



Quality Improvement Program Description

Introduction

The mission of KYHC is to provide members the highest quality health care services at the lowest possible cost. KYHC is committed to improving the health status of the population it serves while delivering high quality cost-effective treatment in an environment that provides prompt access to services and continuous quality improvement. KYHC is dedicated to ensuring that each member receives the most appropriate care and treatment by the practitioner most qualified to meet the member's needs and preferences.

KYHC's programs are built on a foundation of dedication to high quality collaborative relationships with all stakeholders, and commitment to continuous improvement in care and service. KYHC shares responsibility with its practitioners, providers, community stakeholders and client organizations to provide effective, efficient and timely care and services. Collegial relationships are fostered within the care and service delivery continuum. KYHC's commitment to continuous improvement in care and services is the underpinning for the quality improvement program.

The quality improvement program description explicates the purpose, goals, objectives, scope, structure and processes of the quality improvement program. The purpose of the quality improvement program description is to articulate the mechanisms by which KYHC operationalizes quality improvement activities and fulfills its aim to sustain and improve the health status of members through continuous quality improvement processes.

Quality Improvement Program Mission

The mission of the quality improvement program is to provide the framework to systematically measure and analyze performance, contribute essential information to management decision-making and improve organizational functioning, structures and processes to improve outcomes for members. In this manner, the quality improvement program supports KYHC's mission to provide high quality health care services. KYHC's culture, systems and processes are structured around its mission to improve health care outcomes for all members.

Purpose

The purpose of KYHC's quality improvement program is to create a continuous quality improvement structure and environment that improves processes and systems, resulting in improved health outcomes for health plan members while exceeding customer expectations.

Goals

The goals of the quality improvement program are implemented in concert with KYHC's members, practitioners, providers, community stakeholders, and other health care partners. KYHC's primary quality improvement goal is to improve members' health status through a variety of meaningful activities implemented across all care settings and aimed at improving quality of care delivered and quality of services provided. Other goals are to:

- Deliver consistently high value, high quality health care that incorporates the special needs and preferences of members.
- Continuously improve the clinical care and service provided to members.
- Enhance the community's health status through wellness and preventive health programs for members.
- Pursue opportunities to improve the health status of members and target efforts to the needs of the population.
- Ensure that care and services are available and provided to members in a timely manner appropriate to the needs and preferences of the member.
- Ensure that care and services are coordinated between providers and across all delivery settings through the care management process.
- Establish collegial relationships with providers to achieve superior clinical and customer service outcomes.
- Provide exceptional customer service to internal and external customers that is individualized to the needs and preferences of the customer.

Objectives

The objectives of the quality improvement program are to:

- Maintain comprehensive, current and effective quality improvement policies and procedures to drive the continuous quality improvement process.
- Provide a system for identification and prioritization of opportunities for improvement.
- Measure performance in clinical and service areas using critical performance measures with established performance goals.
- Analyze performance data and identify opportunities to improve performance.
- Implement interventions to improve performance.
- Measure effectiveness of interventions to improve performance.
- Coordinate the quality improvement program with other organization activities and departments.
- Promote principles of prevention, early detection and cost effective utilization of facilities and services.
- Communicate results of quality improvement activities to KYHC's stakeholders, including members and practitioners.

KYHC provides services to a diverse population of different cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the

worth of the individual member and protects and preserves the dignity of each member. KYHC's has established a Cultural Competency Plan based on three frameworks: State definitions of cultural competence, Federal CLAS guidelines, and the Georgetown University National Center for Cultural Competence model. The Plan defines values and principles, and demonstrates behaviors, attitudes, policies and structures that enable staff and providers to work effectively across cultures. The QI Program actively supports the goals and objectives of the Cultural Competency Plan. Objectives to meet the cultural and linguistic needs of members are to:

- Analyze language line (interpreter services line) usage and use results to adjust staffing accordingly.
- Preferentially hire customer service representatives with language skills matching the membership.
- Adjust the network based on results of member demographic analysis which includes assessment of member cultural and linguistic needs and preferences.
- Obtain input from members regarding cultural and linguistic needs and preferences.
- Provide staff and practitioners with information, training and tools to foster culturally competent communication.
- Use practitioner and provider interviews to understand differences in care provided and outcomes achieved.

Objectives to serve members with complex health needs are to:

- Coordinate care for members who receive multiple services such as members receiving medical care from different providers for different conditions.
- Identify and reduce barriers to service for members with complex conditions.
- Provide case management teams that focus on identified high risk members such as members with metastatic cancers and members who have had organ transplants.

