Performance Evaluation Report

Kaiser–Sacramento County (KP Cal, LLC)

July 1, 2011–June 30, 2012

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

June 2013

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Performance Evaluation Report – Kaiser–Sacramento County

July 1, 2011 – June 30, 2012

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal program, which provides managed care services to approximately 4.9 million beneficiaries (as of June 2012)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] 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 designates each compliance review standard, performance measure, and quality improvement project (QIP) to one or more 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.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on Medi-Cal Managed Care (MCMC). 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.

[1] *Medi-Cal Managed Care Enrollment Report—June 2012.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: January 17, 2013.
[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

- Plan-specific evaluation reports include findings for each plan regarding its organizational structure and operations, 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.

This report is specific to DHCS's contracted plan, KP Cal, LLC, in Sacramento County (commonly known as "Kaiser Permanente North" and referred to in this report as "Kaiser–Sacramento County" or "the plan"), which delivers care in Sacramento County, for the review period July 1, 2011, through June 30, 2012. Actions taken by the plan subsequent to June 30, 2012, regarding findings identified in this report, will be included in the next annual plan-specific evaluation report.

Plan Overview

KP Cal, LLC, (Kaiser Permanente's California Medicaid line of business) is a full-scope managed care plan that contracts with DHCS separately in Sacramento and San Diego counties. KP Cal, LLC, previously operated a pre-paid health plan, Kaiser PHP, in Marin and Sonoma counties. The DHCS KP Cal, LLC, contracts for Marin and Sonoma counties ended when Partnership HealthPlan of California (PHP), a County Organized Health System (COHS), became operational in Sonoma County in October 2009 and in Marin County in July 2011. Although KP Cal, LLC, serves Medi-Cal beneficiaries in these two counties as a subcontractor to PHP, HSAG's assessment for this report is limited to the contracting plan, not the subcontractors. Therefore, reports for KP Cal, LLC, will no longer include Kaiser PHP in Marin and Sonoma counties.

This report pertains to the Sacramento County plan for KP Cal, LLC (Kaiser–Sacramento County). Kaiser–Sacramento County serves members in Sacramento County as a commercial plan under a Geographic Managed Care (GMC) Model. In the GMC Model, DHCS contracts with several commercial health plans within a specified geographic area. This provides MCMC enrollees with more choices.

Kaiser–Sacramento County became operational in Sacramento County to provide MCMC services in April 1994. As of June 30, 2012, Kaiser–Sacramento County had 28,730 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2012*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specify that the State or its EQRO must conduct a comprehensive review within a three-year period 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.

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 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing Structure and Operations

HSAG organized, aggregated, and analyzed results from DHCS's compliance monitoring reviews to draw conclusions about Kaiser–Sacramento County'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. DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of DHCS's Medi-Cal Managed Care Division (MMCD) have historically worked in conjunction with the Department of Managed Health Care to conduct joint audits of Medi-Cal managed care plans. In some instances, however, medical performance audits have been conducted solely by DHCS or the Department of Managed Health Care. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each Medi-Cal managed care plan approximately once every three years.

The most recent routine medical performance review of Kaiser–Sacramento County was completed in February 2007, covering the review period of July 1, 2005, through June 30, 2006. HSAG initially reported findings from this review in Kaiser–Sacramento County's 2008–2009 plan-specific evaluation report.[4] As previously reported by HSAG, the February 2007 review showed that Kaiser–Sacramento County had audit findings in the areas of Utilization Management, Continuity of Care, and Administrative and Organizational Capacity; however, the DHCS *Medical Audit Close-Out Report* letter dated July 18, 2007, noted that the plan had fully corrected all audit deficiencies at the time of the audit close-out report.

Additionally, the Department of Managed Health Care conducted a routine medical survey of Kaiser Foundation Health Plan in November 2008 and a follow-up review for a non-routine medical survey in 2009 for the Northern Region; however, these audit results are not specific to Medi-Cal managed care and therefore are not included within this report.

