

**KERN HEALTH SYSTEMS**  
**Quality Improvement Program Description**  
**2023**

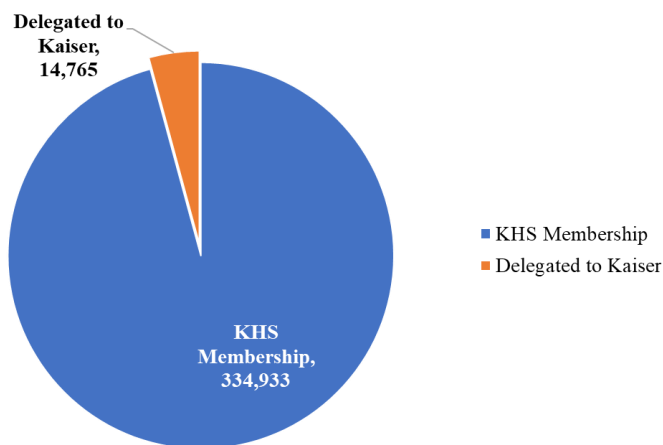
**I. Background**

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 Plan (MCP). 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.

KHS’ total membership in 2023 is ~350,000 members with 49% assigned to the County Hospital system and two large Federally Qualified Health Centers (FQHC). 4% of the membership is delegated to Kaiser.

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.



Characteristics of KHS’ population include

- 46% are male and 54% are female
- 70% of the population have English as their primary language and 29% use Spanish. The remaining 1% is a mix of other languages
- As of 2021, Kern County ranked 51<sup>st</sup> out of 58 for residents with a high school diploma or higher and 47<sup>th</sup> out of 58 with a Bachelor’s degree or higher.

- A majority of members reside in Bakersfield. However the remaining 33.1% are in more rural areas.

Area	Rural Portions per HRSA	KHS Population	Percentage
Bakersfield	N	223,973	66.9%
Delano & North Kern	Y	30,610	9.1%
Arvin/Lamont	Y	21,978	6.6%
Shafter/Wasco	Y	21,596	6.4%
California City & Southeast Kern	Y	9,434	2.8%
Taft & Southwest Kern	Y	8,897	2.7%
Tehachapi	Y	5,632	1.7%
Ridgecrest & Northeast Kern	Y	4,883	1.5%
Lake Isabella & Kern River Valley	Y	4,023	1.2%
Lost Hills & Northwest Kern	Y	2,194	0.7%
Frazier Park & South Kern	Y	1,244	0.4%
Outside Service Area	N/A	465	0.1%

- The following is a breakdown by race and ethnicity of KHS' population

Ethnic or Racial Group	% KHS Enrollment
Hispanic	63%
Caucasian	17%
No valid data, unknown or other	11%
Black/African American	6%
Asian Indian	1%
Filipino	1%
Asian/Pacific	1%

Kern County's service area has been challenged with provider shortages. Large portions of the county are designated as Health Professional Shortage Areas (HPSA) and Medical Underserved Areas/Populations (MUA/P). This issues are more severe and prevalent in Kern County than other counties within California. The following 4 rural areas are in this classification.

- Taft
- Lost Hills/Wasco
- Fort Tejon
- Lake Isabella

Additional facts about Kern County's Health Behaviors as presented by [County Health Rankings & Roadmaps](#) include **higher rates** of adult smoking, adult obesity, physical inactivity, alcohol-impaired driving deaths, sexually transmitted infections, and teen births compared to state-wide statistics. Kern County **ranked better** than California state averages for the food environment index (combination of % of low income and low access to a grocery store), and excessive drinking.

Health Factors			
Health Behaviors	Kern (KE) County	California	United States
Adult Smoking	15%	10%	16%
Adult Obesity	36%	26%	32%
Food Environment Index	7.4	8.9	7.8
Physical Inactivity	33%	22%	26%
Access to Exercise Opportunities	82%	93%	80%
Excessive Drinking	16%	19%	20%
Alcohol-Impaired Driving Deaths	32%	28%	27%
Sexually Transmitted Infections	763.8	599.1	551.0
Teen Births	32	16	19

## II. 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 participate in the Quality Improvement (QI) program.

## III. Purpose

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

KHS recognizes that a strong QI Program must be the foundation for a successful Managed Care Plan (MCP). 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.

KHS' Quality Improvement Program is composed of several systematic processes that monitor and evaluate the quality of clinical care and health care service delivery to KHS members. This structure is designed to:

- Monitor and identify opportunities to monitor, evaluate, and take action to address needed improvements in the quality of care delivered by all KHS network providers rendering services to KHS members.
- Maintain a process and structure for quality improvement with contracting providers that includes identification of quality of care problems and a corrective action process for resolution for all provider entities.
- Promote efficient use of health plan financial resources.
- Identify health disparities and take action to support health equity.

- Oversee and direct processes affecting the quality of covered health care services delivered to members, either directly or indirectly.
- Monitor and improve the quality and safety of clinical care for covered services for KHS members.
- Ensure 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).

This is accomplished through the development and maintenance of an interactive health care system that includes the following elements:

1. Development and implementation of a structure for monitoring, evaluating, and taking effective action to address any needed improvements in the quality of care delivered by all KHS network providers rendering services to KHS members.
2. A process and structure for quality improvement with contracting providers. This includes identification of quality of care problems and a corrective action process for resolution for all provider entities.
3. Oversight and direction of processes affecting the quality of covered health care services delivered to members, either directly or indirectly.
4. Assurance 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. Monitoring and improvement of the quality and safety of clinical care for covered services for members.

