KERN HEALTH SYSTEMS
Quality Improvement Program Description
2022

I. **Mission:** In a commitment to the community of Kern County and the members of Kern Health Systems (KHS), the Quality Improvement (QI) Program is designed to objectively monitor, systematically evaluate, and effectively improve the health and care of those being served. KHS' Quality Improvement Department manages the Program and oversees activities undertaken by KHS to achieve improved health of the covered population. All contracting providers of KHS will participate in the Quality Improvement (QI) program.

II. **Purpose:** Kern Health Systems (KHS), d.b.a. Kern Family Health Care (KFHC), is the Local Initiative managing the medical and mild to moderate behavioral health care for Medi-Cal enrollees in Kern County. Specialty mental health care and substance use disorder benefits are carved out from KHS' Medi-Cal plan and covered by Kern County Behavioral Health and Recovery Services pursuant to a contract between the County and the State. The Kern County Board of Supervisors established KHS in 1993. The Board of Supervisors appoints a Board of Directors, who serve as the governing body for KHS.

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

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

1. Development and implementation of a structure for monitoring, evaluating, and taking effective action to address any needed improvements in the quality of care delivered by all KHS network providers rendering services to KHS members.
2. A process and structure for quality improvement with contracting providers. This includes identification of quality of care problems and a corrective action process for resolution for all provider entities.
3. Oversight and direction of processes affecting the quality of covered health care services delivered to members, either directly or indirectly.
4. Assurance that members have access to covered health care in accordance with federal and state regulations, and our contractual obligations with the California Department of Health Care Services (DHCS).
5. Monitoring and improvement of the quality and safety of clinical care for covered services for members.

III. **Goals and Objectives:** KHS has developed and implemented a plan of activities to encompass a progressive health care delivery system working in cooperation with contracting providers, members, community partners and regulatory agencies. An

evaluation of program objectives and progress is performed by the QI Department on an annual basis with modifications as directed by the KHS Board of Directors. Results of the evaluation are considered in the subsequent year's program description. Specific objectives of the QI Program include:

1. Improving the health status of members by identifying potential areas for improvement in the health care delivery system.
2. Developing, distributing, and promoting guidelines for care including preventive health care and disease management through education of members and contracting providers.
3. Developing and promoting health care practice guidelines through maintenance of standards of practice, credentialing, and recredentialing. This applies to services rendered by medical, behavioral health and pharmacy providers.
4. Establishing and promoting open communication between KHS and contracting providers in matters of quality improvement. This includes maintaining communication avenues between KHS, members, and contracting providers in an effort to seek solutions to problems that will lead to improved health care delivery systems.
5. Providing monitoring and oversight of delegated activities.
6. Performing tracking and trending on a wide variety of information, including
   - Over and underutilization data,
   - Grievances,
   - Potential and actual quality of care issues,
   - Accessibility of health care services,
   - Compliance with Managed Care Accountability Set (MCAS) preventive health and chronic condition management services,
   - Pharmacy services, and
   - Primary Care Provider facility site and medical record reviews to identify patterns that may indicate the need for quality improvement and that ensure compliance with State and Federal requirements.
7. Promoting awareness and commitment in the health care community toward quality improvement in health care, safety, and service.
8. Continuously identifying opportunities for improvement in care processes, organizations or structures that can improve safety and delivery of health care to members.
9. Providing appropriate evaluation of professional services and medical decision making and to identify opportunities for professional performance improvement.
10. Reviewing concerns regarding quality of care issues for members that are identified from grievances, the Public Policy/Community Advisory Committee (PP/CAC), or any other internal, provider, or other community resource.
11. Identifying and meeting external federal and state regulatory requirements for licensure.
12. Continuously monitoring internal processes in an effort to improve and enhance services to members and contracting providers.
13. Performing an annual assessment and evaluation of the effectiveness of the QI Program and its activities to determine
    a. How well resources have been deployed in the previous year to improve the quality and safety of clinical care,
    b. The quality of service provided to members, and
    c. Modifications needed to the QI Program.

Results of the annual evaluation are presented to the QI/UM Committee and Board of Directors.

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

1. The QI Program is designed to monitor, oversee, and implement improvements that influence the delivery, outcome, and safety of the health care of members, whether direct or indirect.
   a. KHS will not unlawfully discriminate against members based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
   b. KHS will arrange covered services in a culturally and linguistically appropriate manner. The QI Program reflects the population served and applies equally to covered medical and behavioral health services. With increased membership, the majority of KHS'membership has shifted from children (45%) to adults (55%). 52% of the membership falls into the adult age group up to age 64 years and approximately 3% fall into the age of 65 years or older. Gender distribution has between moved to an even distribution with 50% female members and 50% male members. The main ethnicity of our members is reported as Hispanic at 63% followed by Whites at 17% and African Americans at 6.4%.

