Performance Evaluation Report

Kern Family Health Care

July 1, 2010–June 30, 2011

Medi-Cal Managed Care Division
California Department of
Health Care Services

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1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4.3 million beneficiaries (as of June 2011)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

Federal law requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO assigns compliance review standards, performance measures, and quality improvement projects (QIPs) to the domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2011.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, Kern Family Health Care ("KFHC" or "the plan"), which delivers care in Kern County, for the review period July 1, 2010, through June 30, 2011. Actions taken by the plan subsequent to June 30, 2011, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

KFHC is a full-scope Medi-Cal managed care plan operating in Kern County. KFHC delivers care to members as a local initiative (LI) under the Two-Plan Model. In a Two-Plan Model county, the DHCS contracts with two managed care plans to provide medical services to members. Most counties offer an LI plan and a nongovernmental, commercial health plan.

Members of the MCMC Program in Kern County may enroll in either the LI plan operated by Kern County or in the alternative commercial plan. KFHC became operational with the MCMC Program in July 1996, and as of June 30, 2011, KFHC had 112,480 MCMC members.[2]

[2] *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

The DHCS conducts this review activity through an extensive monitoring process that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers the DHCS's medical performance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about KFHC's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division have historically in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. In some instances, however, medical performance audits have been conducted solely by the DHCS or DMHC. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each MCMC plan approximately once every three years.

HSAG reviewed the most current medical performance audit reports available as of June 30, 2011, to assess plans' compliance with State-specified standards.

The most recent medical performance review was completed in April 2007, covering the review period of November 1, 2005, through October 31, 2006. HSAG reported findings from this audit in the 2008–2009 plan evaluation report.[3]

The review showed that KFHC had audit findings in the areas of utilization management, availability and accessibility, and member rights. Deficiencies needing continued attention involved:

- Providing notification of prior authorization denial, deferral, or modification.
- Payment of emergency service providers.
- Providing pharmaceutical services and prescribed drugs.
- Ensuring members' right to confidentiality.

The DHCS *Medical Audit Close-Out Report* letter dated August 7, 2007, noted that the plan had fully corrected all audit deficiencies at the time of the audit close-out report. HSAG will report these results in the next performance evaluation report.

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's Member Rights/Program Integrity Unit (MRPIU) is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These member rights reviews are conducted before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

As part of the monitoring process, MRPIU conducts an on-site member rights review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2011.

[3] *Performance Evaluation Report –Kern Family Health Care, July 1, 2008 – June 30, 2009.* California Department of Health Care Services. October 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx

MRPIU conducted an on-site review of KFHC in January 2010, covering the review period of November 1, 2007, through December 20, 2009. HSAG reported the review findings in the 2008–2009 plan evaluation report.[4] The scope of the review included grievances, prior authorization notifications, cultural and linguistic services, and marketing. The MRPIU review found KFHC fully compliant with all areas under the scope of the review.

Strengths

KFHC was fully compliant with the MRPIU review and was able to resolve all medical performance review identified deficiencies through corrective action plans, demonstrating full compliance with the medical performance review and MRPIU contract standards.

Opportunities for Improvement

HSAG did not identify opportunities for improvement in this area.

[4] *Performance Evaluation Report – Kern Family Health Care, July 1, 2008 – June 30, 2009.* California Department of Health Care Services. October 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx

Conducting the Review

The DHCS selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members on an annual basis. These DHCS-selected measures are referred to as the External Accountability Set (EAS). The DHCS requires that plans collect and report EAS rates, which provide a standardized method for objectively evaluating plans' delivery of services.

HSAG conducts validation of these performance measures as required by the DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by the MCMC Program for its EAS-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about KFHC's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness.

Performance Measure Validation

The DHCS's 2011 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[5] measures; therefore, HSAG performed a HEDIS Compliance Audit™ of KFHC in 2011 to determine whether the plan followed the appropriate specifications to produce valid rates. The audit results showed no areas of concern.

[5] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. The following table displays a HEDIS performance measure name key with abbreviations contained in Table 3.2.

