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SECTION 13: QUALITY MANAGEMENT & IMPROVEMENT (QMI)

QUALITY IMPROVEMENT AND HEALTH EQUITY (QIHE) OVERVIEW

Health Plan is accredited by the National Committee for Quality Assurance (NCQA) which demonstrates a commitment to quality management and continuous improvement. Health Plan 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 Improvement and Health Equity (QIHE) Program supports our mission through the development and maintenance of a quality-driven Provider network. The QIHE program is a coordinated, comprehensive, equitable, 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 evidence 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.

SECTION 13: QUALITY MANAGEMENT & IMPROVEMENT (QMI)

SCOPE OF QIHE PROGRAM

The QIHE program monitors and improves an array of indicators to measure critical clinical and service processes and outcomes while removing barriers to care and meeting the cultural, linguistic diverse preferences and needs of Members. 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 medical and behavioral care
- Effectiveness of the quality improvement and health equity program
- Member safety

Other areas that have impact on the QIHE Program include:

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

QUALITY IMPROVEMENT AND HEALTH EQUITY (QIHE) PROCESS

The QIHE 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 risk and need across the continuum of care. 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
- Ambulatory care utilization
- Primary and Urgent care utilization

QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE (QIHEC) AND SUBCOMMITTEES

The key to Health Plan's quality management success is integration of information. Health Plan'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 Health Plan's performance improvement processes. Committee information and data is validated, coordinated, aggregated, communicated, reported, and acted upon in a timely manner to ensure success with all performance improvement and quality initiatives. All committee Members are required to note their attendance 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 Health Plan's QIHE committees require the participation of Providers.

Quality Improvement and Health Equity Committee (QIHEC) – Governing Board of Quality and Health Equity Transformation Program (QIHETP)

The Quality Improvement and Health Equity Committee (QIHEC) is responsible for the implementation and ongoing monitoring of the Quality Improvement and Health Equity Transformation Program (QIHETP). The QIHEC:

- Approves the annual QIHETP Description, Annual Plan and Evaluation
- Recommends policy decisions or oversees recommendations and revisions to the Quality Improvement and Health Equity Activities
- Reviews, analyzes, evaluates, and makes recommendations regarding the progress and outcome of quality improvement QI and Health Equity projects and activities
- Ensures that quality performance standards are met and makes recommendations for improvements
- Institutes actions to address performance deficiencies, identifies necessary actions and ensures follow-up according to plan
- Assists in establishing the strategic direction for all quality and healthy equity initiatives
- Receives subcommittee reports, identifies performance improvement opportunities, and makes recommendations to be incorporated into the QIHETP work plan
- Ensures Provider communication, education and follow-up related to Quality of Care

issues

- Ensures Provider participation in the QIHETP through planning, design, implementation, or review
- Confirms and reports to the Commission that Health Plan 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 *QIHETP Description and Work Plan* and prior year evaluation
- Annually reviews and approves medical review criteria and *Clinical Practice Guidelines*
- Oversees QI and Health Equity 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
- Review and provide feedback on Quality and Equity policies

Committee Members include:

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

  - Pediatrics
  - Internal Medicine

- Practitioners:
  - RN Clinical Director Regional Center
- Community Partners
  - Deputy Director, Standards & Compliance San Joaquin General Hospital
- Health Plan Staff:
  - Compliance Officer
  - Executive Director, Clinical Operations
  - Director, Pharmacy
  - Director, Provider Relations
  - Director, Customer Service
  - Director of Delegate and Provider Relations
  - Director, Compliance
  - Director, Quality
  - Director, HEDIS and NCQA
  - Director, Utilization Management
  - Director, Case Management
  - Director, Clinical Analytics
  - HEDIS and NCQA Manager
  - QM Manager
  - Manager of Case Management
  - Concurrent Review Manager
  - Health Education and Population Health Manager
  - QM Supervisors
  - Utilization Management Supervisor
  - Administrative Assistant

Quality Operations Committee (QOC)

The QOC is designated by Health Plan's executive team to provide oversight and guidance for organization-wide quality activities performed by Health Plan's Quality Improvement and Health Equity Transformation Program sub-committees to the Quality Improvement and Health Equity 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 QIHETP Committee. These activities include development and oversight of:

- National Committee for Quality Assurance (NCQA) Health Plan Accreditation
- HEDIS and MCAS
- Quality Improvement Projects (QIP), and Plan Do Study Act (PDSA) initiatives
- Strength, Weakness, Opportunity and Threat (SWOT) initiatives
- Review and approval of all quality improvement corrective action plans (CAP)
- Wellness and preventive health programs
- Health Education, and Health promotion actions
- Population Health Management
- Member and Provider experience survey results
- Provider access and availability
- Network adequacy
- Grievances and Appeals
- Performance Improvement Projects (PIP)
- 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
- Facility Site Reviews
- Feedback and annul review process of the HPSJ Provider Manual and any new or revised policies and procedures.