Member Rights and Program Integrity Review

MMCD's Member Rights/Program Integrity Unit (MR/PIU) is responsible for monitoring plan compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to member rights and program integrity. The MR/PIU aids plan readiness through review and approval of plans' written policies and procedures that include the areas of member grievances and appeals; prior-authorization request notifications; marketing (for non-COHS plans); Seniors and Persons with Disabilities Sensitivity training; facility site accessibility assessment; cultural and linguistic services; and program integrity (fraud and abuse prevention and detection). The MR/PIU reviews and approves processes over these areas prior to the commencement of plan operations, during plan expansion, upon contract renewal, and upon the plan's change in policy and procedures. The MR/PIU aids and monitors plan compliance through biennial on-site health plan monitoring visits that include the issuance of formal monitoring reports, provision of technical assistance, and follow-up as needed for the resolution of compliance observations and findings.

For this report, HSAG reviewed the most current medical performance reviews and MR/PIU plan monitoring reports available as of June 30, 2012. In addition, HSAG reviewed each plan's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews.

[4] California Department of Health Care Services. *Performance Evaluation Report–Kaiser Permanente (KP Cal, LLC), Sacramento County, July 1, 2008 – June 30, 2009*. December 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

MR/PIU conducted an on-site review of Kaiser–Sacramento County in August 2011, covering the review period of June 1, 2009, through May 31, 2011. The scope of the review included Grievances, Prior Authorization Notification, Cultural and Linguistic Services, and the False Claims Act. MR/PIU identified findings in the categories of Grievances and Prior Authorization Notification. HSAG initially reported on the findings from this review in Kaiser–Sacramento County's 2010–2011 plan-specific evaluation report.

Kaiser–Sacramento County was not required to respond to the findings. MR/PIU will follow up with the plan on the findings during its next review. Listed below are the findings:

- In the area of Grievances, of 100 grievance files reviewed, 4 were missing the required acknowledgement letters.
- In the area of Prior Authorization Notification, of 72 prior authorization files reviewed, 1 contained a prior authorization notification that was sent after the required 14-day time frame.

HSAG found the following information regarding actions the plan has taken that appear to address the findings:

- The plan's 2012 Quality Program Workplan includes a goal that 95 percent of grievance cases are acknowledged within 5 calendar days. Additionally, the workplan indicates that compliance with this goal is monitored monthly.
- Kaiser–Sacramento County's self-report indicates that as of May 2012, specific staff members have been designated as subject matter experts. These subject matter experts are responsible for processing all Medi-Cal plan partner cases to assure focused attention on meeting regulatory requirements for cases involving Medi-Cal members.

Strengths

Kaiser–Sacramento County self-reported that it implemented a process to ensure the plan meets regulatory requirements for cases involving Medi-Cal members.

Opportunities for Improvement

Although Kaiser–Sacramento County implemented a process to ensure the plan meets contract requirements, HSAG noted that the plan established its internal goal to have 95 percent of grievances acknowledged within 5 days; however, the expectation for compliance is that the plan will acknowledge all grievances within 5 days.

Conducting the Review

DHCS annually selects a set of performance measures—in consultation with contracted plans, the EQRO, and stakeholders—to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members. These DHCS-selected measures are referred to as the External Accountability Set (EAS). 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 DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by DHCS for its EAS-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

HSAG evaluates two aspects of performance measures for each plan. First, HSAG assesses the validity of each plan's data using protocols required by the Centers for Medicare & Medicaid Services (CMS). This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the plan's performance in providing quality, accessible, and timely care and services to its MCMC members.

Performance Measure Validation

DHCS's 2012 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[5] measures and an internally developed measure for the statewide collaborative QIP that fell under all three domains of care—quality, access, and timeliness. HSAG performed a HEDIS Compliance Audit™ of Kaiser–Sacramento County in 2012 to determine whether the plan followed the appropriate specifications to produce valid rates.

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

Performance Measure Validation Findings

HSAG auditors determined that Kaiser–Sacramento County followed the appropriate specifications to produce valid rates and no issues of concern were identified.