Table 3.1—HEDIS® 2011 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2011 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Table 3.2 presents a summary of Kern Family Health Care's HEDIS 2011 performance measure results (based on calendar year [CY] 2010 data) compared to HEDIS 2010 performance measure results (based on CY 2009 data). To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. The table shows the plan's HEDIS 2011 performance compared to MCMC-established MPLs and HPLs.

For all but one measure, MCMC based its MPLs and HPLs on the National Committee for Quality Assurance's (NCQA's) national Medicaid 25th percentile and 90th percentile, respectively. For the CDC–H9 (>9.0 percent) measure, a low rate indicates better performance, and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile and the HPL is based on the national Medicaid 10th percentile.

Table 3.2—2010–2011 Performance Measure Results for Kern Family Health Care—Kern County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	23.3%	18.3%	★	↓	19.7%	35.9%
AWC	Q,A,T	38.2%	35.0%	★	↔	38.8%	63.2%
BCS	Q,A	52.1%	50.5%	★★	↔	46.2%	63.8%
CCS	Q,A	62.4%	63.2%	★★	↔	61.0%	78.9%
CDC–BP	Q	65.3%	65.0%	★★	↔	53.5%	73.4%
CDC–E	Q,A	35.2%	32.4%	★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	40.0%	36.5%	★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	51.3%	54.3%	★	↔	53.4%	27.7%
CDC–HT	Q,A	79.9%	79.8%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	29.7%	29.2%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	77.2%	76.4%	★★	↔	69.3%	84.0%
CDC–N	Q,A	81.2%	74.5%	★★	↓	72.5%	86.2%
CIS–3	Q,A,T	66.7%	74.2%	★★	↑	63.5%	82.0%
LBP	Q	75.3%	71.9%	★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	79.1%	78.3%	★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	61.8%	61.1%	★★	↔	58.7%	74.4%
URI	Q	85.8%	85.0%	★★	↔	82.1%	94.9%
W34	Q,A,T	71.0%	70.3%	★★	↔	65.9%	82.5%
WCC–BMI	Q	58.9%	62.3%	★★	↔	13.0%	63.0%
WCC–N	Q	57.7%	47.0%	★★	↓	34.3%	67.9%
WCC–PA	Q	46.2%	29.4%	★★	↓	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, KFHC demonstrated below-average performance in 2011. Four measures had a statistically significant decrease, and one measure had a statistically significant increase. Seven measures fell below the MPLs, and zero measures scored above the HPLs.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at, or above, the established MPLs. The DHCS assesses each plan's rates against the MPLs and requires plans that have rates below these minimum levels to submit an improvement plan to the DHCS. For each area of deficiency, the plan must outline steps to improve care.

For plan measure rates that required a 2010 HEDIS improvement plan, HSAG compared the plan's 2010 improvement plan with the plan's 2011 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

Diabetes Care

KFHC focused improvement efforts on two CDC measures: *HbA1c Poor Control (> 9.0 Percent)* and *Eye Exam (Retinal) Performed*. The plan was able to identify two key barriers, common to both metrics, which hindered performance:

- Member engagement and lack of education/understanding of complications related to diabetes
- Providers unaware of changing recommendations of the American Diabetes Association (ADA) regarding diabetic screenings/tests

To counteract these barriers, the plan implemented several strategies to improve diabetic HEDIS performance:

- Implemented a comprehensive disease management program which includes member education and referrals
- Partnered with Kern Medical Center to create a diabetic clinic for member education and treatment
- Created a member newsletter: *Learning to Live with Diabetes*
- Developed a new and improved process for transition of care of all diabetic patients

Although KFHC had a sound improvement plan and strategy, the plan was unable to bring its HEDIS measures above the MPL for *CDC–E* and *CDC–H9 (>9.0%)* for the second consecutive year. In fact, *CDC-E* decreased by three percentage points even with an improvement plan in place for two years.

Strengths

KFHC had a statistically significant increase in *Childhood Immunization Status—Combination 3*.

Opportunities for Improvement

KFHC has several opportunities for improvement in 2012. The plan should focus efforts on *Comprehensive Diabetes Care* measures, particularly *HbA1c Poor Control (> 9.0 Percent)* and *Eye Exam (Retinal) Performed*. The plan has the opportunity to review improvement plans that are in place and measure the effectiveness of each strategy. This will give the plan an idea of what interventions are working and opportunities for new interventions.

