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QUALITY MANAGEMENT AND IMPROVEMENT (QMI) OVERVIEW

HPSJ is accredited by the National Committee for Quality Assurance (NCQA) which demonstrates a commitment to quality management and continuous improvement. HPSJ staff members, Providers, and representatives from the communities work continuously to meet the highest goals and objectives in health care delivery and quality.

Our Quality Management and Improvement (QMI) Program supports our mission through the development and maintenance of a quality-driven Provider network. The QMI program is a coordinated, comprehensive, and continuous effort to monitor and improve Member safety and performance in all care and services provided.

DEFINITION OF QUALITY

Our definition of quality is an extension of the HPSJ vision that is "**STEEEP**" in Quality.

S - Safe:	Avoiding injuries to Members from the care that is intended to help them
T - Timely:	Reducing waits and sometimes harmful delays for both those who receive and those who give care
E - Effective:	Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse respectively).
E - Efficient:	Avoiding waste, including waste of equipment, supplies, ideas, and energy
E - Equitable:	Providing care that doesn't discriminate because of gender ethnicity, geographic location, socioeconomic status, or any other classifications prohibited by State or federal law.
P - Patient Centered:	Providing care that is respectful of and responsive to individual Member preferences, needs, and values and ensuring that Member values guide all clinical decisions.

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SCOPE OF QMI PROGRAM

The QMI program monitors and improves an array of indicators to measure critical clinical and service processes and outcomes. Components addressed include:

- Accessibility of services
- Availability of services
- Clinical quality improvement
- Service quality improvement
- Adverse outcomes/sentinel events
- Member satisfaction with medical and behavioral healthcare
- Provider satisfaction
- Best practices (*Clinical Practice Guidelines*)
- Continuity and coordination of care
- Effectiveness of the quality improvement program
- Member safety

Other areas that have impact on the QMI Program include:

- Provider credentialing and recredentialing
- Utilization management processes
- Utilization management outcomes
- Inter-rater reliability
- Provider performance
- Pharmacy management
- Facility site reviews

QUALITY MANAGEMENT AND IMPROVEMENT (QMI) PROCESS

The QMI 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. The quality indicators emphasize areas representing high risk, high volume, specific populations, and specific conditions. Indicators are developed with input from the Chief Medical Officer (CMO) and the Quality Management and Utilization Management (QMUM) Committee which include key members of the Provider community. These indicators include, but are not limited to:

- All cause hospital readmissions
- Emergency room (ER) utilization
- Pediatric asthma acute care admissions

QMI COMMITTEES AND SUBCOMMITTEES

The key to HPSJ's quality management success is integration of information. HPSJ's committees may function separately but it is an expectation that data and information be readily available to and from all who are actively involved in HPSJ's performance improvement processes. Committee information and data is validated, coordinated, aggregated, communicated, reported, and acted upon in a timely expedient manner to ensure success with all performance improvement and quality initiatives. All committee members are required to sign in for each meeting and sign an annual "Conflict of Interest" statement. Committee members cannot vote on matters where they have an interest and must abstain until the issue has been resolved. Written minutes are maintained by each committee for each meeting. Many of the HPSJ QMI committees require the participation of Providers.

Quality Management and Utilization Management (QMUM) Committee

The QMUM Committee reports to the Commission and is chaired by the CMO, or the Medical Director in the absence of the CMO. Quality improvement subcommittees that report to the QMUM Committee include:

- Peer Review and Credentialing
- Grievance and Appeals
- Oversight

The QMUM Committee is responsible for the implementation and ongoing monitoring of the Quality Management (QM) program. The QMUM Committee:

- Approves the annual QMI Program Description and Evaluation
- Recommends policy decisions
- Reviews, analyzes, evaluates, and makes recommendations regarding the progress and outcome of quality improvement (QI) projects and activities
- Ensures that quality performance standards are met and makes recommendations for improvements
- Institutes necessary actions and ensures follow-up according to plan
- Assists in establishing the strategic direction for all quality initiatives