**IV. 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. Results of the evaluation are considered in the subsequent year's program description. 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, 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. This includes 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. Monitoring and oversight of delegated activities.
6. Performing tracking and trending on a wide variety of information, including
  - Over and underutilization data,
  - Grievances,

- Potential and actual quality of care issues,
  - Accessibility of health care services,
  - Compliance with Managed Care Accountability Set (MCAS) preventive health and chronic condition management services,
  - Pharmacy services, and
  - Primary Care Provider facility site and medical record reviews to identify patterns that may indicate the need for quality improvement and that ensure compliance with State and Federal requirements.
7. Promoting awareness and commitment in the health care community toward quality improvement in health care, safety, and service.
  8. Continuously identifying opportunities for improvement in care processes, organizations or structures that can improve safety and delivery of health care to members.
  9. Providing appropriate evaluation of professional services and medical decision making and to identify opportunities for professional performance improvement.
  10. Reviewing concerns regarding quality of care issues for members that are identified from grievances, the Public Policy/Community Advisory Committee (PP/CAC), or any other internal, provider, or other community resource.
  11. Identifying and meeting external federal and state regulatory requirements for licensure.
  12. Continuously monitoring internal processes in an effort to improve and enhance services to members and contracting providers.
  13. Performing an annual assessment and evaluation of the effectiveness of the QI Program and its activities to determine
    - a. How well resources have been deployed in the previous year to improve the quality and safety of clinical care,
    - b. The quality of service provided to members, and
    - c. Modifications needed to the QI Program.
 Results of the annual evaluation are presented 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 KHS members. This may range from choice of contracted provider to the provision and a commitment to activities that improve clinical quality of care (including behavioral health), promotion of safe clinical practices and enhancement of services to members throughout the organization.

This year, KHS is developing a Health Equity Program that will integrate and coordinate with the QI Program. The Health Equity Program includes assessment of needs based on race/ethnicity, language, cultural preferences, health disparities and stakeholder engagement. Understanding health disparities is critical to identify the differences in treatment provided to members of different racial/ethnic or cultural groups that are not justified by the underlying health conditions or treatment preferences of patients. KHS will implement multiple programs to monitor, assess and improve healthcare services to reduce health disparities within its membership.

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.
  - a. 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.
  - b. KHS will arrange covered services in a culturally and linguistically appropriate manner. The QI Program reflects the population served and applies equally to covered medical and behavioral health services.
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. New this year is the addition of street medicine providers. Street medicine provider refers to a licensed medical provider who conducts patient visits outside of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be living.
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 Public Policy/Community Advisory Committee (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 Kern County Behavioral Health and Recovery Services (KBHRS) pursuant to a contract between the County and the State.

Application of the Quality Improvement Program occurs with 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 improvement, utilization management, risk management, credentialing, member's rights and responsibilities, and preventive health & health education.

As part of KHS' commitment to ensure the rights of our members to quality health care, the following 6 Rights to Quality Health Care have been adopted.

1. Right to Needed Care
  - Accurately diagnosed and treated
  - Care is coordinated across all the doctors and specialists
2. Right to Equitable Care
  - All people, regardless of their gender, race, ethnicity, geographical location, or socioeconomic status receive the good quality health care they need
  - Developing culturally competent care; for example, by expanding medical translation services, after-hours appointment, mobile health clinics or telehealth, etc.
3. Right to Place of Care
  - Did the patient go to the right place for care?
  - Is the patient going to the ER or Urgent Care for primary care?
  - Is the patient transitioned to the right place for care?
4. Right to Timely Care
  - Timely access to care
  - How long did the patient have to wait to get health care appointments and telephone advise?
  - Is the patient up to date with their preventative care?
5. Right to Be Part of Your Care
  - Patients and their families are part **of the care team** and play a role in decisions.
  - Information is shared fully and in a timely manner so that patients and their family members can make informed decisions.
6. Right to Safe Care
  - Conduct continuous quality assurance and improvement
  - Customer and provider satisfaction surveys or interviews
  - Chart audits
  - Site reviews
  - Administration of medications

V. **Authority:** Lines of authority originate with the Board of Directors and extend to contracting providers.

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, effectiveness evaluation, 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 Public Policy/Community Advisory Committee (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):
  - i. Oversight of the QI Program
  - ii. Chairperson of the QI/UM Committee
  - iii. Chairperson of associated subcommittees
  - iv. Supervision of Health Services staff
  - v. Oversight and coordination of continuity of care activities for members
  - vi. Proactive incorporation of quality outcomes into operational policies and procedures
  - vii. Oversight of all committee reporting activities 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 (CMO):** 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: Director of Quality Improvement, Director of Health Education and Cultural & Linguistics Services, Population Health Management (PHM) Director, Utilization Management (UM) Director, Pharmacy Director, and other related staff
  - i. Supervision of all Quality Improvement Activities performed by the QI Department

- j. Monitoring covered medical and behavioral health care provided to ensure they meet 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 a designee performing the functions of the CMO when the CMO position is not filled.

- 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. They provide the following functions.

Peer review, address quality of care issues and recommend provider discipline and Corrective Action Plans.

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.