KFHC also can reduce measures falling below the MPLs. The plan's 2010's HEDIS scores revealed two measures below the MPLs as opposed to seven in 2011. The plan should use these data to refocus on HEDIS performance in 2012.

Conducting the Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas.

HSAG reviews each QIP using the Centers for Medicare & Medicaid Services' (CMS') validating protocol to ensure that plans design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, the DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about KFHC's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Projects Conducted

KFHC had two clinical QIPs in progress during the review period of July 1, 2010–June 30, 2011. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. The goal for KFHC's second project was to improve the health care services provided to diabetic members 18 to 75 years of age. Both QIPs fell under the quality and access domains of care.

The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a PCP in an office or clinic setting. Accessing care in a primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

Blood glucose monitoring, dyslipidemia/lipid management, and retinopathy screening assist in the development of appropriate treatment plans to decrease the risk of diabetes complications. Lack of appropriate testing in diabetics may indicate suboptimal care and case management. The plan's

project attempted to increase HbA1c testing, LDL-C screening, and retinal eye exams to minimize the development of diabetes complications.

Quality Improvement Project Validation Findings

The table below summarizes the validation results for both QIPs across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Kern Family Health Care—Kern County July 1, 2010, through June 30, 2011

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	89%	90%	*Met*
Internal QIPs				
Comprehensive Diabetes Care	Annual Submission	84%	92%	*Partially Met*
	Resubmission	92%	100%	*Met*

[1] **Type of Review**—Designates the QIP review as a new proposal, annual submission, or resubmission. A resubmission means the plan was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Validation results during the review period of July 1, 2010, through June 30, 2011, showed that KFHC's annual submission of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met*. KFHC received an overall validation status of *Partially Met* for the *Comprehensive Diabetes Care* QIP. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted this QIP and, upon subsequent validation, achieved an overall *Met* validation status.

Table 4.2 summarizes the validation results for both of KFHC's QIPs across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for Kern Family Health Care—Kern County (Number = 2 QIP Submissions, 2 QIP Topics) July 1, 2010, through June 30, 2011

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies†	71%	14%	14%
Implementation Total†		**93%**	**4%**	**4%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	76%	18%	6%
	IX: Real Improvement Achieved†	88%	0%	13%
	X: Sustained Improvement Achieved	0%	100%	0%
Outcomes Total		**77%**	**15%**	**8%**

*The activity average rate represents the average percentage of applicable elements with a Met, Partially Met, or Not Met finding across all the evaluation elements for a particular activity.
†The sum of an activity or stage may not equal 100 percent due to rounding.

KFHC accurately documented the design and implementation stages in both QIPs, scoring 100 percent *Met* for all evaluation elements in six of the seven activities. However, for both QIPs, Activity VII was scored down for not documenting how interventions would be standardized or monitored based on their effect on the study indicator outcomes.

For the outcomes stage, the plan was scored down in Activity VIII in both QIPs for providing an inaccurate or incomplete interpretation of the results. Additionally, for the *Comprehensive Diabetes Care* QIP, the plan did not provide an interpretation of the success of the overall study. In Activity IX, the plan's score was lowered since none of the *Comprehensive Diabetes Care* QIP study indicators demonstrated statistically significant improvement. For Activity X, the plan did not achieve sustained improvement for the *Reducing Avoidable Emergency Room Visits* QIP outcome. Activity X was scored *Partially Met* for this QIP since the plan's Remeasurement 2 rate was improved over baseline; however, there had been an initial decline in performance from baseline to Remeasurement 1. The plan will need to report improvement in a subsequent measurement period to achieve sustained improvement. The *Comprehensive Diabetes Care* QIP did not progress to a second remeasurement period; therefore, HSAG did not assess Activity X. Sustained improvement is defined as improvement in performance over baseline that is maintained or

increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes

Table 4.3 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods.