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

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

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

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

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

Application of the Quality Improvement Program occurs with all procedures, care, services, facilities, and individuals with direct or indirect influence over the delivery of health care to members.

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

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

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

   a. Approve and support the QI Program direction, effectiveness evaluation, and resource allocation. Support takes the form of establishing policies needed to implement the program.
   b. Receive and review periodic summary reports on quality of care and service and make decisions regarding corrective action when appropriate for their level of intervention.
   c. Receive, review, and make final decisions on issues involving provider credentialing and recredentialing recommendations from the Physician Advisory Committee (PAC).
   d. Receive input from the Public Policy/Community Advisory Committee (PP/CAC).
   e. Receive reports representing actions taken and improvements made by the QI/UM Committee, at a minimum, on a quarterly basis.
   f. Evaluate and approve the annual QI Program Description.
   g. Evaluate and approve the annual QI Program Work Plan, providing feedback as appropriate.
   h. Evaluate and approve the annual QI Program Evaluation.
   i. Monitor the following activities delegated to the KHS Chief Medical Officer (CMO):
      i. Oversight of the QI Program
      ii. Chairperson of the QI/UM Committee
      iii. Chairperson of associated subcommittees
      iv. Supervision of Health Services staff
      v. Oversight and coordination of continuity of care activities for members
      vi. Proactive incorporation of quality outcomes into operational policies and procedures
      vii. Oversight of all committee reporting activities to link information

The Board of Directors delegates responsibility for monitoring the quality of health care delivered to members to the CMO and the QI/UM Committee with administrative processes and direction for the overall QI Program initiated through the CMO.

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

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

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

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

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

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

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

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

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

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

a. **Drug Utilization Review (DUR) Committee:** The Pharmacy & Therapeutics Committee has provided ovsight of medication prescribing practices by contracting providers, usage patterns by members and assistance with study design and clinical guidelines development. This committee will cease to exist after the transition of the pharmacy benefit to MCRx. The DUR Committee will continue.

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

c. **Managed Care and Accountability Set (MCAS) Committee:** develops a tiered, multi-pronged approach to improve on all health care quality measures identified by the CA Department of Health Care Services (DHCS). These measures are typically focused on preventive health care and chronic condition management needs for Medi-Cal members. The committee monitors the status of KHS' performance with these measures and modifies strategies and interventions accordingly.

d. **Grievance Review Committee (GRC)**: provides input towards satisfactory resolution of member grievances and determines any necessary follow-up with Provider Network Management, Quality Improvement, Pharmacy and/or Utilization Management.

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

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

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

i. **Objectives** – The QI/UM Committee provides review, oversight, and evaluation of delegated and non-delegated QI activities, including accessibility of health care services and care rendered, continuity and coordination of care, utilization management, credentialing and recredentialing, facility and medical record compliance with established standards, member satisfaction, quality and safety of services provided, safety of clinical care and adequacy of treatment. Grievance information, peer review and utilization data are used to identify and track problems and implement corrective actions. The QI/UM Committee monitors member/provider interaction at all levels, throughout the entire range of care, from the member's initial enrollment to final outcome.

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

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

iii. **Studies** – The review and approval of proposed studies is the responsibility of the QI/UM Committee, with subsequent review of audit results, corrective action, and reassessment. A yearly comprehensive plan of studies to be performed is developed by the CMO, CHSO, Director of Quality Improvement, and the QI/UM Committee, including studies that address the health care and demographics of members.

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

i. Identify methods to increase the quality of health care and service for members
ii. Design and accomplish QI Program objectives, goals, and strategies
iii. Recommend policy direction

iv. Review and evaluate results of QI activities at least annually and revise as necessary
v. Institute needed quality improvement actions and ensure follow-up
vi. Develop and assign responsibility for achieving goals
vii. Monitor quality improvement, including compliance with MCAS preventive health and chronic condition management measures
viii. Monitor clinical safety
ix. Prioritize quality problems
x. Oversee the identification of trends and patterns of care
xi. Monitor grievances and appeals for quality issues
xii. Develop and monitor Corrective Action Plan (CAP) performance
xiii. Report progress in attaining goals to the Board of Directors
xiv. Assess the direction of health education resources
xv. Ensure incorporation of findings based on member and provider input/issues into KHS policies and procedures
xvi. Provide oversight for the KHS UM Program
xvii. Provide oversight for KHS credentialing
xviii. Provide oversight of the Health Education Department
xix. Assist in the development of clinical practice and preventive care health guidelines

