Health Plan of San Joaquin

Mountain Valley Health Plan

Quality Improvement and Health Equity Transformation Program Description

QIHEC Approval: September 18, 2024

Health Commission Approval: October 30, 2024

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Introduction

San Joaquin County Health Commission (SJHC) operates under two business names. The Health Plan of San Joaquin (Health Plan) and Mountain Valley Health Plan (MVHP), jointly referred to "Health Plan". The San Joaquin County Health Commission (SJCHC) is a Knox-Keene Act (KKA) California state licensed health care service plan serving California Medicaid (Medi-Cal) members, operating under the regulatory oversight of the California Department of Managed Health Care (DMHC) and the California Department of Healthcare Services (DHCS). The SJHC is contracted with the State of California Department of Health Care Services (DHCS) to serve as the local initiative under a two-plan model serving enrollees in San Joaquin County and Stanislaus County as Health Plan of San Joaquin and to serve El Dorado and Alpine County enrollees as Mountain Valley Health Plan. SJHC administers medical and behavioral benefits to Medi-Cal beneficiaries. To simplify and streamline the narrative herein, when plan operations are held at the organization level, the organization will be termed "Health Plan", when differentiation by service area is warranted, county or business name will be used to distinguish operations. In the absence of differentiation, Health Plan operations are carried out with uniformity.

The Health Plan's Quality Improvement and Health Equity Transformation Program (QIHETP) describes a constellation of care, programs and services designed to meet Quality, Equity and Population Health standards set forth by the contract quality, equity, population health, access and availability and selected California Advancing and Innovating Medi-Cal (Cal AIM) requirements stated in the Department of Health Care Services (DHCS) 2024 Contract, the Department of Managed Health Care (DMHC) regulations, and the National Committee for Quality Assurance (NCQA) standards. Health Plan also participates in Health Plan Accreditation, the recognition program sponsored by the NCQA. Beginning in 2026, all Medi-Cal plans contracted with DHCS will be required to achieve and maintain Health Plan Accreditation. Health Plan maintains NCQA Health Plan Accreditation (HPA). HPA renewal efforts concluded in June 2024 with successful continuation of "Accredited" status. By 2026, Health Plan anticipates achieving NCQA Health Equity Accreditation as required by the DHCS 2024 contract.

To further Health Plan's commitment to equity and inclusion, Health Plan actively promotes diversity in recruitment and hiring. The plan includes equity through interviewing, blind resume review, dedicates resources to identifying candidates from underrepresented backgrounds and whenever possible deploys methods of reducing bias through interviewing and hiring.

Mission, Vision and Values

The QIHETP supports Health Plan's mission and vision through the development and maintenance of a quality driven network of care for all lines of business. Every three years, the plan evaluates the relevance of the mission, vision and core values to ensure alignment with the needs of the members it serves, the community, the provider network, the organization staff, that there is full alignment with regulatory requirements, and that adjustments are made accordingly

Vision
Healthy Communities with Equitable Access to Quality Care.

Mission
Provide high quality healthcare for our members through community partnerships.

Values
Health Plan prides itself in its six core values. These values were developed on the principle that our values are behaviors that resonate, are genuine, and embody our activities daily.

- Accountability: We are accountable to members, providers, our communities, and each other.
- Diversity, Equity and Inclusion (DEI): We believe in promoting a foundation of compassion and respect for diversity, equity and inclusion strengthening our organization and community by embracing opportunities for growth and leveraging the uniqueness of individuals ideas, thoughts and cultures.
- Partnerships: We actively engage in community partnerships to advance quality care and health equity.
- Stewardship: We serve as a responsible steward of entrusted resources.
- Excellence: We act with integrity and aim for excellence in all we do.
- Teamwork: We demonstrate teamwork in all our interactions.

Quality Improvement Health Equity Transformation Program Overview

The QIHETP describes the structure, resources, and framework within the health care ecosystem of the plan's service areas and surrounding catchment. The QIHETP is designed to continuously monitor evaluate, plan, and take timely action to address incidences of non-compliance and provide necessary improvements in access and quality of care and services in any setting, and take appropriate action to address health disparities by providing equitable care and services. The QIHETP Description provides a clear definition of authority, its relationship to other components and departments within the organization, and its accountability to the governing body of the organization. This document describes the program's mission, philosophy, goals, objectives, staffing resources, and committee hierarchy. The QIHETP Description, along with the Quality Improvement and Health Equity Transformation Work Plan, outlines the major initiatives the QIHETP will undertake in the coming year.

Health Plan partners with the delivery system through contracting with providers and facilitating coordination and referrals with providers along the care continuum to ensure the needs of plan members are facilitated with an eye toward continuous quality and improvement. Health Plan provider contracts require that providers cooperate with quality activities and allow the plan to use their performance data to improve quality.

When necessary, Health Plan partners with Subcontractors and Downstream Subcontractors. Health Plan is accountable for all Quality and Health Equity functions and responsibilities that are delegated to Subcontractors and Downstream Subcontractors including quality and equity activities. Accountability consists of ensuring quarterly and annual ongoing oversight monitoring and evaluation of quarterly and annual reporting, approval of reports and procedures of reports, obligations to report findings and oversight of remedies and actions if their obligations are not satisfactorily performed. Oversight of subcontractors and downstream subcontractors includes the ability to perform delegated activities, including initial determinations that the subcontractor and downstream sub-contractor have the administrative capacity, experience, and budgetary resources to fulfill their contractual obligations and ensure health equity standards are met. The findings of continuous monitoring and evaluation of subcontractors and downstream subcontractors are made available to DHCS at least annually and more frequently when directed by DHCS. Delegates and

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downstream subdelegates are monitored by the Delegation Oversight department with ongoing reporting of monitoring activities and findings to the Audits and Oversight Committee and the Quality and Health Equity Committee (QIHEC) through Health Plan's existing and enhanced Quality Improvement System (QIS). These activities include the standards set forth in 42 CFR sections 4338.330 and 438.340, 28 CCR section 1300.70 and are consistent with the DHCS Comprehensive Quality Strategy, DHCS Population Health Program Guide, and NCQA Health Plan Accreditation Standards.

The QIHETP aligns with the DMHC Quality and Health Equity standards, and the DHCS Comprehensive Quality Strategy and Bold Goals initiatives. Health Plan's QIHETP is positioned at the intersection of Quality Improvement and Health Equity to meet DHCS, DMHC, and NCQA requirements. The QIHETP serves to bridge activities encompassing Population Health, Case and Disease Management, Behavioral Health and Social Work, Utilization Management, Data Analytics, Provider Relations, Cultural and Linguistics Services, Health Education, Compliance and Delegation oversight teams. The activities also include external partners such as Network Providers, Subcontractors and Downstream Subcontractors, and the Community Advisory Committee (CAC), which is overseen by the San Joaquin Health Commission as the governing board.

The QIHETP outlines the delivery system programs and quality metrics that enable Health Plan Members to maintain or improve optimal health status and remediate or manage the debilitation caused by emerging or apparent chronic medical or behavioral illness or disability.

QIHETP activities include but are not limited to:

- Alignment between Quality, Equity and Population Health initiatives
- Ensuring Health Plan Quality objectives align with DHCS whereby priority Managed Care Accountability Set (MCAS) Measures meet the National Medicaid Managed Care 50th percentile as identified by the NCQA Quality Compass.
- Ensuring Preventive Health programs, quality, and equity strategies address quality of care and access for children less than 21 years of age to include:
    - Promotion of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings.
    - Bright Futures/American Academy of Pediatrics (AAP) preventive services to Members and their families.
    - Identifying and addressing underutilization and disparities of children's preventive services, plan equity-focused interventions to address over/under utilization of physical and behavioral healthcare services, including but not limited to, EPSDT services such as well child visits, developmental screenings, and immunizations.
        - Providing information to all Network Providers regarding the Vaccine for Children Program (VFC) Program and to promote and support enrollment of applicable Network Providers in the VFC program to improve access to and administration of immunizations.
    - Ensure proper screening for women and pregnant persons to ensure individuals at high risk are given appropriate follow up.
    - Identify and facilitate equitable care for children with special healthcare needs, and that seniors and persons with disabilities receive care and treatment according to identified risk and need.
    - Ensure Network Providers receive standardized training on EPSDT utilizing the developed DHCS Medi-Cal for Kids and Teens Outreach and Education Toolkit.

    - Identify Members who have not utilized EPSDT screening services or Bright Futures/AAP preventive services and ensuring outreach to these Members in a culturally and linguistically appropriate manner.
    - Monitor processes and outcomes with achieving compliance with preventive guidelines.
    - Engage in planned health equity focused interventions to address gaps in the quality of and access to care for Members less than 21 years of age, including preventive and screening services.
    - Engage with local entities when developing interventions and strategies to address deficiencies in performance measures related to health care services for members less than 21 years of age.
- Ensure quality and equity activities align with clinical practice guidelines:
    - Ensure quality programs promote physical and behavioral health care through the design of programs which focus on medical and behavioral health conditions.
    - Ensure quality and equity activities align with appropriate utilization.
- Behavioral health care programs that focus on the following:
    - Prevention and screening for evaluation of cognitive development, neurodivergent disabilities, functional and social impairment, substance use, and abuse
    - Programs that support, recovery, resiliency, and rehabilitation
    - Exchange of information between behavioral and medical practitioners
    - Appropriate diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care
    - Monitoring of psychotropic medications
    - Primary and secondary behavioral health programs
- Access to primary and specialty health care providers and services:
    - Member engagement with primary care.
    - Accessibility of practitioners and providers
    - Availability of routine, regular, non-urgent and urgent and medical, ancillary, specialty, and behavioral health appointments
    - Language accessibility at the time of appointment

  Continuity of Care and Coordination across settings and at all levels of care, including:
    - Referrals between members and community-based organizations (CBOs)
    - Transitions of care, with the goal of establishing consistent Provider-Patient relationships,
        - When members transition between practitioners
        - When members move across care settings
- Member experience with respect to clinical quality, access, and availability, and culturally and linguistically competent health care and services, continuity, and care coordination.
- Population Health Activities that are designed to address:
    - Keeping members healthy by focusing on wellness and prevention programs
        - Equitable care for birthing individuals and their children
        - Focusing on Members less than 21 years of age
    - Identify and manage Emerging Risks for high and rising risk members
        - Members with biometric indicators or high-risk behaviors that are known to increase risk for chronic conditions.
        - Members with increased risk of declining medical and/or behavioral health conditions.
    - Ensure effective transition planning across delivery systems or settings through Care Coordination and other means to minimize patient risk and ensure appropriate clinical outcomes for members

    - Offer Case and Disease management programs that facilitate healthcare system navigation
    - Complex Case Management for members with multiple acute and chronic conditions and
    - Enhanced Case Management for members with multiple complex medical and behavioral health conditions and concurring social determinants of health
- Identify and mitigate Member access, experience and clinical outcome disparities by race, ethnicity and language to advance Health Equity

In addition to descriptions of how Health Plan delivers these member services, the QIHETP outlines the plan's adopted principles of Continuous Quality Improvement (CQI). CQI is applied to all aspects of the service delivery system through systematic enhancements of data collection, quantitative and qualitative analysis of results, data driven decision making, up-to-date evidenced-based practice guidelines, explicit criteria developed by recognized sources or appropriately certified professionals or, when evidenced-based guidelines do not exist, consensus of professionals in the field.

Health Plan engages Members and Network providers in the design, planning, and implementation of CQI activities and incorporates feedback they provide, and lessons learned on an ongoing basis. Population Health Management (PHM) strategies are designed to address barriers and reduce existing health disparities related to social drivers of health and reduce disparities in health outcomes experienced by different subpopulations which are incorporated into the QIHETP. Quality goals are embedded with equity and disparity focused priorities and are measured on an ongoing basis.

Health Plan strives to improve health outcomes experienced by enrollees including subpopulations that experience increased systemic access barriers and works intentionally and specifically towards achieving Health Equity for the enrollees. Health Plan commits QIHETP initiatives to action through a comprehensive work plan that is updated quarterly and reported through the Quality and Health Equity Committee (QIHEC).

In addition to a quality and equity plan of action, Health Plan employs an Executive Director of Quality and Equity who functions as the Chief Health Equity Officer (CHEO) and that reports to the Chief Medical Officer (CMO). The CHEO ensures Health equity is prioritized and addressed throughout the organization, including quality, and that Health Plan's Corporate Equity Goals are carried out. This includes ensuring that contractors, subcontractors, and downstream subcontractors receive diversity, equity, and inclusion training. The QIHEC is co-chaired by the CMO and the CHEO. The QIHETP takes member and provider feedback into consideration when developing quality and equity strategies and interventions. Members are involved in the Community Advisory Committee to ensure that a member focused approach with a family-centric focus and through provider feedback through the QIHEC to guide the development of interventions that are relevant and have the greatest potential for success. Providers are involved in quality and equity by offering feedback on quality and equity activities during regular meetings held with stakeholders from provider offices as well as Health Plan staff. Physician leadership from the high-volume health centers meet regularly with the Health Plan Chief Medical Officer, Chief Operations Officer and health plan quality and equity stakeholders. Providers participate in the QIHEC and a mix of providers representing the characteristics of the membership serve as voting members of the QIHEC which reports to the SJCHC. They participate in the QIHEC by providing input on the development and approval of quality and equity programs and activities.