Performance Measure Results

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

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions (internally developed measure)*
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient Visits*
AWC	*Adolescent Well-Care Visits*
CAP–1224	*Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
CAP–256	*Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
CAP–711	*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
CAP–1219	*Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
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*
IMA–1	*Immunizations for Adolescents—Combination 1*
LBP	*Use of Imaging Studies for Low Back Pain*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*
MPM–DIG	*Annual Monitoring for Patients on Persistent Medications—Digoxin*
MPM–DIU	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
W-34	*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 Kaiser–Sacramento County's HEDIS 2012 performance measure results (based on calendar year [CY] 2011 data) compared to HEDIS 2011 performance measure results (based on CY 2010 data). To create a uniform standard for assessing plans on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for first-year measures or measures that had significant specifications changes impacting comparability. The table shows the plan's HEDIS 2012 performance compared to the DHCS-established MPLs and HPLs. While the *All-Cause Readmissions* (ACR) measure was audited to ensure valid and reliable reporting, the reported rates and analysis for this measure will be reported in an interim report of the statewide collaborative in mid-2013.

DHCS based the MPLs and HPLs on the National Committee for Quality Assurance's (NCQA's) national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the CDC–H9 (>9.0 percent) measure. 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—Comparison of 2011 and 2012 Performance Measure Results for Kaiser–Sacramento County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	54.8%	47.2%	★★★	↔	18.8%	31.6%
AMB–ED	‡	--	53.8	--	Not Comparable	--	--
AMB–OP	‡	--	413.3	--	Not Comparable	--	--
AWC	Q,A,T	39.0%	46.8%	★★	↑	39.6%	64.1%
CAP–1224	A	--	99.3%	--	Not Comparable	--	--
CAP–256	A	--	91.8%	--	Not Comparable	--	--
CAP–711	A	--	91.2%	--	Not Comparable	--	--
CAP–1219	A	--	92.9%	--	Not Comparable	--	--
CCS	Q,A	84.1%	83.9%	★★★	↔	64.0%	78.7%
CDC–BP	Q	77.8%	81.7%	★★★	↑	54.3%	76.0%
CDC–E	Q,A	67.5%	71.9%	★★★	↑	43.8%	70.6%
CDC–H8 (<8.0%)	Q	63.1%	61.4%	★★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	21.5%	26.1%	★★★	↓	52.1%	29.1%
CDC–HT	Q,A	94.0%	95.6%	★★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	62.7%	65.6%	★★★	↔	27.3%	45.9%
CDC–LS	Q,A	92.1%	94.3%	★★★	↑	70.4%	84.2%
CDC–N	Q,A	83.1%	89.4%	★★★	↑	73.9%	86.9%
CIS–3	Q,A,T	80.2%	82.4%	★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	80.9%	--	Not Comparable	--	--
LBP	Q	87.5%	92.0%	★★★	↑	72.3%	82.3%
MPM–ACE	Q	--	93.0%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	92.5%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	91.6%	93.3%	★★★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	71.7%	75.0%	★★	↔	59.6%	75.2%
W-34	Q,A,T	69.0%	72.2%	★★	↑	66.1%	82.9%
WCC–BMI	Q	52.8%	73.5%	★★★	↑	19.7%	69.8%
WCC–N	Q	60.3%	75.9%	★★★	↑	39.0%	72.0%
WCC–PA	Q	59.8%	75.6%	★★★	↑	28.5%	60.6%

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS'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] DHCS'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.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = 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.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

Kaiser–Sacramento County continues to demonstrate excellent performance on the required measures, which span all three domains of care. The plan performed above the HPLs on 15 measures compared to 12 in 2011. No measures performed below the MPLs. Kaiser–Sacramento County also achieved statistically significant improvement on 10 measures, and only one measure had a statistically significant decline in performance from 2011 to 2012.

HEDIS Improvement Plans

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

HSAG compared the plan's 2011 IP (if one was required) with the plan's 2012 HEDIS rate for that measure 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.

Kaiser–Sacramento County did not have any measures fall below the MPLs in 2011; therefore, no IPs were required in 2012. Since no measures fell below the MPLs in 2012, the plan will not be required to submit any IPs in 2013.

Strengths

Kaiser–Sacramento County continues to demonstrate excellent performance on providing quality, accessible, and timely services to members.

Opportunities for Improvement

Although the *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)* measure performed above the HPL in 2012, the measure had statistically significant decline from 2011 to 2012. The plan should assess the factors leading to a statistically significant decline in performance on this measure and implement interventions, as appropriate, to prevent further decline in performance.