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

i. Develop special studies based on data obtained from UM reports to review areas of concern and to identify utilization and/or quality problems that affect outcomes of care.
ii. Review over and underutilization practices retrospectively utilizing any or all of the following data: bed-day utilization, physician referral patterns, member and provider satisfaction surveys, readmission reports, length of stay and referral and treatment authorizations. Action plans are developed including standards, timelines, interventions, and evaluations.
iii. Evaluate results of member and provider satisfaction surveys that relate to satisfaction with the UM process and report results to the QI/UM Committee. Identified sources of dissatisfaction require CAPs and are monitored through the QI/UMC.
iv. Identify potential quality issues and report them to the QI Department for investigation
v. Annually review and approve the KHS Health Education program, new and/or revisions to existing policies, and criteria to be utilized in the provision of Health Education services for members.
vi. Identify potential quality issues with subsequent reporting to the QI/UMC.

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

i. 1 KHS CMO or designee (Chairperson)
ii. 2 Participating Primary Care Physicians

iii. 2 Participating Specialty Physicians
iv. 1 Federally Qualified Health Center (FQHC) Provider
v. 1 Pharmacy Provider
vi. 1 Kern County Public Health Officer or Representative
vii. 1 Home Health/Hospice Provider
viii. 1 DME Provider

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

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

2. Physician Advisory Committee (PAC):

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

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

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

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

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

i. Serve as the committee for clinical quality review of contracting providers.

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

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

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

i. KHS CMO (Chairperson)
ii. 1 Family Practice Providers
iii. 1 Pediatrician

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

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

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

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

a. **Role –** the P&T Committee monitors the KHS Formulary, oversees medication prescribing practices by contracting providers, assesses usage patterns by members and assists with study design and clinical guidelines development. This committee will cease to exist after the transition of the pharmacy benefit to Medi-Cal Rx. The DUR Committee will continue.

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

i. Monitor for quality issues regarding appropriate drug use for KHS and members. This includes Drug Utilization Review (DUR) and Drug Use Evaluation (DUE) programs; Retrospective reviews focused on:
- Early fill/completion factor
- Duplication of therapy
- Therapeutic duplications
- SUPPORT ACT: concurrent therapy with opioids

ii. Provide recommendations regarding protocols and procedures for the use of non-formulary medications.
iii. Provide recommendations regarding educational materials and programs about drug products and their use to contracting providers.
iv. Recommend disease state management or treatment guidelines for specific diseases or medical or behavioral health conditions. These guidelines are a recommended series of actions, including drug therapies, concerning specific clinical conditions.
v. Monitor and assess contracting pharmacy activities as needed through review of audits and pharmacy profiling.
vi. Participate in the DHCS' DUR Board and other DHCS organized pharmacy meetings.
vii. Complete DHCS annual report to CMS as it pertains to KHS.

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

i. 1 KHS CMO (Chairperson)
ii. 1 KHS Director of Pharmacy (Alternate Chairperson)
iii. 1 KHS Board Member/Rx Representative
iv. 1 Retail/Independent Pharmacist
v. 1 Retail/Chain Pharmacist
vi. 1 Geriatric Pharmacist
vii. 1 General Practice Provider
viii. 1 Pediatrician
ix. 1 Internal Medicine Provider
x. 1 Obstetrician/Gynecologist
xi. 1 Provider at Large

d. **Meetings –** The DUR Committee meets quarterly with additional meetings as necessary.

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

a. **Role –** The Kern Family Health Care (KFHC) Public Policy/Community Advisory Committee (PP/CAC) provides participation of members in the establishment of public policy of KFHC. Public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public.[1]

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

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

c. **Structure –** The PP/CAC is delegated by the KHS Board of Directors to provide input in the development of public policy activities for KHS. The committee makes recommendations and reports findings to the Board of Directors through the Quality Improvement/Utilization Management Committee.

[1] Knox Keene § 1369; Rule § 1300.69(b) (2)

Appointed members include:

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

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

5. Managed Care Accountability Set (MCAS) Committee

1. **Role –** The purpose of the Kern Health Systems (KHS) Managed Care and Accountability Set (MCAS) Committee is to provide direction and oversight of KHS' level of compliance with the MCAS measures. It also includes direction, input and approval of KHS' strategies and actions to meet or better compliance with the minimum performance level (MPL) for each MCAS measure as set by the Department of Health Care Services (DHCS).

2. **Function –** functions of the MCAS Committee include:

   i. Regularly evaluate the status of compliance with each MCAS measure designated by DHCS using reports and other data to identify strengths and opportunities.
   ii. Establish an organization-wide strategic action plan to address opportunities with MCAS measures.
   iii. Evaluate outcomes of the strategic action plan and modify the strategy and actions as appropriate.
   iv. Assure that all departments who influence member and provider compliance with MCAS measures actively participate in development and implementation of strategic planning and interventions.
   v. Ensure that adequate policies and procedures exist and are up to date to support KHS' compliance with MCAS measures.
   vi. The Executive Sponsor and Chairperson provide an annual update to KHS' Quality Improvment-Utilization Management Committee (QI-UMC) summarizing our strategies and level of compliance with MCAS measures. Outstanding issues from the Committee may be advanced to KHS' QI-UMC as needed.