The SJCHC provides oversight and participation and has the ultimate authority over how the QIHETP may direct necessary modifications to the QIHETP and policies and procedures to ensure compliance with QIHETP standards and the DHCS Comprehensive Quality Strategy. The QIHEC oversees, approves, promotes, and supports the Health Plan strategic plan, goals, and objectives.

Statement of Purpose

The purpose of the QIHETP Description is to maintain the organization's structure, resources, and framework to ensure continuous assessment, planning, implementation, evaluation, and improvements in the quality and equity of care and services rendered by the plan, network providers and received by our members and participants are carried out. When the QIHETP identifies opportunities for clinical, patient safety, and service improvements, Health Plan initiates activities to address issues and measures intervention progress over time to assess any needs for new or different improvement strategies.

The QIHETP supports Health Plan's mission and vision through the development and maintenance of a quality driven network of care for all lines of business. The QIHETP Description provides a clear definition of authority, its relationship to other components and departments within the organization, and its accountability to the governing body of the organization. This document describes the program's mission, philosophy, goals, objectives, staffing resources and committee hierarchy. The QIHETP Description, along with the Quality Improvement and Health Equity Transformation Work Plan, outlines the major initiatives the QIHETP will undertake in the coming year.

In addition, the QIHETP supports its members, providers, and communities by implementing a population management strategy to collaborate with local, state and federal public health agencies and programs as well as with other Health Plans.

A culture of "patient safety" is a high priority. On an ongoing basis, Health Plan fosters a Member Safety culture that is communicated throughout the organization. Health Plan is committed to developing and implementing activities to improve patient safety and clinical practice and aims to engage with both members and provider to promote and implement safety practices.

Philosophy

Health Plan is committed to ensuring that Continuous Quality Improvement (CQI) occurs within the organization as well as throughout the provider network. The Quality Management Department is structured to facilitate ongoing quality improvement processes and activities organization wide. All department leaders and other identified stakeholders play an important role in developing and evaluating the annual QIHETP Work Plan. The Chief Medical Officer and Health Equity Officer co-chair the QIHEC. The Director of Quality or designated alternate chairs the Quality and Health Equity Operations Committee (QIHEOC) and ensures summations of subcommittee activities and progress on the annual QIHETP Work Plan are provided no less than quarterly.

The QIHETP goals are met through stakeholder collaboration and participation on quality initiatives. Therefore, the QIHETP is structured to include the participation and collaboration of staff, the provider network, local partners, state agencies, and members. QIHETP efforts are further enhanced through consultation with our partnering Health Plans and/or health systems. Quality efforts are also enhanced through consultation with state agencies and other subject matter experts. The annual QIHETP Work Plan provides the organization with a mechanism for tracking

yearly planned activities and objectives, time frame for completion, staff responsible, monitoring previously identified issues, and evaluation of the QIHETP. The QIHETP Annual Evaluation provides a description of completed and ongoing activities, and trending of performance measures in quality, safety of clinical care, quality of service, and equity as well as an overall evaluation of the effectiveness of the QIHETP and its progress toward influencing networkwide safe clinical practices.

Definition and Scope of Quality

Health Plan's definition of quality is adapted from the Institute for Health Improvement (IHI) Quadruple Aim. According to IHI, the goal of the Triple Aim is to "Improve the patient care experience, improve the health of a population, provide better outcomes and reduce the per capita health care costs". The Quadruple Aim builds on the idea of the triple aim by acknowledging that without an improved clinical experience on the provider side, the three other patient-centric aspects won't reach their full potential.

Improved Patient Experience
Improving the patient experience aims to enhance the quality of care that patients receive, having a greater focus on individuals and families. Originally, this was the sole aim of healthcare before the Triple Aim was created. It came from the Institute of Medicine's publication, Crossing the Quality Chasm, in which they outlined six domains of healthcare quality or need (STEEP):

Safe	Avoiding injuries to patients from the care that is intended to help them.
Timely	Reducing wait time and sometimes harmful delays for both those who receive and those who give care.
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).
Efficient	Avoiding waste, including waste of equipment, supplies, ideas, and energy.
Equitable	Providing care that doesn't vary because of gender, ethnicity, geographic location, and socioeconomic status.
Patient-Centered	Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

Better Outcomes

Improving the health of the overall population while creating an improved patient experience will help the plan to have more educated patients that can manage their health more effectively. Improving the health of populations takes the first individual aspect of the Triple Aim and expands it towards the whole population. Society is facing an increase in chronic diseases, so improving the patient experience for all individuals will ultimately lead to a decrease in prevalence and/or severity of chronic diseases and overall better chronic care management.

Lower Costs
The triple Aim intends to drive down costs while improving the health of populations by improving quality of care. If members visit providers less frequently because their needs are met using other modalities, their care will be much more affordable.

Improve Clinical Experience

As value-based care becomes more prevalent, the quality of care provided becomes more essential and the provider is the key to ensuring successful value-based care. In order to ensure the success of the triple aim the care given by the provider is key. It all starts there.

QIHETP is designed to monitor, evaluate, and take timely action to address necessary improvements in the quality of care delivered by all its providers in any setting and take action to improve equity. It is comprehensive and addresses both the quality and safety of medical and behavioral health care provided to our members and participants of the Medi-Cal line of business.

Full service Behavioral Health (BH) care benefits are offered to all Medi-Cal members. Prior to October 2024, a portion of the behavioral health services are delegated to Carelon (formerly known as Beacon Health Options). Members who meet criteria for mild to moderate intervention may seek services through any Carelon telehealth provider or Health Plan behavioral health providers. Behavioral health services for members who meet criteria for specialty mental health services or substance use disorder services, are "carved out" of the contract with the state for administration by the County Behavioral Health System. Individuals in need of Behavioral Health Treatment (BHT) are required to obtain a referral by their PCP or a Licensed Psychologist and services will be coordinated through Carelon.

After October 2024, members who meet criteria for mild to moderate intervention are granted access to coordinated behavioral healthcare services through Health Plan's contracted Behavioral Healthcare network. Individuals in need of BHT are referred to Health Plan for care coordination and treatment with appropriate licensed practitioners and staff. Members with acute or severe behavioral health impairment or substance use disorders are referred to County Behavioral Health for services that are carved out from the Health Plan.

An integral part of Health Plan's Care Management Program includes coordination of medical and behavioral health care. Health Plan seeks guidance from Community Medical Centers' Chief Behavioral Health Officer. Input, consultative guidance and recommendations about the BH aspects of the QIHETP are given during the Health Plan QIHEC meetings as well as on an ad hoc basis when the need arises. Health Plan's behavioral health program is staffed by behavioral health care clinicians, providers, and navigation staff. Health Plan collaborates with behavioral healthcare practitioners to monitor and improve the coordination of medical care and medical and behavioral healthcare.

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The QIHETP aligns with and informs the organization's Population Health Management (PHM) initiatives where activities are informed by and aligned with the DHCS Bold Goals, focusing on Pediatric, Maternal, Chronic Conditions, and Behavioral Health needs of populations served.

Additionally, the QIHETP's scope serves to:

- Align in principle with the DHCS Comprehensive Quality Strategy (CQS) and prioritize the DHCS Bold Goals.
- Prioritize the DMHC Quality and Equity Measures (HEQMS) and focus on initiatives that reduce inequities.
- Investigate potential quality gaps.
- Prepare and present cases for peer review, manage the administration of corrective actions, as well as track, trend, and analyze quality management data related to grievances and appeals.

- Develop Population Health Management Program focused interventions designed to address barriers arising from Social Determinants of Health (SDoH), reduce disparities in health outcomes experienced by different subpopulations of Members, and work towards achieving Health Equity by:
  - Developing equity focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services; and
  - Engaging in a Member and family-centric approach in the development of interventions and strategies, and in the delivery of all health care services.
- Oversee quality and health equity-related policies and procedures and ensure compliance with NCQA Standards and other quality and health equity-related regulatory requirements.
- Provide oversight and reporting of Healthcare Effectiveness Data and Information Set (HEDIS®) and cooperate with External Quality Review Organizations (EQRO) auditors in the preparation for annual HEDIS reporting.
- Identify opportunities to improve data capture through quality improvement activities.

Anti-Discrimination Statement

Health Plan will monitor, evaluate, and take effective action to address needed improvement in any setting. The Health Plan is accountable for the quality of all covered services, regardless of additional hired contractors to render services on behalf of the Plan.

Health Plan accepts members who select or are assigned to the plan and ensures that all medically necessary covered services are available to members regardless of race, ethnic group identification, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, existing or prior involvement in the justice system, or identification with other groups defined in Penal Code 422.56. All services are provided in a culturally and linguistically appropriate manner.

Quality and Health Equity Indicators

The QIHETP includes an array of indicators to measure critical clinical processes and outcomes. The QIHETP Work Plan delineates the critical performance measures that define the scope and range of the QIHETP.

Goals of the Quality and Health Equity Program:

- Promote an organization-wide commitment to equality of care and service through strong leadership involvement in improving quality
- Link goals from DHCS' Comprehensive Quality Strategy to Health Plan Corporate QI Objectives and performance improvement activities via quality improvement initiatives
- Address, prevent, and resolve health disparities within the network through monitoring quality data and implementation of targeted interventions
- Enhance continuity and coordination of care among behavioral healthcare and primary health care providers
- Respond actively to customer expectations and patient feedback concerning the quality of patient care delivered and services provided
- Define, oversee, evaluate, and improve the care and service delivered by our staff, network providers, and delegated entities by:

    - Promoting member/patient safety as a high-level priority through mechanisms designed to minimize patient and organizational risk of adverse occurrences
    - Improving and enhancing the quality of patient care provided through ongoing, objective, and systematic measurement, analysis, and implementation of improvement actions
    - Promoting processes to ensure the availability of "safe, timely, effective, efficient, equitable, patient-centered care" and provide oversight within the network
- Comply with legislative regulations, accreditation standards, and professional liability requirements
- Ensure that medically necessary covered services are:
    - Available and accessible
    - Provided in a culturally and linguistically appropriate manner
    - Provided in an equitable manner
    - Provided by qualified, competent practitioners and providers who are committed to Health Plan's mission and vision
- Promote collaborative relationships between Health Plan, providers, delegates, and community partners
- Promote and create condition specific health education and disease prevention materials that are age, culturally, and linguistically appropriate and that encourages optimal health behaviors for members, participants, and staff
- Maintain an appropriate number of credentialed network practitioners to meet the access needs of our members
- Ensure that Network Providers, Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors participate in the QIHETP and Population Needs Assessment
- Ensure that members' protected health information (PHI) is protected, utilized, and released in accordance with state and federal law and regulation
- Follow all accreditation, regulatory, and licensure survey key recommendations within 90 days of identification of improvement opportunity
- Continue implementation of adequate computerized information management systems to support complete data entry, aggregation, display, analysis, and reporting needs for all quality management activities
- Incorporate responsibilities for quality management and improvement into management performance standards

Quality Improvement and Health Equity Transformation Program Objectives

The objectives of the QIHETP are to:

- Align all organizational-wide performance improvement activities with strategic goals
- Review the authority, responsibility, and information flow for the redesigned measurement, analysis, and improvement process and redefine as necessary
- Ensure continued leadership and staff understanding of the tenets of quality/ performance management and improvement to be utilized by all teams
- Establish cross functional teams for each approved Strategic Quality and Health Equity Initiative, organization function, and/or prioritized improvement activity
- Provide information, training, and tools to network behavioral health practitioners, medical providers, and staff to support the provision of culturally competent and linguistically appropriate communication and services to Health Plan members
- Manage and improve the quality and safety of care provided to members, confirming compliance with the QIHETP and applicable standards