Scope

The scope of KYHC's quality improvement program is comprehensive and encompasses all clinical care and service aspects of the organization. The quality improvement program includes an array of indicators to measure critical clinical and service processes and outcomes. The quality improvement work plan delineates the critical performance measures that define the scope and range of the quality improvement program. Components addressed include:

- Accessibility of services.
- Availability of services.
- Clinical quality improvement.
- Service quality improvement.
- Member satisfaction.
- Practitioner satisfaction.
- Clinical practice guidelines.
- Preventive health guidelines.
- Continuity and coordination of care.
- Effectiveness of the quality improvement program.
- Patient safety.
- Utilization management processes.

- Utilization management outcomes.
- Inter-rater reliability.
- Practitioner performance.

Organizational Structure

KYHC's organizational structure is designed to facilitate the activities of the quality improvement program. The organizational structure is described in the following section.

Accountability

KYHC's Board of Directors is the governing body of the organization. The Board of Directors has ultimate responsibility for the quality of care and service delivered by KYHC. The Board of Directors:

- Approves the annual quality improvement program description.
- Approves the annual quality improvement work plan.
- Reviews the annual quality improvement program evaluation.
- Reviews other reports about quality improvement activities as provided by the Quality Improvement Committee.
- Ensures appropriate resources, support and systems necessary to implement the quality improvement program.

Chief Medical Officer

The Chief Medical Officer has substantial active involvement in implementation of the quality improvement program and reports results of QI activities and outcomes to the Board of Directors at least annually. The Chief Medical Officer has the responsibility and authority to implement the quality improvement program and oversees QI activities throughout the organization and within the subcommittees reporting to the Quality Improvement Committee (QIC). The Chief Medical Officer is the co-chairperson of the QIC and provides medical leadership to all aspects of the quality improvement program including coordinating resolution of outstanding issues pertaining to QIC recommendations with appropriate leadership staff. The Chief Medical Officer oversees the development or revision of clinical practice guidelines, medical necessity criteria, new technology assessment processes and performance and outcomes measures. The Chief Medical Officer is responsible for maintaining compliance with State, Federal and accreditation requirements and regulations.

Behavioral Health Director

Behavioral Health services are delegated to an NCQA-accredited MBHO, MHNet. The MHNet, Medical Director is a member of the QIC and has responsibility for oversight of the behavioral health aspects of the QI program.

Quality Improvement Director

The Quality Improvement Director is responsible for day-to-day implementation of the quality improvement program, serves as co-chairperson of the Quality Improvement Committee and operationalizes the quality improvement work plan. The Quality Improvement Director oversees development, implementation, review and revision of quality improvement policies and procedures; monitors data collection and aggregation

processes; prepares the annual quality improvement program evaluation in collaboration with the Chief Medical Officer; and maintains the quality improvement program description and work plan.

Quality Improvement Coordinators

The Quality Improvement Coordinators report to the QI Director and are responsible for data collection for various QI activities, data analysis, implementation of interventions to improve performance and management of the member and provider complaint process. Medical record reviews and HEDIS audits are included in their scope of work.

Functional Areas and Their Responsibilities

The Quality Improvement Department has overall responsibility for all QI activities. The QI Department has adequate staff to fulfill its role. Additional external resources such as quality improvement consultants and HEDIS auditors are available as needed. The QI Department staff report to the QI Director who reports to the Chief Medical Officer.

QI Department is responsible for:

- Maintaining a comprehensive QI Program Description that describes operation.
- Maintaining a detailed QI work plan that delineates KYHC's QI activities.
- Ensuing implementation of all QI activities.
- Coordinating input from other functional areas.
- Conducting or overseeing data collection for all QI activities.
- Preparing data displays including graphs and tables.
- Serving as a resource to all staff regarding QI matters.

Many other functional areas of KYHC are involved in aspects of, and provide support to, the QI Program. These areas include the following.

Clinical Operations is responsible for:

- Conducting pre-certification, concurrent and retrospective analysis of appropriateness of care and services.
- Tracking and trending utilization data.
- Completing an annual evaluation of utilization management activities.
- Overseeing case management activities including those for high risk members and members with complex health needs.
- Tracking and analyzing data regarding clinical outcomes.
- Ensuing outreach and care coordination activities for identified members.
- Fostering continuity and coordination of care.