3. **Structure –** The MCAS Committee includes the following KHS staff

   i. Chief Medical Officer

ii. Chief Health Services Officer
iii. Administrative Director, Health Homes Program
iv. Director of Business Intelligence
v. Director of Case (CM) & Disease Management (DM)
vi. Director of Compliance & Regulatory Affairs
vii. Director of Health Education and Cultural and Linguistics Services
viii. Director of Marketing and Public Relations
ix. Director of Member Services
x. Director of Pharmacy
xi. Director of QI
xii. Director of UM
xiii. Provider Relations Manager
xiv. QI Manager
xv. QI MCAS Lead Registered Nurse (RN)

4. **Meetings –** The Committee meets at least every quarter and more frequently as needed.

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

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

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

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

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

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

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

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

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

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

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

   The CMO is responsible for providing direction to the QI/UM Committee and associated committees including PAC and Drug Utilization Review (DUR) Committee. As Chairperson of the QI/UM Committee and associated committees, the CMO provides assistance with study development and

coordination of the QI Program in all areas to provide continued delivery of quality health care for members. The CMO assists the Director of Provider Network Management with provider network development and works with the CFO to ensure that financial considerations do not influence the quality of health care administered to members.

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

3. **Chief Health Services Officer (CHSO) -** The CHSO position requires a valid Registered Nurse license to practice within the State of California and is experienced in managed care plan administrative and clinical operations. Under direction from the Chief Medical Officer (CMO), this position is responsible for overseeing the activities of the Health Services Department in support of the company's strategic plan; establishing the strategic vision, and the attendant policies and procedures, initiatives, and functions. The Health Services Department includes: Utilization Management, Case and Disease Management, Health Education, and Quality Improvement.

The Chief Health Services Officer provides direct clinical support to the Directors of the Health Services department for both operational and strategic management. The position is responsible for overseeing the development of quality improvement strategies for the enterprise and clinical program development for population-based clinical quality measures. In addition, the position is responsible for directing the development of the clinical quality plan and the integration of quality into the overall business process to ensure that all activities are relevant and meeting the needs of the population served.
Other responsibilities include:

- Evaluates industry best practices, medical research, and other resources to develop clinical programs and tools which facilitate and support quality, cost-effective care.
- Provides oversight to assure accurate and complete quantitative analysis of clinical data and presentation of results of data analysis.
- Meets regularly with Finance Department to review trends in medical costs and to determine areas of focus;
- Reviews analyses of activities, costs, operations and forecast data to determine departmental progress towards stated goals and objectives;

- ♦ Administer and ensure compliance with the National Committee on Quality Assurance (NCQA) standards as determined for accreditation of the health plan;
- ♦ Ensures adherence to all contract and regulatory requirements;
- ♦ Develops short- and long-term objectives and monitors processes and procedures to ensure consistency and compliance;
- ♦ Develops and implements process and program redesigns.

3. **Director of Quality Improvement -** The Director must possess a valid Registered Nurse (RN) license issued by the State of California and completion of a master's degree in Nursing (MSN) or other healthcare field from an accredited college or university. A minimum of five years of experience in a managed health care organization and a minimum of 3 years staff and program management experience. The Director of Quality Improvement has knowledge of managed care systems in a Knox-Keene licensed health plan, applicable standards and laws pertaining to quality improvement programs for the DHCS, NCQA and HEDIS data collection and analysis, study design methods, and appropriate quality tools and applications.

   The Director of Quality Improvement dedicates 100% of his/her time to the Quality Improvement Department and reports to the Chief of Health Services Officer. The Director of Quality Improvement is responsible for the oversight and direction of the KHS Quality Improvement staff. He/She assists the CMO in developing, coordinating, and maintaining the QI Program and its related activities to oversee the quality process and monitor for health care improvement. Activities include the ongoing assessment of contracted/network provider compliance with KHS requirements and standards, including: medical record assessments, accessibility and availability studies, monitoring provider trends and report submissions, and oversight of facility inspections. The Director of Quality Improvement monitors the review and resolution of medically related grievances with the CMO and evaluates the effectiveness of QI systems.

4. **Quality Improvement Manager –** The Quality Improvement Manager possesses a master's degree in health or business administration or bachelor's or Associates Degree in Nursing and five (5) years of experience in the direct patient care setting or operations management, or teaching adult learners, **and** one (1) year of experience in health care Quality Improvement, Utilization Management, or Process Improvement, and two (2) years of management experience.

