DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS

FOLLOW-UP REVIEW REPORT

FOR A

NON-ROUTINE MEDICAL SURVEY

OF

KAISER FOUNDATION HEALTH PLAN, INC.

A FULL SERVICE HEALTH PLAN

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SECTION V: RECOMMENDATIONS

In accordance with section 1380(g), Department analysts offer advice and assistance to the Plan in the form of survey recommendations. The Plan is not required to respond to the Department's recommendations. These recommendations are not a statement of current Plan deficiencies. Survey recommendations are intended to alert the Plan to weaknesses in its operations that have the potential to become deficiencies in the future. Plan executive staff has been apprised of these issues and the possible negative impact to the Plan's operations. The Plan should review and evaluate recommendations and take action as appropriate. Recommendations pertain to both Kaiser North and Kaiser South unless otherwise noted.

Recommendation #1: Reduce the reliance on informal processes in Kaiser South to address and resolve reported quality issues.

Interviews revealed the Plan relies on informal discussions between Physicians and hospitals involving quality issues (e.g. off-line discussions of quality issues, extensive actions taken with limited documentation in formal committee minutes, etc.) making it difficult to substantiate and evaluate actions and to ensure consistent application across the system.

Formal QM program processes should be followed to ensure that quality issues do not become lost within the system, that documentation of issues and actions is properly maintained, and that these issues are included in tracking and analyses.

Recommendation #2: Revise policies and procedures and QM Program Documents to reflect current practices.

Update and revise the April 2008 policies and procedures and QM Program documents. Program structure, process and accountability changes have been implemented since 2008 pursuant to the Survey results. These changes have dealt with fundamental shifts in Plan accountabilities and local delivery system process standards for peer review and quality of service review. These changes are not reflected in policies and procedure documents which serve to guide staff and reinforce compliance efforts within daily operations.

The QM Program document continues to reflect the Plan's position that the responsibility for the program is dispersed among the three entities, rather than a delegated responsibility by the Plan to its separately contracted hospitals and medical groups, with clear delineation of those functions which it delegates and those functions that are not delegated.[11] For example, the

[11] Deficiency 2 in the Final Survey Report: In regard to the Health Plan's delegating its oversight of QM activities to its contracted Medical Centers and Medical Groups: The Plan failed to: (1) "inform each provider [Medical Center and Medical Group] of the plan's QA program, of the scope of that provider's responsibilities, and how it will be monitored by the Plan and (2) "have ongoing oversight procedures in place to ensure that providers [Medical Centers and Medical Groups]are fulfilling all delegated QM responsibilities."[Section 1370 and rule 1300.70(b)(2)(G)(1), rule1300.70(b)(2)(G)(3)]

acknowledgement of the delegation arrangement between the Plan, Medical Groups and Hospitals which outlined roles, responsibilities and expectations of the shared responsibility of the QI program was relegated to attachment #21 of the program document with minimal reference or incorporation into the body of the QM program document.

Recommendation #3: Develop mechanisms to ensure accurate severity scoring of quality issues.

In Cycle 2 of the Level 4 audit, the Plan removed the question that assessed whether the case presented the potential for underscoring the severity of the issue. During the Department's unannounced visits to individual Medical Centers, the question of underscoring the case severity was raised with each facility visited and the barriers in implementing a standard scoring methodology were assessed. The accurate assessment and severity assignment of each reported quality issue is essential to afford the Plan the ability to understand where problems occur and to put the Plan in a position to take swift action to improve services and delivery of care. The Plan should continue its efforts of oversight of case scoring and ensure that all cases reflect the scores as defined in policy. Once case review is completed, the Plan must require clear reasons and approve any proposed changes to the severity scores.

Recommendation #4: Strengthen independent analysis and oversight by Kaiser South (Regional/ Plan Level), through use of MIDAS system.