Contracting/Provider Relations is responsible for:

- Managing communication with providers.
- Conducting non-clinical practitioner office site reviews.
- Maintaining provider contracts in full compliance with all accreditation and regulatory entities.



Credentialing is responsible for:

- Ensuring practitioners are initially credentialed and recredentialed every three years thereafter.
- Ensuring all facilities are initially assessed and reassessed every three years thereafter.
- Completing facility quality site visit assessments as appropriate.
- Taking actions when practitioner performance or quality issues are identified.

Customer Service is responsible for:

- Serving as first responders to member inquiries and resolving issues when possible or if not possible, for forwarding issues to designated staff to follow-up.
- Processing, to the extent possible, member complaints and appeals using established procedures.
- Documenting all member complaint and appeal data including: the nature of the complaint or appeal; the actions taken; and the appropriate complaint or appeal category.
- Immediately referring potential quality of care, clinically urgent, and member safety issue complaints and appeals to designated clinical staff.
- Measuring average speed of telephone answer and abandonment rate; analyzing results; taking action when performance does not meet standard; and reporting results to the Quality Improvement Committee.

Pharmaceutical Management is responsible for:

- Ensuring effective management of the formulary and authorization processes.
- Notifying providers of formulary updates and medication safety alerts.
- Overseeing the pharmacy benefits manager.
- Preparing recommendations to the P&T Committee.
- Providing data and information about drug utilization.

Information Technology is responsible for:

- Preparing reports to measure quality using data sources such as, but not limited to, claims, encounters, and utilization.
- Managing the Practitioner and Hospital Directories including regular updating when new information is obtained.

Committee Structure

KYHC's committee structure consists of a Quality Improvement Committee, Credentialing Committee, and Utilization Management Committee.

Quality Improvement Committee (QIC)

The Quality Improvement Committee oversees the development, implementation, evaluation and revision of the quality improvement program. The QIC has overall responsibility for coordinating all quality improvement activities throughout the organization. This includes quality improvement activities carried out by subcommittees and work groups of the QIC. The QIC meets monthly, reports as needed to the Board of Directors, and maintains written minutes of meetings that document deliberations,

actions, decisions and follow-up plans, if any. The QIC may designate subcommittees and work groups for specific functions. Such subcommittees and work groups report to the QIC at specified intervals.

The Quality Improvement Committee functions include:

- Reviewing annually, revising as needed, and approving the quality improvement program description, quality improvement work plan, quality improvement program evaluation and quality improvement policies and procedures.
- Identifying critical performance measures.
- Establishing performance goals.
- Analyzing and critically evaluating performance data and trends.
- Identifying opportunities for improvement based on performance data.
- Planning and overseeing implementation of interventions to improve performance based on analysis of performance data.
- Planning and overseeing activities to assess the effectiveness of interventions.
- Prioritizing quality improvement activities and efforts to use resources appropriately.
- Recommending policy decisions.
- Reviewing and approving clinical practice guidelines.
- Reviewing and approving preventive health guidelines.
- Developing and approving Disease Management programs.
- Developing and approving wellness programs.
- Reviewing and approving activities of QIC subcommittees and work groups.
- Coordinating quality improvement activities with other performance monitoring activities including credentialing and recredentialing and utilization management.
- Reviewing annually, revising as needed and approving confidentiality policies and procedures.
- Serving as KYHC's internal confidentiality committee.

The Quality Improvement Committee membership includes:

- The Quality Improvement Director, co-chairperson.
- The Chief Medical Officer, co-chairperson.
- The Behavioral Health Medical Director.
- The Director of CM/DM.
- The Quality Improvement Coordinators.
- At least 2 Network Practitioners.

The following subcommittees report directly to the Quality Improvement Committee:

- Credentialing Committee.
- Utilization Management Committee.
- Grievance and Appeal Committee.
- Physician Advisory Committee.
- Member Advisory Committee.

Credentialing Committee

The Credentialing Program is an integral component of the quality improvement process of KYHC. Credentialing is the first step in the quality management process for

practitioners. The intent is to ensure a high quality, responsive network of practitioners to deliver care to and meet the special needs and cultural preferences of the diverse population KYHC serves. Assessment is the first step in the quality management process for facilities. The intent is to ensure high quality service delivery in the full continuum of settings.

