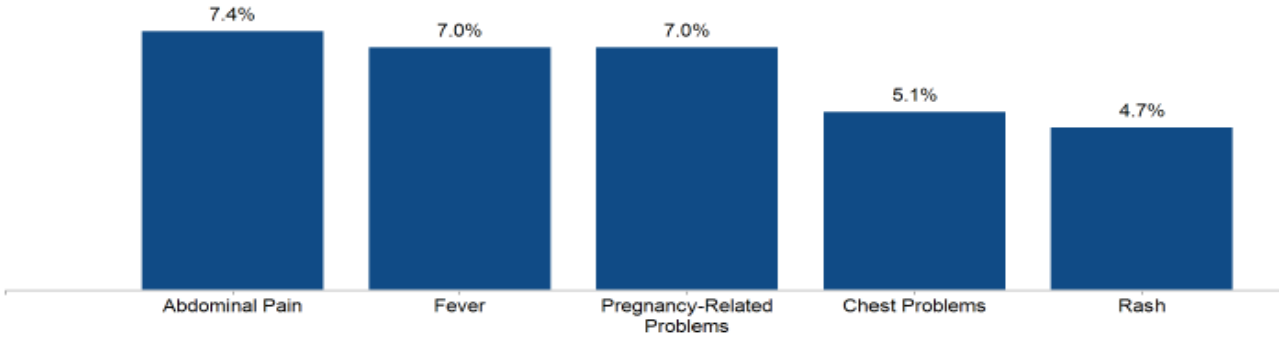
May:

Member Inbound Call Reasons (Rolling Twelve Months)

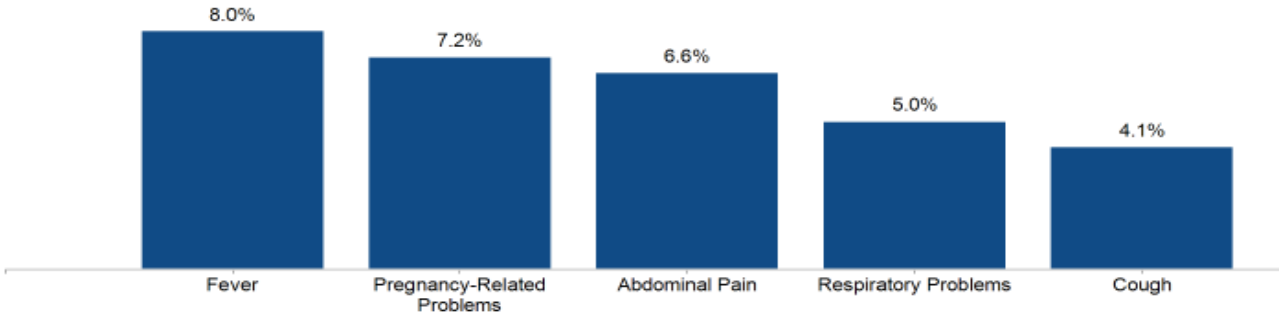


REASON	NUMBER
Symptom Check	2,664
Condition Support	94
Decision Support	5
Wellness Support	18
Health Plan	2,127
Mailing or Message Follow Up	116
Web Tools	3
Other	935

Most Frequent Symptoms - Inbound Symptom Check Calls (May-2019)

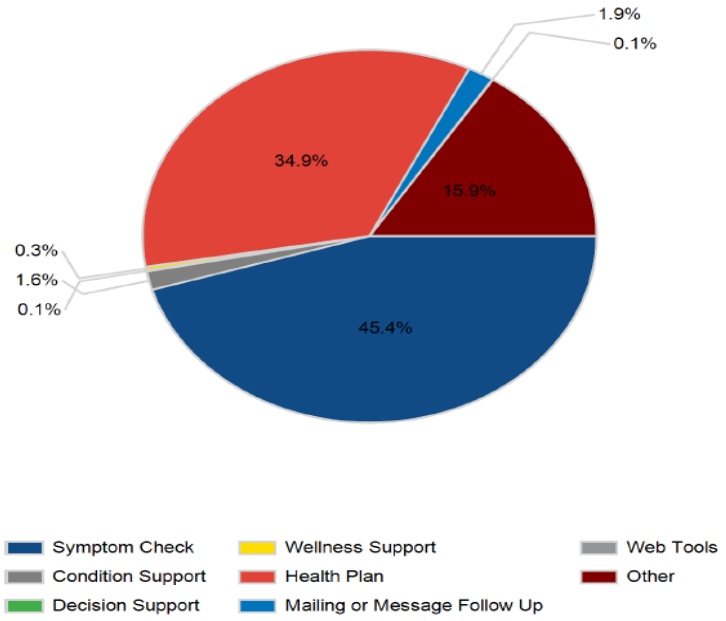


Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



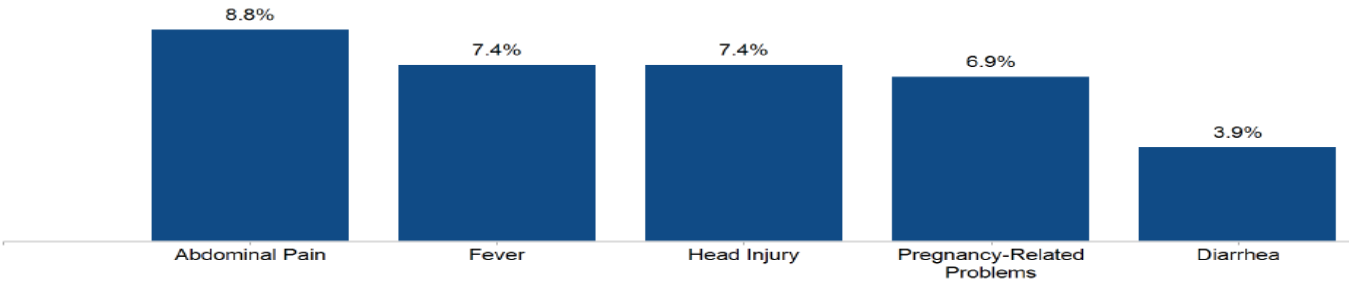
June:

Member Inbound Call Reasons (Rolling Twelve Months)

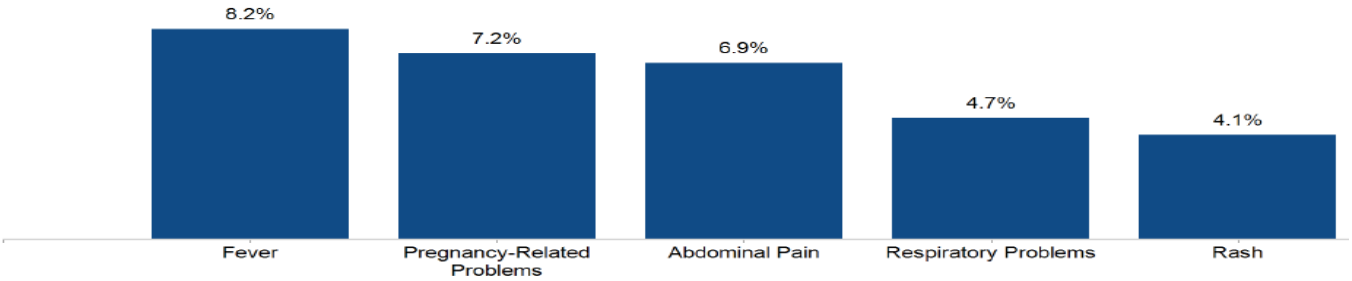


REASON	NUMBER
Symptom Check	2,678
Condition Support	95
Decision Support	6
Wellness Support	18
Health Plan	2,059
Mailing or Message Follow Up	110
Web Tools	3
Other	936

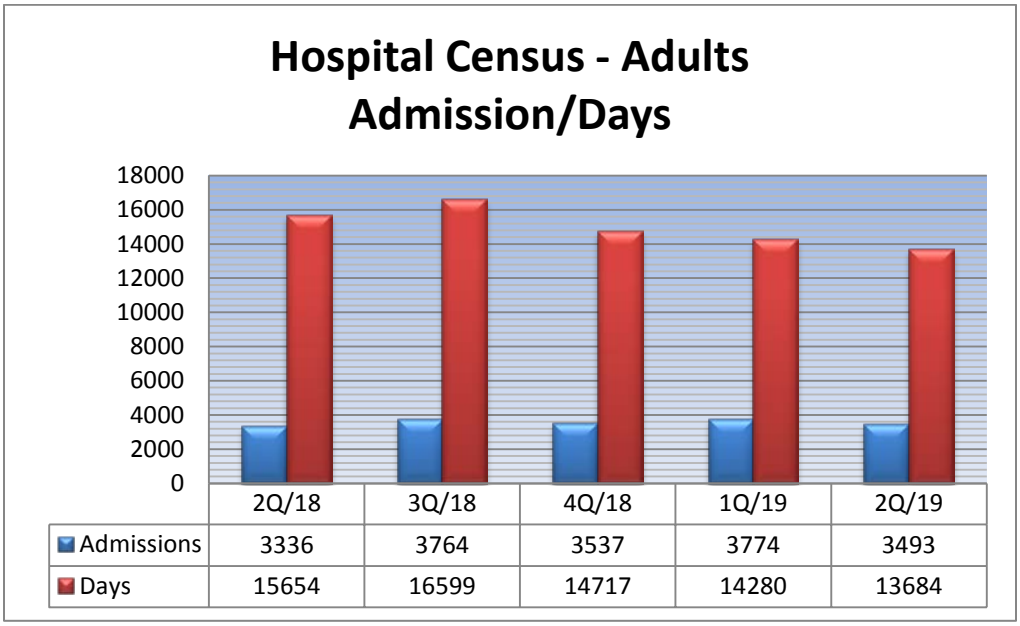
Most Frequent Symptoms - Inbound Symptom Check Calls (Jun-2019)



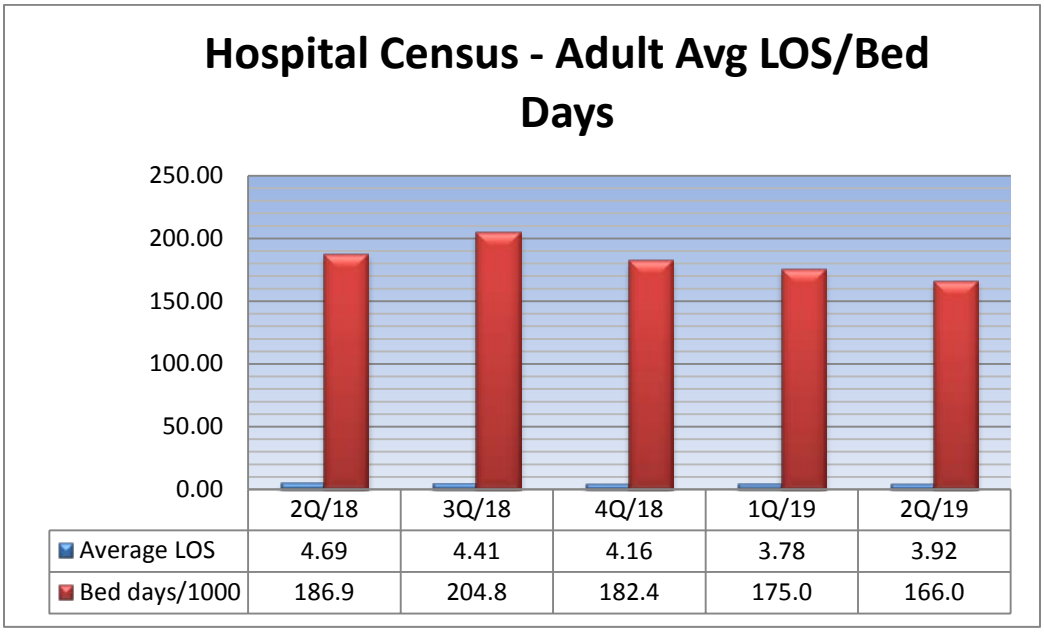
Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