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

applies clinical knowledge and analytical skills to manage and oversee day-to-day operations of the QI team.

5. **Quality Improvement RN Supervisor – T**he QI Supervisor is a new position in 2022 and replaces the previous QI Operations Supervisor position which was non-clinical. This position reports to the QI Manager. This position is a licensed, CA registered nurse with at least Five (5) years of experience in the direct patient care setting, one (1) year of experience in health care Quality Improvement, and two (2) years of management and operations management, experience.

   The QI RN Supervisor is responsible for overseeing the day-to-day operations and activities for designated clinical and non-clinical staff within the QI Department, including oversight of all clinical Grievances, Potential Quality Issues (PQIs), Performance Improvement Projects (PIPs), and any other relevant clinical or non-clinical activities. The QI Supervisor works closely with the QI Senior Analyst and Trainer and QI Manager for coordination of training and orientation of new staff in QI processes and procedures.

7. **QI Program Staffing** – the QI Director and Manager oversee a QI Program staff consisting of the following:

   a. **QI Registered Nurses –** The QI nurses possess a valid California Registered Nursing license and three years registered nurse experience in an acute health care setting preferably in emergency, critical and/or general medical-surgical care. The QI nurses assist in the implementation of the QI Program and Work Plan through the quality monitoring process. Staffing will consist of an adequate number of QI nurses with the required qualifications to complete the full spectrum of responsibilities for the QI Program development and implementation. Additionally, the QI nurses teach contracting providers DHCS MMCD standards and KHS policies and procedures to assist them in maintaining compliance.

   b. **Quality Improvement Program Manager -** The QI Program Manager possesses a bachelor's degree or higher in Healthcare, Business, Data Science, Project Management or related field. They have at least 2 years' experience in Quality Improvement or in a health care environment with relevant Quality Improvement experience. They also have at least two (2) years' experience in project management work.

      Under the direction of the Director of Quality Improvement, the QI Program Manager manages, plans, coordinates, and monitors Quality Improvement Special Programs including but not limited to:
      - Annual Managed Care Accountability Set (MCAS) audit and measurement results submission,
      - QI Department Strategic Goals and Projects, and Special Programs (such as member incentives and engagement, DHCS-required project improvement plans, site reviews, etc.).

   c. **Senior QI Operations Analyst**: The Senior QI Operations Analyst reports to the QI Director and has a master's degree in Business, Statistics, Mathematics, or other related field with academic demonstration of

analytical skills from an accredited school or equivalent AND three (3) years' working experience with a Managed Care Organization (MCO) or similar type organization.

d. This position provides primary oversight, management and validation of data and reports submission for the annual DHCS MCAS/HEDIS audit. This includes serving as the liaison between the QI Department, vendors and internal KHS Department such as IT. They provide similar management and support for other department audits. They are responsible for providing operational department support for department processes, projects, or other assignments and provide data and reports for ongoing activities such as performance improvement projects.

e. **Senior Quality Improvement Coordinator -** The QI Senior QI Coordinator reports to the QI RN Supervisor. He/she is a high school graduate and is licensed/certified in CA as either a certified medical assistant (CMA) or licensed vocational nurse (LVN) with either five (5) years of experience for a CMA or two (2) years experience for a LVN in a physician's office.

   The Senior QI Coordinator assists in department functions related to data collection, data entry, report preparation, record maintenance, and collaboration with other departments, regulatory and contracted agencies. This position will work extensively with MCAS methodology, data collection and intervention development and implementation. The QI Coordinator will be a liaison between the health plan and the provider network for record retrieval and post-MCAS interventions. They also assist with medical record requests for any QI activity.

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

g. **QI Senior Support Clerk** – The QI Senior Support Clerk reports to the QI RN Supervisor and has a high school diploma or equivalent, two years experience in the field health care, and at least one year data entry experience. He/she assists in the department functions related to data collection, data entry, report preparation, and record maintenance, and assists with other projects as needed.

VIII. Program Information – KHS utilizes information provided through the Information Technology (IT), Operations and Provider Network Management departments. Information includes but is not limited to claims, UM data, case management and care coordination data, encounter and enrollment data, and grievance and appeal information. The KHS QI Department identifies data sources, develops studies and provides statistical analysis of results.

IX. Work Plan – The annual QI Work Plan is designed to target specific QI activities, projects, and tasks to be completed during the coming year and monitoring and

investigation of previously identified issues. A focal activity for the Work Plan is the annual evaluation of the QI Program, including accomplishments and impact on members. Evaluation and planning the QI Program is done in conjunction with other departments and organizational leadership. High volume, high risk or problem prone processes are prioritized.