- Foster a supportive environment to ensure our practitioners and providers improve the safety of their professional practice through provider education
- Identify actual or potential opportunities to decrease medical errors and /or improve patient safety through quality review, data collection, and risk factor analysis
- Identify opportunities for patient care and service improvement, then implement and monitor interventions as appropriate
- Establish priorities and outcomes for: conducting focused review studies, emphasizing preventive services, identifying high-volume low-performing practitioners/providers, and high-risk services
- Promote outcome-driven and cost-effective health management programs, including preventive screening and health awareness, education, patient safety, and cultural and linguistic programs complementing QI interventions
- Establish, maintain, and adhere to policies, procedures, criteria, and standards for:
    - Monitoring plan practitioner credentialing and recredentialing
    - Confidentiality regarding member and practitioner/provider information
    - Addressing conflict of interest regarding staff and practitioners
    - Resolution of actual or perceived member concerns (grievances) regarding access to care, quality of care, quality of service or denial of coverage (appeals) and office site quality
- Establish quality standards and educate practitioners regarding quality performance expectations and provide metric compliance feedback
- Communicate the QIHETP process to both network providers/practitioners and members
- Ensure availability, accessibility, delivery, coordination, support, and review effectiveness as appropriate for:
    - Continuity of care within the network
    - Health education services
    - Cultural and linguistic services
    - Members with complex care needs
    - Members with behavioral health needs
- Establish medical and behavioral health standards reflecting current literature and benchmarks, design and implement strategies to improve compliance, and evaluate and monitor performance and adherence to guidelines
- Identify, monitor, and address quality of care issues and trends affecting the healthcare and safety of members
- Implement and monitor results of corrective actions and interventions; document practitioner/provider performance
- Respond timely to address and resolve member-specific issues
- Review and revise the organization wide Quality Program as necessary
- Reinforce CQI principles through systematic monitoring of processes, data collection, qualitative and quantitative analysis of data, design of interventions for process improvement and determination of actual effectiveness of interventions
- Evaluate current case management systems to identify care coordination issues for the organization and design a patient-focused system that promotes collaboration between transition of care, case management, quality, and utilization management
- Demonstrate compliance with the quality improvement standards of regulators and accrediting organizations
- Evaluate the QIHETP Description annually, modifying as necessary to achieve organizational effectiveness

- Foster multi-departmental collaboration on HEDIS/MCAS Initiatives to increase the likelihood that compliance rates will improve.
- Meet the MCAS goals as part of the QIHETP, as well as work toward any strategic quality goals, set forth by DHCS

The above goals and objectives are tied to the QIHEC Work plan. Performance against these goals and objectives are continuously monitored to determine if stakeholder expectations are being met. Additionally, Health Plan will work to align with DHCS' Comprehensive Quality Strategy goals reducing racial, ethnic, and other existing health disparities, as required by DHCS, DMHC & NCQA.

Quality Improvement and Health Equity Transformation Program Quality Process Methodology

The QIHETP includes a comprehensive array of clinical and service indicators that provide information about the systems, processes, and outcomes of clinical care and service delivery. Clear, well-defined quality indicators represent what is most important to Health Plan in measuring and evaluating quality. The measures are developed using sound methodological principles and are rooted in best practice guidelines. Measured performance data is assessed to ensure reliability so that decisions can be made with confidence.

Quality indicators are reflective of areas that are high risk, high volume, problem prone specific populations, and specific conditions, as well as industry standard measures. Most indicators are rate-based outcome measures. Indicators are measurable and have a goal against which to measure performance. Indicators are developed with input from the CMO, CHEO and the QIHEC.

To understand and properly implement QIHEC-related practices and projects, there are approaches being utilized. Such models help collect and analyze data for test change, provide guidance for effort and improvement in efficiency, member safety, or quality outcomes. These models include:

- Plan-Do-Study-Act (PDSA)
  Performance Improvement Projects (PIPs)
- Regional Quality and Health Equity Improvement Projects

Plan-Do-Study-Act (PDSA)

The PDSA methodology is a rapid cycle, continuous QI process designed to perform small tests of change, which allows more flexibility throughout the improvement process. As part of this approach, Health Plan performs real-time tracking and evaluation of its interventions. PDSAs are the most common continuous quality improvement model utilized by Health Plan and have four major elements or stages:

A. **Plan**: The first step involves identifying preliminary opportunities for improvement. At this point the focus is to analyze data to identify concerns and ideas for improving process and to determine anticipated outcomes. Key stakeholders and/or people served are identified, data compiled, and solutions proposed.
B. **Do:** This step involves using the proposed solution, and if it proves successful, as determined through measuring and assessing, implementing the solution usually on a trial basis as a new part of the process.
C. **Study:** At this stage, data is again collected to compare the results of the new process with those of the previous one.
D. **Act, Adopt or Adapt:** This stage involves making the changes a routine part of the targeted activity. It also means "Acting" to involve others (other staff, program

components or consumers) - those who will be affected by the changes, those whose cooperation is needed to implement the changes on a larger scale, and those who may benefit from what has been learned. Finally, it means documenting and reporting findings and follow-up.

The process flow below illustrates the progression in which Health Plan applies the PDSA methodology.

Health Plan complies with the reporting requirements set forth by DHCS:

- Medical Director Identified: PDSA Cycle Worksheets must identify Health Plan's Medical Director who approved the PDSA cycle prior to it being submitted to DHCS
- Timeline: DHCS will notify Health Plan of submission due dates
  Submission: Health Plan must submit PDSA Cycle Worksheets to DHCS's quality mailbox at: dhcsquality@dhcs.ca.gov

Performance Improvement Projects (PIPs)

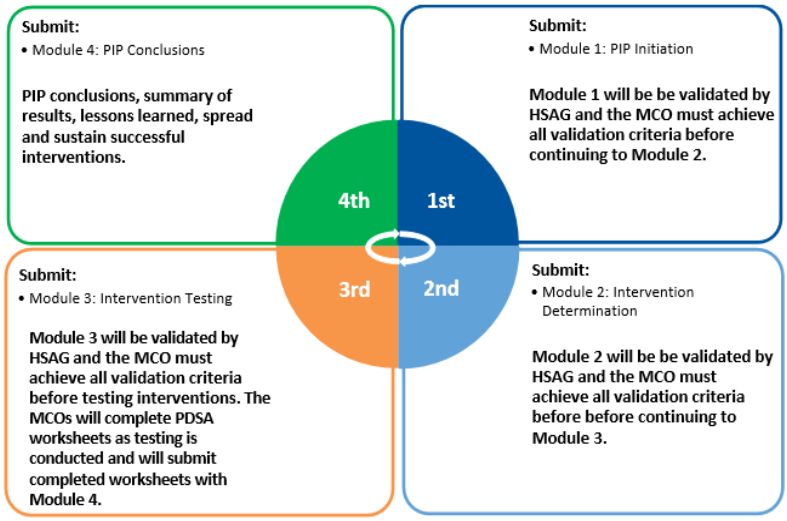
A Performance Improvement Project (PIP) is an approach utilized by Health Plan to implement the continuous study and improvement of the processes of delivering healthcare services to meet the needs of its members. The main purpose of a PIP is to positively impact healthcare delivery and outcomes of care. PIPs involve a concerted improvement effort toward a particular area of concern affecting our members. The goal of this methodology is to enhance and improve the outcomes of care, to ensure member safety, to increase efficiency of member care and related processes, to reduce costs, and to reduce risks and liability. For such projects to achieve real improvements in care, and to ensure confidence in reported improvements, Health Plan PIPs are designed, conducted, and reported in a methodologically sound manner that meets all state and federal requirements. Health Plan collaborates with Health Services Advisory Group (HSAG), DHCS' current External Quality Review Organization (EQRO), in the validation of its PIPs according to CMS' EQR protocol. PIPs are also made in accordance with 42 CFR §438.330, that requires MCPs to have a quality program that:

1. Includes ongoing PIPs designed to have a favorable effect on health outcomes and beneficiary satisfaction.
2. Focuses on clinical and/or nonclinical areas that involve the following:
   a. Measuring performance using objective quality indicators
   b. Implementation of equity focused interventions to achieve improvement in the access to and quality of care and system interventions to achieve quality improvement

c. Evaluating effectiveness of the interventions based on the performance measures
d. Planning and initiating activities for increasing and sustaining improvement

3. A PIP's quality improvement framework is detailed in the following modules:
   a. Module 1 – PIP Initiation
   b. Module 2 – Intervention Determination
   c. Module 3 – Intervention Testing
   d. Module 4 – PIP Conclusions

The process flow below illustrates the progression in which Health Plan will submit and HSAG will validate the modules throughout the PIP process:



Health Plan seeks pre-approval from DHCS on priority topics for PDSAs based on the prior year performance of the MCAS measures. DHCS strongly recommends that the Plan's PIP topics align with demonstrated areas of poor performance, such as low HEDIS or Consumer Assessment of Healthcare Providers and Systems (CAHPS®) scores, and/or EQRO recommendations.

Regional Quality and Health Equity Improvement processes follow the PDSA methodology and involve DHCS Quality Nurse Consultants. However, they are narrow in scope and prioritize reducing health disparities identified in quality measure reporting.

Performance Goal Methodology

A sound, rigorous measurement methodology is developed and followed for each performance measure. Performance goals for each measure are discussed with and approved by the QIHEC. Performance goals may be based on historical performance, normative data, industry benchmarks, or internally agreed-upon performance expectations. Baseline results may be used as the performance goal or threshold for future measurement.

A. Data Collection

Performance data for measures are collected, aggregated, and presented to the QIHEOC and QIHEC for review and recommendations quarterly at a minimum. Multiple data points are displayed through visualization techniques to better show historical performance and facilitate data analysis and trending. Qualitative and quantitative 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 analyzed.

The Quality Improvement projects themselves consist of four (4) cycles:

- Development (pre-initiation)
- Baseline measurement (initiation)
- Intervention to improve performance and outcomes
- Follow-up/Re-measurement to ensure that the interventions continue to be effective

B. Data Resources
Health Plan uses multiple data sources to monitor, analyze and evaluate the QI Program and QI activities. These sources include, but are not limited to the following:

- Enrollment
- Claims Data
- Encounter Data
- Supplemental Data
- Pharmacy Data
- Health Risk Assessments
- Utilization Management
- Advanced Data Sources

Analysis of Performance Data and Development of Interventions

When performance does not meet standards or when a quality issue is identified for improvement and designated as a priority by the QHEOC or the QIHEC, quantitative and qualitative analysis is conducted to evaluate trends over time, identify the root causes, and recommendation(s) for interventions are formulated that are designed to address the root causes. Opportunities are prioritized. Interventions are implemented based on the results of analysis and determination as to which is likely to be most effective in improving performance. Interventions aimed at clinical care issues are developed considering professionally recognized standards of care.

Analytical Resources

Health Plan dedicates staff and information systems to analyzing and reporting clinical and service quality data. Employed and contracted staff include Bachelor's and master's level prepared personnel with statistical analysis training and experience conducting quantitative and qualitative analysis of health care data. The Analytics team performs analysis on quality and equity metrics to help prioritize quality and equity activities. The Analytics team helps prepare the quality and equity teams for meaningful quantitative and qualitative analysis.

Configuration, Data Systems, and Business Intelligence teams ensure data is ingested, staged, and available for use in quality activities. They maintain enrollment, claims, encounter, pharmacy,

registry, and supplemental data sources. These data are made available to software systems that turn data into information to guide better healthcare safety, care, and experience.

Software resources include but are not limited to the claims systems, HEDIS software, CACTUS, Healthy Data Systems, Microsoft products, statistical analysis software, the care management system, and other systems to support the QI Program.

Measuring Effectiveness of Interventions

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 fiscal or calendar year. Effectiveness is evaluated with each re-measurement cycle. It includes quantitative and qualitative analysis, including an analysis of statistical significance and meaningful improvement and allows for comparison with the baseline or previous measurement to determine if interventions have been effective at improving performance. Findings from these measurements are reported to the QHEOC and the QIHEC, and to the governing board which is the County Health Commission.

NCQA Accreditation

The plan achieved NCQA Health Plan Accreditation (HPA) in 2015 and has voluntarily maintained accreditation status by complying with NCQA's triennial survey requirements and submitting HEDIS rates annually. Health Plan participates in all required NCQA accreditation activities as required by the 2024 DHCS Contract. Health Plan ensures that its fully delegated subcontractors and fully delegated subcontractors achieve and maintain full HPA. Health Plan will also achieve NCQA Health Equity Accreditation (HEA) by January 1, 2026. By maintaining HPA, Health Plan is deemed to meet the DHCS requirements for Credentialing and is exempt from the DHCS medical review audit for credentialing. By achieving HEA, Health Plan's equity and diversity activities are strengthened and validated.

NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance
has awarded

San Joaquin County Health Commission

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

ACCREDITED NCQA HEALTH PLAN

CHAIR, BOARD OF DIRECTORS | PRESIDENT | CHAIR, REVIEW OVERSIGHT COMMITTEE

07/03/2024 DATE GRANTED

07/03/2027 EXPIRATION DATE

Health Equity Program

The Health Equity Program Description supports Health Plan's mission and vision through the development and maintenance of a quality driven, health equity focused, network of care for all lines of business. The Chief Health Equity Officer works with various internal and external teams and stakeholders to continuously monitor and implement activities to improve Health Equity and reduce Health Disparities among Health Plan's membership. This work aligns with the California DHCS's Bold Goals to impact Health Disparities, DMHC's Quality and Equity requirements, the plan's corporate goals and the requirements for NCQA Health Plan Accreditation and Health Equity Accreditation. Health Plan has a matrix Health Equity Framework that has four key Pathways. The Pathways run concurrently and are specific to the key stakeholders for the Health Plan:

1. Internal Pathway focused on Health Plan Employees, Leadership and Culture
2. Member Pathway focused on impacting members' health disparities
3. Partner Pathway focused on all key stakeholder partners, and;
4. Community Pathway focused on system collaboration and overall community health equity efforts.

Reporting to the Chief Health Equity Officer is the Cultural and Linguistics, the Population Health Management, and Health Education Teams.

Cultural and Linguistic (C&L) Program

The Cultural and Linguistic (C&L) program is managed by the C&L Department. The C&L Department is responsible for assessing the cultural and linguistic needs of Health Plan members and enhancing the effectiveness of the program based on the results of the assessment. The C&L program activities are developed based on the NCLAS standards, reviewed, and approved by the Health Equity and the Compliance Departments and reported to the HEOC. The C&L Team reports to the Chief Health Equity Officer.

The C&L department collaborates with other Health Plan departments and community partners to promote cultural competence, appropriateness, and linguistic services awareness for our members. The C&L leader develops and revises policies and procedures to foster the cultural and linguistic readiness of the organization.

The C&L needs of our members are identified through membership data reporting. Health Plan membership culture and linguistic characteristic data distributed by the DHCS is used to aid in the assessment of characteristics and needs of our membership population. The threshold languages as determined by DHCS are based on reported members' demographics. English, Spanish, and Chinese are identified as the threshold and concentration languages for San Joaquin County, English and Spanish for Stanislaus County.

The Population Needs Assessment (PNA) is completed with the collaboration of other departments. The PNA assessment aids in:

- Assessment of members' characteristics
- Determination of cultural and linguistic needs
- Determination of barriers to health care
- Understanding of race, ethnicity, and language gaps
- Assessing provider network composition, with active recruiting and retaining culturally and linguistically competent providers that reflect member needs
- Assessing the cultural and linguistic provisions and capabilities of staff, contractors, and downstream subcontractors

Health Plan provides interpretation and translation services to our members at no cost. C&L objectives are built around sensitizing our providers and staff on how Health Plan can integrate culturally and linguistically appropriate services into daily activities and continuously provide linguistically and culturally congruent, high quality of care to its diverse membership.

Diversity, Equity and Inclusion

In addition to providing culturally competent care, Health Plan is committed to promoting diversity, equity and inclusion practices both within the organization and externally throughout the network and community by offering the following:

- Provide staff and practitioners with the services and training to support culturally competent communication.
- Ensure diverse hiring through recruitment and retention policies and practices.
- Promote transparency in sharing cultural background and linguistic capability of the network through the provider directory.
- Expand CAC with community members of diverse backgrounds to better understand the needs of the community we serve

- Identify and analyze health disparities in our membership population and implement activities that mitigate social determinants of health and promote more equitable care.
- Provide adequate interpreting services to meet member needs, expanding these services through onsite interpreting, video remote interpreting (VRI), and over-the-phone interpreting (OPI)
- Measure language access engagement across membership and develop strategies for improving linguistically and culturally appropriate communication and services to improve health outcomes
- Promote awareness of auxiliary aids such as large print, audio, braille, and electronic format through the means of collecting and appropriately sharing members' alternative format selections
- Foster relationships with multicultural community partners to offer programs that engage diverse populations.

Health Education

Health Plan's Health Education Program is an interdepartmental initiative set in place to ensure that members have the knowledge and tools required to achieve optimal health outcomes. In doing so, these objectives ensure that Health Plan is compliant with the California DHCS Health Education standards. Health Education services encompass multiple initiatives which include provision of health education materials and content, policies and procedures, and programs aimed at completing annual objectives set to improve the health of the community at large.

Health Plan's Wellness and Prevention programs aim to prevent disease, disability, and other conditions; prolong life; promote physical and mental health and efficiency; and improve overall quality of life and well-being. Topics and areas of focus are selected through the population health needs assessment (PNA) process where Health Plan considers top chronic conditions across current members, HEDIS gaps in care data, and community health needs assessments from the perspective counties in which members reside. Health Plan will also conduct community and member stakeholder interviews to assess health education and cultural linguistic needs as part of the PNA. Maintaining strong community connections remains at the center of our work here at Health Plan, health education team members continue to work with local partners, community-based organizations, schools, and other organizations to gather feedback on areas of interest and requests for health education presentations and partnerships. Health Plan's Wellness and Prevention program is presented as an addendum to the Population Health Management Program Description.

Health Education services are available to members at no cost. All services are designed to complement the work of providers in promoting patient self-management and disease prevention through healthy behaviors. Initiatives are dedicated to the promotion and empowerment of healthy lifestyles.

The Health Education and Population Health team is integrated into the QIHETP and reports to the Chief Health Equity Officer. Population Health Patient Health Navigators provide approved health education and health promotion to members through targeted outreach campaigns designed to meet overarching Medical Management Department quality and equity objectives. This is inclusive of initiatives, pilot programs, and provider partnership programs that align with HEDIS, MCAS, and HEQMS measures. Targeted outreach campaigns utilize stratified gaps in care data to educate members on preventive services including but not limited to lead and HgbA1C screenings, well child and annual visits, immunizations, cervical, breast, and colorectal cancer screenings.

Health Education messages relating to the QIHETP are also integrated into member and provider communications. The quarterly member newsletter will include an annual feature relating to the QIHETP program, member rights, and the grievance and appeals process.

The Health Education (HE) program serves the following purposes:

- Develop Health Educational Materials
- Plan, develop, and implement Health Plan health education programs
- Ensure that the Health Education programs meet requirements of state and departmental objectives and regulations
- Develop and expand HE programs based on the expansion of membership and demographic changes occurring in local communities
- Support the Health Plan Care Management Programs
    - Support Social Work, Case Management, and Disease Management programs by way of informing educational materials, supporting Health Plan Health Education Programs, and creating outreach connections to community resources
    - Providing support to other departments in creating, writing, and reviewing health education messages and materials
- Distribute Member Communications and Health Messages
    - FOCUS Member Newsletter
    - Health Articles
- Share Health Education Promotion Content and seasonal health education messages

Health Education Oversight: Oversight includes the review of health education materials utilized across multiple departments within the Health Plan to ensure compliance with review timelines as specified in the APL 18-016B (Readability/Suitability Checklist) where all health education materials must be reviewed periodically. This review incorporates the implementation of new DHCS Health education requirements in internal health education processes.
Community Engagement: Engage Community Stakeholders and the local health departments in Population Health Level work and addressing the cultural and linguistic needs of the community through participation in the Health Education Committee, providing a space for Health Plan to strategize with community partners on activities in support of objectives as outlined in the PNA.
Member Communications: Consistent review of communication outlets to ensure the provision of quality and timely preventive health messages shared through Health Plan website, newsletters, health articles, and other opportunities to communicate with members when possible.
Member and Provider Engagement: Ensure Health Plan Member involvement in the Community Advisory Committee (CAC) in respective counties. Provide opportunities for provider input and review through provider education outlets such as lunch and learns, provider newsletter, provider alerts, and through strategic partnerships such as the provider partnership program.
Strategic Partnerships: Health Plan will enter partnerships with First 5 programs and providers, WIC providers, and every Local Education Agency (LEA) in each county within their service area for school-based services to strengthen provision of EPSDT/MKT within schools.
Wellness Programs for Children Under 21 years of age: Maintain a program to ensure the provision of all physical, behavioral, and oral health services to Members less than 21 years of age. Health Plan identifies and improves gaps in the quality of and access to care.

Health Equity: Health Plan will provide Diversity, Equity, and Inclusion (DEI) training that will be specific to the regions served, and will address demographics, health related social needs, disparity impacts, including seniors and persons with disabilities, those with chronic conditions, those with specialty mental health service and/or substance use needs, those with intellectual and

developmental disabilities, and children with special healthcare needs. DEI training will incorporate the following:

- Explicit consideration of structural and institutional racism and their impact on members, staff, network providers, subcontractors, and downstream subcontractors
- Information about relevant health inequities and identified cultural groups in the service area(s) including:
  - Beliefs about illness and health
  - Member experience and perceived discrimination and the impact of implicit bias
  - Lesbiany, gay, bisexual, transgender, queer, or questioning, intersex, asexual and more (LQTBQIA+) concerns and the need for gender affirming care
  - Methods for interacting with the healthcare system
  - Traditional and home remedies which may impact how the provider should treat the member and
  - Language and literacy needs

- Leveraging the strong partnership between Provider Services, Population Health, and the Health Education team brings regulatory requirements, health disparities, cultural awareness and SDOH-related information to provider teams and to the communities Health Plan serves. The Health Equity – focused provider education will incorporate information required by the APL 23-025, which states that member specific characteristics related to religion, ancestry, national origin, creed, mental disability, physical disability, medical condition, genetic information, health status, and marital status will be considered when creating educational materials for the provider network. Furthermore, health equity-focused education will also leverage stratified data provided by the C&L Team which identifies gaps in interpreter and translation services. The ultimate goal is to improve the quality of care delivered by providing culturally specific, linguistically congruent communication with the populations Health Plan serves. Last, but not least, education provided to both providers and members will incorporate the feedback obtained from members of the CAC by recommending opportunities to eliminate barriers in care.

Case Management

Case Management identifies members for which our programs can impact health outcomes and social determinates of health through preventative services, education, coordination of care, and by assisting those who need help navigating the system to facilitate appropriate delivery of care using Registered Nurses, Licensed Social Workers, Licensed Behavioral Health Professionals and Health Navigators.

Health Plan takes a member centric, preventative, and restorative approach by offering multiple programs and interventions and activities to support and re-enforce the efforts of the Health Plan provider community by promoting vaccinations, local clinics, and HEDIS measures as well as assisting members with housing, energy, food, clothing, and financial support. Some of these programs are:

- Complex Case Management
- Condition Management and education for chronic conditions impacting our members most often
- Prenatal Education for High-Risk pregnancies
- Major Organ Transplant Community Based Adult Services (CBAS)

- Program of All-Inclusive Care for the Elderly (PACE)
- Social Services Case Management

Complex Case Management focuses on adult members with the highest risk. Those with multiple complex physical or behavioral health conditions and socio-economic challenges. Case Management endeavors to take a preventative and restorative approach to care.

Complex Case Management is distinguished from standard case management in that the degree and complexity of illness are typically severe, the level of engagement required to manage the complexity is typically intense, and the number of resources required for the member to regain optimal health or improved functionality is typically extensive (See Complex Case Management Program Description).

Cases are selected for case management based on criteria that address various demographics, including:

- Age
- Psychosocial and economic status
- Support systems
- Diagnoses severity of illness
- Ability to participate in activities of daily living
- Presence of multiple diagnoses, conditions, disabilities, and/or health care needs

Objectives for serving members with complex health needs are to:

- Identify gaps in preventative care and promote the benefits of addressing gaps in care
  - Provide case management services as a mechanism to optimize the use of the member's health care benefits while providing high quality integrated health care to members with ongoing or complex health care needs and help coordinate care with multiple providers for multiple conditions
  - Provide case management which focuses on development of an Individualized Care Plan (ICP) though which member education, care coordination, and transition of care to community based behavioral health services for members with behavioral and mental health care needs, and substance abuse treatment needs are supported
  - Enhance continuity and coordination among and between primary and behavioral health care providers in a timely manner
  - Ensure that members receive coordinated, appropriate, and timely access to primary and specialty care services
  - Identify and reduce barriers to services for members, such as: lack of transportation, shelter, and/or the need for cultural and linguistic outreach education

Behavioral Health

Health Plan provides services for members with non-specialty mental health services. The services for members needing specialty mental health, including substance use disorder services, are carved out to the County Behavioral Health Services Agencies. To ensure the coordination and delivery of medically necessary behavioral health care services the plan has established a Memorandum of Understanding (MOU) with the County Behavioral Health Service Agencies in each service area for services and interventions for members with Specialty Mental Health Services including outpatient and inpatient needs. In addition to its MOU with County Behavioral Health agencies, Health Plan also manages its members

Commented [KC5]: Factor 2: monitor and improve behavioral healthcare

Commented [KC6R5]: Monitoring: the Health Plan provides services for non-specialty mental health, while specialty mental health services are coordinated through County Behavioral Health Services. There are established processes, such as Memoranda of Understanding (MOUs) with County Behavioral Health Agencies, to ensure that both non-specialty and specialty behavioral healthcare services are monitored and coordinated for members.