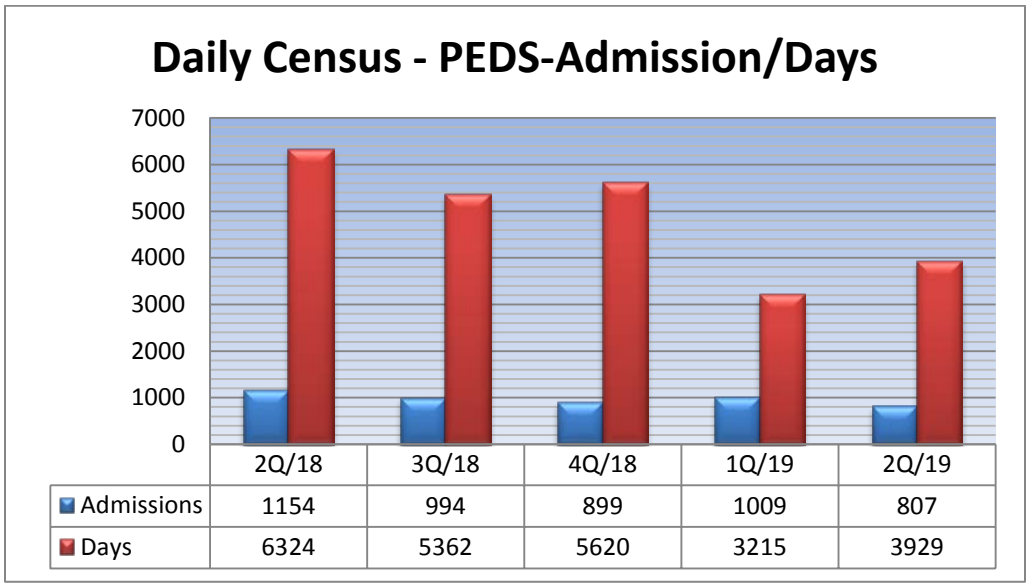
Inpatient 2nd Quarter Trending



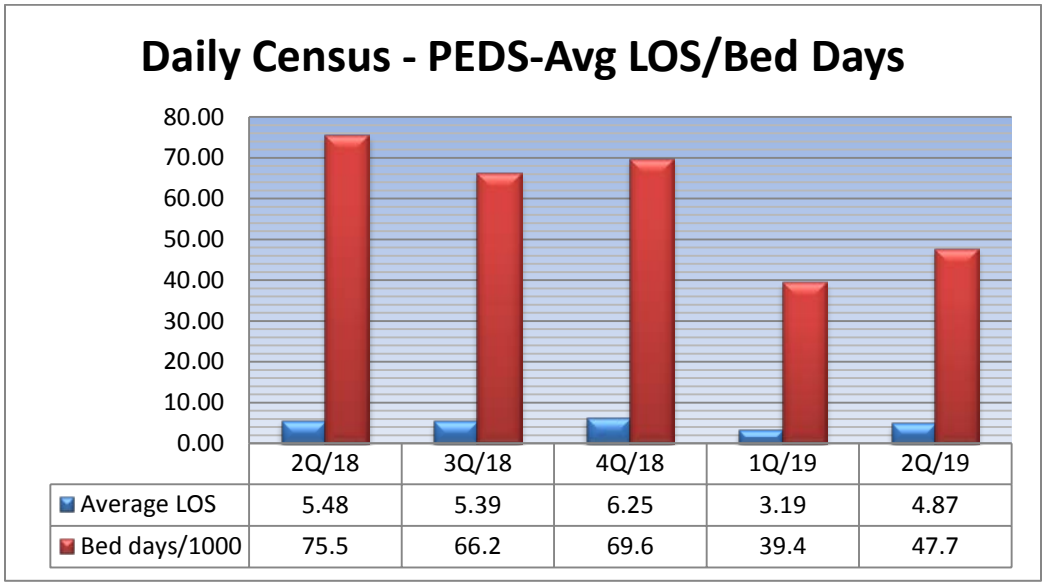
	2Q/18	3Q/18	4Q/18	1Q/19	2Q/19
Admissions	3336	3764	3537	3774	3493
Days	15654	16599	14717	14280	13684



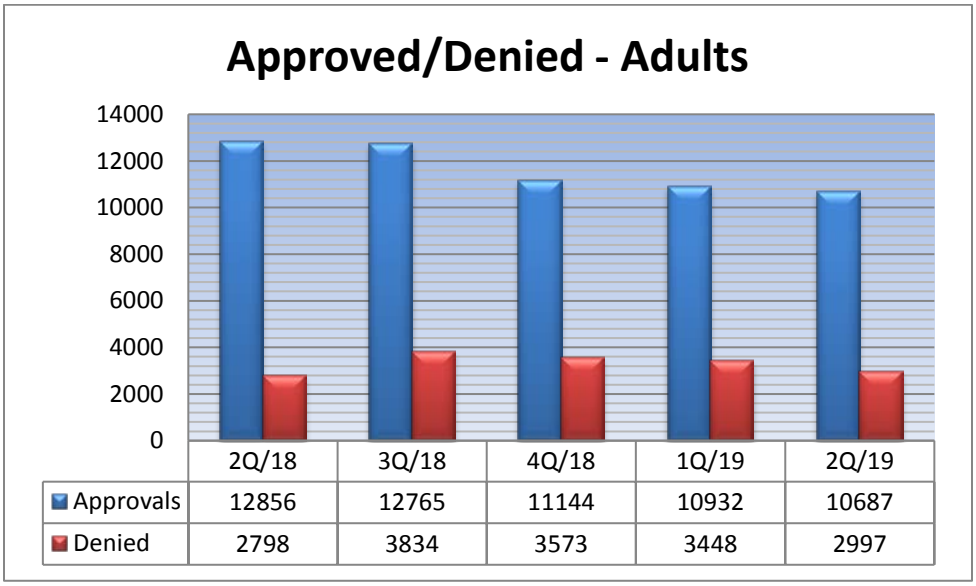
	2Q/18	3Q/18	4Q/18	1Q/19	2Q/19
Average LOS	4.69	4.41	4.16	3.78	3.92
Bed days/1000	186.9	204.8	182.4	175.0	166.0

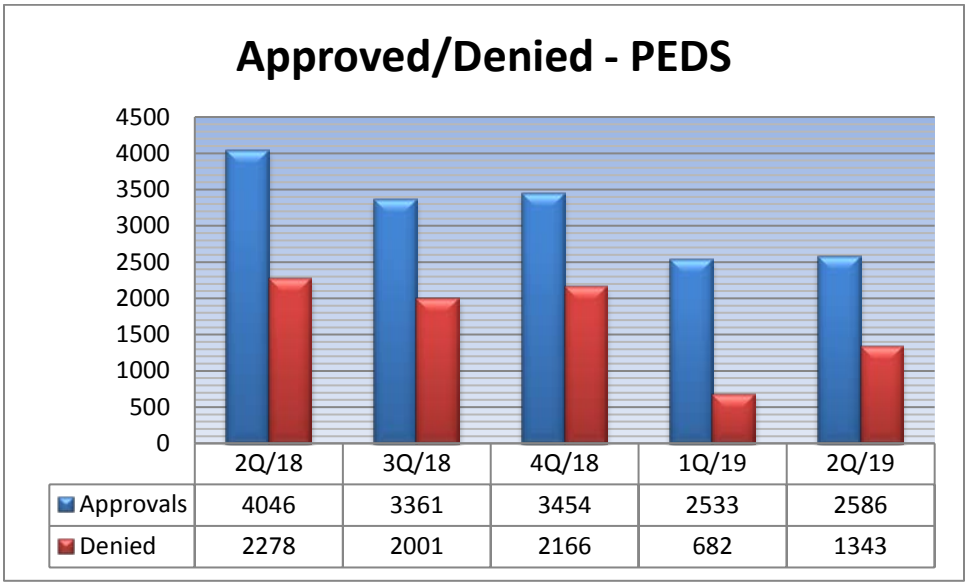


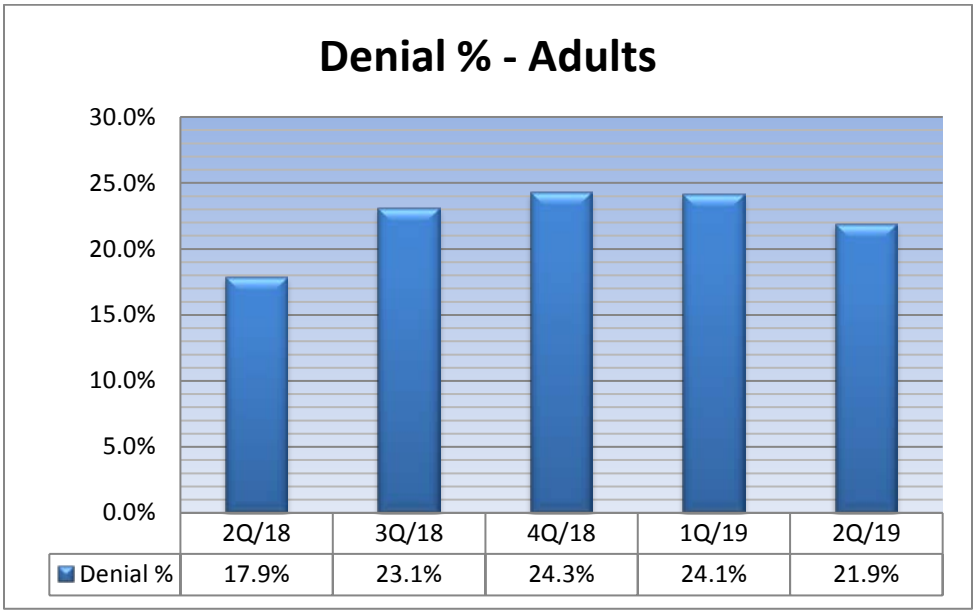
	2Q/18	3Q/18	4Q/18	1Q/19	2Q/19
Admissions	1154	994	899	1009	807
Days	6324	5362	5620	3215	3929

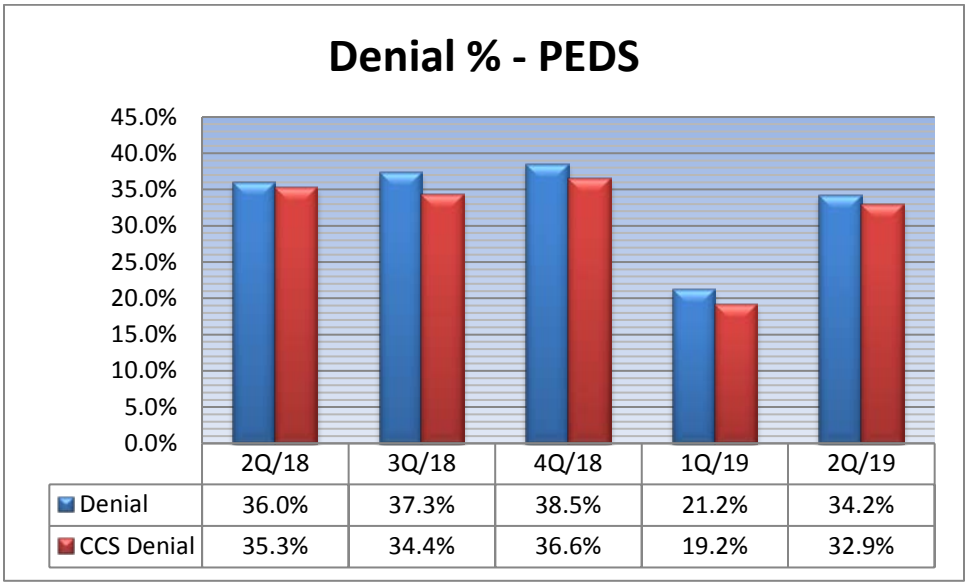


	2Q/18	3Q/18	4Q/18	1Q/19	2Q/19
Average LOS	5.48	5.39	6.25	3.19	4.87
Bed days/1000	75.5	66.2	69.6	39.4	47.7


Approved/Denied - Adults
14000
12000
10000
8000
6000
4000
2000
0
2Q/18 3Q/18 4Q/18 1Q/19 2Q/19
Approvals 12856 12765 11144 10932 10687
Denied 2798 3834 3573 3448 2997