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, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of plans' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using the CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the plan's QIP objectives (QIP results). HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about Kaiser–Sacramento County's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Project Objectives

Kaiser–Sacramento County had three clinical QIPs in progress during the review period of July 1, 2011, through June 30, 2012, including one QIP in the proposal stage. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the current DHCS statewide collaborative QIP. The plan's second project, an internal QIP, aimed to increase awareness of and counseling for childhood obesity in children 3 to 17 years of age. Additionally, the plan participated in the new statewide *All-Cause Readmissions* collaborative QIP, which focused on reducing readmissions for members aged 21 years and older. All three QIPs fell under the quality and access domains of care.

The current statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider in an office or clinic setting. At the initiation of the QIP, Kaiser–Sacramento County had identified 1,038 ER room visits that

were avoidable, which was 11.6 percent of the plan's ER visits. The plan's objective was to reduce this rate by using both member and provider improvement strategies. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize development of chronic disease.

The new statewide collaborative QIP proposal focused on reducing readmissions due to all causes within 30 days of an inpatient discharge. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members leading to improved health outcomes.

The weight assessment QIP targeted members 3 to 17 years of age. By increasing the documentation of body mass index (BMI) and nutrition and physical activity referrals, the plan would have a better assessment of the obesity issues for the targeted age group, thereby providing an opportunity to improve the quality of care delivered to children. Childhood obesity is a condition not often addressed that can be an indicator of suboptimal preventive care. The plan's objective was to increase these rates by implementing member, provider, and system improvement strategies.

Quality Improvement Project Validation Findings

The table below summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Kaiser–Sacramento County July 1, 2011, through June 30, 2012

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 ER Visits	Annual Submission	87%	100%	*Met*
*All-Cause Readmissions**	Proposal	Not Applicable	Not Applicable	*Pass*
Internal QIPs				
Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents	Annual Submission	97%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a 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 noncritical) 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*.

*During the review period, the *All-Cause Readmissions* QIP was reviewed as a *Pass/Fail* only, since the project was in its study design phase.

Validation results during the review period of July 1, 2011, through June 30, 2012, showed that Kaiser–Sacramento County's annual submission of its *Reducing Avoidable Emergency Room Visits* QIP and its *Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents* QIP both received an overall validation status of *Met*. For the *All-Cause Readmissions* proposal, the plan appropriately submitted the common language developed for the study design phase and received a *Pass* score.

Due to unique, one-time validation scoring used for the initial submission of the study design stage for the *All-Cause Readmissions* statewide collaborative proposal, this QIP will not be included in the following QIP validation table. Additionally, since the QIP had not progressed to the implementation stage, it will not be included in the outcomes table or discussion.

Table 4.2 summarizes the aggregate validation results for Kaiser–Sacramento County's QIPs across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for Kaiser–Sacramento County (Number = 2 QIP Submissions, 2 QIP Topics) July 1, 2011, through June 30, 2012

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)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	90%	10%	0%
	VII: Appropriate Improvement Strategies	86%	14%	0%
Implementation Total		**88%**	**12%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	IX: Real Improvement Achieved**	63%	0%	38%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total		**84%**	**0%**	**16%**

*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 stage and/or activity totals may not equal 100 percent due to rounding.

Kaiser–Sacramento County submitted Remeasurement 1 data for the *Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents* QIP, so HSAG assessed Activities I through IX. For its *Reducing Avoidable Emergency Room Visits* QIP, the plan submitted a third remeasurement period and was assessed for Activities I through X.

The plan successfully applied the QIP process for the design and implementation stages, scoring 100 percent *Met* on all applicable evaluation elements for four of the six applicable activities. For the outcomes stage, the plan's *Reducing Avoidable Emergency Room Visits* QIP was scored down for not demonstrating statistically significant improvement in Activity IX and for not achieving sustained improvement in 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 and Interventions

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 Kaiser–Sacramento County July 1, 2011, through June 30, 2012

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**	**Remeasurement 3 1/1/10–12/31/10**	**Sustained Improvement¥**
Percentage of ER visits that were avoidable^	11.6%	10.8%	14.3%*	15.5%*	No

QIP #2—Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents				
QIP Study Indicator	**Baseline Period 1/1/09–12/31/09**	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
Percentage of members 3–17 years of age who had an outpatient visit with a primary care provider and who had evidence of BMI percentile documentation in the medical record	38.1%	52.8%*	‡	‡
Percentage of members 3–17 years of age with documentation in the medical record of counseling for nutrition during the measurement year	46.7%	60.3%*	‡	‡
Percentage of members 3–17 years of age with documentation in the medical record of counseling for physical activity during the measurement year	24.5%	59.8%*	‡	‡

^A lower percentage indicates better performance.