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 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)
- Compliance Director
- Medical Director or designee
- Director of Delegate and Provider Relations
- Directors of Utilization and Case Management
- Directors of Clinical, Analytics, and Pharmacy
- Director of HEDIS and Accreditation

Ad Hoc Members of the QOC include:

- Director of Claims
- Director of IT
- Director of Community, Market and Member Engagement

Peer Review and Credentialing Committee (PRCC)

The PRCC is a "Medical Peer Review" committee. PRCC Members are appointed by the Commission to which the committee also reports. The PRCC 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 PRCC:

- Oversees and evaluates Health Plan'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 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. . The G&A Committee meets at least quarterly and reports to the QMUM Committee. Committee Members include the:

- QI Supervisor
- QI Manager
- Director of QM
- CMO
- Medical Director
- Appeals Nurse
- QM Nurse
- UM Manager
- Compliance Director or designee
- Delegate and Provider Relations Director
- Customer Service Director

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

- Pharmacy

The G&A Committee:

- Oversees and ensures the integrity of the grievance and appeal process, including tracking for timeliness and resolution
- Evaluates grievances and potential quality issues (PQIs).
- Reviews and evaluates grievance and appeals (G&A) trend reports and 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 Health Plan's health education programs. These programs go under evaluation by Health Plan's internal Health Educator. HE Committee Members discuss resources, health education classes, and other community services that are beneficial to Health Plan Members. The Committee is meant to foster partnerships and garner resources in Stanislaus, San Joaquin, Alpine and El Dorado counties and serves as a central location to discuss health education initiatives between local community-based organizations, health clinics, and private entities. Health Plan's Health Educator serves as the HE Committee coordinator. The HE Committee meets ad hoc and not less than semi-annually 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
- HEDIS/NCQA

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

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

Community Advisory Committee (CAC)

CAC Members (including a Commissioner, a Provider, and Health Plan Members) are selected by CAC coordinators and reviewed with the Commission. Factors such as racial ethnic representation, language, 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 Health Plan Members.

The CAC reports directly to the Commission through the Chief Medical Officer. It establishes and monitors Health Plan's relevant public policies:

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

The CAC also reviews and makes recommendations on Health Plan's:

- Health education activity
- Population Needs Assessments
- Health Plan Member website

Health Plan solicits feedback including but no limited to the Community Advisory Committee and Quality Improvement Committee to inform the development of Provider manual and review policies and procedures.

To maintain and ensure ongoing community engagement through the CAC, Health Plan shall:

- Routinely engage with Members and families through focus groups, listening sessions, surveys and/or interviews and incorporate results into policies and decision-making when appropriate.
- Maintain the process for incorporating Health Plan Member and family input policies and decision-making.
- Monitor and measure the impact of the above.
- Maintain processes to share with Members and families on how their input impacts Health Plan policies and decision-making.

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 Health Plan'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 Health Plan's quality standards
- Submits to the Commission approved, signed minutes reflecting the committee decisions and actions of each meeting

NETWORK PROVIDER COMMITTEE PARTICIPATION

Contracted Providers are expected to cooperate with Health Plan's quality improvement activities to improve the quality of care and service and Member experience. Cooperation includes collection and evaluation of data and participation in Health Plan's QI programs. Practitioners understand that Health Plan 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

Health Plan has a process for identifying and receiving reports of potential Quality of Care issues. Health Plan uses licensed personnel to perform case reviews, investigate potential Quality of Care issues, and determine the severity of the issue. Based upon these investigations, Health Plan will determine the appropriate follow-up action required for individual cases. Health Plan 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 Health Plan 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*, Health Plan's 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.
- 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 PRCC 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.

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
- Effectiveness of Care
- Access and Availability of Care
- Experience With Care
- Utilization
- Health Plan Descriptive Information

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 can effectively monitor Members' health, prevent further complications and identify issues that may arise with their care. Providers may also benefit financially because Health Plan currently provides financial incentives based on Provider's HEDIS scores. Health Plan 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.
- Enter vaccine information into the California Immunization Registry and Regional Vaccine Registry

CLINICAL PRACTICE GUIDELINES

Providers can access *Clinical Practice Guidelines* on Health Plan's website at www.hpsj-mvhp.org. *Clinical Practice Guidelines* are guidelines about a defined task or function in preventive care and 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 EXPERIENCE SURVEY

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

PROVIDER SATISFACTION SURVEY

Each year, Health Plan 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 reviewed by both Health Plan leadership and various departments within Health Plan. Action plans are incorporated into goals and objectives for the following year to address issues identified by the Provider community.

PATIENT SAFETY

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

Health Plan 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.

Members, their families, Providers, and Health Plan staff, are able to report errors or close calls without fear of reprisal and where errors can be viewed as opportunities for improvement.

Health Plan's commitment to patient safety is demonstrated through 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 Providers regarding the availability and use of clinical practice guidelines. Members are educated about the use of guidelines using Member facing health education materials.
- Education of Providers regarding improved safety practices in their practice through the

Provider newsletter, Member profiles, and Health Plan 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 information between the Hospital and PCP when Members are admitted to and discharged from acute care facilities
- 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

Health Plan 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.