Commented [KC7R5]: Improving: the plan incorporates efforts for behavioral health care improvement, such as providing telehealth services to ensure access to mental health care, implementing behavioral health screenings, and creating care plans for members with behavioral health needs. The Health Plan monitors behavioral health outcomes through annual evaluations of behavioral health programs, incorporating feedback from members and stakeholders

receiving Behavioral Health Treatment. Health Plan has a large network of providers to serve these members. In addition, Health Plan maintains a robust telehealth network to assist and ensure adequate member access to necessary behavioral health services. Health plan collaborates with County Behavioral Health Services to find ways to improve continuity and coordination of behavioral health care services for members.

Background

Health Plan maintains their own direct mental health network of providers, which include all eligible Medi-Cal providers for non-specialty mental health, including psychiatric services. Health Plan ensures that all Behavioral Health activities are conducted in compliance with state and federal laws and regulations. Telehealth mental health and behavioral health treatment include the delivery of non-specialty mental health telehealth, behavioral health treatment services, utilization management of behavioral health treatment and the credentialing and maintenance of providers related to the delivery of these services are handled by Health Plan. Care coordination and Case Management is offered for all members with behavioral health conditions and/or needs.

The scope of Health Plan's Behavioral Health Quality Improvement and Equity Program encompasses the ongoing assessment, monitoring, and improvement of all aspects of care and service delivered to members, including member safety. The diverse populations served represent multiple cultural and linguistic groups, and includes pediatric, adult, and geriatric individuals with mental health and substance use disorders, as well as individuals with developmental disabilities and other special needs. The outcome of the analysis is incorporated into what the Health Plan includes during the annual evaluation of all behavioral health programs and their effectiveness.

Integrated Behavioral Health Programs Through the Federally Qualified Health Centers (FQHC)

Health Plan is partnered with the following FQHC groups:

- Community Medical Centers
  Their Behavioral Health Services help when habits, behaviors, stress, worry, or emotional concerns about physical or other life problems are interfering with a person's daily life and/or overall health. They have a team of clinicians who work closely with their PCPs to help patients manage the physical, behavioral, and emotional aspects of their health. They offer a broad spectrum of mental health services including medication management, and professional counseling for couples, individuals, families, children, and adolescents.

- Livingston Community Health
  Their Behavioral Health services support mental health for adults and children with case management, crisis intervention, and both family and individual counseling. Their staff is dedicated to providing quality, culturally responsive, behavioral health services that promote wellness, recovery, and resilience for our community.

- San Joaquin General Hospital Clinics
  SJGH currently has a MOU with the Adult mental Services program that is part of the San Joaquin County health Care Services Agency's mental Health Division for a psychiatrist and a LCSW, to assist its clinic providers in managing behavioral health problems.

Commented [KC8]: Factor 2: monitor and improve behavioral healthcare

Commented [KC9R8]: Coordination/ Integration: Integrated Behavioral Health Programs are part of the Health Plan's strategy to improve access to behavioral healthcare. These programs work in partnership with FQHCs (Federally Qualified Health Centers) to ensure members receive both physical and mental health services. This collaboration is crucial.

Commented [KC10]: Factor 4: Involvement of designated behavioral healthcare practitioner

Commented [KC11R10]: behavioral health practitioners, including psychiatrists and other clinicians, collaborate with primary care providers in integrated behavioral health models. These behavioral health experts help to evaluate and enhance care plans, participate in the QIHEC, and provide guidance in managing both medical and behavioral health conditions

Commented [NB12R10]: This section does not indicate who the designated BH practitioner is for HP

- Stanislaus Health Services Agency (HSA)
  Stanislaus HSA has been using the Integrated Behavioral Health model to identify, elevate, and accelerate promising behavioral care practices. In this program, behavioral health clinicians work with primary care providers as a team to treat the whole person, addressing physical and mental health needs. Through this model, patients who are identified needing behavioral health intervention are paired with a social worker as well who helps ensure that patients are seen by a psychiatrist within 3-4 weeks. Specialists make recommendations for treatment/management which the patients' PCPs help implement and follow-through. Stanislaus HSA also has Behavioral Health Provider Education efforts which is a partnership with Health Plan on educating internal providers on recent measure specifications as well as process updates on Beacon and County Behavioral Health referrals and management.

- Golden Valley Health Centers
  Golden Valley Health Centers (GVHC) prides itself in its behavioral health program that offers the following services:
    - Individual and Group therapy for adults and children
    - Patient -directed Treatment Plans
    - Case management
    - Psychiatric Care

GVHC's behavioral health team consists of psychiatrists, social workers, and case managers, working in partnership with its PCPs. To date, GVHC has 11 clinic sites, offering Integrated Behavioral Health program services.

Another key component of GVHC's Behavioral Health Program is the Medication Assisted Treatment (MAT) program that helps patients recover from opioid addiction through a combination of counseling and medication. Its goal is to treat withdrawal, prevent relapse, and help patients get back to a healthier life. In this program, each patient is treated uniquely so each care plan will be built just for him/her. Regardless of how long the process may take, GVHC will be there to assist the patient with achieving the recovery deserved. MAT program is currently being offered in two GVHC locations/sites.

Alpine county offers integrated Behavioral Health services and one unit of continuum of services. El Dorado Community Health Centers also offer integrated behavioral health services on site.

Student Behavioral Health Incentive Program (SBHIP)
The DHCS received $389 million one-time funding, available over three years for increasing student behavioral health services to be distributed throughout the state of CA. The SBHIP program began January 1, 2022. Dollars will be expended across 3 priority areas including: planning, infrastructure, and early prevention and intervention with the goal to incentivize new partnerships, and enhance existing partnerships between Health Plans, schools, and counties. DHCS plans to provide incentive payments through Medi-Cal managed care plans.

SBHIP provides incentives to increase coordination among Medi-Cal Managed Care Plans, Local Education Agencies (LEAs), and county mental Health Plans with the understanding that it will significantly impact the delivery of services to this population and ultimately benefit all delivery systems. Creating a comprehensive and continuous system of care for Medi-Cal students to access the entire scope of available benefits is consistent with the national movement of increasing access to Medicaid services in schools.

The goals of the SBHIP are:

- To increase the number of K-12 students receiving preventive, early intervention, and behavioral health services
- Maximize all available partnership additional funds, including but not limited to, School-Based Medi-Cal Administrative Activities, Mental Health Services Act, Mental Health Student Services Act, and Local Control Funding Formula funds
- Invest in greater prevention and earlier identification can enhance learning and student wellness. Additionally, with over 50% of California children enrolled in Medi-Cal, significant investment of infrastructure of behavioral health access in schools for Medi-Cal students will indirectly build needed capacity and access for non-Medi-Cal students
- Break down silos and improve coordination of child and adolescent behavioral health services for those enrolled in Medi-Cal through increased communication with schools, school-affiliated programs, managed care providers, counties and mental health providers
- Increase the number of TK-12 students enrolled in Medi-Cal receiving behavioral health services provided by schools, school-affiliated providers, county behavioral health departments and county offices of education
- Increase non-specialty services on or near school campuses
- Address health equity gaps, inequalities, and disparities in access to behavioral health services

Health Plan has established relationships with the County Office of Educations (COE) in all counties and has established Memorandum of Understanding with Local Education Agencies. In Stanislaus County the COE selected the following school districts to partner with Health Plan – Newman Crows-Landing, Keyes Union, Stanislaus Union, Riverbank Unified and Waterford Unified. In San Joaquin County the COE selected the following school districts to partner with Health Plan – Escalon Unified, San Joaquin COE, Linden Unified and Venture Academy. In El Dorado County the partnerships are with Black Oak Mines, Camino Union, El Dorado Union High and Lake Tahoe. In Alpine County there is a Behavioral Health wellness program. Health Plan worked with the counties in 2022 and 2023 to complete the SBHIP assessment which includes stakeholder meetings, qualitative and quantitative data collection, a community resource map and an external provider behavioral health referral process. DHCS approved both assessments. Targeted interventions were selected in each county. Health Plans, COEs and the school districts are partnering with County Behavioral Health, local providers and community-based organizations to implement the targeted interventions.

San Joaquin County interventions are the following:

- Escalon Unified - Building Stronger Partnerships to Increase Access to Medi-Cal Services. Schools working together with neighboring community mental health practitioners or agencies to create a network of available clinicians, counselors and other mental health professionals that can work together for the students
- Linden Unified – Care Teams – provide outreach, access, and facilitation of prevention, early intervention, and other behavioral health services to students and families
- Venture Academy – Behavioral Health Wellness Programs. Build out onsite wellness century, buy equipment and staff the wellness center – mental health clinicians, school counselors and other staff will be available to respond to students
- COE – IT Enhancements for Behavioral Health Services. Enhance the San Joaquin COE billing system building a crosswalk for all school districts and counties to bill managed care plans and other insurance billing systems

Stanislaus County will implement all interventions in each school district. The interventions are the following:

- Expand Behavioral Health (BH) Workforce: Districts hire student and family support person(s), an unlicensed BH role to assist in outreach, helping families and communities become familiar with services and increase awareness and understanding of mental health services
- Behavioral Health Screening and Referrals: Implement a universal mental health screener and web-based request for assistance form and enhance internal and external referral tracking
- Behavioral Health Wellness Programs: New licensed positions to provide mild to moderate behavioral health services appropriate for treatment through school-based counseling
- IT Enhancements for Behavioral Health Services: Identify and implement a software system with a developed practice management system that supports third-party billing services

El Dorado County LEAs will implement every intervention. This includes building stronger partnerships to expand Medi-Cal services and to expand the behavioral health workforce.

Alpine County will implement a behavioral health wellness program and work with the Alpine Unified local education agency.

Long Term Care

As of January 1, 2023, all California Medi-Cal managed care Health Plans (MCPs) are responsible for ensuring safe transitional care for enrollees eligible for long-term care (LTC) services. MCPs also ensure reimbursement for the network furnishing institutional long term care services. Health Plan has an adequate network of LTC providers within the service areas and when identified, outside the service area to ensure access for members to all medically necessary services including LTC and to meet network adequacy requirements. Members are placed in a care facility that provides the level of care most appropriate to the members' medical needs unless the member has elected hospice. All contracted facilities are licensed and certified by the California Department of Public Health and eligible to participate in the Medi-Cal Program.

The LTC Quality Program monitors the quality and appropriateness of care and encompasses the requirements in APL23-004 by adhering to plan policies. All monitoring will be summarized in the annual report and evaluation of the LTC Program. Reporting follows the approved quality and equity reporting framework.

Organizational Structure

Health Plan's organizational structure is the framework for all QIHETP activities. The organizational structure includes accountability for the program, committee structure, and the appropriate personnel to design, develop and implement the program.

Accountability

The SJCHC has the ultimate authority and responsibility for the management of quality of care and service delivered by Health Plan. The SJCHC is Health Plan's governing body whose role is to oversee, approve, promote, and support the strategic plan, goals and objectives of the program. The SJCHC has the ultimate responsibility for the direction and oversight of the QIHETP. Health Plan

Commented [KC13]: Factor 1: Reporting relationships of QI Department staff, QI Committee, and any subcommittee

Commented [KC14R13]: Reporting relationships are defined, including the roles of the QIHEC and subcommittees such as the Peer Review Committee and Grievance and Appeals Committee. These report to the SJCHC

implements and maintains written policies and procedures that specify the responsibilities of the SJCHC which include at a minimum:

- Approving the overall QIHETP and the annual plan of the QIHETP;
- Appointing an accountable entity or entities within the organization responsible for the oversight of the QIHETP;
- Receiving written QIHEC progress reports that describe actions taken, progress in meeting QIHETP objectives, and improvements made, and
- Directing necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity standards and the DHCS Comprehensive Quality Strategy

The SJCHC:

- Reviews and approves the annual QIHETP description
- Reviews and approves the annual QIHETP work plan
- Reviews and approves the annual QIHETP evaluation
- Reviews and approves other reports about quality improvement activities as provided by the QIHEC
- Ensures appropriate resources are available to implement the quality improvement and health equity program

The SJCHC assigns the authority and responsibility of implementing and communicating the Quality Improvement and Health Equity Program to the QIHEC. The QIHEC is charged with overseeing implementation of the QIHETP. One member of the Commission is assigned to membership on Health Plan's QIHEC.

The SJCHC meets a minimum of ten (10) times a year and maintains written minutes including discussions and actions from each meeting. Meeting agendas include presentation of Health Plan's committee and sub-committee reports for review, recommendations, and approval. The SJCHC meetings are widely publicized, open to the public, and meet the conditions of the Ralph M. Brown Act.