Approved/Denied - PEDS
4500
4000
3500
3000
2500
2000
1500
1000
500
0
2Q/18 3Q/18 4Q/18 1Q/19 2Q/19
Approvals 4046 3361 3454 2533 2586
Denied 2278 2001 2166 682 1343





Continuity of Care

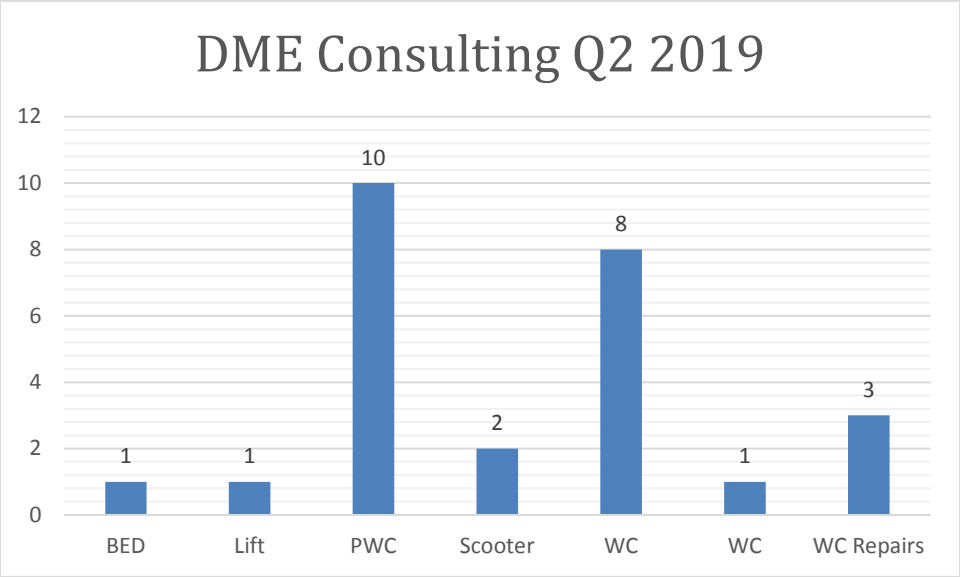
Total Referral – 40

Total Approval – 40

Total Denial - 0

Total SPD COC -12

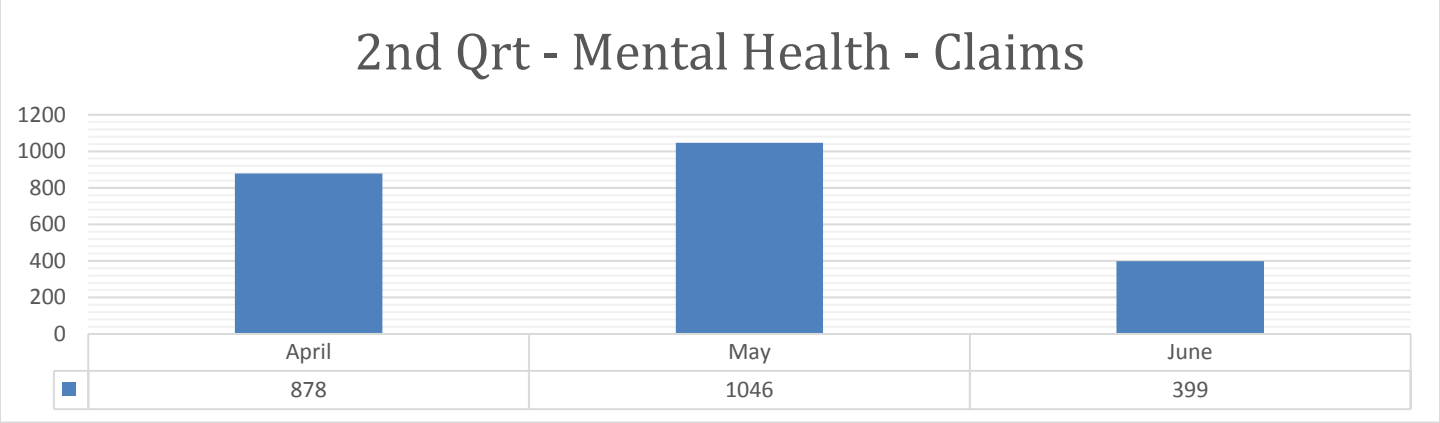
DME Consulting



Autism Reporting

UNIQUE CASES		Mild	Moderate	Severe	Total	Undetermined
MEMBER COUNT		6	39	10	55	234
Severity %		10.91%	70.91%	18.18%	100%	
SEVERITY	Apr	May	Jun	Total		
MILD		3	1	4		
MODERATE	2	23	13	38		
SEVERE	3	8	1	12		
Approved FBA	43	51	52	146		
Approved Treatment	50	60	64	174		
PENDING DX	96	66	83	245		
	Apr	May	Jun	Total		
AGE 7 OR LESS	60	77	67	204		
AGE 8 OR GREATER	41	23	31	95		
TOTAL	101	100	98	299		
% < 7	59.41%	77.00%	68.37%	68.23%		
% > 8	40.59%	23.00%	31.63%	31.77%		

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
2018	August	4,743	190	178	368
	September	557	27	26	53
	October	598	22	23	45
	November	770	41	41	82
	December	853	52	64	116
2019	January	8,557	327	259	586
	February	8,910	412	140	552
	March	265	24	1	25
	April	1,012	39	0	39
	May	553	14	0	14
	June	729	5	0	5
Totals		**27,547**	**1,153**	**732**	**1,885**

LTM Effectiveness* : 7 %

12-Month Effectiveness (Jan 2018 - Dec 2018) : 9 %

* This figure does not include an estimate of those patients who will return within 90 or 180 days.
It solely calculates based upon the patients who have returned to date for letters sent within the last twelve months.

Medical Data Collection Summary Report

Period Covered: July, 2018 through June, 2019
Prepared for: KERN HEALTH SYSTEMS - (12049397)

Reported Cases

	Members	
Received Eye Exam:	25,253	
Diabetes?:	1,279	5.1%
Diabetic Retinopathy:	136	.5%
Glaucoma:	187	.7%
Hypertension:	1003	4.0%
High Cholesterol	377	1.5%
Macular Degeneration:	28	.1%

Estimated Number of Cases

Total Members:	247,377	
Diabetes?:	5,476	2.2%
Diabetic Retinopathy:	483	.2%
Glaucoma:	917	.4%
Hypertension:	24,095	9.7%
High Cholesterol	37,077	15.0%
Macular Degeneration:	296	.1%

KERN HEALTH SYSTEMS
CASE MANAGEMENT DEPARTMENT MONTHLY REPORT

Reporting Period: April 1st, 2019- June 31st, 2019

During the months of April thru June, a total of 1,488 members were managed by the Case Management Department.

Episode Type	Closed Episodes	Open Episodes	Referral Episodes	Total
Case Management	661	104	23	788
Behavioral Health Case Management	637	57	6	700

Episode Source other than ACG Modeler	Behavioral Health Management Episodes	Case Management Episodes
All Internally Generated Complex Case Management	102	94
All Internally Generated Disease Management	2	1
All Internally Generated Grievance	1	2
All Internally Generated Hospital Discharge	0	1
All Internally Generated Member Request	1	0
All Internally Generated Medical Director	0	9
All Internally Generated UM Generated	8	14
CM DM HE Facility Based Social Worker	0	3
BH Mental Health	39	0
CM DM HE Health Education	2	0
CM DM HE Member Services	17	11
CM DM High ER Utilizer	150	0
Contract Physician/Provider	1	2
DM HE Social Worker Case Management	17	3
Internally Generated Complex Case Management	1	7

Closure Reasons	Behavioral Health Case Management Episode	Case Management Episode
Deceased	3	5
Declined Services	107	39
Does not meet criteria	20	67
Medical Director Decision	11	36
Member Disenrolled	7	11
Member Enrolled	1	0
Member Goals Completed	76	60
Non-Compliant-MD Approval obtained	0	3
Not Eligible	0	3
Reassigned	3	5
Refused Services	0	5
Unable to Contact	294	359

Members Closed and Referred to HHP	Behavioral Health Case Management Episode	Case Management Episode
HHP	100	92

Closed Episodes with Admits within 30 days after Closure	Total
Behavioral Health Case Management	28
Case Management	65
Percentage of closed cases Readmitted	0.07 Percent

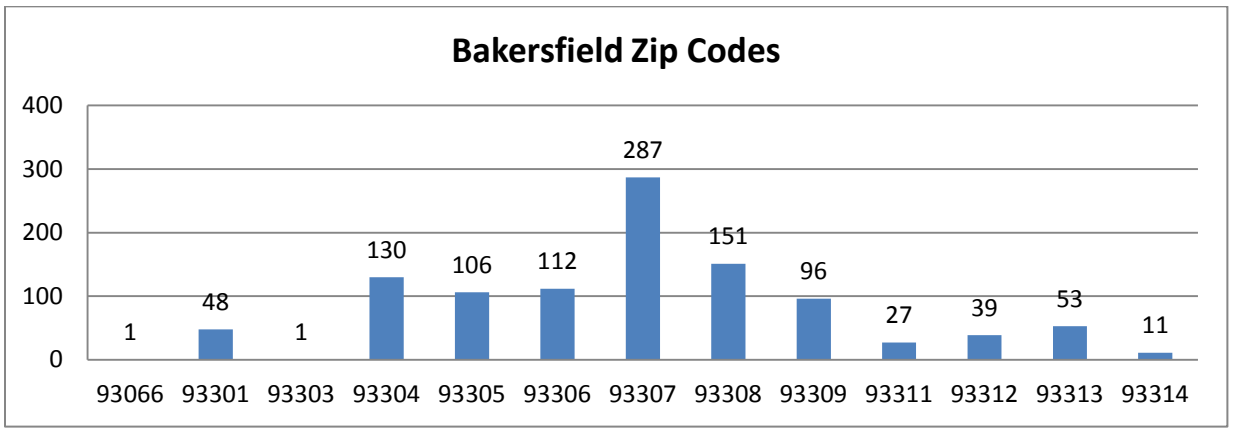
Assessments/Plan of Care	Behavioral Health Case Management Episode	Case Management Episode	Total
Assessments	78	104	182
Plan of Care	76	103	179

During the month of April thru June, 95% of the members managed were 65 years of age or younger.

Age	65 and under	Over 65	Total
Case Management	719	69	788
Behavioral Case Management	687	13	700

Of the 1,488 members managed during the months of April thru June, the majority of members were female at 60%. The majority of members' ethnicity was Hispanic at 40%.

