KERN HEALTH SYSTEMS

QUALITY IMPROVEMENT-UTILIZATION MANAGEMENT (QI-UM) COMMITTEE MEETING

Thursday, November 10, 2022
at
7:00 a.m.
VIRTUAL MEETING

2900 Buck Owens Blvd.
Bakersfield, CA 93308

For more information, call (661) 664-5000

AGENDA

Quality Improvement (QI) / Utilization Management (UM) Committee Meeting

Kern Health Systems
2900 Buck Owens Boulevard
Bakersfield, California 93308

VIRTUAL MEETING
Thursday, November 10, 2022

7:00 A.M.

All agenda item supporting documentation is available for public review at Kern Health Systems in the Administration Department, 2900 Buck Owens Blvd, Bakersfield, CA 93308 during regular business hours, 8:00 a.m.–5:00 p.m., Monday through Friday, following the posting of the agenda. Any supporting documentation that relates to an agenda item for an open session of any regular meeting that is distributed after the agenda is posted and prior to the meeting will also be available for review at the same location.

COMMITTEE MEMBERS: Yanis Almanza; Jennifer Ansolabehere, PHN; Satya Arya, MD; Debra Cox; Danielle C Colayco, PharmD; Allen Kennedy; Michael Komin, MD; Philipp Melendez, MD; Chan Park, MD; Martha Tasinga, MD, CMO

1) Quality Improvement – Utilization Management Committee Resolution to Allow Virtual Committee Meeting Participation Pursuant to Government Code Section 54953 (Fiscal Impact: None) - APPROVE

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

4) Announcements

5) CMO Report

CA-6) QI-UM Committee held in Q3 Summary of Proceedings– APPROVE

CA-7) Physician Advisory Committee (PAC) held in Q3 Summary of Proceedings – APPROVE

CA-8) Public Policy – Community Advisory Committee (PP-CAC) held in Q3 Summary of Proceedings – APPROVE

CA-9) Drug Utilization Review (DUR) Committee held in Q3 Summary of Proceedings - APPROVE

Pharmacy Reports
CA-10) Pharmacy TAR Log Statistics for Q3 2022 – RECEIVE AND FILE

Quality Improvement Reports
11) Quality Improvement Program Report for Q3 2022 – APPROVE
- QI Reporting for Q3
- Initial Health Assessment (IHA) Bi-Annual Audit Summary
- Potential Quality Issues (PQI) Audit Summary
- Policy 2.70-I Potential Quality of Care Issues (PQI)
- Policy 2.71-P Facility Site Review and Medical Records Review

Utilization Management Reports

12) Utilization Management Program Reporting for Q3 2022 – APPROVE
- UM Program Overview
- Delegated UM Functions

Kaiser Organization Summary Reports

CA-13) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**
- KFHC APL Grievance Report for Q3 2022 – RECEIVE AND FILE
- KFHC Volumes Report for Q3 2022 – RECEIVE AND FILE
- Kaiser Reports will be available upon Request

Population Health Management Reports

14) Population Health Management (PHM) Reporting for Q3 2022 – APPROVE

Member Services Reports

15) Grievance Operational Board Update for Q3 2022 – APPROVE
16) Grievance Summary Reports for Q3 2022 – APPROVE

Provider Network Management Reports

17) Credentialing Statistics for Q3 2022 – APPROVED
CA-18) Board Approved New & Existing Contracts Report – RECEIVE AND FILE
CA-19) Credentialing & Recredentialing Summary Report – RECEIVE AND FILED
CA-20) Network Review for Q3 2022 – RECEIVE AND FILE

Health Education Reports

CA-21) Health Education Activity Report for Q3 2022 - APPROVE

ADJOURN MEETING TO THURSDAY, MARCH 16, 2023 @ 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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

KERN HEALTH SYSTEMS

To: KHS QI-UM Committee

From: Martha Tasinga, MD, Chief Medical Officer

Date: November 10, 2022

Re: AB 361 Remote Meeting Resolution

Background

The Governor's executive order suspending certain requirements of the Brown Act regarding board meetings has expired, but the proclamation of a state of emergency is still in place. The Legislature has amended Govt Code 54953 to include provisions allowing remote meetings during a state of emergency under certain conditions. The attached resolution allows the Board and Committees to continue meeting remotely until the state of emergency is lifted and social distancing is no longer recommended or required. If the Committee adopts the resolution, it will have to renew the resolution every 30 days.

Recommended Action

The QI-UM Committee adopt the resolution and continue with remote meetings during the month of November 2022 or until the state of emergency is lifted.

KERN HEALTH SYSTEMS

RESOLUTION

In the matter of:

A RESOLUTION OF THE QI-UM COMMITTEE OF KERN HEALTH SYSTEMS PROCLAIMING A LOCAL EMERGENCY, RATIFYING THE PROCLAMATION OF A STATE OF EMERGENCY, AND AUTHORIZING REMOTE TELECONFERENCE MEETINGS FOR THE MONTH OF NOVEMBER 2022

Section 1. WHEREAS

(a) Kern Health Systems is committed to encouraging and preserving public access and participation in meetings of the QI-UM COMMITTEE; and

(b) Government Code section 54953, as amended by AB 361, makes provisions for remote teleconferencing participation in meetings by members of a legislative body, without compliance with the requirements of Government Code section 54953, subject to the existence of certain conditions; and

(c) a required condition is that there is a proclaimed state of emergency, and state or local officials have imposed or recommended measures to promote social distancing; and

(d) Governor Newsom declared a State-wide state of emergency due to the Covid-19 pandemic on March 4, 2020, which declaration is still in effect, and state and local health officials continue to recommend social distancing; and

(e) the QI-UM COMMITTEE does hereby find that the resurgence of the Covid-19 pandemic, particularly through the Delta variant, has caused, and will continue to cause, conditions of peril to the safety of persons that are likely to be beyond the control of services, personnel, equipment, and facilities of Kern Health Systems, and desires to proclaim a local emergency and ratify both the proclamation of state of emergency by the Governor of the State of California and the Kern County Health Department guidance regarding social distancing; and

(f) based on the above the QI-UM COMMITTEE of Kern Health Systems finds that in-person public meetings of the Board would further increase the risk of exposure to the Covid-19 virus to the residents of the Health Authority, staff, and Directors; and

WHEREAS, as a consequence of the local emergency, the QI-UM COMMITTEE does hereby find that it shall conduct committee meetings without compliance with paragraph (3) of subdivision (b) of Government Code section 54953, as authorized by subdivision (e) of section 54953, in compliance with the requirements to provide the public with access to the meetings as prescribed in paragraph (2) of subdivision (e) of section 54953; and

WHEREAS, all meetings of QI-UM COMMITTEE will be available to the public for participation and comments through virtual measures, which shall be fully explained on each posted agenda.

Section 2. NOW, THEREFORE, BE IT RESOLVED that the QI-UM COMMITTEE of Kern Health Systems hereby finds, determines, declares, orders, and resolves as follows:

1. This Committee finds that the facts recited herein are true and further finds that this Committee has jurisdiction to consider, approve, and adopt the subject of this Resolution.

2. Proclamation of Local Emergency. The QI-UM hereby proclaims that a local emergency now exists throughout the Health Authority, as set forth above.

3. Ratification of Governor's Proclamation of a State of Emergency. The QI-UM hereby ratifies the Governor's Proclamation of State of Emergency, effective as of its issuance date of March 4, 2021.

4. Remote Teleconference Meetings. The Chief Medical Officer, staff, and QI-UM COMMITTEE are hereby authorized and directed to take all actions necessary to carry out the intent and purpose of this Resolution including conducting open and public meetings in accordance with Government Code section 54953(e) and other applicable provisions of the Brown Act.

5. Effective Date of Resolution. This Resolution shall take effect on Nov. 1, 2022, and shall be effective until the earlier of Nov. 31, 2022, or such time the QI-UM COMMITTEE adopts a subsequent resolution in accordance with Government Code section 54953(e)(3) to extend the time during which Kern Health Systems may continue to teleconference without compliance with paragraph (3) of subdivision (b) of section 54953.

6. Termination of this Resolution. This Resolution will automatically terminate on the day that both the Governor's Declaration of Emergency and any local agency guideline for social distancing are no longer in effect.

The Clerk of the QI-UM COMMITTEE shall forward copies of this Resolution to the following:

Office of Kern County Counsel

Kern Health Systems

I, Amy Daniel, Clerk of the QI-UM COMMITTEE of Kern Health Systems, hereby certify that the following resolution, on motion of Director _____, seconded by Director _____, was duly and regularly adopted by the QI-UM COMMITTEE of Kern Health Systems at an official meeting thereof on the 10th day of NOVEMBER 2022, by the following vote and that a copy of the resolution has been delivered to the Chairman of the QI-UM COMMITTEE.

AYES:

NOES:

ABSENT:

_____
Amy Daniel, Clerk
QI-UM COMMITTEE
Kern Health Systems

SUMMARY OF PROCEEDINGS

Quality Improvement (QI) / Utilization Management (UM) Committee
(VIRTUAL) MEETING

Kern Health Systems
4th Floor Kern River Room
2900 Buck Owens Boulevard
Bakersfield, California 93308

Virtual Meeting
Thursday, July 28, 2022
7:00 A.M.

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Members Present: Yanis Almanza; Allen Kennedy; Danielle C Colayco, PharmD; Michael Komin, MD; Philipp Melendez, MD; Chan Park, MD; Martha Tasinga, MD, CMO

Members Absent: Jennifer Ansolabehere, PHN; Satya Arya, MD; Debra Cox

Meeting was called to order at 7:07 A.M. by Dr. Martha Tasinga, M.D., Chief Medical Officer

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STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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3) Announcements – **N/A**

4) Closed Session – **N/A**

5) CMO Report – **Dr. Martha Tasinga shared the following with the committee:**

   - **Katie Sykes, Consultant for Population Health Management is reviewing our current Model of Care (MOC) and updating it to include our PHM program changes in order to prepare for CalAIM.**

CA-6) QI/UM Committee Summary of Proceedings May 26, 2022 – APPROVED
Melendez-Kennedy: All Ayes

7) Physician's Advisory Committee (PAC) Summary of Proceedings 2nd Quarter 2022–RECEIVED AND FILED
Melendez-Kennedy: All Ayes
   - April 2022
   - May 2022
   - June 2022

CA-8) Public Policy and Community Advisory Summary of Proceedings 2nd Quarter 2022 – APPROVED
Melendez-Kennedy: All Ayes

CA-9) Drug Utilization Review Committee Summary of Proceedings-1st Quarter 2022-RECEIVED AND FILED
Melendez-Kennedy: All Ayes

Pharmacy Reports
CA-10) Pharmacy TAR Log Statistics 2nd Quarter 2022 – RECEIVED AND FILED
Melendez-Kennedy: All Ayes

Quality Improvement Department Reports
Melendez-Colayco: All Ayes

11) Quality Improvement Program Report 2nd Quarter 2022 – APPROVED
- Executive Summary

12) QI Annual Program Reports APPROVED
- 2021 QI Program Evaluation
- 2022 QI Program Description
- 2022 QI Program Workplan

Ms. Jane Daughenbaugh, Director of Quality Improvement, reviewed with the committee the executive summary for the 2nd Quarter of 2022 QI Department reports. Some key points discussed were:

1. **COVID-19 Updates**
   - **Due to the pandemic and stay-at-home directives, a backlog of Facility Site and Medical Records Reviews had evolved. Our target date for full resolution was June 30, 2022, and that target was met.**
2. **Potential Inappropriate Care (PIC) Notifications**
   - **PQIs dipped slightly in the 2nd quarter but were essentially consistent with the 1st quarter. The increase since the first quarter is due to a change in process to refer all grievances with a validated PQI to the Quality Department for a full investigation.**
3. **Quality Improvement Projects**
   - **Health Care Disparity – Well Care Visits**
   - **Child/Adolescent Health Asthma Medication Ratio**
   - **SWOT Analysis and Action Plan Project**
   - **PDSA's – Breast Cancer Screening and Well Care Visits with Clinica Sierra Vista.**
4. **MCAS Committee**
   - **The MCAS Audit and Rate Submission for MY2021 was completed by June 1st with final rates submitted to DHCS and NCQA. MY2021 resulted in 5 out of 15 measures meeting the minimum performance level and 9 out of 15 measures improved compared to the previous year.**

UM Department Reports – Melendez-Kennedy: All Ayes

13) Combined UM Reporting 2nd Quarter 2022 – APPROVED
- Executive Summary
- VSP DER Effectiveness Report
- VSP Medical Data Summary
- Policies and Procedures

Deborah Murr, Chief Health Services Officer, reviewed with the committee the UM Department reports. Some key points discussed were:

- **UM continues to implement an initiative to support the authorization compliance which includes enhancements to our Medical Management platform JIVA, increasing automation, and simplification of our prior authorization requirements.**
- **New projects include Long-Term Care, Community Support Services for Social Determinants of Health, Dual Special Needs Plan, and NCQA Accreditation.**

Kaiser Organization Summary Reports

CA-14) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**

- KFHC APL Grievance Report 2nd Quarter 2022 – RECEIVED AND FILED
- KFHC Volumes Report 2nd Quarter 2022 – RECEIVED AND FILED
- Kaiser Reports will be available upon Request

Member Services Department Summary Reports – Melendez-Kennedy: All Ayes

15) Grievance Operational Board Update – APPROVED
- Executive Summary
- 2nd Quarter 2022

16) Grievance Summary Reports – APPROVED
- Executive Summary
- 2nd Quarter 2022

Provider Network Management Department Summary Reports
Park-Kennedy: All Ayes

17) Re-credentialing Report 2nd Quarter 2022 – APPROVED
CA-18) Board Approved New Contracts Report – RECEIVED AND FILED
CA-19) Board Approved Providers Report – RECEIVED AND FILED
CA-20) Provider Relations Network Review Report 2nd Quarter 2022 – RECEIVED AND FILED
- Executive Summary

Melissa Lopez, provider Relations Manager, presented to the committee all initial and re-credentialing files for providers and facilities. Some key points discussed were:

- **There were 4 new contracts approved in Q2.**
- **KHS randomly sampled 15 PCP, 15 Specialists, 15 psychiatrists, 5 Mental Health, 5 Ancillary, and 5 OB/GYN providers to ensure compliance with phone answering timeliness and appointment availability. All provider types surveyed were compliant with both components surveyed.**

- **No DHCS issues were identified in Q2 regarding the Quarterly Monitoring Report and Response Template.**

QI-UM Policies and Procedures – Melendez-Park: All Ayes
21) 2.70-I Provider Preventable Conditions – APPROVED
22) 2.72-I Potential Quality of Care Issues – APPROVED

- **Power Point Presentation given by Jane Daughenbaugh; she went over both policies in detail with the committee.**

Health Education Department Summary Report
CA-23) Health Education Activity Report 2nd Quarter 2022 – HELD UNTIL NEXT MEETING

- **Isabel went over the Executive Summary with the committee but will present 2nd Quarter Report at the next meeting.**

Meeting adjourned by Dr. Martha Tasinga, M.D., Medical Director @ 8:29 A.M. to Thursday, November 10, 2022 at 7:00 A.M.

SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE (VIRTUAL) MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Blvd.
Bakersfield, California 93308

Wednesday, August 3, 2022
7:00 A.M.

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COMMITTEE RECONVENED

Members Present: Atul Aggarwal, M.D.; Hasmukh Amin, M.D.; David Hair, M.D.; Miguel Lascano, M.D.; Martha Tasinga, M.D., C.M.O.

Members Absent: Gohar Gevorgyan, M.D.; Ashok Parmar, M.D.; Raju Patel, M.D.

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

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STAFF RECOMMENDATION SHOWN IN CAPS

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COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

CLOSED SESSION

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

Audit – Group PRV PRV013922

Dr. Miller presented an overview of an audit conducted due to an increase in authorization requests for invasive dermatologic procedures. Specific concern was the request for acne surgery and other facial injections that do not meet current evidence-based practice guidelines for medical necessity. Additionally, there is limited documentation, and often limited clinical details, to support a clear treatment plan for an invasive procedure.

A random sample of 30-cases were sent for independent medical review and all cases (100%) did not meet established evidence-based criteria and were deemed inappropriate and were therefore submitted to PAC for further review and consideration. Dr. Tasinga further informed the members that a meeting was held with the Group of providers involved in this review, the group was receptive and understanding of KHS' audit. The group expressed interest in working collaboratively with KHS including education to their providers.

Members discussed this is not within the 1st – 4th Standard of treatment

options and further is not being conducted within the standard of the community with other dermatology providers in the network.

Action: M/S/C
Letter to Group indicating request for written response:

a. Results of audit reviewed at the PAC meeting held 8/3/22 and that meeting with the group was beneficial and well received.
b. Not a standard of practice being done by other Dermatologist in the network; nor is it the standard of care within the first 4 treatment standards
c. Documentation lacking with very limited treatment plan and records reviewed had no indication of medical necessity.
d. Expect group/providers to follow Milliman Care Criteria/Guidelines including American Dermatology standards be followed as well

CREDENTIALING REPORT
Initials –

Comprehensive reviews resulting in unfavorable recommendation – please refer to Peer Review Minutes due to confidentiality and protection under Business and Professions Code 1157.

Comprehensive reviews were conducted for initial credentialing applications listed below for review of additional adverse information and/or information related to malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the previous five years.

- **PRV078429 – Provider previously on probation in 2011 with early completion of probation due to loss of clinical privileges in 2010 due to unprofessional conduct towards staff. Provider explanation received and reviewed with no further incidents of this nature.**

- **PRV081621 – Provider previously on probation in 2016 with early completion of probation due to Workers Compensation investigation regarding anti-psychotic medication. Provider explanation received and reviewed with no further incidents of this nature.**

Recredentialing -

Comprehensive reviews were conducted for recredentialing applications listed below for review of additional adverse information and/or information related to malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the previous three years.

- **PRV035803– Reviewed information regarding MBC Public Reprimand; documentation of completed education course received. No further actions or incidents regarding this provider have been received.**

ADDITIONAL SERVICE PROVIDER REQUESTS:

- **Preventive Medicine – Provider type has submitted application for network participation and Credentialing is requesting assistance identify scope of practice and if appropriate for KHS network participation – Dr. Tasinga asked this item to be tabled pending further research.**

- **Hyperbaric Therapy - Provider type has submitted application for network participation and Credentialing is requesting assistance identify scope of practice and if appropriate for KHS network participation – Dr. Tasinga asked this item to be tabled pending further research.**

MONITORING REPORT:

Ongoing Monitoring of Accusations or Disciplinary Actions: please refer to Peer Review Minutes due to confidentiality and protection under Business and Professions Code 1157.

COMMITTEE RECONVENED TO OPEN SESSION @ 7:54 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on June 1, 2022 – APPROVED
Amin-Hair: All Ayes

5) Review Medi-Cal Rx Diabetic Device Coverage – RECEIVED AND FILED

Bruce communicated the recent coverage of blood pressure machines under Medi-Cal Rx, which used to be billed to the plan, and restated the coverage of diabetic devices such as Continuous Glucose Monitors (CGM's), Insulin Pumps, and Diabetic Devices.

The committee discussed and understood the coverage and operations of Medi-Cal Rx and KHS responsibilities.

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 8:03 A.M. TO WEDNESDAY, SEPTEMBER 7, 2022 @ 7:00 A.M

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE (VIRTUAL) MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Blvd.
Bakersfield, California 93308

Tuesday, September 13, 2022
7:00 A.M.

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COMMITTEE RECONVENED

Members Present: David Hair, M.D.; Miguel Lascano, M.D.; Ashok Parmar, M.D.; Raju Patel, M.D.; Martha Tasinga, M.D., C.M.O.

Members Absent: Atul Aggarwal, M.D.; Hasmukh Amin, M.D.; Gohar Gevorgyan, M.D.

Meeting called to order at 7:04 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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

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ADJOURNED TO CLOSED SESSION @ 7:32 A.M.

CLOSED SESSION

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

CREDENTIALING REPORT
Initials:
There were no comprehensive reviews for September Initial Files.

Recredentialing:
Comprehensive reviews were conducted for recredentialing applications listed below for review of additional adverse information and/or information related to malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the previous three years.

- **PRV000831; PRV006759; PRV000442; PRV004880; PRV000383; PRV052776 – Reviewed Member & Quality Grievances for each provider; however, Dr. Tasinga reported that more work needs to be implemented on reporting grievances per member ratio to show true depiction of the data. There were no issues reported as a result of these grievances.**
- **PRV004750 – Reviewed information regarding NPDB Settlement including physician explanation which was accepted. No further actions or incidents regarding this provider have been received.**

- **PRV000449 – Reviewed statement from Compliance performance indicator report indicating an ongoing open case is in process; Compliance recommends, while no FWA has been substantiated at this time, proceed with recredentialing and Compliance will present further findings upon case closure if necessary.**
- **PRV055636 - Reviewed statement from Compliance performance indicator report indicating complaint sent to DHCS regarding billing for services not rendered. Case is being closed and provider did reprocess adjustments to claims submitted. Compliance will monitor accordingly and recommends to proceed with recredentialing.**

COMMITTEE RECONVENED TO OPEN SESSION @ 7:41 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on September 13, 2022 – APPROVED
Lascano-Parmar: All Ayes

5) Review MCG Summary of Changes 26th Edition 2022 – APPROVED
Lascano-Parmar: All Ayes

6) Review Policy 4.35-P Provider Hearings – APPROVED
Lascano-Hair: All Ayes

- **Yolanda Herrera, Credentialing Manager presented the recommended updates to the hearing procedures within applicable and current State laws, including Business & Professions Code and NCQA Credentialing Standards. Removed all "practitioner/provider" reference using general term "provider" which encompasses both physicians and ancillary providers as recommended by DSR Health Law; added enhanced explanation of Scope of Hearing and added Exceptions to Hearing Rights; added Reporting to Appropriate Authorities language and required timeframes. Removed Attachments as the MBC 805 Report form changes periodically and current version must be used. Daponde Simpson Rowe (DSR Health Law) performed a regulatory review making further updates and revisions to bring into compliance with DHCS Contract language, DHCS All Plan Letters regarding credentialing, CalAIM and California Business and Professions Code where applicable.**

7) Review Policy 4.48-P Provider Disciplinary Action – APPROVED
Lascano-Hair: All Ayes

- **Yolanda Herrera, Credentialing Manager presented the recommended updates to the hearing procedures within applicable and current State laws, including**

Business & Professions Code and NCQA Credentialing Standards. Removed all "practitioner/provider" reference using general term "provider" which encompasses both physicians and ancillary providers as recommended by DSR Health Law; added enhanced explanation of Scope of Hearing and added Exceptions to Hearing Rights; added Reporting to Appropriate Authorities language and required timeframes. Removed Attachments as the MBC 805 Report form changes periodically and current version must be used. Daponde Simpson Rowe (DSR Health Law) performed a regulatory review making further updates and revisions to bring into compliance with DHCS Contract language, DHCS All Plan Letters regarding credentialing, CalAIM and California Business and Professions Code where applicable.

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 7:46 A.M. TO WEDNESDAY, OCTOBER 5, 2022 @ 7:00 A.M

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

The meeting facilities at Kern Health Systems are accessible to persons with disabilities. Disabled individuals who need special assistance to attend or participate in a meeting of the KHS Finance Committee may request assistance at the Kern Health Systems office, 2900 Buck Owens Blvd., Bakersfield, California or by calling (661) 664-5000. Every effort will be made to reasonably accommodate individuals with disabilities by making meeting material available in alternative formats. Requests for assistance should be made five (5) working days in advance of a meeting whenever possible.

SUMMARY

PUBLIC POLICY/COMMUNITY ADVISORY COMMITTEE

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Tuesday, September 27, 2022
11:00 A.M.

COMMITTEE RECONVENED

Members: Janet Hefner, Jennifer Wood, Jasmine Ochoa, Mark McAlister, Cecilia Hernandez-Colin, Beatriz Basulto, Tammy Torres, Yadira Ramirez, Michelle Bravo, Alex Garcia, Quon Louey, Kaelsun Singh Tyiska, Rukiyah Polk
ROLL CALL: 10 Present; 3 Absent – Cecilia Hernandez-Colin, Alex Garcia, Kaelsun Singh Tyiska

Meeting called to order by Louie Iturriria, Director of Marketing and Public Relations, at 11:01 AM.

NOTE: The vote is displayed in bold below each item. For example, Hefner-Wood denotes Member Hefner made the motion and Member Wood seconds the motion.

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" WERE CONSIDERED TO BE ROUTINE AND APPROVED BY ONE MOTION.

COMMITTEE ACTION SHOWN IN CAPS

1) Public Policy/Community Advisory Committee Resolution to Allow Virtual Committee Meeting Participation Pursuant to Government Code Section 54953 (Fiscal Impact: None) - APPROVED
Hefner-McAlister: All Ayes

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

Alan Avery, Chief Operating Officer announced to the committee that the Consent Agenda items are always open for discussion. He reiterated that we would like Committee feedback on any issue placed on the agenda.

CA-4) Minutes for Public Policy/Community Advisory Committee meeting on June 29, 2022
APPROVED
Wood-Ochoa: 10 Ayes; 3 Absent – Hernandez-Colin, Garcia, Singh-Tyiska

CA-5) Report on September 2022 Medi-Cal Membership Enrollment RECEIVED AND FILED
Wood-Ochoa: 10 Ayes; 3 Absent – Hernandez-Colin, Garcia, Singh-Tyiska

CA-6) Report on KFHC Grievance Summary for second quarter ending June 30, 2022
RECEIVED AND FILED
Wood-Ochoa: 10 Ayes; 3 Absent – Hernandez-Colin, Garcia, Singh-Tyiska

CA-7) Report on Population Health Management for second quarter ending June 30, 2022
RECEIVED AND FILED
Wood-Ochoa: 10 Ayes; 3 Absent – Hernandez-Colin, Garcia, Singh-Tyiska

CA-8) Report on Health Education for second quarter ending June 30, 2022
RECEIVED AND FILED
Wood-Ochoa: 10 Ayes; 3 Absent – Hernandez-Colin, Garcia, Singh-Tyiska

9) Report on Member Services Grievance Operational Report for second quarter ending June 30, 2022
RECEIVED AND FILED

10) Marketing Department Report
PRESENTATION

Louie Iturriria, Director of Marketing and Public Relations presented the Marketing Reports to the committee and went over these highlights:

- **The U.S. Department of Health and Human Services public health emergency (PHE) order remains in place. As a result, the DHCS continues to freeze Medi-cal redeterminations. Thus, the Kern County Department of Human Services**

suspension of their "automated discontinuance process" for Medi-cal redeterminations continues.

Quon Louey, Committee Member asked; when does KHS anticipate the Public Health Emergency to end?

Louie Iturriria answered this question:
Once the PHE ends, Medi-Cal enrollees will need to renew their Medi-Cal annually, and the majority must do this through the manual mailing process. We will need to know which of our members need to renew their Medi-Cal through this manual mailing process, so we can encourage them to complete the renewal process, so they don't lose coverage. The County also needs updated contact information for Medi-Cal enrollees - so that Medi-Cal enrollees receive important mailings from the County.

11) 2022 Population Needs Assessment Findings
PRESENTATION

Isabel Silva, Director of Health Education and Cultural and Linguistics Services presented the 2022 Population Needs Assessment Findings, and went over these highlights:

- **KFHC contract with DHCS requires that it conduct a Population Needs Assessment and Action Plan each year. The goal of the 2022 KHS Population Needs Assessment (PNA) is to improve health outcomes for KHS members and ensure that KHS is meeting the needs of it's members through 3 key points discussed in her presentation.**

Meeting adjourned by Louie Iturriria, Director of Marketing and Public Relations, at 11:56 AM to December 13, 2022 at 11:00 AM.

SUMMARY OF PROCEEDINGS

DRUG UTILIZATION REVIEW (DUR) COMMITTEE (VIRTUAL MEETING)

KERN HEALTH SYSTEMS
2900 Buck Owens Blvd.
Bakersfield, California 93308

Wednesday, September 28, 2022
6:30 P.M.

All agenda item supporting documentation is available for public review at Kern Health Systems in the Administration Department, 2900 Buck Owens Blvd., Bakersfield, 93308 during regular business hours, 8:00 a.m. – 5:00 p.m., Monday through Friday, following the posting of the agenda. Any supporting documentation that relates to an agenda item for an open session of any regular meeting that is distributed after the agenda is posted and prior to the meeting will also be available for review at the same location.

COMMITTEE MEMBERS PRESENT: Alison Bell, Pharm. D; Kimberly Hoffmann, Pharm. D; Sarabjeet Singh, M.D.; Vasanthi Srinivas, M.D.; Martha Tasinga, M.D., C.M.O.; Bruce Wearda, R.Ph., Director of Pharmacy

COMMITTEE MEMBERS ABSENT: Dilbaugh Gehlawat, M.D.; James Patrick (Pat) Person, R.Ph.; Sam Ratnayake, M.D.; Joseph Tran, Pharm. D

Meeting called to order at 6:52 P.M. by Dr. Martha Tasinga, M.D.

1) Drug Utilization Review Committee Resolution to Allow Virtual Committee Meeting Participation Pursuant to Government Code Section 54953 (Fiscal Impact: None) – APPROVED
Hoffmann-Srinivas: All Ayes

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

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

- **Bruce Wearda announced two new staff members joining tonight's meeting. Michelle Curioso, KHS Population Health Management Director, as well as special guest, Hydee Nguyen, KHS current Pharmacy Intern.**

CA-4) Minutes for KHS Drug Utilization Review Committee meeting on June 29, 2022 – APPROVED

CA-5) Report of Plan Utilization Metrics – RECEIVED AND FILED

Kim Hoffmann asked for clarification on blood pressure machine and CGM coverage through Medi-Cal Rx (MCRx).
Bruce Wearda, KHS Director of Pharmacy, outlined and reviewed the coverage criteria as stated in the MCRx provider manual

Bell-Srinivas: All Ayes (All Consent Agenda items CA-4 to CA-5)

6) Report of Plan MTM Metrics – RECEIVED AND FILED

The committee discussed efforts and actions of the KHS Pharmacy Department, that identified members with possible inappropriate pharmacy regimens. Specifically, the focus was on drug interactions and therapeutic duplications.

The committee reviewed the number of identified cases from the beginning of the transition to Medi-Cal Rx and noted the trending. As KHS Pharmacy staff increased their outreach efforts, it was noted a decrease in number of instances occurred.

An example of a member's drug profile and corresponding interventions relating to drug interactions was also shared.

7) Support Act Update Pharmacy – RECEIVED AND FILED

The committee discussed trends of Opioid Utilization and other related drug categories. Increasing utilization trends of potentially inappropriate opioid and similar regimens were reviewed. It was discussed if the uptrends were due to Medi-Cal Rx, pandemic, or both.

8) DHCS Contract – Resume Requirement – DISCUSSION

Bruce shared that DHCS' contract requires certain licensed personnel to be seated and verified on clinical committees. Therefore, DHCS has requested updated resumes of these committee members. Bruce asked the committee to submit them as soon as possible, and he thanked those committee members who have done so already.

9) Executive Order N-01-19: Medi-Cal Rx Update - DISCUSSION

The committee discussed the Executive Order 01-19. Bruce shared DHCS DUR plan specific edits. The committee reviewed the various edits from the state.

The numerous bulletins put out by the state in September, particularly related to the reactivation of specific DUR edits and prior authorization. These requirements were reviewed. The timeline of reinstating other DUR edits and PA requirements was also discussed.

MEETING ADJOURNED AT 7:49 P.M. BY DR. MARTHA TASINGA, M.D., C.M.O. TO MONDAY, NOVEMBER 21, 2022 @ 6:30 P.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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To: KHS QI-UM Committee

From: Bruce Wearda, Director of Pharmacy

Date: November 10, 2022

Re: QI Executive Summary -- Pharmacy Report – KHS Processed Prior Authorizations

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Background

KHS as part of a Medicaid Managed Care system is regulated by two governing bodies, the Department of Managed Health Care (DMHC) and the State of California's Medicaid division of the Health Department, Department of Health Care Services (DHCS) better known as Medi-Cal. They have regulations that specify turnaround times for processing along with other elements of how the prior authorization (Treatment Authorization Request (TAR)) is handled. Some of these elements include a licensed individual reviewing, if denied, the criteria used, a Notice of Action (NOA) letter sent to the member, among others. The following report depicts how the plan is doing in respect to these required actions. KHS conducts a monthly audit of 5% of the TARs received for the month reviewed. The following report shows how many of the sample met the required actions in accordance with the requirements.

***Please note: Pharmacy services were carved out to Medi-Cal Rx beginning 1/1/22. Some supplies and medical devices are still processed through KFHC. This reflects those requests.

Discussion NA

Fiscal Impact NA

Requested Action

For Informational Purposes Only

No items of concern identified.

Quarter/Year of Audit	2022	2022	2022	2022	2022	2022	2022	2022	2022			
Month Audited	Jan	Feb	Mar	April	May	June	July	Aug	Sept			
Total TAR's for the month	151	54	48	43	18	23	27	20	35			
Turn Around Time Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%			
Notice of Action Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%			
APPROVED TAR'S												
Timeliness - Reviewed & Returned in 1 busines day	2/2	0	1/1	2/2	1/1	0	1/1	1/1	2/2			
Date Stamped	2/2	0	1/1	2/2	1/1	0	1/1	1/1	2/2			
Fax copy attached	2/2	0	1/1	2/2	1/1	0	1/1	1/1	2/2			
Decision marked	2/2	0	1/1	2/2	1/1	0	1/1	1/1	2/2			
DENIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	0	0	0	0	0	0	0	0	0			
Initally Denied - Signed by Medical Dir and/or Pharm	0	0	0	0	0	0	0	0	0			
Letter sent within time frame	0	0	0	0	0	0	0	0	0			
Date Stamped	0	0	0	0	0	0	0	0	0			
Fax copy attached	0	0	0	0	0	0	0	0	0			
Decision marked	0	0	0	0	0	0	0	0	0			
Correct form letter, per current policies used	0	0	0	0	0	0	0	0	0			
NOA Commentary Met	0	0	0	0	0	0	0	0	0			
MODIFIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	0	0	0	0	0	0	0	0	0			
Date Stamped	0	0	0	0	0	0	0	0	0			
Fax copy attached	0	0	0	0	0	0	0	0	0			
Decision marked	0	0	0	0	0	0	0	0	0			
Correct form letter, per current policies used	0	0	0	0	0	0	0	0	0			
NOA Commentary Met	0	0	0	0	0	0	0	0	0			
DUPLICATE TAR'S												
Timeliness - Reviewd & Returned in 1 business day	0	0	1/1	0	0	0	0	0	0			
Date Stamped	0	0	1/1	0	0	0	0	0	0			
Fax copy attached	0	0	1/1	0	0	0	0	0	0			
CANCELLED *^#												
Returned to Provider to submit to MCRx	125	42	28	25	7	8	13	7	8			

* Total number of TAR's

^ Not required for monitoring

Per DHCS instruction, do not deny MCRx services

KERN HEALTH SYSTEMS

To: **KHS QI-UM Committee**

From: **Jane Daughenbaugh, Director of Quality Improvement**

Date: **November 10, 2022**

Re: **Quality Improvement Department Report, Q3 of 2022**

Background:

This report provides a summary of key activities and issues related to the Quality Improvement (QI) Department during the 3rd Quarter of 2022.

Discussion:

See pages 2-4 of this document

Requested Action:

Review and approval of the report

Additional QI Documents:

- Potential Quality Issues (PQI) Audit Summary
- Initial Health Assessment (IHA) Bi-Annual Audit Summary
- Overview of revisions to Policy 2.71-P Facility Site Review and Medical Record Review

KERN HEALTH SYSTEMS

Quality Improvement Department
Executive Summary
3rd Quarter 2022

I. COVID-19 Updates

During the pandemic, site reviews were conducted virtually. Effective July 1st of this year, our Certified Site Review (CSR) nurses switched back to conducting the reviews on site and are restarting interim reviews. DHCS provided approval for Managed Care Plans (MCPs) to continue completing medical record reviews virtually on an ongoing basis.

II. Potential Quality of Care (PQI) Notifications

Compared to the previous quarter, PQI notifications decreased by ~43%. The overall decline in PQIs is due to a change in the grievance review process. The overall volume of cases has not changed. However, as of August 1st, the grievance review process was modified to include a clinical review of medical records and/or provider response to adequately classify and resolve any QOC grievances. Previously, the in-depth investigation was conducted under the PQI process once there was evidence that a grievance may involve a PQI. As a result, there was a decrease in PQI referrals.

There is a notable increase in Level 1 and level 2 PQIs compared to Q1 2022. This is due to multiple factors including the expansion of clinical reviews for grievances, staffing changes, and initiation of PQI audits. We will continue to monitor to identify any trends.

We have begun conducting analysis of PQIs by provider for inpatient and outpatient PQIs. The report in the full Q3 report shows the table of results with provider names de-identified. There are several factors considered in evaluating trends of PQIs amongst our providers. The data reviewed for each provider was a very low volume of PQIs for most providers and generally was not statistically valid (<30). “Provider E” and “Provider C” were the only ones who consistently appeared quarter over quarter. However, after reviewing entire timeframe from Q1 2021 through Q2 2022, the rate per 1,000 discharges for Provider E was only 2.2 and Provider C had only one PQI higher than a level 0.

For outpatient PQIs, one provider (Provider G) appeared in 4 of 6 quarters. However, the ratio of PQI referrals was only 1.3 PQIs per 1000 visits for those 4 quarters. This is a low rate, and we will continue to monitor for any trends.

Analysis was also conducted of PQIs’ by race and ethnicity. Based on the ratio of PQI’s per 1000 members, the Korean population was the highest group. However, in reviewing raw data the volumes are not statistically valid. The only statistically valid volumes per ethnic group were Caucasian, African American, Hispanic, and no valid data. Of these groups, the top two are Caucasian and Hispanic. Both Caucasian and African American groups are about the same. Most cases were level 0's with no quality of

care issue identified. We will continue monitoring the YTD 2022 data and adding 2023 data to build a statistically valid volume for as many ethnic groups as possible.

III. Facility Site Reviews (FSR) and Medical Record Review (MRR)

Effective July 1, 2022, the critical elements providers must pass increased from 9 to 14 and the new list is included in the full QI Report. The new Site and Medical Record Review tools and standards were also implemented starting July 1, 2022, per instruction from DHCS. The new All Plan Letter for Site Reviews is anticipated to be released in the 4th quarter.

For Q3 2022, 90 IHA's were completed. 12 of the 90 IHAs reviewed were non-compliant. Education was provided for the non-complaint charts.

A new All Plan Letter (APL) is being finalized by DHCS for Site and Medical Record Reviews and is anticipated to be in effect this Fall.

IV. Quality Improvement Projects

A. ***Performance Improvement Projects:***

1. Health Care Disparity in WCV (Well Care Visits ages 3-21) focusing on annual well care visits. Kern Pediatrics has partnered with us on this project. The overarching goal is to increase compliance with the preventive health service by 10% points. The PIP is currently in the Intervention Testing Phase and the 2nd round of testing was completed with a 63% success rate. Test interventions will continue through the PIP end date of 12/31/2022.

   A preliminary outcome for one member outreach campaign to close the gap in care for a well child visit resulted in 9.2% successful completion compared to 7.62% who closed their gaps with no outreach.

   The third Member Engagement and Rewards Program (MERP) campaign will be completed in November as mailers and text messaging were delayed due for regulatory reasons. Outcomes for these interventions will be included by end of the year.

2. Child/Adolescent Health Asthma Medication Ratio (AMR) focusing on increasing the level of compliance for members 5-21 years of age by approximately 15%. This measure focuses on proper use of asthma controller medication versus overutilization of rescue medications. One of the interventions focused on members creating an asthma action plan with their PCP. The most recent outcome is that 72% of members were successfully reached and 52% of those members agreed to participate in the program. Test interventions will continue through the PIP end date of 12/31/2022.

B. **Organizational Quality Incentives Project:** This is a short-term project to implement actions to improve KHS' MCAS compliance for MY2022.

The Member Services Outreach Pilot for Members with MCAS gaps in care is continuing. Since the pilot began, roughly 12k outreach calls have been made with 53.5% of those members being reached. Of the members that were reached, 33% scheduled appointments. Since the program started June 1st, there has been an overall improvement for those members in compliance with MCAS measures of 19%.

Key Accomplishments:

- Standing Orders: CBCC Amendment has been executed and initial list of members have been provided
- Standing Orders: Premier Specialty Group amendment has been provided and list is ready to be provided to Dr. Brar once contract is signed.P4P Kick off meeting was conducted
- Existing Data Sources for DHCS data development was complete

Next Steps:

- Obtain integrated DHCS data Gap analysis report
- Develop business requirements for Pilot Outcome reports
- Identify and obtain approval for 2023 P4P measures

VI. MCAS Updates

As of September 2022, 6 out of 15 measures showed improvement compared to this month last year.

- Breast Cancer Screening,
- Controlling Blood Pressure,
- Hemoglobin A1c Control for Patients with Diabetes,
- Chlamydia Screening,
- Well care visits for infants 0-15 months, and
- Well care visits for infants 15-30 months

The full set of results are in the packet for your review.

VII. There is one policy update being presented today, 2.71-P Facility Site Review and Medical Record Review.

KERN HEALTH SYSTEMS

QUALITY IMPROVEMENT DEPARTMENT

QUATERLY QI-UM COMMIITTEE REPORT

Q3 2022

KERN HEALTH SYSTEMS
Quality Improvement Department Quarterly QI-UM Committee Report
Q3 2022

The purpose of this report is to provide a summary of the quarterly activities and outcomes for the QI department. It provides a window into the performance of the Quality Improvement Program and Department. It serves as an opportunity for programmatic discussion and input from the QI-UM Committee members. Areas covered in the report include:

KERN HEALTH SYSTEMS
Quality Improvement Department Quarterly QI-UM Committee Report
Q3 2022

I. COVID-Update:

The daily average cases in Kern County towards the end of Q3 2022 have decreased by 31% compared to Q2 2022, with 272 daily average cases towards the end of the month.

II. Potential Quality of Care Issue (PQI) Notifications:

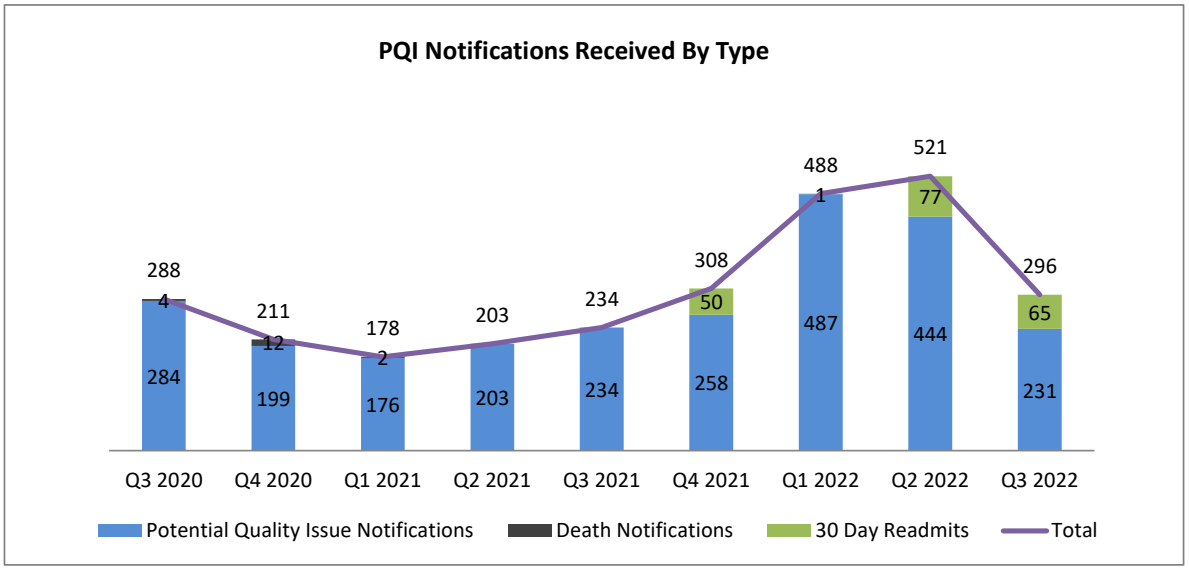
QI receives notifications from various sources to review for PQI notifications.

On receipt of a PQI notifications, a high-level review is completed by a QI RN to determine what level of Potential Quality Issue exists.

PQIs are assigned a level based on the outcome of the review. The levels assigned are as follows:

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

KERN HEALTH SYSTEMS
Quality Improvement Department Quarterly QI-UM Committee Report
Q3 2022



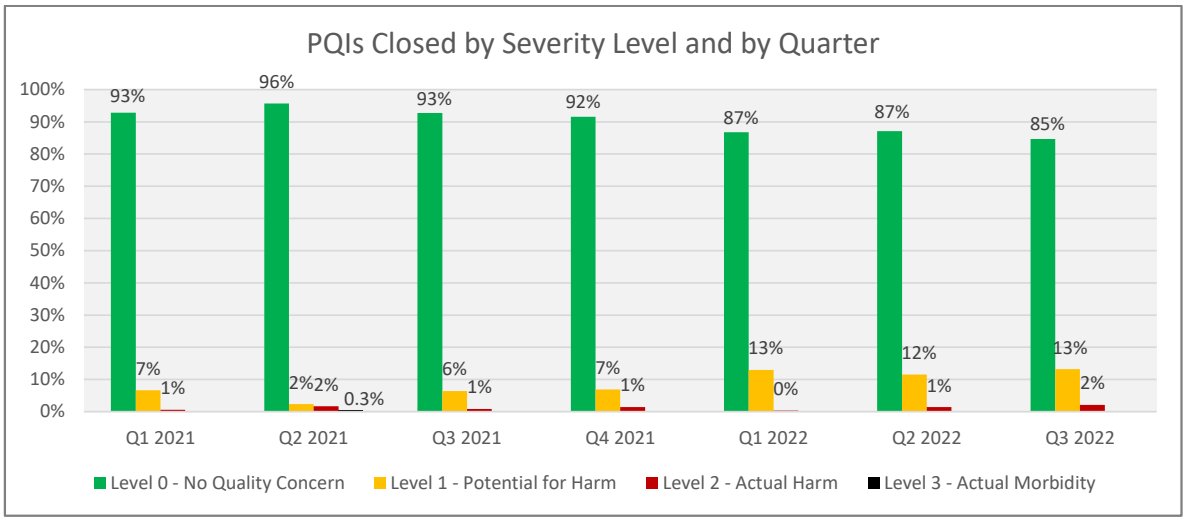
From the above chart, there were 231 PQI notifications, 65 30-Day Readmits, and no death notifications received for Q3 2022. Compared to previous quarter the notifications significantly decreased by about 43%. The overall decline in PQIs is due to the transition in the grievance review process. The overall volume of cases has not changed, however there was a significant change in the grievance process. As of August 1st, the grievance review process has been expanded to include a clinical review of medical records and/or provider response to adequately classify and resolve QOC grievances. The medical director reviews all QOC grievances to determine if the grievance should be closed in favor of the member, or in favor of the plan/provider. Only QOC grievances resolved in favor of the member are sent to QI for further investigation. This change resulted in a shift of the initial aspect of the investigation from the PQI process to the grievance process. This resulted in an overall decrease of PQI referrals. Previously, all QOC grievances were closed in favor of the member and sent to QI for further investigation.

The fifty 30-day readmission reviews conducted each quarter were completed timely for the third quarter. There were no trends identified over time.

For the third quarter, we received a total of 2,564 grievances of which 352 were classified as Quality-of-Care (QOC) Grievances and referred to QI for further investigation as a PQI. The ratio of QOC grievances decreased by two percentage points from Q2 to Q3 2022.

KERN HEALTH SYSTEMS
Quality Improvement Department Quarterly QI-UM Committee Report
Q3 2022

PQIs Closed by Severity Level:



From the above chart majority of PQIs closed were level 0s. There is a notable increase in Level 1 and level 2 PQIs since Q1 2022. This is due to multiple factors including the expansion of clinical reviews for grievances, staffing changes, and initiation of PQI audits. We will continue to monitor to identify any trends.

Below is the table with the no. of PQIs Closed by severity and by quarter for reference.

Severity Level	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022
Level 0 - No Quality Concern	168	289	216	251	255	499	404
Level 1 - Potential for Harm	12	7	15	19	38	66	63
Level 2 - Actual Harm	1	5	2	4	1	8	10
Level 3 - Actual Morbidity		1					

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PQIs Trending by Provider:

Beginning Q3 2022, we will be reporting on trending of PQI notifications by inpatient and outpatient providers. In the below table we have identified the top 5 inpatient providers in each quarter based on highest PQI's closed and sorted in the order of Severity level 3 followed by levels 2,1 and 0. We have also compared PQIs with per 1000 discharges for each inpatient facility. Provider/Facility names will not be disclosed for reporting purpose but will have a specific letter to represent their specific data (i.e., "Provider A"). If the same provider is repeated in other quarters, they will keep the same letter for consistency in reporting. The providers who repeatedly remain in the top 5 quarter over quarter are color coded orange.

Top 5 Inpatient Providers

Provider	Level 0	Level 1	Level 2	Level 3	Grand Total	Total Discharges	Per 1000 Discharges
Q2 2022							
PROVIDER A			1		1	3	333.33
PROVIDER B	5	2	1		8	1,295	6.18
PROVIDER C	4		1		5	-	-
PROVIDER D	1		1		2	-	-
PROVIDER E	6	5			11	1,955	5.63
Q1 2022							
PROVIDER F	5		1		6	1,296	4.63
PROVIDER E	1	3			4	2,031	1.97
PROVIDER G		1			1	-	-
PROVIDER C	2				2	-	-
PROVIDER H	2				2	-	-
Q4 2021							
PROVIDER I			1		1	233	4.29
PROVIDER E	4	1	1		6	2,257	2.66
PROVIDER J		1			1	73	13.70
PROVIDER F	3				3	1,366	2.20
PROVIDER B	2				2	1,100	1.82
Q3 2021							
PROVIDER K	1	1	1		3	-	-
PROVIDER E	4	1			5	2,521	1.98
PROVIDER C	8				8	-	-
PROVIDER B	3				3	1,297	2.31
PROVIDER L	2				2	101	19.80
Q2 2021							
PROVIDER M		1			1	90	11.11
PROVIDER N		1			1	877	1.14
PROVIDER O		1			1	159	6.29
PROVIDER C	14				14	-	-
PROVIDER E	2				2	1,985	1.01
Q1 2021							
PROVIDER N	3		1		4	1,283	3.12
PROVIDER C	8				8	-	-
PROVIDER K	3				3	-	-
PROVIDER E	2				2	2,776	0.72
PROVIDER P	2				2	248	8.06

Please note '-'indicates there are no discharges identified hence no PQIs per 1000.

There are several factors to consider while evaluating trends in PQIs amongst our providers and population. Since the above data reflects a low volume of PQIs for most providers, the data is not statistically valid (<30). "Provider E" is the only provider who consistently appeared quarter over quarter. However, we aggregated for the entire timeframe from Q1 2021 through Q2 2022 to evaluate a more statistically significant volume. Results

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showed they had a total 30 PQIs and 13,525 discharges which equates to a rate for PQI referrals per 1000 discharges of 2.2. This does not appear to be of concern. "Provider C" appeared in 4 quarters out of 6. He had 37 total PQIs of which 1 had a level 2 and remaining all were level 0s. We did not identify trends for both the providers. We will continue to monitor for any issues. If we identify any significance, we will investigate the trends by provider, diagnosis, service and/or procedure for any specific issues.

In the below table we have identified top 5 outpatient providers in each quarter based on highest PQI's closed and sorted in the order of Severity level 3 followed by levels 2,1 and 0. Then compared PQIs with per 1000 visits for that outpatient facility. Provider/Facility names have been replaced as 'Provider A' and so on for each provider on the list for reporting purpose, if the same provider repeated in other quarters, they have a consistent provider letter to represent their data. The provider who repeatedly remain in the top 5 quarter over quarter are color coded orange.