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

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

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

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

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

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

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

2. **Managed Care Accountability Set (MCAS)** – KHS is contractually required to submit data and measurement outcomes for specific health care measures identified by DHCS. The measures are a combination of ones selected by DHCS from the library of Healthcare Effectiveness Data and Information Set (HEDIS) and the Core Measures set from the Centers for Medicare and Medicaid Services (CMS). An audit is performed by DHCS's EQRO to validate that the data collection, data used and calculations meet the specifications assigned by DHCS.

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

#	**MEASURE** Total Number of Measures = 36 (10 Hybrid and 26 Administrative)	**MEASURE ACRONYM**	**MEASURE TYPE METHODOLOGY**	**HELD TO MPL?**
1	Breast Cancer Screening	BCS	Administrative	Yes
2	Cervical Cancer Screening	CCS	Hybrid/Admin**	Yes
3	Child and Adolescent Well-Care Visits	WCV	Administrative	Yes
4	Childhood Immunization Status: Combination 10	CIS-10	Hybrid/Admin**	Yes
5	Chlamydia Screening in Women	CHL	Administrative	Yes-i
6	Follow-Up After ED Visit for Mental Illness – 30 days*	FUM	Administrative	Yes

#	MEASURE Total Number of Measures = 36 (10 Hybrid and 26 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
7	Follow-Up After ED Visit for Substance Abuse – 30 days*	FUA	Administrative	Yes
8	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%)*	HBD	Hybrid/Admin**	Yes
9	Controlling High Blood Pressure	CBP	Hybrid/Admin**	Yes
10	Immunizations for Adolescents: Combination 2*	IMA-2	Hybrid	Yes
11	Lead Screening in Children	LSC	Hybrid/Admin**	Yes
12	Prenatal and Postpartum Care: Postpartum Care	PPC-Pst	Hybrid/Admin**	Yes
13	Prenatal and Postpartum Care: Timeliness of Prenatal Care	PPC-Pre	Hybrid/Admin**	Yes
14	Well-Child Visits in the First 30 Months of Life – 0to 15 Months – Six or More Well-Child Visits	W30-2+	Hybrid/Admin**	Yes
16	Ambulatory Care: Emergency Department (ED) Visits	AMB-ED ii	Administrative	No
17	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	Administrative	No
18	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	Administrative	No
19	Asthma Medication Ratio ii	AMR	Administrative	No
20	Adults' Access to Preventive/Ambulatory Health Services	AAP	Administrative	No
21	Colorectal Cancer Screening*	COL	Hybrid/Admin**	No

#	MEASURE Total Number of Measures = 36 (10 Hybrid and 26 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
22	Contraceptive Care—All Women: Most or Moderately Effective Contraception	CCW-MMEC	Administrative	No
23	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	CCP-MMEC60	Administrative	No
24	Topical Fluoride for Children	TFL-CH	Administrative	No
25	Depression Remission or Response for Adolescents and Adults	DRR-E	ECDS	No
26	Developmental Screening in the First Three Years of Life	DEV	Administrative	No
27	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	Administrative	No
28	Follow-Up After Emergency Department Visit for Mental Illness	FUM	Administrative	No
29	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	FUA	Administrative	No
30	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase	ADD-C&M	Administrative	No
31	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Initiation Phase	ADD-Init	Administrative	No

#	MEASURE Total Number of Measures = 36 (10 Hybrid and 26 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
32	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Administrative	No
33	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	NTSV CB	Administrative	No
34	Pharmacotherapy for Opioid Use Disorder	POD	Administrative	No
35	Plan All-Cause Readmissions	PCR ii	Administrative	No
36	Postpartum Depression Screening and Follow Up*	PDS-E	ECDS	No
37	Prenatal Depression Screening and Follow Up*	PND-E	ECDS	No
38	Prenatal Immunization Status	PRS-E	ECDS	No
39	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	ECDS	No

i. MCPs held to the MPL on the total rate only
ii. Stratified by Seniors and Persons with Disabilities (SPDs)

* Measures must be stratified by race/ethnicity. DHCS to provide further direction.
** Hybrid/Admin: MCPs/PSPs have the option to choose the methodology for reporting applicable measure rates

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

The MCAS measure results since MY2019 were significantly impacted by the COVID-19 pandemic. Primary factors impacting KHS’ compliance with the MCAS measures included:

- Stay at home orders for public safety
- Provider staffing resource challenges
- Provider office closures

As the pandemic continues, we are focusing on supporting members to return to their PCPs to receive routine and preventive health services. This support is occurring through the MERP program and expansion of rewards available to members for receiving needed preventive health services. New measures included in this year's rewards program are:

- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Testing
- Blood Lead Testing (for infants up to 2 yrs.).