Table 4.3—Quality Improvement Project Outcomes for Kern Family Health Care—Kern County (Number = 2 QIP Submissions, 2 QIP Topics) July 1, 2010, through June 30, 2011

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement¥**
Percentage of ER visits that were avoidable	15.9%	16.9%*	14.7%*	No
QIP #2—Comprehensive Diabetic Care				
QIP Study Indicator	**Baseline Period 1/1/08–12/31/08**	**Remeasurement 1 1/1/09–12/31/09**	**Remeasurement 2 1/1/10–12/31/10**	**Sustained Improvement¥**
The percentage of diabetic members 18–75 years of age who received an HbA1c test during the measurement year	79.8%	79.9%	‡	‡
The percentage of diabetic members 18–75 years of age who received an LDL-C screening during the measurement year	76.4%	77.2%	‡	‡
The percentage of diabetic members 18–75 years of age who received a retinal eye during the measurement year or a negative retinal exam in the year prior to the measurement year	34.06%	35.2%	‡	‡

¥ Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

*A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05)

‡The QIP did not progress to this phase during the review period and could not be assessed.

For the *Reducing Avoidable Emergency Room Visits* QIP, the plan reported a statistically significant decrease in the percentage of avoidable ER visits. A decrease for this measure reflects an improvement in performance. Collaborative interventions were initiated in early 2009 and potentially correspond to the improvement in performance. While the plan demonstrated improvement from Remeasurement 1 to Remeasurement 2, this improvement was preceded by a

decline in performance from baseline to Remeasurement 1. The plan will have to maintain the recent improvement in a subsequent measurement period in order to achieve sustained improvement.

For the *Comprehensive Diabetes Care* QIP, the plan reported slight improvement from baseline to Remeasurement 1 for all three study indicators; however, the increase was not statistically significant and may be due to chance. The plan implemented several interventions in 2009, including the development of a diabetes clinic to provide education, monitoring, and timely treatment to diabetic members. The plan had not progressed to a second remeasurement period for this QIP, so HSAG could not assess for sustained improvement.

Strengths

KFHC accurately documented the design and implementation stages for both QIPs, scoring 100 percent *Met* for all applicable evaluation elements in six of the seven activities. Additionally, the plan achieved a statistically significant decline in avoidable ER visits.

Opportunities for Improvement

KFHC has an opportunity to improve its QIP documentation in order to increase compliance with the validation requirements. HSAG recommends that KFHC use HSAG's QIP Completion Instructions, which will help the plan address all required elements within the activities. In addition to addressing deficient evaluation element scores of *Partially Met* or *Not Met*, the plan should also address all elements scored *Met* with a *Point of Clarification* in order to avoid these scores from being lowered to a *Partially Met* or *Not Met* score in a subsequent validation.

The plan has an opportunity to improve its intervention strategies to achieve sustained improvement in QIP outcomes. At a minimum, barrier analysis should be performed to identify and prioritize barriers for each measurement period. More frequent analyses may allow the plan to identify changes or trends that are not evident from an annual analysis alone.

KFHC should include a plan to evaluate the efficacy of the interventions—specifically, using subgroup analysis to determine if the initiatives are affecting the entire study population in the same way. The plan should evaluate the outcomes by gender, age, provider, and/or other selected groupings, which will enable the plan to address, through the development of plan-specific interventions, any disparities that may exist in the study population in relationship to the study outcomes. The evaluation of the interventions should be clearly documented. Based on the evaluation results, the plan should make appropriate revisions or implement new interventions, if necessary. If the intervention evaluation demonstrates that an intervention is successful, the plan should clearly document the process used to monitor and standardize the intervention in the QIP.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

The quality domain of care relates to a plan's ability to increase desired health outcomes for Medi-Cal managed care members through the provision of health care services and the plan's structural and operational characteristics.

The DHCS uses the results of performance measures and quality improvement project (QIP) to assess care delivered to members by a plan in areas such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, the DHCS monitors aspects of a plan's operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems.

KFHC showed below-average performance based on its 2011 performance measure rates (which reflect 2010 measurement data), QIP outcomes, and the results of the medical performance and member rights reviews. Four measures had a statistically significant decrease, and one measure had a statistically significant increase. Seven measures fell below the MPLs, and zero measures scored above the HPLs. For the second straight year, the plan was unable to bring its HEDIS measures *CDC–E* and *CDC–H9 (>9.0%)* above the MPL.