Top 5 Outpatient Providers

Provider	Level 0	Level 1	Level 2	Level 3	Grand Total	Total Outpatient Visists	Per 1000 Visists
Q2 2022							
PROVIDER A	8	1	1		10	-	-
PROVIDER B			1		1	419	2.39
PROVIDER C	4		1		5	-	-
PROVIDER D	1	2			3	198	15.15
PROVIDER E	2	2			4	248	16.13
Q1 2022							
PROVIDER F			1		1	615	1.63
PROVIDER G	6	1			7	2,983	2.35
PROVIDER H	5	1			6	4,925	1.22
PROVIDER I	5	1			6	2,897	2.07
PROVIDER J	2	1			3	3,230	0.93
Q4 2021							
PROVIDER K				1	1	-	-
PROVIDER L	3	1			4	-	-
PROVIDER G	2	1			3	2,812	1.07
PROVIDER A	1	1			2	-	-
PROVIDER M	1	1			2	-	-
Q3 2021							
PROVIDER G	1		1		2	3,414	0.59
PROVIDER N	2	1			3	216	13.89
PROVIDER I	2	1			3	2,735	1.10
PROVIDER O	5				5	-	-
PROVIDER P	4				4	-	-
Q2 2021							
PROVIDER Q	1			1	2	2,394	0.84
PROVIDER R			1		1	758	1.32
PROVIDER S			1		1	7	-
PROVIDER T		1			1	837	1.19
PROVIDER U		1			1	913	1.10
Q1 2021							
PROVIDER V			1		1	979	1.02
PROVIDER G	3	1			4	2,815	1.42
PROVIDER W	2	1			3	374	8.02
PROVIDER X	4				4	341	-
PROVIDER J	4				4	2,859	1.40

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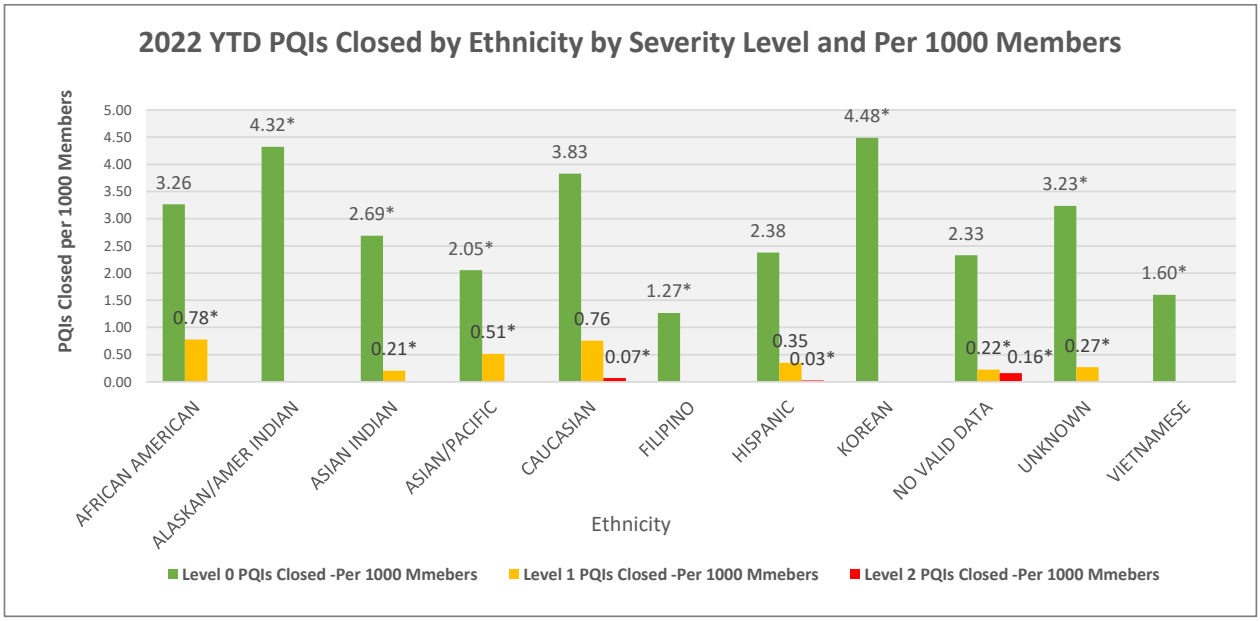
Since the above data reflects the PQI Volumes are not statistically valid (<30) by individual quarter, we looked for any provider who appear on the top 5 list in more than one quarter and calculated the aggregate PQI volume per 1,000 visits. While there were some providers who have a higher ratio per 1,000 visits, they are not considered statistically valid due to the actual low volume of PQI referrals. One provider (Provider G) appeared in 4 of 6 quarters. However, when we aggregated the data for the 6 quarters, the ratio of PQI referrals was 1.3 PQIs per 1000 visits for 4 quarters. This appears to be a low rate of PQIs. We will continue to monitor for trends or any significant increase in issues.

2022 YTD PQIs Closed by Ethnicity:



* Indicates the PQI volume was not statistically valid (>30).

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		No. of PQI Closed 2022 YTD							
		Level 0		Level 1		Level 2		Total PQI Closed	
Ethnicity	KHS Membership YTD 2022	PQI	Per 1000	PQI	Per 1000	PQI	Per 1000	PQI	Per 1000
AFRICAN AMERICAN	20533	67	3.26	16	0.78			83	4.04
ALASKAN/AMER INDIAN	694	3	4.32					3	4.32
ASIAN INDIAN	4837	13	2.69	1	0.21			14	2.89
ASIAN/PACIFIC	1949	4	2.05	1	0.51			5	2.57
CAUCASIAN	57991	222	3.83	44	0.76	4	0.07	270	4.66
FILIPINO	3950	5	1.27					5	1.27
HISPANIC	216651	515	2.38	76	0.35	6	0.03	597	2.76
KOREAN	223	1	4.48					1	4.48
NO VALID DATA	31372	73	2.33	7	0.22	5	0.16	85	2.71
UNKNOWN	3710	12	3.23	1	0.27			13	3.50
VIETNAMESE	624	1	1.60					1	1.60
Grand Total	**342534**	**916**	**2.67**	**146**	**0.43**	**15**	**0.04**	**1077**	**3.14**

In reviewing the above data solely by membership ratios (per 1000 members), the Korean population would be the highest group. However, in reviewing raw data the volumes are not statistically valid. Only statistically valid volumes per ethnic group are Caucasian, African American, Hispanic, and no valid data. Of these groups, the top two are Caucasian and Hispanic. Both Caucasian and African American groups are about the same. Most cases were level 0's with no quality-of-care issue being identified. We will continue monitoring the YTD 2022 data and adding 2023 data to build and evaluate a statistically valid volume for as many ethnic groups as possible.

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III. Facility Site Reviews (FSR) and Medical Record Review (MRR) Description:

Certified Site Reviewers perform a Facility Site Review on all contracted primary care provider sites (including OB/GYNs and pediatricians) as well as providers who serve a high volume of SPD beneficiaries. Per PL 14-004, certified site reviewers complete FSRs and MRRs for providers credentialed per DHCS and MMCD contractual and policy requirements.

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

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

Critical Elements:
Based on DHCS recommendation, changes were made and implemented to existing critical elements to align with the new tools and standards on 7/1/2022. Below is the updated list of critical elements related to the potential for adverse effect on patient health or safety, previously there were 9 now they are 14:

1. Exit doors and aisles are unobstructed and egress (escape) accessible.
2. Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag
3. Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia. Epinephrine 1mg/ml (injectable) and Diphenhydramine (Benadryl) 25 mg (oral) or Diphenhydramine (Benadryl) 50 mg/ml (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose (any type of glucose containing at least 15 grams). Appropriate sizes of ESIP needles/syringes and alcohol wipes.
4. Only qualified/trained personnel retrieve, prepare, or administer medications.
5. Physician Review and follow-up of referral/consultation reports and diagnostic test results
6. Only lawfully authorized persons dispense drugs to patients.
7. Drugs and Vaccines are prepared and drawn only prior to administration
8. Personal Protective Equipment (PPE) for Standard Precautions is readily available for staff use
9. Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport, or shipping.
10. Needlestick safety precautions are practiced on site.
11. Cold chemical sterilization/high level disinfection: a) Staff demonstrate/verbalize necessary steps/process to ensure sterility and/or high-level disinfection of equipment.

12. Cold chemical sterilization/high level disinfection: c) Appropriate PPE is available, exposure control plan, Material Safety Data Sheets and clean up instructions in the event of a cold chemical sterilant spill.
13. Autoclave/steam sterilization c) Spore testing of autoclave/steam sterilizer with documented results (at least monthly)
14. Autoclave/steam sterilization Management of positive mechanical, chemical, and biological indicators of the sterilization process.

Scoring and Corrective Action Plans

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

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

Corrective Action Plans (CAPs)

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

A new APL for Site and Medical Record Reviews is anticipated in October. Internal policies and procedures will be updated to reflect the changes when communication from DHCS is received.

We resumed on-site facility site reviews beginning July 1st and will continue performing virtual medical record reviews which complies with DHCS' requirements. The new site review tools and standards were also implemented July 1st. Our next priority is to resume interim reviews by mid-October.

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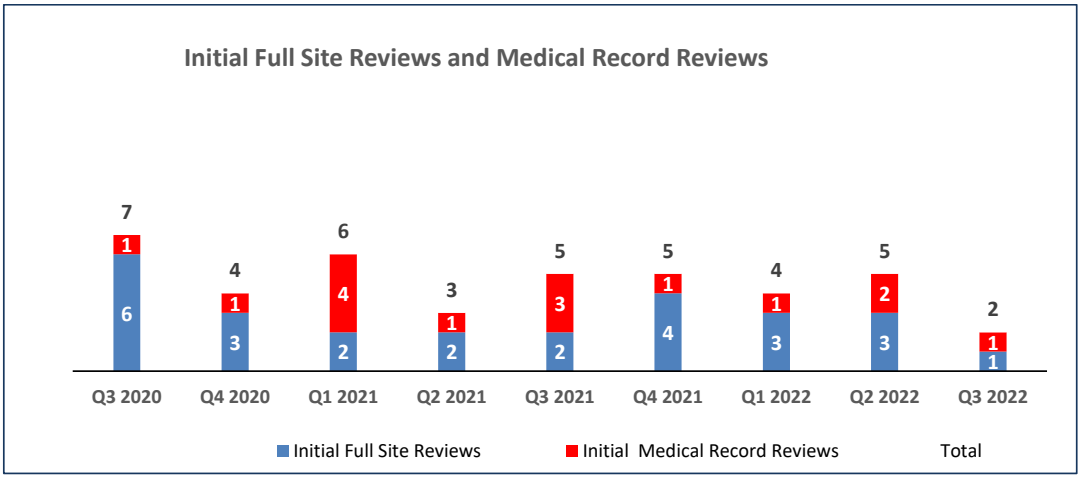
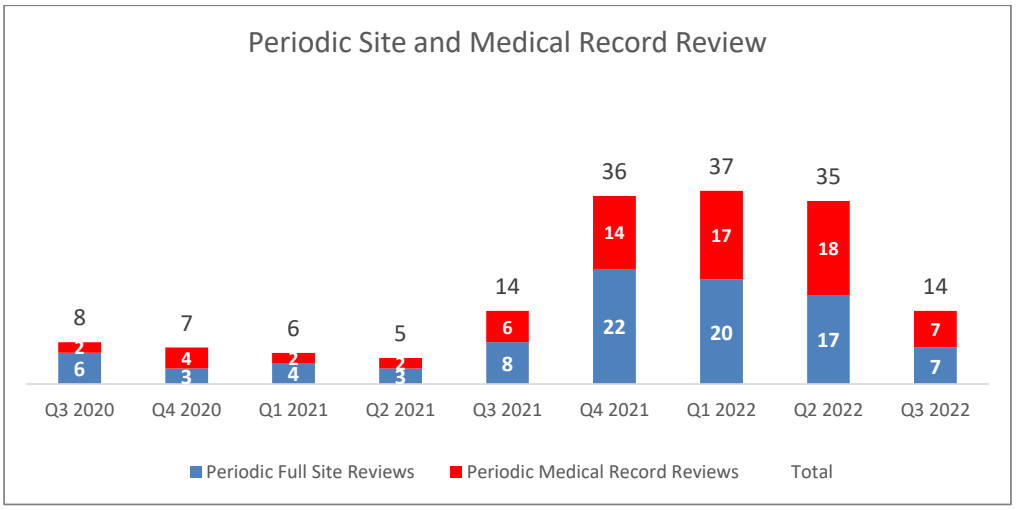
A. Initial Facility Site Review and Medical Record Review Results:



The number of initial site and medical record reviews is determined by the number of new providers requesting to join KHS' provider network. There was 1 IFSR and 1 IMRR conducted in Q3 of 2022.

B. Periodic Full Site and Medical Record Reviews

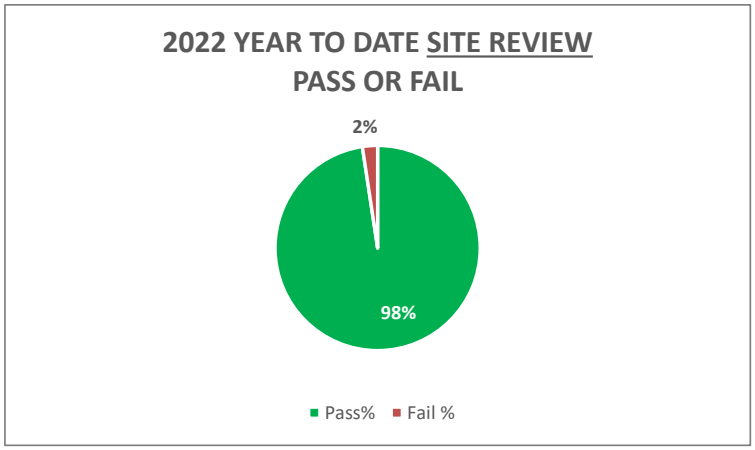
Periodic reviews are required every 3 years. The due date for Periodic FSRs is based on the last Initial or Periodic FSR that was completed. The volume of Periodic Reviews is not controlled by KHS. It is based on the frequency dictated by DHCS.



The above chart reflects the number of Periodic Full Site Reviews and Medical Record Reviews that were due and completed for each quarter. The decrease in site and medical reviews in Q3 2022 is due to the completion of backlog reviews by of June 30th. While there's a decrease in volume of site reviews completed, by switching to the new tools and standards in July, the time taken to complete a review has increased by 2.5 times more than reviews with the previous tools. All reviews have been completed timely and we're on track to meet the required timeframes.

Year to Date (YTD) Initial and Periodic FSR Pass or Fail Rate:

Effective in Q4 of 2021, we changed identification in this QI Quarterly report to use DHCS' standard of 80% or higher to identify providers who passed. Prior to that, we were using 90%, meaning they had no deficiencies in Critical Elements, Pharmaceutical or Infection Control. Scoring 80% - 89% is considered a "conditional pass" and requires a CAP only for the elements that were non-compliant. A score below 80% is considered a Fail and requires a CAP for the entire site or medical record review.



In 2022 YTD, 98% of the Initial and Periodic site reviews performed passed, 2% of the sites scored less than 80%. There were 51 site reviews completed YTD, 1 of these reviews failed in the first audit. We will continue to monitor this for any trends.

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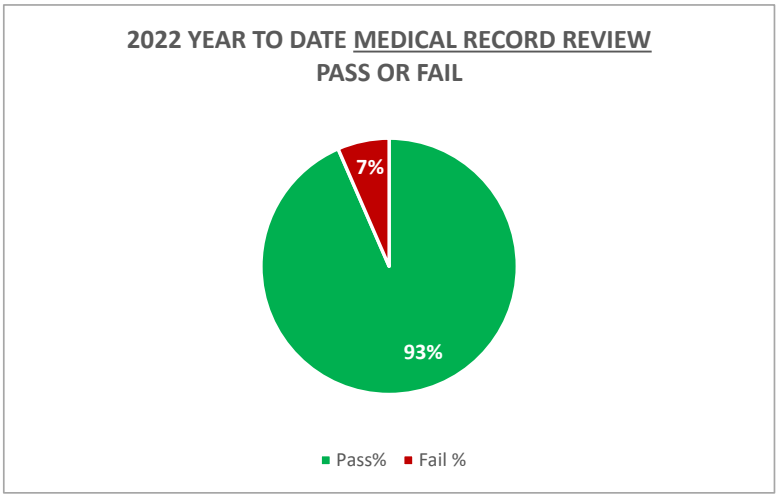

In 2022 YTD, 93% of the Initial and Periodic medical record reviews performed passed, 7% of them scored less than 80%. There were 46 medial record reviews completed YTD, 3 of these reviews failed in the first audit. We will continue to monitor this for any trends.

For Q3 2022, top #3 deficiencies identified for Opportunities for improvement in site reviews are:

1. Spore testing did not have documented results (C/E)
2. Emergency Medication
3. Personal Protective Equipment (PPE)

For Q3 2022, top #3 deficiencies identified for Opportunities for improvement in medical record reviews are:

1. Adult Immunization not given according to ACIP guidelines
2. Child immunization
3. Fluoride Varnish

There is one common deficiency 'Adult Immunization not given according to ACIP guidelines' identified from previous quarters for medical record review. This has been impacted by COVID-19. Several Provider offices were conducting telehealth visits and not in office visits, making it extremely difficult to provide adult immunizations. We will continue to monitor for any trend in the issues identified.

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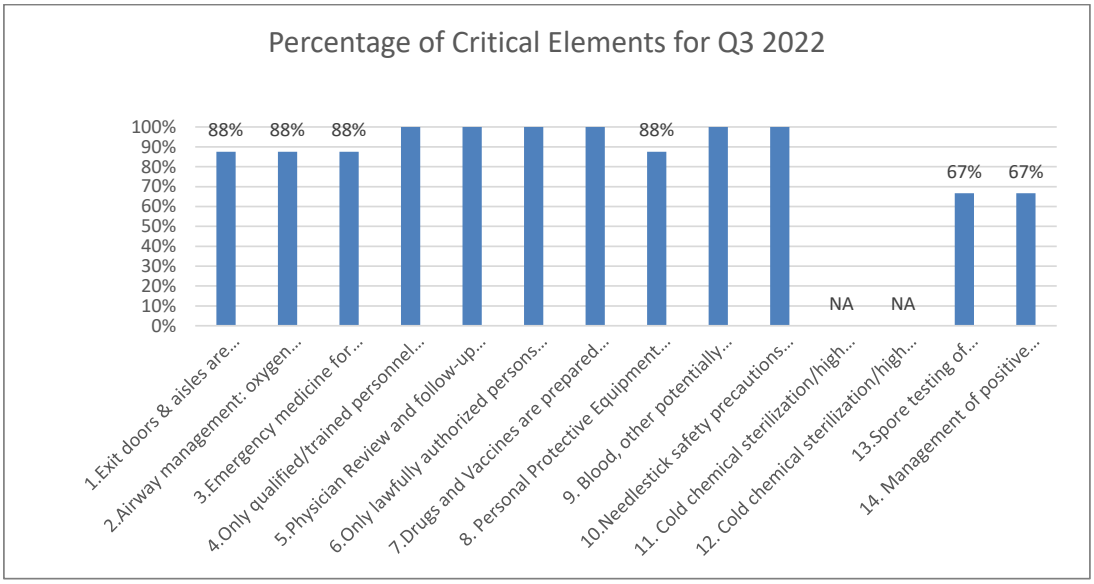
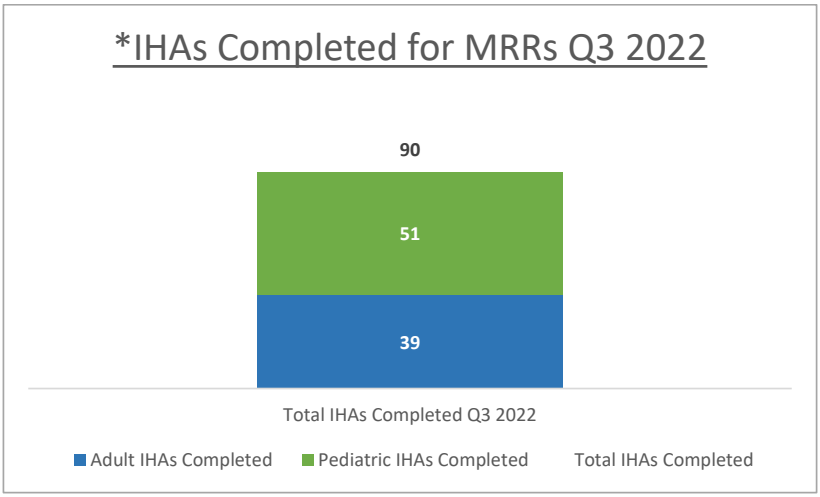
C. Critical Elements (CE) Percentage for Site reviews:



From the above chart, 6 out of 14 CE's were at 100%. There were 8 FSRs completed for Q3 out of which one site have failed multiple CE's accounting for the 88% score. CE #11 and #12 were not applicable for any of the sites, hence it does display any score. CE #13 and #14 were applicable only to three of the sites out of which one of the sites failed, hence the score is 67%. Since there were only 8 sites, this score is considered statistically invalid. For the sites that did not score 100% a CAP was issued, and deficiencies were corrected within 10 business days. We will continue to monitor for any trends.

D. IHA's percentage for MRRs:



***Percentage-of IHAs completed = IHEBA+SHA's**

For Q3 2022, based on the medical record reviews, 90 IHA's were completed. 51 total pediatric charts and 39 adult charts. 42 out of the 51 pediatric charts were compliant and 9 were non-compliant. 36 out of the 39 were found to be compliant for the adult charts and 3 adult IHA's were found to be non-compliant. Education was provided for the non-complaint charts. Compared to previous quarter, the volume of IHAs completed declined by 58% because fewer MRRs were completed this quarter (fewer MRRs since the Backlog was completed).

Interim Reviews:

Interim Reviews are conducted between Initial and first Periodic Full Site Reviews or between two Periodic Full Site Reviews. Typically, they occur about every 18 months. These reviews are intended to be a check-in to ensure the provider is compliant with the 9 critical elements and as a follow up for any areas found to be non-compliant in the previous Initial or Periodic Full Site Review. Due to the pandemic, KHS has not been conducting Interim Reviews since January of 2021. We are currently in the process of reimplementing interim reviews and will provide a status update in the next quarterly report.

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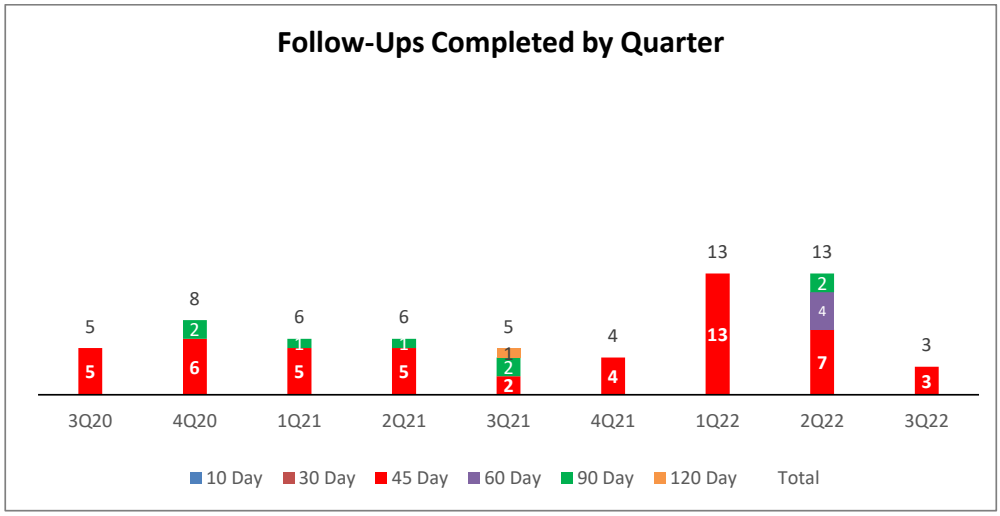
E. Follow-up Reviews after a Corrective Action Plan (CAP):



There were 3 45-day follow ups completed in Q3 of 2022. The decrease in site and medical review follow-ups in Q3 2022 is due to the completion of backlog reviews by of June 30th.

IV. Quality Improvement Projects

A. Performance Improvement Projects (PIPs)

DHCS initiated a cycle of PIPs for 2020-2022 in November of 2020 through the EQRO, HSAG. The 2 current PIPs are:

Health Care Disparity in Well Care Visits ages 3-21 (WCV)

This PIP targets health care disparities to improve the health and wellness of low-income children and adolescents, ages 3 to 21, through well-care visits. After reviewing the baseline data, a narrowed focus has been identified for the 8–10-year-old population. The Health Equity PIP is currently in the intervention testing phase. This phase leverages our Member Engagement and Rewards Program (MERP) by conducting robocalls and mailers that offer rewards for completing well-care visits. Two MERP campaigns have been completed with the following outcomes: The first phase of testing included 1,076 non-compliant members. 30 robocalls and mailers were successfully sent. Of the 30 robocalls and mailers, 5 members completed a well-care visit which is a 17% success rate. The second phase of testing included 1,121 non-compliant members. Of the 8 successful robocalls, 5 well-care visits were completed which is a 63% success rate. Of the 862 mailers sent, 134 well-care visits were completed which is a 16% success rate.

The third MERP campaign is still underway and is scheduled to conclude on 09/31/2022. The third cycle concluded at the end of September and data is being compiled for review and analysis. The fourth cycle will have some overlap as robocalls began mid-month. However, mailers and text messaging were delayed due to various regulatory reasons. Outcomes for these interventions will be included by end of the year.

Child/Adolescent Health-Asthma Medication Ratio (AMR)

The AMR PIP targets children and adolescents ages 5-11 and 12-21 who are non-compliant with their asthma medications. A two-pronged approach is being used for this project. One group of members is utilizing the Asthma Mitigation Project (AMP) for focused interventions. The AMP was developed as a special project by the Central California Asthma Collaborative (CCAC) to provide in home or virtual assessments, support, and education to asthmatics, including a subset of KHS members who are non-compliant for the AMR MCAS measure. The second group of members are a part of KHS' collaborative effort from the Health Education and Pharmacy teams for focused interventions.

The AMR PIP is in the testing phase, which is focused on collaborating with KHS providers to educate a subset of our members who are non-compliant with their Asthma medication and develop an Asthma Action Plan to support management of their condition. Outcomes for KHS' internal interventions for the third cycle include a success rate of 72% for member outreach and 52% of the members who were contacted agreed to participate in the program. We're pending outcomes for completed medical record requests and Asthma Action Plans. However, for the previous cycle we had a success rate of 100% completion of Asthma Action Plans for members enrolled in the program. Outcomes for the AMP program with the CCAC will be included by end of the year.

B. Member Engagement and Rewards Project (MERP):

MERP Campaign #3 for 2022 was launched mid-September with robocalls. A total of 22,783 robocalls were scheduled for this campaign. Measures included in campaign are:

- Breast cancer screening (BCS)
- Cervical cancer Screening (CCS)
- Chlamydia Screening in Women (CHL)
- Lead Screening in Children (LSC)
- Well-Child Visits in the First 30 Months of Life (W30)
- Child and Adolescent Well-Care Visits (WCV)
- Prenatal and Postpartum Care (PPC)
- Initial Health Assessment (IHA)

Text messaging is delayed as scripts need to be approved by DHCS. Mailers are pending due to revision needed to include updated language assistance tag lines.

For campaign #2, robocalls were completed between 6/14/22- 6/21/22. 63% of the 13,282 robocalls were successful.

C. SWOT Analysis Project:

The SWOT for RY 2022 was concluded by DHCS, and no further submissions are required at this time. QI opted to continue our work on the current SWOT because of the progressive and promising outcomes of our interventions. This was supported by our DHCS nurse consultant. The SWOT team continued to meet with community partners to discuss collaboration possibilities. We've established quarterly meetings with Kern County Public Health Department (KCPHD) to stay current on future community events that our two entities could collaborate to achieve best outcomes for KHS members.

D. Organizational Quality Incentives Project:

The Member Services Outreach Pilot for Members with MCAS gaps in care is continuing. Since the pilot began, roughly 12k outreach calls have been made with 53.5% of those members being reached. Of the members that were reached, 33% scheduled appointments. Since the program started June 1st, there has been an overall improvement for those members in compliance with MCAS measures of 19%.

Key Accomplishments:

- Standing Orders: CBCC Amendment has been executed and initial list of members have been provided
- Standing Orders: Premier Specialty Group amendment has been provided and list is ready to be provided to Dr. Brar once contract is signed.
- P4P Kick off meeting was conducted
- Existing Data Sources for DHCS data development was complete

Next Steps:

- Obtain integrated DHCS data Gap analysis report
- Develop business requirements for Pilot Outcome reports
- Identify and obtain approval for 2023 P4P measures

E. NCQA Accreditation Readiness Review Consultant RFP Project:

The Mihalik Group is the vendor selected and will be presented to the Board in October. Establishing a contract for 2023 is the focus with re-assessment of scope and cost following the vendor's readiness review and action plan.

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V. Managed Care Accountability Set (MCAS) Updates (also referred to as HEDIS): Below are the YTD MY2022 rates compared to MY2021 MCAS rates:

MCAS MY2022 & MY2021 Performance Trending Metrics

Measure	Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
BCS	2021	35.66%	37.10%	38.70%	40.39%	42.15%	44.56%	45.89%	47.08%	▼ 48.06%	49.17%	50.47%	51.40%
	2022	32.94%	34.63%	36.88%	38.52%	39.97%	41.51%	42.90%	49.72%	▲ 50.82%			
CBP	2021	0.00%	0.99%	2.56%	3.51%	4.31%	5.77%	6.22%	6.64%	▼ 6.96%	10.00%	12.40%	15.06%
	2022	3.79%	7.66%	11.84%	14.64%	16.47%	21.09%	23.60%	26.57%	▲ 29.09%			
CCS	2021	39.74%	39.81%	40.71%	42.05%	43.05%	44.87%	45.78%	46.55%	▲ 47.23%	48.09%	48.81%	49.36%
	2022	38.04%	38.61%	39.73%	40.80%	41.74%	42.71%	43.61%	45.95%	▼ 46.92%			
HBD*	2021	99.87%	95.58%	89.09%	81.99%	77.34%	74.82%	72.39%	70.86%	▼ 69.64%	68.67%	67.19%	73.98%
	2022	99.88%	94.55%	94.51%	92.75%	92.75%	92.64%	73.54%	71.85%	▲ 60.67%			
CHL	2021	16.67%	26.25%	33.23%	36.78%	40.91%	43.87%	46.07%	48.26%	▼ 49.49%	51.43%	52.37%	53.40%
	2022	0.00%	6.28%	35.66%	39.51%	41.79%	44.34%	46.89%	48.58%	▲ 50.16%			
CIS-10	2021	9.59%	10.78%	12.43%	14.47%	21.31%	21.88%	22.45%	22.79%	▲ 23.15%	23.61%	24.09%	24.71%
	2022	11.93%	13.27%	14.49%	15.58%	16.24%	16.52%	16.77%	16.98%	▼ 17.23%			
FUA 30Day follow up	2021	13.04%	12.88%	11.68%	11.60%	11.81%	12.46%	13.76%	13.49%	▲ 13.82%	13.53%	14.05%	15.60%
	2022	2.90%	7.26%	8.65%	10.05%	9.96%	9.58%	10.34%	10.94%	▼ 10.99%			
FUM 30Day follow up	2021	5.56%	12.75%	16.78%	18.72%	20.46%	19.58%	21.34%	21.27%	▲ 22.15%	22.43%	22.20%	19.93%
	2022	10.00%	11.88%	12.34%	12.69%	13.36%	14.97%	13.92%	14.01%	▼ 14.01%			
IMA-2	2021	21.16%	22.16%	23.79%	24.84%	25.73%	26.93%	27.66%	29.43%	▲ 29.88%	30.41%	30.70%	30.91%
	2022	20.56%	21.77%	22.79%	24.36%	25.19%	26.30%	27.09%	25.45%	▼ 25.81%			
LSC	2021	40.77%	42.98%	44.79%	46.11%	46.98%	47.90%	48.80%	49.24%	▲ 49.57%	49.76%	49.92%	50.05%
	2022	37.45%	39.29%	40.27%	41.36%	42.84%	43.68%	44.48%	45.26%	▼ 45.88%			
PPC-Pre	2021	25.62%	29.74%	31.80%	33.39%	34.99%	38.38%	40.17%	42.28%	▲ 43.94%	44.14%	44.26%	44.00%
	2022	17.20%	21.14%	24.27%	26.29%	29.44%	32.85%	35.92%	26.78%	▼ 29.72%			
PPC-Post	2021	37.74%	46.16%	51.23%	56.89%	58.32%	57.22%	57.86%	57.65%	▲ 59.06%	63.14%	66.45%	67.11%
	2022	41.33%	44.48%	50.57%	51.19%	51.36%	54.00%	53.77%	54.21%	▼ 55.15%			
W30 (0-15M)	2021	8.56%	10.12%	11.90%	13.55%	14.91%	16.18%	17.37%	18.18%	▼ 18.91%	19.67%	19.94%	20.11%
	2022	9.86%	11.17%	12.29%	13.94%	15.15%	16.29%	17.52%	18.51%	▲ 19.09%			
W30 (15-30M)	2021	35.69%	39.18%	41.44%	43.23%	44.35%	45.37%	46.52%	47.20%	▼ 47.51%	47.64%	47.81%	47.85%
	2022	38.33%	41.13%	42.95%	44.90%	46.22%	47.19%	48.04%	48.73%	▲ 49.13%			
WCV	2021	1.11%	3.71%	7.14%	11.02%	14.24%	17.59%	20.63%	24.99%	▲ 28.42%	31.66%	34.36%	36.70%
	2022	1.38%	3.50%	7.00%	10.77%	13.71%	17.07%	20.40%	24.77%	▼ 27.65%			

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The above chart displays trending rates for MY2021 and MY2022. As of September 2022, **6 out of 15 (BCS, CBP, HBD, CHL, W30 -0-15M, W30 -15-30M) measures showed improvement compared to this month last year**. HBD* is an inverse measure where the lower rate indicates better performance. Measures that did not show improvement compared to last year are CCS, CIS, FUA, FUM, IMA, LSC, PPC-Pre and Post, and WCV. Green arrow indicates rate increased and Red arrow indicates rate decreased compared to previous year September2021. **14 out of 15** measures showed improved compared to previous month. Some of the measures like CIS, PPC-Pre and FUM are showing significant drop compared to previous year, we are in the process of validating those rates to ensure they are accurate.

VI. Policy Updates: There is one policy update for today's meeting, 2.71-P Facility Site Review and Medical Record Review.

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VII. Appendix A

MCAS Committee

Date | time: 09/22/2022 @ 9:00 to 10:00 AM

Location: GoTo Meeting
Join on your computer or mobile app
Click here to join the meeting

Phone Number: 929.352.2833
Access Code: 746 804 340#

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Meeting Called By: Jane Daughenbaugh

Attendees:

☐ Adriana Salinas	✓ Amy Daniel	✓ Andrea Longoria	✓ Brianna Gudmundson
☐ Bruce Wearda	✓ Cesar Delgado	✓ Chanell Hull	✓ Christina Kelly
✓ Dan Diaz	✓ Deborah Murr	☐ Emily Duran	☐ Isabel Silva
✓ Jake Hall	✓ Jane Daughenbaugh	✓ Jane MacAdam	✓ Jeff Pollock
✓ John Miller	✓ Kailey Collier	✓ Lisa Amarillas	☐ Loni Hill-Pirtle
✓ Louie Iturriria	☐ Marilu Rodriguez	☐ Martha Tasinga	✓ Melissa McGuire
✓ Monica Bandaru	✓ Nate Scott	✓ Angelica Diaz	✓ Julie Oxford
✓ Flor Del Hoyo Galvan	✓ Misty Dominguez	☐	☐
☐	☐	☐	☐

Agenda Items

Topic	Presenter	Time allotted

KERN HEALTH SYSTEMS
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	****Introductions & General Updates**		
	• QI MCAS/HEDIS Supervisor ○ Timeshia Mackey – starting 09/26/2022	Jane Daughenbaugh	5 minutes
	Notes: *Timeshia is coming to KHS from Bakersfield Heart Hospital's Risk Management and Compliance dept. and will be onboarding next week.*		
✓	• Member Engagement & Rewards Program (MERP) Update ○ 2022 Campaign #3	Kailey Collier	
	Notes: *Campaign #3 currently underway this month and consists of robocalls and mailers.* • *Robocalls began last week and will conclude next Tues., anticipate 22,000 calls* • *Marketing is working with Printing to complete updating mailers to align with DHCS' directive on language tag lines* • *Text messaging is still anticipated for this campaign and scheduled to be completed in November* ○ *Scripts have been sent to Compliance and is awaiting DHCS approval*		
	Follow-Up Action Items		
	• Committee Review – Inventory of Current Organizational Wide Efforts to Improve MCAS Rates	~~Marilu Rodriguez~~	10 minutes
✓	*Notes:* *Topic will be discussed in November's Committee meeting*		
	• Reporting for MCAS Direct Member Outreach Pilot	Jane Daughenbaugh & Monica Bandaru	5 minutes
	Notes: *This topic was discussed with the OQIP Updates (see topic below)*		
	****Managed Care Accountability Set (MCAS) Compliance Rates**		
✓	• Overview MY 2021 Final Rates ○ QI Touchbase with DHCS nurse consultant Arlene Silva on 08/30/2022 ○ Committee Feedback	Monica Bandaru & Jane Daughenbaugh	15 minutes
	Notes:		

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	• Year-To-Date MCAS Rates ○ HEDIS Dashboard ○ Committee Feedback	Jane Daughenbaugh & Julie Oxford	5 minutes
	Notes: *HEDIS Dashboard/CMO Packet handout was reviewed* • *Currently we are not meeting MPL for any measures* • *HEDIS Dashboard can be used to determine where to focus initiatives* ○ *At the beginning of the year, use the dashboard to see which measures had the largest gap in meeting the minimum performance level (MPL)* ○ *Towards the end of the year focus on measures we are close to meeting MPL and focus initiatives on these measures to push them over the MPL* *Q&A* • *Jake commented that the volume of members also needs to be considered – for example if 1,400 members are needed to meet MPL but only 800 members remain in the eligible population it would hinder our ability to meet MPL*		
✓	****Organizational Quality Incentive Program (OQIP) Updates**	Deb Murr & Jane Daughenbaugh	10 minutes
	Notes: *OQIP Initiatives Inventory handout reviewed* • *PCP Support for Prenatal Care – completed* • *Member Service Outreach* ○ *2 rounds of outreach calls were completed* ○ *Jane reviewed the outcomes handout – see 'Results MCAS Outreach Both Sets of Providers'* ▪ *Reports will be sent every 2 weeks* ▪ *One report each month will show now change compared to prior reports due to claims lag* ○ *Cesar noted noncompliant member reports are refreshed weekly* ○ *Jane commented she feels the data supports continuing this effort* • *Mobile Preventive Health Services Pilot* ○ *Currently working with Adventist Health who will provide mobile services in McFarland area in September and October* ○ *Looking at expanding this to other mobile health providers and into more areas* • *Pay-for-Performance (P4P) Bonus Payment Program* ○ *Jake provided an overview – currently targeting Pediatricians* ○ *Jane inquired if we could isolate these 5 providers and compare them with their peers not in the program to gauge improvement* ▪ *Cesar stated this can be done* ○ *Jake was asked to provide an update at the next Committee meeting*		

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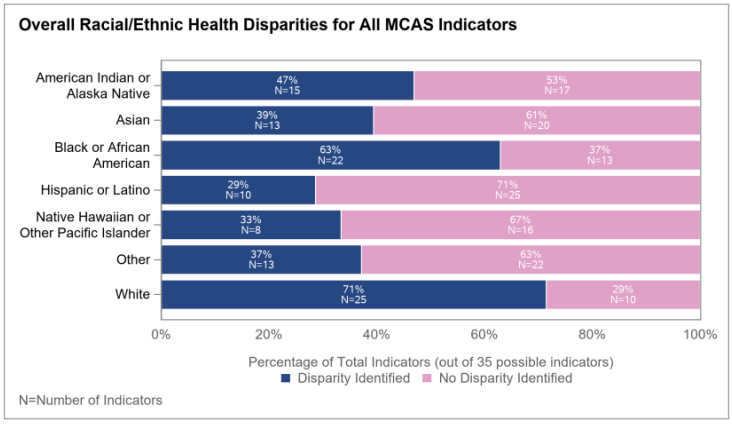
	• *Proactive Member Screening (Standing Orders)* ○ *Collaborating with CBCC and Dr. Brar's office* ○ *List of noncompliance members are given to the providers who then conduct outreach and provide screening and follow-up and communicate the results to the member's PCP* ○ *Focusing on care to each provider's specialty* • *Existing Supplemental Data* ○ *Cesar provided an overview* ○ *Target date on data integration for all measures is TBD – Jane asked Cesar to provide target date at the next Committee meeting* • *2023 Redesign of P4P* ○ *Jake provided an overview* • *Quarterly Provider Visits* ○ *Jane provided an overview – goal is to coordinate reports to share at provider quarterly meetings* ○ *Cesar suggested a 'mini-packet' which profiles the provider and compares them with their peers that are not being met with to show outcomes to see if these meetings are having an impact* ○ *Jane stated she has asked Ema to schedule a meeting with her and Cesar to discuss this further*		
	****Measurement Year 2022 MCAS Audit Updates**		
✓	• Measures stratified by race/ethnicity in MY 2022 ○ Measures held to MPL: ▪ Child and Adolescent Well-Care Visits (WCV) ▪ Childhood Immunization Status: Combo 10 (CIS10) ▪ Follow-Up After ED Visit for Mental Illness (FUM) ▪ Follow-Up After ED Visit for Substance Abuse (FUA) ▪ Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9%) - (HBD) ▪ Controlling High Blood Pressure (CBP) ▪ Immunizations for Adolescents: Combo 2 (IMA2) ▪ Prenatal and Postpartum Care: • Timeliness of Prenatal Care (PPC-Pre) • Postpartum Care (PPC-Pst) ○ Measures not held to MPL ▪ Colorectal Cancer Screening – (COL) ▪ Postpartum Depression Screening and Follow-Up – (PDS-E)	Jane Daughenbaugh & Monica Bandaru	5 minutes

	▪ Prenatal Depression Screening and Follow-Up – (PND-E)  *Figure 1.7 – Overall Racial/Ethnic Disparities for All MCAS Indicators from *2020 Health Disparities Report* by Managed Care Quality and Monitoring Division of DHCS (page 10)		
	Notes: *Jane provided an overview of the listed measures that will be stratified by race/ethnicity in measurement year (MY) 2022* • *Currently working with Cotiviti and Cesar's team* • *State has not provided any guidelines on stratification other than the race/ethnicity values*		
	• Measures Reported Using Electronic Clinical Data Systems (ECDS) in MY 2022* ○ Depression Remission or Response for Adolescents and Adults – (DRR-E) ○ Postpartum Depression Screening and Follow-Up – (PDS-E) ○ Prenatal Depression Screening and Follow-Up – (PND-E) ○ Prenatal Immunization Status – (PRS-E) ○ Depression Screening and Follow-Up for Adolescents and Adults – (DSF-E) *National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS®) for 2022 Measurement Year 2022, Volume 2, Technical Specifications for Health Plans (section K, Pages 570-664)	Monica Bandaru	5 minutes
	Notes: • *Gradually NCQA is including a growing number of ECDS measures in HEDIS®*		

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	• *DHCS is requiring 5 measures to be reported through ECDS for MY 2022* • *BI is working on data prep and how to feed this data into Cotiviti* • *Jane stated she anticipates all hybrid measures will be phased out and transitioned to ECDS measures over the next several years*		
✓	**Wrap-Up:** • Committee Comments/Suggestions? • Next Meeting – Monday, November 8, 2022	All Attendees	
	Notes: *Deb commented that as we continue to strategize on closing gaps for MCAS measures she would like for the Committee to provide input*		

Action Items

Action Item	Owner	Target Date
Provide update on Pay-for-Performance (P4P) Bonus Payment Program to the Committee	Jake Hall	11/8/2022
Provide target date for implementation of data integration for all measures	Cesar Delgado	11/8/2022
Follow-up with Ema re: schedule a meeting between Cesar and Jane to discuss Provider Quarterly Visit reporting	Jane Daughenbaugh	

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Initial Health Assessment (IHA) Audit

Completed: August 2022
Presented by: Kailey Collier, RN

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What is an IHA?

Comprehensive assessment during members' initial encounter with Primary Care Provider (PCP)

Consists of:

- History & Physical
- Staying Healthy Assessment (SHA)

Must be completed within 120 days of enrollment

Purpose of IHA

- Establish relationship between members and PCPs
- Assists PCPs in learning about members' health care history and needs
- Assess members' lifestyle behaviors to identify opportunities for healthy living
- Support members in achieving positive outcomes and improving overall health

IHA Audit Overview

- Initiated in July 2022
- Twice a year (Jan and July) QI RNs audit PCPs by sampling a selection of members identified through an automated report
- Minimum of 100 charts
- Goal: Ensure all components of IHA have been completed and documented in accordance with regulatory requirements

IHA Audit Outcomes

116 charts audited

17 PCPs

Overall Score: 75%

Follow-Up

- Educational letters were sent to all providers with scoring and areas of deficiency
- Resources and training for the SHA are referenced in the letters
- Bulletins and informational references available on KHS' public website

Potential Quality of Care Issues (PQI) Audit

3rd Quarter 2022

Presented by: Kailey Collier, RN

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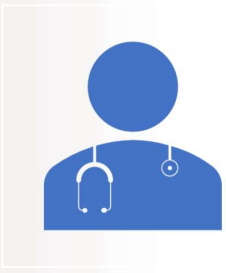
PQI Audit Overview

Quarterly clinical auditing process developed for monitoring of PQI reviews.



Purpose: Ensure compliance with KHS policies and procedures, and appropriate clinical assessment and documentation.

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PQI Audit Process

- QI Manager conducts quarterly audits of 3-5 cases completed for each QI RN who performs PQI reviews.
- Audit results that do not achieve a passing score of 90%
  - QI Manager follows corresponding action plan and addresses areas of deficiency with assigned QI RN to remedy deficiencies within 5 business days.
  - Corrections to be reflected on next audit

PQI Audit Findings
3rd Quarter 2022

- RNs audited: 7
- PQI cases per RN: 3-5
- Total cases audited: 24
- Overall scores: 100% (All RNs)

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Potential Quality of Care Issues (PQI)				POLICY #: 2.70-I	
DEPARTMENT: Quality Improvement					
Effective Date: 7/21/2020	Review/Revised Date:	DMHC		PAC	X
		DHCS		QI/UM COMMITTEE	X
		BOD	X	FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Senior Director of Provider Network

_____ Date _____
Director of Compliance and Regulatory Affairs

_____ Date _____
Director of Member Services

_____ Date _____
Director of Quality Improvement

IMPACTED DEPARTMENTS:
All Departments

DEFINITIONS:

Complaint: A complaint is the same as a Grievance. ~~Where the~~When KHS is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.

Corrective Action Plan (CAP): This is a plan approved by the Chief Medical Officer (CMO) to prevent a quality issue from occurring again in the future. A CAP is an agreement between the provider and KHS that describes the problem and appropriate measures to achieve resolution. If the CAP includes reassignment of patients, the CMO or his/her designee notifies the Chief Network Administration Officer to coordinate patient panel changes.

Grievance: A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by ~~the~~ KHS to make an authorization decision.

Potential Inappropriate Care (PIC): This is the term Department of Health Care Services (DHCS) has identified for a Potential Quality of Care issue. They define it as a grievance related to the overuse, underuse, or misuse of health care services[1] It is a possible adverse variation from expected clinician performance, clinical care, or outcome of care. PICs require investigation to determine if an actual quality issue or opportunity for improvement exists.

Potential Quality Issue: A Potential Quality Issue (PQI) is defined as a possible adverse variation from expected clinician performance, clinical care, or outcome of care. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists. Not all PQIs represent quality of care issues.

Quality of Care (QOC) issue: Quality of Care means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Screening Process: This process includes a complete review of the referral. The QI RN assigned to the episode will determine if further investigation is warranted based on the data gathered in the PQI Referral.

PURPOSE

To provide a defined method for identifying and processing PQI issues, to determine opportunities for improvement in delivery of health care to Kern Health System members, and to direct appropriate follow up actions based upon investigative outcomes, risk, and severity. The policy also supports continuous review of the quality of care provided to members to ensure that a level of care, which meets professionally recognized standards of practice, is being delivered to all enrollees and that quality of care problems are identified and corrected for all provider entities.[2]

This policy also ensures that KHS' Quality Improvement System (QIS) effectively monitors, evaluates, and takes effective action to address any needed improvements in the quality of care delivered by all

[1] DHCS Managed Care Program Data (MCPD) Primary Care Provider Assignment (PCPA) Technical Documentation, March 27, 2020, version 1.3

[2] Tit. 28, § 1300.70

Providers rendering services on behalf of KHS in any setting.[3]

POLICY AND PROCEDURES:

I. All PQI referrals are screened by a QI RN to validate that a PQI issue exists.

A. Cases are reviewed using professionally recognized, evidence-based standards of care to assess care provided.

II. PQI Sources for Identification include, but are not limited to, the following sources:

A. Information gathered through Utilization Management.
B. Referrals from any health plan staff.
C. Facility site reviews.
D. Claims and encounter data.
E. Pharmacy utilization data.
F. Managed Care Accountability Set (MCAS) medical record abstraction process.
G. Medical Record Audits
H. Complaints/Grievances and Appeals from members
I. Provider Preventable Condition (PPC) Reviews
J. Providers or other health care organizations

III. PQI Referrals

A. May be reported by any of the following:
   1. Any KHS staff member via the Potential Quality of Care Issue (PQI) Referral Form (Appendix A).
   2. If a PPC is identified via the daily PPC report, a PQI episode will be created in KHS' medical management system for review. Refer to Policy 2.72-I Provider Preventable Condition Policy.
   3. If a PPC is identified during the Utilization Management (UM) review process, a referral will be made to QI indicating a PPC has been identified for appropriate PPC reporting and PQI review. Refer to Policy 2.72-I Provider Preventable Condition Policy.
   4. Any KHS member, member of the community, or provider can call 661.632.1590 (Bakersfield) or 800.391.2000 (outside of Bakersfield), or 711 for TTY/TDD, or they can complete the Grievance form located on KHS' public website and submit it via mail or online.

B. PQI Referrals Via a Grievance
   1. Grievances received by the KHS Grievance Team are reviewed by a Grievance Coordinator (GC) who makes an initial classification recommendation of the Grievance. See KHS Policy 5.01-P, KHS Member Grievance and Appeals, for classification types.
   2. All grievances received are referred to the assigned QI grievance nurse along with a copy of the original grievance to evaluate whether a ~~PQI~~ Quality of Care (QOC) issue may be present. Processing of Grievances follows the timeframes identified in KHS Policy 5.01-P, KHS Member Grievance and Appeals.
   ~~2.~~
   3. The QI nurse assigned to review the grievance evaluates whether a ~~PQI~~ QOC issue may be present. If additional information or medical records are needed to complete the screening, it is returned to the GC so they may request that of the member or provider associated with the grievance~~.~~.

[3] Title 28, CCR, Section 1300.70 and 42 CFR 438.330

4. If the QI nurse agrees that a QOC grievance exists, it is classified with the appropriate Quality of Care disposition.
~~3.~~
5. The QI nurse completes review of the original grievance and any other pertinent information to determine if a ~~PQI~~ QOC may be present and documents a clinical summary of their review.
6. The assigned GC requests records in accordance with Sections IV.B.1 and IV.B.2 below. The requests are made using the forms in Appendix B (Initial and Final Medical Record Request Forms).
~~4.~~
~~5.~~7. If the QI RN determines that a ~~PQI~~ QOC may be present, the grievance is referred to the designated medical director physician for review and final determination of whether a ~~PQI~~ QOC is present.
~~6.~~8. When the medical director determines a ~~PQI~~ QOC is present, a referral to the QI Department is made to complete the PQI investigation process.
~~7.~~9. The medical director includes in their final determination a summary of their review and findings.
~~8.~~10. The GC is notified of the outcome of the medical director's ~~PQI~~ QOC review to complete a ~~notification~~ resolution to the member including a clear and concise explanation of the Plan's decision to the members grievance.
~~9.~~11. The QI nurse assigned to the grievance opens a PQI referral episode and requests any additional medical records required for the PQI investigation. ~~The assigned GC requests records in accordance with Sections IV.B.1 and IV.B.2 below. The requests are made using the forms in Appendix B (Initial and Final Medical Record Request Forms).~~ The PQI referral is assigned to a QI nurse to begin the PQI investigation process.

~~10.~~12. Grievances referred as a PQI are entered into KHS' medical management system. The assessment covers all information on the ~~–~~ PQI Notification Referral Form (see Appendix A). Once the referral is submitted in KHS' Medical Management System, an episode is created and moved into a work queue for a QI RN to begin the investigation process.

IV. PQI REVIEW PROCESS

A. All notifications to and requests of providers shall be sent via certified mail. Communications may be done by phone or fax. However, all notifications and requests will also include written communication and be sent by certified mail to ensure delivery and identify the date of receipt. A copy of the certified mail receipt is scanned and retained within the medical management system episode. A copy of the certified mail signature of delivery and receipt will also be scanned and retained within the medical management system episode.

B. All PQI referrals received by the QI department will include an investigation of existing clinical documentation that can be used to determine if a QOC issue exists. A QI nurse will screen the PQI referral and determine if any additional records need to be requested or if the clinical information needed to determine if a QOC issue is present are already available (e.g., through Utilization Management, Case Management, Health Homes, etc.). If additional medical records are needed, the QI nurse will identify what records are needed and notify the QI Senior Coordinator (SC) or other designated support staff to initiate the records request.
   1. The QI nurse uses the PQI Medical Records Request Form in Appendix B.

a. When this form is completed and sent to the provider, the QI nurse will upload the form into KHS' Medical Management System.
b. If there has been no response from the provider within 10 business days of the 1st request, the QI nurse will request records a second time.
c. The QI nurse will also notify the Provider Network Management (PNM) representative assigned to the provider and include a copy of the records request form to assist with obtaining the requested records.