Ethnicity	Female	Male	Total
AFRICAN AMERICAN	94	73	167
ALASKAN/AMER INDIAN	3	2	5
ASIAN INDIAN	5	7	12
ASIAN/PACIFIC	6	5	11
CAUCASIAN	349	219	568
FILIPINO	7	4	11
HAWAIIAN	0	1	1
HISPANIC	372	221	593
NO VALID DATA	55	50	105
UNKNOWN	5	10	15



Outlying Areas

City	Total
ARVIN	25
BARSTOW	1
BODFISH	6
BORON	2
BUTTONWILLOW	1
CALIENTE	2
CALIF CITY	22
CANYON CNTRY	1

CRESCENT CITY	1
DELANO	70
EDISON	1
FRAZIER PARK	7
FRESNO	2
GARDEN GROVE	1
GLENN	1
HOLTVILLE	1
INYOKERN	3
LAKE ISABELLA	25
LAMONT	25
LANCASTER	1
LEBEC	2
LOST HILLS	4
MARICOPA	8
MC FARLAND	19
MOJAVE	13
N/A	20
NORTH EDWARDS	1
PASO ROBLES	1
ROSAMOND	6
SANTA FE	1
SANTA MARGARITA	1
SANTA MARIA	1
SHAFTER	34
TAFT	45
TEHACHAPI	31
VENTURA	1
WASCO	29
WELDON	6
WILDOMAR	1
WOFFORD HEIGHTS	4

Notes Completed

Note Source	Behavioral Case Management Episode	Case Management Episode
Activity Note	1,755	1,454
Add Episode Note	33	21
Care Plan Problem Note	201	203
Change Status Note	2,373	2,025
Edit Episode Note	0	92
Episode Note	130	426
Goals	236	254
Interventions	523	395

Letters

Letter Template	Behavioral Health Case Management Episode	Case Management Episode
Appointment Letter English	43	29
Appointment Letter Spanish	8	25
Consent Form English	10	40
Consent Form Spanish	2	18
Discharge English	48	79
Discharge Spanish	6	20
Educational Material	175	168
Mental Health Alert to PCP	2	0
Suicide Hospital Letter to MD	1	0
Unable to Contact	475	565
Welcome Letter Bilingual	73	146

Activity Type

Activity Type	Behavioral Health Case Management Episode	Case Management Episode
Fax	95	173
Letter Contact	574	697
Member Services	38	30
Phone Call	1,451	1,783

Activities Completed

Activities Completed	Total
CMA's	2,582
Nurses	1,337
Social Workers	922

Activity Name

Activity Name	Behavioral Health Case Management Episode	Case Management Episode
Appointment Reminder Calls	1	33
Basic Needs	0	4
Centric Appointment	0	5
Community Resources	12	13
Contact Member	183	121
Contact Pharmacy	1	10
Contact Provider	177	277
Create Work Item	50	22
HHP	100	92
HRA	0	1
ICT	35	44
Incoming Call	1	8
Inpatient Discharge Follow Up	55	107
Language Line	78	130
Mail Appointment Letter	44	15
Mail Authorization	1	4
Mail Consent Letter	11	45
Mail Discharge Letter	54	97
Mail Educational Material	135	165
Mail Pill Box	30	40
Mail Pocket Calendars	37	77
Mail Provider Directory	6	8
Mail Unable to contact letter	85	120
Mail Urgent Care Pamphlet	22	5
Mail Welcome Letter	70	12
Phone call/Member on MM closure	0	1
Mental Health Alert to PCP	2	0
Palliative Care	4	0
Plan of care	79	102

Provided Information	2	20
Request Medical Records	57	142
Return Mail	28	4
Schedule Physician Appointment	52	46
Transportation	29	39
Verbal consent to be received	697	757

Seniors and Persons with Disabilities (SPDs):

There were a total of 323 SPD members that were enrolled from April thru June, according to the risk stratification reports.

There are a total of 13,862 SPD members through June 2019

SPD Members are stratified into the Complex Case Management Group through use of the John Hopkins Predictive Modeler and represent 43 percent of the Complex Group from April thru June 2019.

2018 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 completed in 2018 is as follows:

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	☐ Leadership Support ☐ Mentoring	Met/Not Met	Year End 2018	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 a. Outpatient Clinical Supervisor hired b. Director of Utilization Management hired	☐ Goal met
UM	☐ Staff Realignment of Health Service Departments	Met/Not Met	Year End 2018	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 cross training for outpatient, inpatient, California Children Services, Claims and Disputes review.	☐ Goal met
UM	☐ Update UM Program Description ☐ Completion of 2018 Annual UM Program Evaluation ☐ Development and implementation of 2019 UM Program Description	Met/Not Met	Year End 2018	1. Review, and revise the annual UM Program Description, Program Plan, and Evaluation including Medical and Behavioral Health. 2. Acquire approval of 2019 UM Program Description and the 2018 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 2018 ☐ Annual UM Program Evaluation was completed and approved ☐ UM Program Description was reviewed, revised and approved
UM	☐ Resources for growth and development-Certified Case Manager	Met/Not Met	Year End 2018	1. Case Management Society of America – standards of practice provided to the Case Management staff-all Case Managers are Registered Nurses 2. Organizational Membership recommended for the team that allows for Director, Managers, and Supervisors to both access 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 -(6) staff attained CCM in 2018-(4) MSW, (2) RN
UM	☐ Oversight of all delegated UM functions for the following services: Kaiser VSP Health Dialog	Met	Year End 2018	1. Evaluate effectiveness of the UM program for policy adherence to include compliance with state, federal, and NCQA standards. 2. Approve 2018 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- Kaiser onsite audit conducted May 2019 Next Steps: ☐ Continue quarterly review of delegated services UM reports, annual audit of Policy and Procedures, collaborations annual denial file review. Ad hoc review as identified. ☐ Report delegated services findings to KHS PAC and UM/QI Committees.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	☐ Remote workforce support	Met	Year End 2018	1. VPN/RDP connectivity support for weekend coverage and UM staff remote workforce	☐ Goal met
UM	☐ Provide UM Training Programs	Met	Year End 2018	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 for both medical and mental//behavioral health conditions	☐ Goal met Next Steps: ☐ Continue to update and provide training as needed ☐ Training is based on Regulatory standards and changes ☐ 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 2019 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 2018	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: ☐ Continue annual review, update and approval of UM Criteria for 2018/2019
UM	☐ Periodic reports to Quality Committee and Executive Committee	Met/Not Met	Year End 2018	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: ☐ Continue to review, revise and approve Utilization management policies and procedures at designated timeframes. Ongoing and ad hoc report to committees
UM	☐ Timely and complete notification of denials of care	Met/Not Met	Year End 2018	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**  	☐ Goal Not Met -expectation is to remain consistent at 90% or greater. JIVA implementation impacted notifiction related to new platform functionality and user learning curve ☐ Staff re-education/training on JIVA system and criteria attachment ongoing as warranted

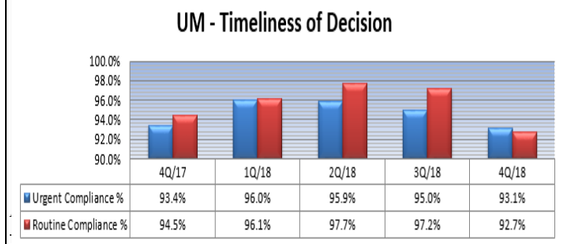
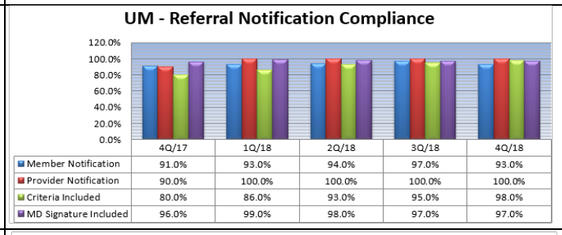
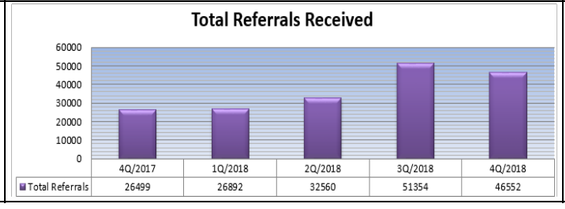
	4Q/17	1Q/18	2Q/18	3Q/18	4Q/18
Member Notification	91.0%	93.0%	94.0%	97.0%	93.0%
Provider Notification	90.0%	100.0%	100.0%	100.0%	100.0%
Criteria Included	80.0%	86.0%	93.0%	95.0%	98.0%
MD Signature Included	96.0%	99.0%	98.0%	97.0%	97.0%

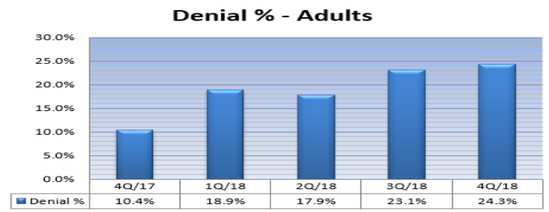
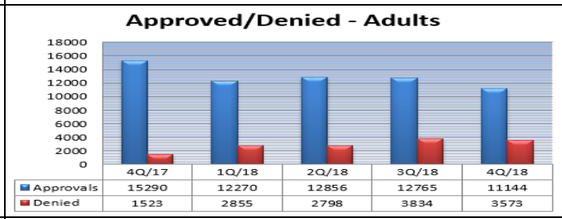
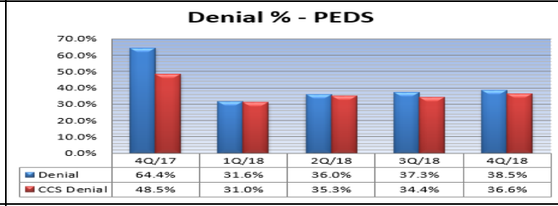
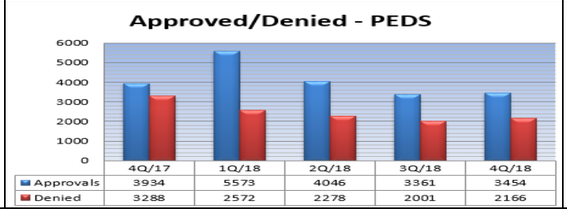
Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	☐ Member Satisfaction with UM processes completion and analysis ☐ Physician satisfaction with UM programs; i.e. communication, access, authorization process	Met/Not Met	Year End 2018	1. Annually survey satisfaction 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 2018 by SPH Analystics Member Satisfaction Survey completed in 2018 by SPH Anayltyics ☐ Favorable/consistent 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 2018	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	☐ Goal Met
UM	Interrater reliability audits	Met/Not Met	Year End 2018	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.	☐ Goal Met
UM	Emergency Room (ER) Utilization	Met/Not Met	Year End 2018	1. ER intensive case management follow up for the top 50 ER utilizers. 2. Regular monthly report and ongoing program. Interventions include contacting the member, providing education, making the follow up appointment, and checking to ensure that the appointment was kept. 3. Partnerships with community entities to support efforts for educational suupport and coordination of care. 4. Social Workers providing resources to high ER utilizers 5. Transitional Care involving immediate post acute interventions to avoid readmission, ER utilization through coordination of care and member education.	☐ Goal Met
UM	UM Health Services Program Administrator (additional duties)	Met/Not Met	Year End 2018	Medication Therapy Managment, DME effectiveness, Synagis, Hepatitis C, BHT reporting, Diabetic clinics, and community outreach completed. 2. UM Health Services Program Administrator partners with KHS Business Intelligence team 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 4. Over and under utilization analysis on various specialty services	☐ Goal Met
UM	DHCS/DMHC Audit	Met/Not Met	Year End 2018	DHCS performed a medical audit in August 2018. UM had 1 finding in the audit related to coordination of treatemnt plans for BHT services every 6 months--CAP submitted and approved.	☐ Goal Not Met
UM	Systems Review	Met/Not Met	Year End 2018	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 to include UM, CM, DM, HE, QI, and Health Homes	☐ 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>Quarterly State Reports Submission</td><td>Met/Not Met</td><td>Year End 2018</td><td>Quarterly report and mailing- a) Out of Network; b) CBAS; c) Mental Health; e) BHT-CDE and BHT-Quarterly; f) Dental Anesthesia; g) Palliative
Delegated Kaiser reporting required for all reports listed to DHCS</td><td>☐ Goal Met</td></tr>
<tr><td>DHCS</td><td>Quality Improvement/Utilization Management Committee (QI/UMC)</td><td>Met/Not Met</td><td>Year End 2018</td><td>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.</td><td>☐ Goal Met</td></tr>
<tr><td>DHCS</td><td>Quality Improvement/Utilization Management Committee (QI/UMC)</td><td>Met/Not Met</td><td>Year End 2018</td><td>Eleven (11) of the eleven (11) positions were filled; Four (4) QI/UMC meetings were held in the reporting period with attendance
<table>
<tr><th>Role</th><th>Attended</th></tr>
<tr><td>CMO</td><td>4</td></tr>
<tr><td>Family Practitioner #1</td><td>3</td></tr>
<tr><td>Family Practitioner #2</td><td>3</td></tr>
<tr><td>Specialist #1 (ENT)</td><td>4</td></tr>
<tr><td>Specialist #2</td><td>Open</td></tr>
<tr><td>FQHC Provider</td><td>4</td></tr>
<tr><td>Pharmacy Provider</td><td>3</td></tr>
<tr><td>KR Dept of Public Health</td><td>1</td></tr>
<tr><td>Home Health/Hospice Provider</td><td>2</td></tr>
<tr><td>DME Provider</td><td>4</td></tr>
</table></td><td>☐ Goal Met</td></tr>
<tr><td>DHCS</td><td>Physician Advisory Committee (PAC)</td><td>Met/Not Met</td><td>Year End 2018</td><td>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.</td><td>☐ Goal Met</td></tr>
</table>