KFHC did not have any deficiencies in the area of quality for the medical record review audit or the MRPIU review.

KFHC's QIPs fell under both the quality and access domains of care, indicating accurate documentation of QIP study design and implementation. However, both QIPs received low scores due to failure of documentation on:

- How interventions would be standardized, or monitored, for study indicator outcomes
- Failing to provide accurate, or complete, interpretation of results

Additionally, the *Comprehensive Diabetes Care* QIP did not provide an interpretation of success in the overall study. For this QIP, KFHC must report improvement in a subsequent measurement period to achieve sustained improvement.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of, and access to, all covered services for Medi-Cal managed care members. The DHCS has contract requirements for plans to ensure access and availability of services to members. The DHCS uses monitoring processes, including audits, to assess a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services under the Medi-Cal Managed Care Program.

Performance measures, QIP outcomes, and member satisfaction results are used for evaluating access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to care and the availability of these services to receive care according to generally accepted clinical guidelines.

The plan demonstrated below-average performance based on a review of 2011 performance measure rates related to access, QIP outcomes, andmedical performance and member rights reviews. KFHC's performance measures performed between MPLs and HPLs for most measures, despite a statistically significant increase in the *Childhood Immunization Status—Combination 3* measure. Additionally, KFHC had a statistically significant decrease in *Comprehensive Diabetes Care—Medical Attention for Nephropathy*. Other access-related measures were below the MPLs and had no statistically significant change: *Adolescent Well-Care Visits, Comprehensive Diabetes Care—Eye Exam (Retinal) Performed,* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*. Some measures were between MPLs and HPLs and had no statistically significant change: *Breast Cancer Screening, Prenatal and Postpartum Care—Postpartum Care,* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

For access-related compliance standards, KFHC either fully met contract requirements or resolved deficiencies prior to the close-out period.

The plan had average QIP performance within the access domain. KFHC had a statistically significant decline in avoidable ER visits, meaning the QIP had some success in limiting avoidable trips to the ER. The plan realized a small improvement from baseline to Remeasurement 1 for all three indicators of its *Comprehensive Diabetes Care* QIP, attaining a higher percentage of members who received testing for diabetes care.

Timeliness

The timeliness domain of care relates to a plan's ability to make timely utilization decisions based on the clinical urgency of the situation, to minimize any disruptions to care, and to provide a health care service quickly after a need is identified.

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified.

KFHC exhibited average performance in the timeliness domain of care based on 2011 performance measure rates, and medical performance and member rights reviews. The plan had a statistically significant increase in performance for the *Childhood Immunization Status* measure, but the rate remained below the HPL as in the previous year. Other timeliness-related measures were between MPLs and HPLs with no statistically significant change: *Prenatal and Postpartum Care—Postpartum Care* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. Two measures were below MPLs and had no statistically significant improvement: *Adolescent Well-Care Visits* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*.

KFHC demonstrated full compliance with contract standards that relate to timeliness.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2009–2010 plan-specific evaluation report. KFHC's self-reported responses are included in Appendix A.

Conclusions and Recommendations

In the next annual review, HSAG will evaluate KFHC's progress with these recommendations along with its continued successes.

Overall, KFHC showed below-average performance in providing quality and accessible health care services and demonstrated average performance in providing timely health care services to its MCMC members. The plan has several opportunities for improvement.

Based on the overall assessment of KFHC in the areas of quality, timeliness, and accessibility of care, HSAG recommends the following:

- Focus improvement efforts on the *Comprehensive Diabetes Care* QIP, analyze and evaluate the improvement plans, and measure effectiveness of strategies and interventions.
- Reduce the amount of measures that fall below the MPLs, and/or lacked statistically significant improvement, by using 2011 data to focus efforts on 2012 HEDIS performance.
- Review HSAG's QIP Completion Instructions to ensure all required elements within activities are addressed to improve the plan's QIP documentation and increase compliance with validation requirements.
- Use a *Point of Clarification* to address all elements scored *Met* to prevent those scores from being lowered to a *Partially Met* or *Not Met* score in subsequent validations.
- Perform a barrier analysis to identify and prioritize barriers in each measurement period to improve intervention strategies and QIP outcomes.
- Evaluate the efficacy of interventions using subgroup analysis to determine if initiatives are affecting the whole study population in the same way, evaluate outcomes by selected subgroups, identify any disparities that exist in the study population as they pertain to study outcomes, and make the necessary revisions in the QIP interventions while clearly documenting the process used.