2. If there has been no response from the provider within 10 business days of the 2nd request, the QI nurse will notify the Chief Medical Officer (CMO) or their designee (a physician) for a final outcome based on the information available. This will be documented in KHS' Medical Management System.
3. When indicated, a referral to or coordination with KHS's other medical management programs such as, Case Management, Disease Management and Health Homes will be made to coordinate care for complex or challenging member issues.

C. Once the records have been received, they are uploaded into KHS' Medical Management System for review by the assigned QI nurse. After investigation by the QI RN, a summary of the review is created using the SBAR format (Situation, Background, Assessment, and Recommendation) and presented to the CMO or their designee for review and determination in KHS' Medical Management System.
D. When the QI nurse refers the PQI to the CMO or their designee, a task is entered for follow up with the CMO or their designee if no action has occurred by the CMO or their designee within 1 week of referral.
E. The QI nurse contacts CMO, or their designee assigned to the episode to request completion of the PQI referral.
F. If there is still no follow-up by the CMO or their designee, the QI nurse will notify the QI manager for escalation.
All PQI referrals are referred to the CMO or their designee for final determination of severity level and any follow up direction.
G. The CMO or their designee reviews the documentation within KHS' Medical Management System for the indicated PQI issue and documents the final determination of existence of a QOC and the PQI Severity Level.
1. The Medical Director documents follow up actions appropriate for the needed improvement and coordinates those items with the QI RN.

H. PQI Severity Level
1. The PQI severity level is determined by the CMO or their designee following their investigation. The exception to this is Level 0 when it is determined through the screening process completed by a QI RN. Based on the outcome of the review, the episode is designated with a Severity Level of one of the following levels:
- Level 0 = No Quality of Care Concern
  - The PQI is then closed.
- Level 1 = Potential for Harm
  - Follow-up = Track and trend the area of concern for the specific provider, and the CMO or their designee or their designee may provide additional actions that are individualized to the specific case or provider.
- Level 2 = Actual Harm
  - Follow-up = Implement a Corrective Action Plan plus direction from CMO or their designee or their designee that is individualized to the specific case or provider.

- Level 3 = Actual Morbidity or Mortality Failure
    - Follow-up = Implement a Corrective Action Plan plus direction from CMO or their designee or their designee that is individualized to the specific case or provider.

2. Copies of all written correspondence and pertinent documents are filed in KHS' Medical Management system.

I. The CMO or their designee will request any written information or clarification necessary from the provider for Levels 2 and 3 regarding the issue in question. All QOC issues are tracked for re-credentialing purposes. Input regarding QOC episodes is presented to the Physician Advisory Committee for consideration in re-credentialing providers or recommending other actions.

1. If the contracted provider fails to respond to the CMO or their designee's correspondence within 2 weeks of sending the request, the provider will be referred to the Chief Medical Officer (CMO). The CMO will coordinate with the Provider Network Management Department as needed.

J. Corrective Action Plan

1. The CMO or their designee determines if a CAP is needed. The response to the CAP is expected within 30 calendar days of sending the CAP requirement to the provider. The CMO or their designee uses the Corrective Action Plan Form in Appendix C and completes the following sections:
    a. Date
    b. Provider Name
    c. Deficiency #
    d. Expected Outcomes
2. The QI nurse creates a task in the medical management system for follow up with the provider if no response to the CAP issues has been received within the expected 30 calendar days.
3. The QI nurse contacts the provider to request the providers CAP response within 1 week. Contact may be done by phone and documented in the medical management system for the PQI episode. However, written response request within 1 week is sent by the QI nurse from the CMO or their designee via certified mail.
4. The QI nurse notifies the assigned PNM representative for the provider of the need for the CAP response from the provider.
5. If there is still no CAP response from the provider, the QI nurse will notify the CMO or their designee for further direction.
6. The CMO or their designee will attempt to contact the provider and request the CAP response. This may be done by phone and must be documented in the episode in the medical management system.
7. The QI nurse sets an activity in the episode to follow up with the CMO or their designee if no further response has been received from the provider.
8. The CMO or their designee may refer the PQI to the Physician Advisory Committee for further action.
9. Responses from the provider to a CAP issued are reviewed by the CMO or their designee. That physician makes the determination for acceptance of the CAP as completed. If a CAP response is not accepted, the CMO provides a written response to the provider with input and additional instruction for CAP completion.
10. If the CAP has not been received by day 31, the case is forwarded to the CMO for further determination, including possible review by the Physician Advisory Committee (PAC). Upon completion, the CAP will be reviewed by the CMO or their designee.

11. The CMO or their designee completes the plan portion of the CAP form (Appendix C). The CAP may include but is not limited to:
    i. Required attendance at continuing education programs applicable to the issue identified and approved by KHS.
    ii. Required training/re-training and/or certification/re-certification for performance of those procedures that require specific training and professional certification.
    iii. Track and trend analysis of the adverse quality issues identified in the clinician's practice patterns and
    iv. In-service training for clinicians and/or their staff.

K. Tracking and Trending
    1. Tracking and trending is performed to ensure that an identified QOC has been resolved. This is also done to identify any continuing patterns of concerns and opportunities for improvement.
    2. The CMO or their designee requesting the tracking and trending identifies and documets the specific areas for focus. The standard period of time to track and trend is 6 months unless otherwise specified by the CMO or their designee. All cases selected for tracking and trending are logged by the QI SC into KHS' Medical Management System as well as tracked on a spreadsheet.
    3. When a new PQI referral is received, the assigned QI nurse reviews the Track and Trend lg to see if the provider in the new referral is on active track and trending. If the provider is on the active list, the QI nurse notes that in their investigative review and includes that information in the referral to the Medical Director. All PQI referrals in which the provider is on the active Track and Trend log are referred to the CMO or their designee for PQI Severity Level determination and instructions for any follow up actions.

L. Providers with no further QOC occurrences during the duration of time they are actively tracked and trended are moved to the inactive Track and Trend log. Extension of active track and trending occurs at the direction of the CMO or their designee and because of their review of new QOC issues presented to them.

M. Provider-specific trends will be reported to Provider Network Management for inclusion in the re-credentialing process.

V. AUDITING

A. Each quarter, the QI Manager will conduct an audit of a sample of PQI episodes (Attachment A, PQI Audit Tool) completed per QI nurse who processes PQIs to evaluate that they are
    1. Complying with this policy and procedure,
    2. Employing appropriate clinical assessment skills and
    3. Documenting the PQI referral process properly.

    Any issues identified in the audit will have follow up action with the QI RN documented to support correction.

VI. DELEGATION

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. KHS will communicate the policy requirements to all delegated entities and subcontractors. KHS will ensure that all their own policies and procedures, as well as the policies, procedures, and practices of any delegates, sub plans, contracted providers, or

subcontracted Independent Physician Associations or medical groups, comply with these requirements and those located in any applicable APL.

REFERENCES:

Policy 2.72-I Provider Preventable Condition Policy
Policy 4.40-P Corrective Action Plans
Policy 4.48-P Provider Disciplinary Action
Policy 5.01-I KHS Member Grievance and Appeals
Policy 5.01-P KHS Member Grievance and Appeals
APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights"
Title 22, CCR, Section 53858(e)(2) The immediate submittal of all medical quality of care grievances to the medical director for action.
DHCS Managed Care Program Data (MCPD) Primary Care Provider Assignment (PCPA) Technical Documentation, March 27, 2020, version 1.3

APPENDICES & ATTACHMENTS

Appendix A Potential Inappropriate Care (PQI) Referral
Appendix B Medical Record Request Form
Appendix C Corrective Action Plan
Attachment A: Quarterly PQI Nurse Audit Tool

REVISIONS

October 2022: Policy received approval from DMHC 10/14/2022. **September 2022:** Policy accepted by DHCS File and Use criteria on 9/23/2022. **May 2022:** Policy approved by the QI/UM Committee. **April 2022:** Updates made to include PPC process and policy reference. **March 2022:** Updates made per DHCS CAP. **February 2022**: Changed the name of PIC to PQI to align with the term used in our contract with DHCS. Changed grievance review process so that all grievances received are reviewed by a QI nurse for evaluation of PQI presence, referral to medical director if a PQI may exist for final determination and further direction. Changed PQI process so that all PQI referrals go to the CMO or designated medical director for severity level determination and direction for follow up. Added verbiage to support assurance that PQI investigations and any CAPs issued are completed. Included additional layer of quarterly auditing for nurses' PQI work. **May 2021:** Clarified time frames throughout the policy to distinguish calendar or business days. Reduced the amount of time response for 2nd request for medical information is due. Changed references to Medical Director to Chief Medical Officer or their designee. Modified who is notified when member re-assignment is planned from the CEO to the Chief Network Administration Officer. Added new Corrective Action Form. **June 2020:** Policy revised to incorporate legal counsel's guidance. Jane Daughenbaugh, Director of Quality Improvement **April 2020** – Policy created Jane Daughenbaugh, Director of Quality Improvement.

Appendix A – PQI Referral Form

Kern Health Systems
Potential Inappropriate Care Referral Form
Confidential Report

OCCURRENCE	
Date of Occurrence: Click here to enter a date.	**QI Referral Date:** Click here to enter a date.
PROVIDER/MEMBER INFORMATION	
Provider First Name: **Provider Last Name:** **Provider NPI Number:** **Street Address1:** **Street Address2:** **City:** **State:** **Zip:** **Phone:** - - **Extension:**	**Member First Name:** **Member Last Name:** **Member ID:** **Street Address1:** **Street Address2:** **City:** **State:** **Zip:** **Phone:** - - **DOB:** ☐ **Male** ☐ **Female**
NARRATIVE DESCRIPTION OF OCCURRENCE (Factual Only)	
Summary of Complaint: **Desired Outcome of Person Filing Grievance:** **Report Prepared by (Name):** **Title:** Select One **Other, Specify:** **Date:** Click here to enter a date. **Date Submitted as PQI to QI Department:** Click here to enter a date. **ALL INFORMATION ABOVE MUST BE COMPLETED BEFORE SENDING TO QI DEPT** **SEND REQUEST TO THE "QI PQOC TEAM" EMAIL DISTRIBUTION**	

Appendix B - QI Department PQI Medical Records Request Form

Kern Family Health Care™

Initial Medical Record Request

DATE: Click here to enter a date.

TO:

COMPANY:

PHONE #:

FROM:

Name

Address: 2900 Buck Owens Blvd, Bakersfield, CA 93308

PHONE:

RE:
DOB:
MBR#:

To Whom It May Concern:
Kern Family Health Care is in the process of reviewing a grievance, regarding the above member. In order to complete our review, we will need the following information: ***All updated medical records from*** Click here to enter a date. ***to current***

*** Please include the following information and forward as soon as possible***

☐ **Registration Sheet**	☐ **Nurses Notes**	☐ **Physician Notes**
☐ **Lab/X-ray Reports**	☐ **Op Reports**	☐ **Signed Consent forms**
☐ **ER Notes**	☐ **Prescriptions**	☐ **Diagnoses**
☐ **History & Physical**	☐ **Physician Orders**	☐ **Discharg Plan (if inpatient)**
☐ **Discharge summary (if inpatient)**	☐ **Pre-op work-up**	☐ **Post-op notes (if inpatient)**
☐ **Pathology report(s)**	☐ **Other:**	

RN Requesting Records: **Date RN Returned Records Needed:** Click here to enter a date.
Please return this letter (or copy) with requested information within **10 days**. If you have any questions, please feel free to email us at QI-PQOC-Team@KHS-net.com or call us at (661) 664-5053. Thank you for your prompt assistance in this matter.

Mail to: Kern Health Systems
2900 Buck Owens Blvd
Bakersfield, CA 93308
Attn: QI Department

or

Fax to: Kern Health Systems
(661) 473-7575
Attn: QI Department

Kern Family Health Care™

Final Medical Record Request

DATE: Click here to enter a date.

TO:

COMPANY:

PHONE #:

FROM:

Name

Address: 2900 Buck Owens Blvd, Bakersfield, CA 93308

PHONE:

RE:
DOB:
MBR#:

To Whom It May Concern:
Kern Family Health Care is in the process of reviewing a grievance, regarding the above member. In order to complete our review, we will need the following information: ***All updated medical records from*** Click here to enter a date. ***to current***

*** Please include the following information and forward as soon as possible***

☐ **Registration Sheet**	☐ **Nurses Notes**	☐ **Physician Notes**
☐ **Lab/X-ray Reports**	☐ **Op Reports**	☐ **Signed Consent forms**
☐ **ER Notes**	☐ **Prescriptions**	☐ **Diagnoses**
☐ **History & Physical**	☐ **Physician Orders**	☐ **Discharg Plan (if inpatient)**
☐ **Discharge summary (if inpatient)**	☐ **Pre-op work-up**	☐ **Post-op notes (if inpatient)**
☐ **Pathology report(s)**	☐ **Other:**	

RN Requesting Records: **Date RN Returned Records Needed:** Click here to enter a date.
Please return this letter (or copy) with requested information within **10 days**. If you have any questions, please feel free to email us at QI-PQOC-Team@KHS-net.com or call us at (661) 664-5053. Thank you for your prompt assistance in this matter.

Mail to: Kern Health Systems
2900 Buck Owens Blvd
Bakersfield, CA 93308
Attn: QI Department

or

Fax to: Kern Health Systems
(661) 473-7575
Attn: QI Department

APPENDIX C – Corrective Action Plan Form

Kern Health Systems
Corrective Action Plan

Date: _____ **Provider Name:** _____

Deficiency #: _____

Deficiency Description (KHS Completes):

Expected Outcomes (KHS Completes):

Actions Taken (Completed by Provider):

Implementation Date (Completed by Provider): _____

Evidence of Completion/Supporting Documentation if Applicable (Completed by Provider):

Provider Signature **Date**

_____ _____

KHS Medical Director Name: _____

☐ Approved ☐ Rejected **Medical Director Signature** _____

Date: _____

Comments:

_____

661-664-5000
661-664-5151
kernhealthsystems.com
2900 Buck Owens Boulevard, Bakersfield, CA 93308-6316

Updated Site & Medical Record Review Policy & Procedure

October 2022

Presented by: Monique Barrios, RN

KERN HEALTH SYSTEMS

Site Reviews-Key Changes

- Current requirements for Facility Site Reviews (FSRs) and Medical Record Reviews (MRRs)
  - Last updated 8 years ago
- DHCS updated the requirements in July of 2022.
  - Due to the pandemic, implementation was delayed
  - New requirements effective July 1st, 2022
- To meet the new requirements, KHS:
  - Retiring 8 Site Review policies
  - Created 1 new policy incorporating new requirements from DHCS

KERN HEALTH SYSTEMS

Site Reviews-Key Changes

- 5 new critical elements added:
  - Airway Management no longer requires Oral Airways. Bulb syringes added to pediatric offices.
  - Demonstration of correct sterilization process of equipment
  - Cold chemical sterilant spill clean-up plan
  - Management of issues regarding equipment cold sterilization
  - Autoclave/Steam Sterilization
- Failed Critical Elements must be corrected within 10 *business* days
- Language added around Supplemental Facilities

Medical Record Review-Key Changes

- Pediatric Preventive Care (Well Child Visits)
  - Behavioral health screenings
  - Added Labs (Lipids, Hepatitis C, HIV)
  - Dental and Oral Assessments
- Adult Preventive Care
  - Behavioral health screenings
  - Added Labs (HbA1c, Hepatitis B&C, HIV)
- OB
  - Comprehensive Assessment in all 3 Trimesters vs. just 1st Trimester

**MRRs approved by DHCS to be conducted virtually or onsite*

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Facility Site Review and Medical Record Review				POLICY #: 2.71-P	
DEPARTMENT: Health Services — Quality Improvement					
Effective Date: 01/01/2022	Review/Revised Date:	DMHC	X	PAC	X
		DHCS	X	QI/UM COMMITTEE	X
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Director of Quality Improvement

POLICY:

Per Department of Health Care Services (DHCS) All Policy Letter (APL) ~~20-006~~22-017, Kern Health Systems (KHS) is responsible for oversight of the site review policies whether KHS retains site review functions, delegates them to another Managed Care Plan (MCP), or subcontracts site review. KHS develops and maintains a standardized system-wide process for conducting reviews of provider facility sites and medical records that minimize evaluation criteria and guidelines in compliance with the State Department of Health Care Services (DHCS) contractual requirements. KHS' Chief Medical Officer or designee is accountable for the Facility Site Survey process.

Kern Health Systems (KHS) personnel will perform a facility site and medical record review on all contracted primary care providers (PCP) (including OB/GYNs, IPAs, clinics, and hospital ambulatory care clinics serving as PCPs). Physical Access Reviews (PARs) will also be completed for providers who serve a high volume of Seniors and People with Disabilities (SPD) beneficiaries, in accordance with Letters, MMCD Policy Letter 02-02 and 10-016, Title 22, CCR Section 53856, and W & I Code 14182(b)(9).

KHS makes the results of the FSR Attachment C tool available to members via Provider Directories. The Provider Directories display the accessibility indicator per Medi-Cal Managed Care Division (MMCD) Policy Letter 11-009. The Provider Directories identify whether the provider site has access in the following categories: Parking (P), Exterior Building (EB), Interior Building (IB), Restroom (R), Exam Room (E), and Exam Table/Scale (T).

Only a Certified Master Trainer (CMT) or Certified Site Reviewer (CSR) conduct initial and subsequent site reviews, consisting of a Facility Site Review (FSR) and Medical Records Review (MRR), regardless of a PCP site's other accreditations and certifications.

KHS conducts an initial and subsequent site review, consisting of an FSR and MRR, for all contracted Primary Care Provider (PCP) sites receive regardless of the site's other accreditations and certifications. KHS ensures the following:

A. Each PCP site has passed an initial FSR and, as applicable, corrects all deficiencies in order to close their Corrective Action Plan (CAP) prior to adding the provider(s) to the MCP's network and assigning MCP members to the provider(s).
B. Each PCP ~~passes~~ completes an initial MRR after the PCP is assigned members, and, as applicable, submits all appropriate documentation to address all deficiencies to close their CAP.~~.~~
C. Each PCP site ~~passes~~ completes a periodic subsequent site review~~s~~, consisting of both an FSR and MRR, at least every three years after the initial FSR.
D. DHCS' most current FSR and MRR tools and standards are being utilized when conducting site reviews
E. All PCP sites are held to the same standards.
F. The site review status of each contracted PCP site is properly tracked.
G. KHS collaborates with Health Net or any other local MCP to determine how we notify each other of site review statuses and results for shared providers.

KHS issues a Certified Quality Provider Site certificate to providers that successfully pass a site review. This certificate is valid for up to three years and affirms that the site has been deemed a DHCS Certified Quality Provider Site. ~~KHS works with the DHCS assigned Nurse Evaluator to ensure we use the most current certificate template.~~ Certificates are issued and revoked to shared provider sites in coordination with the county collaborative partner.

KHS notifies its providers in advance for scheduled site reviews. However, inspection of an MCP's facilities or other elements of a review may be conducted without prior notice, in conjunction with other medical surveys or as part of an unannounced inspection program[1].

KHS may choose to delegate site review responsibilities to another MCP. However, KHS retains ultimate responsibility for oversight of site review completion, results, any necessary corrective action plan (CAP), and monitoring of assigned PCP sites per county collaboration.

DEFINITIONS:

Ancillary Service Providers: Free standing facilities that provide diagnostic and therapeutic services, such as, but not limited to laboratory, infusion, radiology, imaging, cardiac testing, renal dialysis, occupational therapy, speech therapy, physical therapy, pulmonary testing, and cardiac rehabilitation.

High Volume Specialists: Ancillary and CBAS Providers as a whole. Specialty, Ancillary and CBAS types, whose claim numbers exceed the established average, will be considered High Volume SPD Specialties, Ancillary and CBAS Providers.

PROCEDURES:

1.0 SITE REVIEW PROCESS

A. Initial Site Review

An initial site review consists of an initial FSR and an initial MRR. The initial FSR and the initial MRR might not occur on the same date. The FSR is conducted first to ensure the PCP site operates in compliance with all applicable local, state, and federal laws and regulations. KHS does not assign members to providers until their PCP sites receive a passing FSR score and completes all CAPs. An initial FSR is not required when a new provider joins a PCP site that has a current passing FSR score.

A DHCS Site Identification Number ("DHCS Site ID") is a unique identifier and must be assigned by designated MCPs to each PCP site reviewed. DHCS releases sets of DHCS Site ID numbers for each county. In the event of an ownership change at an established PCP site, a new DHCS Site ID will be assigned. The new DHCS Site ID may be the existing Site ID but with a modifier to represent a change of ownership at the site. Local county MCPs collaborate to manage and assign the DHCS Site ID numbers specific to the county

Once a PCP site passes the initial FSR's and completes all Corrective Action Plans (CAPs)~~R~~, KHS begins assigning members to the PCPs at that site. KHS will complete the initial MRR of a new PCP site within 90 calendar days of the date that KHS first assigns members. KHS may defer this initial MRR for an additional 90 calendar days only if the new PCP does not have enough assigned MCP members to complete the MRR on the required minimum number of medical records (see Subsequent Site Reviews below for details regarding the required minimum number of medical records). If, after 180 days following assignment of members, the PCP still has fewer than the required number of medical records, KHS will complete the MRR using the total number of medical records it has available and adjust the scoring according to the number of medical records reviewed.

KHS may choose to conduct the MRR Review portion of the site review on site or virtually. The virtual process must comply with all applicable Health Insurance Portability Accountability Act (HIPAA) standards at all-times.

There are additional scenarios that require KHS to conduct an initial site review. Examples of these scenarios include, but are not limited to, instances when:

a. A new PCP site is added to KHS's network.
b. A newly contracted provider assumes a PCP site with a previous failing FSR and/or MRR score within the last three years.
c. A PCP site is returning to the Medi-Cal managed care program and has not had a passing FSR in the last three years.
d. At the discretion of KHS, a separate site review may be conducted for solo practices/organizations.
~~c.~~e. Upon identification of multiple independent practices that occupy the same site, a separate site review must be completed for all PCP practices at that site and a unique alphanumeric DHCS Site ID must be assigned for each independent PCP practice at the site if ownership is different. MCPs must develop processes within their local county collaborative in regard to conducting separate site reviews for shared sites.
~~d.~~f. There is a change of ownership of an existing provider site.
~~e.~~g. A PCP site relocates. When a PCP site relocates, KHS:

- Completes an initial FSR within 60 days of notification or discovery of the completed move.
- Allows assigned KHS members to continue to see the provider ~~.~~ at the new location, but not assign new Members until the initial site review is completed.

Upon passing the initial FSR and closing CAPs, if applicable, the following will occur:

i. ~~i.~~ The PCP site may be formally added to the Network.

ii. ~~ii.~~ New and established relocating Members can be formally assigned to the new Provider location[MB1].

- ~~o~~ If the relocated PCP site does not pass the initial FSR within two attempts, or does not complete required CAPs per established timelines, the following will occur:
  i. ~~i.~~ The relocated PCP site may not be added to the MCP's Provider Network.
  ii. ~~ii.~~ The previous PCP site must be removed from the Network, if the site has closed.
  iii. ~~iii.~~ Current assigned membership must be reassigned to another Network PCP, if the previous site has closed.
  iv. ~~iv.~~ The relocated PCP site may reapply six months from the last FSR survey.

~~f.~~h Does not assign new members to providers at the site until the PCP site receives passing FSR and MRR scores.

f. If KHS were to expand to a new service area, KHS will complete an initial site review on a specified number of PCP sites as outlined in the bulleted list below. The FSR portion of the initial site review must be completed prior to the start of KHS expanding its operations.

- Five percent of the PCP sites in KHS' proposed network, or on thirty PCP sites, whichever is greater in number.
- All remaining proposed PCP sites within the first six months of operation or expansion.
- All PCP sites in the network if there are thirty or fewer PCP sites in the network.
- New and/or expanding MCPs may use site reviews of existing county MCPs as evidence of completion of the required initial site reviews.
- MCPs must submit data and relevant information to DHCS, in a format and timeframe to be specified by DHCS, for the instances described above.

PCP sites that are subject to site reviews must include a variety of PCP types (Family Medicine, Internal Medicine, Pediatric, etc.) and subcontracted entities (solo practice, Medical Group, etc.) from throughout the provider network.

B. Supplemental Facilities – Mobile, Satellite, School Based, and Other Extension Clinics

Supplemental facilities assist in the care delivery of primary care services to geographically remote areas that lack health care services, as well as assist the underserved population in areas where there may be access to care concerns.

- Supplemental facilities may offer a variety of clinical services including, but not limited ~~to:~~to preventive care, immunizations, screenings, and/or chronic care management (excluding specialty services).
- Mobile clinics are self-contained units including vans, recreational vehicles, and other vehicles that have been repurposed to provide space for various clinic ~~services, and~~services and may also serve to deliver equipment to locations that operate temporary clinics.
- In general, supplemental facilities that provide primary care services may serve as an extension of a PCP site, a community-based clinic, a Federally Qualified Health Center (FQHC) county facility, or a standalone clinic with Members assigned.
- KHS must conduct an initial site review and subsequent site reviews of supplemental facilities at least every three years thereafter, with a focus on areas relevant to the services being provided by the supplemental facilities.
- KHS must establish a process to complete the oversight of supplemental facilities and collaborate with MCPs within a given county

~~B.~~C. Subsequent Site Reviews

KHS conducts subsequent site reviews, consisting of an FSR and MRR, at least every three years, beginning no later than three years after the initial FSR. KHS may conduct site reviews more frequently per county collaborative decisions, or when determined necessary based on monitoring, evaluation, or CAP follow-up issues.

~~The MRR score is based on a standard review of ten randomly selected KHS member medical records per provider, consisting of five pediatric and five adult or obstetric medical records. For PCP sites serving only pediatric or only adult patients, all ten medical records will be reviewed using the appropriate preventive care criteria. For OB/GYNs acting as PCPs, all medical records will be reviewed using preventive care criteria for adults or pediatrics (pregnant under age 21 years) and obstetrics. During the MRR, site reviewers have the option to request additional medical records for review. If the site reviewer chooses to review additional medical records, KHS will calculate the scores accordingly.~~

~~If a PCP site documents patient care performed by multiple PCPs in the same medical record, KHS will consider these medical records as a shared medical record system. KHS will consider shared medical records as those that are not identifiable as separate records belonging to any specific PCP. KHS will review a minimum of ten medical records if two or three PCPs share records, twenty medical records if four to six PCPs share records, and thirty medical records if seven or more PCPs share records. If there are multiple providers in one office that do not share medical records, each PCP will be reviewed separately and receive a separate score.~~

~~C.~~D. Scoring

KHS will base FSR and MRR scores on available documented evidence, demonstration of the criteria, and verbal interviews with site personnel. If a site reviewer chooses to review additional criteria not included on the FSR or MRR tools, the site reviewer will not include the additional criteria in the existing scoring method. KHS will not alter scored criteria or assigned weights in any way.

Critical elements have the largest potential for adverse effects on patient health or safety and therefore have a scored weight of two points while all other review elements have a scored weight of one point. The PCP site must correct all critical element deficiencies identified during a site review, focused review, or monitoring visit within ten calendar days of those reviews or visits. KHS will verify that CAPs related to critical elements are completed within 30 calendar days of the site review, focused review, or monitoring visit. KHS will ensure that PCP sites found to be deficient in any critical element during an FSR have fully corrected all deficiencies, regardless of the PCP site's FSR score. Any MRR section score of less than 80 percent requires a CAP for the entire MRR regardless of the total MRR score.

All MRR tool review elements have a scored weight of ~~one point~~one-point each. The MRR score is based on a standard review of ten randomly selected KHS member medical records per provider, consisting of five pediatric and five adult or obstetric medical records. For PCP sites serving only pediatric or only adult patients, all ten medical records will be reviewed using the appropriate preventive care criteria. For OB/GYNs acting as PCPs, all medical records will be reviewed using preventive care criteria for adults or pediatrics (pregnant under age 21 years) and obstetrics. During the MRR, site reviewers have the option to request additional medical records for review. If the site reviewer chooses to review additional medical records, KHS will calculate the scores accordingly.

If a PCP site documents patient care performed by multiple PCPs in the same medical record, KHS will consider these medical records as a shared medical record system. KHS will consider shared medical records as those that are not identifiable as separate records belonging to any specific PCP. KHS will review a minimum of ten medical records if two or three PCPs share records, twenty medical records if four to six PCPs share records, and thirty medical records if seven or more PCPs share records. If there are multiple providers in one office that do not share medical records, each PCP will be reviewed separately and receive a separate score. If a minimum number of records are not available for review due to limited patient population, the reviewer will complete the MRR, document the rationale, and adjust the score as needed.

In the event that there are multiple Providers in one office that do not share medical records, each PCP must be reviewed separately and receive a separate score. A minimum of ten medical records must be reviewed per Provider.

During the MRR, site reviewers have the option to request additional medical records for review to ensure adequate review of all Provider specialties, Member populations, etc. If the site reviewer chooses to review additional medical records, the MCP must calculate the scores accordingly.

MCPs may choose to conduct the MRR portion of the site review onsite or virtually. The virtual process must comply with all applicable HIPAA standards at all times, regardless of the chosen method. Both onsite and virtual MRRs may include the review of medical records for Members belonging to another MCP, and may include the viewing, collection, storage, and transmission of Protected Health Information (PHI)

If a PCP site receives a failing score from one MCP, all other MCPs will consider the PCP site as having a failing score. KHS will use the county collaborative process to identify shared providers and to determine methods for sharing site review information, including CAPs and provider terminations (See Policy 4.39 for Provider Terminations).

When a PCP site receives a failing score on an FSR or MRR, KHS will notify the PCP site of the score, all cited deficiencies, and all CAP requirements. KHS may choose to remove any PCP site with a failing FSR or MRR score from its network. If KHS allows a PCP site with a failing FSR or MRR score to remain in its network, KHS will require and verify that the PCP site has corrected the identified deficiencies within the CAP timelines established in this policy. KHS will not assign new members to network PCP sites that receive a failing score on an FSR or MRR until KHS has verified that the PCP site has corrected the deficiencies and the CAP is closed.

PCP sites that receive a failing score on either the FSR or MRR for two consecutive site reviews must receive a minimum passing score on the next FSR and MRR (including PCP sites with open CAPs in place) to remain in the MCP's provider network. If the PCP site fails on its third consecutive attempt, despite KHS' ongoing monitoring and assistance, the PCP site will be removed from KHS' provider network, and its members will be reassigned to other network providers, as appropriate and as contractually required.

~~D.~~E. Corrective Action Plan (CAP)

A CAP is required for all cited deficiencies for PCP sites that have a deficiency in a critical element or receive a conditional passing score on the FSR or MRR tool, on a focused review, or for deficiencies identified by KHS or DHCS through oversight and monitoring activities. CAPs are required as indicated:

Review	Exempted Pass	Conditional Pass	Fail
FSR	a. Score of 90% and above with no deficiencies in critical elements, infection control, or pharmacy b. CAP not required	a. Score of 90% and above with deficiencies in critical elements, infection control, or pharmacy b. Score of 80% and above. c. CAP required	a. Score below 80% b. CAP required

Review	Exempted Pass	Conditional Pass	Fail
MRR	a. Score of 90% and above, with all section scores at 80% and above b. CAP not required	a. Score of 90% and above with one or more section scores below 80% b. Score of 80% and above c. CAP required.	a. Score below b. 80% c. CAP required
MCPs may require a CAP regardless of score for other findings identified during the survey that require correction.			

KHS will not assign new Members to Providers who fail to correct site review deficiencies within the established CAP timelines. For Providers that fail to comply with their CAP, the MCP must verify that the PCP site has corrected the deficiencies and the CAP is closed before assigning new Members. Ultimately, KHS must remove any Provider from their Network that does not come into compliance with review criteria and CAP requirements within the established timelines, and the MCP must expeditiously reassign that Provider's Members to other Network Providers

KHS may decide to provide additional training and give technical assistance when a PCP site fails an FSR prior to contracting with KHS. Precontracted providers who do not pass the initial FSR within two attempts may reapply to KHS after six months.

When conducting the site review, KHS is responsible for follow-up, re-review, closure of CAPs, and monitoring re-reviews. CAP documentation will identify:

a. The specific deficiency,

b. Corrective actions needed,

c. Projected and actual dates of the deficiency correction,

d. Reevaluation of timelines and dates. And

e. Responsible persons

CAPs for non-critical elements may be verified via document submission. CAPs for critical elements will be verified onsite. Closed CAP documentation will include:

a. Documentation of problems in completing corrective actions (if any),

b. Resources and technical assistance provided by the MCP,

c. Evidence of the corrections,

d. Completion and closure dates, and

e. Name and title of the MCP reviewer.

KHS will follow the timeline below for CAP notification and completion:

CAP Timeline	CAP Action(s)
FSR and/or MRR Completion Day	KHS will provide the PCP site a report containing: a.Verbal notification of any CE findings and a signed attestation by the PCP/site designee and KHS staff confirming that a discussion regarding CE findings occurred. (This serves as the start of the CE-CAP timeline.) b. A formal written request for CAPs to address all CEs, if applicable, the day of the site visit but no later than one business day after site visit completion ~~a.~~ c.The FSR and/or MRR score~~ss.~~ site visit but no later than one business day after site visit completion. ~~b. Any critical element findings, if applicable; and~~ ~~c.~~a. d. A formal written request for CAPs for all critical elements, if applicable~~.~~ the day of the site visit but no later than one business day after site visit completion
Within 10 calendar days of the FSR and/or MRR	a. The PCP site will submit a CAP and evidence of corrections to KHS for all deficient critical elements, if applicable. b. KHS will provide a report to the PCP site containing FSR and/or MRR findings, along with a formal written request for CAPs for all non-critical element deficiencies. c. KHS will provide educational support and technical assistance to PCP sites as needed. ~~c.~~d. KHS must review, approve, or request additional information on the submitted CAP(s) for CE findings

CAP Timeline	CAP Action(s)
Within 30 calendar days from the date of the FSR and/or MRR report	a. KHS will conduct a focused review to verify that CAPs for critical elements are completed. b. The PCP site must submit a CAP for all non-critical element deficiencies to KHS. c. KHS will provide educational support and technical assistance to PCP sites as needed.
Within 60 calendar days from the date of the FSR and/or MRR report	a. KHS will review, approve, or request additional information on the submitted CAP(s) for non-critical findings. b. KHS will continue to provide educational support and technical assistance to PCP sites as needed.
Within 90 calendar days from the date of the FSR and/or MRR report	a. All CAPs must be closed. b. Providers can request a definitive, time-specific extension period to complete the CAP(s), not to exceed 120 calendar days from the date of the initial report of FSR and/or MRR findings.
Beyond 120 days from the date of the FSR and/or MRR report	a. KHS will request approval from DHCS to complete a CAP review for any extenuating circumstances that prevented completion of a CAP within the established timeline. b. KHS will conduct another FSR and/or MRR, as applicable, within 12 months of the applicable FSR and/or MRR date(s).

KHS will not assign new members to providers who do not correct site review deficiencies within the established CAP timelines. KHS will verify that the PCP site has corrected the deficiencies and the CAP is closed. KHS will remove any provider from the network who does not come into compliance with review criteria and CAP requirements within the established timelines, and KHS will appropriately reassign that provider's KHS members to other network providers[KCRB2].

F. ~~2.1 CREDENTIALING AND RECREDENTIALING~~

For a new provider on a site that has not previously been reviewed, initial provider credentialing and site review will occur simultaneously.

Providers at a site are credentialed according to DHCS contractual and policy requirements. A site review shall be completed as part of the initial credentialing process if a new provider at a site that has not previously been reviewed is added to a contractor's provider network. A site review need not be repeated as part of the initial credentialing process if a[KCRB3] new provider is added to a provider site that has a current passing site survey score. A site review survey need not be repeated as part of the recredentialing process if the site has a current passing site survey score. A passing Site Review Survey shall be considered "current" if it is dated within the last three years and need not be repeated until the due date of the next scheduled site review survey, as determined necessary from monitoring activities.

~~E.~~G. Monitoring

KHS will monitor all PCP sites between each regularly scheduled site review. Monitoring methods may include site reviews, but KHS also uses additional methods such as information gathered through established internal KHS systems (e.g., quality improvement), as well as provider and program-specific reports from external sources of information. KHS will monitor and evaluate all critical elements for all PCP sites between scheduled site reviews. When KHS identifies deficiencies through monitoring, KHS will determine the appropriate course of action, such as conducting a site review or additional focused reviews, to educate and correct the deficiencies according to established CAP timelines.

~~F.~~H. Physical Access Reviews (PARs)

The Physical Accessibility Review Survey (Attachment C) assesses the physical accessibility of provider sites for PCPs and high-volume specialist, ancillary, and CBAS providers who serve KHS SPD members. Physical accessibility reviews are available to any contracted provider that requests to be evaluated, regardless of whether they are determined to be high volume.

KHS conducts PARs for new PCP sites at the time of initial credentialing or contracting, and every three years thereafter as a requirement for participation in the California State Medi-Cal Managed Care (MMCD) Program. PARS are conducted for PCP sites regardless of the status of other accreditation and/or certifications.

The following types of providers will be excluded from PAR site visits:

- Non-contracted providers;
- Transportation providers;
- Durable Medical Equipment (DME) pick-up sites;
- Laboratories out of service area;
- Licensed and State-certified long-term care facilities; and
- Delegated entities, including Vision Services Plan (VSP), Managed Behavioral Health Services, and Pharmacy Benefit Managers (PBMs).

A PAR will be conducted utilizing the DHCS MMCD Facility Site Survey Tool, APL 15-023 Attachments C, D, or E when appropriate. Assessment includes, but is not limited to,

parking, building, elevator and clinic areas, exam rooms, lobbies, and restrooms. Medical equipment assessed may include, but is not limited to, height adjustable exam tables, member accessible weight scales, infusion chairs and/or beds, physical therapy equipment, and imaging equipment such as for mammography or Magnetic Resonance Imaging (MRI). KHS staff members are trained to conduct the PAR utilizing the requirements and process as described in MMCD PL 12-006 and DHCS APL 15-023. KHS must make this physical accessibility information available through its website and provider directory. The information provided must, at a minimum, display the level of access results met per provider site as either Basic Access or Limited Access. Additionally, KHS must indicate whether each site has the Medical Equipment (and/or Participant Area) Access (appropriate to ancillary or CBAS providers) as defined in FSR Attachment C, and identify whether each provider site has or does not have access in the following categories: parking, building exterior, building interior, exam room, restroom, and medical equipment.

KHS will utilize the following methodology to identify high-volume specialist, ancillary, and CBAS providers who serve KHS SPD members. At least annually, KHS will use internal claims data from the past 12 months to identify all specialist, Ancillary, and CBAS Providers who served a KHS SPD member; at a minimum, the report will include the following data categories:

1. Provider name, NPI number,
2. KHS internal provider ID number;
3. Medi-Cal specialty description.
4. Place of service, and
5. Number of SPD related claims.

KHS will total the number of claims for each specialty types and, determine the average number of claims for all specialties, Ancillary and CBAS Providers as a whole. Specialty, Ancillary and CBAS types, whose claim numbers exceed the established average, will be considered High Volume SPD Specialties, Ancillary and CBAS Providers. The provider sites in each of these specialties will then be required to undergo a Physical Accessibility Review Survey.

~~G.~~I. Focused Review

A focused review is a targeted review of one or more specific areas of the FSR or MRR. KHS~~SH~~ will not substitute a focused review for a site review. KHS may use focused reviews to monitor providers between site reviews to investigate problems identified through monitoring activities or to follow up on corrective actions. Reviewers may utilize the appropriate sections of the FSR and MRR tools for the focused review, or other methods to investigate identified deficiencies or situations. All deficiencies identified in a focused review require the completion and verification of corrective actions according to CAP timelines established in this policy and procedure.

~~H.~~J. County Collaboration

KHS will collaborate locally within each Medi-Cal managed care county to establish systems and implement procedures for the coordination and consolidation of site reviews

for mutually shared PCPs.[2] KHS and Health Net have equal responsibility and accountability for participation in the site review collaborative processes.

The Collaborative Process are:

1) Standardize policy and procedures for FSR's and MRR's
2) Standardize tolls for CAP's
3) Standardize Protocols which will limit access to audit results only to authorized health plan representatives
4) Standardized certified reviewers training and certification programs
5) Standardized protocols for designated vendor's responsibility and reporting (if applicable)

KHS submits an initial written description and periodic update reports as requested and instructed by DHCS describing the county collaboration processes, which will include, but are not limited to, the following:

1) Names and titles of each MCP's participating personnel.
2) A work plan that includes goals, objectives, activities, and timelines.
3) Scheduled meeting dates, times, and locations.
4) Meeting processes and outcomes.
5) Communication and information-sharing processes.
6) Roles and responsibilities of each MCP.
7) Delegated activities and use of delegated or sub-delegated entities.
8) Memorandum of Agreement requirements established KHS and Health Net.

KHS will establish policies and procedures to define local collaborative methodology for:

1) Identification of shared providers,
2) Confidentiality, disclosure, and release of shared provider review information and site review results,
3) Site review processes,
4) Issuance of Certified Quality Provider Site certificates,
5) Oversight and monitoring of review processes,
6) Site review personnel and training processes, and
7) Collection and storage of site review results

~~I.~~K. MCP Site Review Personnel

KHS will designate a minimum of one physician, Nurse Practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN), to be certified by DHCS as the MCP's CMT. The CMT has the overall responsibility for the training, supervision, and certification of site reviewers, as well as monitoring site reviews and evaluating site reviewers for accuracy.

KHS will determine the composition of the teams performing site reviews. Each site review will have a designated CSR who is responsible for and signs the FSR and MRR tools. Only physicians, NPs, PAs, or RNs are eligible to become CSRs. A variety of personnel may be part of the site review team, including pharmacists, dietitians, and others to provide assistance and clarification.

An RN[3] is the minimal level of site reviewer acceptable for independently performing site reviews. RN reviewers can independently make determinations regarding implementation of appropriate reporting or referral of abnormal review findings to initiate peer review procedures. An RN can only delegate site review tasks to a subordinate based on the subordinate's legal scope of practice and on the degree of preparation and ability required by the site review tasks that the RN would delegate.

KHS has written policies and procedures that clearly define the duties and responsibilities of all site review personnel. KHS ensures that site review activities established for CSRs comply with the CSR's scope of practice as defined by state law, in accordance with the state licensing and certification agencies and are appropriate to the site reviewers' level of education and training by completing a minimum of 10 FSR's and 10 MRR' s for recertification, attending a DHCS sponsored Inter rated workshop in person every two years, and achieving a 10% variance on FSR and MRR.

~~J.~~L. MCP Site Review Training and Certification

Physicians, NPs, PAs, and/or RNs that are designated by KHS to be CMTs or site reviewers will meet the certification and recertification requirements outlined in the respective table below to be certified as a CMT or CSR. CMT candidates must apply for certification directly to DHCS using Attachments 1-41 of this policy and procedure, Application for DHCS Site Review Master Trainer Certification. Applications will be submitted to KHS's assigned DHCS Nurse Evaluator. Upon certification and recertification, CMTs will receive a certificate signed by DHCS. CMTs must be recertified every three years.

KHS is responsible for ensuring that all site reviewers are appropriately trained, evaluated, certified, and monitored. KHS may collaborate with another MCP to determine local systems for training and certifying site reviewers. Training must include DHCS seminars, KHS classes, individual or small group training sessions provided by a CMT, and self-study learning programs. KHS can only certify physicians, PAs, or RNs as CSRs, and recertify them every three years thereafter. Upon certification and recertification, CSRs will receive written verification of certification by KHS.

~~K.~~M. Inter-rater Review Process

Candidates for CMT and CSR certifications will complete an inter-rater review process as part of both the initial certification and recertification processes. The inter-rater for CMT

candidates is a DHCS Nurse Evaluator. The inter-rater review process requires the CMT candidate to concurrently complete and score a site review with the DHCS Nurse Evaluator using the DHCS FSR and MRR tools and standards. The inter-rater for CSR candidates is KHS' CMT. The inter-rater review process requires the CSR candidate to participate with KHS' CMT to concurrently complete and score a site review utilizing the DHCS FSR and MRR tools and standards. The CMT or CSR candidate must achieve the required inter-rater score as described in the tables below to be certified.

If the CMT or CSR candidate does not meet the appropriate inter-rater score variance, they may repeat the process one time. The appropriate inter-rater (DHCS Nurse Evaluator or KHS' CMT) and the candidate with the failing inter-rater score will jointly assess training needs and implement a training plan prior to conducting the second inter-rater review. CMT and CSR candidates that do not meet the appropriate inter-rater variance score for the second inter-rater review must wait ~~12~~6 months to reapply for certification.

Initial Certification Requirements	CMT	CSR
Possess a current and valid California RN, Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), NP, or PA license.	X	X
Be employed by or subcontracted with an MCP.	X	X
Submit Attachment A, Application for DHCS Site Review Master Trainer Certification.	X	
Have experience in conducting training in a health-related field, or conducting quality improvement activities such as medical audits, site reviews, or utilization management activities within the past three (3) years.	X	
Complete twenty (20) FSRs and twenty (20) MRRs, and one (1) year of experience as a CSR.	X	
Achieve an inter-rater score within 5% of FSR and 5% of MRR from the DHCS Nurse Evaluator.	X	
Attend didactic site review training or completion of DHCS site review training modules on the current site review tools under supervision of a CMT.		X
Complete ten (10) FSRs and ten (10) MRRs with a CSR or CMT.		X
Achieve an inter-rater score of 10% in FSR and 10% in MRR with designated CMT.		X

Recertification Requirements	CMT	CSR
Possess a current and valid California RN, MD, DO, NP, or PA license.	X	X
Be employed by or subcontracted with an MCP.	X	X
Be responsible for staff training on the most current DHCS site review tools and standards.	X	
Participate in DHCS-sponsored site review trainings as well as site review work group (SRWG) meetings and teleconferences.	X	
Maintain CMT certification.	X	
Complete a minimum of twenty (~~2~~30) site reviews following initial certification or recertification.	X	X
Attend DHCS-sponsored inter-rater workshops in person or virtually ~~–~~every ~~two~~ three years.	X	X
Achieve a 10% variance on the MRR, on the interrater score as defined by the SRWG and DHCS.		X
Achieve an inter-rater score within 5% of FSR and 5% of MRR from the DHCS Nurse Evaluator.	X	

KHS will develop policies and procedures for ongoing supervision and monitoring of site review personnel to ensure reliability of site review findings and data submitted to DHCS. Each MCP must maintain certification records including, but not limited to, site review training activities and supporting documentations to support the certification requirements.

~~L.~~N. Data Submission Procedures

KHS will submit site review data to DHCS every six months (July 31 for the period January - June, and January 31 for the period July - December) in an approved format uploaded to a designated DHCS secure site. KHS may submit data more frequently than every six months. For preoperational and expansion site reviews, KHS will submit site review data to DHCS at least six weeks prior to site operation. DHCS will make available the database containing all necessary tables and data input forms for the mandatory bi-annual submission of site review data. DHCS will reject site review data if KHS submits it in nonconforming formats.

KHS is ~~–~~required to collect PHI as part of the MRR ~~process, and~~process and must include the PHI in the bi-annual data submission to DHCS.

~~M.~~O. DHCS-Conducted Site Reviews

DHCS conducts separate site reviews to validate KHS' FSR and MRR processes. Prior to an expansion to a new county by KHS, DHCS conducts initial FSRs, followed by initial MRRs upon KHS beginning operations and assignment of KHS members, as outlined in APL ~~2-0006~~22-017, of randomly chosen PCP sites in KHS' network. DHCS also conducts subsequent site reviews on PCP sites within KHS networks. DHCS will notify KHS of critical findings in writing via email within 10 ~~calendar~~ business days following the date of the FSR and/or MRR and provide a written report summarizing all of DHCS' review findings within 30 calendar days following the date of the FSR and/or MRR.

Within 30 calendar days from the date of the DHCS-conducted site review report, KHS must provide a CAP to DHCS responding to all cited deficiencies documented in the report. KHS' CAP response must include:

a. The identified deficiency(ies) and
b. A description of action(s) taken to correct the deficiency(ies)

If a deficiency is determined to require long-term corrective action, KHS' CAP response must include indication that KHS has:

a. Initiated remedial action(s)
b. Developed a plan to achieve an acceptable level of compliance, and
c. Documented the date the provider is in full compliance or when full compliance will be achieved.

Additional supporting documentation and remedial action may be required if DHCS determines CAPs are insufficient to correct deficiencies.

KHS will be notified approximately four weeks in advance of DHCS-conducted site reviews. KHS must notify its providers in advance of site reviews, whether the site review is conducted by DHCS or by KHS. However, inspection of KHS' facilities or other elements of a review may be conducted without prior notice, in conjunction with other medical surveys or as part of an unannounced inspection program.

KHS is responsible for ensuring that our delegates and/or subcontracted entities comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Plan Letters (PLs). These requirements must be communicated by KHS to all delegated entities and subcontractors.

All contracting plans within a county have equal responsibility and accountability for the coordination and consolidation of provider site reviews and therefore are expected to participate in these collaborative activities.

All Health Plans within the county shall collaborate to determine processes for scheduling facility site reviews, notification of survey status and/or results on shared providers. Site

review responsibilities may be shared equally by all plans within a county, delegated to one or more plans or individual physician practices (e.g., IPA) and/or subcontracted to other agencies or entities. The Chief Medical Officer or their designee is ultimately responsible for site review activities.

A Full Scope Site Review Survey can be waived for a pre-contracted provider site if the provider or another local plan has documented proof that a current full scope survey with a passing score was completed by the other Health Plan within the past 3 years. Prior to initiating plan operation in a service area, an initial full scope survey shall be completed on 5% of the provider network, or on 30 PCP sites, whichever is greater in number. The 5% or 30 PCP sample sites shall include a variety of providers from throughout the provider network and/or from each subcontracted entity. If there are 30 or fewer PCP sites in the network, 100% of the sites must be completed prior to beginning plan operations. Corrective actions shall be completed per APL ~~20-006~~22-017. An initial full scope survey shall be completed on 100% of the remaining proposed PCP sites within the first six (6) months of plan operation or expansion.

The most current site review and medical record surveys shall be shared with and accepted by all Health Plans both intra and inter-county contracting with the provider(s). Each Health Plan is responsible for tracking the survey status of all contracted Medi-Cal managed care provider sites.

Delegation or site review responsibilities are a determination made by each plan. However, each collaborating health plan shall determine the acceptance of surveys completed by the entities delegated or subcontracted by another local plan.

2.0 INTERIM~~FOCUSED~~ REVIEW

Each Health Plan is responsible for systematic monitoring of all PCP sites between each regularly scheduled full scope site review surveys which includes the fourteen (14 critical elements. PCP office self-assessment system may be considered as part of the overall monitoring. Other performance assessments may include previous deficiencies, patient satisfaction, grievance, and utilization management data.

A. Deficiencies identified during the monitoring process will be noted in a Corrective Action Plan to assist the PCP in meeting requirements. This Corrective Action Plan (CAP) includes deficiencies noted during the monitoring review, specified corrective actions, their actions, their evidence of corrections, date corrections, date corrections were implemented, physician or designee responsible for corrective actions and name and title of Reviewer. In addition, there is a section for Health Plan verification of Corrections.

The CAP includes Disclosure and Release statements regarding CAP submission timeline and authorization to furnish results of the reviews and corrective actions to Health Plans participating in the collaboration, government agencies that have authority over the Health Plans and authorized county entities in the state of California.

The signed Corrective Action Plan documents are placed in the PCP's file that is maintained by the Health Plan responsible for completing the review.

~~**2.1 CREDENTIALING AND RECREDENTIALING**~~

~~For a new provider on a site that has not previously been reviewed, initial provider credentialing and site review will occur simultaneously.~~

~~Providers at a site are credentialed according to DHCS contractual and policy requirements. A site review shall be completed as part of the initial credentialing process if a new provider at a site that has not previously been reviewed is added to a contractor's provider network. A site review need not be repeated as part of the initial credentialing process if a new provider is added to a provider site that has a current passing site survey score. A site review survey need not be repeated as part of the recredentialing process if the site has a current passing site survey score. A passing Site Review Survey shall be considered "current" if it is dated within the last three years and need not be repeated until the due date of the next scheduled site review survey, as determined necessary from monitoring activities.~~

As providers at a site may change over time, the timeline for provider recredentialing and subsequent site review surveys may become independent processes that are not on a synchronized schedule.

3.0 FULL SCOPE SITE REVIEW

A Full Scope Site Review shall be the system-wide standard for conducting the initial and subsequent periodic reviews of contracted Primary Care Physician sites.

A full scope review consists of the DHCS Facility Site Review Survey and Medical Record Review Survey. Reviewers shall only review criteria that are appropriate to their level of education expertise, training and professional licensing scope of practice as determined by the California statute. The responsible reviewer for each survey shall be at minimum an RN, who shall sign the site review and/or medical record survey.

Facility Site and Medical Record Reviews are performed at least every three (3) years.