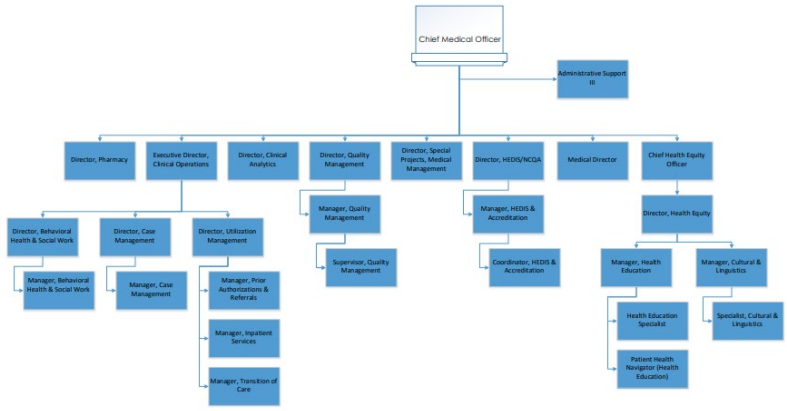
The SJCHC is comprised of eleven (11) members and thirteen 13 seats, and the Board of Supervisors of the Member Counties shall appoint one member each to the Health Commission. Members shall represent the interest of the public, the County, beneficiaries, physicians, hospitals, health care providers or other health care organizations. Appointments shall consider racial, ethnic, gender and age diversity as well as qualifications set forth herein. The commission members serve at the pleasure of the appointing board of supervisors.

(a) Three members shall be physicians, one of whom may represent traditional providers of Medi-Cal services. These members shall be chosen from among those nominated by the San Joaquin Medical Society
(b) One member shall be a physician representing the public practice of medicine. San Joaquin County Director of Health Care Services shall nominate this member
(c) One member shall represent the Hospital Council of Northern and Central California. The San Joaquin County Directory of Health Care Services shall nominate this member after consulting representatives of hospitals in the County and the Hospital Council of Northern and Central California

(d) Two members shall be community representatives who demonstrate sensitivity and awareness of the problems of serving Medi-Cal constituents
(e) Two members of the San Joaquin Board of Supervisors shall serve as ex-officio members.
(f) One member shall be appointed by the Alpine County Board of Supervisors and shall be:
    a. A member of the Alpine County Board of Supervisors
    b. A County employee
    c. A Medi-Cal Beneficiary who is also a Health Plan member; or
    d. A Health Plan contracted Health Care Provider.
(g) One member shall be appointed by the El Dorado County Board of Supervisors and shall be:
    a. A member of the El Dorado County Board of Supervisors
    b. A County employee
    c. A Medi-Cal Beneficiary who is also an Health Plan member; or
    d. A Health Plan contracted Health Care Provider.
(h) The San Joaquin County Administrative Officer or the designee of the County Administrative Officer shall serve as an ex-officio member
(i) The Director of the San Joaquin County Health Care Services shall serve as an ex-officio member.

The County Health Commission appoints a member to serve on the QIHEC. Appointments are staggered; with each appointment lasting no longer than two (2) years; with the opportunity for reappointment should the member agree. Please see page 68 for the committee structure that supports the Quality Program.

Key Personnel



Chief Medical Officer (CMO)

Health Plan maintains 1 (one) full time CMO who has an unrestricted license in the state of California as a physician in the field of medicine. The CMO reports to the Chief Executive Officer and communicates directly with the County Health Commission, as necessary. The CMO has ultimate responsibility and oversight for the QIHETP, Grievances and Appeals, Credentialing and

Commented [KC15]: Factor 3: The Chief Medical Officer (CMO) is responsible for oversight of the QIHETP and the QIHEC. The CMO chairs the QIHEC, Peer Review, and Credentialing Committees and is responsible for ensuring compliance with regulatory standards, providing medical leadership, and overseeing quality improvement activities. The Medical Director (MD) works under the CMO, assisting with operations management and advising on QI initiatives

Peer Review, NCQA Accreditation, HEDIS reporting, Population Health, Health Education, and activities.

The Chief Medical Officer:

- Ensures medical and other health services decisions are rendered by qualified medical personnel and are not influenced by fiscal or administrative management considerations
- Ensures the medical and other health care provided meets acceptable standards of care
- Ensures that medical personnel follow medical protocols and rules of conduct
- Develops and implements medical policy consistent with applicable standards of care
- Demonstrates a commitment to and promotes the QIHETP through peer and community communication and resource allocation
- Provides supervision, in collaboration with the Chief Health Equity Officer to all QIHETP activities
- Serves as the key medical management contact for the regulatory and oversight agencies
- Identifies and oversees the Quality and Disease Management, Case and Utilization Management, Pharmacy and Clinical Programs and Medical Management Analytic departments activities that meet the needs of Health Plan providers, members, and regulators
- Serves as Chair of the Quality Improvement and Health Equity Committee (QIHEC), Peer Review & Credentialing (PR&C) and Physician Advisory Committees, and serves other committees as required
- Supervises all QIHEC activities in collaboration with the Chief Health Equity Officer
- Assigns, as appropriate, authority for aspects of the QIHETP to the Director of Quality Management and Medical Director
- Ensures that effective collaborative work and problem solving is maintained between assigned departments, and other internal and external stakeholders
- Oversees accreditation and compliance activities to ensure agreed upon and mandated standards are met
- Identifies medical delivery system quality issues; develops and oversees implementation of corrective action plans
- Collaborates with network practitioners/providers and the provider community in a manner that engenders positive relationships, practitioner/provider support and network stability
- Oversees the development, dissemination, implementation and evaluation of clinical practice, preventive health, and benefit interpretation guidelines
- Oversees the provision of medical management for safe and effective health care services, including behavioral healthcare services in conjunction with the Medical Director, and the Pharmacy Director
- Recommends all medical review criteria used for medical necessity determinations
- Establishes prioritization of QM issues and improvement activities based on member impact, safety, and available resources
- Reviews and approves Quality Management policies and procedures

Medical Director(s) (MD)

Health Plan maintains at least one full time Medical Director who has a valid, unrestricted license in the state of California as a physician in the field of medicine. The MD reports to the CMO and is responsible for managing the operations of the Medical Management Department.

The Medical Director:

- Participates in the coordination of the Medical Management department, Quality, Utilization, and Care Management, Pharmacy and Health Education activities
- Organizes and prepares written responses to requests and inquiries from regulatory agencies that involve Medical Services under the direction of the CMO, and guidance of the Compliance Officer
- Coordinates the implementation of organizational and/or system changes to Medical Services required by regulatory agencies
- Coordinates relationships and/or activities with regulatory agencies and community-based partners
- Participates in the implementation of the annual QIHETP Description and Work Plan; assures that the recommendations made by the CHC and the QIHEC are carried out promptly in collaboration with the CMO
- Develops programs to increase awareness and provide educational opportunities to practitioners/providers and members regarding the goals and activities of the Health Plan in conjunction with Provider Service, Health Education and Community, Marketplace and Member Engagement (CMME) department leadership
- Advises on complex, controversial and/or unique claims that are outside the realm of medical policy; arbitrates member and practitioner/provider grievances and appeals in a timely manner
- Works closely with the CMO to identify medical service issues that have an impact on plan benefits and their administration; assist subordinate managers in resolving medical claims review, grievances, appeals, and other medical management issues
- Assists in identifying and analyzing care and quality issues and trends; makes recommendations based on findings; develops and implements agreed upon changes
- Identifies data needs for both internal and external use to ensure that Health Plan and practitioners/providers have appropriate data and information with which to manage healthcare service utilization, cost, and quality
- Assists in the identification and development of quality and utilization management programs and policies and procedures
- Coordinates and participates in accreditation and compliance activities affecting utilization management, care management and quality improvement; reviews and analyzes proposed legislation that would affect the activities and makes appropriate recommendations
- Serves on Quality Management and Utilization Management, Grievance Committee, Peer Review and Physician Advisory Committees, and other committees as required
- Reviews and assists with the development of Quality Management policies and procedures

Executive Director of Quality and Equity (EDQE) vacant

The EDQE is responsible for the strategic direction of the quality and equity functions of the Health Plan consistent with contractual and regulatory requirements. The EDQE reports to the CMO. The EDQE is also responsible for providing strategic direction for Health Plan's health equity programs and initiatives that promote health equity and reduce health disparities.

- Develops operational objectives and plans, ensures the development and implementation of associated business plans and tactics for Quality and Equity in alignment with NCQA, DHCS, and DMHC
- Assists the CMO and MDs in identifying relevant and effective programs, policies, and procedures for quality, credentialing, grievances, appeals and Health Equity based on regulatory requirements, opportunities, issues and trends

- Collaborates across departments to ensure the quality program meets or exceeds NCQA and regulatory standards
- Collaborates with Provider Services and other internal and external stakeholders to ensure effective implementation of provider and member interventions to improve quality and HEDIS measures including Health Equity measures and maintains compliance with Health Equity Transformation Program goals and activities and facility Site Review/Medical Record Review
- Engages with staff, subcontractors, downstream subcontractors, network providers, community-based organizations, local health departments, behavioral health, social services, members and provider outreach
- Serves as a representative and spokesperson for Health Plan is support of Health Equity with key county partners
- Participates in state and local work groups such as DHCS, DMHC, CHCF, NCQA, ACAP, and CAHP to expand Health Plans influence on benefit design, regulations, and policy direction

Director of Quality Management (DQM) vacant

The DQM is, responsible for the direct oversight, supervision, and management of the quality staff that implement QIHETP activities focusing on quality improvement. The DQM reports to the CMO.

The Director of Quality Management:

- Oversees the implementation of an organization wide quality management and improvement program
- Oversees quality improvement projects, initiatives and activities
- Plans, implements, and evaluates the QIHETP under the direction of the CMO and in collaboration with the CHEO
- Oversees the coordination of support to QIHEC and Peer Review Committees
- Coordinates and supports the patient safety program
- Supports the adoption and oversees the implementation of knowledge-based practice guidelines, performance measures, and benchmarks
- Oversees the creation of cross-functional QM teams as appropriate for qualitative and quantitative analysis to identify patterns and trends in care delivery and service utilization
- Oversees and facilitates root cause analysis for all adverse patient care trends
- Coordinates and oversees staff training and education to promote excellence in quality practices and ensure compliance with all applicable laws and regulations
- Collaborates with leadership and staff to develop and maintain policies and procedures that ensure the delivery of high-quality health care and prevents harm to members
- Maintains current knowledge related to health care federal and state laws and regulations and quality accreditation standards
- Reports patient care data and core measurement outcomes to federal and state entities
- Coordinates data inventory efforts and available data sources
- Collaborates with leadership and QM staff in the development of the Annual QIHETP, Evaluation, and QIHETP Work Plan
- Collaborates with the CMO and MD to ensure appropriate allocation of resources to maintain an effective QIHETP
- Coordinates and oversees ongoing quality accreditation activities
- Develops and revises Quality Management and Credentialing/Recredentialing policies and procedures

- Collaborates with medical management and other departments to ensure that the QIHETP and Credentialing program meets or exceeds NCQA and regulatory standards

Quality Management Manager(s) (QMM)

The QMM reports to the CMO and is responsible for developing, planning, and implementing the Quality Management and Improvement Programs activities for Health Plan.

The Quality Management Manager(s):

- Gathers and evaluates clinical data within the organization; performs follow-up evaluations of data and organizational performance to ensure consistent improvement; coordinates and/or conducts root-cause analysis investigations for specific patient care trends and all adverse effects
- Oversees and evaluates the organization's reporting and compliance with patient care benchmarks and measurements
- Reviews identified QI metric results and trends and takes timely and effective action based on findings
- Develops and implements unit policies and procedures that promote best practice; makes recommendations on revisions; communicates to appropriate individuals in a timely and effective manner
- Participates in DHCS/IHI state-wide collaborative to address childhood health disparities. Assists with the planning, implementation, monitoring and reporting of the collaborative initiatives
- Serves as liaison to statewide and community agencies to identify and resolve program issues; assists with the preparation and delivery of reports on Quality Improvement Initiatives (QIP) activities
- Works closely with interdepartmental units to establish and improve workflow and processes, identifies issues and opportunities; resolves issues or makes recommendations as required
- Develops and monitors business plans and the department budget; hires, supervises and retains a competent staff
- Collaborates with the Compliance department to ensure QIHETP documentation and follow up for implementation of regulatory issues are completed
- Compiles and reviews data; completes and submits various routine and ad hoc reports as required
- Manages quality improvement projects, initiatives, and activities including grievances and appeals

Quality Management Supervisor (QMS)

The QMS reports to the DQM and is responsible for providing oversight of and coordinating daily operations for QI, grievances, appeals, and Facility Site Reviews (FSR).