- Receives subcommittee reports, identifies performance improvement opportunities, and makes recommendations to be incorporated into the QI work plan
- Ensures Provider communication, education and follow-up related to Quality of Care issues
- Ensures Provider participation in the QM program through planning, design, implementation, or review
- Confirms and reports to the Commission that HPSJ activities comply with all state, federal, regulatory, and NCQA standards
- Reports to the Commission any variance from quality performance goals and the plan to correct
- Submits to the Commission approved, signed minutes reflecting the committee decisions and actions of each meeting
- Presents to the Commission an annual reviewed and approved *QM Program Description and Work Plan* and prior year evaluation
- Annually reviews and approves medical review criteria and *Clinical Practice Guidelines*
- Oversees QI activities that validate quality management effectiveness through customer feedback reporting including:
- Provider and Member satisfaction/experience surveys
- Reviews and approves the annual Healthcare Effectiveness Data and Information Set (HEDIS) and Managed Care Accountability Set (MCAS) rates and provides feedback about improvement initiatives
- Reviews and approves the annual Consumer Assessment of Health care Providers and Systems (CAHPS) survey results and provides feedback about improvement initiatives
- Reviews and approves the annual Behavioral Health Member Experience survey results and provides feedback about improvement initiatives.
- Promotes education activities and continuing education unit (CEU) programs on QI for Providers
- Maintains compliance with standards for mandated reporting of diseases or conditions to the local health department

Committee members include:

- Physicians specializing in:
    - Obstetrics/Gynecology
    - Podiatry
    - Family Practice
    - General Surgery
    - Psychiatry

- Pediatrics, or
- Internal Medicine

- Practitioners:
  - RN Clinical Director Regional Center
- Community Partners
  - Deputy Director, Standards & Compliance San Joaquin General Hospital
- HPSJ Staff:
  - Director, Quality
  - Director, HEDIS and NCQA
  - Director, Care and Utilization Management
  - Director, Clinical Analytics
  - HEDIS and NCQA Manager
  - QM Supervisors
  - Manager of Case Management
  - Utilization Management Supervisor
  - Concurrent Review Manager
  - Health Education and Population Health Manager
  - Grievance and Appeals
  - Lead Grievance and Appeals Coordinator
  - Lead Credentialing Specialist
  - Credentialing Specialist
  - Director, Provider Relations
  - Director, Customer Service
  - Compliance Officer
  - Administrative Assistant

Quality Operations Committee (QOC)

The QOC is designated by the HPSJ's executive team to provide oversight and guidance for organization-wide quality and risk management initiatives and activities performed by HPSJ's quality management sub-committees to the Quality Management Utilization Management (QMUM) Committee. The QOC develops and recommends policies, analyzes and evaluates the progress, results, and outcomes of all quality improvement activities, implements needed actions, and ensures appropriate and timely follow-up.

The QOC strives to improve the quality of health care and service by developing, implementing, and evaluating processes, programs, and measurement activities and by making recommendations to the QMUM Committee. These activities include development and oversight of:

- NCQA
- HEDIS
- Quality Improvement Projects (PIP), and PDSAs
- Review and approval of all quality improvement corrective action plans
- Wellness and preventive health programs
- Health Education, and Health promotion actions
- Population Health Management
- Policy and procedures
- Member and Provider experience survey results
- Provider access and availability
- Network adequacy
- Grievances and Appeals
- Quality Improvement Projects (QIP)
- Risk management
- Review and approval of all quality improvement corrective action plans
- Utilization management
- Wellness and preventative health programs
- Health education standards/guidelines
- Policy and procedures
- Member and Provider experience survey results
- Provider access and availability
- Network adequacy
- Appeals and grievances
- Delegation oversight

The QOC generally meets every other month, with a minimum of four (4) meetings per year. The QOC reports to the QMUM Committee by summary report no less than quarterly. The QOC submits to the QMUM Committee approved, signed minutes reflecting the committee decisions and actions of each meeting.

The QOC is chaired by the Director of Quality and Utilization Management. The Committee Chair facilitates and manages the committee meetings. The Chief Medical Officer (CMO) serves as the committee sponsor.

Committee members include, but are not limited to:

- Chief Medical Officer (CMO)
- Chief Operating Officer (COO)
- Compliance Director
- Medical Director or designee
- Director of Provider Services
- Director of Utilization and Case Management
- Director of Clinical Programs, Analytics, and Pharmacy

Ad Hoc members of the QOC include:

- Director of Claims
- Director of IT
- Director of Marketing
- Director of Finance

Peer Review and Credentialing Committee (PR&CC)

The PR&CC is a "medical Peer Review" committee. PR&CC members are appointed by the Commission to which the committee also reports. The PR&CC is chaired by the CMO and is composed of Providers representing primary and specialty care, as well as other health care practitioners. The Committee meets at least quarterly and reports to the QMUM Committee.