3.1 INITIAL SITE REVIEW

The initial site review is the first onsite inspection of a site that has not previously had a full scope survey or a PCP site that is returning to the Medi-Cal managed care program and has not had a passing full scope survey within the past three (3) years. It is the responsibility of the Health Plan that performed the Facility Site and Medical Record Review to follow-up and close any provider Corrective Action Plan(s).

Health Plans may review sites more frequently when determined necessary based on monitoring, evaluation, or corrective action plan (CAP) follow-up issue.

4.0 FACILITY SITE REVIEW PROCESS

The Site Reviewer will conduct the Facility Site review with the DHCS Site Review tool and accompanying interpretive guidelines.

There are fourteen (14) critical survey elements identified to have potential for adverse effect on patient health or safety. The elements include:

A. Exit doors and aisles are unobstructed and egress (escape) accessible.
B. Airway management equipment: oxygen delivery system, nasal cannula or mask, bulb syringe, Ambu bag, appropriate to practice and populations served are present on sit
C. Emergency medicine such as asthma, chest pain, hypoglycemia, and anaphylactic reaction management: Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg./ml (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose. Appropriate sizes of ESIP needles/syringes and alcohol wipes.
D. Only qualified/trained personnel retrieve, prepare or administer medications.
E. Physician review and follow-up or referrals/ consultation reports and diagnostic test results.
F. Only lawfully authorized persons dispense drugs to patients;
G. Drugs and Vaccines are prepared and drawn only prior to administration.
H. Personal protective equipment (PPE) for Standard Precautions is readily available for staff use.
I. Needlestick safety precautions are practiced on-site.
J. Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers for collection, processing, storage, transport, or shipping.

~~a. Staff demonstrate/verbalize necessary steps/process to ensure sterility and/or high-level disinfection of equipment.~~

~~b. Appropriate PPE is available, exposure control plan, MSDS and clean up instructions in the event of a cold chemical sterilant spill.~~

K. Cold chemical sterilization/high level ~~disentfectiton~~disinfection

a. Staff demonstrate/verbalize necessary steps/process to ensure sterility and/or high-level disinfection of equipment.
b. Appropriate PPE is available, exposure control plan, MSDS and clean up instructions in the event of a cold chemical sterilant spill
c. Autoclave steam sterilization

~~b. Appropriate PPE is available, exposure control plan, MSDS and clean up instructions in the event of a cold chemical sterilant spill~~

K. Autoclave steam sterilization

L. a. Spore testing of autoclave/steam sterilizer is completed (at least monthly), with documented results.

M. b. Management of positive mechanical, chemical, and/or biological indicators of the sterilization process

The PCP and/or site contact will be notified of all critical element deficiencies found during a full scope site survey, focused survey or monitoring visit.

All critical element deficiencies shall be corrected by the provider within ten (10) calendar business days of the survey date. All corrected critical element deficiencies will be verified as completed by the site reviewer within thirty (30) calendar days of the survey date. Sites found deficient in any critical element during the Full Scope Site Review shall be required to correct 100% of the survey deficiencies regardless of the survey score.

The Site Reviewer will calculate the Facility Site Survey tool score and at the exit interview discuss the findings with the PCP and/or site contact focusing on those area that are critical elements, other areas requiring improvement and the need for a corrective action plan.

5.0 SITE REVIEW DATA SUBMISSION PROCEDURES

Site review data will be submitted to the DHCS nurse evaluator every six months by July 31st and January 31st of each calendar year. Data may be submitted more frequently than every six months. For pre-operational and expansion site reviews, site review data must be submitted to the DHCS nurse evaluator at least six weeks prior to site operation, and then by July 31st and January 31st of each calendar year, thereafter. DHCS will make available the database containing all necessary table and data input forms for the mandatory bi-annual submission of site review data.

ATTACHMENTS:

A. Medical Record Review Standards

B. Medical Record Review Tool

C. Facility Site Review Standards

D. Facility Site Review Tool

E. Attachment C: Physical Accessibility Review Survey

REFERENCES:

Department of Health Care Services (DHCS) Policy Letter (PL) 12-006 12-00622-017

Department of Health Care Services (DHCS) All-Plan Letter (APL) 15-023

Department of Health Care Services (DHCS) All-Plan Letter (APL) 22-01720-006

DHCS All Plan Letter 15-023 – Facility Site Review Tools for Ancillary Service and Community Based Adult Services Providers

DHCS Medi-Cal Contract Exhibit A, Attachment III, Subsection 5.2.14

Revision 2022.08: Policy updated to comply with All-Plan Letter (APL) 20-006 and PARs survey. **Revision 2021.12:** Policy was approved by PAC and QI-UM Committees. **Revision 2021.10:** Policy created by Director of Quality Improvement and RN, DHCS Certified Master Trainer to comply with DHCS All-Plan Letter (APL) 20-006.

[1]See Title 28 CCR, section 1300.80
[2] Health and Safety Code (HSC), section 1342.8.
3 Business and Professions Code (BPC), section 2725.

To: KHS QI-UM Committee

From: Utilization Management Department

Date: 11/10/2022

Re: Utilization Management Q3, 2022 Review

Background:

The Kern Health System (KHS), Utilization Management (UM) Department provides comprehensive medical necessity review in a time sensitive, efficient manner while aligning practice with all regulatory and statutory requirements to ensure appropriate utilization of resources with the end goal of ensuring the members we serve receive the highest quality, medically necessary care possible.

Discussion:

The purpose of this report is to highlight utilization trends, outcomes and to transparently identify future goals as well as opportunities for improvement

Fiscal Impact:

N/A

Requested Action:

Request to approve and file the Utilization Management Q3/2022 Report.

Utilization Management QI/UM Quarterly Committee Reporting
Period July 1, 2022, thru September 30, 2022

Utilization Management Q3/2022 Executive Summary

Introduction

The Utilization Management Department continues to apply the proven principles of managed care through prospective, concurrent, and retrospective review. The goal of the UM Department is to ensure that the medical necessity review process is completed in a time sensitive, efficient manner while aligning practice with all regulatory and statutory requirements so that the members we serve receive the highest quality, medically necessary care possible without the overutilization of resources.

Q3 Review

In quarter three, membership has remained stable with approximately 340,000 enrolled lives resulting in the processing of 65,871 authorization requests. The increased volume of membership and subsequent referrals has impacted turnaround times. As such, in Q3 the Utilization Management Department has implemented initiatives focused on ensuring compliance.

Q3 Initiatives:

- Enhancements to the medical management platform used to process authorizations.
- Increased access for providers to evidenced based criteria used to process authorization requests.
- Consistent review and revision of the Prior Authorization list based on utilization data trends.

Q4 Initiatives

Key performance metrics from Q3/2022 indicate that opportunity exists regarding timeliness of member notification of decision as well as acute care bed day management. To address variances identified in Q3, new initiatives are in development including:

- Implementation of a new Notification of Action process
- Adoption of an alternative acute admission management model with increased focus on per diem and tertiary admissions.

Respectfully Submitted,

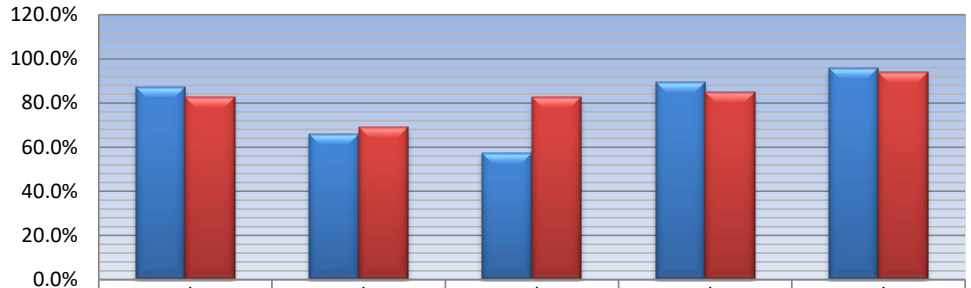
Misty Dominguez

Misty Dominguez, MSN, RN, NE-BC, CCM

Utilization Management QI/UM Quarterly Committee Reporting
Period July 1, 2022, thru September 30, 2022

Outpatient Statistical Trends: Q3 2022

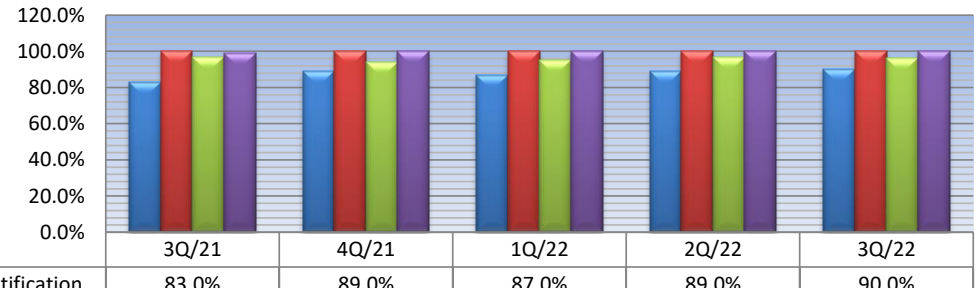
UM - Timeliness of Decision



	3Q/21	4Q/21	1Q/22	2Q/22	3Q/22
Urgent Compliance %	87.4%	66.0%	57.4%	89.3%	95.9%
Routine Compliance %	82.7%	68.8%	82.6%	84.9%	94.1%

Timeliness of Decision Summary: Q3: 65,871 referrals were processed. 5,984 were reviewed for timeliness of decision. In comparison to the 2nd quarter's processing time, timeliness of decision improved from 84.9% in Q2 to 94.1% for routine referrals with urgent referral following the same trend improving from 89.3% to 95.9%.

UM - Referral Notification Compliance



	3Q/21	4Q/21	1Q/22	2Q/22	3Q/22
Member Notification	83.0%	89.0%	87.0%	89.0%	90.0%
Provider Notification	100.0%	100.0%	100.0%	100.0%	100.0%
Criteria Included	97.0%	94.0%	95.0%	97.0%	96.0%
MD Signature Included	99.0%	100.0%	100.0%	100.0%	100.0%

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

Referral Notification Compliance Summary: Overall referral notification compliance average has improved from Q3 2021- 95% to Q3 2022 to 97%, however opportunity to improve member notification of decision exists.

Utilization Management QI/UM Quarterly Committee Reporting
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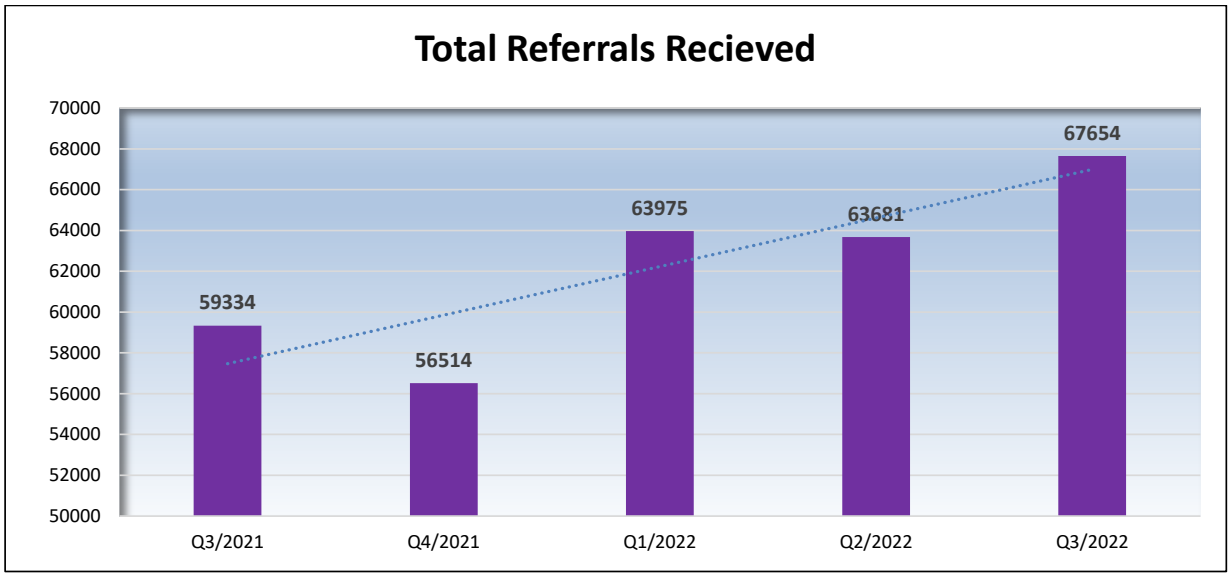
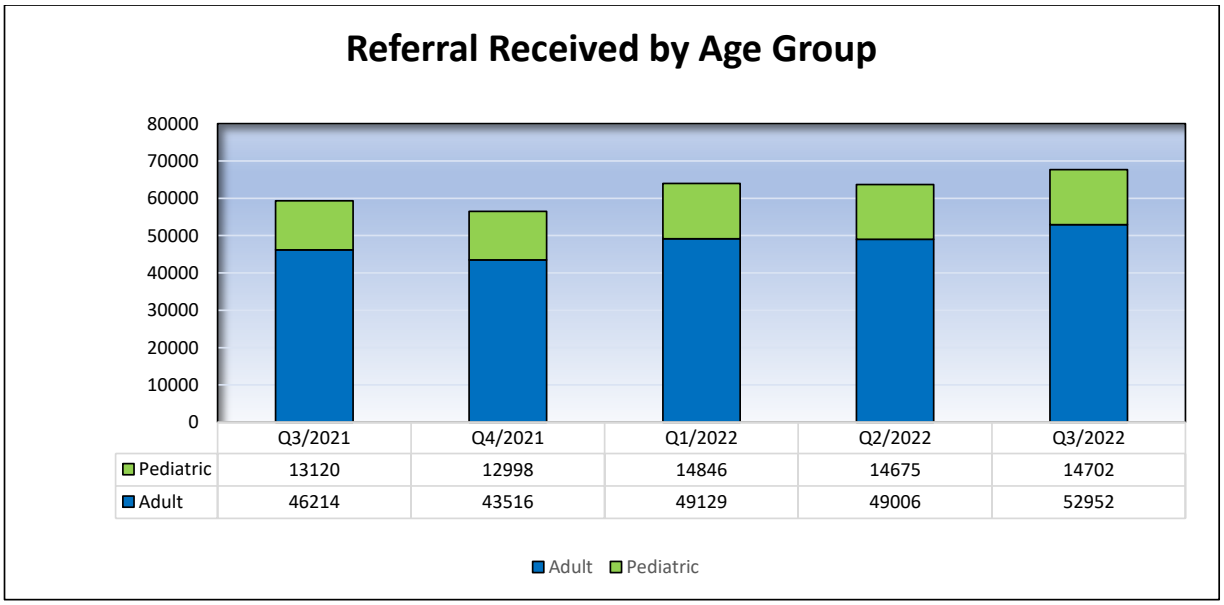
Q3/ 2022 Outpatient Referral Statistics





- In Q3/ 2022, 8320 (12%) more referrals were processed compared to Q3/2021.
- 21% Pediatric vs 79% Adult based requests

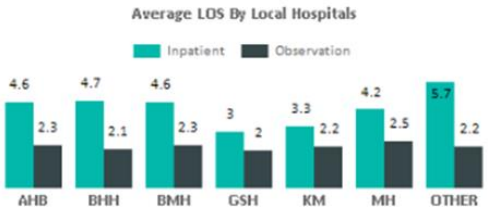
Utilization Management QI/UM Quarterly Committee Reporting
Period July 1, 2022, thru September 30, 2022

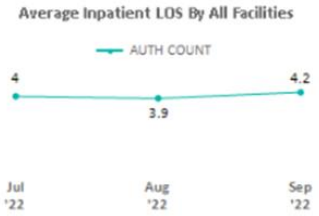
KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(Inpatient/Observation)

Dates of Discharge Between : 7/1/2022-9/30/2022

Adult Admission(Inpatient/Observation)





Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
ADVENTIST HEALTH BAKERSFIELD	636	2617	4.11
ADVENTIST HEALTH COMMUNITY CAR	46	129	2.80
ADVENTIST HEALTH DELANO	79	230	2.91
ADVENTIST HEALTH MEDICAL CENTE	7	20	2.86
ADVENTIST HEALTH ST HELENA	1	3	3.00
ANTELOPE VALLEY HOSPITAL	4	21	5.25
BAKERSFIELD HEART HOSPITAL	85	368	4.33
BAKERSFIELD MEMORIAL HOSPITAL	724	2824	3.90
CHILDRENS HOSPITAL OF LOS ANGE	1	4	4.00
GOOD SAMARITAN HOSPITAL	35	103	2.94
KECK HOSPITAL OF USC	103	461	4.48
KERN COUNTY MEDICAL AUTHORITY	715	2265	3.17
KERN VALLEY HEALTHCARE DISTRIC	18	55	3.06
MERCY HOSPITAL	605	2196	3.63
OROVILLE HOSPITAL	2	4	2.00
RIDGECREST REGIONAL HOSPITAL	41	145	3.54
SANTA MONICA UCLA MC AND ORTHO	13	79	6.08
UCLA MEDICAL CENTER	20	238	11.90
USC NORRIS CANCER HOSP	5	62	12.40
USC NORRIS CANCER HOSPITAL	3	60	20.00
USC VERDUGO HILLS HOSPITAL	3	7	2.33
Total	**3146**	**11891**	**3.78**

Non Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
ANTELOPE VALLEY HOSPITAL	42	280	6.67
LANCASTER HOSPITAL CORPORATION	11	71	6.45
HENRY MAYO NEWHALL	11	41	3.73
FRESNO COMMUNITY HOSPITAL AND	11	155	14.09
RIVERSIDE COMMUNITY HOSPITAL	10	100	10.00
RIVERSIDE COUNTY REGIONAL	8	40	5.00
HUNTINGTON MEMORIAL HOSPITAL	5	21	4.20
LOMA LINDA UNIVERSITY MEDICAL	5	82	16.40
SAINT AGNES MEDICAL CENTER	4	16	4.00
KAWEAH DELTA MEDICAL CENTER	4	26	6.50
LAC USC MEDICAL CENTER	4	19	4.75
STANFORD HEALTH CARE	4	42	10.50
Total	**228**	**1680**	**7.37**

Inpatient ALOS summary:

All Acute ALOS: PAR 3.78 days non-PAR:7.37 days
Tertiary ALOS: PAR: 9.53 days non-PAR:10.55 days

Utilization Management QI/UM Quarterly Committee Reporting
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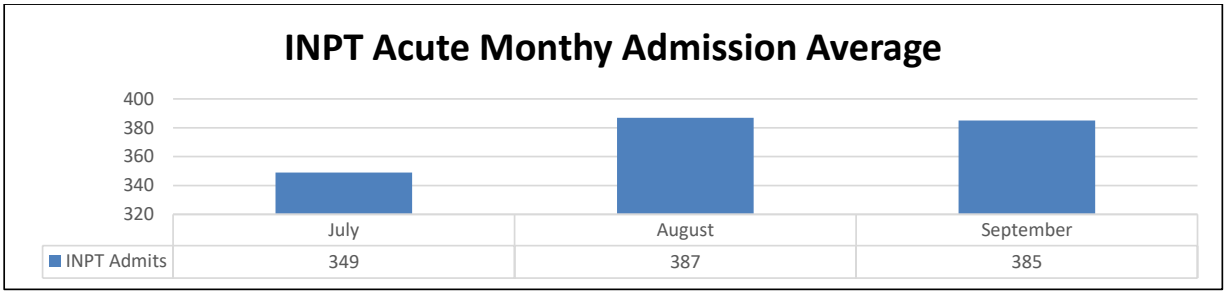
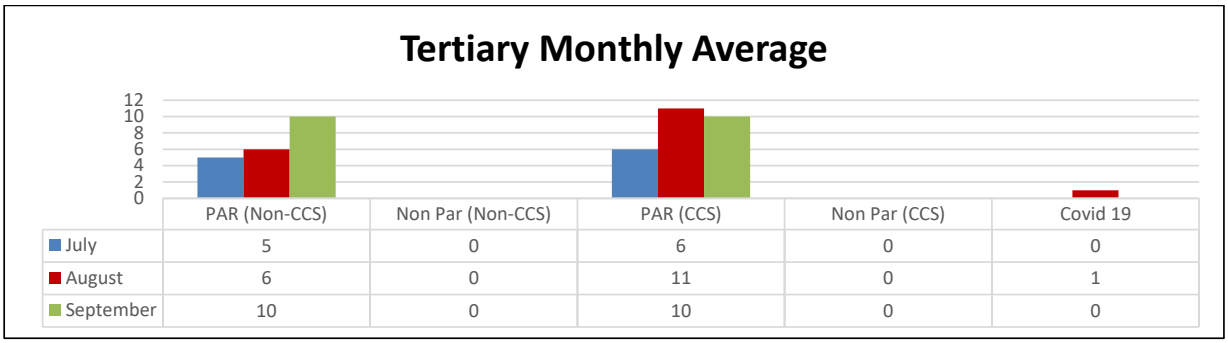
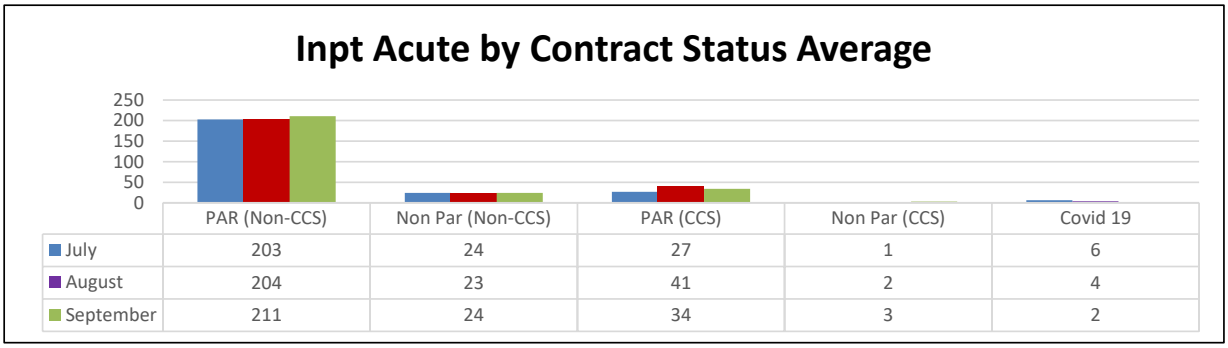


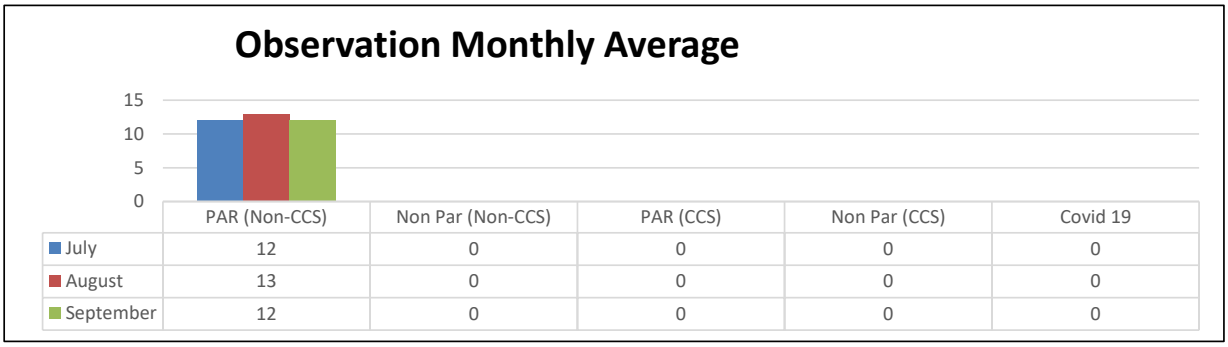
	July	August	September
INPT Admits	349	387	385



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
July	5	0	6	0	0
August	6	0	11	0	1
September	10	0	10	0	0



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
July	203	24	27	1	6
August	204	23	41	2	4
September	211	24	34	3	2



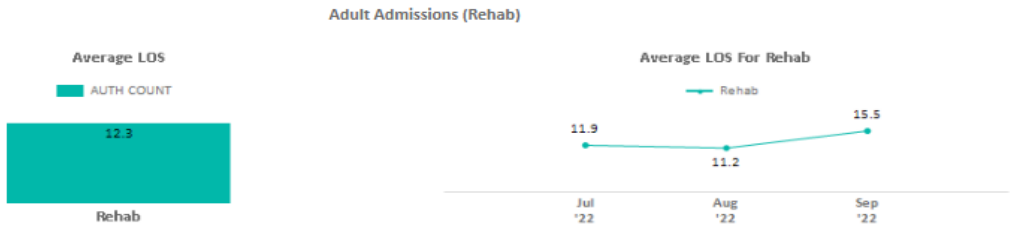
	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
July	12	0	0	0	0
August	13	0	0	0	0
September	12	0	0	0	0

Utilization Management QI/UM Quarterly Committee Reporting
Period July 1, 2022, thru September 30, 2022

KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(SNF/Rehabilitation)

Dates of Discharge Between : 7/1/2022-9/30/2022



Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
ENCOMPASS HEALTH REHABILITATIO	33	406	12.30
Total	**33**	**406**	**12.30**

Non Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
Total			**NaN**

KHS Monthly Inpatient and LOS Report

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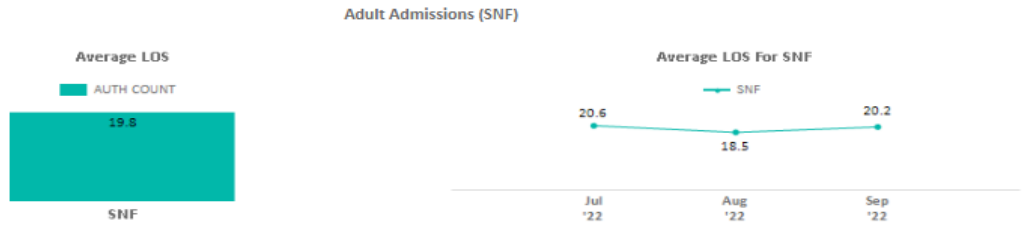

Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
ANGEL CONGREGATE LIVING, INC	5	92	18.40
CAPRI IN THE DESERT	10	187	18.70
EVERLASTING HEALTHCARE	2	20	10.00
MAGNIFIQUE CONGREGATE LIVING I	10	295	29.50
NAPOLI IN THE DESERT	7	168	24.00
PARKSIDE CONGREGATE LIVING, IN	20	378	18.90
ROSE DESERT CONGREGATE	11	291	26.45
SAN MARINO IN THE DESERT	7	147	21.00
SORRENTO IN THE DESERT	10	164	16.40
UNITED CARE FACILITIES	88	1344	15.27
VALLEY VIEW CARE CENTER	24	538	22.42
VFP HOMES	14	293	20.93
Total	**208**	**3917**	**18.83**

Non Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
PACIFICA HOSPITAL OF THE VALLE	4	188	47.00
NORTHRIDGE CARE CENTER INC	1	41	41.00
VALLEY CONVALESCENT HOSPITAL	1	9	9.00
DELANO REGIONAL MEDICAL CENTER	1	59	59.00
COMMUNITY SUBACUTE AND TRANSIT	1	18	18.00
THE HELPING HANDS CLHF	1	50	50.00
LINK TO CARE CONGREGATE HOME	1	8	8.00
VALLEY VIEW CARE CENTER	1	44	44.00
Total	**11**	**417**	**37.91**

Post Acute Summary:

33 Acute rehab admissions with an ALOS of 12.3 days

219 SNF admission in Q3 with an ALOS of 18.83 days at PAR facilites and 37.91 days at non-PAR facilities.

Utilization Management QI/UM Quarterly Committee Reporting
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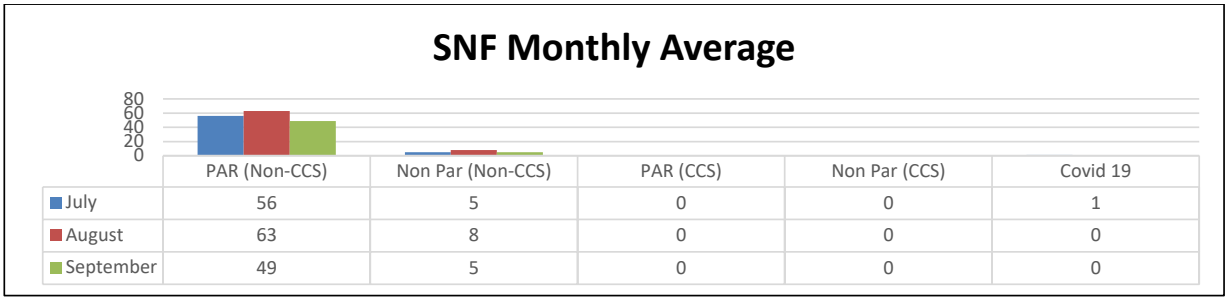
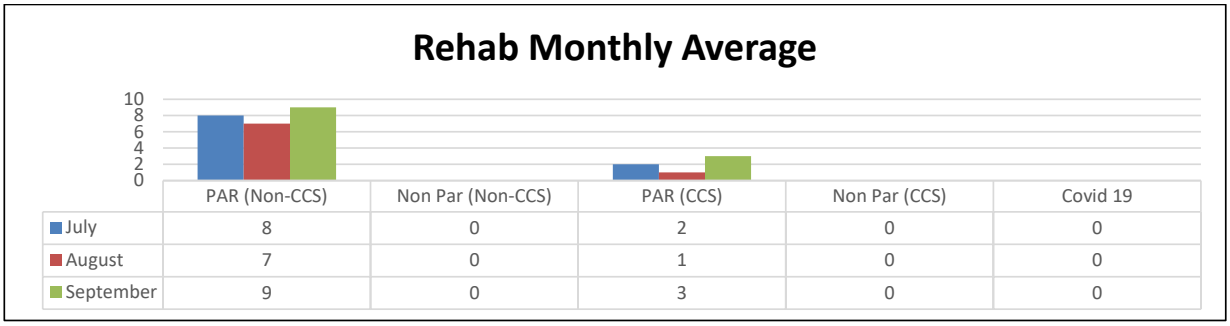
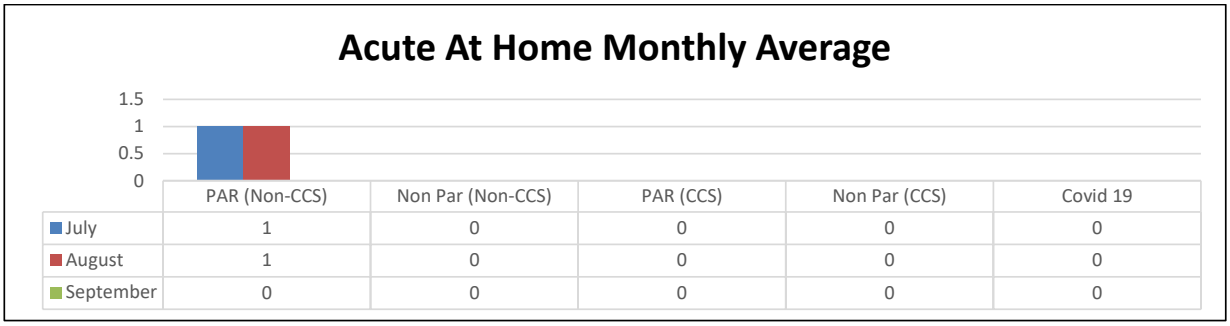


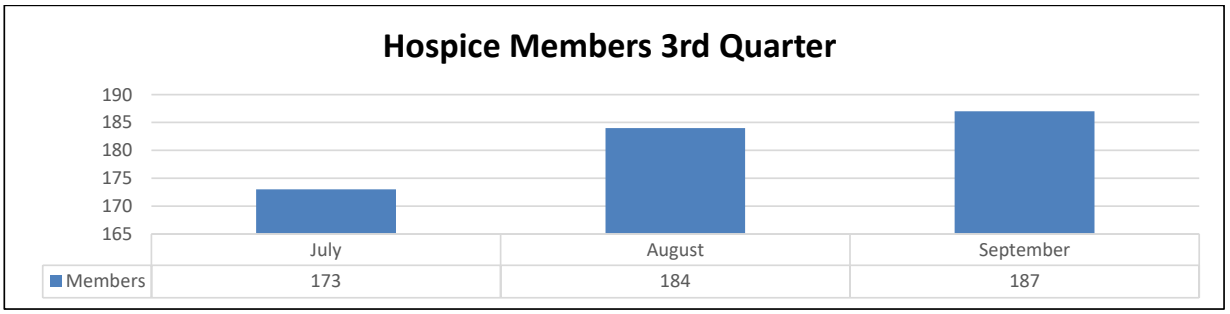
	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
July	56	5	0	0	1
August	63	8	0	0	0
September	49	5	0	0	0



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
July	8	0	2	0	0
August	7	0	1	0	0
September	9	0	3	0	0



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
July	1	0	0	0	0
August	1	0	0	0	0
September	0	0	0	0	0



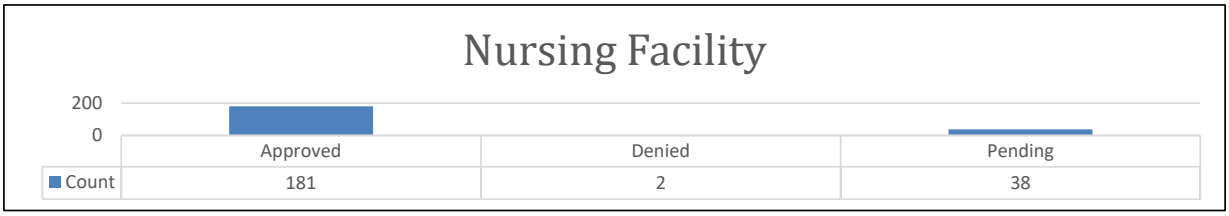
	July	August	September
Members	173	184	187

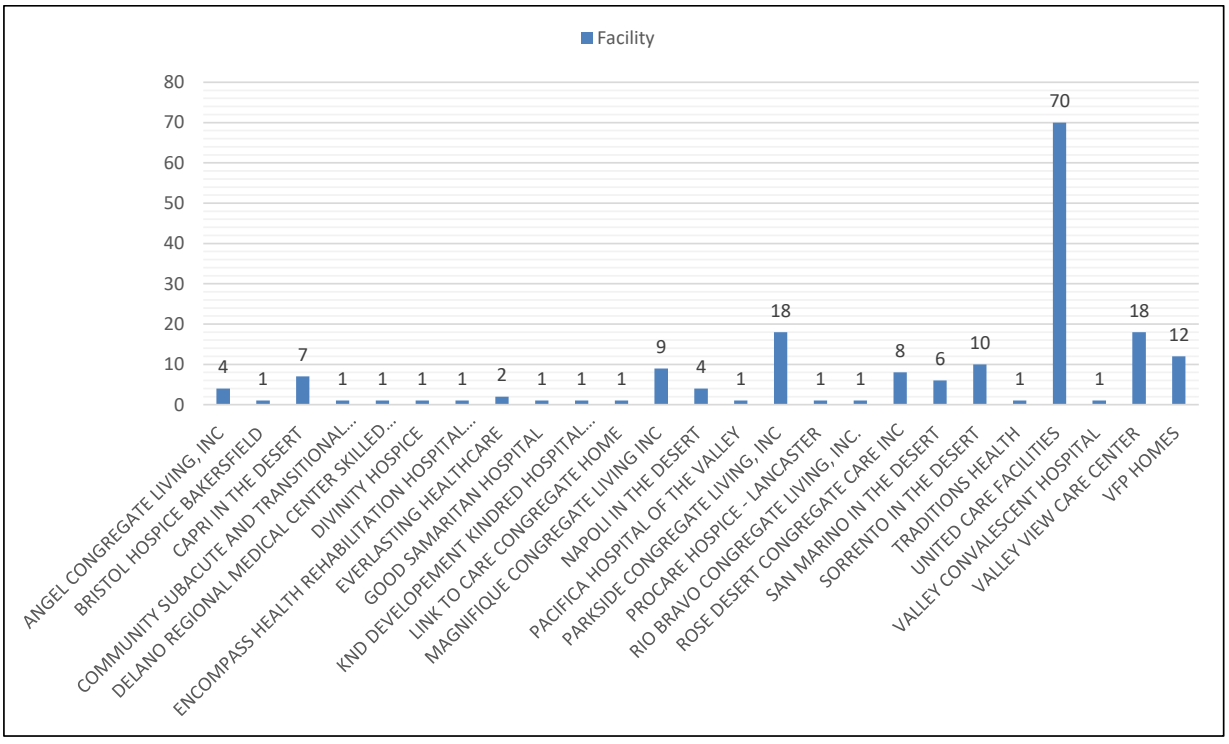
Utilization Management QI/UM Quarterly Committee Reporting
Period July 1, 2022, thru September 30, 2022

Nursing Facility Services Report

Purpose: Kern Health Systems covers medically necessary Nursing Facility Services for eligible members. KHS members requiring Nursing Facility Services are identified and placed in health care facilities, which provide the level of care most appropriate to the member's medical needs. For members requiring long-term care, KHS coordinates the members care and initiates disenrollment per DHCS criteria. Monthly and quarterly reporting is completed as per Policy 3.42, Sec. 5, for nursing facility services and to identify any current trends.

Summary: Summary: During the 3rd quarter 2022, there were 221 referrals for Nursing Facility Services. The average length of stay was 23.1 days for these members. During the 3rd quarter there were only 2 denials.

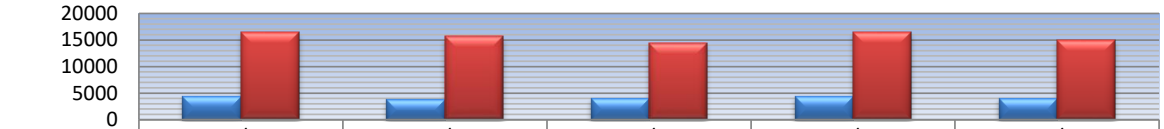




Utilization Management QI/UM Quarterly Committee Reporting
Period July 1, 2022, thru September 30, 2022

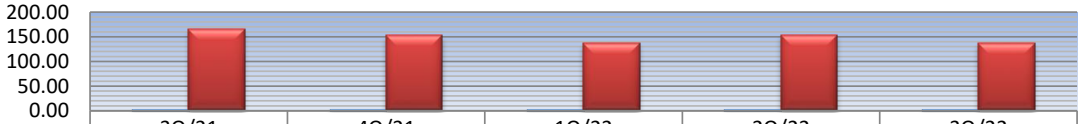
Adult Inpatient 3rd Quarter Trending

Hospital Census - Adults Admission/Days



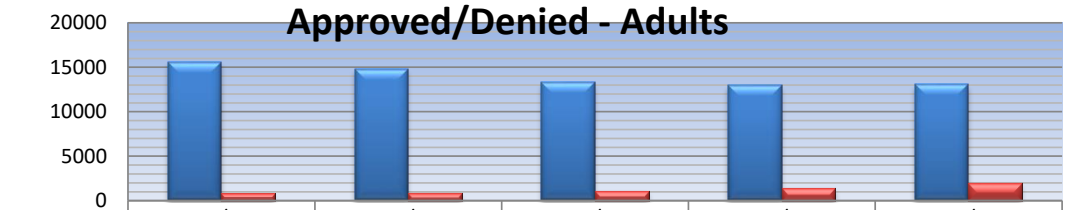
	3Q/21	4Q/21	1Q/22	2Q/22	3Q/22
Admissions	4505	3911	4066	4468	4027
Days	16405	15674	14376	16556	15004

Hospital Census - Adult Avg LOS/Bed Days



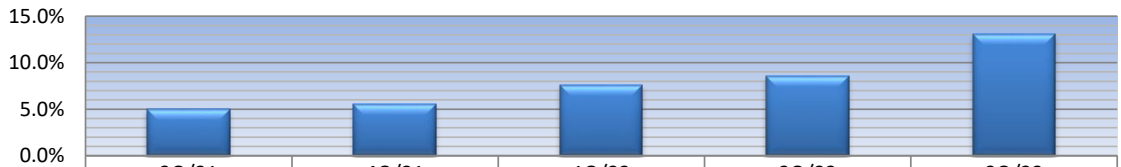
	3Q/21	4Q/21	1Q/22	2Q/22	3Q/22
Average LOS	3.64	4.01	3.54	3.71	3.73
Bed days/1000	166.3	152.1	137.1	153.5	137.1

Approved/Denied - Adults



	3Q/21	4Q/21	1Q/22	2Q/22	3Q/22
Approvals	15583	14802	13281	12960	13037
Denied	822	872	1095	1412	1967

Denial % - Adults



	3Q/21	4Q/21	1Q/22	2Q/22	3Q/22
Denial %	5.0%	5.6%	7.6%	8.5%	13.1%

Utilization Management QI/UM Quarterly Committee Reporting
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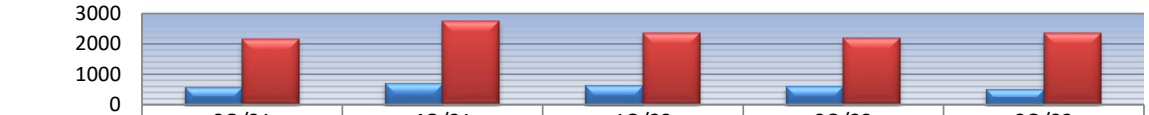
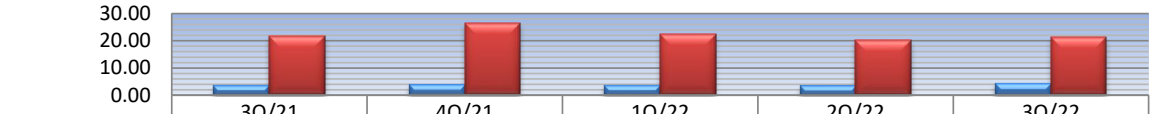
Pediatric Inpatient Q3 Trending

Daily Census - PEDS-Admission/Days



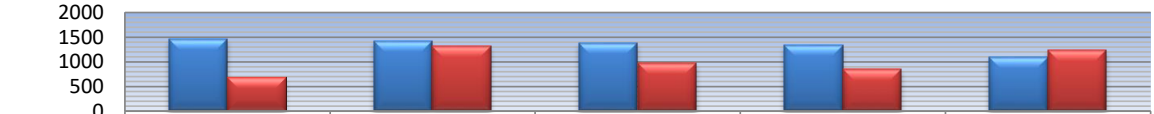
	3Q/21	4Q/21	1Q/22	2Q/22	3Q/22
Admissions	579	698	625	615	513
Days	2142	2733	2364	2184	2339

Daily Census - PEDS-Avg LOS/Bed Days



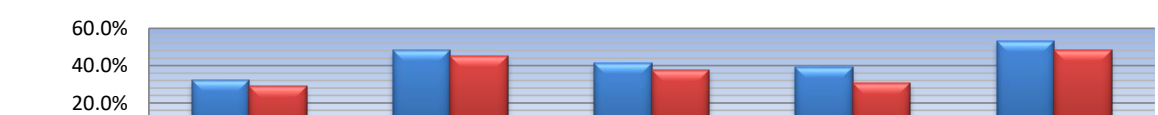
	3Q/21	4Q/21	1Q/22	2Q/22	3Q/22
Average LOS	3.70	3.92	3.78	3.55	4.56
Bed days/1000	21.7	26.5	22.5	20.2	21.4

Approved/Denied - PEDS



	3Q/21	4Q/21	1Q/22	2Q/22	3Q/22
Approvals	1458	1420	1384	1332	1098
Denied	684	1313	980	852	1241

Denial % - PEDS



	3Q/21	4Q/21	1Q/22	2Q/22	3Q/22
Denial %	31.9%	48.0%	41.5%	39.0%	53.1%
CCS Denial %	28.8%	45.3%	37.8%	30.5%	48.5%

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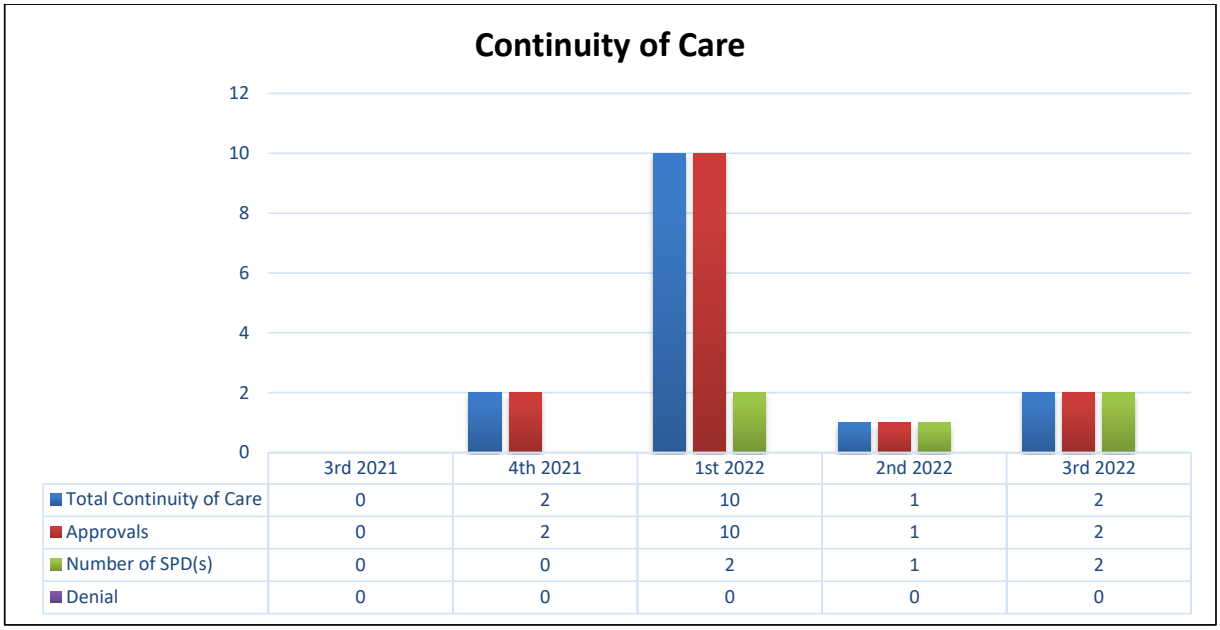
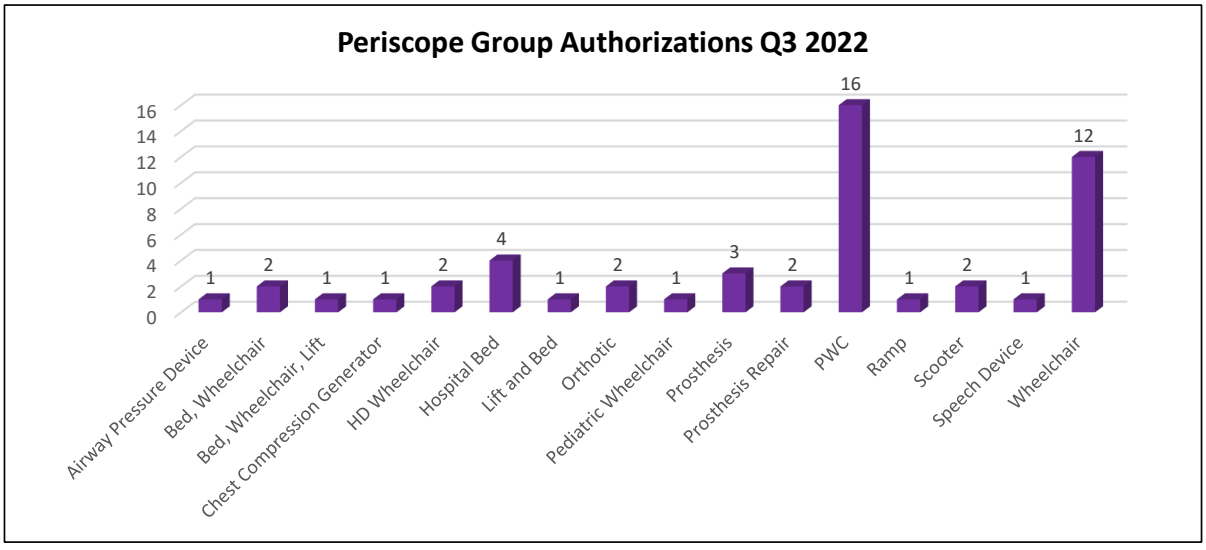


	3rd 2021	4th 2021	1st 2022	2nd 2022	3rd 2022
Total Continuity of Care	0	2	10	1	2
Approvals	0	2	10	1	2
Number of SPD(s)	0	0	2	1	2
Denial	0	0	0	0	0



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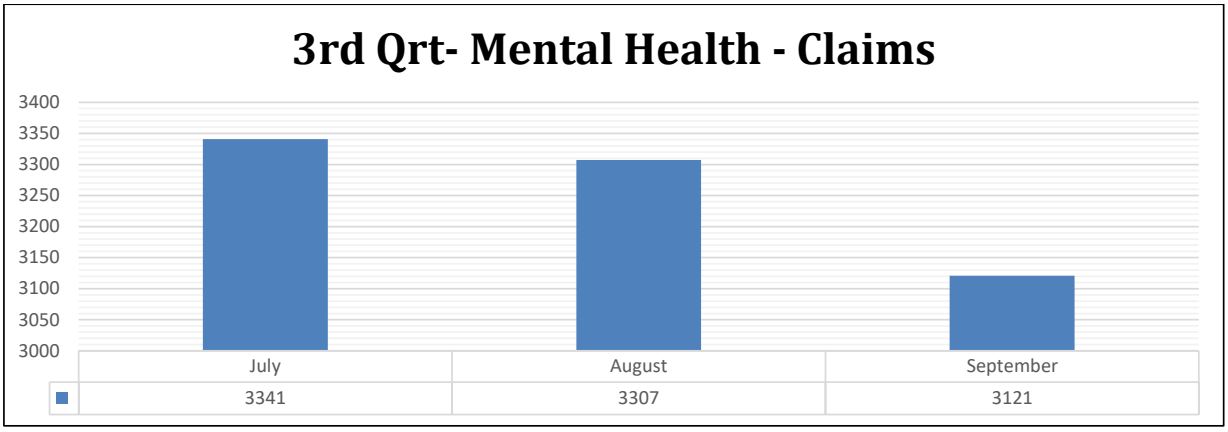


ABA (Applied Behavioral Anaysis) Services

UNIQUE CASES		Total
MEMBER COUNT		536

SEVERITY	Jul	Aug	Sept	Total
Approved FBA	137	176	133	446
Approved Treatment	86	108	99	293
	Jul	Aug	Sept	Total
AGE 7 OR LESS	123	127	120	370
AGE 8 OR GREATER	50	70	46	166
TOTAL	173	197	166	536
% < 7	71.10%	64.47%	72.29%	69.03%
% > 8	28.90%	35.53%	27.71%	30.97%

Initial Health Assessment (IHA) Letters to Members

Letters to the member's PCP with a count of their assigned members who still need an IHA. These letters direct the PCP to the Provider Portal to review their list and perform outreach.

Letters are also mailed to the PCP regarding members who have open authorizations.

Open authorizations are defined as any auth that has not expired and has no claim attached to it. The auth does not need to be fulfilled to no longer be considered open.

Letters are mailed out to each PCP at each location where they have members assigned.

July

- IHA Letters Mailed – 312
- Open Authorization letters mailed – 127

August

- IHA Letters Mailed – 309
- Open Authorization letters mailed – 123

September

- IHA Letters Mailed – 308
- Open Authorization letters mailed – 116

Utilization Management QI/UM Quarterly Committee Reporting
Period July 1, 2022, thru September 30, 2022

UM Internal Auditing Results Q3/2022

Purpose: Quarterly audits of referrals that have been delayed by the UM Department is done to monitor compliance with the Kern Health Systems' Policy and Procedure 3.22 Referral and Authorization Process, Section 4.2.1 Deferrals, Section 4.2.1.1

Audit Period: July 1, 2022, to September 30, 2022
Sample Size: 10% or 10 per month (whichever is greater)

Authorization Delayed:

Month	July	August	September
Total Referrals Processed	20,221	23,461	22,189
Total Referrals Delayed	18	28	16
Percent of Delays	<1%	<1%	<1%
Percent of Audit (10 percent or 10 referrals whichever is larger)	10 referrals	10 referrals	10 referrals
Number of Referrals in Audit	10	10	10

Q3: Findings: No Notice of Action/ Process of Referrals indicator errors.
Actions: Continue current process

Referrals Denied:

Month	July	August	September
Total Referrals Processed	20,221	23,461	22,189
Total Referrals Denied	1559	1775	1824
Percent of Denials	7%	7%	8%
Percent of Audit	10%	10%	10%
Number of Referrals in Audit (Not Included: Search and Serve, or Mental Health Referrals)	136	160	166

Q3 Findings: Total cases Reviewed: 462, TAT findings: 152/52%, Missing Signatures: .01%/ 1, NOA findings: 24/5%, Processing Error: 15/3%
Actions: Findings discussed with individual staff as appropriate and refresher training has been provided. Q4 Action Plan developed to address timely notification Turn Around Times.