The Credentialing Committee oversees development, implementation and administration of the Credentialing Program. The Credentialing Committee is responsible for decisions about credentialing and recredentialing of practitioners and approving facilities for the network. Information about credentialing activities is shared with the Quality Improvement Committee. Activities around practitioner profiling and performance issues are coordinated by the Quality Improvement Director. The Credentialing Committee is fully described in credentialing policies and procedures.

The Credentialing Committee meets monthly and maintains written minutes of meetings that document deliberations, actions, decisions and follow-up plans, if any. The Chief Medical Officer is actively involved in the credentialing and recredentialing process.

The Credentialing Committee functions include:

- Making credentialing and recredentialing decisions for practitioners.
- Making decisions regarding inclusion of facilities in the network.
- Developing and modifying credentialing and recredentialing policies and procedures and overseeing their implementation.
- Reviewing the credentialing and recredentialing policies and procedures at least annually and making revisions as needed.

The Credentialing Committee membership includes:

- The Chief Medical Officer, chairperson.
- The Credentialing Director.
- The Clinical Director.
- Three network practitioners representing different areas of specialty.

Utilization Management Committee (UMC)

The Utilization Management Committee is responsible for development, implementation, administration, evaluation and revision of the care management program. The UMC oversees the process through which the care management plan is administered. The UMC meets monthly and maintains written minutes of meetings that document deliberations, actions, decisions and follow-up plans, if any. The UMC is fully described in utilization management policies and procedures.

The Utilization Management Committee functions include:

- Reviewing annually, revising as needed, and approving the care management plan, care management policies and procedures, and the care management program evaluation.
- Reviewing and approving medical necessity criteria.
- Reviewing individual cases as necessary.
- Reviewing and evaluating the medical necessity appeals process.

- Establishing utilization goals.
- Reviewing and analyzing utilization management data including readmissions; emergent, urgent and routine referrals; inter-rater reliability; and timeliness of utilization decisions.
- Analyzing provider's utilization patterns including referral trends, treatment patterns and inpatient admissions.
- Identifying opportunities for improvement based on utilization data.
- Implementing interventions to improve performance.
- Evaluating member and practitioner satisfaction with the utilization management processes annually.

The Utilization Management Committee membership includes:

- The Clinical Director, chairperson.
- The Chief Medical Officer, co-chairperson.
- Two Care Managers.

Grievance and Appeal Committee

The Grievance and Appeal Committee (GAC) is responsible for maintaining compliance with contractual, Federal, State and accrediting body requirements related to grievances and appeals. The GAC meets quarterly and maintains written minutes of meetings that document deliberations, actions, decisions and follow-up plans, if any.

The Grievance and Appeals Committee functions include:

- Tracking and analyzing member grievances and appeals.
- Performing quantitative and qualitative analysis of data when performance does not meet standards.
- Implementing actions to improve performance when opportunities are identified.

The Grievance and Appeals Committee membership includes:

- The Quality Improvement Director, chairperson.
- The Compliance Officer.
- The Member Services Director.
- The Appeals Coordinator.
- The QI Coordinator.

Provider Advisory Committee

The Provider Advisory Committee is an advisory committee to the Quality Improvement Committee. It meets semi-annually and provides input to the quality improvement program. The Quality Improvement Director summarizes the content of the Provider Advisory Committee input and submits the summary to the QIC.

The Provider Advisory Committee functions include:

- Evaluating provider and member satisfaction survey results.
- Formulating strategies for improving provider and member satisfaction based on the satisfaction survey data.
- Reviewing medical necessity criteria.
- Reviewing outcomes measures used in provider profiling.

- Informing KYHC about issues within the provider community.

The Provider Advisory Committee may provide input on relevant clinical issues including:

- Selection of clinical or service improvements.
- Design and implementation of quality improvement activities.
- Evaluation of quality improvement activities.
- Analysis of member and provider satisfaction survey results.
- Clinical practice guideline selection, implementation and evaluation.
- Activities to assess and improve access and improve access to care and service.
- Development of wellness programs.

The Provider Advisory Committee membership includes:

- The Chief Medical Officer.
- The Care Management Director.
- The Quality Improvement Director.
- The VP of Network Development.
- Three network practitioners.

Member Advisory Committee

The Member Advisory Committee is an advisory committee to the Quality Improvement Committee. It meets semi-annually and provides input to the quality improvement program. The Quality Improvement Director summarizes the content of the Member Advisory Committee input and submits the summary to the QIC.