The PR&CC:

- Oversees and evaluates HPSJ's credentialing and recredentialing process for evaluating and selecting Providers
- Reviews the qualifications of new and continuing Providers
- Ensures a fair and effective Peer-Review process to make recommendations regarding credentialing decisions
- Reviews Provider quality service and performance data, including Member complaints, Facility Site Reviews, and access and availability studies and reports, and identifies opportunities for improvement
- Determines whether health care services were performed in compliance with standards of practice and directs corrective action measures when standards are not met
- Evaluates and makes recommendations on all Provider adverse actions and takes appropriate disciplinary action against Providers who fail to meet established standards and/or legal requirements as appropriate

- Ensures and oversees a formal and objective Provider appeal process
- Submits to the Commission approved, signed minutes reflecting the committee decisions and actions of each meeting

Grievance and Appeals (G&A) Committee

The Director of Quality (DQ) serves as chair of the G&A Committee. G&A Committee members are appointed by the DQUM. The G&A Committee meets at least quarterly and reports to the QMUM Committee. Committee members include the:

- Grievances
- Director of QM
- CMO/Medical Director
- Appeals Nurse
- QM Nurse
- UM
- Chief Compliance Officer or designee
- Provider Services Director

Ad hoc members of the G&A Committee include representatives from the following departments:

- Pharmacy
- Human Resources
- Claims

The G&A Committee:

- Oversees and ensures the integrity of the grievance and appeal process, including tracking for timeliness and resolution
- Evaluates grievances for potential quality issues (PQIs).
- Reviews and evaluates grievance and appeals (G&A) trend reports and Member communications; identifies and makes recommendation for improvements
- Ensures compliance with regulatory and contractual requirements
- Submits to the QOC and QMUM Committee approved, signed minutes reflecting the committee decisions and actions of each meeting

Health Education Committee (HEC)

Membership of the HE Committee is dependent upon the current needs of HPSJ health education programs. These programs go under evaluation by the HPSJ internal Health Educator. HE Committee Members are able to discuss and provide resources, health education classes, and other community services that are beneficial to HPSJ members. The Committee is meant to foster partnerships and garner resources in Stanislaus and San Joaquin counties and serves as a central location to discuss health education initiatives between local community-based organizations, health clinics, and private entities. HPSJ's Health Educator serves as the HE Committee coordinator. The HE Committee meets bi-monthly and reports to the QOC Committee.

Committee members include, but are not limited to:

- Network physicians
- Public health nurses and Education Program Coordinators
- Advice Line nurses
- Community Health Educators
- School district Health Services Coordinators
- Disease Management Specialists

The HEC :

- Assesses the health and safety education needs of the Member population
- Makes recommendations on health promotion and education efforts that assist Providers with population management and Members with self-management
- Analyzes results of customer feedback information; identifies and makes recommendations for opportunities for improvement
- Evaluates and make recommendations on language and cultural appropriateness of all Member education materials and communications

Compliance Committee (CC)

- The CC is appointed and chaired by the Chief Compliance & Privacy Officer, and reports to the HPSJ CEO and Board of Directors. Internal departments represented as members of the CC include:
- Chief Financial Officer
- Chief Information Officer
- Chief Medical Officer

Ad Hoc members of the CC include:

- Security Officer
- Marketing
- Human Resources
- Claims Operations
- Compliance
- Delegation Oversight
- Information Technology
- External Affairs
- Customer Service
- Finance
- Pharmacy
- Provider Services/Contracting
- Quality Management
- Utilization/Care Management

The CC is charged with assisting the Health Commission Board of Directors in overseeing HPSJ's Compliance Program with respect to:

- a. Compliance with the Department of Health Care Services (DHCS) contract, laws and regulations applicable to regulatory requirements
- b. Compliance with policies, as applicable to the Medi-Cal program, by employees, officers, directors, and other agents of the company; and
- c. Measures that prevent and detect, and correct fraud, waste and abuse or other incidents non-compliance.

Community Affairs Committee (CAC)

CAC members (including a Commissioner, a Provider, and HPSJ Members) are appointed by the Commission. Factors such as ethnic representation, demography, occupation, and geography are considered in the selection of the committee's members. At least fifty percent (50%) of the CAC is comprised of HPSJ Members.

The CAC reports directly to the Commission through the Chief Medical Officer. It establishes and monitors HPSJ's public policies that govern:

- Quality of Provider facilities
- Access standards

- Transportation availability
- Language requirements
- Cultural issues
- Member health education needs

The CAC also reviews and makes recommendations on HPSJ's:

- Financial data
- Monthly Member grievance report
- Grievance resolution reports
- Enrollment/disenrollment reports
- Health education activity

The CAC submits to the Commission approved, signed minutes reflecting the committee decisions and actions of each meeting.