NAR/ Appeal/Audit Review:

Q3 Findings: None

UM Internal Auditing Results Q3/2022 continued

Referrals Modified:

Audit Detail: The referrals that qualify for a modification are: Change in place of service, change of specialty, change of provider or reduction of service

Month	July	August	September
Total Referrals Processed	20,221	23,461	22,189
Total Referrals Modified	234	320	320
Percent of Modifies	1%	1%	1%
Percent of Audit (10 percent or 10 referrals whichever is larger)	10%	10%	10%
Number of Referrals in Audit	24	32	32

Q3 Findings: Total cases Reviewed: 88, TAT indicator finding: 50/ 57%, Missing Signatures: 0/ 0, NOA finding: 1/ 2%, Processing Error: 2/ 2%

Actions: Findings discussed with individual staff as appropriate and refresher training has been provided.
Q4 Action Plan developed to address timely notification Turn Around Times.

Auto Approval Processing:

Month	July-September 2022- 3rd quarter
Total Referrals Approved	36,632
Percent of Audit	>1%
Number of Referrals in Audit	30

Q3 Findings: 29 of 30 cases without error, 1 case did not meet medical necessity.
Actions: Finding discussed with individual staff as appropriate and refresher training has been provided.

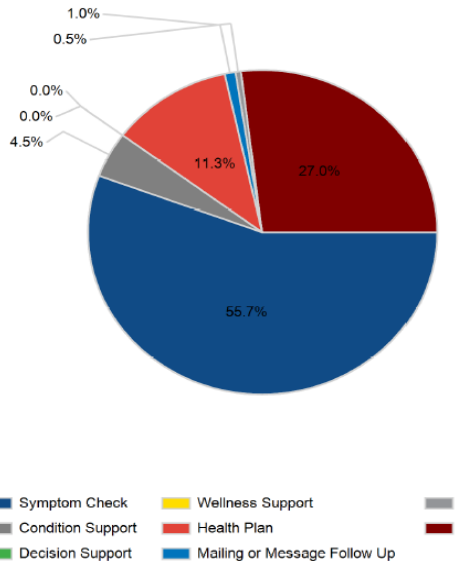
Approved Referral Review:

Month	July-September 2022- 3rd quarter
Total Referrals Approved	36,632
# of Referrals/Percent of Audit	30/ >1%
Findings	29 of 30 appropriate

Q3 Findings: 29 of 30 cases without error, 1 case did not meet medical necessity.
Actions: Finding discussed with individual staff as appropriate and refresher training has been provided.

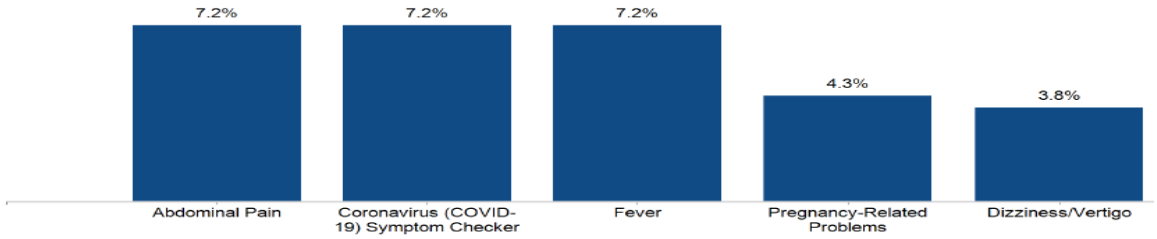
Health Dialog Report

Member Inbound Call Reasons (Jul-2022)

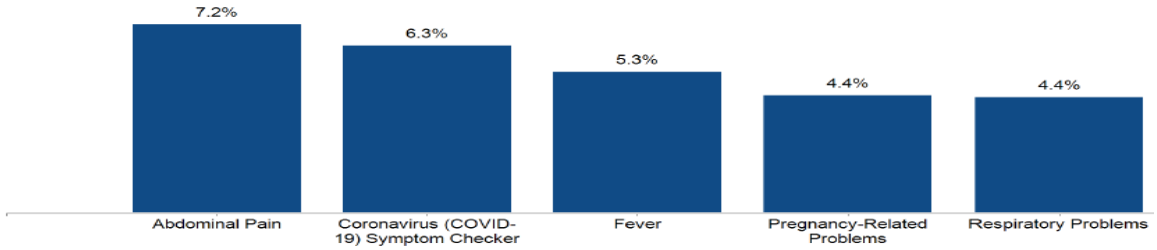


REASON	NUMBER
Symptom Check	221
Condition Support	18
Decision Support	0
Wellness Support	0
Health Plan	45
Mailing or Message Follow Up	4
Web Tools	2
Other	107

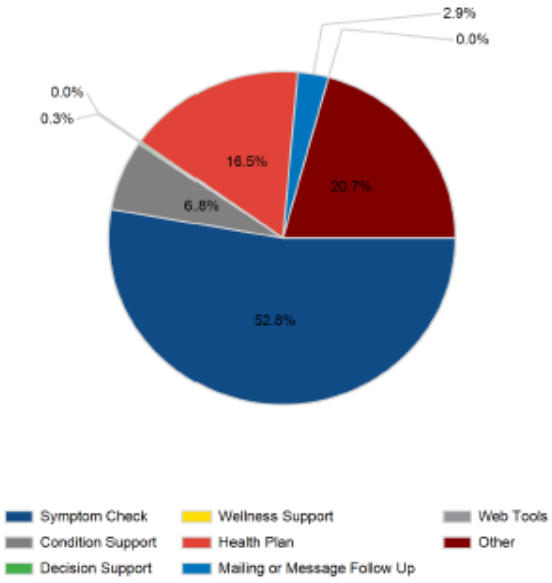
Most Frequent Symptoms - Inbound Symptom Check Calls (Jul-2022)



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

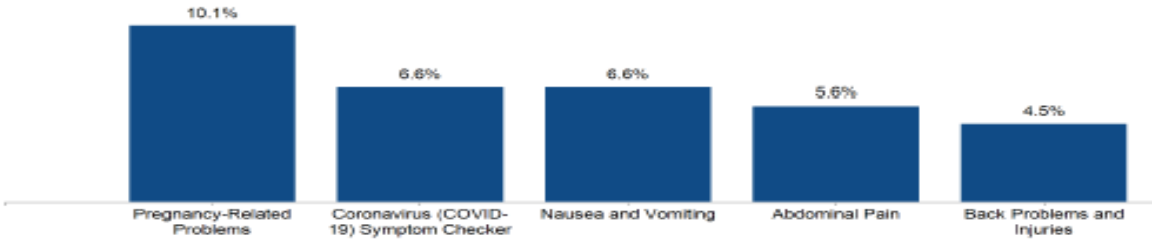


Member Inbound Call Reasons (Aug-2022)

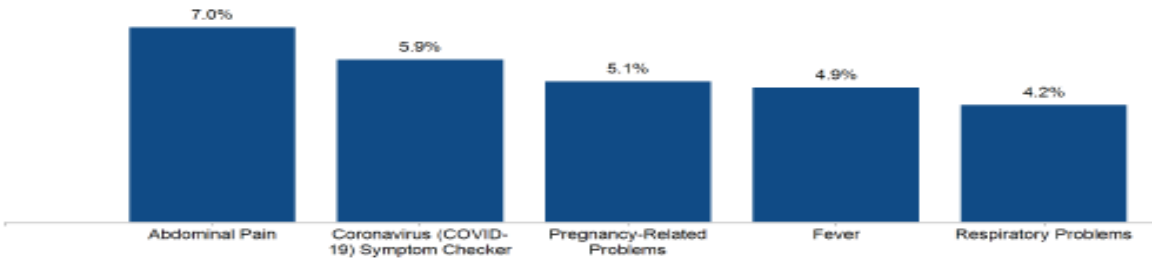


REASON	NUMBER
Symptom Check	201
Condition Support	26
Decision Support	1
Wellness Support	0
Health Plan	63
Mailing or Message Follow Up	11
Web Tools	0
Other	79

Most Frequent Symptoms - Inbound Symptom Check Calls (Aug-2022)

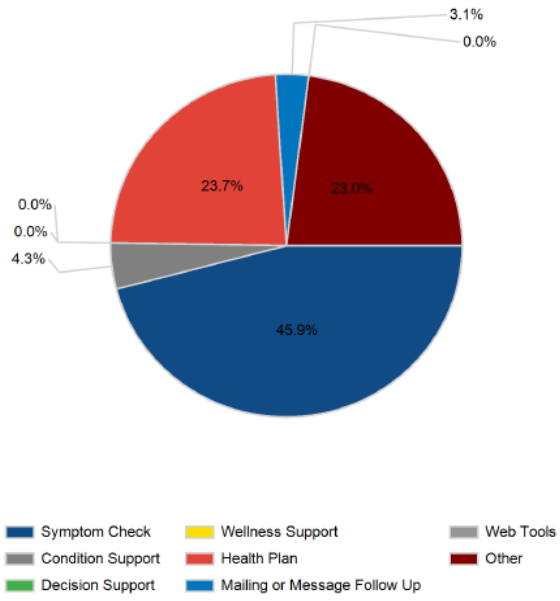


Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



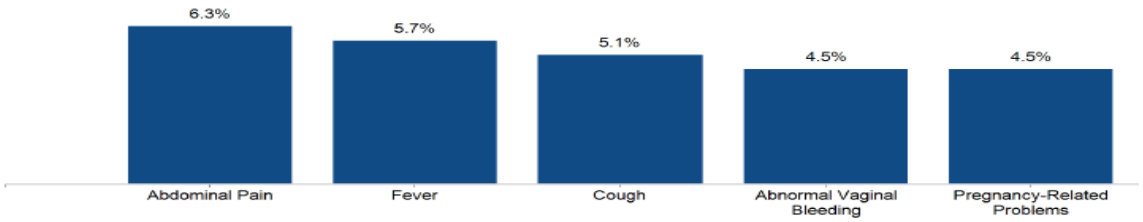
Utilization Management QI/UM Quarterly Committee Reporting
Period July 1, 2022, thru September 30, 2022

Member Inbound Call Reasons (Sep-2022)

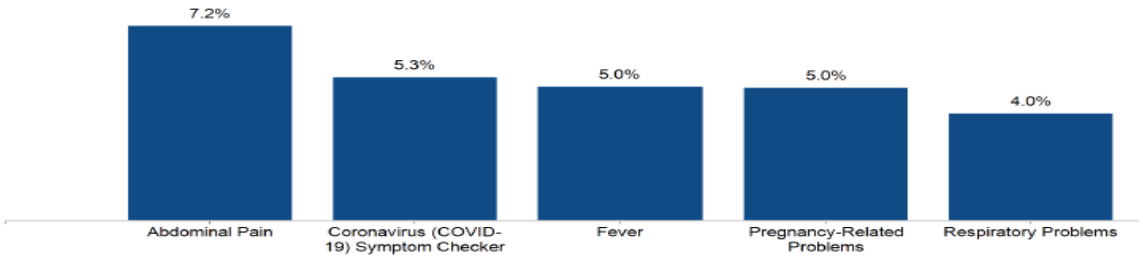


REASON	NUMBER
Symptom Check	180
Condition Support	17
Decision Support	0
Wellness Support	0
Health Plan	93
Mailing or Message Follow Up	12
Web Tools	0
Other	90

Most Frequent Symptoms - Inbound Symptom Check Calls (Sep-2022)



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



vsp vision care

Diabetic Exam Reminder Effectiveness Report

Client: KERN HEALTH SYSTEMS - 12049397

Reminder Year:	Reminder Month:	Reminders Sent	Received Exam Within 0-90 Days	Received Exam Within 91-180 Days	Total Exams Within 180 Days
2021	October	3,896	87	119	206
	November	268	15	13	28
	December	881	36	38	74
2022	January	2,120	93	76	169
	February	231	22	11	33
	March	1,357	57	45	102
	April	448	24	14	38
	May	8,494	264	94	358
	June	6,845	158	7	165
	July	374	6	0	6
	August	1,416	17	0	17
	September	711	0	0	0
Totals		**27,041**	**779**	**417**	**1,196**

LTM Effectiveness* : 4 %

12-Month Effectiveness (Apr 2021 - Mar 2022) : 6 %

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

vsp vision care

Medical Data Collection Summary Report

Period Covered: October, 2021 through September, 2022
Prepared for: KERN HEALTH SYSTEMS - (12049397)

Overview

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

Summary of Findings

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

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

Reported Cases

	Members	
Received Eye Exam:	22,639	
Diabetes[1]:	1,196	5.3%
Diabetic Retinopathy:	263	1.2%
Glaucoma:	492	2.2%
Hypertension:	580	2.6%
High Cholesterol	226	1.0%
Macular Degeneration:	77	.3%

Estimated Number of Cases

Total Members:	327,081	
Diabetes[1]:	8,213	2.5%
Diabetic Retinopathy:	736	.2%
Glaucoma:	1,370	.4%
Hypertension:	35,339	10.8%
High Cholesterol	50,073	15.3%
Macular Degeneration:	478	.1%

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

####/MD

To: KHS QI-UM Committee

From: Michelle Curioso, Director of Population Health Management

Date: 10/25/2022

Re: Population Health Management Quarter 3 Report

Background

The Kern Health System, (KHS) Population Health Management (PHM) Department provides a comprehensive integrated process that evaluates and manages the utilization of health care services and resource delivery to members. The PHM Department identifies members' health care and social needs which supports improved health outcomes for individuals. In collaboration with medical providers and partnering agencies, the Department helps members access resources and preventative services and ensures that members stay healthy.

Discussion

The purpose of this report is to provide updates on PHM's progress and successes on its activities. The report also highlights data trends and addresses opportunities for improvement. The data is generated through KHS' electronic health record, JIVA system. The reporting period is Quarter 3, July 1st, 2022, through September 30th, 2022.

Fiscal Impact

None

Requested Action

Request to approve and file PHM Quarter 3 Report.

Kern Family Health Care

KERN HEALTH SYSTEMS
POPULATION HEALTH MANAGEMENT QUARTER 3 REPORT

Introduction

The Kern Health System, (KHS) Population Health Management (PHM) Department provides a comprehensive integrated process that evaluates and manages the utilization of health care services and resource delivery to members. The PHM Department identifies members' health care and social needs which supports improved health outcomes for individuals.

When a KHS member enrolls in PHM services, they receive:

- Health care support from registered nurse
- A care plan based on recommended treatment
- Assistance from a social worker (SW) and certified medical assistant (CMA), as needed
- Help coordinating services among providers
- Assistance in finding community service/resources

In collaboration with medical providers and partnering agencies, the Department helps members access resources and preventative services and ensures that members stay healthy. The team is comprised of Registered Nurse Case Managers, SWs, and CMAs.

Purpose

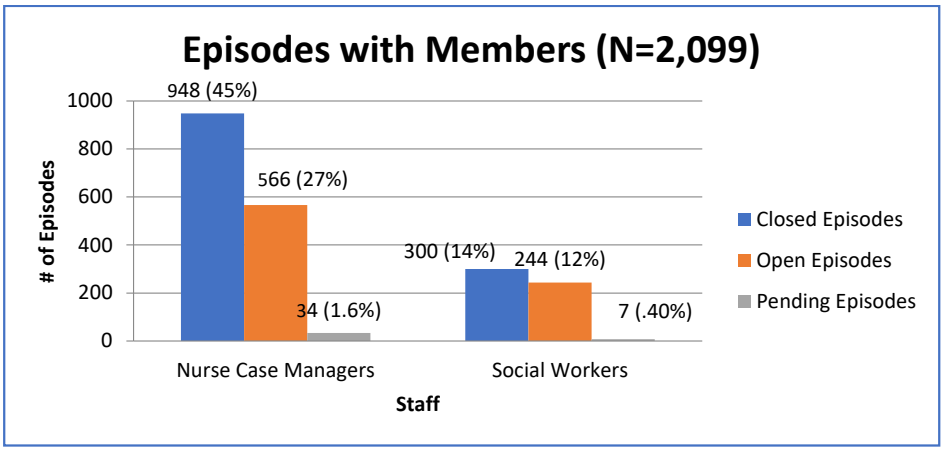
The purpose of this report is to provide updates on PHM's progress and successes on its activities. The report also highlights data trends and addresses opportunities for improvement. The data is generated through KHS' electronic health record, JIVA system. The reporting period is Quarter 3, July 1st, 2022, through September 30th, 2022.

Kern Family Health Care

Data

Table 1: Episodes with Members

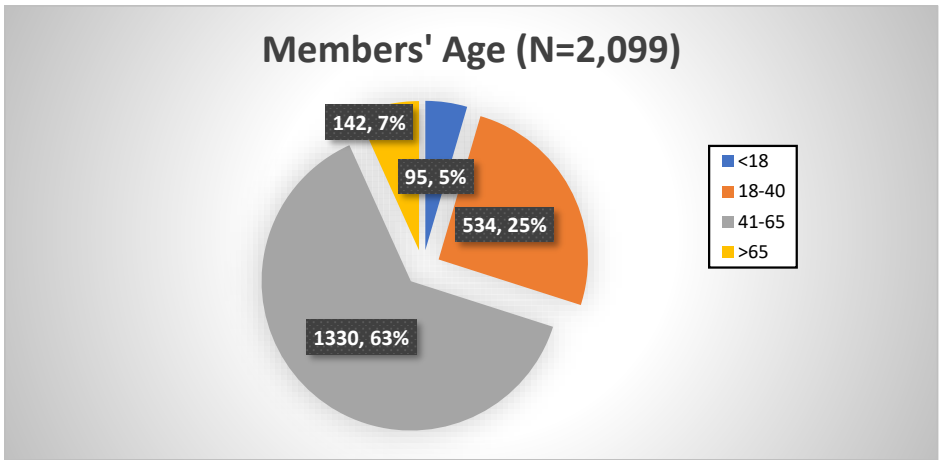
During the months of July thru September, a total of 2,099 members were managed by the Population Health Management Department.



The nurses provide medical care management and coordination of care to members and help navigate the healthcare system. The SWs plan and implement social service delivery programs, promote coordination, continuity of care, and quality management in support of KHS members. Table 1 illustrates the total number of cases that have been cases managed by nurses and SWs of the 2,099 members. The reasons for closures include successful completion of goals in the care plans, lost to follow up and declined program services.

Table 2: Member's Age

During the months of July thru September, of the 2,099 members, there were 63% members who were 65 years of age, and 7% members were less than 18 years of age.



Kern Family Health Care

Table 3: Gender

Of the 2,099 members managed during the months of July thru September, there were 56% members who were female and 44% members who were male.

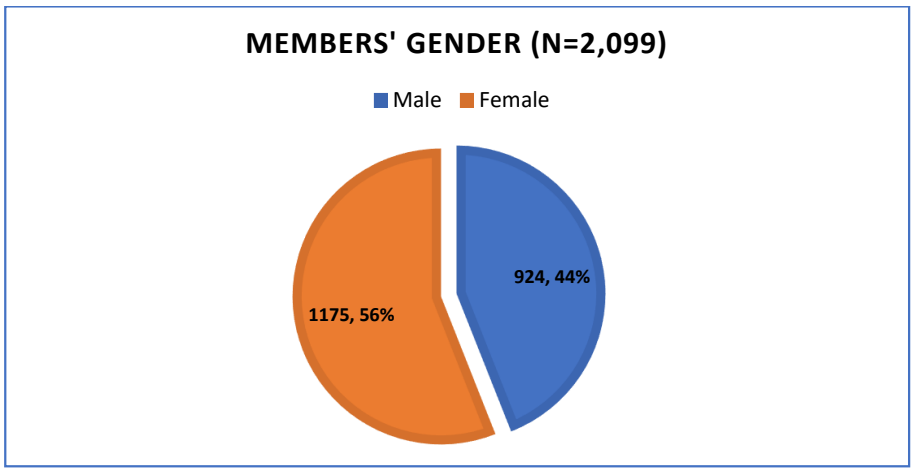
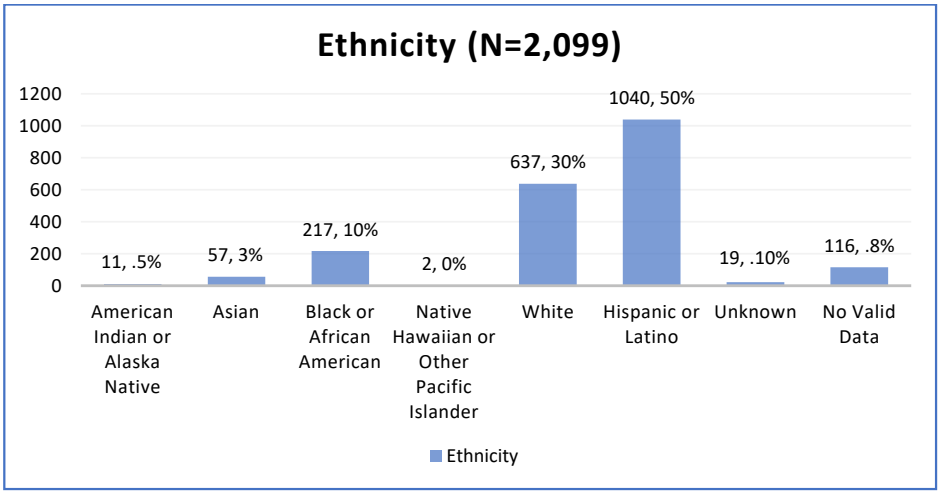


Table 4: Ethnicity

The KHS members are diverse, with most members (50%) identifying as Hispanic and small proportion are American Indian or Alaskan Native, Asian, and Native Hawaiian or Other specific Islander. While the racial and ethnic composition of KHS members continues to change, it is important to create culturally sensitive systems and policies. Spanish-language education, documents, and services will continue to be needed as the Hispanic population continues to grow.



Kern Family Health Care

Table 5: Member's by Zip Codes

The top 3 zip codes where members reside are in 93307, 93304 and 93308.

Location	Number of Members	% of Members
Bakersfield	1,551	74%
Outlying Areas	548	26%
Total	2,099	100%

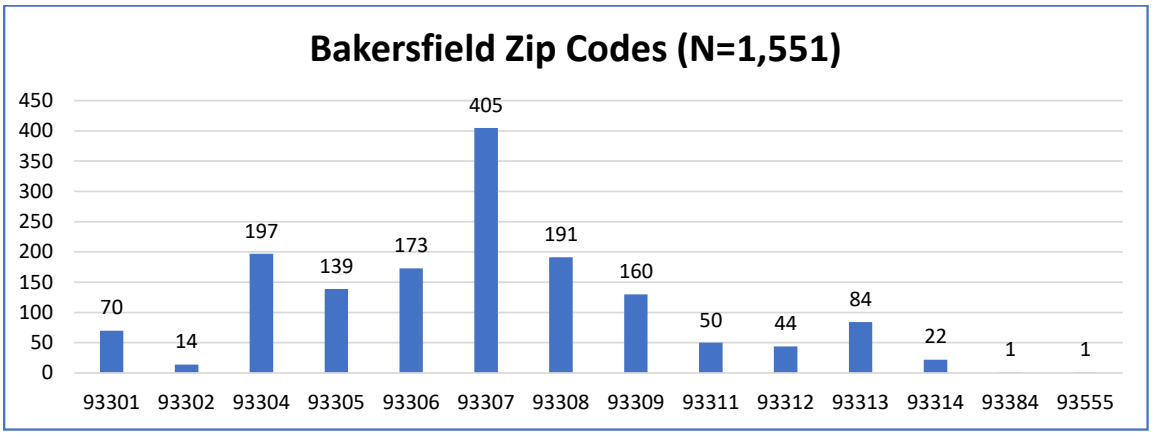
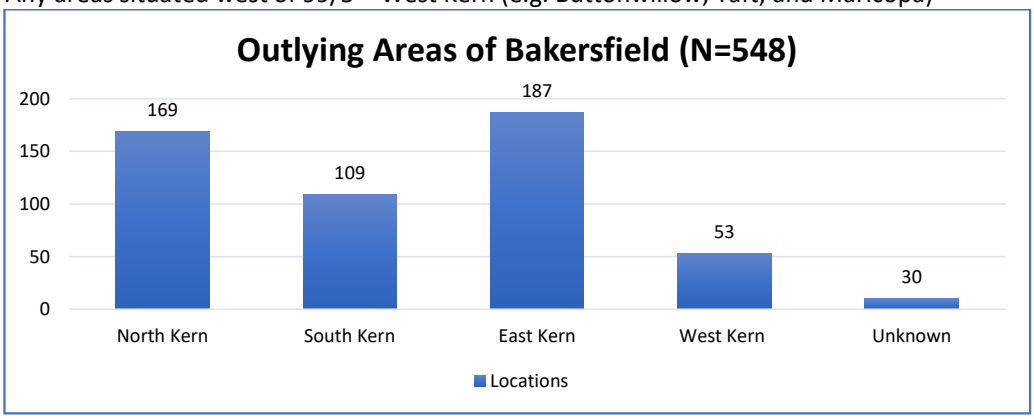


Table 6: Members Residing in Outlying Areas

Even when members have health insurance coverage, these individuals with limited funds, mobility issues, or lack of transportation options still may not be able to get the care they need, especially those that live in the outskirts of Bakersfield. About 26% members receiving PHM services reside in the outlying areas. The PHM team will continue to connect members to ancillary services (e.g., transportation). The data illustrates the total number of members who reside in the outlying areas. Outlying areas is defined as any areas outside of greater Bakersfield. This is the dividing boundaries:

- Any areas situated south of 58 = South Kern (e.g. Arvin, Lamont, and Lebec)
- Any areas situated north of 46 = North Kern (e.g. Delano, McFarland, and Wasco)
- Any areas situated east of 99/5 = East Kern (e.g. Lake Isabella, Ridgecrest, and Mojave)
- Any areas situated west of 99/5 = West Kern (e.g. Buttonwillow, Taft, and Maricopa)

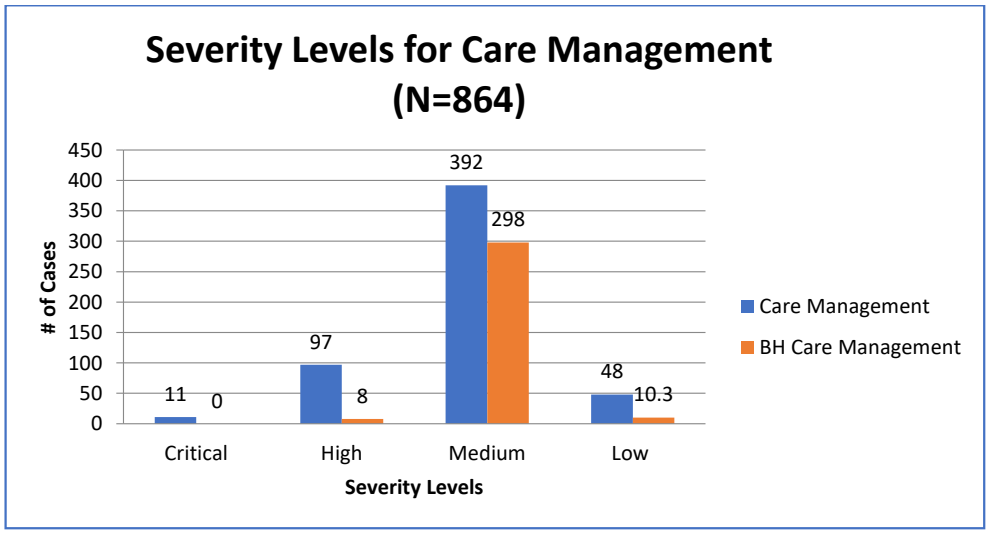


Kern Family Health Care

Table 7: Severity Levels for Case Management

PHM assign members to risk tiers that are critical, high, medium, and low risk levels, with the goal of determining appropriate care management programs or other specific services. These members are assigned to appropriate staff.

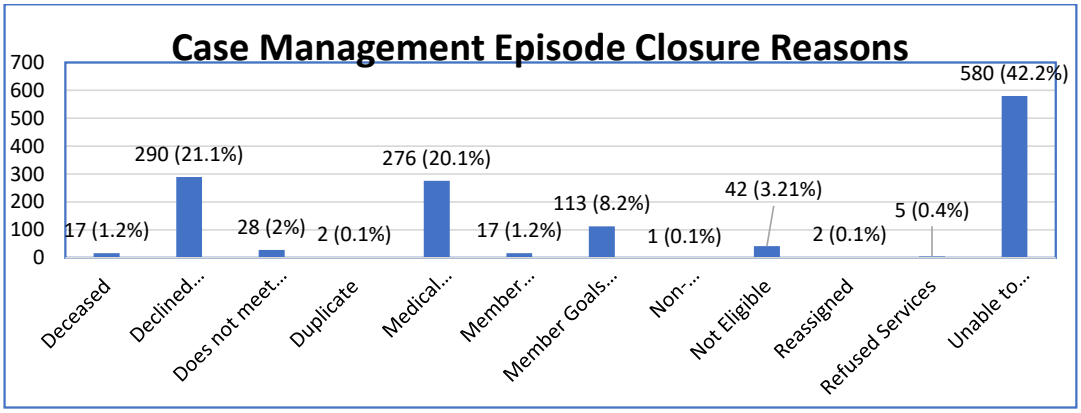
1. **Critical**-Requires minimum of weekly contact and significant care coordination assistance with acute needs.
    - Examples include frequent admits with ER visits, Falls, limited adherence to provider instructions, care plan, caregiver, or unstable social situation, including lack of support or caregiver burnout.
2. **High**-Requires minimum contact every two-four week and has active care coordination needs.
    - Examples include an admit or ER visit within 6 months or fall with injury within the last 6 months, SNF admission within last year, questionable adherence with medications and/or care plan, or social issues.
3. **Medium**- Minimum contact every 30 days. Member in process of change and requires minimum support and follow up with care coordination.
    - Examples include no admits or ER visits in the past year, no mechanical falls, adherent with medications and care plan, no outstanding social issues, significant provider engagement/control.
4. **Low**-Case Management not required. Provide educational materials and recommendations as needed, confirm care coordination is in effect and plan for closure.



Kern Family Health Care

Table 8: Case Management Episode Closure Reasons

A total of 1,373 Episodes were closed during the Months of July thru September 2022.



There are opportunities to increase the number of completions with member goals (8.2%). One strategy is to conduct a random chart audit to review member's goals and ensure goals are simple and realistic.

About 42% of members were closed due to unable to contact. This also captures members who are engaged and actively participating with their plans of care and receiving KHS services but suddenly, these members are unable to contact for various reasons. There are opportunities to clearly define this category, and separate members who are receiving services versus member who are not receiving services. Additionally, PHM will work toward identifying strategies to better promote PHM services to members; thereby, decreasing the percentage of members to decline (21.1%) KHS services/programs. PHM will obtain feedback from members on reasons why they declined services.

#	Reasons for Closure	Definitions
1	Declined services	Contacted members but declined KHS services
2	Does not meet criteria	individuals are enrolled in hospice, possess Medicare benefits (e.g. Kaiser), and reside in long term care facility for >30 days
3	Duplicate	Duplicate referrals
4	Medical director decision	Transferred to another KHS program/services
5	Member disenrolled	Members dropped from the KHS, moved out of county, have secondary insurance
6	Member goals completed	Successfully achieved goals in the plan of care
7	Non-compliant—MD approval obtained	Members who are noncompliant with care, exhausted all resources and reviewed by medical director
8	Not eligible	members who are not eligible for KHS services
9	Reassigned	Reassigned members to another staff
10	Refused services	Currently receiving case management services but no longer desire to continue with services
11	Unable to contact	Lost to follow up, exhausted all resources to contact members. This includes members who are engaged, actively participating with care and suddenly unable to contact members for whatever reasons.

Table 9: Members Contacted

During July thru September, a total of 7,325 members were identified for an outside vendor to contact for completion of a Health Risk Assessment (HRA).

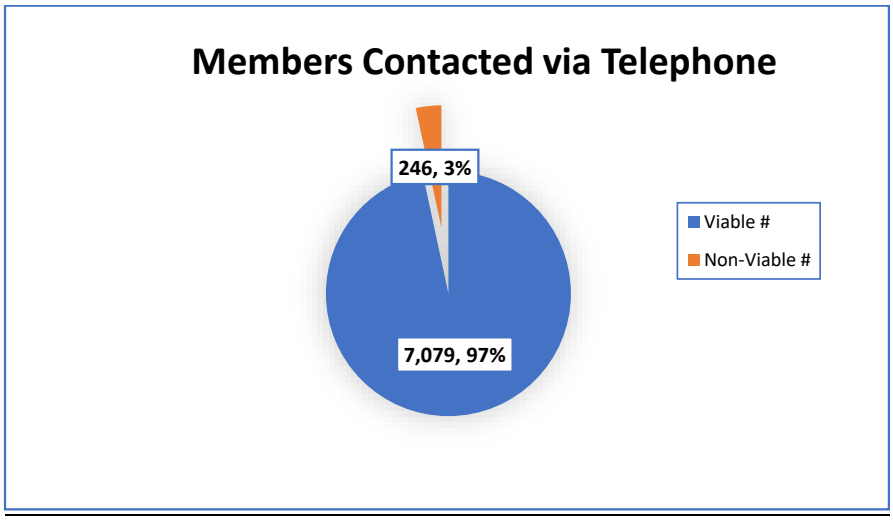
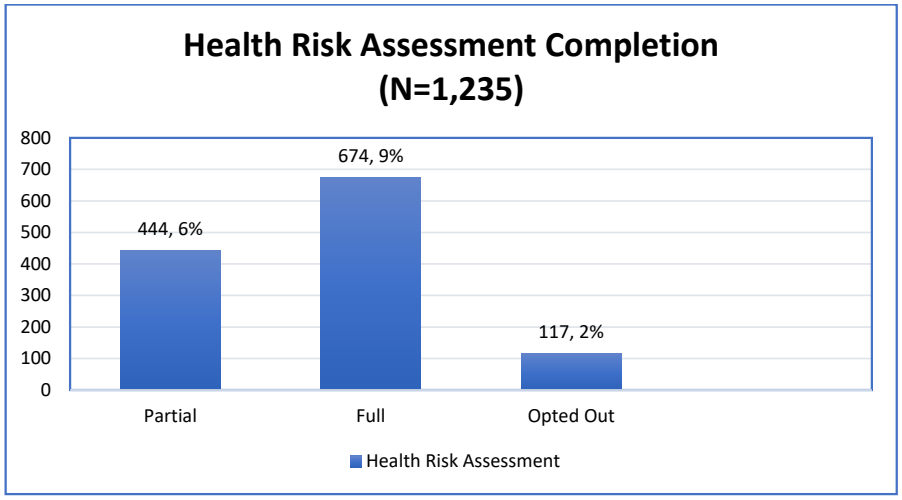


Table 10: SPD Health Risk Assessment (HRA) Information

KHS uses the HRA survey to assess each newly enrolled SPD member's current health risk within 45 days of enrollment for those identified by the risk stratification method or algorithm as higher risk, and within 105 days of enrollment for those identified as lower risk. The Department of Health Care Services (DHCS) is required to provide CMS with detailed information about the KHS HRA processes to ensure that each assessment method includes the specified components. Of the 7,079 that were contacted, only 1, 235 members completed the HRA questionnaire.



Kern Family Health Care

Table 11: Care Management and Coordination Services

The Table illustrates the various types of care management and coordination services provided to members. These services include schedule physician appointments, appointment reminder calls, medication reviews, and develop plans of care. Member with challenges/barriers on their care are reviewed and discussed in the interdisciplinary care team (ICT) to obtain guidance from the KHS team.

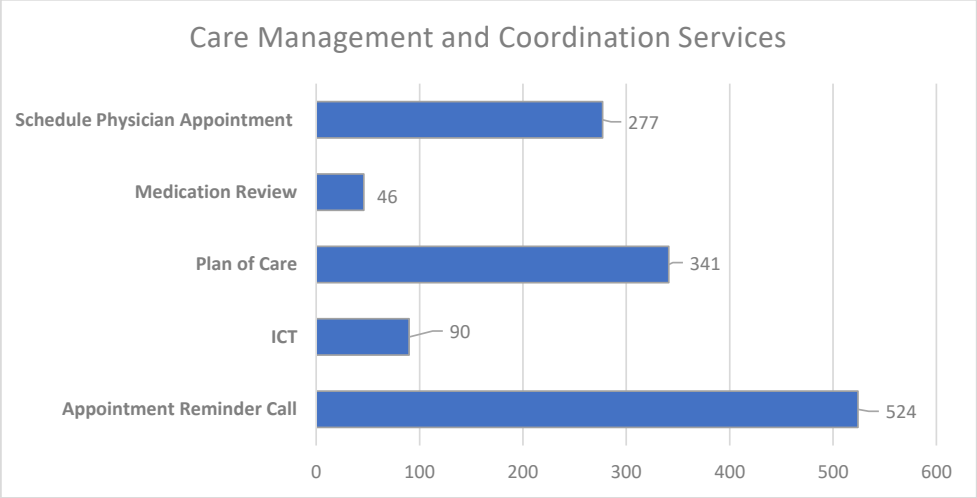


Table 12: Other Services Provided to Members

Other services that are available to the members include language line for language interpreting and translation service; transportation services to get to their medical appointments; and referral to various community resources (e.g. Food Bank, Housing Authority, and In Home Supportive Services, etc.).

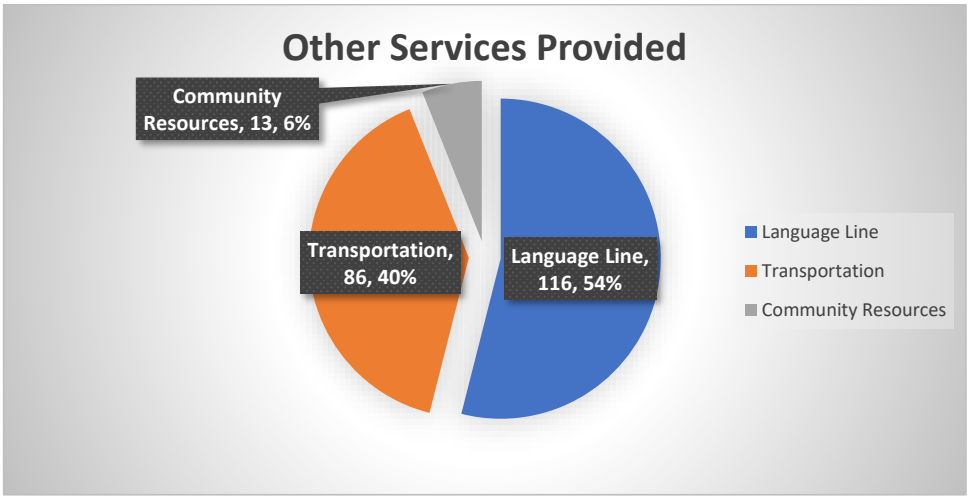
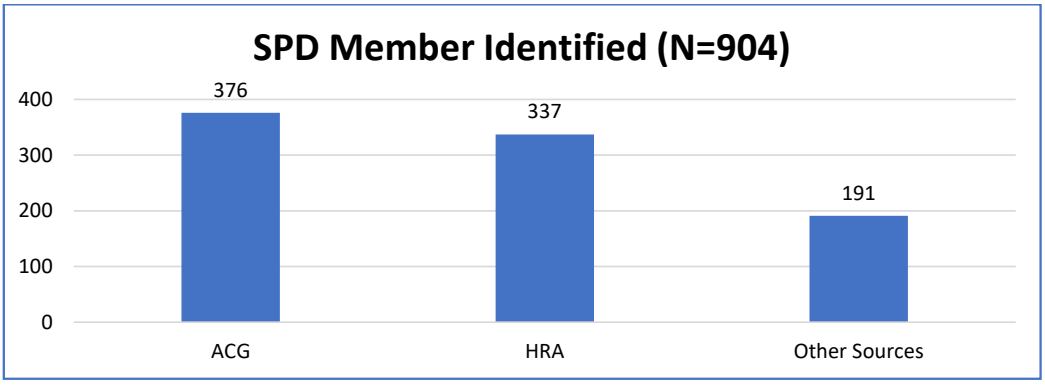


Table 13: Seniors and Persons with Disabilities (SPDs)

SPD Members are identified for Complex Case Management using the John Hopkins Adjusted Clinical Groups (ACG) Predictive Modeler, Health Risk Assessments and other sources including member requests and outside and internal requests. This allows KHS to identify populations with similar characteristics and develop targeted interventions.

The ACG Modeler is generated monthly to identify members at risk of hospitalizations in six (6) months and members with the greatest need for health intervention or care management. These members are enrolled in complex care management. Members with multiple co-morbidities are identified and referred to KHS specialty programs and services. In the table below, of the 2,099 members, the SPD population represents a total of 904 (43%) of the Complex Group in July thru September 2022.



Steps to Take

1. In the next quarterly report, the KHS PHM Department's performance will be compared to the NCQA, HEDIS and MCAS measures, aligning to DHCS requirement.
2. Review and streamline processes and procedures on data gathering and analysis to highlight key priorities in the quarterly report.
3. Explore strategies in improving member enrollment to KHS services/programs.
4. Provide staff development training to enhance their knowledge and skills in care management and coordination.
5. Investigate how staff can have a stronger engagement/participation with existing members
6. Leverage existing resources with community partners.
7. Continue to expand partnership with various community agencies/organizations.

Conclusions

Everyone has a role in making population health a priority, focusing on health disparities, ensuring access and continuum of care, and bridging the gaps in services. These tasks cannot be done alone without creating linkages with community partners. The Steps to Take have been identified above to improve PHM services and data reporting. This includes incorporating additional data in the quarterly report that aligns with DHCS, NCQA, HEDIS and MCAS requirements. We look forward to continuing to improve this report as we add more measures that will be useful to the Committee.

KERN HEALTH SYSTEMS

To: QI/UM Committee Meeting

From: Nate Scott

Date: November 10, 2022

Re: Executive Summary for 3rd Quarter 2022 Operational Board Update - Grievance Report

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Background

Executive Summary for 3rd Quarter 2022 Operational Board Update - Grievance Report: When compared to the previous four quarters, we have identified the following significant trends as they relate to the Grievances and Appeals received during the 3rd Quarter, 2022.

- The increase in appeals can be attributed to an approximate 1.70% increase of referrals received and processed by the Utilization Management Department from Quarter 2 to Quarter 3, 2022. There was also an approximate 2.5% increase in denials.
- Discrimination grievances continues to rise from quarter to quarter. The Plan discusses these grievances with members of our Executive and Compliance teams and take into consideration our members' perceptions when they report these grievances.
- Quality of Care and Exempt grievances rose from Quarter 2 to Quarter 3, 2022. Member Services no longer offers to file a grievance on behalf of a member as all dissatisfactions are forwarded to the Grievance Coordinators for logging and processing. The overall increase in volume led to more grievances being processed in these categories.

Requested Action

Receive and File

KERN HEALTH SYSTEMS

3rd Quarter 2022 Operational Report

Alan Avery
Chief Operating Officer

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3rd Quarter 2022 Grievance Report

Category	3rd Quarter 2022	Status	Issue	Q2 2022	Q1 2022	Q4 2021	Q3 2021
Access to Care	132		Appointment Availability	117	169	131	148
Coverage Dispute	0		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	346		Questioning denial of service	259	138	266	329
Other Issues	30		Miscellaneous	20	41	36	18
Potential Inappropriate Care	514		Questioning services provided. All cases forwarded to Quality Dept.	415	479	256	164
Quality of Service	86		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	120	125	55	53
Discrimination (New Category)	73		Alleging discrimination based on the protected characteristics	34	15		
Total Formal Grievances	1181			965	967	744	712
Exempt	2328		Exempt Grievances-	2087	1404	1431	1520
Total Grievances (Formal & Exempt)	3509			3052	2371	2175	2232

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KHS Formal Grievances and Appeals per 10,000 members = 12.08/month

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Additional Insights-Formal Grievance Detail

Issue	2022 3rd Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	55	31	0	11	13
Coverage Dispute	0	0	0	0	0
Specialist Access	77	26	0	19	32
Medical Necessity	346	140	0	140	66
Other Issues	30	22	0	3	5
Potential Inappropriate Care	514	164	120	230	0
Quality of Service	86	55	0	10	21
Discrimination	73	54	0	0	19
Total	1181	492	120	413	156

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3

KERN HEALTH SYSTEMS

To: QI/UM Committee Meeting

From: Nate Scott

Date: November 10, 2022

Re: Executive Summary for 3rd Quarter 2022 Grievance Summary Report

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Background

Executive Summary for the 3rd Quarter Grievance Summary Report:
The Grievance Summary Report supports the high-level information provided on the Operational Report and provides more detail as to the type of grievances KHS receives on behalf of our members.

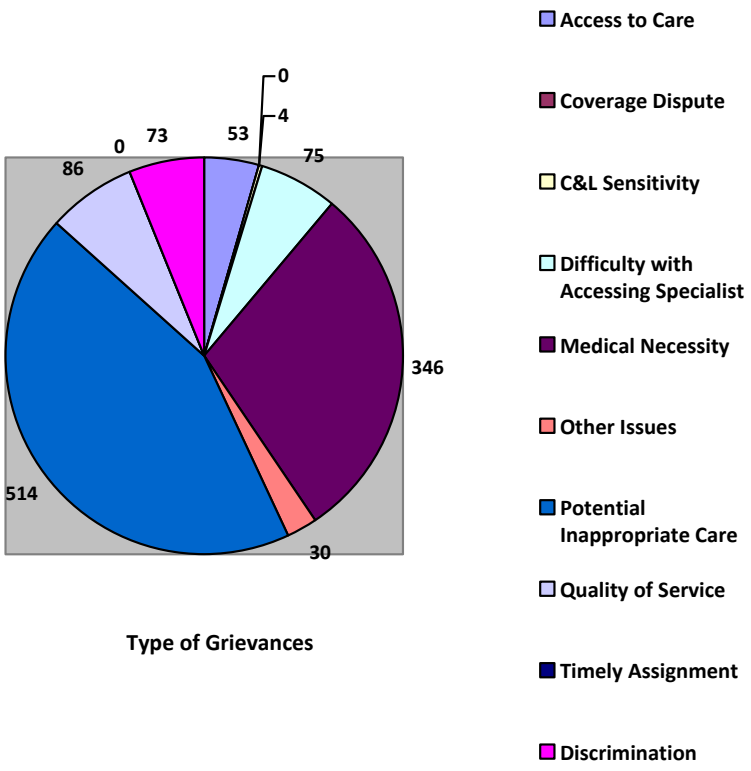
Kaiser Permanente Grievances and Appeals
During the third quarter of 2022, there were one hundred and one grievances and appeals filed by KFHC members assigned to Kaiser Permanente. The Grievance Summary Report breaks down the cases by Grievance Category.

Requested Action

Receive and File

3rd Quarter 2022 Grievance Summary

Issue	Number	In Favor of Health Plan	Under Review by Q.I	In favor of Enrollee	Still under review
Access to care	53	29	0	11	13
Coverage dispute	0	0	0	0	0
Cultural and Linguistic Sensitivity	4	3	0	1	0
Difficulty with accessing specialists	75	25	0	18	32
Medical necessity	346	140	0	140	66
Other issues	30	22	0	3	5
Potential Inappropriate care	514	164	120	230	0
Quality of service	86	55	0	10	21
Timely assignment to provider	0	0	0	0	0
Discrimination	73	54	0	0	19



KHS Grievances per 10,000 members = 12.57/month

During the third quarter of 2022, there were one thousand, one hundred and eighty-one standard grievances and appeals received. Four hundred and thirteen cases were closed in favor of the Enrollee. Four hundred and ninety-two cases were closed in favor of the Plan. One hundred and twenty cases are under review by the KHS Quality Improvement Department. One hundred and fifty-six cases are still under review. Of the one thousand, one hundred and eighty-one standard grievances and appeals received, one thousand forty-five cases closed within thirty days; one hundred thirty-six cases were pended and closed after thirty days.

3rd Quarter 2022 Grievance Summary

Access to Care

There were fifty-three grievances pertaining to access to care. Twenty-nine closed in favor of the Plan. Eleven cases closed in favor of the Enrollee. Thirteen cases are still under review. The following is a summary of these issues:

Fifteen members complained about the lack of available appointments with their Primary Care Provider (PCP). Seven cases closed in favor of the Plan after the responses indicated the offices provided appropriate access to care based on Access to Care standards. Three cases closed in favor of the Enrollee after the responses indicated the offices may not have provided appropriate access to care based on Access to Care standards. Five cases are still pending review.

Five members complained about the wait time to be seen for a Primary Care Provider (PCP) appointment. Three cases closed in favor of the Plan after the responses indicated the members were seen within the appropriate wait time for a scheduled appointment or the members were at the offices to be seen as a walk-in, which are not held to Access to Care standards. Two cases closed in favor of the Enrollee after the responses indicated the members were not seen within the appropriate wait time for a scheduled appointment.

Seven members complained about the telephone access availability with their Primary Care Provider (PCP). Three cases closed in favor of the Plan after the responses indicated the members were provided with the appropriate telephone access availability. Four cases are still pending review.

Twenty-six members complained about a provider not submitting a referral authorization request in a timely manner. Sixteen cases closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner. Six cases closed in favor of the Enrollee after it was determined the referral authorization request may not have been submitted in a timely manner. Four cases are still under review.

Coverage Dispute

There were no grievances pertaining to a Coverage Dispute issue.

Cultural and Linguistic Sensitivity

Four members complained about the lack of available interpreting services to assist during their appointments. One case closed in favor of the Enrollee after the response from the provider indicated the member may not have been provided with the appropriate access to interpreting services. Three cases closed in favor of the Plan after the responses from the providers indicated the members were provided with the appropriate access to interpreting services.

Difficulty with Accessing a Specialist

3rd Quarter 2022 Grievance Summary

There were seventy-five grievances pertaining to Difficulty Accessing a Specialist. Twenty-five cases closed in favor of the Plan. Eighteen cases closed in favor of the Enrollee. Thirty-two cases are still under review. The following is a summary of these issues:

Nine members complained about the lack of available appointments with a specialist. Four cases closed in favor of the Plan after the responses indicated the members were provided the appropriate access to specialty care based on Access to Care Standards. One case closed in favor of the Enrollee after the responses indicated the members may not have been provided with the appropriate access to care based on the Access to Care Standards for specialty appointments. Four cases are still under review.

Three members complained about the wait time to be seen for a specialist appointment. Two cases closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate wait time for a scheduled appointment based on Access to Care Standards. One case is still under review.

Four members complained about the telephone access availability with a specialist office. One case closed in favor of the Plan after the response indicated the member was provided with the appropriate telephone access availability. Three cases are still under review.

Forty-seven members complained about a provider not submitting a referral authorization request in a timely manner. Twelve cases closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner. Fourteen cases closed in favor of the Enrollee after it was determined the referral authorization request may not have been submitted in a timely manner. Twenty-one cases are still under review.

Eleven members complained about the availability with scheduling Non-Emergency Medical Transportation. Seven of the cases closed in favor of the Plan after the responses determined the member received the appropriate scheduling from the transportation vendor. One case closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate scheduling from the transportation vendor. Three cases are still under review.

One member complained about Physical Access with a specialist. This case closed in favor plan after it was determined the member was provided with the appropriate service.

Medical Necessity

There were three hundred and forty-six appeals pertaining to Medical Necessity. One hundred and forty cases were closed in favor of the Plan. One hundred and forty cases closed in favor of the Enrollee. Sixty-Six cases are still under review. The following is a summary of these issues:

3rd Quarter 2022 Grievance Summary

Three hundred and forty-six members complained about the denial or modification of a referral authorization request. One hundred and twenty-eight of the cases were closed in favor of the Plan as it was determined that there was no supporting documentation submitted with the referral authorization requests to support the criteria for medical necessity for the requested specialist or DME item; therefore, the denials were upheld. Twelve of the cases were closed in favor of the Plan and partially overturned. One hundred and forty cases were closed in favor of the Enrollee as it was determined medical necessity was met and the denials were overturned and approved. Sixty-six cases are still under review.

Other Issues

There were thirty grievances pertaining to Other Issues that are not otherwise classified in the other categories. Twenty-two cases were closed in favor of the Plan after the responses indicated appropriate service were provided. Three cases closed in favor of the Enrollee after the responses indicated appropriate service may not have been provided. Five cases are under review.

Potential Inappropriate Care

There were five hundred and fourteen grievances involving Potential Inappropriate Care issues. These cases were forwarded to the Quality Improvement (QI) Department for their due process. Upon review, one hundred and sixty-four cases were closed in favor of the Plan, as it was determined a quality-of-care issue could not be identified. Two hundred and thirty cases were closed in favor of the Enrollee as a potential quality of care issue was identified and appropriate tracking or action was initiated by the QI team. One hundred and twenty cases are still pending further review with QI.

Quality of Service

There were eighty-six grievances involving Quality of Service issues. Fifty-five cases closed in favor of the Plan after the responses determined the members received the appropriate service from their providers. Ten cases closed in favor of the enrollee after the responses determined the members may not have received the appropriate services. Twenty-one cases are under review.

Timely Assignment to Provider

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

Discrimination

There were seventy-three grievances pertaining to Discrimination. Fifty-four cases closed in favor of the Plan as there was no discrimination found. Nineteen cases are still open, pending investigation and resolution. All grievances related to Discrimination, are forwarded to the DHCS Office of Civil Rights upon closure.