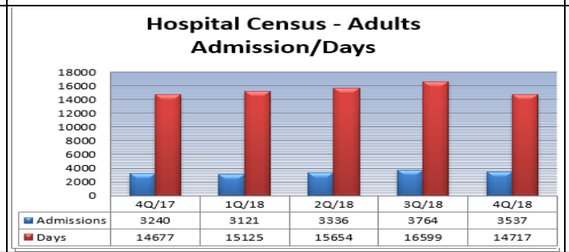
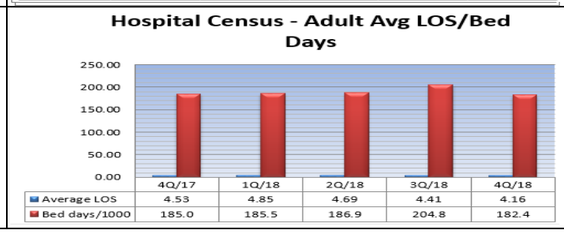
<table>
<tr><th>Required By</th><th>Goals</th><th>Metrics</th><th>Target Completion Date</th><th>Action Steps & Monitoring</th><th>Results</th></tr>
<tr><td>DHCS</td><td>Physician Advisory Committee (PAC)</td><td>Met/Not Met</td><td>Year End 2018</td><td>Ten (10) PAC meetings were held during the reporting 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>5</td></tr><tr><td>Clinical Psychologist</td><td>10</td></tr><tr><td>Eye Specialist</td><td>10</td></tr><tr><td>OB/GYN</td><td>6</td></tr><tr><td>Pain Medicine</td><td>9</td></tr><tr><td>Family Practitioner</td><td>9</td></tr><tr><td>Family Practitioner</td><td>8</td></tr></table></td><td>☐ Goal Met</td></tr>
<tr><td>DHCS</td><td>Pharmacy and Therapeutics Committee (P&T)</td><td>Met/Not Met</td><td>Year End 2018</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>☐ Goal Met</td></tr>
<tr><td>DHCS</td><td>Pharmacy and Therapeutics Committee (P&T)</td><td>Met/Not Met</td><td>Year End 2018</td><td>The Pharmacy and Therapeutics Committee has a total of (12) committee positions as follows:
<table><tr><th>Role</th><th>Attended</th></tr><tr><td>CMO</td><td>4</td></tr><tr><td>Retail Pharmacy/Independent</td><td>2</td></tr><tr><td>Pediatrician</td><td>4</td></tr><tr><td>Retail Pharmacy/Chain (Walgreens)</td><td>4</td></tr><tr><td>Board Member/RX Representative</td><td>4</td></tr><tr><td>Pharmacy/Spcialty Practice</td><td>Open</td></tr><tr><td>Pharmacy/Geriatric Specialist</td><td>4</td></tr><tr><td>Internal Medicine</td><td>2</td></tr><tr><td>General Practice/Cardiologist</td><td>2</td></tr><tr><td>General Practice/Geriatrics</td><td>Open</td></tr><tr><td>OB/GYN</td><td>4</td></tr><tr><td>KHS Director of Pharmacy/Alt Chair</td><td>4</td></tr></table></td><td>☐ 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 2018</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 every four months and provides recommendations and reports findings to the Board of Directors.</td><td>☐ 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 2018</td><td>PP/CAC has twelve (12) committee positions.
Nine (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>Role</th><th>Attended</th></tr><tr><td>Chair</td><td>4</td></tr><tr><td>Member</td><td>3</td></tr><tr><td>Member</td><td>3</td></tr><tr><td>Member</td><td>0</td></tr><tr><td>Community Representative</td><td>3</td></tr><tr><td>Community Representative</td><td>4</td></tr><tr><td>KC Department of Public Health</td><td>3</td></tr><tr><td>KC Department of Human Services</td><td>3</td></tr></table></td><td>☐ Goal Met</td></tr>
</table>

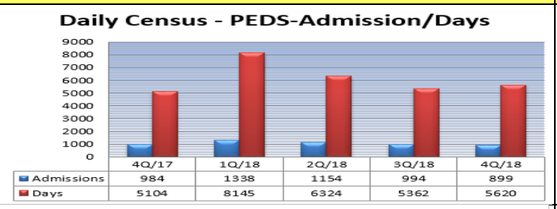
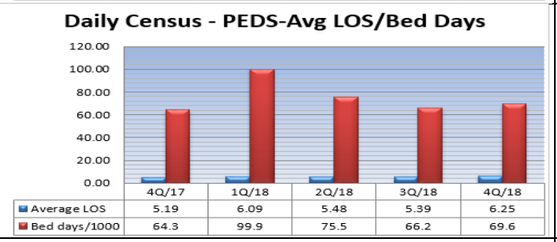
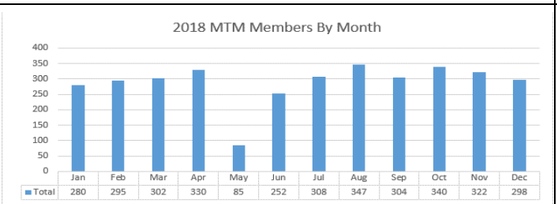
Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Utilization Management Process Policy/Procedure Revision/Development and Implementation	Met/Not Met	Year End 2018	1. UM Policies and Procedures are reviewed at least annually and updated at a minimum every 2-3 years. 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, Diabetes Prevention Program, Early and Periodic Screening, Diagnostic, and Treatment, Alcohol Misuse and Behavioral Counseling Interventions in Prmary Care, Mental Health Parity, Telehealth, Continuity of Care, Palliative, Transgender, Family Planning, Freestanding Birth Centers and Mid Wife Services, Blood Lead Screening, and others to meet the reporting and medical identification requirements set forth by the Department of Health Care Services (DHCS) in APL. Mega Regs and contract update necessitated multiple policy updates for 2018.	☐ Goal Met
UM	Revisions in Criteria and/or Approach to UM Activities	Met/Not Met	Year End 2018	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 are drafted in 2018 by the Senior 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. 6. As part of the JIVA Medical Management implementation project, KHS transitioned from static MCG criteria to interactive Care Web QI format that allows for interactive criteria application and detailed summary of decision making to providers	☐ Goal Met Next steps in CQWI JIVA implementation will be to incorporate a Point of Service Decision Making tool through a direct interface to the MCG criteria with the providers who submit authorization requests electronically via the Provider Portal.
UM	Monitoring UM Decision Turn-Around Times, Volume, and Denial Rates	Met/Not Met	Year End 2018	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.	☐ Goal Met for monitoring/oversight

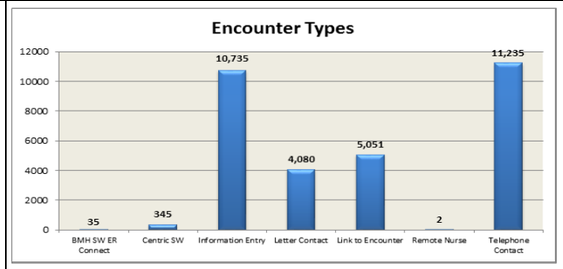
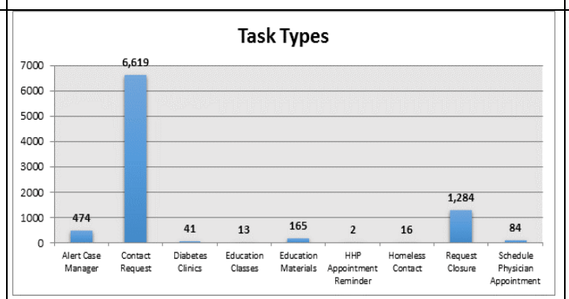
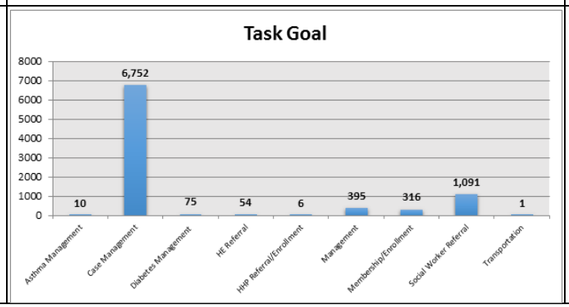
Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Timeliness of Decision Trending	Met/Not Met	Year End 2018	Quarterly audits are conducted to ensure compliance with regulatory requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy 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  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	☐ Goal Not Met Q4 >95% in 2018
UM	Timeliness of Decision Trending	Met/Not Met	Year End 2018		☐ Goal Not Met Q1 >90% in 2018
UM	Referral Count	Met/Not Met	Year End 2018		☐ Goal Met

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Denial % - Adults	Met/Not Met	Year End 2018		☐Goal Not Met overall average 21% which falls short of the <12% by recommended industry standard (CCS, other carve out services removed). Providers were re-educated on the documenation necessary for medical decision making. In addition, efforts for reducing overutilization of vascular studies heavily impacted the denial rate related to inappropriate requests for diagnostic and interventional services. Medical necessity denials related to no additional documenation not received led to an increase in administrative type denials. Modification were excluded as these represent approvals.
UM	Approved/Denied Adult Referral Count	Met/Not Met	Year End 2018		☐Goal Met
UM	Denial % - Peds	Met/Not Met	Year End 2018		☐ Goal Met- majority of denials related to carved out services; i.e. CCS, Kern Regional Center- not under KHS benefit
UM	Approved/Denied Peds Referral Count	Met/Not Met	Year End 2018		☐ 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>Monitoring of Emergency Services --Health Dialog</td><td>Met/Not Met</td><td>Year End 2018</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></th><th></th><th colspan="3">Downward Redirection</th><th colspan="3">Upward & Downward Redirection</th></tr><tr><th>Member's Initial Intended Treatment Plan or Setting</th><th>Number of Symptom Check Calls</th><th>DENOMINATOR</th><th>NUMERATOR</th><th>PERCENT</th><th>DENOMINATOR</th><th>NUMERATOR</th><th>PERCENT</th></tr><tr><td>Call 911</td><td>43</td><td>20</td><td>8</td><td>40.0%</td><td>20</td><td>8</td><td>40.0%</td></tr><tr><td>Emergency Room</td><td>871</td><td>297</td><td>200</td><td>67.3%</td><td>447</td><td>249</td><td>55.7%</td></tr><tr><td>Urgent Care</td><td>420</td><td>82</td><td>63</td><td>76.8%</td><td>111</td><td>84</td><td>75.7%</td></tr><tr><td>Call Provider or Office Visit</td><td>407</td><td>59</td><td>29</td><td>49.2%</td><td>243</td><td>134</td><td>55.1%</td></tr><tr><td>Home Treatment</td><td>485</td><td>N/A</td><td>N/A</td><td>N/A</td><td>393</td><td>283</td><td>72.0%</td></tr><tr><td>None</td><td>529</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td></tr></table></td><td>☐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>☐ Goal Met < ALOS 3.5 or less for acute setting</td></tr>
<tr><td>UM</td><td>Monitoring of Inpatient Admissions-Adults</td><td>Met/Not Met</td><td>Ongoing</td><td> 
</td><td>☐Goal Met</td></tr>
<tr><td>UM</td><td>Monitoring of Inpatient Admissions-Adults Average LOS</td><td>Met/Not Met</td><td>Year End 2018</td><td> 
</td><td>☐ Goal Met-based on all Levels of Care including SNF/LTC/Rehab</td></tr>
</table>