Pharmacy and Therapeutics Advisory (P&TA) Committee

The P&TA Committee is chaired by the Director of Pharmacy and is comprised of in-house pharmacists and pharmacy Providers, PCPs, and Specialists. The P&TA Committee meets quarterly and reports to the Commission.

The P&TA Committee:

- Reviews, oversees, and approves HPSJ's prescription drug formulary
- Identifies processes to evaluate pharmacy safety and effectiveness
- Ensures the reliable function and maintenance of a notification system for drug alerts
- Develops, approves, and maintains pharmacy criteria, policies and procedures that ensure safe and effective formulary management and authorization processes
- Reviews pharmacy data and reports and makes recommendations for improvement
- Establishes and oversees specialty advisory panels, as necessary, to provide expert opinion on clinical matters for P&TA Committee consideration
- Develops and approves Member and Provider education to address patient safety
- Oversees the Pharmacy Benefit Manager (PBM) to ensure practices meet HPSJ's quality standards
- Submits to the Commission approved, signed minutes reflecting the committee decisions and actions of each meeting

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NETWORK PROVIDER COMMITTEE PARTICIPATION

Contracted providers are expected to cooperate with HPSJ quality activities to improve the quality of care and service and member experience. Cooperation includes collection and evaluation of data and participation in HPSJ's QI programs. Practitioners understand that HPSJ may use practitioner performance data for quality improvement activities.

All Providers who participate on our QMI committees or subcommittees receive a stipend for each meeting attendance. If you have an interest in being a participant on one of these committees, please call the CMO at (209) 461-2276

QUALITY OF CARE ISSUES

Potential Quality of Care issues may include any of the following types of cases:

- An issue that reflects a health care delivery system problem
- A clinical issue or judgment that affects a Member's care and has the potential for mild to moderate adverse effect
- A clinical issue or judgment that affects a Member's care and has the potential for serious adverse effect
- A clinical issue with a significant outcome, including:
    - Unnecessary prolonged treatment, complications, or readmission; or,
    - Member management or lack of treatment that results in significantly diminished health status, impairment, disability, or death
- An unexpected occurrence involving death or serious physical or psychological injury
- A service issue resulting in inconvenience or dissatisfaction of the Member
- A service issue resulting in the Member seeking a change of Provider or disenrollment from a health network
- Unexpected death

MONITORING OF QUALITY-OF-CARE ISSUES

HPSJ has a process for identifying and receiving reports of potential Quality of Care issues. HPSJ uses licensed personnel to perform case reviews, investigate potential Quality of Care issues, and determine the severity of the issue. Based upon these investigations, HPSJ will determine the appropriate follow-up action required for individual cases. HPSJ will also aggregate potential Quality of Care issues data to help identify problems within the Provider network.

REPORTING A POTENTIAL QUALITY OF CARE ISSUES (PQI)

Members, Providers, and HPSJ staff may report PQI issues. A PQI can be reported to a Quality Management Nurse using the Administrative or Clinical PQI report form *Clinical Potential Quality Issue Report Form*. Providers and Members can also report PQI issues by contacting the Customer Service Department at (209) 942-6320 or (888) 936-7526.

Processing of PQI

- Upon receipt of a *Potential Quality Issue Report Form*, HPSJ Quality Management (QM) staff will date stamp, log, and document/evaluate the reasons/screening criteria for PQI and ensure that all supporting documentation is gathered and included.
- PQIs are prioritized based on the urgency of review.
- The QM nurse initiates an investigation of the PQI by requesting and reviewing pertinent medical records and eliciting input from Member and Providers involved.
- Once all information is received, non-urgent PQIs are processed within 30 days.
- All PQIs are reviewed by the Medical Director or designee to substantiate if the case can be closed or is determined to be a quality issue.
- PQIs are assigned an action code directing the course for resolution and/or escalation to QMUM Committee and/or PR&CC review.

Communication to Provider or Party Filing the Complaint

- Each PQI is reviewed by a Medical Director who designates an action code that indicates requirement to complete Provider notification by letter.
- PQIs that are presented to QMUM and or PR&CC are reviewed by committee members for any recommendations to provide notification to the Provider.
- Member requests for notification are reviewed by the HPSJ Compliance Department for approval prior to any Member notification.