3rd Quarter 2022 Grievance Summary

Kaiser Permanente Grievances and Appeals

During the third quarter of 2022, there were one hundred and one grievances and appeals received by KFHC members assigned to Kaiser Permanente.

Access to Care

There were eleven grievances pertaining to Access to Care.

Medical Necessity

There were eleven appeals pertaining to Medical Necessity.

Coverage Disputes

There were nineteen appeals pertaining to Coverage Disputes.

Quality of Care

There was one grievance pertaining to Quality of Care.

Quality of Service

There were fifty-nine grievances pertaining to a Quality of Service.

KERN HEALTH SYSTEMS

To: **KHS QI-UM Committee**

From: **Yolanda Herrera, CPMSM, CPCS**
Credentialing Manager

Date: **November 10, 2022**

Re: **3rd Quarter 2022 – PNM Credentialing Statistics**

Background

During the monitoring/reporting period July 1, 2022 through September 30, 2022 there were a total of 122 Initially Credentialed Providers and 79 Recredentialed Providers.

15 New Contracts were approved:
1-CSS/Housing Transition, Deposits & Tenancy & Sustaining Services
1-Anesthesiology (ASC Based)
1-Physical Therapy
1-Psychiatry
3-DME
1-Pharmacy/DME
2- SNF/CLF
2-Hearing Aid Dispenser
1-Hospital Based Radiology
1-Home Health
1-Hospice

Discussion

- All credentialing and recredentialing files were approved.
- All New Contracts were approved.

Fiscal Impact

N/A

Requested Action

N/A

KERN HEALTH SYSTEMS
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	NAME	DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
1	Angel Congregate Living Inc	Angel Congregate Living Inc 38356 Desert View Drive Lancaster CA 93551	SNF/CLF	New Contract	PRV079425	PRV079425	Yes Eff 7/1/22
2	Baz, Malik MD	Baz Allergy, Asthma & Sinus Center, Inc. dba: Baz Allergy, Asthma & Sinus Center 7471 N. Fresno Street Fresno CA 93720	Allergy & Immunology	New Contract	PRV080097	PRV080098	Yes Eff 7/1/22
3	Boynton, Scott DPM	Scott R. Boynton dba: BHH Center for Wound Healing 3012 Sillect Ave Ste. B Bakersfield CA 93308	Podiatry/Wound Care	New Contract	PRV069875	PRV069875	Yes Eff 7/1/22
4	High Desert Medical and Sleep Supplies Inc	High Desert Medical and Sleep Supplies Inc 112 North China Lake Blvd Ridgecrest CA 93555	DME	New Contract	PRV074242	PRV074242	Yes Eff 7/1/22
5	InfuSystem Inc	InfuSystem Inc 3851 W Hamlin Road Rochester MI 48309	DME	New Contract	PRV014530	PRV014530	Yes Eff 7/1/22
6	Wible Pharmacy	Kavish Prajapati Inc dba: Wible Pharmacy 3045 Wible Road Bakersfield CA 93304	DME/Pharmacy	New Contract	PRV080099	PRV080099	Yes Eff 7/1/22
7	Active Life Chiropractor	Sabol & Walker Chiropractice Inc dba: Active Life Chiropractor 3015 Calloway Drive D6 Bakersfield CA 93312	Physical Therapy	New Contract	PRV059581	PRV059581	Yes Eff 7/1/22

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	NAME	DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
8	Walia, Sandeep MD	Sandeep S. Walia MD, A Professional Medical Corporation dba: West Coast Eye Institute 215 China Grade Loop Bakersfield CA 93308	Ophthalmology	New Contract	PRV055003	PRV064010	Yes Eff 7/1/22
9	Bhardwaj, Rahul MD	Kern Nephrology Medical Group 5030 Office Park Drive Bakersfield CA 93309	Nephrology	Existing	PRV080100	PRV000313	Yes Eff 7/1/22
10	Bhogal, Neil MD	Kern Gastroenterology Medical Group 5959 Truxtun Avenue Ste. 200 Bakersfield CA 93309	Gastroenterology	Existing	PRV080101	PRV000338	Yes Eff 7/1/22
11	Castillo, Romeo MD	Bartz-Altadonna Comm Health Center 9300 N. Loop Blvd California City CA 93505	Family Practice	Existing	PRV001133	PRV029961	Yes Eff 7/1/22
12	Demidov, Pavel BCBA	California Psychcare , Inc. 5500 Ming Avenue Ste 140 Bakersfield CA 93309	Qualified Autism Provider / Behavioral Analyst	Existing	PRV080104	PRV011225	Yes Eff 7/1/22
13	Edwards, Kenia MD	Ridgecrest Regional Hospital 1011 N China Lake Blvd Ste. A Ridgecrest CA 93555	OB/GYN	Existing	PRV078226	ALL SITES	Yes Eff 7/1/22
14	Fajardo-Gomez, Oscar MD	Reedley Community Hospital dba: AH Community Care - Hanford 1025 N. Douty Street Hanford CA	Psychiatry	Existing	PRV080105	PRV040784	Yes Eff 7/1/22
15	Fonte, Nanette MD	Bassel Hadaya MD dba: Antelope Valley Nephrology Medical Group, Inc 1759 W Avenue J Ste. 101 Lancaster CA 93534	Nephrology	Existing	PRV052525	PRV013986	Yes Eff 7/1/22

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	NAME	DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
16	Garcia Aristizabal, Luz MD	Omni Family Health 2505 Merced Street Fresno CA 93721	Pediatrics	Existing	PRV080127	PRV000019	Yes Eff 7/1/22
17	Hamilton, Jessica MD	Planned Parenthood Mar Monte, Inc. 2633 16th Street Bakersfield CA 93301	Family Practice	Existing	PRV031128	PRV000476	Yes Eff 7/1/22
18	Jungles, Haley CRNA	Regional Anesthesia Assoc. Inc KM & ASC -1700 Mt Vernon Avenue Bakersfield CA 93306	Anesthesiology	Existing	PRV077766	PRV037540	Yes Eff 7/1/22
19	Kahlon, Rajpreet NP-C	Infusion & Clinical Services Premier Urgent Care of Central California *All Locations - 5401 White Lane Bakersfield CA 93309 Alternate Affiliation: Nephrology Medical Group	Internal Medicine	Existing	PRV077685	ALL SITES	Yes Eff 7/1/22
20	Khadka, Keshav NP-C	Kern County Hospital Authority 3551 Q Street Ste. 100 Bakersfield CA 93301	Urology	Existing	PRV079220	ALL SITES	Yes Eff 7/1/22
21	Lee, Eugene MD	Kern County Hospital Authority 3551 Q Street Ste. 100 Bakersfield CA 93301	General & Vascular Surgery	Existing	PRV077883	ALL SITES	Yes Eff 7/1/22
22	Manalo, Rendell DO	Bassel Hadaya MD dba: Antelope Valley Nephrology Medical Group, Inc 1759 W Avenue J Ste. 101 Lancaster CA 93534	Nephrology	Existing	PRV011954	PRV013986	Yes Eff 7/1/22
23	Nastor, Diane NP-C	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	Rheumatology	Existing	PRV070587	ALL SITES	Yes Eff 7/1/22
24	Portillo, Eilda PA-C	Omni Family Health 355 N Campus Drive Ste. E Hanford CA 93230	Family Practice	Existing	PRV066421	PRV000019	Yes Eff 7/1/22

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	NAME	DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
25	Reyes Acosta, Vicky RD	Dignity Health Medical Foundation ECM 3737 San Dimas Street Ste 101 Bakersfield CA 93301	Registered Dietician	Existing	PRV080128	PRV012886	Yes Eff 7/1/22
26	Rodela, Jesus BCBA	Center for Autism/Related Disorders 8302 Espresso Drive Ste. 100 Bakersfield CA 93312	Qualified Autism Provider / Behavioral Analyst	Existing	PRV080126	PRV032083	Yes Eff 7/1/22
27	Rogers, Lisa PA	Emergency Physicians Urgent Care, Inc. dba: Accelerated Urgent Care *All Locations 212 Coffee Road Ste. 101 Bakersfield CA 93309	Family Practice	Existing	PRV078985	ALL SITES	Yes Eff 7/1/22
28	Satou, Gary MD	Ridgecrest Regional Hospital 1081 N China Lake Blvd Ridgecrest CA 93555	Pediatric Cardiology	Existing	PRV001436	ALL SITES	Yes Eff 7/1/22
29	Schott, Katherine CNM	Planned Parenthood Mar Monte, Inc. 2633 16th Street Bakersfield CA 93301	Family Practice	Existing	PRV080129	PRV000476	Yes Eff 7/1/22
30	Smith, Jacob CRNA	Regional Anesthesia Assoc. Inc KM & ASC -1700 Mt Vernon Avenue Bakersfield CA 93306	Anesthesiology	Existing	PRV077763	PRV037540	Yes Eff 7/1/22
31	Solorio, Edgar NP-C	Ridgecrest Regional Hospital 1041 N China Lake Blvd Ridgecrest CA 93555	Family Practice	Existing	PRV080130	ALL SITES	Yes Eff 7/1/22
32	Yang, Sung MD	Bassel Hadaya MD dba: Antelope Valley Nephrology Medical Group, Inc 1759 W Avenue J Ste. 101 Lancaster CA 93534	Nephrology	Existing	PRV034283	PRV013986	Yes Eff 7/1/22

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NAME	LEGAL NAME/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
Community Action Partnership of Kern	Community Action Partnership dba: CAPK 5005 Business Park North Bakersfield CA 93309	CSS/Housing Transition, Deposits & Tenancy & Sustaining Services	New Contract	PRV080716	PRV080716	Yes Eff 9/1/22
Hernandez, Blas MD	Blas D. Hernandez, MD 3850 San Dimas Street Bakersfield CA 93301	Anesthesiology	New Contract	PRV006187	PRV006187	Yes Eff 9/1/22
Movement Space Physical Therapy Inc	Movement Space Physical Therapy 1811 Oak Street Ste 150 Bakersfield CA 93301	Physical Therapy	New Contract	PRV080668	PRV080668	Yes Eff 9/1/22
Nguyen, Charles MD	Pacific Health Education Cognitive Center Inc 5300 California Avenue Ste 220 Bakersfield CA 93309	Psychiatry	New Contract	PRV081627	PRV063315	Yes Eff 9/1/22
Strive Medical LLC	Strive Medical LLC 5500 Ming Avenue Ste 395 Bakersfield CA 93309	DME	New Contract	PRV081628	PRV081628	Yes Eff 9/1/22
Orthokinetix	West Coast DME & Supplies LLC dba: Orthokinetix 1835 Chicago Avenue Ste A Riverside CA 92507	DME	New Contract	PRV012138	PRV012138	Yes Eff 9/1/22
Berz, David MD	Bakersfield Hematology Oncology Group Inc 9800 Brimhall Road Ste. 200 Bakersfield CA 93312	Hematology / Oncology	Existing	PRV078429	PRV071514	Yes Eff 9/1/22
Mehtani, Janak MD	Clinica Sierra Vista 7800 Niles Street Bakersfield CA 93306	Psychiatry	Existing	PRV081621	PRV000002	Yes Eff 9/1/22
Abudu, Sheriff MD	Hospitalist Medicine Phys of Calif Inc dba: Sound Hospitalist of California 2615 Chester Avenue Bakersfield CA 93301	Internal Medicine / Hospitalist	Existing	PRV073442	PRV014433	Yes Eff 9/1/22
Ammari, Razan MD	Emergency Physicians Urgent Care, Inc. dba: Accelerated Urgent Care *All Locations 212 Coffee Road Ste. 101 Bakersfield CA 93309	General Practice	Existing	PRV002007	ALL SITES	Yes Eff 9/1/22
Aseltine, Robyn LCSW	Reedley Community Hospital dba: AH Community Care - Hanford 1025 N. Douty Street Hanford CA	Clinical Social Worker	Existing	PRV081622	PRV040784	Yes Eff 9/1/22
Bains, Jasmeet MD	Adventist Health Delano dba: Delano Prompt Care Clinic 1201 Jefferson Street Delano CA 93215 Additional affiliation: Adventist Health Tehachapi Mobile RHC	Family Practice	Existing	PRV043990	ALL SITES	Yes Eff 9/1/22

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Bankhead, Alan PA-C	Adventist Health Physicians Network 2701 Chester Avenue Ste. 202 Bakersfield CA 93301	Orthopedic Surgery	Existing	PRV003516	PRV029329	**Yes** **Eff 9/1/22**
Bashir, Muhammed MD	Baz Allergy, Asthma & Sinus Center, Inc. dba: Baz Allergy, Asthma & Sinus Center 7471 N. Fresno Street Fresno CA 5410 W Cypress Ave Ste. 102 Visalia CA	Allergy & Immunology	Existing	PRV081630	PRV080098	**Yes** **Eff 9/1/22**
Brito Gonzalez, Ariel MD	Clinica Sierra Vista 7800 Niles Street Bakersfield CA 93306	Family Practice	Existing	PRV081631	PRV000002	**Yes** **Eff 9/1/22**
Bolourian-Kashi, Kioumars MD	Hospitalist Medicine Phys of Calif Inc dba: Sound Hospitalist of California 2615 Chester Avenue Bakersfield CA 93301	Internal Medicine / Hospitalist	Existing	PRV055517	PRV014433	**Yes** **Eff 9/1/22**
Broussea, Erica LCSW	Reedley Community Hospital dba: AH Community Care - Hanford 1025 N. Douty Street Hanford CA	Clinical Social Worker	Existing	PRV081625	PRV040784	**Yes** **Eff 9/1/22**
Cabahug, Mariette NP	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	Internal Medicine	Existing	PRV080322	ALL SITES	**Yes** **Eff 9/1/22**
Cheng, Marsha MD	Clinica Sierra Vista 2400 Wible Road Ste. 14 Bakersfield CA 93304	Internal Medicine	Existing	PRV080586	PRV000002	**Yes** **Eff 9/1/22**
Chiritescu, Anca MD	Ridgecrest Regional Hospital 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	Psychiatry	Existing	PRV081632	PRV029495	**Yes** **Eff 9/1/22**
Civelli, Valerie MD	Clinica Sierra Vista 7800 Niles Street Bakersfield CA 93306	Family Practice	Existing	PRV081078	PRV000002	**Yes** **Eff 9/1/22**
De Vera, John-Menard NP-C	Bartz-Altadonna Comm Health Center 9300 N. Loop Blvd California City CA 93505	Family Practice	Existing	PRV081633	PRV029961	**Yes** **Eff 9/1/22**
Diaz, Rocio NP-C	Dignity Health Medical Foundation dba: DHMG-Bakersfield 3737 San Dimas Street Ste 101 Bakersfield CA 93301	Family Practice	Existing	PRV002187	PRV012886	**Yes** **Eff 9/1/22**
Enriquez, Faustino NP-C	Emergency Physicians Urgent Care, Inc. dba: Accelerated Urgent Care *All Locations 212 Coffee Road Ste. 101 Bakersfield CA 93309	Family Practice	Existing	PRV081634	ALL SITES	**Yes** **Eff 9/1/22**
Grewal, Namdeep MD	Clinica Sierra Vista 7800 Niles Street Bakersfield CA 93306	Family Practice	Existing	PRV081079	PRV000002	**Yes** **Eff 9/1/22**
Guardado, Luana BCBA	Autism Behavior Services Inc 4900 California Ave Tower B, 2nd Floor Bakersfield CA 93309	Qualified Autism Provider / Behavioral Analyst	Existing	PRV081619	PRV062872	**Yes** **Eff 9/1/22**

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Hernandez, Jose MD	Adventist Health Delano Delano Urgent Care (Primary Care) 1201 Jefferson Street Delano CA 93215	Pediatrics	Existing	PRV001000	PRV005653	**Yes** **Eff 9/1/22**
Hiyama, Lauren MD	Baz Allergy, Asthma & Sinus Center, Inc. dba: Baz Allergy, Asthma & Sinus Center 7471 N. Fresno Street Fresno CA 5410 W Cypress Ave Ste. 102 Visalia CA	Allergy & Immunology	Existing	PRV041279	PRV041280	**Yes** **Eff 9/1/22**
Horowitz, Arthur LCSW	Reedley Community Hospital dba: AH Community Care - Hanford 1025 N. Douty Street Hanford CA	Clinical Social Worker	Existing	PRV081635	PRV040784	**Yes** **Eff 9/1/22**
Ibarra, Amanda BCBA	Autism Behavior Services Inc 4900 California Ave Tower B, 2nd Floor Bakersfield CA 93309	Qualified Autism Provider / Behavioral Analyst	Existing	PRV081623	PRV062872	**Yes** **Eff 9/1/22**
Javier, Rosy NP-C	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	Internal Medicine	Existing	PRV076783	ALL SITES	**Yes** **Eff 9/1/22**
Kapadia, Ravi MD	Infusion & Clinical Services dba: Premier Valley Medical Group 5401 White Lane Bakersfield CA 93309	General Surgery	Existing	PRV077366	ALL SITES	**Yes** **Eff 9/1/22**
Kyaw, Htoo MD	Atul Aggarwal MD Cardiology Clinic 1018 Calloway Drive Bakersfield CA 93312	Cardiovascular Disease	Existing	PRV080244	PRV000343	**Yes** **Eff 9/1/22**
Laimer, Hannah DO	Reedley Community Hospital dba: AH Community Care - Taft 501 6th Street Taft CA 93268	Family Practice	Existing	PRV081636	PRV032339	**Yes** **Eff 9/1/22**
Lepe, Jeanette BCBA	California Psychcare Inc 624 Commerce Drive Unit E Palmdale CA 93551	Qualified Autism Provider / Behavioral Analyst	Existing	PRV081620	PRV011225	**Yes** **Eff 9/1/22**
Levingston, Laura NP-C	Rheumatology Services Medical Group 8329 Brimhall Road Ste. 801 Bakersfield CA 93312	Rheumatology	Existing	PRV069763	PRV014106	**Yes** **Eff 9/1/22**
Lien, Alan PA-C	LA Laser Center PC *All locations 5600 California Avenue Ste. 101 & 103 Bakersfield CA 93309	Dermatology	Existing	PRV058893	ALL SITES	**Yes** **Eff 9/1/22**
Lindborg, Ryan MD	Kern County Hospital Authority 3551 Q Street Bakersfield CA 93301	General Surgery	Existing	PRV081082	ALL SITES	**Yes** **Eff 9/1/22**
Lopez, Lissette PA-C	Emergency Physicians Urgent Care, Inc. dba: Accelerated Urgent Care *All Locations 212 Coffee Road Ste. 101 Bakersfield CA 93309	Family Practice	Existing	PRV081637	ALL SITES	**Yes** **Eff 9/1/22**
Masghati, Salome MD	Ridgecrest Regional Hospital 1011 N China Lake Blvd Ridgecrest CA 93555	OB/GYN	Existing	PRV080162	ALL SITES	**Yes** **Eff 9/1/22**

KERN HEALTH SYSTEMS
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Mejia, Blanca PsyD	Omni Family Health 1530 E Manning Avenue Reedley CA 93654	Psychology	Existing	PRV065149	PRV000019	**Yes** **Eff 9/1/22**
Musa, Omar NP-C	Clinica Sierra Vista 67 Evans Road Wofford Heights CA 93285	Family Practice	Existing	PRV080149	PRV000002	**Yes** **Eff 9/1/22**
Neagos, Negoita PA-C	Telehealthdocs Medical Corporation *All Locations 2215 Truxtun Avenue Ste. 100 Bakersfield CA 93301	Endocrinology	Existing	PRV081624	ALL SITES	**Yes** **Eff 9/1/22**
Nwosu, Ikenna MD	Clinica Sierra Vista 7800 Niles Street Bakersfield CA 93306	Family Practice	Existing	PRV080852	PRV000002	**Yes** **Eff 9/1/22**
Ogle, Ayesha NP-C	Bartz-Altadonna Comm Health Center 9300 N. Loop Blvd California City CA 93505	Internal Medicine	Existing	PRV047593	PRV029961	**Yes** **Eff 9/1/22**
Pettigrew, Howard MD	Baz Allergy, Asthma & Sinus Center, Inc. dba: Baz Allergy, Asthma & Sinus Center 7471 N. Fresno Street Fresno CA 5410 W Cypress Ave Ste. 102 Visalia CA	Allergy & Immunology	Existing	PRV081638	PRV080098 PRV041280	**Yes** **Eff 9/1/22**
Rahvar, Maral MD	LA Laser Center PC *All locations 5600 California Avenue Ste. 101 & 103 Bakersfield CA 93309	Dermatopathology	Existing	PRV079638	ALL SITES	**Yes** **Eff 9/1/22**
Riggs, David MD	Adventist Health Delano dba: Delano Prompt Care Clinic 1201 Jefferson Street Delano CA 2300 7th Street Wasco CA	General Practice	Existing	PRV029627	PRV000190 PRV005653 PRV005640	**Yes** **Eff 9/1/22**
Roldan, Xenia MD	Clinica Sierra Vista 8787 Hall Road Bakersfield CA 93306	Family Practice	Existing	PRV000293	PRV000002	**Yes** **Eff 9/1/22**
Sabry, Angela MD	Baz Allergy, Asthma & Sinus Center, Inc. dba: Baz Allergy, Asthma & Sinus Center 7471 N. Fresno Street Fresno CA 5410 W Cypress Ave Ste. 102 Visalia CA	Allergy & Immunology	Existing	PRV052562	PRV080098 PRV041280	**Yes** **Eff 9/1/22**
Sahar, David MD	California Institute of Cosmetic and Reconstructive Surgery 2901 Sillect Avenue Ste. 201 Bakersfield CA 93308	Plastic Surgery	Existing	PRV080104	PRV011225	**Yes** **Eff 9/1/22**
Sekhavat-Tafti, Sima PA-C	Kern County Hospital Authority 3551 Q Street Bakersfield CA 93301	General Surgery	Existing	PRV079221	ALL SITES	**Yes** **Eff 9/1/22**
Sethi, Sheba MD	Bright Heart Health Medical Group 2960 Camino Diablo Ste. 105 Walnut Creek CA 94597	Addiction Medicine	Existing	PRV081639	PRV061628	**Yes** **Eff 9/1/22**
Siddiqui, Arsalan MD	Kern Radiology Medical Group Inc 2301 Bahamas Dr. *All Locations Bakersfield CA 93301	Diagnostic Radiology	Existing	PRV042262	ALL SITES	**Yes** **Eff 9/1/22**

KERN HEALTH SYSTEMS
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Softa, Ridhima NP-C	Pinnacle Primary Care, Inc. 1520 Brundage Lane Bakersfield CA 93304	Family Practice	Existing	PRV048438	PRV000353	**Yes** **Eff 9/1/22**
Stegall, Anne NP-C	Hospitalist Medicine Phys of Calif Inc dba: Sound Hospitalist of California 2615 Chester Avenue Bakersfield CA 93301	Internal Medicine / Hospitalist	Existing	PRV078972	PRV014433	**Yes** **Eff 9/1/22**
Walker, Robin NP-C	Reedley Community Hospital dba: AH Community Care - Taft 501 6th Street Taft CA 93268	Family Practice	Existing	PRV080585	PRV032339	**Yes** **Eff 9/1/22**
Warner, Thomas PA-C	Omni Family Health 2505 Merced Street Fresno CA 93721	Family Practice	Existing	PRV062105	PRV000019	**Yes** **Eff 9/1/22**
Williams, Alysia NP	Kern County Hospital Authority 3551 Q Street Bakersfield CA 93301	General Practice	Existing	PRV077741	ALL SITES	**Yes** **Eff 9/1/22**

KERN HEALTH SYSTEMS
3rd Quarter 2022
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Report Date: October 4, 2022

Department: Provider Network Management

Monitoring Period: July 1, 2022 through September 30, 2022

Population:

Providers	Credentialed	Recredentialed
MD's	54	36
DO's	5	4
AU's	0	0
DC's	0	2
AC's	0	0
PA's	10	6
NP's	20	13
CRNA's	0	0
DPM's	2	0
OD's	0	1
ND's	0	0
RD's	0	0
BCBA's	10	2
LM's	0	0
Mental Health	7	4
Ocularist	0	0
OT	0	0
Ancillary	13	11
CSS	1	0
TOTAL	**122**	**79**

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Acupuncture	0	0	0	0
Addtiction Medicine	1	0	1	0
Allergy & Immunology	4	0	4	0
Anesthesiology / CRNA	2	3	5	0
Audiology	0	0	0	0
Autism / Behavioral Analyst	10	2	12	0
Cardiology	1	3	4	0
Chiropractor	0	2	2	0
Colon & Rectal Surgery	0	1	1	0
Critical Care	0	0	0	0
Dermatology	2	0	2	0
Emergency Medicine	1	3	4	0
Endocrinology	1	3	4	0
Family Practice	30	6	36	0
Gastroenterology	1	1	2	0
General Practice	5	3	8	0

KERN HEALTH SYSTEMS
3rd Quarter 2022
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
General Surgery	5	5	10	0
Genetics	0	0	0	0
Gynecology	0	0	0	0
Gynecology/Oncology	1	1	2	0
Hematology/Oncology	1	0	1	0
Hospitalist	5	0	5	0
Infectious Disease	0	0	0	0
Internal Medicine	12	4	16	0
Mental Health	7	4	11	0
MidWife (Certified)	0	0	0	0
MidWife (Licensed)	0	0	0	0
Naturopathic Medicine	0	0	0	0
Neonatology	0	0	0	0
Nephrology	0	2	2	0
Neurological Surgery	0	2	2	0
Neurology	0	2	2	0
Obstetrics & Gynecology	1	4	5	0
Ocularist	0	0	0	0
Occupational Therapy	0	0	0	0
Ophthalmology	2	2	4	0
Optometry	0	1	1	0
Orthopedic Surgery / Hand Surg	0	0	0	0
Otolaryngology	0	2	2	0
Pain Management	0	5	5	0
Pathology	0	0	0	0
Pediatrics	4	5	9	0
Physical Medicine & Rehab	0	0	0	0
Plastic Sugery	2	0	2	0
Podiatry	2	0	2	0
Psychiatry	6	2	8	0
Pulmonary	1	1	2	0
Radiation Oncology	1	0	1	0
Radiology	1	1	2	0
Registered Dieticians	0	0	0	0
Rheumatology	2	0	2	0
Sleep Medicine	0	0	0	0
Thoracic Surgery	0	0	0	0
Urology	0	2	2	0
Vascular Medicine	0	0	0	0
Vascular Surgery	1	0	1	0
KHS Medical Directors	0	0	0	0
TOTAL	**112**	**72**	**184**	**0**

KERN HEALTH SYSTEMS
3rd Quarter 2022
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

ANCILLARY	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Ambulance	0	0	0	0
Cancer Center	0	0	0	0
Cardiac Sonography	0	0	0	0
Comm. Based Adult Services	0	1	1	0
Dialysis Center	0	0	0	0
DME	3	1	4	0
Hearing Aid Dispenser	2	0	2	0
Home Health	1	0	1	0
Home Infusion/Compounding	0	0	0	0
Hospice	1	1	2	0
Hospital / Tertiary Hospital	0	0	0	0
Laboratory	0	1	1	0
Lactation Consultant	0	0	0	0
MRI	0	0	0	0
Ocular Prosthetics	0	0	0	0
Pharmacy	0	3	3	0
Pharmacy/DME	1	1	2	0
Physical / Speech Therapy	1	0	1	0
Prosthetics & Orthotics	0	0	0	0
Radiology	0	0	0	0
Skilled Nursing	4	0	4	0
Sleep Lab	0	0	0	0
Surgery Center	0	1	1	0
Transportation	0	0	0	0
Urgent Care	0	2	2	0
Community Support Services	1	0	1	0
TOTAL	**14**	**11**	**25**	**0**

Defer = 0 **Denied = 0**

KERN HEALTH SYSTEMS

To: KHS QI-UM Committee

From: Provider Network Management Department

Date: 10/27/2022

Re: Provider Network Management - Network Review Q3, 2022

Background:
The Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS) maintain accessibility, availability, and adequacy standards the Plan is required to meet. The Plan's standards and monitoring activities are outlined in policy and procedure 4.30-P accessibility standards. The Plan utilizes the Provider Network Management Network Review to monitor accessibility, availability, and adequacy standards.

Discussion:
The Provider Network Management Network Review provides the overview and results for the Plan's After-Hours Survey, Appointment Availability Survey, Accessibility Grievance Review, Geographic Accessibility and DHCS Network Certification, Network Adequacy and Provider Counts, and DHCS Quarterly Monitoring Report Template Review**.**

Fiscal Impact: N/A

Requested Action: N/A

KERN HEALTH SYSTEMS

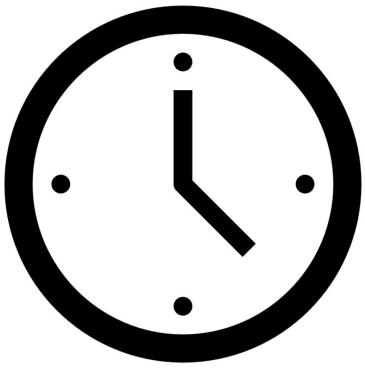
Provider Network Management
Network Review
Quarter 3, 2022

- **After-Hours Survey Report**
- **Appointment Availability Survey Report**
- **Grievance Review (Q4, 2021 and Q1, 2022 Review Period)**
- **Geographic Accessibility & Network Certification**
- **Network Adequacy & Provider Counts**
- **DHCS Quarterly Monitoring Report/Response Template (QMRT) (Q2, 2022 Review Period)**

KERN HEALTH SYSTEMS

After-Hours Calls

Quarter 3, 2022



Provider Network Management

AFTER-HOURS CALLS

Q3, 2022

Introduction

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

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

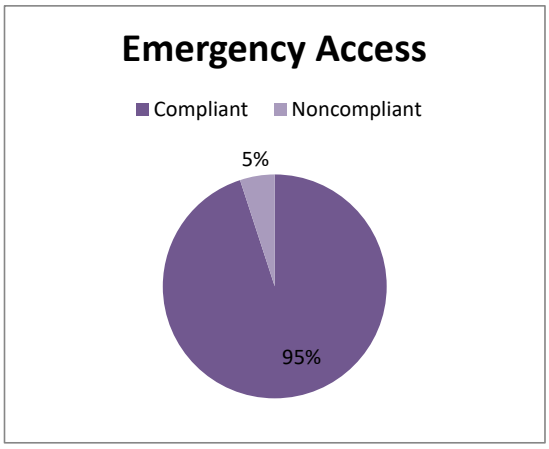
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

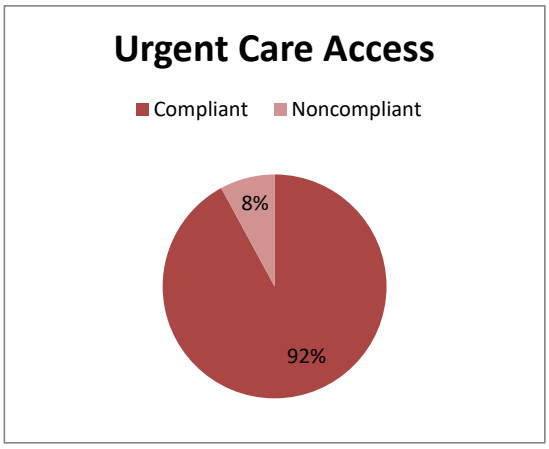
An initial survey is conducted by Health Dialog; the results are forwarded to the Plan's Provider Network Analyst Team who make additional follow up calls based on compliant/noncompliant data received from the survey vendor.

Providers who are found noncompliant with either/both standard(s) are notified via mailed letter and contacted by their Plan-assigned Provider Relations Representative. Providers who are found to be noncompliant for a second consecutive quarter are be notified by mailed letter and contacted by the Deputy Director of Provider Network or designee. Providers who are found noncompliant for a third consecutive quarter will be engaged via a Corrective Action Plan (CAP).

Results

During Q3 2022 139 provider offices were contacted. Of those offices, 132 were compliant with the Emergency Access Standards and 128 were compliant with the Urgent Care Access Standards.





AFTER-HOURS CALLS

Q3, 2022

Tracking, Trending, and Provider Outreach

The Plan utilizes the after-hours survey calls to monitor compliance at a network-wide level. The Plan found compliance for Emergency Access remained in line with prior quarters, with percentages in Q3 2022 above 90%. The Plan worked with the multi-location FQHC group that was noncompliant in Q2 222 with the Urgent Access standard and was able to confirm they became compliant in Q3 2022. With the multi-location FQHC group compliant with the Urgent Access standard in Q3 2022, the Plan returned to percentages in line with prior quarters with the Urgent Access standard above 90%.

Compliance with after-hours standard	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022
Emergency Access	96%	94%	98%	99%	94%	95%
Urgent Care Access	91%	89%	96%	92%	81%	92%

The Plan reviews results of provider groups against prior quarters. The Plan conducts provider outreach as appropriate and maintains ongoing quarterly tracking/trending.

During Q3 2022, the Plan identified two offices which were noncompliant for a three consecutive quarters. The Plan does not believe a Corrective Action Plan (CAP) would be beneficial at this time as the Plan's Provider Relations Representative has made contact with the two locations. The Plan has confirmed that both offices are actively working to correct their after-hours recordings. The Plan will follow up on a weekly basis until the offices are found to be compliant.

During Q3 2022, the Plan identified five offices which were noncompliant for two consecutive quarters. The Plan's Provider Relations Representatives and Deputy Directory of Provider Network conducted targeted education with the identified provider groups regarding their contractual obligation to meet regulatory access standards.

For all other offices identified with a single instance of noncompliance during Q3 2022, the Plan's Provider Relations Representatives conducted targeted education and sent letters notifying the provider groups of the survey results and Plan policy (template attached).

Upon review, the Plan has found that the outreach and education conducted via both letter and the Provider Relations Representatives/Deputy Director of Provider Network has seen success, as nine previously noncompliant provider groups in Q2 2022 were found to be compliant during Q3 2022.

KERN HEALTH SYSTEMS

[DATE]

[OFFICE NAME]
Attn: Office Manager
[ADDRESS]
[CITY], [STATE] [ZIP]

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

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

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

The purpose of this letter is to notify you of the identified non-compliance issues.

During [QUARTER, YEAR], a call was placed to your office at [PHONE]. The results of that call found that your office was non-compliant with the [STANDARD] after-hours access standard(s) as set forth in the KHS standards in our policy and outlined above.

For your convenience, I have attached a copy of our Policy related to access standards. Please review this policy with your staff to ensure compliance. Your office will remain on the list of providers to be surveyed for compliance with KHS access standards. In order to ensure member access, it is imperative these standards are regularly evaluated.

Please call me if you have any questions or concerns related to this policy. KHS will assist in any way possible to ensure compliance with these standards.

Sincerely,

Melissa Lopez
Provider Relations Manager
661-617-2642

661-664-5000
661-664-5151
kernhealthsystems.com
2900 Buck Owens Boulevard, Bakersfield, CA 93308-6316

3.9 Facility Hours

Type of Service	Standard
Emergency Care	24 hours per day, 7 days per week
After Hours Urgent and Emergency Care	Primary and specialty care providers must provide or arrange after hours access for treatment of urgent and emergency conditions by telephone and/or personal contact.

Each contracted provider shall offer their KHS Medi-Cal members hours of operation that are no less than the hours of operation offered by the contracted provider to other patients. If the contracted provider only serves Medi-Cal beneficiaries, the hours of operation should be comparable to the hours offered to Medi-Call FFS.

Office hours, including after hours availability, should be posted on the outside entrance of the office with the office daytime and after hours phone numbers.

3.10 Telephone Accessibility

Providers and administrative personnel must maintain a reasonable level of telephone accessibility to KHS members. At minimum, the following response times are required:

Nature of Telephone Call	Response Time
Emergency medical or Kern County Mental Health Crisis Unit	Member should be instructed to call 9-1-1 or 661-868-8000
Urgent medical	30 Minutes
Non-urgent medical	By close of following business day
Non-Urgent Mental Health	By close of following business day
Administrative	By close of following business day

Provider offices must provide procedures to enable patient access to emergency services 24 hours per day, seven days per week. Patients must be able to call the office number for information regarding physician availability, on call provisions or emergency services. An answering machine or service must be made available after normal business hours with direction in non-emergency and emergency situations.

Contracted providers must answer or design phone systems that answer phone calls within six rings. Providers should address each telephone call regarding medical advice or issues promptly and efficiently and must ensure that non-medical personnel do not give medical advice. Only PAs, NPs, RNs and MDs may provide medical advice. A sample policy that providers may incorporate into their own body of policies is included as Attachment A.

KHS provides or arranges for the provision of 24/7 triage screening services by telephone. KHS ensures that telephone triage or screening are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes. KHS provides triage or screening services through medical advice lines pursuant to §1348.8 of the Health & Safety Code. Refer to *KHS Policy and Procedure 3.15-I 24-hour Telephone Triage Service*.

3.11 Full-time equivalent (FTE) Provider to Member Ratios

KHS shall maintain a provider network capacity of the following full-time equivalent provider to member ratios:

Primary Care Physicians	1:2,000
Total Physicians	1:1,200

4.0 MONITORING

The Provider Relations Department shall be responsible for monitoring Plan compliance with access standards.

4.1 Quarterly Access Review

On a quarterly basis KHS will conduct a review of Plan's compliance with after hours and appointment availability access standards. This will include, but is not limited to after hours survey calls, appointment availability survey, a review of access grievances, and a review of data received from the 24-Hour Telephone Triage Service employed by KHS (as outlined in *KHS Policy and Procedure 3.15-I 24-hour Telephone Triage Service).* Based on this review, KHS will take action as applicable including appropriate provider education; if a provider continues to be found out of compliance based on the results of the quarterly review, the provider may be issued a corrective action plan (CAP) as described in *KHS Policy and Procedure #4.40-P Corrective Actions Plans*

The appointment availability survey will consist of quarterly calls made to a sample of contracted primary care and specialist providers (included mental health providers) to assess the provider's and the Plan's level of compliance with appointment availability standards.

The after hours survey calls will consist of quarterly calls made to all contracted primary care provider offices to assess the provider's and the Plan's level of compliance with after-hours standards.

As appropriate, results of the annual Member (§4.3) and Provider (§4.4) Satisfaction surveys will be incorporated into KHS' quarterly access review for additional tracking and trending.

Results of the KHS's quarterly access review will be reported to the QI/UM Committee as outlined in §5.0 - Reporting.

KERN HEALTH SYSTEMS

Appointment Availability Survey

Quarter 3, 2022

Provider Network Management

Appointment Availability Survey

Q3, 2022

Introduction

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

In line with KHS policies and procedures and Department regulation, the quarterly appointment availability survey monitors:

Type of Appointment	Time Standard
Urgent primary care appointment	Within 48 hours of a request
Non-urgent primary care appointment	Within 10 business days of a request
Urgent appointment with a specialist	Within 96 hours of a request
Non-urgent appointment with a specialist	Within 15 business days of a 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	Within 15 business days of a request
First prenatal OB/GYN visit	The lesser of 10 business days or within 2 weeks upon request

When it is necessary for a provider or enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice and consistent with the objectives of KHS *Policy 4.30-P Accessibility Standards*. The standard and monitoring process for the availability of a rescheduled appointment shall be equal to the availability of the initial appointment, such that the measure of compliance shall be shared.

The survey was conducted internally by KHS staff; compliance is determined using the methodology utilized by the DHCS during the 2017 Medical Audit in which they conducted a similar appointment availability survey.

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

Appointment Availability Survey

Q3, 2022

Appointment Availability Survey Results

A random sample of 15 primary care provider offices, 15 specialist offices, 5 non-physician mental health offices, 5 ancillary offices, and 5 OBGYN offices were contacted during Q3 2022. Furthermore, the Plan conducted an ad-hoc review of appointment availability with VSP providers.

Of the primary care providers surveyed, the Plan compiled the wait time in hours to determine the Plan's average wait time for an urgent primary care appointment. The Plan compiled the wait time in days to determine the Plan's average wait time for a non-urgent primary care appointment. The average wait time for an urgent primary care appointment was **38.2 hours** for Q2 2022. The average wait time for a non-urgent primary care appointment was **4.3days** for Q3 2022. **Based on these results, the Plan was determined to be compliant in both the urgent and non-urgent time standards for primary care appointments in Q3 2022.**

Of the specialist providers surveyed, the Plan compiled the wait time in hours to determine the Plan's average wait time for an urgent specialist appointment. The Plan compiled the wait time in days to determine the Plan's average wait time for a non-urgent specialist appointment. The average wait time for an urgent specialist appointment was **76.6 hours** for Q3 2022. The average wait time for a non-urgent specialist appointment was **12.2 days** for Q3 2022. **Based on these results, the Plan was determined to be compliant in both the urgent and non-urgent time standards for specialist appointments in Q3 2022.**

Of the non-physician mental health providers surveyed, the Plan compiled the wait time in days to determine the Plan's average wait time for an appointment with a non-physician mental health provider. The Plan's average wait time for a non-physician mental health provider appointment was **2.7 days** for Q3 2022. **Based on these results, the Plan was determined to be compliant with the time standard for a mental health appointment in Q3 2022.**

Of the ancillary providers surveyed, the Plan compiled the wait time in days to determine the Plan's average wait time for an appointment with the ancillary provider. The Plan's average wait time for an ancillary appointment was **0 days** for Q3 2022, as each ancillary provider surveyed had a same-day appointment. **Based on these results, the Plan was determined to be compliant with the time standard for an ancillary appointment in Q3 2022.**

Of OB/GYN providers surveyed, the Plan compiled the wait time in days to determine the Plan's average wait time for a first prenatal appointment with an OB/GYN. The Plan's average wait time for a first prenatal appointment with an OB/GYN was **4.0 days** for Q3 2022. **Based on these results, the Plan was determined to be compliant with the time standard for an OB/GYN first prenatal appointment in Q3 2022.**

Appointment Availability Survey

Q3, 2022

KERN HEALTH SYSTEMS

Tracking, Trending, and Provider Outreach

The Plan utilizes the quarterly appointment availability survey to monitor compliance at a network-wide level. The Plan reviewed the results of the Q3 2022 appointment availability survey against the results of prior quarters. The Plan recognized minor increases in wait time for primary care and specialists for urgent appointments, and minor increases in weait time for specialist non-urgent appointments. The Plan does not consider this increase as a trend at this time as the results are in line with prior quarters. The Plan's average wait time remains within regulatory standards for all appointment types.

Average urgent wait time in hours	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022
Primary Care	26.9	28.5	32.9	20.6	16.2	38.2
Specialist	61.6	49.6	54.5	90.5	67.0	76.6

Average wait time in days	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022
Primary Care	3	4	2.5	4.3	6.5	4.3
Specialist	11.4	6	6.3	11.9	9.5	12.2
Non-Physician Mental Health	8	4.2	2.4	2.4	3.0	2.7
Ancillary	8.6	1	1	10.8	0.8	0
OB/GYN	7.4	4.4	3.8	3.2	4.6	4.0

The Plan reviews individual provider/group results against prior quarters. The Plan conducts provider outreach as appropriate and maintains ongoing quarterly tracking/trending.

For all providers identified as newly noncompliant during Q3 2022, the Plan sent letters notifying the providers of the survey results and Plan policy (template attached).

Phone Answering Timeliness Results

Utilizing the methodology outlined above, KHS conducts a phone answering timeliness survey in conjunction with the appointment availability survey. During Q3 2022 calls were answered within an average of 2.9 rings.

	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022
Average rings to answer	1.5	3.0	1.8	1.6	1.9	2.9

Follow-up Survey and Best Practices

In Q3 2022, the Plan conducted a follow-up appointment availability survey, resurveying all providers found to be previously noncompliant in Q2 2022. The previously noncompliant providers consisted of 2 primary care, 5 specialist, 1 non-physician mental health, and 2 OBGYNs.

Appointment Availability Survey

Q3, 2022

Based on the results of this follow-up survey, the Plan identified only 1 specialist provider who remained noncompliant with Plan appointment availability standards. The Plan has remained in contact with the specialist who has remained noncompliant. The provider is an Allergy and Immunology specialist, which there is a high-demand due to a statewide shortage of this specialty. The provider has brought midlevels into his office and is currently working on bringing in additional providers. The Plan has determined that it would not be advantageous to continue surveying the provider at this time due to these reasons.

KERN HEALTH SYSTEMS

[DATE]

[OFFICE NAME]
Attn: Office Manager
[ADDRESS]
[CITY], [STATE] [ZIP]

Kern Health Systems (KHS) uses an appointment availability survey program to assess compliance with access standards for Kern Family Health Care (KFHC) Members. The Department of Health Care Services (DHCS), and KHS policy 4.30-P *Accessibility Standards* requires that patients be able to call an office for information regarding physician and appointment availability, on call provisions, or emergency services.

During [Quarter, Year] KHS contacted your office and conducted an appointment availability survey in regards to scheduling [STANDARD/SPECIALTY] appointment. Based on the results of the survey, we found your office was not complaint with KHS availability standards. With this letter, I have included a copy of KHS policy that outlines required appointment availability standards.

The purpose of this letter is to notify you of the identified non-compliance and to remind you of your contractual obligations related to access standards. Please call me if you have any questions or concerns related to this policy. KHS will assist in any way possible to ensure compliance with these standards.

Sincerely,

Melissa Lopez
Provider Relations Manager
661-617-2642

661-664-5000
661-664-5151
kernhealthsystems.com
2900 Buck Owens Boulevard, Bakersfield, CA 93308-6316

Additionally, KHS shall ensure its network of providers meets compliance with time and distance standards as required by the Department Health Care Services' (DHCS) annual network certification.

For geographic service areas (zip codes) found to not meet the above standards, KHS shall maintain alternative access standards, to be filed and approved with the DHCS and DMHC.

3.6 **Appointment Waiting Time and Scheduling:**
The "appointment waiting time" means the time from the initial request for health care services by a Member or the Member's treating provider to the earliest date offered for the appointment for services inclusive of the time for obtaining authorization from the plan, and completing any other condition or requirement of the plan or its contracting providers. KHS shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition. Members must be offered appointments within the following timeframes:

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

Exceptions to Appointment Waiting Time and Scheduling:

KERN HEALTH SYSTEMS

Access Grievance Review

Quarter 3, 2022

(Q4 2021 and Q1 2022 Review Period)

Provider Network Management

Access Grievance Review

Q3, 2022 (Q4 2021 and Q1 2022

Introduction and KHS Policy and Procedure

As outlined in KHS policy 5.01-P, *Member Grievance*, member grievances are documented, investigated, and resolved within thirty (30) calendar days by the KHS Member Services Department. On a quarterly basis, KHS' Provider Network Management Department reviews all access grievances from the previous quarter, in order to identify any potential access issues or trends within the Plan's network or amongst the Plan's contracted providers. The time standards for access to a primary care appointment, specialist appointment, in-office wait time, and provider telephone are outlined in KHS policy *4.30-P Accessibility Standards.*

Categorization

As of Q2 2020, the Member Service Department uses twenty-three DHCS recognized Grievance Types (or "dispositions") to categorize grievances. Grievances categorized as *Geographic Access*, *Provider Availability*, *Technology/Telephone*, or *Timely Access* are considered access grievances for the purposes of this review. The Plan reviews these grievance types against prior quarters, and the graphs utilized within this review only includes data that is in line with these grievance types.

Grievance Totals

There were **one hundred and nine (109)** access-related grievances in Q4 2021 and **one hundred and thirty-seven (137)** access-related grievances in Q1 2022 which were received and reviewed by the KHS Grievance Committee. In **sixty-six (66)** of the cases in Q4 2021 and **seventy-eight (78)** of the cases in Q1 2022, no issues were identified and were closed in favor of the Plan. The remaining **forty-three (43)** cases in Q4 2021 and **fifty-nine (59)** cases in Q1 2022, were closed in favor of the enrollee; the KHS Grievance Department sent letters to the providers involved in these cases, notifying them of the outcome.

The **forty-three (43)** grievances in Q4 2021 and **fifty-nine (59) in Q1 2022** that were closed in favor of the enrollee were forwarded to the Plan's Provider Network Management Department. For each of these grievances, the members initial complaint, the provider's response, the Members Service Department's investigation, and the Grievance Committee's decision are reviewed by the Provider Network Management Department.

The access grievances found in favor of the enrollee for Q4 2021 and Q1 2022 were categorized by the KHS Grievance Department as follows:

Quarter	Q4 2021	Q1 2022
Timely Access	18	23
Provider Availability	10	20
Technology / Telephone	15	16

Access Grievance Review

Q3, 2022 (Q4 2021 and Q1 2022

Tracking and Trending

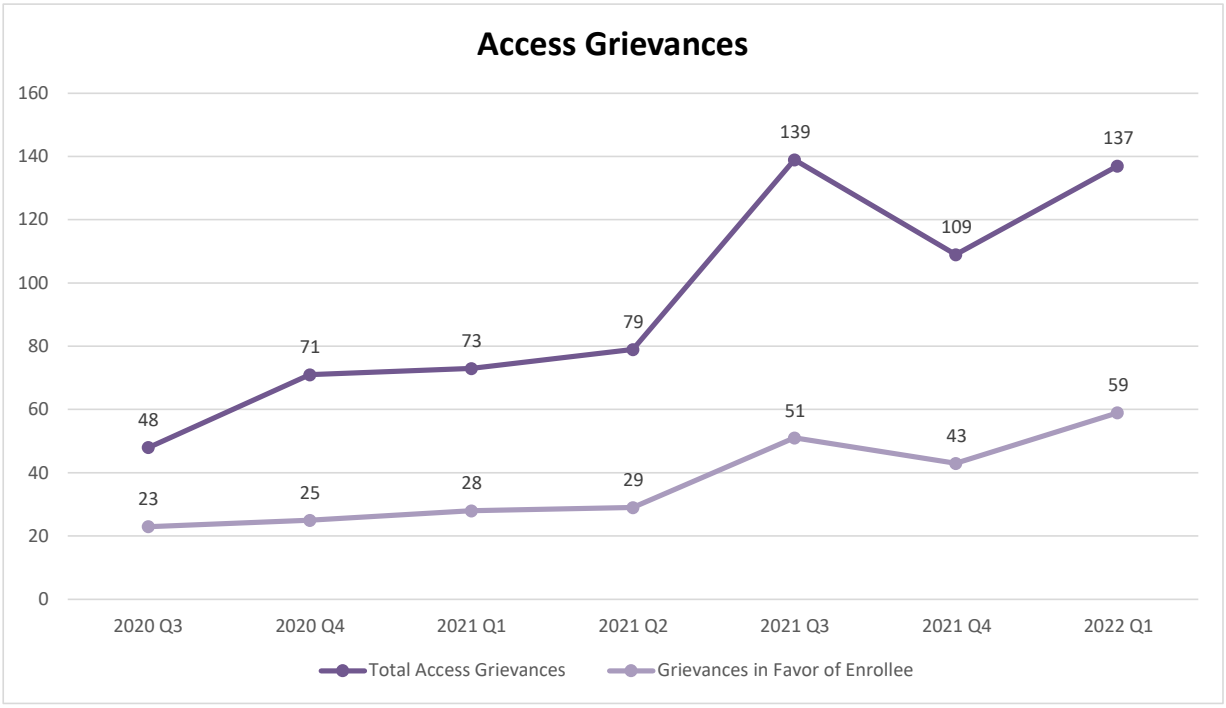
The Provider Network Management Department reviewed all access grievances found in favor of the enrollee received in Q4 2021 and Q1 2022 to identify any potential access issues or trends within the Plan's network or amongst the Plan's contracted providers. In addition to a review conducted against prior quarters, the Plan reviews Access Grievances against outcomes of other monitoring conducted as part of the quarterly *Provider Network Management, Network Review* (e.g. Appointment Availability Survey, DHCS' QMRT review, Network Adequacy).