Revisions to the provider Pay-for-Performance Program are in place for this year to increase providers successfully closing member gaps in care.

Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis and Action Plan DHCS advised the MCPs that financial penalties would not be imposed for RY2021 non-compliant MCAS measures. However, a SWOT Analysis and Action Plan was initiated last year due to KHS not meeting the required MCAS measures for MY2020. This was a requirement of KHS by DHCS. The SWOT plan will be completed by the end of May 2022. It started with an analysis of KHS' strengths, weaknesses, and opportunities to support development of an action plan to improve compliance with the measures. The SWOT emphasis is on the children's and women's domains of healthcare and includes the following three strategies.

Strategy 1: Increase awareness of low performing providers' MCAS rates in real time to allow for more timely interventions in 2021-2022.

Strategy 2: Leverage existing relationships with Community Based Organizations (CBOs) and Kern County Public Health Department (KCPHD) to identify shared activities to promote children's health services in Kern County.

Strategy 3: Increase access to children's preventative health services available to members in rural Kern County.

Plan, Do, Study, Act (PDSA) Projects
As a result of KHS' MY2020 MCAS scores, the QI Department is performing two PDSA's required by DHCS. PDSAs are Rapid-Cycle Improvement Projects. Our first PDSA is focused on the Breast Cancer Screening (BCS) measure in the Women's Health Domain. The second PDSA is utilization of robocalls via the Member Engagement and Rewards Program (MERP) campaign for the W30 measure with a focus on W15 (0-15 months). We are partnering with Clinica Sierra Vista (CSV) for the W30 PDSA. The plan anticipates completion of the PDSAs by mid-May.

3. **COVID Quality Improvement Plan (QIP)**
All MCPs are required by DHCS to develop a COVID QIP regardless of MCAS compliance. This was initiated in September of 2021. 3 strategies were developed for KHS to support our members with information about COVID and the vaccine. The strategies focused on the following domains of healthcare:

Behavioral Health, Chronic Disease, and Women's health. The plan anticipates completion of the QIP by the end of March.

4. **Performance Improvement Projects (PIPs)** – KHS is mandated to participate in two (2) PIPs. These PIPs span over an approximate 18-month time frame and are each broken out into four (4) modules. Each module is submitted to HSAG/DHCS for review, input, and approval incrementally throughout the project. For 2020-2022, the following two (2) PIPs were approved by DHCS for KHS:
   - The first PIP is targeted on a health disparity as outlined in DHCS' Health Equity PIP Topic Proposal Form and is called, Disparities in Well Child Visits, Improving the Health and Wellness of Low-Income Children and Adolescents, Ages 3 to 21, Through Well-Care Visits. This PIP is focused on improving the health and well-being of children, ages 8 to 10 years, by aligning the Well Child Visit with industry standards of care and evidence-based practices.
   - The second PIP is focused on improving the health of members, ages 5-21 years with persistent asthma and who have a ratio of controller medication to total asthma medications of 0.5 or greater. It will focus on improvement opportunities for two member programs:
     - Asthma Mitigation Project (AMP)
     - Asthma Preventive Health Program

5. **Potential Inappropriate Care (PIC) Issues/Potential Quality of Care Issue (PQI) -** This is a possible adverse deviation from expected clinician performance, clinical care, or outcome of care. PICs are investigated to determine if an actual quality issue or opportunity for improvement exists. Based on definition changes by DHCS, we are changing this term to Potential Quality of Care Issues (PQI). To ensure any grievance received/identified is evaluated for Quality of Care (QOC) issues, KHS has added an additional QI RN FTE dedicated to screening all grievances for a possible PQI. When a possible PQI is identified with a grievance, the QI RN summarizes their review and refers the grievance to the KHS' QI medical director for review, final determination of classification of the grievance as a QOC, and direction on any additional actions needed.

6. **Member Services -** The Director of Member Services presents reports regarding customer service performance and grievances monthly to the CEO, CMO and Chief Operations Officer. At least quarterly, reports are presented to the QI/UM Committee for review and recommendations.

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

8. **Corrective Actions –** Corrective Action Plans (CAP) are designed to eliminate deficiencies, implement appropriate actions, and enhance future outcomes when an issue is identified. CAPs are issued in accordance with *KHS Policy and Procedure 2.70-I Potential Quality of Care Issues (PQI)*. All access compliance activities are reported to the Deputy Director of Provider Network who prepares

an activity report and presents all information to the CEO, CMO, Chief Operations Officer, Chief Network Administration Officer, and QI/UM Committee.