HEALTH CARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

HEDIS consists of a set of performance measures utilized by health plans to compare how well a plan performs in the following areas:

- Quality of care
- Access to care
- Member satisfaction

Improving a practice's HEDIS scores has benefits for Providers and Members. Consistently

performing well in HEDIS measures can help save Providers time while also potentially reducing health care costs. By proactively managing Members' care, Providers are able to effectively monitor Members' health, prevent further complications and identify issues that may arise with their care. Providers may also benefit financially because HPSJ currently provides financial incentives based on Provider's HEDIS scores. HPSJ has tools that can be made available to PCPs to increase and improve HEDIS measures. Please contact the Provider Services Department at (209) 942-6340 for information on HEDIS tools and incentives.

TIPS FOR IMPROVING HEDIS SCORES

- Keep accurate, legible, and complete medical records for all Members. Each document in the medical record must contain the Member name and DOB to be acceptable for HEDIS
- If paper charts are used, document the Member's full name and DOB on the front and back of every page.
- Send out reminders and follow up with Members for annual preventative services.
- Encourage Members to keep appointments for appropriate preventive services.
- Document in the Members chart when preventative or other services are declined.
- Make sure that staff is familiar with HEDIS measures to understand which measures health plans are required to report.

CLINICAL PRACTICE GUIDELINES

Providers can access *Clinical Practice Guidelines* on the HPSJ website at www.hpsj.com. *Clinical Practice Guidelines* are guidelines about a defined task or function in clinical practice, such as desirable diagnostic tests or the optimal treatment regimen for a specific diagnosis; generally based on the best available clinical evidence.

MEMBER SATISFACTION SURVEY

Annually HPSJ administers an industry standard survey instrument utilizing a contracted certified survey vendor targeting a statistically significant number of members enrolled with HPSJ. The questions are carefully selected to measure access, quality, and satisfaction with HPSJ. The results are then analyzed by the HPSJ HEDIS and Accreditation team and shared with the executive team as well as various departments within HPSJ. Action plans are formalized into service expectations for the following year. The results are then measured each year to document HPSJ's commitment to serving our communities health care needs.

PROVIDER SATISFACTION SURVEY

Each year HPSJ Providers are surveyed by an independent survey company that surveys all PCPs, a random selection of Specialists, and a random selection of ancillary providers. Results are carefully studied by both the HPSJ executive team and various departments within HPSJ. Action

plans are incorporated into goals and objectives for the following year to address issues identified by the Provider community.

PATIENT SAFETY

HPSJ is committed to a culture of patient safety as a high-level priority. On an ongoing basis, HPSJ fosters a patient safety culture that is communicated throughout the organization. HPSJ is committed to developing and implementing activities to improve patient safety and clinical practice.

The first goal of the patient safety initiative is to avoid injuries to Members resulting from the care that is intended to help them. HPSJ defines Patient Safety as "freedom from accidental injury caused by errors in medical care." Medical errors refer to unintentional, preventable mistakes in the provision of care that have actual or potential adverse impact on Members.

The second goal of our patient safety initiative is to establish and maintain a blame-free environment where Members, their families, Providers, and HPSJ staff, are able to report errors or close calls without fear of reprisal and where errors can be viewed as opportunities for improvement.

HPSJ's commitment to patient safety is demonstrated though the identification and planning of appropriate patient safety initiatives. The patient safety initiatives promote safe health practices through education and dissemination of information for decision-making and collaboration between our practitioners and members, and through:

- Evaluation of pharmacy data for provider alerts about drug interactions, recall, and pharmacy over and under-utilization
- Education of Members regarding their role in receiving safe, error free health care services through the member newsletter and the HPSJ website
- Education of Members and Providers regarding the availability and use of clinical practice guidelines
- Education of Providers regarding improved safety practices in their practice through the Provider newsletter, member profiles, and the HPSJ website
- Evaluation for safe clinic environments during office site reviews and dissemination of information regarding Facility Site Review findings and important safety concerns to members and providers
- Education to Members regarding safe practices at home through health education and incentive programs
- Intervention for safety issues identified through case management, care management, and the grievance and clinical case review processes

- Evaluation and analysis of data collected regarding hospital activities relating to member safety, including but not limited to the rate of hospital-acquired infections and all cause readmissions within thirty (30) days of discharge
- Collaboration and exchanges of admission notes and discharge summary between the Hospital and PCP when Members are admitted to the acute care facility
- Dissemination of information to Providers and Members regarding activities in the network related to safety and quality improvement
- Monitoring Hospital safety scores using publicly reported *Leapfrog* data: www.leapfroggroup.org/cp

HPSJ receives information about actual and potential safety issues from multiple sources including, Member and Provider grievances, potential quality issues (PQI), pharmacy data, and through Facility Site Review (FSR) Corrective Action Plans.