Development of 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. **Drug Utilization Review (DUR) Committee (DURC):** Serves to objectively appraise and evaluate, and select pharmaceutical product utilization for appropriateness and potential Fraud, Waste, and Abuse for formulary addition or deletion to ensure the optimal use of therapeutic agents. The DURC meets quarterly to review products to evaluate efficacy, safety, and ease of use. cost. Medications are evaluated on their clinical use policies are developed for managing drug use and administration. Concepts outlined in the Substance Use-Disorder

Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT Act) are monitored and enacted.

The Medi-Cal Rx Pharmacy Benefit Management organization, Magellan, assumed operations occurred January 1, 2022

- 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.
- c. **Managed Care and Accountability Set (MCAS) Committee:** develops a tiered, multi-pronged approach to improve on all health care quality measures identified by the CA Department of Health Care Services (DHCS). These measures are focused on preventive health care and chronic condition management needs for Medi-Cal members. The committee monitors the status of KHS' performance with these measures and modifies strategies and interventions accordingly.
- d. **Grievance Review Committee (GRC):** provides input towards satisfactory resolution of member grievances and determines any necessary follow-up with Provider Network Management, Quality Improvement, Pharmacy and/or Utilization Management.

**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 their 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 for quality and timeliness of UM decisions, referrals, 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, Director of Quality Improvement, 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 quality improvement actions and ensure follow-up
  - vi. Develop and assign responsibility for achieving goals
  - vii. Monitor quality improvement, including compliance with MCAS preventive health and chronic condition management measures
  - 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 underutilization 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. 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.
  - vi. 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 CMO or designee (Chairperson)
  - ii. 2 Participating Primary Care Physicians
  - iii. 2 Participating Specialty Physicians
  - iv. 1 Federally Qualified Health Center (FQHC) Provider
  - v. 1 Pharmacy Provider
  - vi. 1 Kern County Public Health Officer or Representative
  - vii. 1 Home Health/Hospice Provider
  - viii. 1 DME Provider

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 CMO 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 CMO (Chairperson)
- ii. 1 Family Practice Providers
- iii. 1 Pediatrician
- iv. 1 Obstetrician/Gynecologist
- v. 1 Eye Specialist
- vi. 1 Pain Medicine Provider
- vii. 1 Cardiologist
- viii. 1 Internal Medicine Provider

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. 1. Drug Utilization Review Committee (DUR):**

a. **Role** – The DUR Committee monitors medication prescribing practices by providers, assesses usage patterns by members, and assists with study design and clinical guidelines development.

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

- i. Monitor for quality issues regarding appropriate drug use for KHS and members. This includes Drug Utilization Review (DUR) and Drug Use Evaluation (DUE) programs; Retrospective reviews focused on:
    - Early fill/completion factor
    - Duplication of therapy
    - Therapeutic duplications
    - SUPPORT ACT: concurrent therapy with opioids
  - ii. Provide recommendations regarding protocols and procedures for the use of non-formulary medications.
  - iii. Provide recommendations regarding educational materials and programs about drug products and their use to contracting providers.
  - iv. 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.
  - v. Monitor and assess contracting pharmacy activities as needed through review of audits and pharmacy profiling.
  - vi. Participate in the DHCS' DUR Board and other DHCS organized pharmacy meetings.
  - vii. Complete DHCS annual report to CMS as it pertains to KHS.
- c. **Structure** – The QI/UM Committee has delegated the responsibility of oversight of pharmaceutical activities related to members to the DUR 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 CMO (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 Geriatric Pharmacist
  - vii. 1 General Practice Provider
  - viii. 1 Pediatrician
  - ix. 1 Internal Medicine Provider
  - x. 1 Obstetrician/Gynecologist
  - xi. 1 Provider at Large
- d. **Meetings** – The DUR Committee meets quarterly with additional meetings as necessary.

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

- a. **Role** – The Kern Family Health Care (KFHC) Public Policy/Community Advisory Committee (PP/CAC) provides participation of members in the establishment of public policy of KFHC. Public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and



convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public.<sup>1</sup>

- b. **Function** – The functions of the PP/CAC are as follows:
- i. Ensure culturally appropriate service or program design;
  - ii. Establish priorities for health education and outreach program;
  - iii. Evaluate member satisfaction survey results and identify opportunities for improvement and act on them;
  - iv. Evaluate health education and cultural and linguistic Population Needs Assessment to identify opportunities of need and improvement and act on them;
  - v. Establish plan marketing materials and campaigns;
  - vi. Communication of needs for provider network development and assessment;
  - vii. Identify community resources and information to support KHS member needs;
  - viii. Periodically review the KHS grievance processes;
  - ix. Report program data related to Case Management and Disease Management to provide input and recommendations;
  - x. Review changes in policy or procedure that affects public policy;
  - xi. Advise on educational and operational issues affecting members who speak a primary language other than English;
  - xii. Advise on cultural and linguistic issues.

- c. **Structure** – The PP/CAC is delegated by the KHS 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 through the Quality Improvement/Utilization Management Committee.