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Monitoring of Inpatient Admissions-PEDS	Met/Not Met	Year End 2018		☐ Goal Met
UM	Monitoring of Inpatient Admissions-PEDS Average LOS	Met/Not Met	Year End 2018		☐ Goal Met
UM	Transition of Care Program-30 day Readmissions	Met/Not Met	Year End 2018	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. Transitional care 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. MSW are placed in the TOC clinics to provide care coordination and resource information for housing, food, and other social determinants of health.	☐ Goal Met -readmission rate <12%
UM	Transition of Care Program-Medication Reconciliation with Pharmacist Education and intervention	Met/Not Met	Year End 2018		☐ Goal Met-cost savings experience in reduction in ER/UC utilization
CM	Case Management/Coordination of Care-Member Risk	Met/Not Met	Year End 2018	During the year of 2018, there were a total of 2,168 members that were managed by the CM Staff department. The majority of members from January through June of 2018 were high risk at 66%. 44% were low risk. In June we changed our medical documentation system and moved to measuring Acuity. From June to December, the Acuity was as follows: Acuity / Episodes 0 105 1 1,978 2 235 3 125 4 105	☐ Goal Met

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
CM	Case Management/Coordination of Care-Encounter	Met/Not Met	Year End 2018	 **Activity Type** / **Behavioral Health Case Management Episode** / **Case Management Episode** Fax: 164 / 485 Letter Contact: 678 / 1,755 Member Services: 57 / 105 Phone Call: 2,074 / 3,804 (blank): 1,526 / 4,502	☐Goal Met
CM	Case Management/Coordination of Care-Tasks	Met/Not Met	Year End 2018		☐ Goal Met
CM	Case Management/Coordination of Care	Met/Not Met	Year End 2018		☐ Goal Met

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Monitoring Under-utilization	Met/Not Met	Year End 2018	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. 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 monthly update 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.	☐ Goal Met
UM	Process for Monitoring Over-utilization	Met/Not Met	Year End 2018	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 Case Management social worker receives a report that identifies members with multiple ER and/or UC usage for review and follow-up. 2. This helps to identify PCP access issues, members needing guidance on medical services, needs for disease management, and inappropriate behavior of members seeking controlled drugs. Finding solution to ER Overutilization is a major focus for KHS and will continue to be included in the business's ongoing Projects plan. 3. Specialty referrals for the members are reviewed concurrently by the RN Clinical Intake Coordinators. 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.	☐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 2018	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.	☐ Goal Met -Medical Loss Ratio ongoing strategies for improvement ER Utilization Reduction-GOAL 42% 1-2 Day Inpt Stay Reduction-GOAL 36% 30 Day Readmission Reduction-GOAL 10% Potentially Preventable Admissions-GOAL 25% Tertiary LOS Reduction-GOAL 5.66 Tertiary Utilization/Redirection-GOAL $6.32 UCLA Redirection-GOAL 10 Urgent Care Utilization Reduction-GOAL 34.3
UM	CCS Collaboration	Met/Not Met	Year End 2018	Ongoing supportive and collaborative partnership with county CCS. KHS worked with CCS to identify transportation duplication among KHS membership. KHS has co-located a CCS staff RN for an intergrative approach for managing the bifurcated benefits based on diagnosis to reduce/eliminate duplication and or delay in services.	☐ Goal Met
UM	Health Home Program	Met/Not Met	Year End 2018	Six (6) Health Home-like models were implemented in 2018 in preparation of teh State HHP program preparedness on 7/1/2019. within contracted Provider Network to provide holistic whole person medical, social, and Behavioral health services to members in a new care delivery model. Care coordination is among the core elements of the program to ensure timely and robust medical and behavioral managemetn of chronic conditions while addressing the social determinants impacting the members' health and quality of life.	☐ 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 MCG Clinical guideline Integration	Met/Not Met	Year End 2018	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.	☐ Goal Met MCG CWQI incorporated into the Medical Management Implementation JIVA UM platform November 2018. ☐ Goal Not Met MCG Point of Service module will be added in July 2019-delays due to configuration and certification issues with JIVA Medical Managment platform.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Physician Profiling	Met/Not Met	Year End 2018	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, HEDIS/MCAS 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 burden administrative burden to the provider, reduce medical costs, and reward providers whose pracrtice patterns are aligned with industry standards that in turn improve health and consistency among the community providers.	☐Goal Met 2D profiling will be used by Medical Mgmt and Executives for physician trending and educational opportunities conducted by KHS clinical staff. Phase 2 of the Physician Profiling project is anticipated to be completed by Q3 2019.
UM	Medical Management Platform	Met/Not Met	Year End 2018	UM/CM/DM/HE workflow implementation in June 2018. QI was implemented in October 2018 to promote full Health Services oversight of each members' complete medical management history and care coordination. Health Homes module scheduled for final entry 6/2019	☐ Goal Met

KERN FAMILY HEALTH CARE
UTILIZATION MANAGEMENT
2019 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, Mental Health, 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

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
- 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 but is not limited to:

- History and physicals
- Office and ancillary service notes
- Treatment plans and Progress notes
- Health Risk Assessments
- Psychosocial history
- Risk Stratification
- Diagnostic results, such as laboratory results, or x-rays
- Specialty Consultation reports, including photographs, operative, and pathology reports
- Pharmacy profiles
- Telehealth communications
- Hospital records
- Behavioral Health/Mental Health
- Information regarding benefit

The review considers individual patient needs and the characteristics of the local delivery system. Based on patient circumstances, applicable UM criteria may be modified to a given instance. The relevant circumstances, described below, are discussed with the physician/practitioner reviewer and requesting physician in order to render an appropriate decision:

- Age
- Comorbidities
- Complications
- Home environment, as appropriate
- Progress toward accomplishing treatment goals
- Family support
- Psychosocial situation and needs
- Benefit structure including coverage for post-acute or home care when needed
- Delivery system capabilities and limitations such as availability of behavioral health care
- services, skilled nursing facilities, sub-acute care facilities or home care in the service area that supports the patient after discharge

Local hospitals' ability to provide all recommended services within the estimated length of stay
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
- Autism Spectrum Disorder/Behavioral Intervention Services
- Concurrent review
- 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 (CBAS)
- Respite Care (DHCS approved KHS benefit enhancement)
- Pulmonary Rehabilitation(DHCS approved KHS benefit enhancement)
- Maternity Care
- Gender Dysphoria
- Acupuncture
- Chiropractic
- Dental Anesthesia
- Genetics
- Major Organ Transplants (kidney, cornea)
- Durable Medical Equipment (DME)/Prosthetics and Orthotics (P&O)/Soft Goods
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplemental Shift Nursing Services
- External (Out-of-Plan) referrals (including post stabilization care requests)
- Discharge planning/Rehabilitation Services
- Occupational and Physical Therapy Services
- Speech and Language Therapy 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
- Pain management
- Spinal Cord Stimulators for the Management of Chronic Pain
- 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
- 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
- Clinical staff training for quality and accuracy

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.

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) and Behavioral Intervention services with Kern Regional Center (KRC) through a Memorandum of Understanding. This coordination is essential in order to provide members with uninterrupted medical 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 including Diabetic clinics, and the member's practitioner.

Authority and Responsibility

KHS Board of Directors

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

Structure

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

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

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

Monitor the following activities delegated to the KHS Chief Medical Officer or designee:

- Oversight of the UM Program
- Chairperson of the QI/UM Committee
- Chairperson of associated subcommittees
- Supervision of Health Services staff to include UM, QI, Pharmacy, Health Homes (HHP), 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 administrative processes and direction for the overall UM Program initiated through the Chief Medical Officer.

<u>Chief Medical Officer (CMO) Responsibilities:</u>

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: Senior 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.

Medical Director (s):

The 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. The Medical Director (s) 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;
- Direct responsibility for prior authorization review and medical necessity determinations based on application of evidence based medical criteria and MCAL established guidelines;
- Identify fraud, waste, and abuse through multi-disciplinary internal staff participation;
- Obtains support of the medical community for QI, UM, DM, HE, HHP, 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;
- 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 results of site reviews to ensure patient safety
- 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 (OPEN) and ENT
1	Participating Home Health/Hospice Representative
1	Kern County Public Health Officer or designee
1	Participating FQHC Provider
2	Other Participating Ancillary Representatives-Durable Medical Equipment and Independent Pharmacy
1	Participating Hospital Representative
1	OPEN

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

Meeting Schedule

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

Physician Advisory Committee (PAC)

Key Responsibilities

- Serve as advisor to the Board of Directors on health care issues, peer review and provider discipline. Review and comment on Credentialing/Recredentialing Policies and Procedures;
- Review and comment on other issues such as grievances and/or appeals, provider quality issues, and other peer review matters as directed by the KHS Chief Medical Officer or designee or as requested by the Board of Directors;
- Perform assigned functions under the Credentialing policies and procedures, the QI program, the UM program, the complaint/grievance process, and the practitioner/provider organizations appeal process;
- Serve as the committee for clinical quality review of contracting providers;
- Evaluate, assess and make decisions regarding contracting provider issues, grievances and clinical quality of care issues referred by the KHS CMO or designee and develop and recommend actions plans as required;
- Review provider qualifications, including adverse findings and recommend to the Board of Directors approval or denial of participation with initial credentialing and every three years in conjunction with recredentialing. When indicated, the time frame form credentialing/recredentialing may be shortened. Report Board action regarding credentialing/recredentialing to the QI/UMC at least quarterly;
- Review contracting providers referred by the KHS CMO or designee due to grievance and/or complaint trend review, other quality indicators or other information related to contracting provider quality of care or qualifications;
- Review, analyze and recommend any changes to the KHS Credentialing and Recredentialing program policies and procedures on an annual basis or as deemed necessary;
- Monitor any delegated credentialing/recredentialing process, facility review and outcomes for all delegated actions related to providers;
- Review and distribute preventive care guidelines for members, including infants, children, adults, elderly, Seniors and Persons with Disabilities, and perinatal patients;
- Base preventive care and disease management guidelines on scientific evidence or appropriately established authority;
- Develop, review and distribute disease management and behavioral health guidelines for selected diagnosis and treatments administered to members;

- Periodically review and update preventive care and clinical practice guidelines as presented by the CMO or designee;
- Review and assess new medical technologies and new applications of existing technologies for potential addition as covered benefits for members;
- Assess standards of health care as applied to members and providers, assist with development of indicators for studies and review guidelines that are promulgated to contracting providers;
- 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-PCP-(1) OPEN
1	General Internist
1	Pediatrician
1	Obstetrician/Gynecologist
1	Non-invasive Specialist-Clinical Psychologist
1	Invasive Specialist-Pain Medicine
1	Practitioner at Large-Ophthalmology
1	OPEN

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

Meeting Schedule
The PAC meets monthly or more frequently if necessary.

Reporting Relationship

- The PAC reports recommendations to the QI/UM Committee quarterly
- The QI/UM Committee reports PAC recommendations to the Board of Directors quarterly through the Chief Medical Officer or their designee.

Pharmacy and Therapeutics Committee (P&T)

Key Responsibilities

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

Membership

1	KHS Chief Medical Officer (Chairperson) or designee
1	KHS Director of Pharmacy (Alternate Chairperson)
1	KHS Board Member/Rx Representative
1	Retail/Independent Pharmacy

1 Retail Chain Pharmacy
1 Pharmacy/Specialty Practice-OPEN
1 Pharmacy/Geriatric Specialist
1 Pediatrician
1 Internal Medicine
1 General Practice /Cardiologist
1 General Practice/Geriatrics-OPEN
1 OB/GYN Practitioner

Meeting Schedule
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)
3 KHS Members
2 KHS Members-OPEN
2 Community Representatives
2 Participating Health Care Practitioner-OPEN
1 Kern County Department of Public Health Representative
1 Kern County Department of Human Services

The PP/CAC meets at least quarterly with additional meetings as necessary.

Grievance Review Team (GRT)

The GRT provides input towards satisfactory resolution of member grievances and 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
1 KHS Director of Pharmacy
1 KHS Senior Director of Health Services, or designee
1 KHS Director of Member Services

Meeting Schedule Grievance Review Team meets on a weekly basis or sooner if necessary.

Program Staff Responsibilities

Chief Executive Officer (CEO)

Appointed by the Board of Directors, the CEO has the overall responsibility for KHS management and viability. Responsibilities include:

- Lead KHS mission, vision and direction, organization and operation;
- Developing strategies for each department including the QI Program; Human Resources direction and position appointments;
- Fiscal efficiency;
- Public relations;
- Governmental and Community liaison;
- Contract approval.