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

   KHS targets significant chronic conditions and develops educational programs for members and practitioners. Members are informed about available programs through individual letters, member newsletters and through KHS Member Services. Providers are informed of available programs through KHS provider bulletins and the KHS Provider Manual. Tracking reports and provider reports are reviewed and studies performed to assess performance. KHS assesses the quality of covered health care provided to members utilizing quality indicators developed for a series of required studies. Among these indicators are the MCAS measures developed by NCQA and CMS. MCAS reports are produced annually as well as throughout the year and have been incorporated into QI assessments and evaluations.

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

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

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

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

   Grievances with a PQI identified are referred to the QI department as a PQI referral for further investigation and action. All potential quality of care issues

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

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

   i. **Drug Utilization Review** – KHS performs drug utilization reviews to provide oversight of prescribed medications. DUR is a structured, ongoing program that evaluates, analyzes, and interprets drug usage against predetermined standards and undertakes actions to elicit improvements and measure the results. The objectives of DUR are to improve the quality of patient care by assuring safe and effective drug use while concurrently managing the total cost of care.

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

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

   DHCS distributed a new All Plan Letter (APL), APL 20-006, for Site and Medical Record Reviews that was scheduled to take effect July 1, 2020. Due to the COVID-19 pandemic, DHCS has delayed implementation of this new APL until July 1, 2022. Policies and procedures have been updated to align with the new APL and education for KHS staff and KHS' provider network will be provided in advance of implementation.

   iii. **Coordination of Care Studies** – KHS performs Coordination of Care Studies to reduce the number of acute inpatient stays that

were followed by an acute readmission for any diagnosis within 30 days.

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

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

b. **Fraud, Waste, and Abuse (FWA)** – The Quality Improvement Department provides support to KHS' Fraud, Waste, and Abuse program in the following ways:

i. **PQI Referrals** – In the course of screening and investigating PIC referrals, the QI Department consistently evaluates for any possible FWA concerns. All FWA concerns are referred to KHS' Compliance Department for further evaluation and follow up.

ii. **FWA Investigations** – The QI Department clinical staff may provide clinical review support to the Compliance Department for FWA referrals being screened or investigated.

iii. **FWA Committee –** The Director of QI or their designee is an active member of KHS' FWA Committee to provide relevant input and suggestions for topics and issues presented.

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

XI. KHS Providers: KHS contracts with physicians and other types of health care providers. The Provider Network Management Department conducts a quarterly assessment of the adequacy of contracting providers. All PCPs and specialists must meet KHS credentialing and recredentialing standards. Contracting providers must meet KHS requirements for access and availability. Members may select their PCPs based on cultural needs and preferences. The Provider Directory lists additional languages spoken by PCPs or their office staff.

XII. Annual Evaluation of the KHS Quality Improvement Program: On an annual basis, KHS evaluates the effectiveness and progress of the QI Program and Work Plan, and updates the program as needed. The CMO, with assistance from the Director of Quality Improvement, Pharmacy Director, Director of Health Education and Cultural & Linguistics Services, Director of Marketing, Director of Member Services and Deputy Director of Provider Network, documents a yearly summary of all completed and ongoing QI Program activities with documentation of evidence of improved health care or deficiencies, status of studies initiated, or completed, timelines, methodologies used, and follow-up mechanisms.

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

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

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

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

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

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

XVII. Provider Participation:

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

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

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

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

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

XIX. On-Site Medical Records: Member medical records are not kept on site. Paper documents supporting UM, Grievance and Quality Improvement processes are securely shredded following use.

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

1. In collaboration with other Kern County Health Plans – delegation for Site Reviews as described in APL 20-006, Site Reviews: Facility Site Review and Medical Record Review and the applicable MOU.
2. Kaiser Permanente – delegation of QI and UM processes with oversight through the QI/UM committee.
3. VSP – delegation of QI and UM processes with oversight through the QI/UM committee.

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

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

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

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

1. **Provider Network Management Department –** provider credentialing and recredentialing, using site visits to monitor safe practices and facilities.
2. **Member Services Department –** by analyzing and taking actions on complaint and satisfaction data and information that relates to clinical safety.
3. **UM Department –** in collaboration with the Member Services Department, by implementing systems that include follow-up to ensure care is received in a timely manner.

XXIII. Enforcement/Compliance: The Director of Quality Improvement is responsible for monitoring and oversight of the QI Program, including enforcement of compliance with KHS standards and required activities. Compliance activities can be found in sections of policies related to the specific monitoring activity. The general process for obtaining compliance when deficiencies are noted, and CAPs are requested, is delineated in

policies. Compliance activities not under the oversight of QI are the responsibility of the Compliance Department.

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

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KHS Board of Directors (Chair) Date

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Chief Executive Officer Date

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Chairman QI/UM COMMITTEE Date