¥ Sustained improvement is defined as improvement in performance over baseline, which 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.

Reducing Avoidable Emergency Room Visits QIP

For the *Reducing Avoidable Emergency Room Visits* QIP, the plan did not meet its objective of a 10 percent decrease in the percentage of avoidable ER visits over the course of the project. Instead, Kaiser–Sacramento County demonstrated a statistically significant decline in performance from the first to the second remeasurement period and from the second to the third remeasurement period (3.5 and 1.2 percentage points, respectively). An increase in the rate for this project outcome represents a decline in performance. The plan did not demonstrate sustained improvement since the most recent measurement period's rate was higher than the baseline rate. A critical analysis of the plan's improvement strategy led to the following observations:

- The plan did not provide any results of its annual barrier analyses except for the results of the member and provider surveys. The plan discussed the survey results; however, interventions were not implemented to address the identified barriers.
- The only two plan-specific interventions were implemented prior to the start of the project and were then carried over throughout the project; however, the plan did not provide evaluation results of the effectiveness of these interventions.
- Most of the plan's improvement efforts were focused on the collaborative interventions. The collaborative interventions were initiated in early 2009; however, they were not associated with any improvement in the outcome. Kaiser–Sacramento County reported some success with the collaborative hospital intervention. The plan contacted approximately 77 percent of the members within 14 days of their ER visit at the participating hospital in CY 2010. For the participating hospital, the avoidable ER visit rate was 12.6 percent compared to the plan's overall rate of 15.5 percent.

Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents QIP

For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* QIP, Kaiser–Sacramento County demonstrated statistically significant improvement for all three study outcomes from baseline to the first remeasurement period. Additionally, the percentage of members receiving physical education counseling exceeded the DHCS HPL. The plan had not progressed to the point of reporting a second remeasurement period, so HSAG could not assess for sustained improvement. A critical analysis of the plan's improvement strategy led to the following observations:

- The plan reported performing appropriate barrier analyses and creating fishbone diagrams; however, this information was not included in the QIP documentation.
- The plan initially targeted educating pediatric physician chiefs on the childhood obesity (WCC) HEDIS measure and how the components are documented in the electronic medical records. The pediatric chiefs then went back to their facilities and trained the other providers and medical

staff. Additionally, the plan added a prompt "flag" for BMI in the electronic medical records system software to alert providers to collect the BMI data. The software then would calculate the BMI percentile for the provider. The plan reported that based on the BMI percentile, the provider was prompted to provide counseling for nutrition and physical education; however, the plan did not specify which BMI values corresponded to the recommendations for counseling. The plan discussed the evaluation of the interventions without providing actual results.

- Kaiser–Sacramento County proposed implementing a new "BMI as a Vital Sign" education toolkit for physicians and other medical staff in 2011.

Strengths

Kaiser–Sacramento County accurately documented the necessary requirements for the design and implementation stages with 100 percent and 88 percent, respectively, of the applicable evaluation elements scored *Met*. For the outcomes stage, the plan accurately analyzed and interpreted the study indicator outcomes. The plan achieved these scores without the benefit of resubmission, indicating proficiency with the QIP validation process.

Kaiser–Sacramento County's internal QIP on childhood obesity has positively affected the plan's performance on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* (WCC) measure, which was a first-year measure for HEDIS 2009. Additionally, with a more complete assessment and an improved referral/counseling process related to obesity, the plan has a better understanding of the obesity issues for its members aged 3 to 17 years.

Opportunities for Improvement

As part of its barrier analyses, Kaiser–Sacramento County should consider including subgroup analyses to determine if interventions are affecting the entire study population in the same way. The plan should evaluate the outcomes by factors such as gender, age, provider, etc., to understand any disparities that may exist in the study population in relationship to the study outcomes. Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.