Appointed members include:

- i. 1 Ex-officio Non-Voting Member: KHS Director of Marketing and Public Affairs (Chairperson)
- ii. 1 Member of the KHS Board of Directors
- iii. 7 KFHC Members (minimum to ensure at least 51% of committee members are plan enrollees)
- iv. 1 Participating Health Care Provider
- v. 1 Kern County Department of Human Services Representative
- vi. Kern County Department of Public Health Representative
- vii. 2 Community Representatives

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

## 5. **Managed Care Accountability Set (MCAS) Committee**

*This committee has been placed on hold temporarily and replaced with a rapid response, Strike Team. The primary function of the Strike Team is to address*

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<sup>1</sup> Knox Keene § 1369; Rule § 1300.69(b) (2)

*non-compliance with MCAS measures from Measurement Year (MY) 2021 and anticipated non-compliance for MY 2022. The MCAS Committee will be re-evaluated for role and function after the Strike team has raised KHS above the Red Tier level of compliance. Criteria for each level of MCAS compliance are outlined in the table below.*

<b>Tiers</b>	<b>Green Tier</b>	<b>Orange Tier</b>	<b>Red Tier</b>
<b>Criteria</b>	No more than 1 MCAS measure below the Minimum Performance Level (MPL) per health domain	2 or more MCAS measures below the MPL in any one (1) health domain	3 or more MCAS measures in 2 or more health domains

The following Role, Function, Structure, and Meetings will remain as outlined below. However, the committee will be temporarily on hold as described above. As part of resumption of the committee, evaluation of these committee components will be re-evaluated and updated based on the outcomes and learnings from the Strike Team work.

1. **Role** – The purpose of the Kern Health Systems (KHS) Managed Care and Accountability Set (MCAS) Committee is to provide direction and oversight of KHS’ level of compliance with the MCAS measures. It also includes direction, input and approval of KHS’ strategies and actions to meet or better compliance with the minimum performance level (MPL) for each MCAS measure as set by the Department of Health Care Services (DHCS).
2. **Function** – functions of the MCAS Committee include:
  - i. Regularly evaluate the status of compliance with each MCAS measure designated by DHCS using reports and other data to identify strengths and opportunities.
  - ii. Establish an organization-wide strategic action plan to address opportunities with MCAS measures.
  - iii. Evaluate outcomes of the strategic action plan and modify the strategy and actions as appropriate.
  - iv. Assure that all departments who influence member and provider compliance with MCAS measures actively participate in development and implementation of strategic planning and interventions.
  - v. Ensure that adequate policies and procedures exist and are up to date to support KHS’ compliance with MCAS measures.
  - vi. The Executive Sponsor and Chairperson provide an annual update to KHS’ Quality Improvement-Utilization Management Committee (QI-UMC) summarizing our strategies and level of compliance with MCAS measures. Outstanding issues from the Committee may be advanced to KHS’ QI-UMC as needed.

- 3. Structure** – The MCAS Committee includes the following KHS staff
- i. Chief Medical Officer
  - ii. Chief Health Services Officer
  - iii. Administrative Director, Health Homes Program
  - iv. Director of Business Intelligence
  - v. Director of Case (CM) & Disease Management (DM)
  - vi. Director of Compliance & Regulatory Affairs
  - vii. Director of Health Education and Cultural and Linguistics Services
  - viii. Director of Marketing and Public Relations
  - ix. Director of Member Services
  - x. Director of Pharmacy
  - xi. Director of QI
  - xii. Director of UM
  - xiii. Provider Relations Manager
  - xiv. QI Manager
  - xv. QI MCAS Lead Registered Nurse (RN)
- 4. Meetings** – The Committee meets at least every quarter and more frequently as needed.

**6. Grievance Review Committee (GRC)**

- a. Role** – The GRC provides input towards satisfactory resolution of member grievances and determines any necessary follow-up with Provider Network Management, Quality Improvement, Pharmacy and/or Utilization Management.
- b. Function** - functions of the GRC 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 timeframe.
  - 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 CMO (Chairperson) or designee
  - ii. 1 KHS Director of Member Services or designee
  - iii. 1 KHS Director of Provider Network Management or designee
  - iv. 1 KHS Chief Operations Officer or designee
  - v. 1 KHS Grievance Coordinator (Staff)

- vi. 1 KHS Director of Compliance and Regulatory Affairs or designee
- vii. 1 KHS Director of Quality Improvement or designee
- viii. 1 KHS Pharmacy Director or designee

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

The Director of Member Services provides performance reports at least quarterly to the QI/UM Committee.

**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), CMO, 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 CMO 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 CMO 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 their 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 Drug Utilization Review (DUR) 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 Network Management 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. **Director of Quality Improvement** - 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 other healthcare field from an accredited college or university. A minimum of five years of experience in a managed health care organization and a minimum of 3 years staff and program management experience. The Director of Quality Improvement 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 Director of Quality Improvement dedicates 100% of his/her time to the Quality Improvement Department and reports to the Chief of Health Services Officer. The Director of Quality Improvement is responsible for the oversight and direction of the KHS Quality Improvement staff. He/She 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 contracted/network 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 Director of Quality Improvement monitors the review and resolution of medically related grievances with the CMO and evaluates the effectiveness of QI systems.

4. **Quality Improvement Manager** – The Quality Improvement Manager possesses a master's degree in health or business administration or bachelor's or Associates Degree in Nursing and five (5) years of experience in the direct patient care setting or operations management, or teaching adult learners, **and**

one (1) year of experience in health care Quality Improvement, Utilization Management, or Process Improvement, and two (2) years of management experience.