The Member Advisory Committee functions include:

- Evaluating member satisfaction survey results.
- Formulating strategies for improving member satisfaction based on the satisfaction survey data.
- Evaluating complaint data and the effectiveness of the complaint resolution process.
- Informing KYHC about issues within the member community.

The Member Advisory Committee reviews and provides input on issues relevant to members including:

- Selection of clinical or service opportunities for improvement.
- Design and implementation of quality improvement activities.
- Evaluation of quality improvement activities.
- Development of Disease Management programs.
- Development of wellness programs.
- Member materials developed for education about clinical practice guidelines and other topics.
- Analysis of member satisfaction survey results.
- Assessment and improvement of access to care and services.
- Review of the quality improvement program.
- Review of member information for readability, ease of understanding and adherence to principles of readable design.

The Member Advisory Committee membership includes:

- The Director of Member Services.
- The Quality Improvement Director.
- Three members.

Quality Improvement Process

It is KYHC's view that all organizational systems and processes are interdependent. Because of this interdependence, KYHC's quality improvement program uses a disciplined, comprehensive approach that includes measurement of all organizational systems and processes. The quality improvement process is continuous and consistent throughout the organization.

Quality Improvement Principles

KYHC uses the following principles in its approach to quality improvement.

- Quality improvement is an organizational commitment.
- Quality is built into processes.
- Quality improvement focuses on processes and not people.
- Decisions are based on data.
- A scientific approach is applied to quality improvement activities that includes:
 - Establishing priorities.
 - Measuring performance.
 - Analyzing data.
 - Identifying opportunities for improvement.
 - Implementing interventions to improve performance.
 - Remeasuring to evaluate the effectiveness of interventions.

Critical Performance Measures

KYHC's quality improvement program includes a comprehensive array of clinical and service indicators that provide information about the systems, processes and outcomes of clinical care and service delivery. Explicit well-defined critical performance measures represent what is most important to KYHC in defining quality. The measures are developed using sound methodological principles. The performance data that are a result of measurement are reliable so that decisions can be made with confidence.

The demographic characteristics and health risks of the covered population are considered in establishing priorities for the development of critical performance measures. These indicators are related to the structures, processes or outcomes of care or service delivery. Indicators may be rate-based, for which performance is measured and tracked overtime; scalar, for which a scale such as temperature or satisfaction rating scale is used; or sentinel events that are intensively analyzed each time they occur. The critical performance measures are established with consideration of:

- High volume or high-risk diagnoses or services or special populations.
- Geographic-specific epidemiological and demographic data.
- Contractual and regulatory requirements.

The critical performance measures include services provided in institutional or facility settings, individual provider's offices, community settings, and within and across multiple care settings.

Continuous Quality Improvement Teams

Continuous quality improvement teams, multidisciplinary in structure, are engaged on a short-term task-focused basis. They are most frequently activated for indicator development, performance analysis and planning interventions. The focus is defined and specific. This is a parsimonious and effective method to utilize staff resources. The membership of the team depends upon the type of issue and task. Teams include individuals who are directly involved in the day-to-day management of the issue to provide a full understanding of the system and to plan appropriate measurement steps and effective interventions to improve performance. It is the personal, individual, front line experience with the topic under review that makes members valuable to the team process. Staff most closely involved with a process understand it best and know the system capabilities.

The meeting frequency and longevity of the team are variable and dependent on the task and goals of the team. The team provides written reports or meeting minutes to the designated committee on a specified basis.

Measurement of Critical Performance Measures

A sound, rigorous measurement methodology is developed and followed for each critical performance measure. Performance goals for each critical performance measure are established by the Quality Improvement Committee. Performance goals may be based on historical performance, normative data or industry benchmarks. The initial performance goal for an indicator is often to "obtain baseline data." Performance goals specify the type of change considered an improvement.

Some indicators, although they have sustained acceptable levels of performance and variation, will always be measured because of the importance of knowing that performance is maintained or because of reporting requirements. Efforts to further improve performance may require systemic changes that are not considered feasible. The performance goal in these instances may be to continue the same performance in subsequent measurement cycles. Other indicators may be deleted from the quality improvement program because they provide data that the QIC considers less valuable than alternative uses of the resources involved.

Performance data for critical performance measures are collected, aggregated and presented to the QIC for analysis on a rolling schedule. Multiple data points are displayed together on graphs to show historical performance and facilitate data analysis and trending. Each analysis includes evaluating the effectiveness of previous interventions. This part of the analysis influences the next step in planning. The entire process is conducted as close in time as possible to the events being measured. Interventions are planned and implemented based on the data analysis.