When multiple interventions are implemented, the plan should incorporate a method to evaluate the effectiveness of each intervention and document the evaluation results for each measurement period.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of above average, average, or below average in the areas of quality, access, and timeliness domains of care. A score is calculated for performance measure rates, QIP validation, and QIP outcomes as measured by statistical significance and sustained improvement for each domain of care. A final score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the plans' medical performance and MR/PIU reviews, when applicable, to determine overall performance within each domain of care. A more detailed description of HSAG's scoring process is included in Appendix A.

Quality

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

DHCS uses the results of performance measures and quality improvement projects (QIPs) to assess care delivered to beneficiaries 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, 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.

Overall, Kaiser–Sacramento County performed above average in the quality domain of care. Measures falling into the quality domain of care performed exceptionally, with 15 of 19 quality measures scoring above the HPLs in 2012 and 10 quality measures having statistically significant improvement from 2011 to 2012. One quality measure, *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*, had statistically significant decline in performance from 2011 to 2012, although the measure's rate was still above the HPL.

Kaiser–Sacramento County's QIPs fell within the quality domain of care. The plan successfully applied the QIP process for the design and implementation stages, receiving an overall *Met* validation status. The *Reducing Avoidable Emergency Room Visits* QIP had a decline in performance over the course of the project; however, the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* QIP showed statistically significant improvement for all three study outcomes from baseline to the first remeasurement period.

The plan did not have any outstanding medical performance review issues during the review period and had a quality program description that supports providing quality care to Medi-Cal managed care members.

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 MCMC beneficiaries. DHCS has contract requirements for plans to ensure access to and the availability of services to members and 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. Medical performance reviews, MR/PIU reviews, performance measures, and QIP outcomes are used to evaluate 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 beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

Overall, Kaiser–Sacramento County performed above average in the access domain of care. Of the ten comparable access measures, six measures performed above the HPLs in 2012, and five measures had statistically significant improvement from 2011 to 2012.

The plan was fully compliant with access-related standards from the most recent medical performance and MR/PIU reviews. In addition, Kaiser–Sacramento County's 2011 Quality Program Evaluation states that all assessed 2011 access standards were met by the plan. The evaluation report also indicates that access to care complaints decreased 25 percent in 2011 compared to a similar time frame in 2010.

The plan's QIPs fell into the access domain of care. As indicated above, the *Reducing Avoidable Emergency Room Visits* QIP had a decline in performance over the course of the project. This decline in performance suggests there may be barriers to members accessing their primary care providers, resulting in them accessing the ER for health care services instead.

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.

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.

Overall, Kaiser–Sacramento County performed average in the timeliness domain of care. One measure falling into the timeliness domain of care performed above the HPL, and two timeliness measures had statistically significant improvement from 2011 to 2012.

The plan had two deficiencies noted during the review period related to timely grievance acknowledgement and prior authorization notification.

Follow-Up on Prior Year Recommendations

DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2010–2011 plan-specific evaluation report. Kaiser–Sacramento County's self-reported responses are included in Appendix B.

Recommendations

Based on the overall assessment of Kaiser–Sacramento County in the areas of quality, timeliness, and accessibility of care, HSAG recommends the following to the plan:

- Revise internal goals for providing timely grievance acknowledgement letters and prior authorization notifications to align with State and federal requirements of 100 percent.
- Assess the factors leading to a statistically significant decline in performance on the *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)* measure and implement interventions, as appropriate, to prevent further decline in performance.
- Consider including subgroup analyses as part of the QIP barrier analyses to determine if interventions are affecting the entire study population in the same way. Additionally, evaluate the outcomes by factors such as gender, age, provider, etc., to understand any disparities that may

exist in the study population in relationship to the study outcomes. Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.

- When multiple QIP interventions are implemented, incorporate a method to evaluate the effectiveness of each intervention and document the evaluation results for each measurement period.

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

Quality, Access, and Timeliness

Scale
2.5–3.0 = Above Average
1.5–2.4 = Average
1.0–1.4 = Below Average

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in the areas of quality, access, and timeliness domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.2)

Quality Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) greater than negative three, if there are two or less measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than three.
3. To be considered ***Below Average***, a plan will have three or more measures below the MPLs than it has above the HPLs.

Access Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus and the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Timeliness Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects (QIPs)

(Refer to Tables 4.1 and 4.3)

Validation *(Table 4.1)*: For each QIP submission and subsequent resubmission(s), if applicable.