In the next annual review, HSAG will evaluate KFHC's progress with these recommendations along with its continued successes.

Appendix A. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

for Kern Family Health Care

The table (grid) on the following page provides EQR recommendations from the July 1, 2009, through June 30, 2010 Performance Evaluation Report, along with KFHC's self-reported actions that address the recommendations. Neither Health Services Advisory Group, Inc. (the external quality review organization for Medi-Cal Managed Care) nor any State agency has confirmed implementation of the actions that the plan self-reported in the grid.

Table A.1—Grid of KFHC's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	KFHC's Self-Reported Actions That Address the EQR Recommendation
As the Comprehensive Diabetes Care QIP progresses, evaluate the effectiveness of the interventions. If improvements are not made, conduct sub-group analysis to identify specific barriers to improving care for diabetic members and adjust interventions to address these barriers.	In December 2011, KHS Comprehensive Diabetes Care QIP was closed by HSAG/DHCS. KHS requested an extension because a great deal of effort continues within the diabetic population. After a teleconference between HSAG and KHS regarding additional interventions, both the DHCS and HSAG agreed that the diabetic project be allowed to continue. It was not sufficient to continue with the existing interventions. An agreement was made between the DHCS, HSAG and KHS authorizing KHS to start a new Diabetes QIP with a baseline year of 2011. The baseline year of 2011 data would be collected during HEDIS 2012. On January 30, 2012, the proposed Comprehensive Diabetes Care QIP was submitted.
In addition to focusing improvement efforts on diabetes care, target improvement efforts toward Childhood Immunization Status, the other area of performance that fell below the MPL.	Use of Imaging Studies—implement a Provider Pay for Performance. Analyze provider compliance rates from HEDIS data. Notify providers of their compliance rate. Prenatal and Postpartum Care—a 30second TV commercial aired in English and Spanish to educate members on the importance of prenatal care within the first 12 weeks of gestation. Direct outreach by the KHS Health Education Dept. to ensure members are established with an OB, enrolled in WIC, aware of KHS' contract delivery hospitals and the benefits of breastfeeding. The project includes educating postpartum members on the importance of completing the postpartum visits, newborn's first exam, and communicating the newborn's birth to their Medi-Cal worker. These initiatives will be augmented by the new Pay for Performance program. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis—after HEDIS 2012, KHS will notify providers of their HEDIS compliance rates in this measure. KHS is a participant and contributor to the AWARE Program. AWARE develops the criteria on how to identify high prescribers to which KHS will pull provider names and generate the AWARE Reports on high antibiotic prescribers. The AWARE program will send out the reports and educational mailings to providers notifying providers of their rates. KHS will utilize AWARE reports to identify these providers and create trending reports. KHS is implementing a process to audit the member's medical record. These initiatives will be augmented by the new Pay for Performance program. Adolescent Well Care Visit—implement Pay for Performance for PCPs and OB/GYNs to be paid an incentive for each adolescent well-care visit completed. Analyze provider compliance rates from HEDIS data and notify providers of their HEDIS compliance rates in this measure. Also, through targeting mailings of noncompliant members, members and/or their parents are encouraged to schedule their child's well care visit in order to receive education on sensitive issues, such as: suicidal thoughts, depression, bullying, sex, birth control, STDs, and drinking and driving.