Continuous quality improvement is realized when data are collected and analyzed; interventions are planned and implemented; measurement is repeated; and performance continually improved. The cycle is continuous and maintained on a schedule that is not limited by the end of the calendar year.

Behavioral Health

KYHC delegates mental health and chemical dependency services to an NCQA-accredited MBHO, MHNet. Behavioral health services are closely aligned with disease management for specified populations such as diabetics, asthmatics and post-partum women. The quality improvement program includes specific measurement activities to evaluate behavioral health care accessibility and availability, member experience and coordination between medical care and behavioral health care services.

The behavioral health program delegate is responsible to provide all aspects of behavioral health care services to KYHC member's, coordinate behavioral health care with behavioral health and medical practitioners and perform credentialing of behavioral health practitioners including evaluation of behavioral health facilities. Annually, the QIC reviews and approves the delegate's QI Program Description. The behavioral health aspects of the QI program are contained in the delegate's QI program description which is incorporated by reference. The QIC reviews reports, at least semiannually, from the delegate about all delegated quality improvement activities.

Patient Safety

KYHC is committed to improving member safety throughout the network. Many of the critical performance measures include inherent member safety issues which are considered when analyzing data. Activities associated with these measures include:

- Review of member complaints including quality of care complaints.
- Investigation of sentinel and adverse events.
- Assessment of after-hours office coverage for PCPs.
- Assessment of practitioner compliance with KYHC's access and availability standards.
- Review and member experience feedback.
- Actions to improve continuity and coordination of care between medical and behavioral health providers and between all facility settings.
- Analysis of HEDIS results.

Additional patient safety activities are:

- Analysis of satisfaction data to identify patient safety issues.
- Follow-up and reminder activities for members in Disease Management programs.
- Practitioner office site visits which assess various patient safety issues, particularly environmental safety.
- Notification to members of recalled medications by pharmacy staff and the pharmacy benefits manager.
- Availability of member safety information on KYHC's web site.

KYHC collaborates with network practitioners and providers fostering a supportive environment to assist them in improving member safety in their individual work environment. Treatment record documentation guidelines, available to practitioners on KYHC's web site or in paper copy, by request, include measures of safety such as continuity and coordination of care, legibility and follow through of testing. When record review is conducted, practitioners receive the results to improve safety in these areas. The member and provider newsletters contain additional information about safe practice protocols and procedures. Such information is also available on KYHC's web site.

Identified safety issues are tracked by the Quality Improvement Department until satisfactory resolution. Member safety issues identified initially as quality of practitioner office site complaints are also tracked by the Credentialing Department to determine if the site visit threshold is triggered. When this happens, an office site visits conducted and actions taken as appropriate to the findings.

Quality Improvement Work Plan

The quality improvement work plan is the schedule of activities for the quality improvement program. The quality improvement work plan includes the main tasks that cover the scope of the quality improvement program including quality of clinical care, quality of service, and safety of clinical care; yearly objectives; yearly planned activities; time frames for completion of each task; the person responsible for the task; monitoring of previously identified issues; and scheduled evaluation of the quality improvement program. It is prepared as a calendar with a rolling schedule. At any point in time a full year of activities is visible. Quality improvement activities and indicators are ongoing and continuous. They are not discontinuous at the end of the year.

The quality improvement work plan is not a static document. It is approved annually by the QIC but is revised and developed more fully in response to the analysis of performance data, interventions, remeasurement timeframes and the addition and deletion of indicators on an ongoing basis.

The Board of Directors approves the quality improvement work plan annually.

Annual Evaluation

The Quality Improvement Director develops the annual quality improvement program evaluation. The QIC reviews and critically evaluates the annual quality improvement program evaluation. The annual quality improvement program evaluation includes:

- A description of completed and ongoing quality improvement activities that address quality and safety of clinical care and quality of service.
- Trended performance data from indicators to assess the quality and safety of clinical care and quality of service.
- An analysis of demonstrated improvements in care and service.
- An evaluation of the overall effectiveness of the quality improvement program including progress toward influencing safe clinical practices throughout the network.



The quality improvement program evaluation is reviewed by the Board of Directors.

Delegation

KYHC delegates behavioral health care services and quality improvement functions to an NCQA-accredited MBHO, MHNet.