Under the direction of the Director of QI, the QI Manager conducts oversight and management of state and regulatory and contractual compliance for the QI program. This includes managing the HEDIS and Managed Care Accountability Set (MCAS) audit and initiatives to improve health outcomes related to those measures. They also manage quality improvement initiatives for Performance Improvement Projects (PIPs), Improvement Plans (IPs), Facility Site Reviews (FSRs), delegation audits, and other external quality reviews. The manager applies clinical knowledge and analytical skills to manage and oversee day-to-day operations of the QI team.

5. **Quality Improvement MCAS/HEDIS Supervisor** – The QI Supervisor is a new position in 2022 and replaces the previous QI Operations Supervisor position. This position reports to the Chief Medical Officer. This position has a bachelor’s degree or higher in a healthcare related field with at least one (1) year of experience in Quality Improvement, and two (2) years of management and operations management, experience.

The QI RN Supervisor is responsible for supervising the day-to-day operations and activities of the clinical and non-clinical staff within the MCAS/HEDIS unit within the Quality Improvement department. The supervisor coaches, mentors, and leads team to ensure timely and accurate reporting to meet accreditation, regulatory requirements and performance measure targets. They works in a coordinated effort with the CMO and QI Director to ensure productive and efficient operations.

7. **QI Program Staffing** – the QI Director and Manager oversee a QI Program staff consisting of the following:
  - a. **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.
  - b. **Quality Improvement Program Manager** - The QI Program Manager possesses a bachelor’s degree or higher in Healthcare, Business, Data Science, Project Management or related field. They have at least 2 years’ experience in Quality Improvement or in a health care environment with relevant Quality Improvement experience. They also have at least two (2) years’ experience in project management work.

Under the direction of the Director of Quality Improvement, the QI Program Manager manages, plans, coordinates, and monitors Quality Improvement Special Programs including but not limited to:

- Annual Managed Care Accountability Set (MCAS) audit and measurement results submission,
  - QI Department Strategic Goals and Projects, and Special Programs (such as member incentives and engagement, DHCS-required project improvement plans, site reviews, etc.).
- c. **Senior QI Operations Analyst:** The Senior QI Operations Analyst reports to the QI Director and has a master's degree in Business, Statistics, Mathematics, or other related field with academic demonstration of analytical skills from an accredited school or equivalent AND three (3) years' working experience with a Managed Care Organization (MCO) or similar type organization.
- d. This position provides primary oversight, management and validation of data and reports submission for the annual DHCS MCAS/HEDIS audit. This includes serving as the liaison between the QI Department, vendors and internal KHS Department such as IT. They provide similar management and support for other department audits. They are responsible for providing operational department support for department processes, projects, or other assignments and provide data and reports for ongoing activities such as performance improvement projects.
- e. **Senior Quality Improvement Coordinator** - The QI Senior QI Coordinator roles report to the QI Manager or QI MCAS/HEDIS Supervisor depending upon the team assigned. He/she is a high school graduate and is licensed/certified in CA as either a certified medical assistant (CMA) or licensed vocational nurse (LVN) with either five (5) years of experience for a CMA or two (2) years experience for a LVN in a physician's office.

The Senior QI Coordinator assists in department functions related to data collection, data entry, report preparation, record maintenance, and collaboration with other departments, regulatory and contracted agencies. This position will work extensively with MCAS methodology, data collection and intervention development and implementation. The Senior QI Coordinator assists with medical record requests and record preparation for any QI activity. The role also provides administrative support for provider site review activities.

**VIII. Program Information** – KHS utilizes information provided through the Information Technology (IT), Operations and Provider Network Management departments. Information includes but is not limited to claims, UM data, case management and care coordination 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 Quality Improvement Manager on an annual basis and is presented to the PAC, QI/UMC and Board of Directors for review and approval. Timelines and responsible parties are designated in the Work Plan.
2. The Work Plan includes the objectives and scope of planned projects or activities that address the quality and safety of clinical care and the quality of service provided to members.
3. After review and approval of quality study results including action plans initiated by the QI/UMC, KHS disseminates the study results to applicable providers. This can occur by specific mailings or KHS' Provider bulletins to contracting providers.
4. The activities in the QI Work Plan are annually evaluated for effectiveness.
5. QI Work Plan responsibilities are assigned to appropriate individuals.

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

1. **Quality Studies** – Studies are conducted across the spectrum of health care as described below.
  - a. **Primary Care Physician (PCP) and Specialist Access Studies** – KHS performs physician access studies per KHS Policy 4.30, Accessibility Standards. Reporting of access compliance activities is the responsibility of the Provider Network Management Manager 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 <sup>1</sup>	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 Director of UM 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. **Managed Care Accountability Set (MCAS)** – KHS is contractually required to submit data and measurement outcomes for specific health care measures identified by DHCS. The measures are a combination of ones selected by DHCS from the library of Healthcare Effectiveness Data and Information Set (HEDIS) and the Core Measures set from the Centers for Medicare and Medicaid Services (CMS). An audit is performed by DHCS’s EQRO to validate that the data collection, data used and calculations meet the specifications assigned by DHCS.