Table A.1—Grid of KFHC's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	KFHC's Self-Reported Actions That Address the EQR Recommendation
Review the 2010 plan-specific CAHPS results report and develop strategies to address the Rating of All Health Care, Rating of Health Plan, and Getting Care Quickly priority areas.	Rating of All Health Care ◆ Reduce barriers a member might encounter while seeking care: KHS Member Services provides assistance to members who are having difficulty getting an appointment with their primary care provider (PCP), choosing a PCP, finding a PCP near their residence, and filing a grievance if the member is having access to care issues with his/her PCP or specialist. 24-hour access by calling 1-800-391-2000. KHS's Grievance Committee meets weekly to review member grievances including complaints about access to care. Access to care issues are tracked by the KHS Provider Relations Department and in Member Services through the Customer Service and Inquiry Module (CSIM). Access to care issues are included when a provider's contract is reviewed for re-credentialing. Biweekly management meetings are held to address access to care issues. KHS member satisfaction surveys. KHS offers transportation assistance which includes but is not limited to bus passes. Discussion regarding eliminating authorization for urgent care centers. KHS will be implanting an Auto Authorization program for specialty consults to eliminate administrative barriers to specialty consultation. ◆ Develop tools to improve members' overall health care experiences. Summer 2009—Member newsletter article on questions to ask during provider visits. The article covered questions related to medications, lab tests, treatments, and health issues. Members were instructed to cut out the article and bring to their appointment. KHS provides a quarterly member newsletter that provides useful information and helpful tools, such as a checklist of questions members can clip and use for their appointment with their PCP. Members have 24-hour access to KHS' audio health library. Hundreds of health topics can be listened to in English and Spanish. KFHC Web site for members.

Table A.1—Grid of KFHC's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	KFHC's Self-Reported Actions That Address the EQR Recommendation
	English and Spanish educational brochures and wall racks to hold brochures distributed to provider offices, includes but is not limited to, emergency room posters and brochures. Toolkit distributed to providers to help counsel obese members in a manner that can easily be understood. Developing a robust Care Management System. Rating of Health Plan ◆ New and effective processes that improve care by focusing on systems to help staff provide high-quality, member-centered care: KHS communicates through MHC, CSIM, Workflow, SharePoint, e-mails, authorizations, and telephone. KHS Web site. KHS has a provider portal which can be used for checking eligibility, status of authorizations, referrals etc. Developing a robust Care Management System. KHS Member Services provides a frontline of communication for members and providers who require information and assistance. Member Services is provided many "microsystem" tools for effective communication with all departments. KHS reviews and updates technical and procedural system processes to improve function, quality, and efficiency on an ongoing basis. ◆ Provide high-quality customer service to improve members' perceptions Online authorization system. KHS meets the following referral response standards: Urgent—3 days, Routine—5 days, Pharmacy TAR—24 hrs. KHS Member Services provides outbound calls to new members within 30 days of enrollment to welcome them to the plan and provide assistance. All outgoing written communications with members are reviewed for accuracy and readability. All written communications provided to Medi-Cal members are required to be approved by the Department of Health Care Services. KHS Member Services effectively communicates with providers who may need assistance with claims or referral processing and members who need assistance with authorized service information. KHS Member Services Representatives are trained to provide quality customer service to members including, but not limited to, sensitivity training.

Table A.1—Grid of KFHC's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	KFHC's Self-Reported Actions That Address the EQR Recommendation
	KHS member satisfaction survey. Sensitivity training. Getting Care Quickly ◆ Explore open access scheduling with network providers. A significant portion of the KHS PCP Network currently offers walk-in appointments. KHS contracts with multiple urgent care centers. KHS has eliminated prior authorization for Urgent Care. ◆ Explore the option of telemedicine to enhance provider access in underserved geographic areas. KHS briefly engaged in the practice of telemedicine years ago. Recently we have identified new opportunities for these services and we are currently in discussions with two different specialty providers that offer telemedicine services. ◆ Consider providing providers with instructions or assistance to monitor patient flow. KHS provides feedback to its contract providers on patient complaints. Some of these complaints may be a result of ineffective patient flows. However, KHS does not have the expertise to conduct patient flow analysis. KHS has initiated quarterly provider forums to discuss patient care-related issues including scheduling, prior authorization, etc. KHS could recommend to its providers that they provide an effective way of communicating realistic expectations when a patient arrives for an appt. (i.e., expected wait time) so there are no surprises in this area. KHS does provide suggestions to PCPs on processes to more effectively gather all necessary patient information at one visit or prompts they may want to use to remind them of necessary preventive services that need to be provided at the next patient visit. ◆ Use electronic communication where appropriate. KHS is not a staff model, so the opportunity for KHS to facilitate electronic communication between patient and provider is not an option. KHS does have a Web site wherein members have numerous resources available to them in an electronic format as do providers.