The Quality Management Supervisor:

- Ensures and oversees the effective management of the Quality Management and Improvement Program in conjunction with the DQM
- Oversees and assists with the planning, implementation, and evaluation of the annual QIHETP and Work Plan design through planning, design, implementation, and review in conjunction with the DQM and the QIHEC
- Oversees and supervises the Grievance and Appeals/PQI processes and staff

- Ensures that QM Nurses and A&G Nurses carry out responsibilities as assigned
- Ensures compliance with NCQA and regulatory standards for Quality and Credentialing
- Research identified quality improvement issues; recommends interventions; leads planning and implementation and evaluates outcomes
- Monitors and analyzes identified metrics; takes timely and effective action based on findings
- Assists in the identification and analysis of quality metric trends, issues and opportunities; recommends and implements action plans
- Assists in the development of and implements and maintains unit policies and procedures; makes recommendations on revisions; communicates to appropriate individuals in a timely and effective manner
- Leads external and internal quality and regulatory audits; assists in the development, implementation, and monitoring of corrective action plans
- In conjunction with manager, participates in state-wide collaboratives; assists with the planning, implementation, monitoring and reporting of the collaborative initiatives, PIPs, QIPs and PDSAs as outlined by DHCS or DMHC
- In conjunction with manager, serves as liaison to statewide and community agencies to identify and resolve program issues; assists with the preparation and delivery of reports on QIP activities
- Compiles and reviews data for and completes and submits various routine and ad hoc reports as required
- Collaborates with the Compliance department to ensure Quality Management documentation and follow up for implementation of regulatory issues are completed

Quality Management Nurses (QMN)

The Quality Management Nurse is a Registered Nurse licensed by the State of California. The QMN reports to the QM Manager or QM Supervisor and performs QM activities related to HEDIS, FSR, and complaint/grievance resolution.

The Quality Management Nurses:

- Assists with the planning, implementation, and evaluation of the annual QIHETP and QI Work Plan.
- Coordinates and reports to the QHEOC or QIHEC and department leaders clinical and service quality activity outcomes
- Manages QI Projects (QIP's), QI Activities (QIA's) studies including Grievances, PQIs and any interventions
- Prepares QI studies and reports for submission to the QHEOC and QIHEC
- Identifies opportunities for improvement through monitoring and analysis of clinical and satisfaction data
- Coordinates organizational QM teams for data analysis and identification of opportunities for improvement
- Ensures timely reporting of quality information to state and federal entities
- Ensures accessibility and availability of care studies occur at least annually along with data analysis and identification of performance improvement opportunities
- Assists with development, maintenance, and implementation of QM policies and procedures
- Oversees and monitors assigned administrative functions including annual program descriptions, work plans, evaluations, as well as maintenance of up-to-date definitions and organization charts related to:

- Credentialing
- Utilization Management
- Quality Improvement
- Member Rights and Responsibilities

- Participates in maintaining compliance with NCQA and regulatory standards
- Implements Quality Improvement projects with the individual Provider Offices in collaboration with the Medical Management Team for the Provider Partnership Program

Appeals Nurse, Senior (AN)

The AN is responsible for investigating and processing appeal requests from members and providers in compliance with internal and external requirements, and Health Plan strategies and objectives. The AN reports to the QMNS.

The Appeals Nurse:

- Conducts investigations and reviews of member and provider grievances and appeals

Actively participates in all State Fair Hearings for Appeals
Reviews prospective, concurrent, or retrospective medical records of denied services and provides to Medical Directors for medical necessity review

- Recommends action on and escalates other appeals to Medical Director for review,

approves services as directed

- Ensures that appeals and grievances are resolved timely to meet regulatory timeframes
- Documents and logs appeal/grievance information on relevant Health Plan tracking systems

according to standards

- Ensures compliance with State and NCQA standards for processing appeals
- Generates appropriate written correspondence to providers, members, and regulatory entities
- Reviews member and practitioner Notice of Action letters to ensure regulatory compliance
- Performs any other job-related instructions as requested, with reasonable accommodation

Appeals and Grievance Nurse (A&GN)

The Appeals and Grievance Nurse is a Licensed Vocational Nurse, or a Registered Nurse licensed by the State of California. The A&GN reports to the QM Manager or QM Supervisor and performs QM activities related to complaint/grievance resolution and appeals.

The Appeals and Grievance Nurse:

- Conducts investigations and reviews of member grievances and appeals
- Reviews prospective, concurrent, or retrospective medical records of denied services and provides to Medical Directors for medical necessity review
- Prepares and distributes case reviews, and recommendations as appropriate, to internal and external reviewers

- Generates appropriate written correspondence to providers, members, and regulatory entities; collaborates with internal and external stakeholders to ensure reporting and letters are timely and accurate
- Reviews member and practitioner Notice of Action letters to ensure regulatory compliance; documents findings and escalates as necessary
- Investigates and performs clinical review of the IMR/SFH's, submits Health Plan responses for IMR/SFH's and participates in SFH's as directed
- Documents and maintains activities and records in appropriate Health Plan system(s) according to standards

Director of HEDIS and Accreditation (DHA)

The DHA is responsible for providing strategic direction of HEDIS and NCQA Accreditation programs consistent with contractual and regulatory requirements, and Health Plan strategies and objectives. The DHA reports to the CMO.

The Director of HEDIS and Accreditation:

- Develops operational objectives and plans; ensures the development and implementation of associated business plans and tactics
- Leads and oversees NCQA accreditation activities to ensure ongoing compliance
- Ensures effective implementation and reporting of HEDIS, MCAS, DMHC and Health Equity metric reporting process
- Ensures reporting supports effective implementation of interventions for improvement
- Anticipates the need for and develops and implements relevant and effective quality management programs based on opportunities, issues, and trends
- Assists Chief Medical Officer and Medical Director in identifying data, claims and coding opportunities for quality and equity measure reporting
- Collaborates with medical management and other departments to ensure that the Quality program meets or exceeds NCQA and regulatory standards
- Ensures effective implementation of the NCQA HPA triennial renewal survey
- Collaborates with internal and external stakeholders to develop programs that increase awareness and provide educational opportunities to providers and members regarding Health Plan's Quality Management and Improvement program goals and activities, as well as compliance issues for HEDIS and NCQA
- Conducts or oversees the preparation, implementation, and corrective action plans for internal and external audit activities to ensure practices adhere to recognized clinical and preventative care guidelines, NCQA requirements, regulatory guidelines, and Health Plan criteria
- Develops or oversees the development of relevant, timely and accurate internal and external quality reports, advising leadership as appropriate
- Develops and manages department budgets; implements appropriate interventions
- Develops, implements, and maintains appropriate and required records, documents, policies, and procedures, including contracts. Collaborates with internal and external stakeholders to ensure the collection, storage and retrieval of relevant data and information
- Develops and maintains a health education and population health program that meets all the regulatory and accreditation requirements and with a focus on member care to include cultural and linguistic needs
- Leads or participates in internal and external committees as assigned
- Oversees HEDIS, NCQA, PHM and Consumer Assessment survey vendors

- Promotes, maintains, and ensures that direct reports promote and maintain an environment that supports Health Plan's strategy, vision, mission, and values
- Oversees all applicable Member Experience Surveys including the Consumer Assessment of Healthcare Providers and Systems, DMHC Language Access Experience, and collaborates with Behavioral Health (BH) and Social Work to conduct BH Surveys
- Directs all vendor and consultant relationships related to HEDIS and Accreditation

HEDIS and Quality Reporting Manager (HM)

The HM reports to the DHA and is responsible for the overall management, strategic planning, and maintenance of HEDIS performance, and reporting.

The HEDIS and Quality Reporting Manager:

- Develops multidisciplinary training and education programs for staff, providers, and members regarding HEDIS, MCAS and HEQMS.
- Develops and manages ongoing audit activities to ensure EQRO compliance
- Collaborates with the Directors and Managers of other departments to ensure compliance with HEDIS and quality reporting
- Ensures timely and accurate submission of the HEDIS related documents
- Manages the HEDIS performance and reporting, meeting contractual requirements
- Maintains all vendor and consultant relationships related to HEDIS
- Coordinates all activities related to HEDIS reporting including development of the road map, maintaining the relationship and interaction with the vendor and auditors, leading the audits, medical record collection and abstraction and submission of the final reports
- Develops and oversees the successful implementation of provider and member interventions such as distribution of provider report cards and development and implementation of member incentives
- Ensures completion and analysis of all quality metrics and regulatory required surveys and reports to the appropriate Quality Committees

Accreditation Manager (AM)

The AM reports to the DHA and is responsible for the overall management, strategic planning, and maintenance of NCQA accreditation programs and CAHPS and member experience surveys.

The Accreditation Manager:

- Develops multidisciplinary training and education programs for staff, providers, and members regarding Member Experience and NCQA
- Develops and manages ongoing audit activities to ensure accreditation compliance
- Collaborates with the Directors and Managers of other departments to ensure compliance with the NCQA standards for accreditation and Health Equity accreditation reporting
- Ensures timely and accurate submission of the NCQA and member experience related documents
- Manages Accreditation performance and reporting
- Maintains all vendor and consultant relationships related to NCQA
- Ensures completion and analysis of all NCQA and regulatory required surveys and reports to the appropriate Quality Committees
- Assists with leading quality improvement activities upon request in support of achieving quality and equity organizational goals

HEDIS/NCQA Coordinators (HNCs)

The HNCs report to the HM and AM and are responsible for organizing HEDIS activities and NCQA activities according to established timelines.

The HEDIS/NCQA Coordinators:

- Compile and updates the annual HEDIS measures matrix
- Compile CAHPS and member experience reporting
- Develop HEDIS and/or NCQA Accreditation and member experience project plans based on established guidelines and submits for approval
- Monitor project progress and timelines; escalates issues to supervisor as necessary
- Prepare HEDIS roadmap in collaboration with HEDIS staff and relevant department heads; make recommendations for chase logic; submit for approval
- Schedule QM staff for medical record review and data abstraction
- Coordinate HEDIS medical record review with internal and external staff
- Serves as a secondary point of contact for HEDIS/NCQA vendor related to data runs, chase logic, system issues and submission of data and reports
- Conduct medical record review on immunization data abstraction, aggregation and analysis
- Prepare and conduct HEDIS/NCQA/CAHPS education and training for staff
- Compile various internal and external HEDIS reports
- Assist with HEDIS related health education and promotion activities and member incentives
- Coordinate deliverables and maintains work plans associated with NCQA HPA
- Coordinates deliverables and maintain work plans associated with CAHPS, ECHO and LAP surveys

Quality Coordinator (QC)

The QC is responsible for DMHC/DHCS reporting activities for Health Plan and ensuring that key activities are completed in a timely manner. Work is varied and minimal to moderately complex and requires a minimal to moderate degree of discretion and independent judgment. The QC reports to the QM.

The Quality Coordinator:

- Compiles, formats, prepares, and submits for approval, routine reports required by DMHC/DHCS for distribution to internal and external stakeholders, coordinates review and distribution
- Creates and maintains routine and ad hoc reports and other documents for DMHC/DHCS; arranges for distribution
- Assists in identifying and developing appropriate performance measurement tools
- Assists in preparing for internal and external audits required by DMHC/DHCS, and in the preparation of recommendations, responses, and reports
- Develops and maintains process flows for reporting within the quality department including documenting departmental processes, report generations, and process improvement
- Monitors and adapts to changes in DMHC/DHCS report requirements, and other related materials that are requested by regulators or that require regulatory approval

- Enters and maintains data, information, documents, and files according to standards, including but not limited to appeals and grievance software
- Assists with coordinating documentation collection for HEDIS/NCQA Accreditation

Chief Health Equity Officer (CHEO)

The Chief Health Equity Officer is responsible for providing strategic direction for Health Plan's health equity programs and collaborates with internal and external stakeholders to design and oversee the implementation of programs and initiatives that promote health equity and reduce health disparities. The CHEO reports to the CMO. The Chief Health Equity Officer supports the Chief Medical Officer (CMO) by sharing the responsibility of supervising, advising, and providing oversight of the QIHETP and the Quality and Health Equity Committee (QIHEC). The Executive Director of Clinical Operations is Acting CHEO.