The CEO directly supervises the Chief Operating Officer (COO), Chief Financial Officer (CFO), Chief Medical Officer (CMO), Chief Information Officer (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;
- 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

- 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
- 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
- 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.

Senior Director of Health Services

Under 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 and Disease Management, Health Education, and Quality Improvement.

Position requires a licensure to practice as a Registered Nurse in the State of California. Qualifications for the Senior Director of Health Services include two years of management level experience in utilization management in managed care environment AND one year of experience as a utilization review or medical (physical medicine) nurse OR four years of experience as a utilization review or medical (physical medicine) nurse AND two years of supervisory experience; OR any equivalent combination of experience. A Bachelor's degree in Nursing is desirable.

The Senior Director of Health Services will provide direct clinical support to the Directors of the Health Services department for both operational and strategic management.

The Senior Director is responsible for overseeing the development of quality improvement strategies for the enterprise and clinical program development for population-based clinical quality measures. In addition, the position is responsible for directing the development of the clinical quality plan and the integration of quality into the overall business process to ensure that all activities are relevant and meeting the needs of the population served.

Other responsibilities include:

- 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;
- 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.

Director of Utilization Management

Under the direction of the Senior Director of Health Services, the Director of Utilization Management 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 UM Director will assist in the implementation of the KHS Utilization Management Program Plan and Evaluation and communicate with contract providers regarding required studies and participation. Related duties will include ongoing data collection, medical record reviews, report writing, and collaboration and coordination with other KHS departments, as well as outside agencies.

The Director of UM provides 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.

This position is responsible for collaborative oversight of the Utilization Management functions for KHS. The UM Director will also be responsible for overseeing the production, analysis, and dissemination of contractually mandated reports. This position will assist in ensuring

compliance with Medi-Cal contractual stipulations for Utilization programs. In collaboration with the Senior 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 Senior Director of Health Services for activities within the Utilization Management departments;
- Shares in direction and supervision for ongoing and new projects for the UM program with the Senior Director of Health Services;
- Oversees quality of care investigations and reporting;
- Works closely with the Director of Case Management 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 Health Services 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.

<u>Health Services Manager</u>

The Health Services Manager reports to the Senior 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 Medical Management systems as it relatesto the UM and Pharmacy processes;
- Generates reports for CMO and Senior Director of Health Services to support business decisions;
- Research and analyze qualitative and quantitative data, prepare statistical reports, and submit final report to the state contract manager in conjunction with KHS departmental Analyst(s) 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 Senior Director of Health Services.

<u>UM Outpatient Clinical Supervisor</u>
The UM Outpatient Clinical Supervisor reports to the Director of Utilization Management 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 Director of UM to ensure smooth, efficient and productive operations within the UM Department, as directed by the Senior 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 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 Director of Utilization Management and is responsible for supervising the functions and activities for clinical level positions associated with Inpatient Medical, Mental, Behavioral, and Social Services within the UM Department. The UM Inpatient Clinical Supervisor will work in a coordinated effort with the Director of UM to ensure smooth, efficient and productive operations within the UM Department, as directed by the Senior 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;
- Assists with coordinating discharge planning activities with facility discharge planners;
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan e.g. CCS, Mental Health, Long Term Care, State Waiver Programs.
- Works closely with the Transitional Care team to facilitate needs for members identified as High Risk or requiring coordination of services;
- Identify members who may quality for the Health Homes Program;
- 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.

Health Services Program Administrator

The Program Administrator is responsible for oversight, coordination, planning, management, execution, and finalization of Business related programs that require Business resources. The Program Administrator will be required to conduct program analysis, comprehend technical requirements, define plans for execution, coordinate technical resources assigned to tasks or programs, create program tracking reports, and accurately report to all levels of management on a program(s) status. This position requires the ability to maintain an interdependent relationship with providers, staff and members by providing administrative support on sponsored projects.

- Consult with medical, business, and community groups to discuss service problems, respond to community needs, coordinate activities and plans, and promote programs;
- In a liaison role, assist in the design, review and testing of system generated processes used within KHS;
  Perform complex analytics in support of the overall achievement of strategic goals set out by the Board of Directors and Chief Executive Officer;
- Works closely with the Business Intelligence (BI) 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.

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;
- 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.

<u>UM Nurse and Clinical Intake Coordinators (RN /LVN)</u>
Under the direction of the Kern Health Systems (KHS) Director of Utilization Management, the UM Nurse and Clinical Intake Coordinators will promote coordination and continuity of care and quality management in both the inpatient and ambulatory care settings by the review of referrals and authorization of payment for specialty care and ancillary services. The UM Nurse and Clinical Intake Coordinators are supported by a Non Clinical team for administrative duties and coordination. The review will evaluate the appropriateness of care using established criteria and Plan benefit guidelines. Review will be conducted on a prospective, concurrent, and retrospective basis. The UM Nurse and Clinical Intake Coordinators manages the required caseload 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, Health Home, 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.

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 Director of Utilization Management and in coordination with the Kern Health Systems (KHS) Chief Medical Officer or designee, the Medical Claims Review RN will be responsible for retroactive review of medical service claims and disputes for payment and medical necessity following accurate contract and non-contract guidelines for both Inpatient and Outpatient services. The review will evaluate the appropriateness of care using established criteria and Plan benefit guidelines.

- Reports, track and documents all claims and disputes review activity in appropriate programs such as QNXT, as well as specially developed internal logs for tracking and trending purposes;
- Perform retro review and approval of specialty and ancillary services referrals using established criteria for purposes of payment;
- Perform retro review and approval of hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership;

- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan e.g. CCS, Long Term Care, State Waiver Programs.

UM Social Worker (MSW)/Licensed Clinical Social Worker (LCSW)

The Master of Social Worker or Licensed Clinical Social Worker primary duties are to identify and assist members that are displaying a complex variety of social and or emotional needs and usage of services reflective of abuse, lack of compliance to medical or pharmaceutical instructions, or self-destructive habits. The MSW or LSCW coordinates with these members and the member's PCP in an effort to provide better medical management and to track and gauge the effectiveness of that effort.

- Responsible for the promotion of coordination, continuity of care and quality improvement in both the inpatient and ambulatory care settings;
- Assists the members with psychosocial and discharge planning needs as well as community resources;
- Performs reviews available reports for frequent usages of services and inappropriate usage of services by members;
- Identifies environmental impediments to client or patient progress through both personal or telephonic interviews and review of medical records;
- Investigates suspected child/elder abuse or neglect cases and notify authorized protective agencies when necessary.
- Refers member to community resources to assist in recovery from mental or physical illness and to provide access to services such as financial assistance, legal aid, housing, or education.
- Advocates for members to resolve crises and demonstrate proficiency in de-escalation and interventional techniques
- Provides assistance and education to members as appropriate and in coordination with disease management, works to improve member participation in regular testing and screening along with follow-up visits to their PCP;
- Works collaboratively with the Care Management team to assist with identified social issues;
- Provide guidance and recommendations for the Behavioral and Mental Health Benefits (mild to moderate), including Autism Spectrum Disorders and Behavioral intervention.

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

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.

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;
- Coordination for opioid prescriptions and safeguards to prevent overutilization;
- Creation of clinically efficacious and cost-effective management programs;
- Development, implementation, and monitoring of clinical strategies to improve quality of care for members as well as provide clinical consultative services to contracting providers and KHS staff as necessary to support clinical programs;
- Oversight of clinical programs with supervision of the Pharmaceutical Program prior authorization process enabling open lines of communication with pharmacy providers on issues related to the KHS Formulary, pharmacy policies and procedures;
- Oversight and management of all clinically related activities with the KHS Pharmacy benefits staff.

Pharmacist

This position is responsible for executing the adherence of the Formulary and associated activities regarding pharmaceuticals for a Knox-Keene licensed health maintenance organization (HMO). Development and maintenance of protocols for disease state management that involves pharmaceuticals while serving as a liaison with pharmaceutical vendor representatives and other vendor representatives regarding pharmaceutical issues is critical to ensure appropriate medication decision making.

Pharmacy Technician

Support the KHS Director of Pharmacy in pharmacy activities related to the review, authorization and TAR preparation 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.

UM Department Orientation/Onboarding

Upon completion of the company orientation provided by Human Resources, all new employees assigned to UM for 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 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 with bi-annual assessment through the MCG IRR training module for Medical Directors and Clinical Intake Coordinators and UM Nurse staff. The Director of UM selects specific topics for completion by the Medical Directors, Clinical Intake Coordinators and UM Nurse staff. 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.

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
- 2019 DHCS Contract Exhibit
- DHCS MMCD Letters
- DHCS APL
- DMHC PL
- Knox Keene License
- CMS Federal Regulations

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. 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 utilizes both internal MD staff as well as contracted vendor(s), Advanced Medical Review (AMR), for medical necessity reviews as additional guidance and evidence based scholarly references to ensure appropriate medical decision making.

Independent Medical Review

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

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

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

timeline. The designated turnaround times will align with all DHCS timelines for medical decision making as outlined in KHS contract.

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 medical management documentation platform, JIVA system by Zeomega, to house all clinical information for each member. All health services departments with the exception of Pharmacy, have been implemented on the new platform in 2019.Out of Plan Referrals

Prior authorization is required for all out of plan referrals requesting consultation and/or treatment. Physician requested Out of Area/Out of Network referrals are processed through Provider Relations Department with Letters of Agreement (LOA) for financial reimbursement methodology.
Delegation of Utilization Management Functions

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

UM Delegation to Affiliated Providers

When UM activities are delegated to contract affiliated providers, KHS retains responsibility and oversight of the delegated functions. The delegation is subject to an executed delegation agreement in which UM activities are clearly defined, including:

- Reporting requirements for the delegated entity;
- Reporting requirements for KHS to the delegated entity;
- Evaluation process of the delegated entity's responsibilities;
- KHS Approval of the delegated entity's UM program and processes;
- Mechanisms for evaluating the delegated entity's program reports;
- The delegated entity's ability to collect performance data necessary to assess member experience and clinical experience, as applicable;
- KHS right to revoke and terminate a delegation agreement.

On an annual basis, KHS performs a comprehensive assessment of the delegated UM activities

to include a UM file review. The entity's annual evaluation of delegated UM functions and assessment summaries of activities are presented to KHS Medical leadership for review and approval.

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

Utilization Management Decision Timeframes

Decisions to approve, modify, or deny a requested health care service are based on medical necessity and urgency of the request, and are appropriate for the nature of the member's condition.

When the member faces an imminent and serious threat to his or her health, including, but not limited to, potential loss of life, limb, or other major bodily function, decisions to approve, modify or deny requests from provider, shall be made in a timely fashion appropriate for the nature of the member's condition, not to exceed 72 hours after the Plan's receipt of the information reasonably necessary and requested by the Plan to make a determination.

Second Opinions

Members have a right to a second opinion by a qualified medical professional. A request for second opinion is reviewed to determine whether KHS has appropriately qualified medical professionals with knowledge and expertise in the member's condition who can evaluate the member and provide a second opinion. If so, the member is re-directed within the plan to obtain

a second opinion. When an appropriate, qualified physician is not available within the plan, an out of area/out of network referral with LOA is authorized.

Standing Referrals

Occasionally a member will have a disease that requires prolonged treatment by or numerous visits to a specialty care provider. Once it is apparent that a member will require prolonged specialty services, UM may issue a standing referral. A standing referral is an authorization that covers more visits than an initial consultation and customary follow-up visits and typically includes proposed diagnostic testing or treatment.

A standing referral may be limited by number of visits and/or length of time. It is only valid during periods when the member is eligible with KHS.

A standing referral may be issued to contracted or non-contracted providers as deemed appropriate by the Chief Medical Officer, or their designee(s). The Director of Provider Relations will negotiate letters of agreement for services not available within the network. Members with a need for a standing referral are referred to providers who have completed a residency encompassing the diagnosis and treatment of the applicable disease entity.

Completion of Covered Services

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

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

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

Durable Medical Equipment (DME)

Provider requests for DME, including Prosthetics and Orthotics (P&O), requires prior authorization and benefit coverage review using DME Formulary UM criteria. In the event a request does not meet DME UM criteria, a Medical Director reviews the request for

medical appropriateness. All DME benefit decisions are made by trained staff; medical necessity denial decisions are rendered by KHS Medical directors and appropriate denial notices are issued to the provider and member by KHS.