Kaiser South (Plan level) relies on individual Medical Center-generated reports to monitor peer review and quality activities and relies on data collected and assessed by quality staff employed by the Medical Centers. In contrast, Kaiser North (Plan level) pulls a uniform set of MIDAS data and produces its own regional reports to monitor Medical Center performance. The Northern California Regional Quality staff provides assistance in analyzing and assessing the data to facilitate review by Plan Management Teams. This enables Kaiser North's Quality Oversight Committee to have an independent and more objective source of information rather than relying on self-reported Medical Center information. Kaiser South should consider adopting Kaiser North's method of developing regional reports in order to generate more uniform and objective quality data.

Recommendation #5: Enhance quantitative and qualitative analysis of reported quality data to support accurate issue-spotting and conclusions.

The Department recommends the following to improve Plan analysis of data:

1) Question monitoring results of high-risk areas that show no or few quality issues over several months. It is very unusual for high-risk areas to have no cases meriting review for potential quality concerns over long periods of time. If this occurs, question data collection and deploy other forms of data capture to verify low numbers.

2) Do not report raw numbers without associated analysis of the numbers. The use of rates or percents instead of or in combination with raw numbers will facilitate comparisons and trending.

3) Discuss and evaluate the reporting timeframes, fluctuations in staffing resources and seasonality when evaluating the trends or changes over time. The Plan's reports must be accompanied by explanations for variations leading to root cause analysis of the issue, if needed.

4) Demonstrate thorough review of Medical Center reports by documenting the analysis and deliberation of the reports within meeting minutes.

Recommendation #6: Ensure that peer review and departmental review case summaries include all key facts of the case.

The level of documentation in case files continues to vary between minimal and specific. The Team found case files in which few medical facts were documented.[12] General issues including the member's age and diagnoses were missing, as well as pertinent lab values and other diagnostic information. It is understood that the original peer and/or departmental reviewer has access to the complete medical record. However, based on interviews with the Plan leadership and staff it was determined that the reviewers conducting Level 2, 3 and 4 audits only have access to the information in the file, not the complete medical record. That being true, it is difficult to understand how the latter reviewers can confirm a correct score without all pertinent data. Due to the reliance on peer review and departmental review for higher-level audits, the case summaries should be sufficiently detailed so that a reviewer can clearly discern whether the case was appropriately handled and scored. All quality issues raised should be thoroughly addressed, discussed and reflected in the documentation in the case file.

Recommendation #7: Ensure that rationales for scoring of peer and departmental issues are clearly documented and support the assigned score consistent with the Plan's policies and procedures.

The rationale for the assigned score should "stand on its own." Documentation of the score rationale was found to vary.

Lack of documentation as described in Recommendations #6 and #7 is of concern, particularly if documentation is limited in cases selected for Level 2-4 audits. Some of these audits rely solely on the information contained in the file. In order to determine whether the review score and rationale was appropriate, the auditors need to have a complete case summary. Therefore, if the

[12] Kaiser North had 7 peer review files out of 59 which were non-compliant with complete case summary and Kaiser South had 5 out of 59. Kaiser North had 8 out of 59 and Kaiser South had 3 out of 30 system review files which were non-compliant with complete case summary requirement. For the criteria related to identification and addressing of all issues, Kaiser North had 6 of 59 peer review files non-compliant, Kaiser South had 4 out of 59 peer review files, Kaiser North had 7 of 59 system review files and Kaiser South had 10 out of 59.

files, at the oversight level, are not documented completely or the documented rationale is questionable, it is unclear that the Plan can be confident it is conducting proper oversight.

Recommendation #8: **Continue to emphasize ongoing staff training on the identification of potential quality issues and their handling through peer review and system review processes.**

Over the past two years, the Plan has developed improved oversight tools. However, implementation of the review process at the facility level would continue to benefit from emphasizing process improvement which promotes a climate of accountability rather than blame for reported operational problems. Re-stating expectations for quality review, case scoring guidelines, audits and feedback to QM Departments and facilities will assist in addressing residual concerns regarding the quality process.