KERN HEALTH SYSTEMS

2018

Quality Improvement Program Description

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

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

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

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

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

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

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

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

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

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

5. Providing monitoring and oversight of delegated activities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Physician Advisory Committee (PAC):

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Grievance Review Team (GRT)

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

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

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

c. Structure – Appointed members include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For 2018, the accountability sets are:

Measure	Measure Type Methodology	SPD** Stratification Required	Auto Assignment Algorithm ****
All-Cause Readmissions	Administrative (non-NCQA), defined by ACR collaborative	Yes	No
Ambulatory Care: • Outpatient visits • Emergency Department visits **(Children)***** • Emergency Department visits **(Adults)** • Emergency Department visits **(Total)**	Administrative	Yes	No
Annual Monitoring for Patients on Persistent Medications (2 indicators): • ACE inhibitors or ARBs • Diuretics	Administrative	Yes	No
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Administrative	No	No
Breast Cancer Screening	Administrative	No	No
Cervical Cancer Screening	Hybrid	No	Yes
Childhood Immunization Status – Combo 3	Hybrid	No	Yes
Children & Adolescents' Access to Primary Care Practitioners (4 indicators): • 12-24 Months • 25 Months – 6 Years • 7-11 Years • 12-19 Years	Administrative	Yes	No
Comprehensive Diabetes Care (6 indicators): • Eye Exam (Retinal) Performed • HbA1c Testing • HbA1c Poor Control (>9.0%) • HbA1c Control (<8.0%) • Medical Attention for Nephropathy Blood pressure control (<140/90 mm Hg)	Hybrid	No	Yes, for *HbA1c Testing* **only**
Controlling High Blood Pressure < 140/90 mm Hg (except < 150/90 mm Hg for ages 60-85 without diabetes)	Hybrid	No	Yes
Immunizations for Adolescents (meningococcal, Tdap, HPV)	Hybrid	No	No

2018 Accountability Set (con't)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

XVII. Provider Participation:

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

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

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

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

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

3. Hospital contracts include provisions for the following:

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

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

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

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

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

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

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

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

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

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

2. Credentialing information.

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

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

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

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

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

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

_____

KHS Board of Directors (Chair) Date

_____

Chief Executive Officer Date

_____

Chairman QI/UMC Date

Appendix A

HEDIS 2017
Hybrid Measures

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

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

Administrative Measures

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

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

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