DHCS has established minimum performance levels (MPL) for several of the MCAS measures. This benchmark is the 50<sup>th</sup> percentile based on outcomes published in the latest edition of NCQA’s Quality Compass report and the National HMO Average. Results submitted to DHCS for the designated MCAS measures are compared to the NCQA benchmarks to determine the Managed Care Plan’s (MCP) compliance. When a MCP does not meet the 50<sup>th</sup> percentile or better for a measure we are held accountable to, DHCS may impose financial penalties and require a corrective action plan (CAP). The following table identifies the MCAS measures KHS is held accountable to meet the 50<sup>th</sup> percentile or better for measurement year (MY) 2023. Results for the 2022 measures will be calculated and submitted in report year (RY) 2023,

#	MEASURE Total Number of Measures = 36 (10 Hybrid and 26 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
<b>Behavioral Health Domain</b>				
1	Follow-Up After ED Visit for Mental Illness – 30 days*	FUM	Administrative	Yes
2	Follow-Up After ED Visit for Substance Abuse – 30 days*	FUA	Administrative	Yes
<b>Children’s Health Domain</b>				
3	Child and Adolescent Well- Care Visits*	WCV	Administrative	Yes
4	Childhood Immunization Status: Combination 10*	CIS-10	Hybrid/Admin**	Yes
5	Developmental Screening in the First Three Years of Life	DEV	Administrative	Yesiii
6	Immunizations for Adolescents: Combination 2*	IMA-2	Hybrid/Admin**	Yes
7	Lead Screening in Children	LSC	Hybrid/Admin**	Yes
8	Topical Fluoride for Children	TFL-CH	Administrative	Yesiii
9	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well- Child Visits*	W30-6+	Administrative	Yes
10	Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well- Child Visits*	W30-2+	Administrative	Yes
<b>Chronic Disease Management Domain</b>				
11	Asthma Medication Ratio*	AMR	Administrative	Yes

#	MEASURE Total Number of Measures = 36 (10 Hybrid and 26 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
12	Controlling High Blood Pressure*	CBP	Hybrid/Admin**	Yes
13	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%)*	HBD	Hybrid/Admin**	Yes
<b>Reproductive Domain</b>				
14	Chlamydia Screening in Women	CHL	Administrative	Yes
15	Prenatal and Postpartum Care: Postpartum Care*	PPC-Pst	Hybrid/Admin**	Yes
16	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	PPC-Pre	Hybrid/Admin**	Yes
<b>Cancer Prevention Domain</b>				
17	Breast Cancer Screening*	BCS	ECDS & Admin***	Yes
18	Cervical Cancer Screening	CCS	Hybrid/Admin**	Yes
<b>Report only Measures to DHCS</b>				
19	Ambulatory Care: Emergency Department (ED) Visits	AMB-ED ii	Administrative	No
20	Adults' Access to Preventive/Ambulatory Health Services	AAP	Administrative	No
21	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	Administrative	No
22	Antidepressant Medication Management: Continuation	AMM-Cont	Administrative	No

#	MEASURE Total Number of Measures = 36 (10 Hybrid and 26 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
	Phase Treatment			
23	Colorectal Cancer Screening*	COL-E	ECDS	No^^
24	Contraceptive Care—All Women: Most or Moderately Effective Contraception	CCW-MMEC	Administrative	No
25	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	CCP- MMEC60	Administrative	No
26	Depression Remission or Response for Adolescents and Adults	DRR-E	ECDS	No^^
27	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	ECDS	No^^
28	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	Administrative	No
29	Follow-Up After ED Visit for Mental Illness – 7 days*	FUM	Administrative	No
30	Follow-Up After ED Visit for Substance Use – 7 days*	FUA	Administrative	No
31	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase	ADD-C&M	Administrative	No
32	Follow-Up Care for Children Prescribed	ADD-Init	Administrative	No

#	MEASURE Total Number of Measures = 36 (10 Hybrid and 26 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
	Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Initiation Phase			
33	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Administrative	No
34	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	NTSV CB	Administrative	No
35	Pharmacotherapy for Opioid Use Disorder*	POD	Administrative	No^^
36	Plan All-Cause Readmissions*	PCR ii	Administrative	No
37	Postpartum Depression Screening and Follow Up*	PDS-E	ECDS	No^^
38	Prenatal Depression Screening and Follow Up*	PND-E	ECDS	No^^
39	Prenatal Immunization Status	PRS-E	ECDS	No^^
<b>Long Term Care Report Only Measures to DHCS</b>				
40	Number of Out-patient ED Visits per 1,000 Long Stay Resident Days*	HFS	Administrative^	No
41	Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization*	SNF-HAI	Administrative^	No
42	Potentially Preventable 30- day Post-Discharge Readmission*	PPR	Administrative^	No

i MCPs held to the MPL for the HEDIS® total rates only; the National Committee for Quality Assurance (NCQA) Quality Compass® Medicaid HMO 50th and 90th percentiles represent the MPLs and high-performance levels (HPLs), respectively.

ii Stratified by Seniors and Persons with Disabilities (SPDs) CMS calculated national median is considered the MPL

ECDS: Electronic Clinical Data Systems (electronic reporting method for certain HEDIS measures)

\* Measures must be stratified by race/ethnicity per NCQA categorizations.

\*\* Hybrid/Admin: MCPs/PSPs have the option to choose the methodology for reporting applicable measure rates

\*\*\* ECDS & Admin: MCPs/PSPs will calculate the measures based on MY 2023 ECDS methodology and MY 2022 Administrative methodology. MCPs/PSPs will only be held to the MPL for the MY 2022 Administrative methodology.

# CMS modified measure to reflect Medi-Cal and dual data sources

^ Measures to be calculated at the facility level for each MCP that can be aggregated to the plan level

^^ Measure will be held to the MPL in MY 2024

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.