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
- All criteria are available to the public upon request.

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. 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.

An Inter-Rater Reliability (IRR) process is deployed to evaluate and ensure that UM criteria are applied consistently for UM decision-making. Bi-annually, both physicians and staff involved with making UM decisions participate in the IRR process.

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 reviewed to analyze unfulfilled authorizations or gaps in care to determine interventions directed to ameliorate any identified adverse trends.
- At least quarterly, the Health Services Director's meet quarterly with the CMO and Medical Directors to review trends in utilization across all UM functions to determine if fraud, waste, abuse, or quality concerns warrant investigation. 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.

Medical Loss Ratio

Medical Loss Ratio (MLR) is a metric used in managed health care and health insurance to measure medical costs as a percentage of premium revenues. KHS has placed major emphasis on the reduction of MLR to monitor and manage utilization within the health plan. Areas of focus include achieving an overall Key Performance Indicators (KPI) metrics Goal of <92% across all lines of business-SPD, Family/Other, and Expansion. Dashboards have been created for transparency of all identified KP.

Emergency Services and Hospital Admissions Out of Plan Screening and Stabilization

KHS does not require prior authorization for emergency services. Post- service claims review (for out of plan emergency care) considers whether the member's decision to present to the Emergency Department was reasonable under the circumstance.

Post-stabilization

KHS requires review and authorization for all out of plan post- stabilization care, and follows all statutory requirements and accreditation standards in making post- stabilization care authorization decisions.

Resource Management

Resource Management activities focus on the prudent and clinically appropriate allocation of resources for the provision of health care services. These activities are not subject to direct regulation under the Knox-Keene Act. The UM Program monitors and provides oversight of coordinated performance related to Utilization/Resource Management across the continuum to include:

- Drug Utilization
- Laboratory Utilization
- Product Utilization
- Radiology Utilization
- Surgical Utilization

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 for member discharge planning. Additionally, KHS Facility Based UM Nurses perform concurrent inpatient review for members in local 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 by our hospitalist or the RN.

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, social determinants, 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 Transitional Care Clinics are designed to address potentially avoidable readmission, recidivism, and improve health through member empowerment and early intervention.

Case Management

Case Management (CM) in the UM department is a diverse system of care coordination. Members with catastrophic illnesses are case managed by the UM Case Managers. This coordination of the member's care enables the case manager to assess individual need, identify and plan resources, monitor, track, and evaluate the care being provided. Case management for the member may be short term or ongoing based on their individual needs. CM coordinates all medically necessary services with the Care Management staff within QI to ensure that all appropriate services are reviewed and any identified barriers to care are removed.

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

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

- Promotion and support of the Medical Home as the source of the member's primary healthcare and source of specialty referrals, and enhancing this with the necessary social, care management and medical support to facilitate comprehensive patient-centered planning

- Identification and elimination of potential barriers to seeking and receiving appropriate care within their designated medical home (e.g., housing, transportation, child care, nutrition, mental and behavioral health needs, identification of culturally competent providers and appropriate access, discharge and transitional care planning, health education, etc.)

    Potential assessment and education modules may include:

    1. Social needs
    2. Medical and/or behavioral health home
    3. Appointment attendance
    4. Urgent symptom management
    5. Medication and treatment adherence
    6. Behavioral risk
    7. Condition-specific self-management

As a result of this assessment, the Case Manager will:

- Contact the Primary Care Physician as needed to identify areas where he/she would like assistance (e.g., improving medication compliance)
- Identify communication preferences when more than one provider is involved in the medical care (e.g., does the PCP prefer all coordination go through his/her office or should the disease manager reach out to the specialist as appropriate?)
- Determine the type and frequency of information the PCP wants going forward
- Develop the person-centered care plan in conjunction with the PCP using predictive modeling risk scores with clinical based rules and medical management platforms (e.g., Milliman Care Guidelines, KHS internal criteria, etc.)

The following processes and activities are in place for Case Management/Coordination of Care as part of the Transition of Care Program:

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

The Complex Case Management Group consists of members identified through a Predictive Modeler identifying high risk scores above 0. 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:

- 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
- Medication reconciliation
- Offer health education services
- Emergency room avoidance program
- Homeless identification and care coordination
- Transportation
- Mental and behavioral health care coordination
- Implement continuous quality improvement activities
- Post discharge and Transitional Care clinic
- Maternal Pre and Post Natal Depression

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 with discrimination clauses and tagline notations.

When a physician requests a health care service that is subject to prior authorization and the request has been reviewed, denied, delayed, or modified as a result of UM review, the member and provider are provided a written communication that includes the following required elements:

- A clear and concise explanation of the reasons for the Plan's decision;

• A description of the utilization review criteria used, and the clinical reasons for the decision regarding medical necessity;
• Information as to how the member may file a grievance or appeal with the Plan and, in case
of Medi- Cal members, information and explanation on how to request an administrative hearing in compliance with Title 22 of the California Code of Regulations;
• Notice of availability of language assistance services;
• Written notice to physicians or other health care providers of a denial, delay, or modification of a request, including the name and telephone number of the health care professional responsible for the decision. The telephone number is a direct number or an extension that allows the physician or health care provider easy access to the professional responsible for the UM decision. UM staff and physicians are available during normal business hours to assist members and physicians with UM concerns;
• Written Notice to the physician and member includes information on Independent Medical Review.

Denial notices are issued in accordance with applicable regulations and accreditation standards. The Department of Health Care Services and Department of Managed Health Care provide direction to and oversight of the process of issuing written notification of non-coverage to KHS members.

Appeal Process

KFHC members are notified in writing of his/her right to appeal through the Member Grievance Process within the Notice of Action letter correspondence. 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.

All KHS members have the right to ask for an expedited decision on prior authorization or concurrent requests for health care services and supplies, and/or expedited review of decisions to terminate health care services. When a member's life, health, or ability to regain maximum function could be jeopardized using standard utilization review time frames, or when a provider familiar with the member's clinical situation states that the need for review is urgent, the appeal is expedited.

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 mental 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 Mental health benefit in addition to contracting with the Kern Behavioral Health and Recovery Services (KBHRS) through a Memorandum of Understanding (MOU) and other contracted provider groups for their covered services. 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 when transitioning between mild to moderate and extreme and pervasive mental health conditions. .

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.. 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. KHS is responsible for coverage of the BHT benefit which includes non-ASD diagnosis and provides Continuity of Care for the defined members.

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

Health Home Program

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.

KHS is responsible for providing the following six core HHP services:

- Comprehensive care management,
- Care coordination,
- Health promotion,
- Comprehensive transitional care,
- Individual and family support, and
- Referral to community and social support services.

Program eligibility is based on meeting a set of chronic physical/Substance Use Disorder (SUD) or Severe Mental Illness (SMI) conditions as well as specified acuity criteria. The HHP will serve as the central point for coordinating patient-centered care and will be accountable for:

- Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based Long Term Services and Supports (LTSS), palliative care, and social support needs
- Reducing avoidable health care costs, including hospital admissions/readmissions, Emergency Department visits, and nursing facility stays

Improving member outcomes and reducing health care costs will be accomplished through the partnership between KHS and the Community Based Care Management Entities (CB-CME), either through direct provision of HHP services, or through contractual or non-contractual arrangements with appropriate entities that will be providing components of the HHP services and planning and coordination of other services.

The HHP is structured as a health home network with entities functioning as a team to provide whole-person care coordination as outlined by the Department of Health Care Services. These include but not limited to:

• *Improve care coordination.* A primary function of the HHP is to provide increased care coordination for individuals with chronic conditions. This increased care coordination will be provided through HHP Services, which include homelessness, physical and behavioral health, and care coordination.

• *Integrate palliative care into primary care delivery.* To strengthen the foundation for palliative care delivery, palliative care will be included in an HHP member's needs assessment. Care coordinators may also emphasize the importance of using advanced directives and Physician Orders for Life-Sustaining Treatment (POLST) forms.

• *Strengthen community linkages within health homes.* Linkages to housing and social services are critical to providing comprehensive care coordination in HHP. Requirements for strong linkages to, and assistance and follow-up with, community resources will ensure that these resources are available to HHP members. In addition to linking and coordinating available social services, the multi-disciplinary care team will also encourage HHP members to participate in evidence-based prevention programs such as diabetes management and smoking cessation, and other available programs that are documented to use best practices and have positive outcomes. Information about the availability of these programs will be provided to the member.

• *Strengthen team-based care, including use of community health workers/promotores/other frontline workers.* HHPs will be required to have team-based care, including community health workers where appropriate. Because of the linkages to housing and other social services, and

potential outreach activities, community health workers will have a role in providing HHP services.

• Improve the health outcomes of people with high-risk chronic diseases.

To date, KHS has fully implemented four (6) HHP facilities in collaboration with our Federally Qualified Health Center (FQHC), public hospitals, and community at large providers. Two additional locations are in progress with an anticipated implementation of early 2020.

Transitional Care Program

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;
- 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

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 Medical Officer or designee and the Senior Director of Health Services to identify specific areas requiring a need for process improvement.

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

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.

Delegation of UM Activities

KHS has delegation oversight activities/processes for pre-delegation evaluation, delegation oversight activities, and regular reporting used to monitor delegates according to the standards established by KHS, licensing and regulatory bodies. KHS may delegate Utilization 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 assigned MCALMembers whose UM functions are delegated as part of a two-way agreement under contractual requirement with DHCS. Joint Operations meetings are conducted quarterly in addition to an annual delegation audit to ensure compliance with DHCS regulatory requirements.

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 supports a member initiated Health Library to promote education on a varying number of topics. Reports are generated monthly to monitor their activities as well as identify member patterns during execution of after hour services. Joint Operations meetings are conducted quarterly to ensure compliance with DHCS regulatory requirements.

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

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 CMO, Senior Director of Health Services and other Clinical leadership, provides direct oversight to all KHS medical audits and other inquiries by our regulatory agencies, DHCS and DMHC. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QI/UM Program. CAPs for medical matters are approved and monitored by the QI/UMC.

Integration of Study Outcomes with KHS Operational Policies and Procedures

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

Statement of Conflict of Interest

UM decision-making is based on established criteria, appropriateness of care and service, and existence of coverage. KHS does not provide financial incentive for practitioners or other individuals conducting utilization review for denials of services or coverage. All committee members are required to sign a conflict of interest statement. Committee members cannot vote on matters where they have an interest and must be recuse until the issue has been resolved.

Statement of Confidentiality

Health Insurance Portability and Accountability Act (HIPAA)

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

Confidentiality
To ensure member and practitioner information is held in strict confidence, to safeguard the information received, and to protect against defacement, tampering or use by unauthorized persons or for unauthorized purposes, all member specific information, documents, reports, committee minutes and proceedings are protected from inadvertent release and discovery. All staff members sign a confidentiality statement as a condition of employment. All documentation and information received are confidential and distributed only on a need-to- know basis. Access to this information is restricted to a need-to-know basis. The proceedings and records of the continuous review of the quality of care, performance of medical personnel, utilization of

services and facilities and costs are subject to confidential treatment under Health and Safety Code 1370 and Section 1157 of the California Evidence Code.

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 Senior Director of Health Services; Director of Health Education and Cultural and Linguistics, Director of Case and Disease Management; Director of Pharmacy; and Director of Utilization 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.

UM Program Integration with KHS Quality Management Program

The UM Program is an integral part of the KHS Quality Management Program and incorporates quality, risk and safety processes and initiatives into prospective, concurrent r e v i e w . Identification of quality, safety and risk incidents, patterns and trends through UM clinical review are escalated to the appropriate quality department in a timely manner. Results of

monitoring and analysis of utilization of care and services, including over- and under-utilization trends, are integrated into the KHS Quality Program through reports to the Program's Quality Committees. Utilization reports that display metrics across regional, service area, and medical center level performance are collected and analyzed to identify improvement opportunities, ensure consistency, and decrease variation in practice and care delivery.

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.

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KHS Board of Directors (Chair) Date

_____

Chief Executive Officer Date

_____

Chairman QI/UMC Date