- **Above Average** is not applicable.
- **Average** = *Met* validation status.
- **Below Average** = *Partially Met* or *Not Met* validation status.

Outcomes *(Table 4.3)*: Activity IX, Element 4—**Real Improvement**

- **Above Average** = All study indicators demonstrated statistically significant improvement.
- **Average** = Not all study indicators demonstrated statistically significant improvement.
- **Below Average** = No study indicators demonstrated statistically significant improvement.

Sustained Improvement *(Table 4.3)*: Activity X—Achieved Sustained Improvement

- **Above Average =** All study indicators achieved sustained improvement.
- **Average =** Not all study indicators achieved sustained improvement.
- **Below Average =** No study indicators achieved sustained improvement**.**

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care.

For each **QIP**, the Validation score (1 or 2), the Outcomes score (1, 2, or 3), and the Sustained Improvement score (1, 2, or 3) are entered for each applicable domain of care (Q, A, T). The scores are automatically calculated by adding the scores under each domain of care and dividing by the number of applicable elements.

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical performance reviews and MR/PIUs did not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of this activity is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain.

Appendix B. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

for Kaiser–Sacramento County

The table (grid) on the following page provides EQR recommendations from the July 1, 2010, through June 30, 2011, Performance Evaluation Report, along with Kaiser–Sacramento County's self-reported actions taken through June 30, 2012, that address the recommendations. Neither Health Services Advisory Group, Inc. nor any State agency has confirmed implementation of the actions reported by the plan in the grid.

Table B.1—Grid of Kaiser–Sacramento County's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	Kaiser–Sacramento County's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Ensure that grievance acknowledgement letters and NOA letters are sent out within required time frames.	As of May 2012, specific staff members have been designated as subject matter experts (SMEs). These SMEs are responsible for processing all Medi-Cal Plan Partner cases to further assure focused attention on meeting regulatory requirements for cases involving Medi-Cal members.
Focus efforts to improve the *AWC* measure.	Plan is above the MPL for this HEDIS measure. The following was included in the corrective action plans submitted until the MPL was achieved in reporting year 2011. Efforts during the PSER time period centered on identifying adolescents who were visiting their pediatric provider for any reason, in particular, an urgent care visit. By reviewing the electronic medical record, clinic staff was able to identifying members overdue for AWC and alerted the provider. If appropriate based on the patient's clinical presentation, the provider conducted the elements of a well visit. This workflow was done for commercial members, too, thereby standardizing practice and improving rates.
When implementing multiple interventions, Kaiser–Sacramento County should incorporate a method to evaluate the effectiveness of each intervention.	As the plan was not aware of this requirement during the PSER time period and all QIPs successfully passed validation, this can be considered for projects implemented in 2013.
Conduct another barrier analysis and identify new or revised plan-specific interventions to sustain the reduction of avoidable ER visits.	This collaborative was retired in 2011. Over the course of the project in QIP reports, the plan discussed the primary barrier to reducing avoidable rates. Shortly after the start of the QIP, a performance improvement project was implemented at three Sacramento area Kaiser ERs (subsequently spread to other KP ERs). The Physician-in-Triage PI project established a fast track triage process whereby all members were seen by an ER physician shortly after registration. Patients were triaged, treated, and discharged for most of the non-urgent conditions defined in Avoidable Visit diagnostic codes. With no copay for Medi-Cal members and this speedy process compared to waiting for a same- or next-day appointment in the medical office, there was no disincentive to going to the ER. Subsequently, pediatric office hours were reduced in favor of this workflow. As this workflow has been in place since 2009 and deemed preferable, there is no value in conducting another barrier analysis or revising/ implementing other interventions.
Evaluate the efficacy of the interventions for the *Childhood Obesity* QIP. The plan should use subgroup analysis to determine if initiatives are affecting the entire study population in the same way and evaluate the outcomes by gender, age, provider, etc., to identify any disparities that may exist within the study population in relationship to outcomes.	This QIP was retired at the request of HSAG in 2012. There was never any request for a deeper dive into the efficacy of interventions during the QIP or when it was retired. Based on a HEDIS measure, the only stratification at this point is by age group per the HEDIS specifications. If a deeper "dive" is required, the plan will not be able to do this until late February when the QI nurse returns from leave of absence.