Managed Care Plans are required to meet or exceed the performance levels set forth by Department Health Care Services (DHCS) as outlined in their contract. Based on KHS’ compliance level for MCAS measures for MY2021, KHS was placed in the red tier and is completing a cause-and-effect analysis to understand the barriers of not meeting the MPLs. Three areas were identified for improvement focus, which includes

- Data Accuracy, Completeness, & Timeliness,
- QI Training & Resources for KHS staff & providers, and
- Collaboration & Communication.

Strategies and key action items for the 3 focus areas are as follows:

- *Data Accuracy, Completeness, & Timeliness*
  - Strategy: Develop process for timely, complete, & accurate data to measure MCAS compliance for strategy development and outcomes analysis
  - Key Actions:
    - \* *Implement an organizational standard data QA process*
    - \* *Evaluate options to support consistent data exchange with providers*
    - \* *Analyze audit and perform risk management and remediation on any findings to close gaps*
    - \* *Analyze data by geographic areas and identify areas with higher gaps in care*

- *Special programs with providers in remote geographic areas (geographic barriers)*
    - *Mobile clinics in underserved areas*
    - *Onsite visits to LTC facilities*
  - \* *KHS members are stratified by Race, ethnicity & other SDoH data used to target interventions & develop special programs.*
  - \* *Utilization & outcome data is stratified to identify areas of underutilization such as low performance scores on preventive services*
    - *Target services for CHWs, home visits, doulas etc.*
    - *Basic Population Health Management Program supported with mobile clinics, and home visits to close gaps*
- **Training & Resources**
  - **Strategy:** Develop a quality education program to enable KHS staff & providers to develop & implement effective MCAS improvement strategies
  - **Key Actions:**
    - \* Develop e-learning courses for KHS staff & providers that align with industry-standard, QI principles and methods. Courses will cover current MCAS measures
    - \* Identify organizational structure for the role of a Health Equity Officer, as required in the DHCS CQS. This position will be responsible for carrying out the CQS strategies in collaboration with the Quality Improvement and Population Health Management departments
    - \* Identify and assess members risks guiding the development of care management programs and focused strategies
    - \* Create strategies to engage members as “owners of their own care”. Member Engagement Program - Develop a robust member and community engagement program
    - \* Develop communication strategies that will focus on keeping families and communities healthy via prevention
    - \* Create early interventions for rising risk and patient centered chronic disease management
    - \* Expand on programs that focus on whole person care for high-risk populations, addressing drivers of health
    - \* Implementation of strategic & corporate goals to incorporate equity in internal staffing recruitment, network development/expansion and implementation of PHM programs
- **Collaboration & Communication**
  - **Strategy:** To establish a communication process that supports strategic thought partnership, transparency, & decision-making for MCAS compliance throughout all levels of the organization.
  - **Key Actions:**
    - \* Executive Leadership Team will establish a process for communication & collaboration of QI strategies & activities at all levels of the organization.
    - \* Plan project with CHWs in underserved areas to engage and support members to close care gaps , home visits, working with community centers where members go to meet members,
    - \* Street medicine – leveraging CalAIM Incentive Program (HHIP)

- \* Schools with school wellness program, SBHIP (CalAIM Incentive program), use of school clinics for immunizations, screenings and possible health fairs to close gaps in care
- \* Partner with Department of Public Health for early pregnancy identification and support to initiate prenatal care
- \* ECM sites to close gaps in care,
- \* Utilize specialist for diabetes management for those with HgA1c above 9,
- \* PCP incentive programs supporting practice transformation
- \* Grant funding for telehealth
- \* Expand transportation providers for members in more remote areas of the county by partnering with CBOs and Provider Practices

As previously described, a Strike Team is in place to focus on initiatives that will improve KHS' MCAS scores. The strike team is made up of marketing/member engagement, business intelligence, provider network management, quality, and population health. With this diverse team, key strategies will be developed and monitored closely to identify what the most effective approach in getting members to close their gaps in care and into their primary care physicians for their preventive health services appointments.

3. **Performance Improvement Projects (PIPs)** – KHS is mandated to participate in two (2) PIPs. These PIPs span over an approximate 18-month time frame and are each broken out into four (4) modules. Each module is submitted to HSAG/DHCS for review, input, and approval incrementally throughout the project. For 2020 - 2<sup>nd</sup> Quarter of 2023, the following two (2) PIPs were approved by DHCS for KHS:
  - The first PIP is targeted on a health disparity as outlined in DHCS' Health Equity PIP Topic Proposal Form and is called, Disparities in Well Child Visits, Improving the Health and Wellness of Low-Income Children and Adolescents, Ages 3 to 21, Through Well-Care Visits. This PIP is focused on improving the health and well-being of children, ages 8 to 10 years, by aligning the Well Child Visit with industry standards of care and evidence-based practices.
  - The second PIP is focused on improving the health of members, ages 5-21 years with persistent asthma and who have a ratio of controller medication to total asthma medications of 0.5 or greater. It will focus on improvement opportunities for two member programs:
    - Asthma Mitigation Project (AMP)
    - Asthma Preventive Health Program

Both PIPs will be completed withing the 2<sup>nd</sup> quarter of 2023 and 2 new PIPs will be implemented in the 2<sup>nd</sup> half of the year at the direction of DHCS.