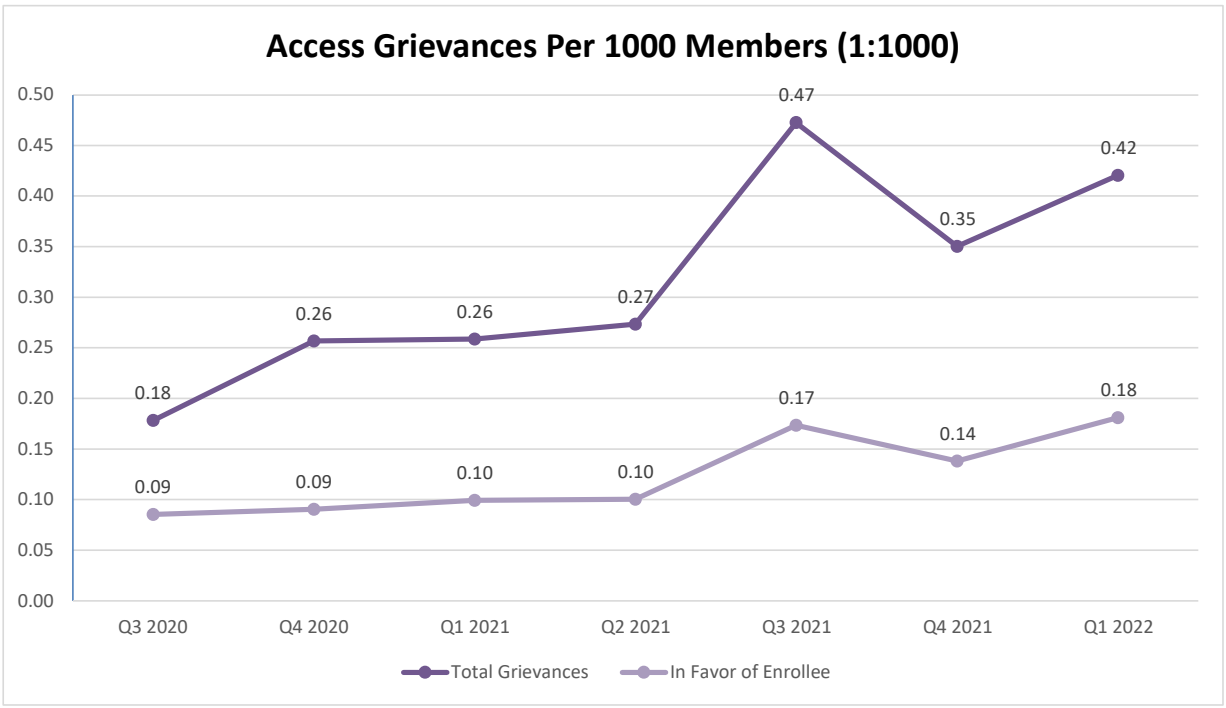
Upon review of Q4 2021 access grievances, the Plan identified a decrease in grievances when compared from Q3 2021, and an increase in access grievances in Q1 2022 when compared to Q4 2021. The Plan did not identify these changes as an issue or trend at this time due to the changes being in line with previous quarters. Additionally, the Plan's Access Grievances Per 1000 members for grievances found in favor of the enrollee remains low, at 0.14 in Q4 2021 and 0.18 in Q1 2022.

The Plan reviews grievances across a four-quarter rolling review period. Trends that are identified are reviewed with the Provider Relations Manager on a case-by-case basis to develop a target-based strategy to address. During Q4 2021 and Q1 2022, the Plan recognized a provider availability trend with Adventist Health Community Care Clinic – Taft due to it losing its PCP providers. The Plan was aware of the issue and worked with the group to address the lack of PCPs. There are now two physician PCPs at Adventist Health Community Care Clinic – Taft. The Plan recognized telephone accessibility issues with Kern Medical Whole Person Care. The Provider Relations Representative has reached out to help resolve the issue. The Plan also recognized a potential trend for in-office wait time for Coastal Kids Stockdale. The Plan will continue to monitor to determine if this is an ongoing issue. The Plan will continue to monitor access grievances for potential trends via the quarterly access grievance review.

Access Grievance Review

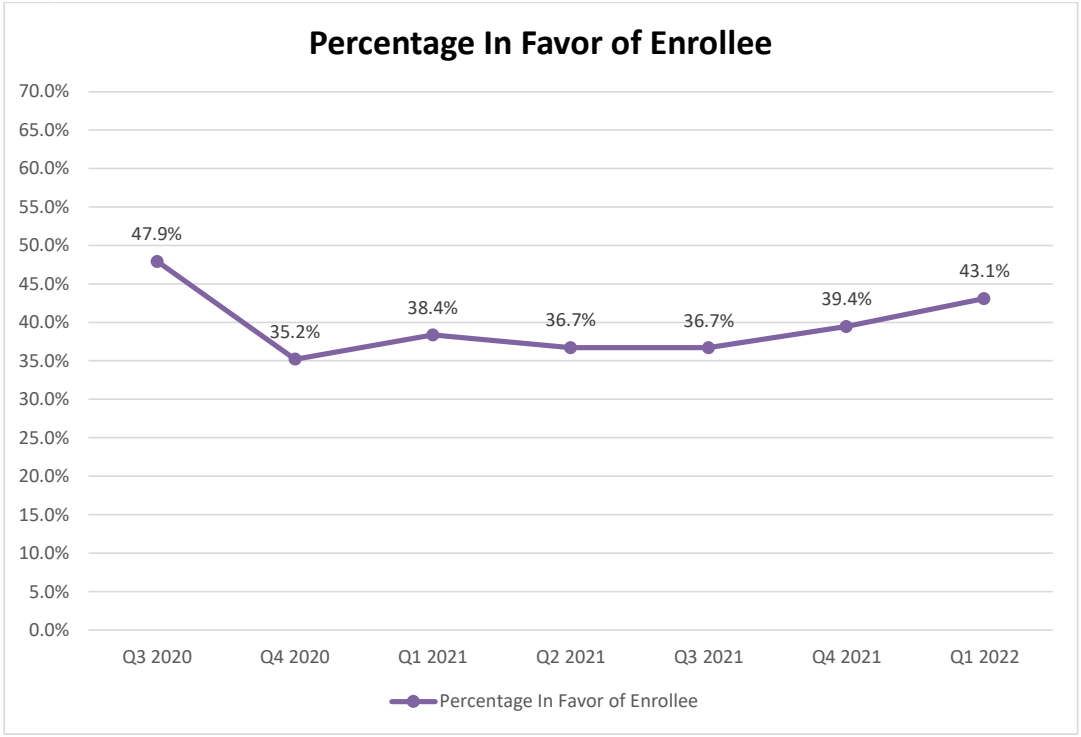
Q3, 2022 (Q4 2021 and Q1 2022

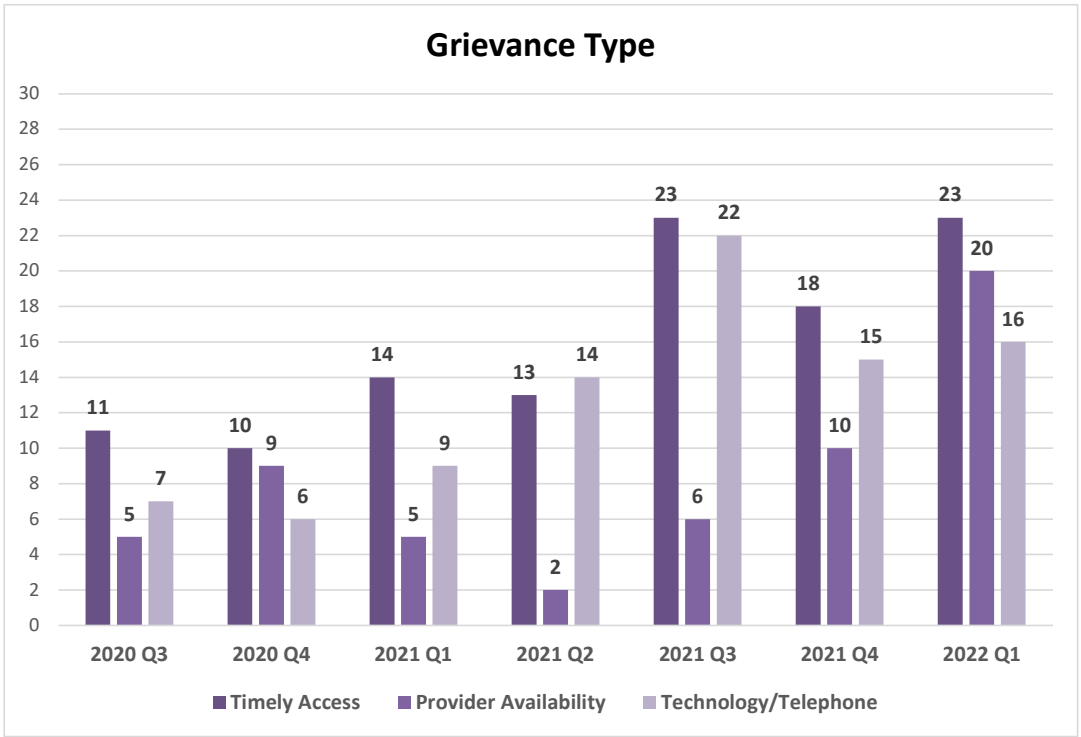




Access Grievance Review

Q3, 2022 (Q4 2021 and Q1 2022





Access Grievance Review

Q3, 2022 (Q4 2021 and Q1 2022

Exempt Grievances

On a quarterly basis, the Plan's Provider Network Management Department reviews all exempt grievances to identify potential trends amongst the provider network. For Q4 2021, there were a total of **1,436** exempt grievances, and there were a total of **1,599** exempt grievances in Q1 2022.

Grievance Type	Q3 Count	Q3% of Total	Q4 Count	Q4% of Total	Q1 Count	Q1% of Total
Authorization	80	4.87%	73	5.08%	57	3.56%
Billing	10	0.61%	13	0.91%	9	0.56%
Case Management/Care Coordination	2	0.12%	2	0.14%	4	0.25%
Continuity of Care	2	0.12%	2	0.14%	2	0.13%
Enrollment	6	0.36%	8	0.56%	0	0.00%
Fraud/Waste/Abuse	0	0.00%	1	0.07%	0	0.00%
Language Access	12	0.73%	7	0.49%	6	0.38%
Member Informing Materials	0	0.00%	0	0.00%	0	0.00%
Out-of-Network	0	0.00%	1	0.07%	2	0.13%
PHI/Confidentiality/HIPAA	0	0.00%	0	0.00%	0	0.00%
Physical Access	3	0.18%	2	0.14%	1	0.06%
Provider/Staff Attitude	827	50.30%	728	50.70%	708	44.28%
Provider Availability	128	7.79%	121	8.43%	191	11.94%
Referral	30	1.82%	32	2.23%	24	1.50%
Scheduling	0	0.00%	0	0.00%	82	5.13%
Technology/Telephone	78	4.74%	59	4.11%	103	6.44%
Timely Access	286	17.40%	227	15.81%	351	21.95%
Transportation	180	10.95%	155	10.79%	56	3.50%
Grand Total	**1644**		**1436**		**1599**	

In reviewing these totals against prior quarters the Plan recognized a decrease in exempt grievances from Q3 2021 to Q4 2021 and an increase from Q4 2021 to Q1 2022; however, the amount of exempt grievances in Q1 2022 was still less than Q3 2021. The count of exempt grievances in Q4 2021 and Q1 2022 show an encouraging, yet slight, downward trend with the volume seen in Q3 2021. The Plan identified an increase in the percentage of Timely Access exempt grievances from Q4 2021 to Q1 2022 after a drop in Q4 2021. The Plan believes this is a natural fluctuation; however, The Plan will continue to monitor to determine if this is an ongoing issue that will need to be addressed. The Plan will continue to monitor exempt grievances for potential trends via the quarterly access grievance review.

Valid Values	The first three characters shall be the plan code, the rest of the characters will be a unique value for each record submitted (not just unique within this submission, but unique across time).
Edits	• First three characters must equal planCode • No duplicates with historical data

2.1.20 Grievance Received Date

File Layout Name	grievanceReceivedDate			
Data Format	Date			
Description	The date the plan received the grievance.			
Usage	**Grievances:**	**Required**	**Appeals:**	Not used
	COC:	Not used	**OON:**	Not used
Valid Values	CCYYMMDD			
Edits	• Must represent a date prior to the current month			

2.1.21 Grievance Type

File Layout Name	grievanceType			
Data Format	Array (May have multiple occurrences) X(36)			
Description	Define the type or types of grievance. Must have at least one value, but may have multiple values.			
Usage	**Grievances:**	**Required (one or more)**	**Appeals:**	Not used
	COC:	Not used	**OON:**	Not used
Valid Values	**Value**	**Definition**		
	Continuity Of Care	Grievance related to continuity of care review standard. Member's perception that their request for continuity of care is being rejected or not considered.		

	Geographic Access	Grievance related to geographic access to a state plan approved provider, pharmacy or hospital within the geographic requirements based on type of appointment and condition of member's health.
	Language Access	Grievance related to the inability to access or concerns with linguistic and interpreter services at the providers office.
	Out-of-Network	Grievance related to inability to obtain services from a non-contracted provider.
	Physical Access	Grievance related to the inability to physically access a provider or health plan due to office closure, not having wheelchair access, inadequate ramp, elevators, inadequate parking, or other requirements under the American with Disabilities Act.
	Provider Availability	Grievance related to the inability to see providers during normal hours of operation or concerns with the providers' hours of operation.
	Timely Access	Grievance related to timely access to a state plan approved provider within the timeframe requirements based on type of appointment and condition of member's health.
	Transportation	Grievance related to inability to access or concerns with transportation services.

	Discrimination	Grievance regarding alleged discrimination by the health plan, provider, or provider's staff based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental or physical disability, medical condition, genetic information, marital status, gender, gender identity, gender expression, or sexual orientation. May also include complaints where the member is treated differently after filing a grievance.
	Disability Discrimination	Grievance regarding alleged discrimination by the health plan, provider, or provider's staff based on disability. Include allegations of failure to provide auxiliary aids, or to make reasonable accommodations in policies and procedures, when necessary to ensure equal access for persons with disabilities.
	Fraud / Waste / Abuse	Grievance related to intentional or unintentional misuse of resources, fraudulent, non-compliant, dishonest or unethical conduct committed by a health network, plan, provider, vendor, consultant, and current or potential member.
	PHI / Confidentiality / HIPAA	Grievance related to the breach of Personal Health Information (PHI) or confidentiality. Privacy rules were not followed. For example, complaints regarding the provider inappropriately accessing, using or disclosing a member's PHI.

	Billing	Grievance related to bills received in error, premium and debt collection notices, reimbursement request, claim adjustment request or bills received after member was told issues were resolved. May include complaints regarding charges for non-covered services, benefits, or drugs not covered, etc.
	Authorization	Grievance related to the timeliness of an authorization or communication regarding the result (approval, denial or modification) of the authorization
	Eligibility	Grievance related to Medi-Cal plan member's eligibility or share of cost requirements.
	Enrollment	Grievance related to Medi-Cal plan enrollment information received, enrollment process, Medi-Cal plan member being disenrolled from plan, providers, or any of its health network, etc.
	Referral	Grievance related to the MCP's processing of referrals to covered services.
	Assault / Harassment	Grievance related to the physical, emotional, or sexual misconduct by a medical professional.
	Case Management / Care Coordination	Grievance related to case management or care coordination.
	Inappropriate Care	Grievance related to the overuse, underuse, or misuse of health care services.

	Member Informing Materials	Grievance regarding written materials provided in alternative formats or translation in threshold languages.
	Provider / Staff Attitude	Grievance related to inappropriate behavior, poor provider/staff attitude (includes non-clinical staff, etc.), rudeness, or mistreatment.
	Technology / Telephone	Grievance related to on-line scheduling systems, health plan system's connectivity, user friendliness, excessive waits, accessibility, via plan's website; or a member's inability to reach a provider or health plan's staff via phone or waiting on the phone too long.
Edits	• Must be in list of valid values • May have multiple values	

2.1.22 MER COC Disposition Date

File Layout Name	merCocDispositionDate			
Data Format	Date			
Description	The date on which The MER COC was determined either Met or Not Met			
Usage	**Grievances:**	Not used	**Appeals:**	Not used
	COC:	**Situational**	**OON:**	Not used
Valid Values	CCYYMMDD			
Edits	• Must be a valid date • Must be a past date • Must be present if cocType = MER Denial • Must be blank if cocType <> MER Denial			

KERN HEALTH SYSTEMS

Geographic Accessibility & DHCS Network Certification

Quarter 3, 2022

Provider Network Management

Geographic Accessibility & Network Certification

Q3, 2022

Geographic Accessibility

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

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

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

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

DHCS Annual Network Certification – 2021/2022

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

As a part of the Annual Network Certification requirement, outlined in APL 21-006, the Plan is required to submit geographic access analysis outlining compliance with the above-listed standards. For all zip codes in which the Plan was not compliant with an above-listed standard, the Plan is able to submit an alternative access standard (AAS) request.

As part of its ongoing monitoring the Plan reviews additions/deletions in the provider network against the most recently completed geographic accessibility analysis. As of the end of Q3 2022, the Plan identified two termination affecting the Plan's ability to provide access within required time or distance standards for the terminated provider's specialty – hematology and neurology. Based on the rural nature of the affected zip codes, the Plan believes alternative access standards were appropriate for the identified specialty/zip codes combination and submitted updated documentation to the DHCS.

Geographic Accessibility & Network Certification

Q3, 2022

During Q3 2022, the DHCS provided the Plan with the July 2022 Taxonomy Crosswalk, along with the representative population points used by the DHCS to calculate time or distance results. The Information was provided to the Plan in preparation of the 2022 Annual Network Certification. As of Q3 2022, the DHCS has not provided the ANC Draft APL.

KERN HEALTH SYSTEMS

Network Adequacy & Provider Counts

Quarter 3, 2022

Provider Network Management

Network Adequacy & Provider Counts

Q3, 2022

Introduction

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

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

Per KHS policy, 4.30-P *Accessibility Standards, §4.6 Full-time equivalent (FTE) Provider to Member Ratios,* "Full-time equivalency shall be determined via an annual survey of KHS' contracted providers to determine the percentage of time allocated to Plan's beneficiaries. The results of the survey will be used to calculate an average FTE percentage which will be applied to the Plan's network of providers when calculating the physician-to-enrollee compliance ratios. The methodology for the survey, results of the survey, and network capacity review of above ratios, will be reported annually to the KHS QI/UM Committee. Due to a maximum member assignment of 1,000 Mid-level providers serving in the Primary Care capacity will be counted as .5 of a PCP FTE, prior to percentage calculation."

Survey Methodology and Results

In 2020, KHS contracted with SPH Analytics to conduct our annual Provider Satisfaction Survey; as a part of that survey, responding providers were asked, "*What portion of your managed care volume is represented by Kern Health Systems?*" Outreach for the survey was placed to every contracted provider within the Plan's network. Responses received, and FTE calculations based on those responses, do not account for providers who refuse to participate in the survey. KHS used the responses collected from Primary Care Providers to calculate the FTE for Primary Care Providers, and used the responses collected from Primary Care Providers and Specialists to calculate the FTE for Physicians.

KHS utilized SPH Analytics, an NCQA certified survey vendor, to conduct the survey for 2022. SPH's methodology involved two waves of mail and Internet, with a third wave of phone follow up to administer the survey.

Based on the results of 2022 survey, KHS calculated a network-wide FTE percentage of **58.19% for Primary Care Providers** and **47.11% for Physicians.**

Network Adequacy & Provider Counts

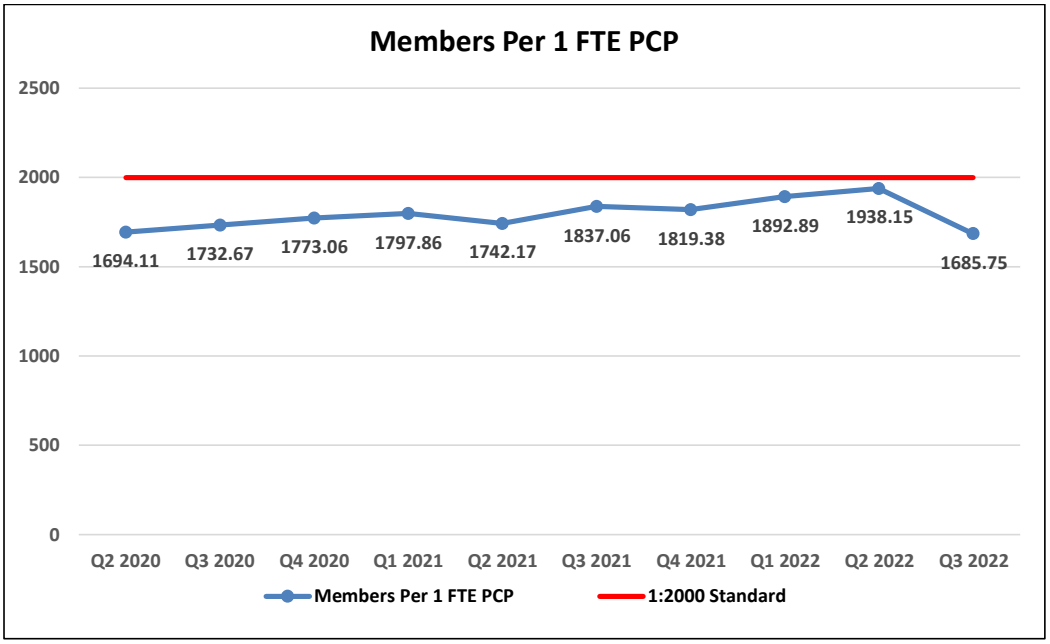
Q3, 2022

Full Time Equivalency Compliance Calculations

Of KHS' 340,801 membership at the close of Q3 2022, 14,130 were assigned and managed by Kaiser and did not access services through KHS' network of contracted providers; due to this, Kaiser managed membership is not considered when calculating FTE compliance.

As of the end of Q3 2022, the plan was contracted with 434 Primary Care Providers, a combination of 232 physicians and 202 mid-levels. Based on the FTE calculation process outlined above, with a 58.19% PCP FTE percentage, KHS maintains a total of **193.78 FTE PCPs**. With a membership enrollment of 326,671 utilizing KHS contracted PCPs, KHS currently maintains a ratio of **1 FTE PCP to every 1685.78 members**; KHS is compliant with state regulations and Plan policy.

PCP to Member Ratio

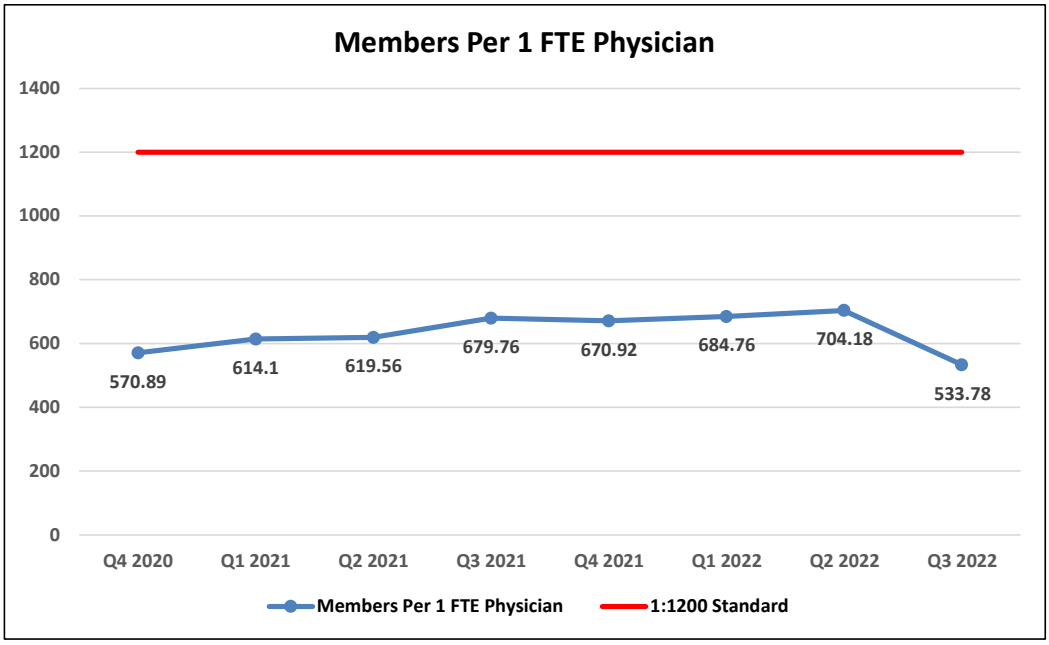


As of the end of Q3 2022, the plan was contracted with 1299 Physicians. Based on the FTE calculation process outlined above, with a 47.11% Physician FTE percentage, KHS maintains a total of **612.00FTE Physicians**. With a total membership enrollment of 326,671 utilizing KHS contracted Physicians, KHS currently maintains a ratio of **1 FTE Physician to every 533.78 members**; KHS is compliant with state regulations and Plan policy.

Network Adequacy & Provider Counts

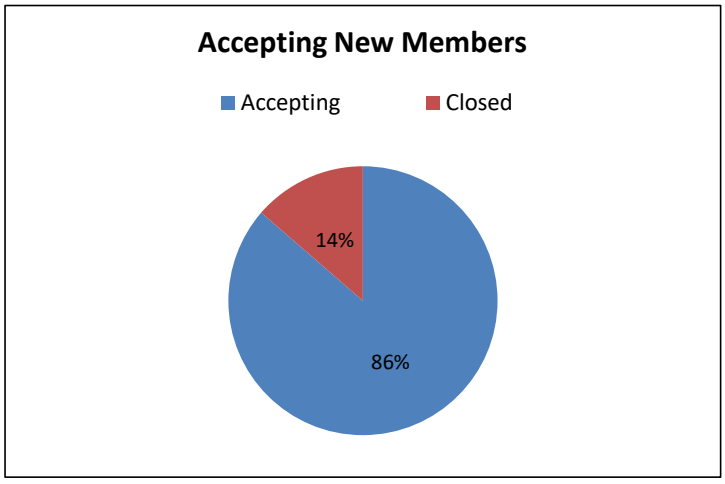
Q3, 2022

Physician to Member Ratio



Accepting New Members

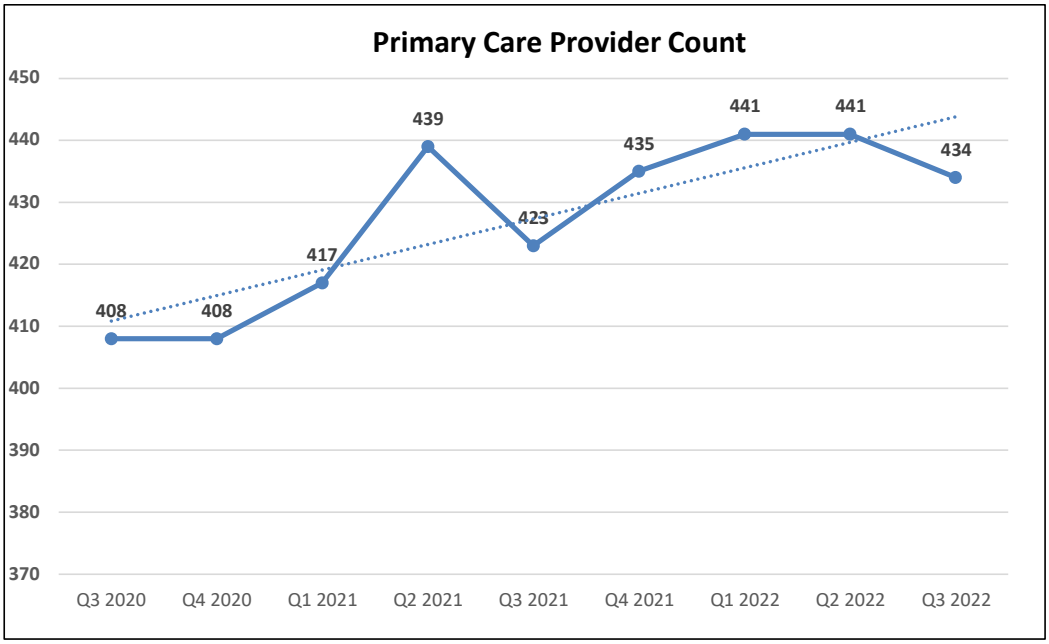
In addition to the Full Time Equivalency Compliance review conducted above, the Plan monitors adequacy of its Primary Care Network by reviewing the count/percentage of Primary Care Providers (PCP) who are accepting new members. **The Plan calculated that 86% of the network of Primary Care Providers is currently accepting new members at a minimum of one location**. The Plan will continue to monitor this percentage quarterly to ensure it maintains an adequate network of Primary Care Providers.

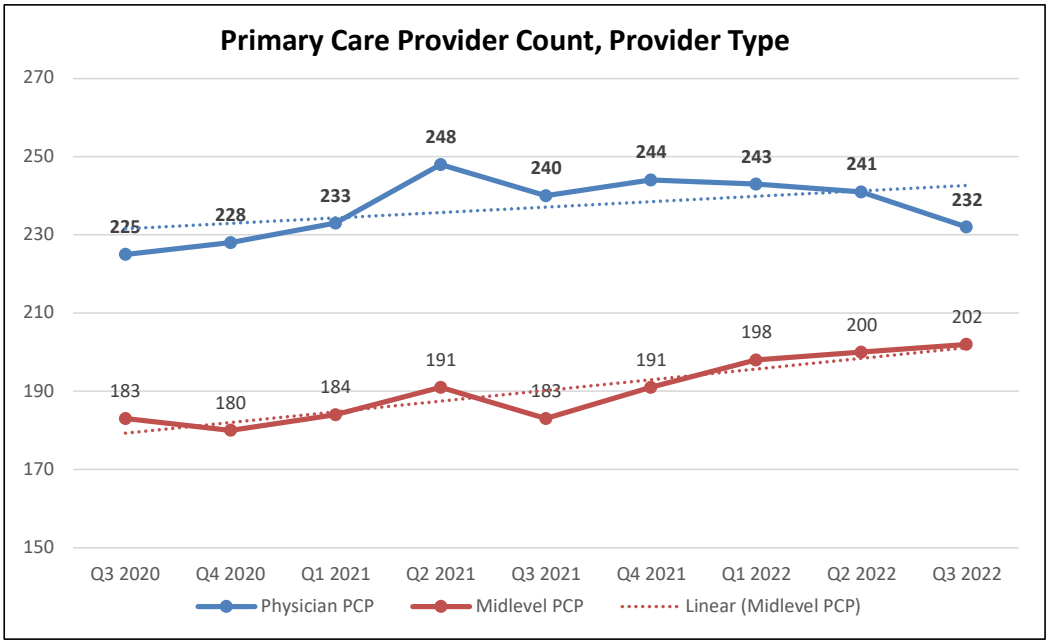


Network Adequacy & Provider Counts

Q3, 2022

Provider Counts – Primary Care Providers

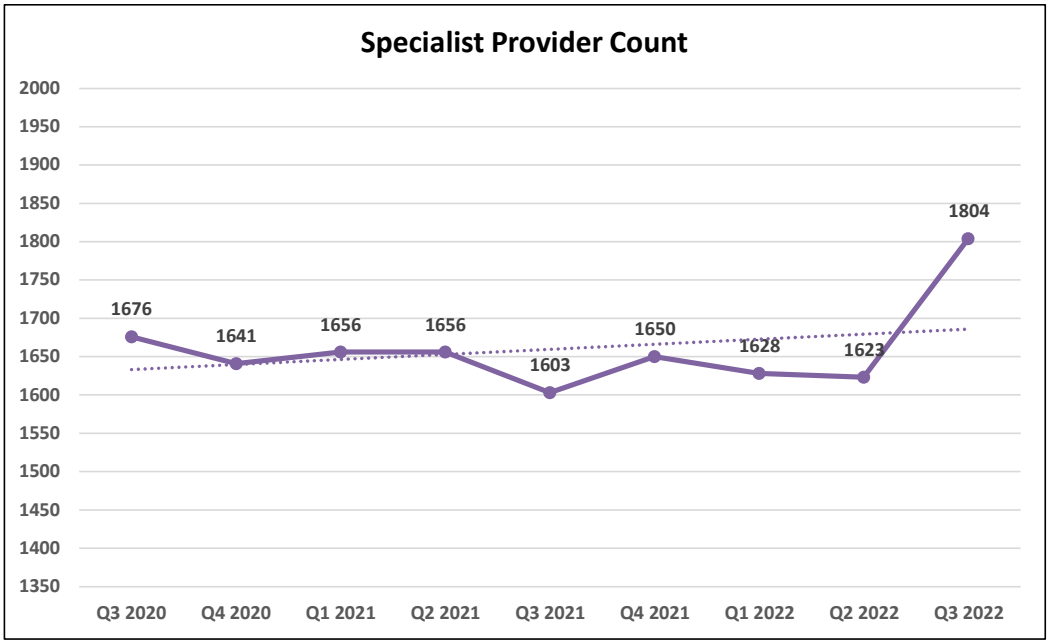




Network Adequacy & Provider Counts

Q3, 2022

Provider Counts – Specialist Providers



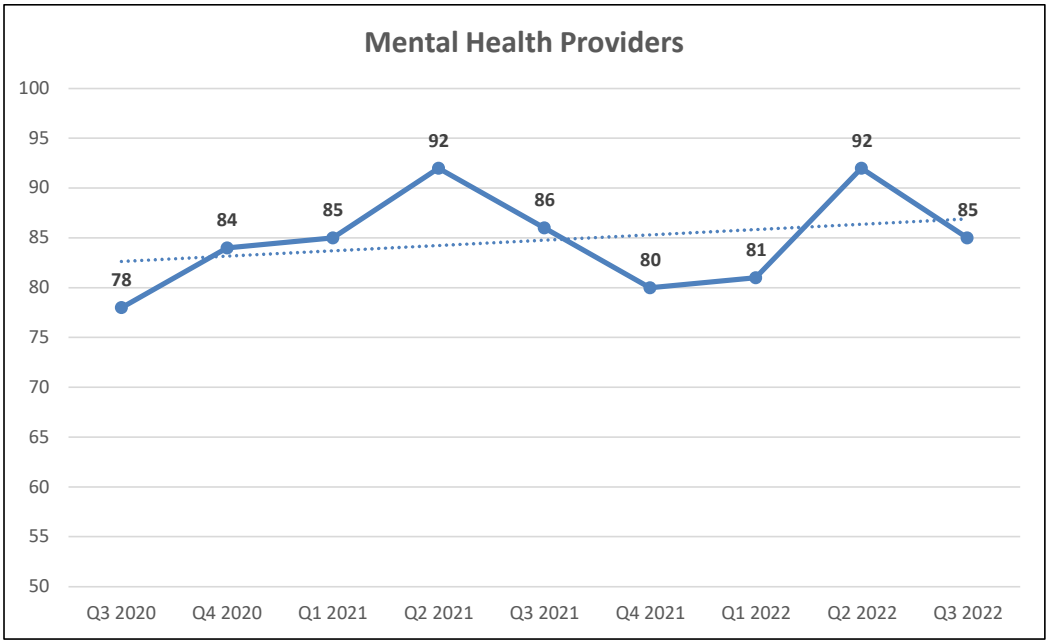
	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022
Cardiology	42	44	43	42	46	46	45	45	46
Dermatology	35	36	33	34	35	35	39	39	43
Endocrinology	20	24	22	23	23	24	25	25	26
Gastroenterology	22	22	23	22	21	24	24	26	31
General Surgery	68	68	67	63	59	62	65	60	63
Hematology	18	20	20	21	19	23	20	21	23
Infectious Disease	10	10	11	10	8	8	8	8	12
Nephrology	22	23	23	27	27	28	25	28	36
Neurology	25	25	26	25	25	25	22	26	29
Oncology	24	26	26	27	25	27	26	26	27
Ophthalmology	30	29	30	30	29	28	27	26	30
Orthopedic Surgery	21	20	20	21	21	22	23	26	29
Otolaryngology	10	10	8	8	9	9	9	9	13
Physical Med & Rehab	24	24	24	11	10	10	10	10	9
Psychiatry	54	47	47	45	48	53	54	53	57
Pulmonary Disease	20	19	18	17	17	20	20	20	21

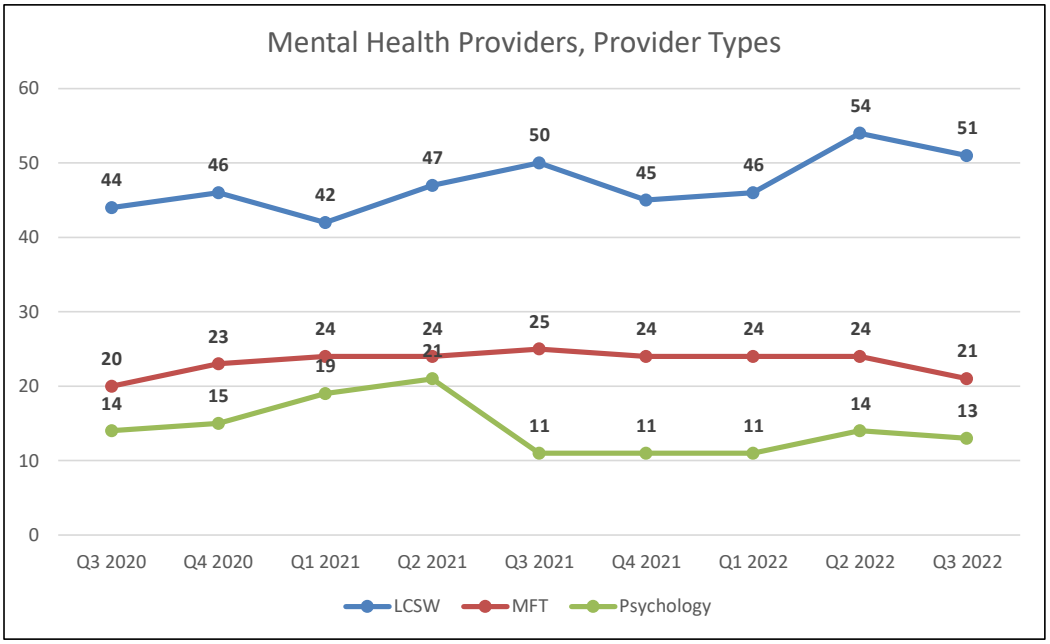
> 5% Increase		> 5% Decrease	
≤ 5% Increase		≤ 5% Decrease	

Network Adequacy & Provider Counts

Q3, 2022

Provider Counts – Mental Health (Psychology, LMFT, LCSW)





Network Adequacy & Provider Counts

Q3, 2022

Provider Counts – Facilities

	2018	2019	2020	2021	Current
Hospital	18	18	18	21	20
Surgery Center	16	17	19	19	19
Urgent Care	17	17	17	19	19

Provider Counts – Other Provider Types

	2018	2019	2020	2021	Current
Ambulance/Transport	15	13	17	16	14
Dialysis	14	16	18	19	19
Home Health	12	13	13	14	15
Hospice	7	11	13	16	17
Pharmacy	136	139	147	150	142
Physical Therapy	29	29	30	29	32

Tracking and Trending

The Plan utilizes the quarterly Network Adequacy and Provider Counts review to monitor fluctuations within the network. The Plan has reviewed the results of the Q2 2022 report and compared against prior quarters (outlined above) and identified that provider counts remain consistent across the review period as illustrated in the graphs above.

Significant Network Change

As outlined in California Health and Safety Code, Section 1367.27, subdivision (r): *Whenever a plan determines (…) that there has been a 10 percent change in the network for a product in a region, the plan shall file an amendment to the plan application with the department.*

Based on instruction from the DMHC, the Plan conducted a 12-month look back to calculate potential percent change in the three categories and determined the network had experienced a Significant Network change.

The Plan initiated the Significant Network Change filing with the DMHC on December 9, 2021 (Filing No. 20214807). On January 10, 2022, the Plan received a comment letter from the DMHC related to the Significant Network Change filing; the Plan responded to the comment letter on February 10, 2022.The Plan received an additional comment letter on March 9, 2022, May 10, 2022, and July 8, 2022, and responded to both within the 30-day timeframe. The Plan continues to work with the DMHC towards approval of this Significant Network Change filling.

KERN HEALTH SYSTEMS

DHCS Quarterly Monitoring Report/Response Template (QMRT)

Quarter 3, 2022

(Q2, 2022 QMRT)

Provider Network Management

Quarterly Monitoring Report/Response Template

Q3, 2022 (Q2, 2022 QMRT)

Introduction

Department of Health Care Services (DHCS) monitors and assesses specific compliance categories on a quarterly basis. Their review is provided to the Plan, and when potential areas of concern are identified, response is required via the Quarterly Monitoring Report/Response Template (QMRT). The Plan reviews all data received from the DHCS against internal access monitoring tools to identify any potential issues or trends within the Plan network.

On 06/28/2022 the Plan received Q2 2022 QMRT and accompanying reports from the DHCS and during Q3 2022 the Plan's Provider Network Management departments reviewed the following categories:

FTE Provider to Member Ratio

DHCS uses the Plan's 274 file submission to calculate and monitor FTE provider to member ratios. For Q2 2022 QMRT no response was requested from the Plan, and the DHCS review found the Plan to be in compliance with the standard:

Service Area and/or Reporting Unit	FTE PCP Per 2,000 members	FTE Physician Per 1,200 members
Kern	13	38

The Plan's standards and monitoring of FTE provider to member ratios are outlined in Plan policy and procedure *4.30-P Accessibility Standards*. While the Plan was unable to replicate the above ratios provided by the DHCS, the Plan's own quarterly monitor (*Network Adequacy and Provider Counts*, *Q3 2022*) also found the Plan to be in compliance with regulatory standards.

Timely Access

DHCS' External Quality Review Organization (EQRO) conducts a timely access survey of Plan providers to ensure compliance with provider availability and appointment wait time standards. For Q2 2022 QMRT the Plan was provided with timely access data reporting providers' ability to respond to the timely access survey and providers' ability to meet the next three (3) appointments within timely access standards.

The Plan was found not to be meeting **Measure 4** (providers with appointment times collected) and **Measure 5** (providers with appointment times within access standards). The Plan response to the findings pointed out that the Plan's results were in line with or higher than the Medi-Cal Statewide averages. For **Measure 4**, the Plan indicated that there may be issues with the survey methodology as front-office staff frequently forward survey questions to the office manager, who is more difficult to get in touch with or who may be not respond. In response to **Measure 4** and **Measure 5**, the Plan pointed to the Plan's standards and monitoring of timely access outlined in Plan policy and procedure *4.30-P Accessibility Standards*, and indicated the Plan's own quarterly monitoring (*Appointment Availability Survey*, *Q3 2022*) found the Plan to be in compliance with regulatory standards.

Quarterly Monitoring Report/Response Template

Q3, 2022 (Q2, 2022 QMRT)

Network Report

DHCS uses the Plan's 274 file to generate Network Report in an effort to improve network provider data quality and support compliance with Annual Network Certification and timely access survey. For Q2 2022 QMRT no response was requested from the Plan, and no Network Report data was provided to the Plan. The Plan's standards and monitoring of accessibility are outlined in Plan policy and procedure *4.30-P Accessibility Standards.*

Mandatory Provider Types

The Plan is required to contract with at least one of the following Mandatory Provider Types within its service area, where available: Freestanding Birthing Centers (FBC), Certified Nurse Midwife (CNM), Licensed Midwife (LM), and Indian Health Facilities (IHF). For Q2 2022 QMRT no response was requested from the Plan, and no Mandatory Provider Type data was provided to the Plan. The Plan maintains ongoing efforts to identify and contract will all provider types, including the above listed Mandatory Provider Types. This requirement is also reviewed by the Plan and DHCS as part of the Plan's Annual Network Certification. The Plan's most recent submission was found to be in compliance with regulatory requirements.

Physician Supervisor to Non-Physician Medical Practitioner Ratios

DHCS uses the Plan's 274 file submission to calculate and monitor Physician Supervisor to Non-Physician Medical Practitioner Ratios. For Q2 2022 QMRT no response was requested from the Plan, and the DHCS' review found the Plan to be in compliance with the standard:

Service Area(s) and/or Reporting Unit	Physician Supervisor Per Non-Physician Medical Practitioner Ratio
Kern	9

The Plan's standards for Physician Supervisor to Non-Physician Medical Practitioner ratios are outlined in Plan policy and procedure *4.04-P Non-Physician Medical Practitioners – Supervision by Physicians.*

Out-of-Network Requests

The Plan reports Out-of-Network (OON) requests to DHCS when a member is requesting to a see a provider or facility when a medically necessary service is not available in the Plan's network. The DHCS analyzes the data to identify potential areas of concern. Based on Q2 2022 data, the Plan identified Hospital, Adult Specialty Care, and Freestanding Birth Center as the three provider types with the highest number of out-of-network requests. The Plan provided a response to the DHCS addressing these three provider types, including the Plan's strategy to reduce the number of requests, barriers/challenges to resolving the number of requests, and contracting/recruiting efforts.

KERN HEALTH SYSTEMS

To: KHS QI-UM Committee

From: Isabel Silva, MPH

Date: 11/10/2022

Re: 3rd Quarter Health Education Department Report

Background

KHS' contract with DHCS requires that it implements and maintains a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all members. The contract also requires that KHS have a Cultural and Linguistic Services Program and that KHS monitors, evaluates and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services.

Discussion

Enclosed is the quarterly health education report summarizing all health education, cultural and linguistic activities performed during the 3rd quarter of 2022.

Fiscal Impact

None

Requested Action

Approve and file

KERN HEALTH SYSTEMS

HEALTH EDUCATION, CULTURAL & LINGUISTIC SERVICES DEPARTMENT

QUARTERLY REPORT

Q3 2022

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
3rd Quarter 2022

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The purpose of this report is to provide a summary of the quarterly activities and outcomes of this department.

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
3rd Quarter 2022

Executive Summary

Report Date: October 21, 2022

OVERVIEW

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

The Executive Summary below highlights the larger efforts currently being implemented by the HE department. Following this summary reflects the statistical measurements for the HE department detailing the ongoing activity for Q3 2022.

- **Asthma Impact Model (AIM) Pilot and Asthma Mitigation Project (AMP)** – These are home-base asthma education and remediation programs offered to members with signs of high-risk or poorly-controlled asthma. 60 and 206 members are enrolled in the AIM Pilot and AMP, respectively. Average Asthma Control Test score has improved from 16.3 at the initial home visit to 21.0 at the post 12th month visit for AIM Pilot members and 17.1 to 20.8 for AMP members. Internal analyses have found participation in the AIM Pilot and AMP to be linked to cost savings in emergency department and inpatient hospital services.

- **Asthma Medication Ratio Performance Improvement Project** – The Health & Wellness (H&W) Team began working the Quality Improvement Department on a project designed to improve member asthma management. H&W has supported this project by educating members on medication management and asthma action plans (AAPs). H&W has also coordinated steps leading to the completion of member AAPs by PCPs, such as AAP mailings, member doctor appointment scheduling and requests for medical records. Since H&W joined the project, 13 members have participated, and 7 AAPs have been completed by PCPs. In the Q3 2022, 1 member participated, and 0 asthma action plans were completed. This project is expected to end in October 2022.

- **Asthma Education Classes -** – H&W staff collected survey responses on KHS' asthma education program from members, network providers, KHS staff, and community asthma stakeholders in Q3 2022. The findings were used to develop strategies to improve member outreach, access to asthma education, and participation in KHS' asthma education program. The H&W Lifestyle Coaches completed the Asthma Management Academy training in Q3 2022. This training prepared the Lifestyle Coaches on the scope of asthma, triggers, mediation and delivery devices and evidence-based assessments and monitoring tools.

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- **Population Needs Assessment –** Data analysis of the focus groups. conducted with parents of African American and Black infants from 0-30 months of age is complete. Findings along with member and provider engagement strategies will be shared with stakeholders to gather feedback and buy-in from departments. Recommended strategies include a new incentive program to facilitate parent participation in a maternal health program and a revised communication plan to reach African American and Black parents.

- **Baby Steps Program --** Accomplishments in Q3 2022 include coordinating, the Baby Steps member satisfaction survey in collaboration with Member Services outreach specialists. Over 400 Surveys were collected from prenatal and postpartum members. Data analysis was completed, and findings will be shared, along with program recommendations, with Steering Committee in Q4 2022. In addition, field testing for the updated pregnancy brochure was completed, the final version is expected in Q4.

- **Diabetes Prevention Program –** Classes for the 2022 cohorts began in April (Spanish) and August (English). There are a total of 62 members enrolled in the program. This cohort has lost a combined total of 375lbs.

- **Cultural and Linguistics Program –**The annual C&L Services audit has been completed and findings are currently being prepared to be shared with each department's management team. The C&L Services in-services are also in progress with all member facing departments. Outreach efforts are also underway to provide C&L services training for providers who were identified in the 3rd quarter of the Interpreter Access Survey conducted by PNM. There are a total of 9 provider specialists who will be receiving training on interpreter services provided by KFHC. C&L has also contracted with The Independent Living center of Kern County to assist with ASL interpreting requests I conjunction with LifeSigns.

- **Tobacco & Nicotine Cessation Classes** – Although registration for classes increased in Q3, overall completion of a full series decreased. This follows an annual trend previous observed where overall attendance decreases towards the end of summer. Efforts are underway to evaluate the program and devise new strategies to engage all nicotine users with special focus on KHS Spanish-speaking population who are less likely to participate in this program compared to English speakers.

- **School Wellness Grant Program** – Awarded schools were provided an orientation in August and have all launched their programs. KHS is in the process of hiring two student interns to work alongside the awarded schools and KHS liaisons through the end of the 2023-2024 academic year. The interns will be responsible for tracking and monitoring the school's progress in implementing their workplans and helping with data collection, activity planning and implementation and evaluation of the wellness programs.

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- **Student Behavioral Health Incentive Program** – KHS continues to coordinate workgroup and stakeholder meetings to allow for discussion and feedback on the needs assessment, targeted interventions and project plans due to DHCS at the end of the year.

Respectfully submitted,

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

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Health Education Services

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
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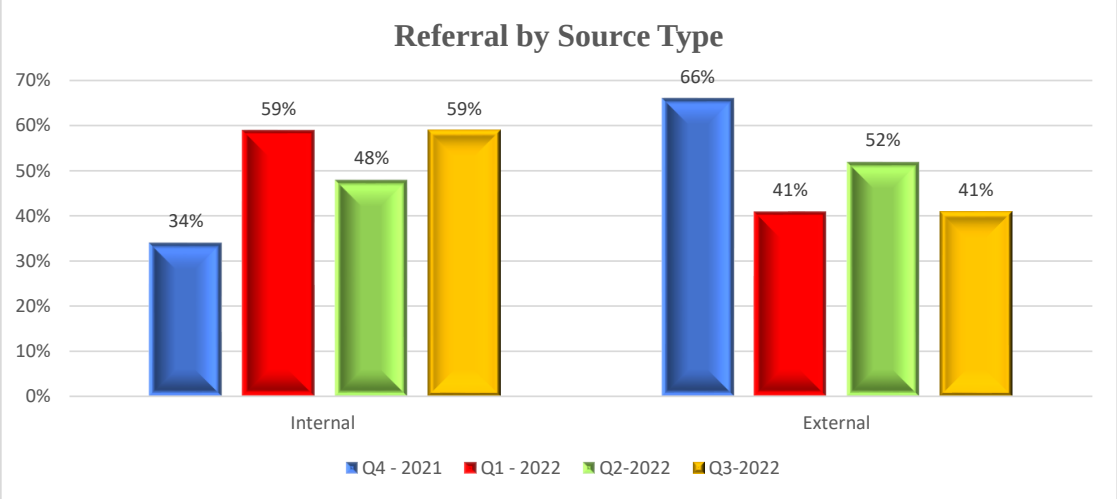
Referrals for Health Education Services

Kern Health Systems (KHS) Health Education Department (HE) receives referrals from both internal and external sources. Internal referrals are received from KHS' member facing departments such as Utilization Management, Member Services and Case Management. Externally, KHS providers, members and community partners can request health education services by calling KHS or submitting requests through the member or provider portals. During Q3 2022, there were 547 referrals for health education services which is a 4% decrease in comparison to the previous quarter. Requests for Nutrition Education continues to be the primary reason for health education services. Additionally, the rate of members who accepted to receive health education services decreased from 45% between Q2 2022 to 36% Q3 2022.



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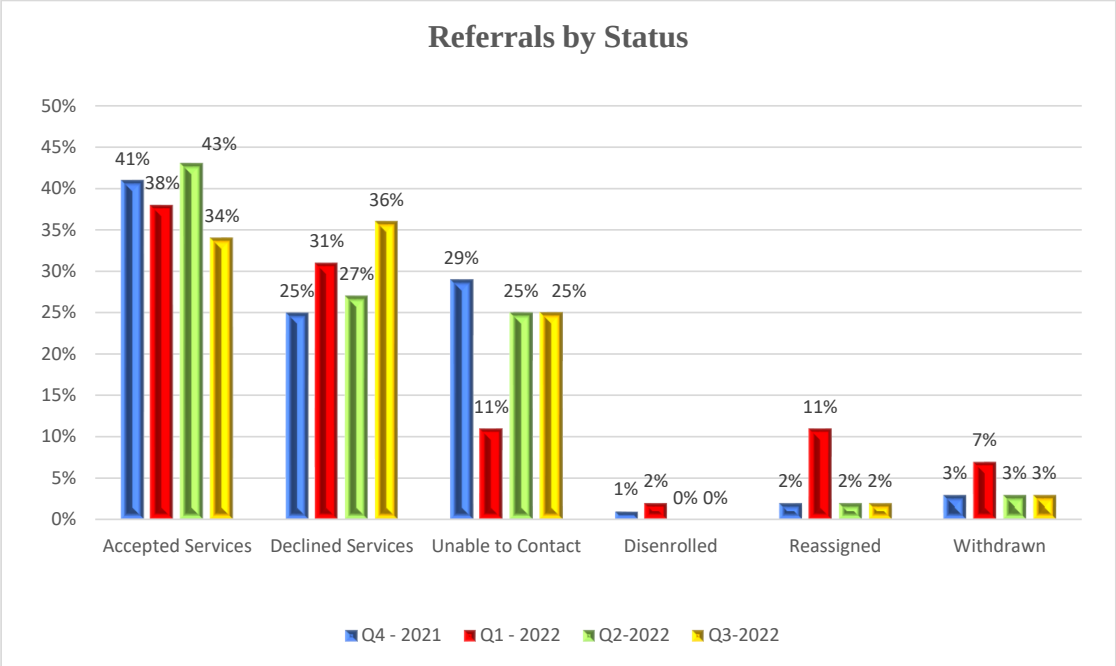

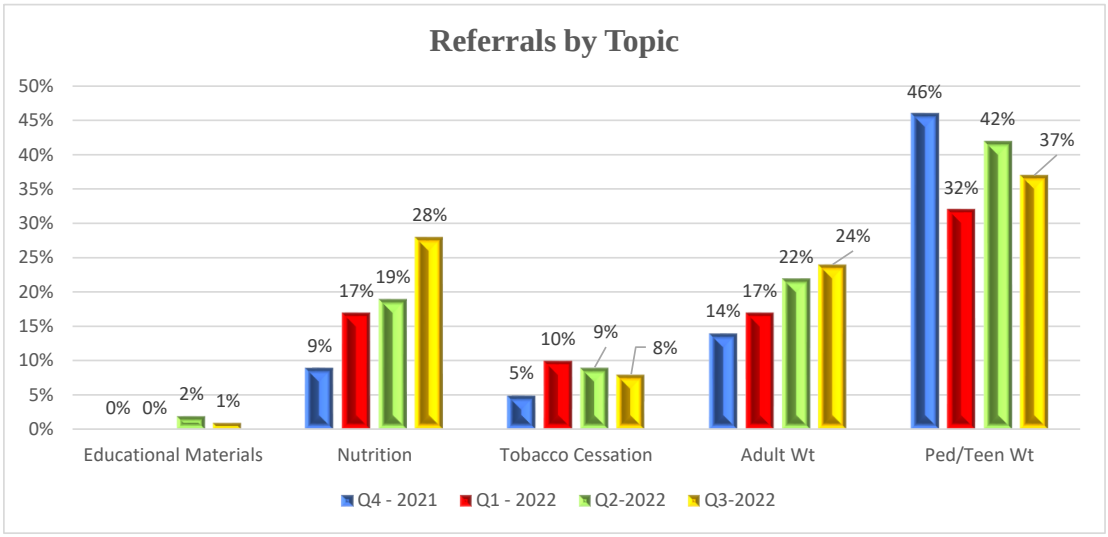

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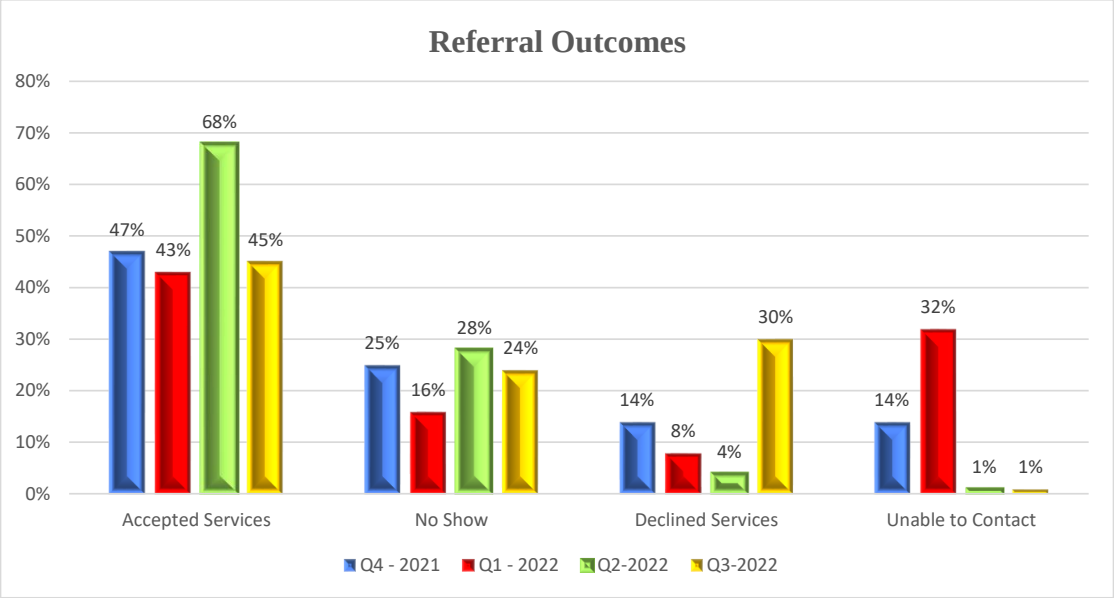
Health Education Referral Outcomes

KHS offers various types of services directly through the KHS HE department or through community partnerships. Services through KHS continues to be the largest share of referral outcomes at 99% for Q3 2022. The rate of members who received health education services decreased from 68% in Q2 2022 to 46% in Q3 2022. The rate of members who do not show for services average 24% of registrants.



Effectiveness of Health Education Services

To evaluate the effectiveness of the health education services provided to members, a 3-month follow up call is conducted on members who received services during the prior quarter. Of the members who participated in the 3-month follow up call, 36 received Nutrition Education, 4 received Tobacco Cessation and 5 received Asthma Education. All findings are based on self-reported data from the members.

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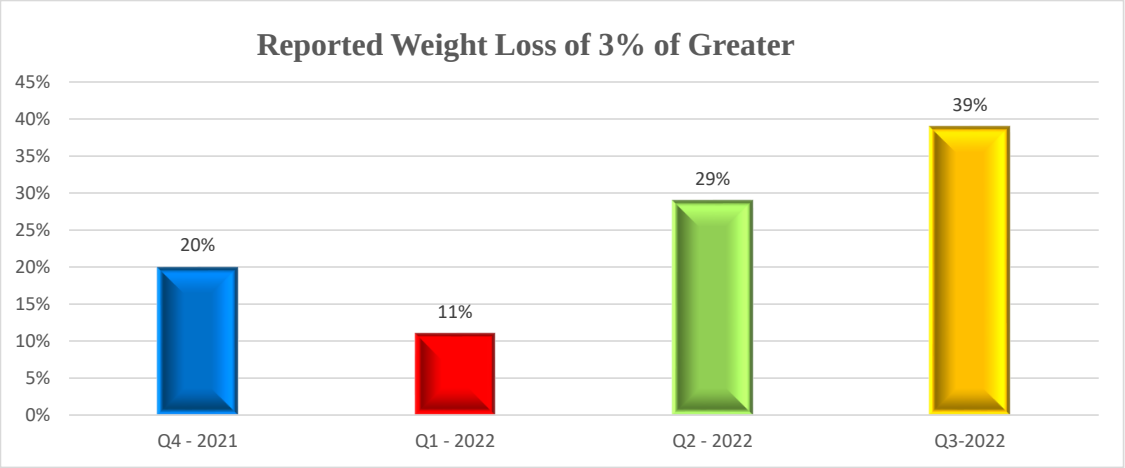

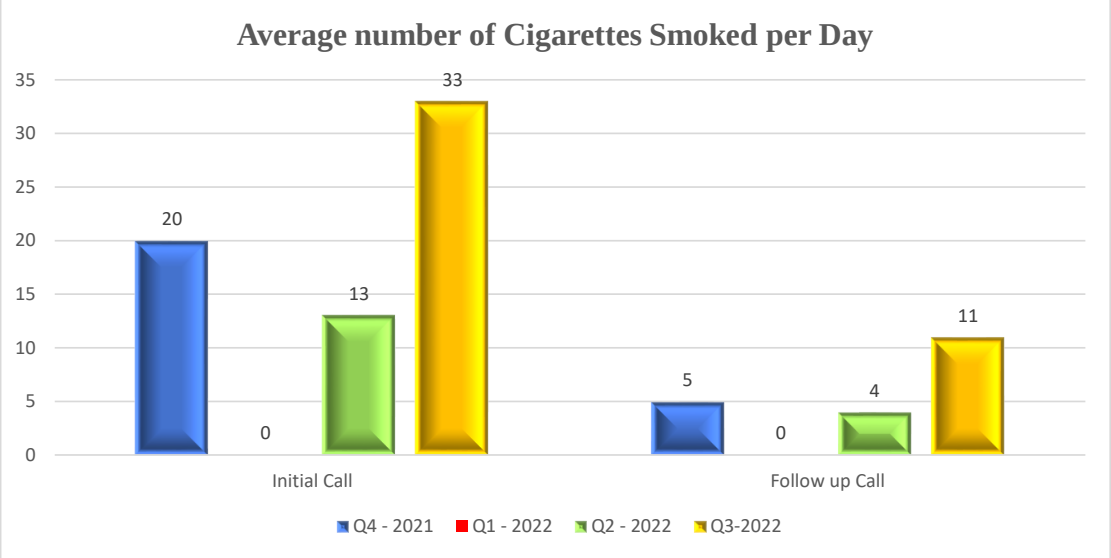

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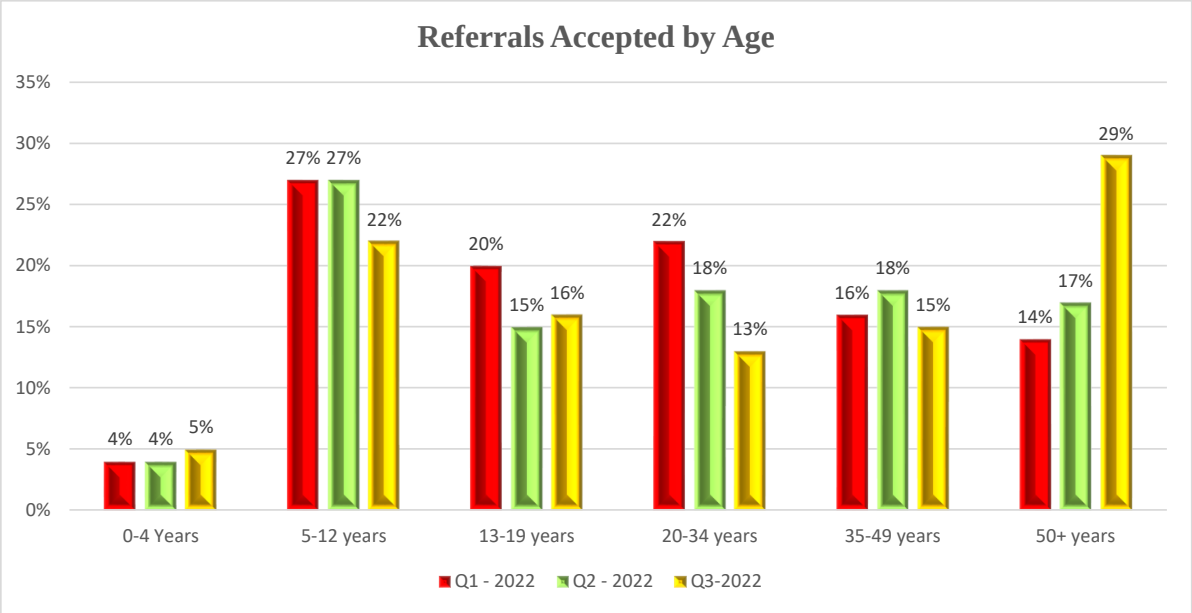
Demographics of Members

KHS provides services to a culturally and linguistically diverse member population in Kern County. KHS' language threshold is English and Spanish, and all services and materials are available in these languages. When non-threshold language requests are received, KHS utilizes professional interpreters to reduce language communication barriers among members. Out of the members who accepted health education services, the largest age groups were 5-12 years followed by 50+ years. A breakdown of member classifications by race and language preferences revealed that many members who accepted services are Hispanic and preferred to receive services in English. During this quarter, 71% of the members who accepted services reside in Bakersfield with the highest concentration in the 93307 area. Additionally, 29% of the members who accepted services reside in the outlying areas of Kern County with the highest concentration in Delano.



* No Data for Q4 – 2021

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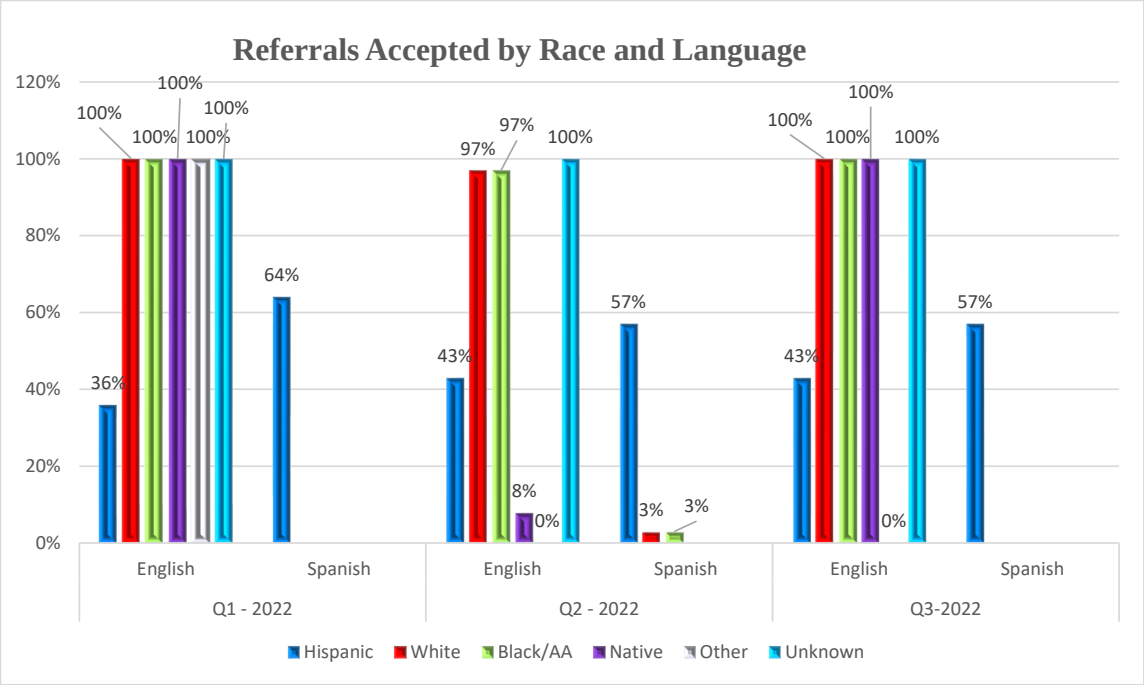

Referrals Accepted by Top Zip Codes

Q4-2021	Q1-2022	Q2-2022	Q3-2022
93307	93306	93307	93307
93304	93307	93305	93304
93305	93304	93306	93306
Lamont	Lamont	Lamont	Delano
Arvin	Arvin	Arvin	Lamont
Delano	Wasco	Delano	Arvin

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Health Education Mailings

The HE department mails out a variety of educational material to assist members with gaining knowledge on their specific diagnosis or health concern. During this quarter, the HE department continued to place most educational mailings on hold due to COVID-19 limitations except for the prenatal and postpartum health guides

Educational Mailings				
	Q4- 2021	**Q1-2022**	**Q2-2022**	**Q3-2022**
Activity and Eating: Small Steps to a Healthier You	3	1	3	3
Control High Blood Pressure	0	0	6	4
Control High Cholesterol	0	0	5	2
Diabetes Management	2	1	7	44
Eat Healthy	3	3	5	5
Exercise	4	3	5	5
Making Meals Better - School Age	0	0	1	0
Prnatal Health Guide	540	575	642	637
Postpartum Health Guide	1,162	1,083	1,272	1,296
Tobacco	0	9,493	57	10
Total	**1,714**	**11,159**	**2,003**	**2,006**

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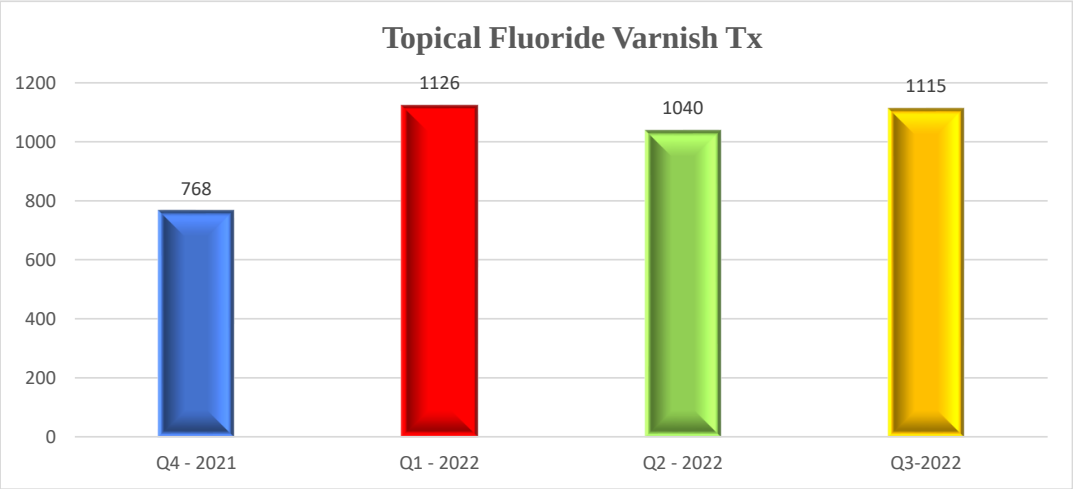
Topical Fluoride Varnish Treatments

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



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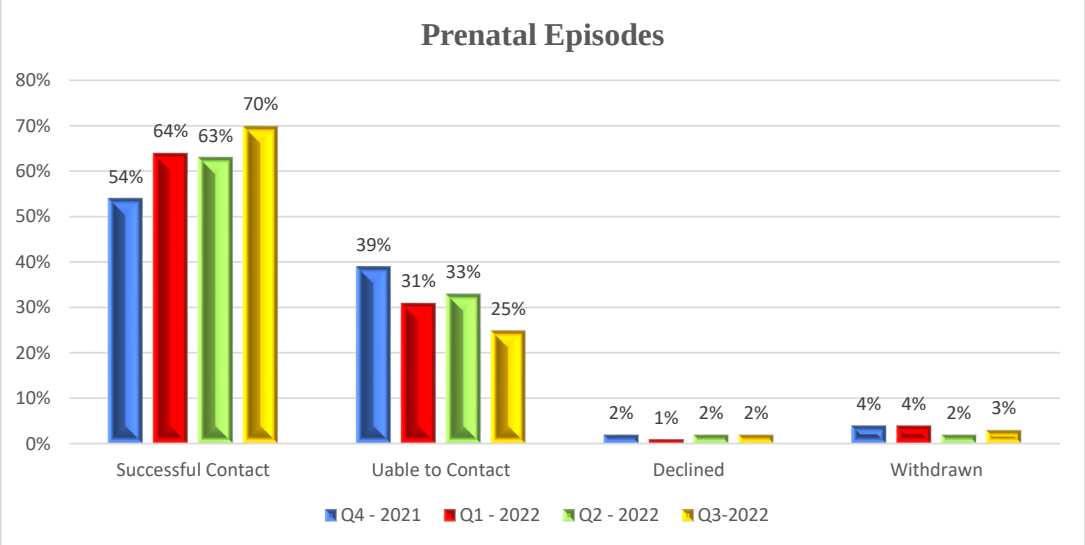
Perinatal Outreach and Education

The HE department performs outreach education calls to members with a positive pregnancy test claim, pregnant teens (under age 18), and postpartum members with a Cesarean delivery or teen pregnancy delivery. In Q2, pregnancy calls were put on hold due to limited capacity. In Q3 2022 prenatal calls resumed, 534 episodes for pregnant members were completed and the rate of successful contacts increased from 64% to 70%. For postpartum, calls were only performed for self-referred members, 7 episodes were completed, and the rate of successful contacts increased from 68% to 100%. Prenatal assessment findings revealed a 18% increase in members identified with diabetes or high blood pressure or were at-risk for diabetes or high blood pressure during pregnancy. Postpartum assessment findings revealed a 99% increase in members reporting that they had already discussed their family planning and birth control options with their provider.



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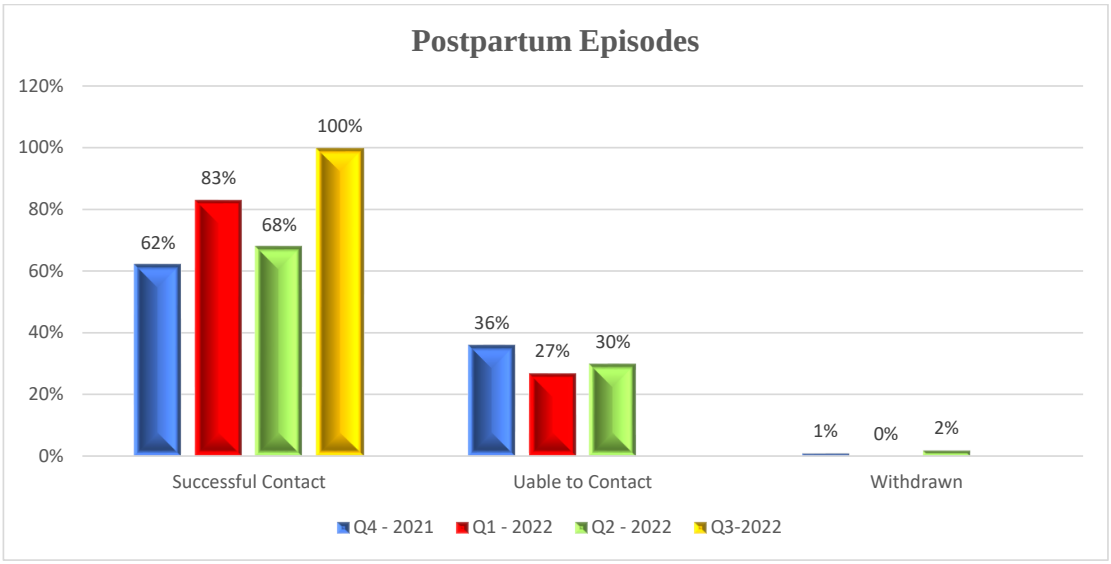

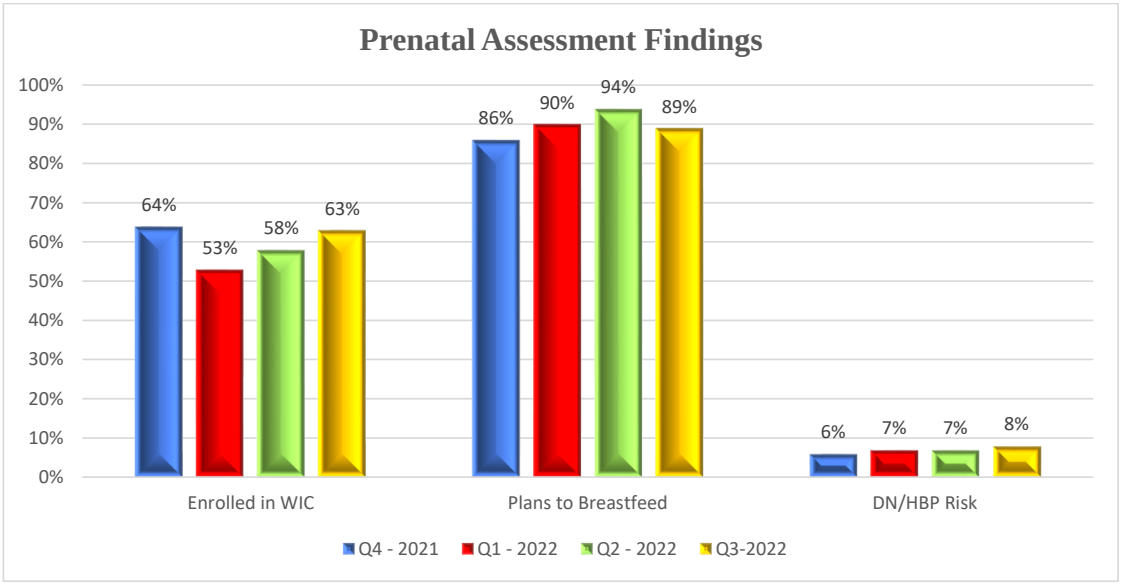

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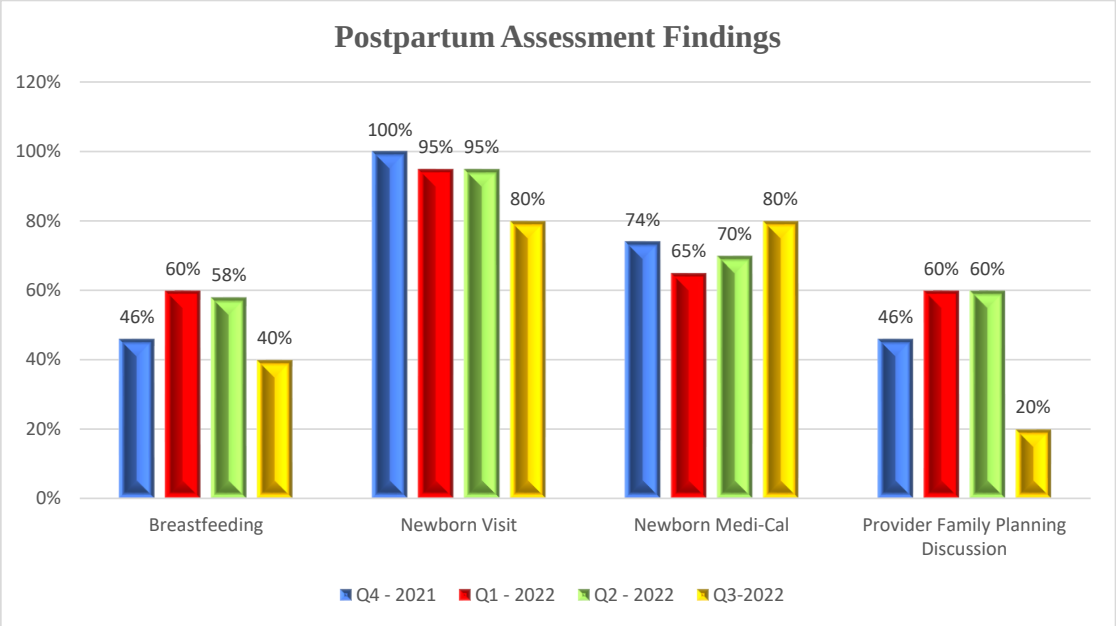

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Health & Wellness Programs

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HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
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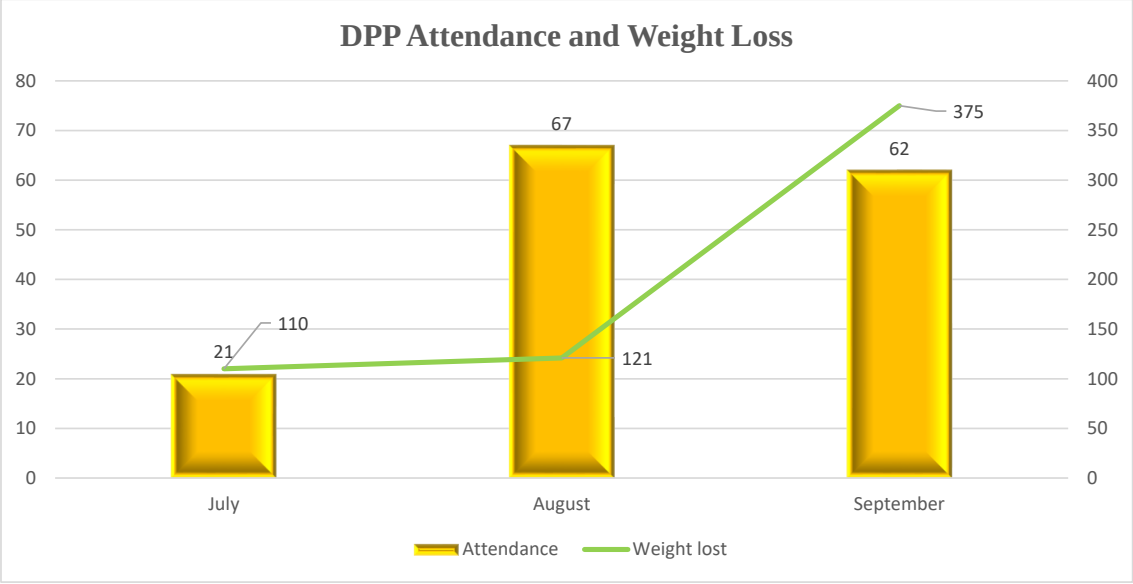
Diabetic Prevention Program

The Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program, taught by peer coaches, designed to prevent, or delay the onset of type 2 diabetes among individuals diagnosed with pre-diabetes who meet the requirements for age, BMI, and prediabetes/risk determination. The participant cannot be pregnant or diagnosed with type 1 or type 2 diabetes at the time of enrollment.

The translated adaptation of the DPP lifestyle intervention is a yearlong structured program consisting of an initial 6-month phase. Within those six months there are 16 weekly classes for the first four months and 4 bi-weekly classes for the next 2 months. For the last six months one class is offered each month with one additional session offered for support, if individually necessary, for each of the last six months. Each session is facilitated by a trained Lifestyle Coach and offers a CDC-approved curriculum. There are regular opportunities for participants to interact with the Lifestyle Coaches. Each session focuses on behavior modification, managing stress and social support.

Classes for the 2022 cohorts began in April (Spanish) and August (English). There are a total of 62 members enrolled in the program. These cohorts have lost a combined total of 375lbs.



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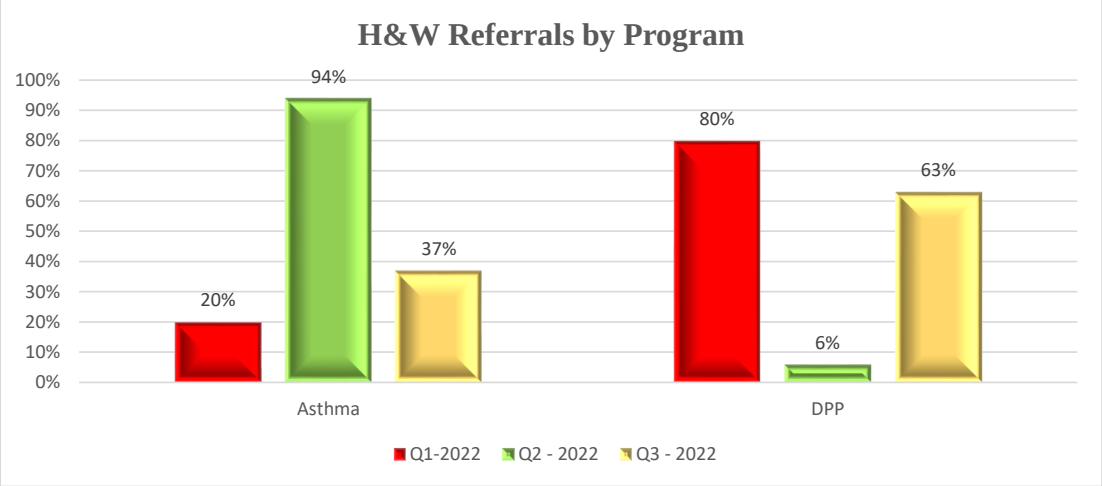
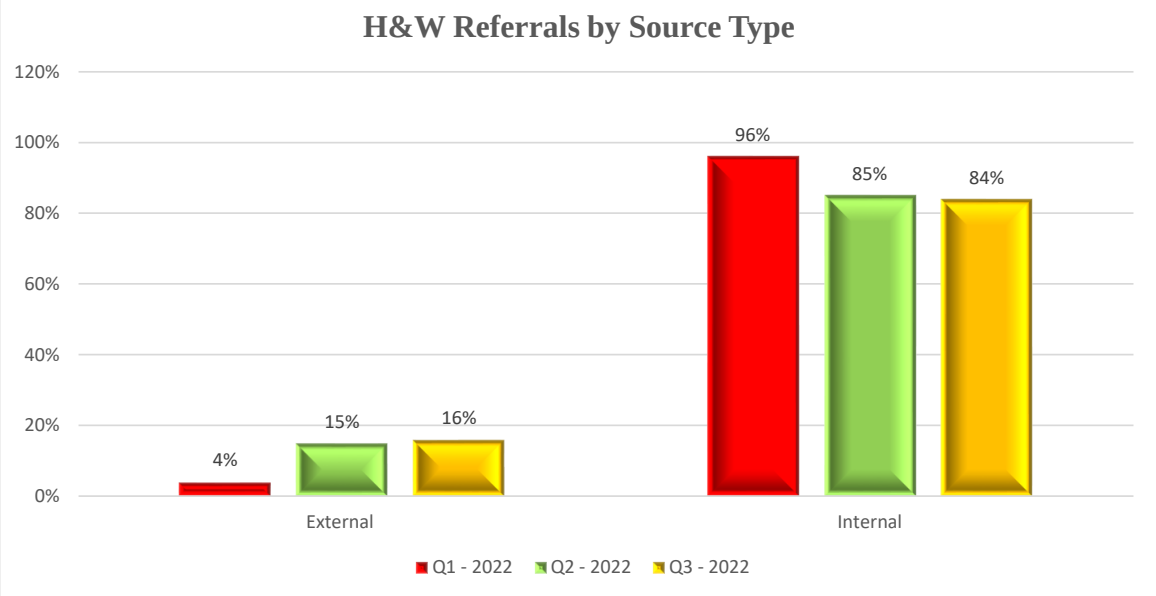
During Q3 2022, there were 117 referrals for asthma education and 205 for DPP services which is a 9% decrease in comparison to the previous quarter.





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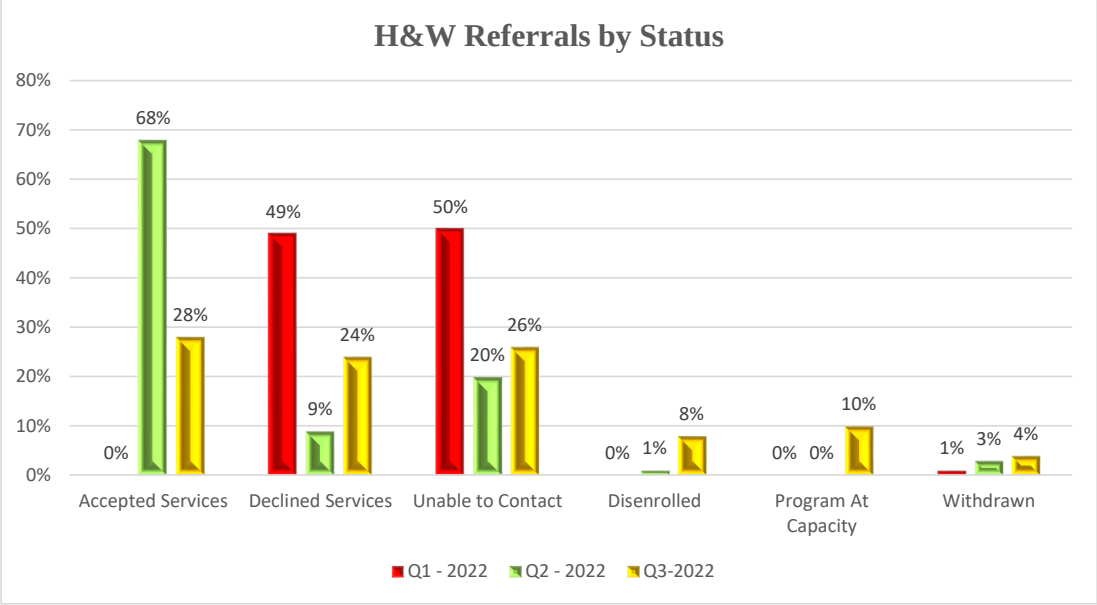
Below is a graph of Health & Wellness referrals by Status. During the second quarter, the episodes in JIVA were closed for those members who declined services or whom we were unable to contact. There are episodes open for members who have accepted services and are still in the process of receiving these services.



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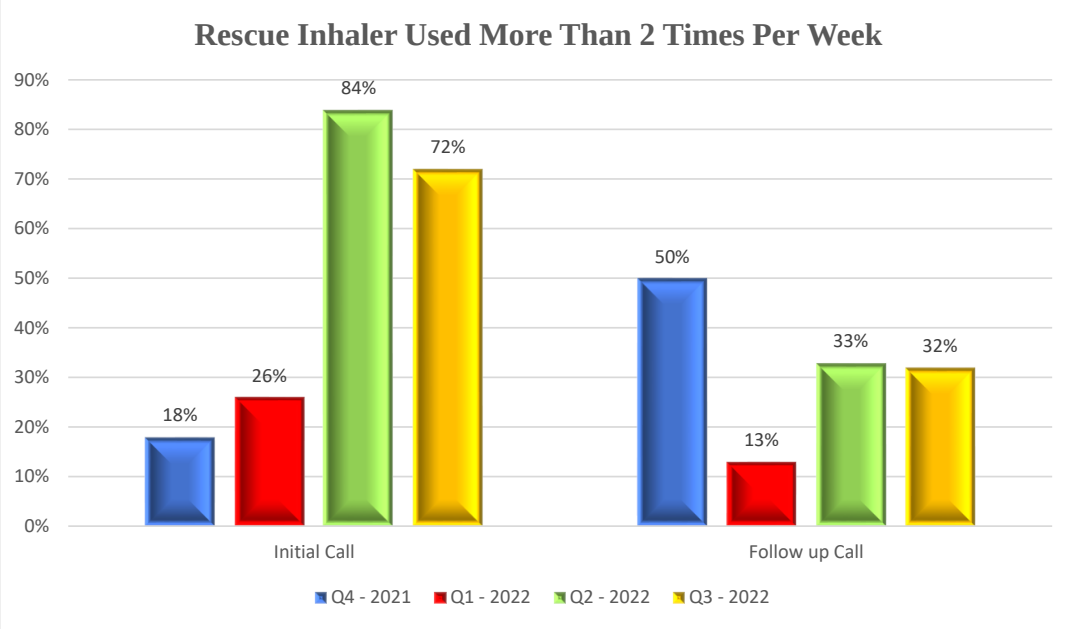
Asthma Follow Up Calls

The HE Department calls members who have attended KFHC asthma classes to offer asthma follow up assessments. These calls occur at 1 month, 3 months, and 6 months after attending the first class. During the assessments, members are asked about their quick relief medication use in the past 4 weeks. This is an indicator of their asthma control. During Q3 2022, the rate of members who report using their quick relief medication 3 or more times a week in the past 4 weeks decreased from 72% during the initial call to 32% at the 3 month follow up.



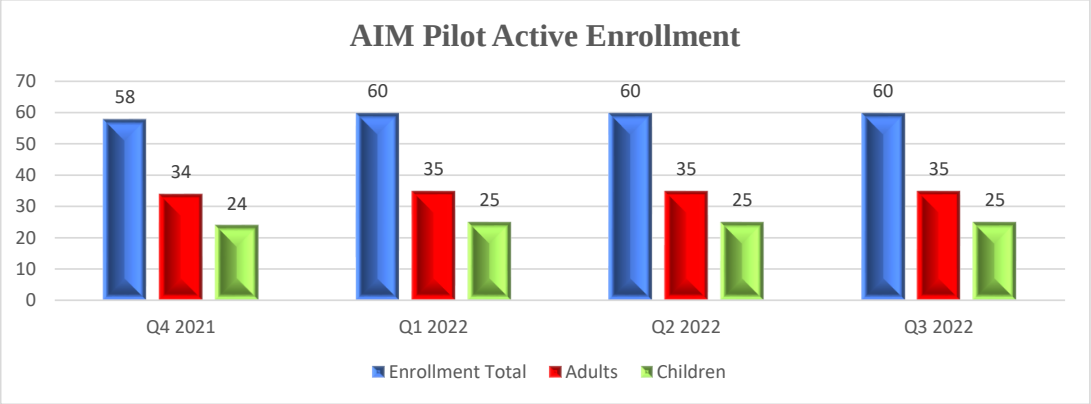
Asthma Mitigation Project

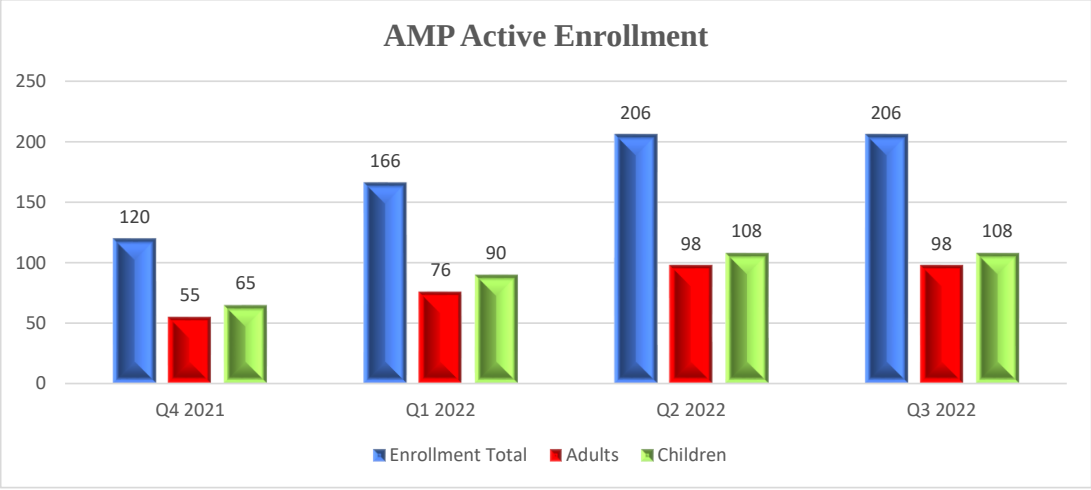
The HE Department offers home-based asthma education and remediation services to members with recent signs of high risk or uncontrolled asthma, such as hospital visits due to asthma emergencies, frequent rescue inhaler use, or frequent asthma symptoms. KHS has partnered with Central California Asthma Collaborative (CCAC) to offer home -based asthma programs to members.

The first program is called the Asthma Impact Model (AIM) Pilot. This program is being sponsored by KHS and includes a home asthma trigger assessment, asthma education, and free supplies to control or eliminate triggers and improve asthma management. The goals of this program are to improve asthma management outcomes, reduce costly health care utilization related

to asthma, improve quality of life, and evaluate the impact of asthma home visiting services on a group of at least 60 members with high risk or uncontrolled asthma. Program enrollment began in March 2019 and will continue through December 2023. Each member is expected to participate for at least a year with follow up home visits and calls lasting through December 2023. The program enrollment goal was reached in June 2020. Some members disenrolled and new members enrolled in the program to maintain an active enrollment total of 60. So far, 56 members have participated for at least 1 year.

The second program is called the Asthma Mitigation Project (AMP). It is being funded by a statewide grant. It includes very similar services as the AIM Pilot. The goals of this program are essentially the same. However, the program enrollment goal is at least 200. Program enrollment began in March 2021 and continued through May 2023. Each member is expected to participate for at least a 1-year period. The program enrollment goal was surpassed in May 2022. So far, 66 members have completed the program.





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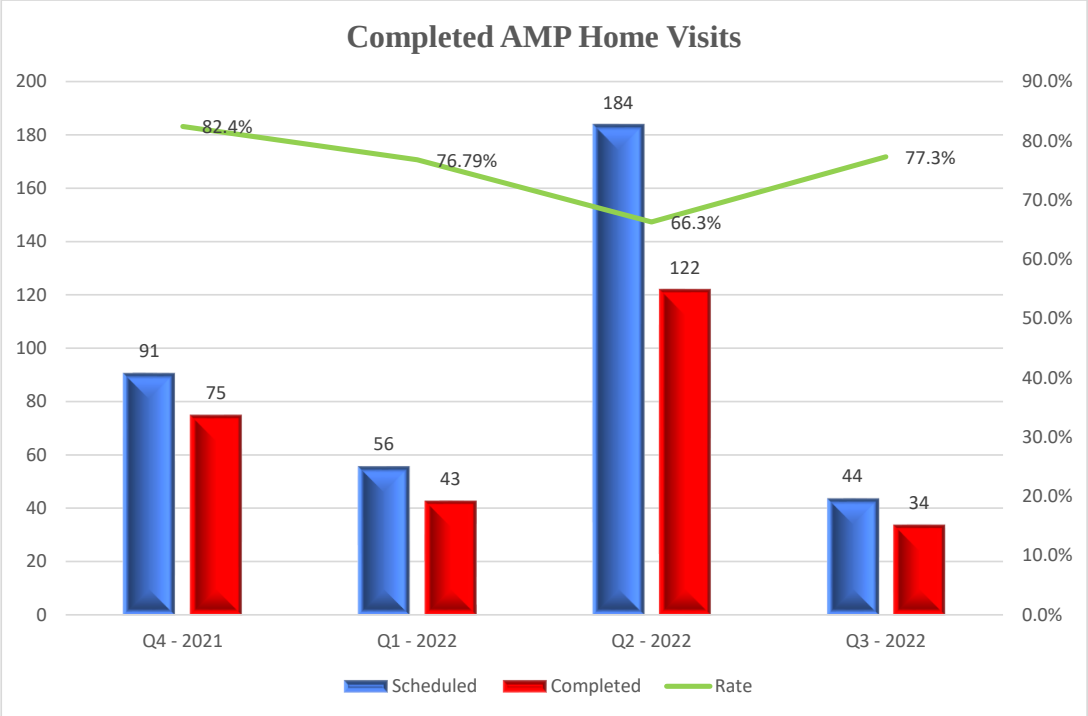
AIM Pilot includes home visits every 3 months. AMP includes 3 home visits that occur during the initial, 6th, and 12th months of program enrollment. Home visits include a home environmental assessment of asthma triggers and education on asthma and trigger management. Health workers also work with members to develop and implement asthma remediation plans, which may include low-cost products and supplies that reduce exposure to triggers in the home.

AIM Pilot follow up calls occur during the months in between home visits, AMP follow up calls occur at the 1st, 2nd, 3rd, and 9th months of the program. Follow up calls include asthma control assessments and referrals to any needed asthma or community resources. CCAC refers members to Kern County 211 or Community Action Partnership of Kern programs for community resources.



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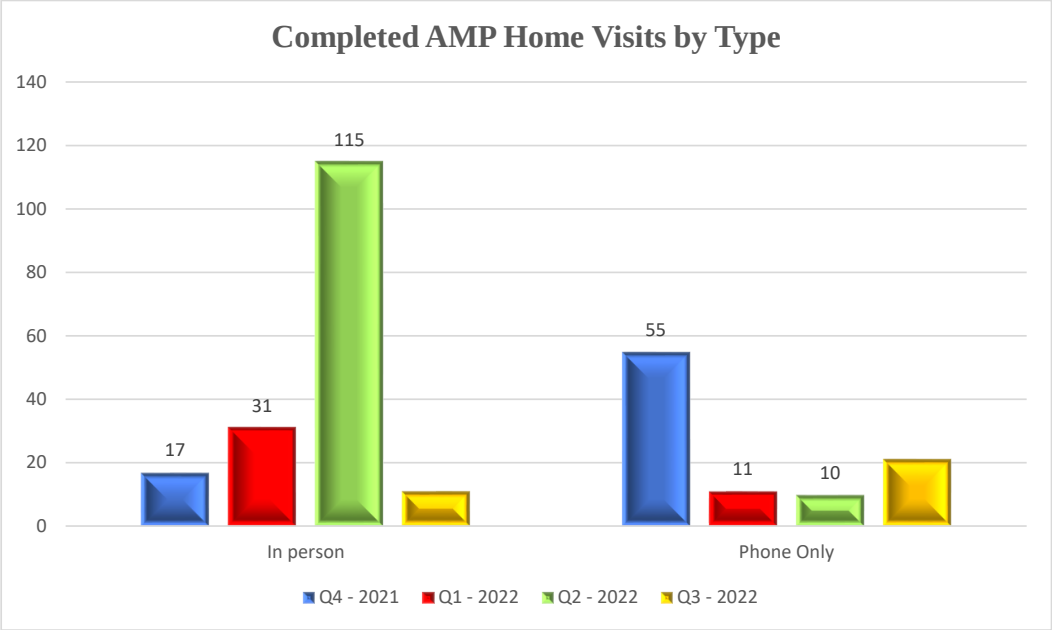

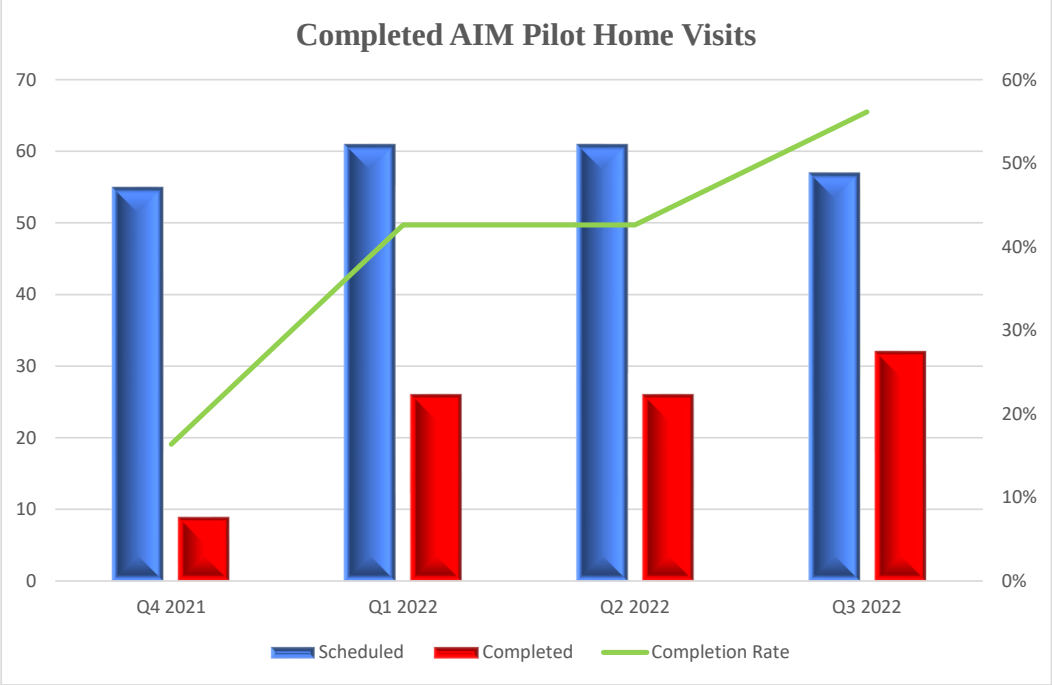

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Cultural & Linguistic Services

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Interpreter Requests

During this quarter, there were 97 requests for Face-to-Face Interpreting, 1365 requests for Telephonic Interpreting, 12 for Video Remote Interpreting (VRI) and 52 requests for an American Sign Language (ASL) interpreter.

Top Face-to-Face Interpreting Languages Requested

Q4-2021	Q1-2022	Q2-2022	Q3-2022
Spanish	Spanish	Spanish	Spanish
Punjabi	Punjabi	Punjabi	Punjabi
Cantonese	Farsi	Vietnamese	Vietnamese

Top Telephonic Interpreting Languages Requested

Q4-2021	Q1-2022	Q2-2022	Q3-2022
Spanish	Spanish	Spanish	Spanish
Punjabi	Punjabi	Punjabi	Punjabi
Arabic	Arabic	Arabic	Arabic

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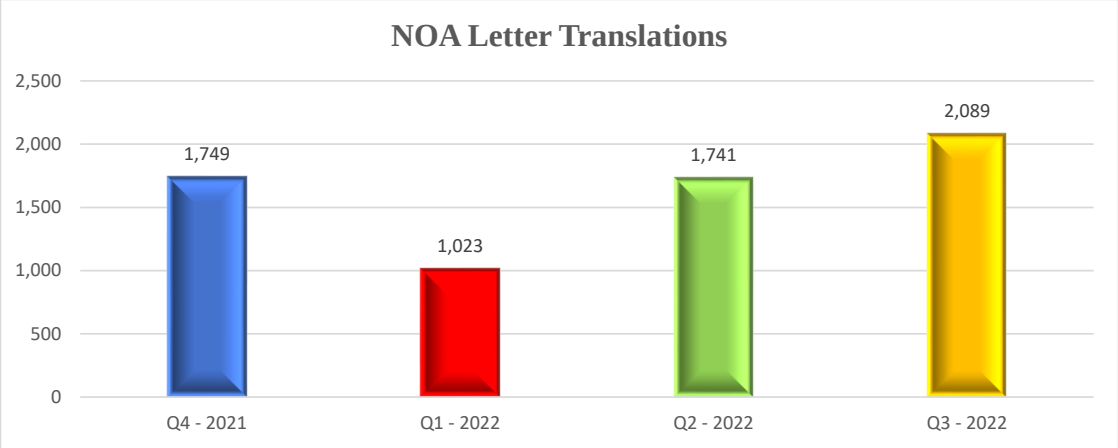
Written Translations

The HE department coordinates the translation of written documents for members. Translations are performed in-house by qualified translators or outsourced through a contracted translation vendor. During this quarter, 2,089 requests for written translations were received of which 94% were Notice of Action letters translated in- house into Spanish for the UM department.



Interpreter Access Survey Calls

Each quarter, the Provider Network Management department conducts an interpreter access survey among KHS providers. During the 3rd quarter, 17 PCPs and 19 Specialists participated in this survey of which a 25% required a follow up in-service on how to access KHS' interpreting services for members.