4. **Potential Inappropriate Care (PIC) Issues/Potential Quality of Care Issue (PQI)** - This is a possible adverse deviation from expected clinician performance, clinical care, or outcome of care. PICs are investigated to determine if an actual quality issue or opportunity for improvement exists. Based on definition changes



by DHCS, we are changing this term to Potential Quality of Care Issues (PQI). To ensure any grievance received/identified is evaluated for Quality of Care (QOC) issues, KHS has added an additional QI RN FTE dedicated to screening all grievances for a possible PQI. When a possible PQI is identified from a grievance, the QI RN summarizes their review and refers the grievance to the KHS' QI medical director for review, final determination of classification of the grievance as a QOC, and direction on any additional actions needed.

5. **Member Services** - The Director of Member Services presents reports regarding customer service performance and grievances monthly to the CEO, CMO and Chief Operations Officer. At least quarterly, reports are presented to the QI/UM Committee for review and recommendations.
6. **Prioritization of Identified Issues** – Action is taken on all issues identified to have a direct or indirect impact on the health and clinical safety of members. These issues are reviewed by appropriate Health Services staff, including the CMO, and prioritized according to the severity of impact, in terms of severity and urgency, to the member.
7. **Corrective Actions** – Corrective Action Plans (CAP) are designed to eliminate deficiencies, implement appropriate actions, and enhance future outcomes when an issue is identified. CAPs are issued in accordance with *KHS Policy and Procedure 2.70-I Potential Quality of Care Issues (PQI)*. All access compliance activities are reported to the Senior Director of Provider Network who prepares an activity report and presents all information to the CEO, CMO, Chief Operations Officer, Sen, and QI/UM Committee.
8. **Quality Indicators** – Ongoing review of indicators is performed to assess progress and determine potential problem areas. Clinical indicators are monitored and revised as necessary by the QI/UM Committee and PAC. Clinical practice guidelines are developed by the DUR 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 MCAS measures developed by NCQA and CMS. MCAS reports are produced annually as well as throughout the year 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 inpatient stay, as appropriate.

The QI Department reviews a sampling of hospital re-admissions that occurred within 30 days of the first hospital discharge each quarter to identify and follow-up on potential inappropriate care issues.

Any issue that warrants further investigation of potential inappropriate care is forwarded from the Utilization Management Department, Member Services Department, or any other KHS Department, to the QI Department for determination whether a PQI issue exists and follow up corrective action based on the severity level of PQI identified. These referrals may include member deaths, delay in service or treatment, or other opportunities for care improvement.

Grievances with a PQI identified are referred to the QI department as a PQI referral for further investigation and action. All potential quality of care issues are reviewed by KHS' CMO or their designee to determine the severity level and follow up actions needed. All cases are tracked and the data provided to the CMO or designee during the provider credentialing/re-credentialing process. Other actions may include tracking and trending a provider for additional PQIs and/or request(s) for a corrective action plan (CAP) for issues or concerns identified during review. The CMO or their designee may present select cases to the PAC for review and direction as needed.

- 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 Site and Medical Record Review** – Facility site and medical record reviews are performed before a provider is awarded participation privileges and every three years thereafter. As part of the facility review, KHS QI Nurses review for the following potential safety issues:
    - Medication storage practices to ensure that oral and injectable medications, and “like labeled” medications, are stored separately to avoid confusion.
    - The physical environment is safe for all patients, personnel, and visitors.

- Medical equipment is properly maintained.
  - Professional personnel have current licenses and certifications.
  - Infection control procedures are properly followed.
  - Medical record review includes an assessment for patient safety issues and sentinel events.
  - Bloodborne pathogens and regulated wastes are handled according to established laws.
- iii. **Coordination of Care Studies** – KHS performs Coordination of Care Studies to reduce the number of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days.
- iv. **Grievance Satisfaction Data** – KHS reviews Member grievances and satisfaction study results as methods for identifying patient safety issues.
- v. **Interventions** – KHS initiates interventions appropriate to identified issues. 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.
- b. **Fraud, Waste, and Abuse (FWA)** – The Quality Improvement Department provides support to KHS’ Fraud, Waste, and Abuse program in the following ways:
- i. **PQI Referrals** – In the course of screening and investigating PIC referrals, the QI Department consistently evaluates for any possible FWA concerns. All FWA concerns are referred to KHS’ Compliance Department for further evaluation and follow up.
- ii. **FWA Investigations** – The QI Department clinical staff may provide clinical review support to the Compliance Department for FWA referrals being screened or investigated.
- iii. **FWA Committee** – The Director of QI or their designee is an active member of KHS’ FWA Committee to provide relevant input and suggestions for topics and issues presented.
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. The Provider Network Management Department 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 CMO, with assistance from the Director of Quality Improvement, Pharmacy Director, Director of Health Education and Cultural & Linguistics Services, Director of Marketing, Director of Member Services and Deputy Director of Provider Network, 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 CMO 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:
  1. 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.
  2. An agreement to provide access to facilities, equipment, books, and records as necessary for audits or inspection to ascertain compliance with KHS requirements.
  3. Cooperation with the KHS QI Program including access to applicable records and information.
  4. 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 documents supporting UM, Grievance and Quality Improvement processes are securely 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 described in APL 20-006, Site Reviews: Facility Site Review and Medical Record Review 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 Network Management Department** – provider credentialing and recredentialing, using site visits to monitor safe practices and facilities.