The CHEO:

- Provides leadership in the design and implementation of strategies and programs to ensure health equity is prioritized and addressed both with internal Health Plan functions and external and community partnerships
- Works collaboratively with all departments across the organization to achieve health equity goals established by NCQA and DHCS, and partners with the Quality team to ensure that the QIHETP program is implemented and monitored to meet or exceed DHCS/DMHC & NCQA requirements
- Ensures organizational policies, procedures, and programs consider health inequities and are designed to promote health equity where possible, including but not limited to: Marketing strategies, medical and other health services policies, member and provider outreach, community advisory committee, quality improvement activities, including delivery system reforms, grievances and appeals, and utilization management
- Develops and implements or oversees the development and implementation of policies and procedures aimed at improving health equity and reducing health disparities
- Engages and collaborates with Health Plan staff, subcontractors, downstream subcontractors, network providers, community-based organizations, local health departments, behavioral health, social services, child welfare systems, members, NCQA and DHCS regulatory officials and other stakeholders in health equity efforts and initiatives. This includes in person meeting attendance within the Health Plan service area
- Implements strategies designed to identify and address root causes of health inequities including but not limited to systemic racism, social determinants of health, and infrastructure barriers for Health Plan members and providers
- Develops or oversees the development of targeted interventions designed to eliminate health inequities
- Develops quantifiable metrics that can track and evaluate the results of the targeted interventions designed to eliminate health inequities
- In collaboration with Compliance, ensures staff, subcontractor, downstream subcontractor, and network provider staff receive mandatory diversity, equity and inclusion training, as specified in the DHCS contract; reviews training materials to ensure materials are up to date with current standards or practice and maintains records of training completion
- Serves as a lead and/or subject matter expert on the Health Equity Committee and in the development of a Health Equity Annual Report
- Serves as a representative and spokesperson for Health Plan in support of Health Equity with key county partners

- Participates in State and industry work groups such as DHCS, DMHC, CHCF, NCQA, ACAP and CAHP to expand Health Plan's influence on benefit design, regulations, and policy direction
- Promotes and maintains, and ensures that direct reports promote and maintain an environment that supports Health Plan's strategy, vision, mission, and values
- Hires, supervises, and retains, and ensures that line staff hire supervise and retain a competent staff
- Focuses on educating internally and externally all Health Plan stakeholders on cultural awareness, cultural competence, implicit bias, and about the specific Health Plan Member sub populations at greatest risk and the specific clinical conditions they have that make up the greatest health risks

Health Education Manager (HEM)

The Health Education Manager is responsible for planning, developing and implementing member and provider health education programs and services consistent with State and department objectives and applicable regulations. The HEM reports to the Executive Director of Clinical Operations.

The Health Education Manager:

- Researches, develops, and maintains the health education program description, work plan, reports, and policies and procedures according to State and NCQA requirements
- Analyzes results from Group Needs Assessments; develops and monitors work plans in collaboration with Health Promotions/C&L based on findings
- Oversees data analysis to identify health education needs; monitors, analyzes, and reports results; recommends and implements changes based on findings
- Collaborates with internal and external partners to measure effectiveness of health education programs and access
- Researches, develops, reviews and edits curriculum, prepares outlines and copy for member and provider health education programs, internal and external publications, and health education materials in coordination with Health Promotions/C&L or other project-specific stakeholders
- Oversees and conducts field testing or member focus groups based on State regulations; implements changes based on results
- Collaborates with Health Promotions/C&L in representing Health Plan's interests on internal and external committees related to health education and health care issues; may partner with participants to develop and implement health education opportunities; represents the plan at the State Health Education committee
- Recommends, develops, and implements partnership strategies
- Builds and maintains community program partnerships for Health Education classes
- Compiles, develops, and submits or oversees the compilation, development, and submission of internal and external reports, including all mandated and regulatory reports, responses and corrective action plans
- Maintains and oversees MOU's, SOW, subcontracts or formal agreements with partner agencies related to Health Education Partners
- Leads the Health Education committee; ensures meeting minutes are completed and archived

Health Education Specialist (HES)

The HES is responsible for assisting with the planning, developing, and implementing of member and provider health education programs and services consistent with State and departmental objectives and applicable regulations. The HES reports to the HEM.

The Health Education Specialist:

- Assists in the development of department population-based health education programs to include action plans and budgets that align with company-wide and department objectives
- Compiles and analyzes data to identify health education needs; monitors and analyzes results, recommends, and implements changes based on findings
- Assists with developing appropriate program interventions based on readability and suitability results
- Collaborates with internal and external partners to measure effectiveness of health education programs and access
- Assists in researching, developing, and reviewing curriculum and content for member and provider health education programs and materials
- Conducts or assists with conducting field testing or member focus groups based on state regulations, assists with developing and implementing appropriate changes based on results
- Researches, maintains, and distributes a directory of health education services, resources and events offered by community organizations, health care facilities, and other agencies in Health Plan's service area available to internal and external stakeholders
- Collaborates, as directed, with Health Promotions/C&L on internal and external committees related to health education and health care issues; may partner with participants to develop and implement health education opportunities; may represent the plan at State Health Education committee meetings
- Coordinates the Health Education committee, including but not limited to preparing agenda, scheduling, and logging meeting minutes
- Assists with the compilation, development, and submission of internal and external reports, including all mandated and regulatory reports, responses, and corrective action plans
- Assists with the collection of data for state mandated Group Needs Assessment (GNA) report by conducting member interviews such as phone and in-person surveys, attending interdepartmental and key external community groups meetings

Patient Health Navigators (PHN)

The Health Education Patient Health Navigators report to the Population Health Supervisor and are responsible for using established protocols to help evaluate members to evaluate compliance with prescribed care plans.

The Patient Health Navigators:

- Conduct initial health risk assessments for selected members and triages as appropriate
- Conduct initial and ongoing education of outreach to and follow-up with members to help ensure they understand and adhere to their care plan
- Assist the member in identifying, completing and/or obtaining the required documents, tests and other items required for medical appointments
- Assist the member in identifying and addressing barriers to their ability to access and keep medical appointments, to include arranging for the provision of transportation, DME, and translation services

- Collaborate with primary care physicians and Health Plan care management staff to identify members requiring specialty care services
- Refer and connect members to appropriate community resources and support services
- Document and maintain activities, and record in appropriate Health Plan system(s) according to standards

Manager, Cultural and Linguistics (CLM)

The Manager of Cultural and Linguistics is responsible for managing C&L programs and identifying opportunities for Health Plan to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs of our members and employees. The CLM reports to the Executive Director of Clinical Operations. This Manager is also responsible for developing and implementing consistent business processes in collaboration with other Health Plan departments to fulfill Health Plan C&L objectives, and regulatory requirements

The Manager of Cultural and Linguistics:

- Develops and maintains a Health Plan Cultural & Linguistics Program based on guidelines established by National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care published by U.S. Department of Health and Human Services (DHHS), Office of Minority Health (OMH) and relevant CA State regulations
- Establishes culturally and linguistically appropriate goals, policies, and management accountability, and infuses them throughout the organization's planning and operations
- Collaborates with member-facing departments to develop action plans and budgets for C&L best practices; monitors progress, and implements appropriate interventions based on results
- Collects and maintains accurate and reliable demographic data to monitor and evaluate the impact of Health Plan C&L Program on health equity and outcomes and to inform service delivery
- Conducts regular assessments of community health assets and needs and uses the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area
- Assesses and communicates the Health Plan service area counties' health assessment reports and suggests goals and objectives for Health Plan that align with the report findings
- Implements and manages translation and interpreting programs including the development and enforcement of a Service Level Agreement (SLA) with the customers
- Performs assessment and/or audit on provider office's language assistance effectiveness in compliance with laws and regulations
- Oversees the procurement and management of third-party vendors, including contract and vendor performance management and timely invoice processing
- Participates in development of grant proposals and community funding efforts related to C&L, including proposal review, research and scoring
- Partners with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness
- Collaborates with Grievances and Appeals department to ensure member grievance resolution processes are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints

- Collaborates with HR to ensure Health Plan recruits, promotes, and supports a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area
- Educates and trains commissioners, Health Plan leadership/staff and providers in culturally and linguistically appropriate policies and practices on an ongoing basis
- Authors and manages C&L policies and procedures per regulatory requirements and Health Plan business practices
- Develops, monitors and reports on the effectiveness of C&L activities; takes actions based on results

Chief Operations Officer (COO)

Under limited supervision, the Chief Operations Officer (COO) is responsible for overseeing the strategy and operations of the Provider Network, Customer Service, Marketing, Member Benefits Administration and other operations in a manner that anticipates and supports current and future strategic and tactical business plans and is consistent with regulations.

The COO Supervises:
- Director of Provider Contracting
- Director of Provider Relations
- Director of Provider Network Strategic Projects
- Director of Customer Service

The Chief Operations Officer:
- Oversees the development and management of division/department budgets
- Oversees the development and maintenance of systems that support business plans
- Promotes and maintains and ensures that direct reports promote and maintain an environment that supports Health Plan's strategy, vision, mission and values
- Hires, develops and retains, and ensures that direct reports hire, supervise and retain competent staff
- Provides key content expertise for organization-wide initiatives
- Represents Health Plan in a manner that promotes a positive image of Health Plan in the community; serves on internal and external committees and other leadership forums
- Develops and implements measurement and reporting capabilities to demonstrate effectiveness of Division programs and strategies, staff and fiscal resources

The COO is tasked with overseeing the following sectors:
Customer Service
- Is an internal champion for a high level of customer service for Health Plan members
- Establishes and implements an efficient Customer Service department operation that is easy for members to access and resolves member issues in a timely and efficient manner with superior customer service communications
- Ensures all regulatory metrics are met or exceeded
- Leverages technology to ensure all relevant forms of communication with members are being utilized by Health Plan Customer Service department
- Ensures members are served in culturally and linguistically appropriate manner

Provider Contracting

- Identifies, develops and oversees the implementation of network development and contracting strategies that ensure a robust provider network that is financially sound, compliant with laws and regulations, quality of access, and collaborative
- Monitors, updates, and implements contract boiler plates as necessary to ensure regulatory compliance and operational needs are met
- Continually assesses the provider market, market movements, and competitive intelligence and incorporates knowledge into strategies in a timely manner
- Manages relationships with external vendors and systems that support contracting such as Contract Manager or NetworX Modeler; monitors and evaluates performance

Provider Services

- Develops and implements clear and documented processes for provider operations (e.g. provider manual, provider communications, and provider on-boarding)
- Acts as business sponsor and owner for all provider services department technology systems and ensures active and proper usage of those systems
- Collaborates with Claims, Finance, Configuration and other departments to ensure seamless provider operations to increase provider satisfaction with Health Plan
- Acts as the business sponsor and owner for all regulatory provider network related reports delivered from Health Plan to regulatory bodies to ensure reports are accurate and timely

Finance:

- Manages the Medical Loss Ratio (MLR) and Provider Incentive Programs along with the Chief Medical Officer and Chief Financial Officer by ensuring sound provider reimbursement rates
- Oversees the identification, preparation and maintenance of appropriate and required data, records, reports, and other documentation.

Compliance:

- Consistently collaborates with Compliance, Government Affairs and other departments to opine on proposed provider network related legislation and regulations towards advocacy for Health Plan operations. Tracks all new provider network legislation and regulations for timely and clear implementation.

Executive Director of Clinical Operations (EDCO)

The Executive Director of Clinical Operations (EDCO) reports to the CMO and is responsible for overseeing strategic direction of the Utilization Management, Care Management, Social Work and Behavioral Health functions.

The Executive Director of Clinical Operations:

- Oversees operational objectives and plans; ensures the development and implementation of associated business plans and tactics
- Anticipates the need for and develops and implements relevant and effective care for UM, CM and Social Work and Behavioral Health programs
- Anticipates, identifies, analyzes, and reports on care opportunities, issues and trends; makes appropriate recommendations; develops and implements agreed upon changes
- Assists Chief Medical Officer and Medical Director in identifying medical service issues that have an impact on plan benefits and their administration; assists subordinate managers in resolving medical claims review, grievances, appeals, and other medical management issues

- Collaborates with internal and external stakeholders to develop programs that increase awareness and provide educational opportunities to providers and members regarding Health Plan's goals and activities
- Oversees the review of quality concerns identified through the QI process and the implementation and monitoring of corrective action plans
- Oversees the preparation of and participates in regulatory audits and external review activities; develops and monitors corrective actions plans
- Oversees routine and ad hoc internal audits and corrective action plans to ensure practices adhere to applicable guidelines and Health Plan criteria
- Oversees the development of relevant, timely and accurate internal and external reports
- Develops and manages department budgets; implements appropriate interventions
- Oversees the collection, storage, and retrieval of relevant data and information
- Oversees the development, implementation, and maintenance of appropriate and required records, documents, policies and procedures

Director of Utilization Management (Director of UM)

The Director of UM reports to the EDCO and is responsible for the direct oversight, supervision and management of the Case Management and Utilization Management Program, Complex Case and Disease Management Program activities, as well as the Social Work program.

The Director of Utilization Management:

- Develops and implements relevant and cost-effective Case, Complex Case, Disease and Utilization Management programs
- Leads the development of UM/CM and complex case management program descriptions
- Ensures development and implementation of relevant disease management programs including Asthma, CHF, and Diabetes by the plan
- Identifies, analyzes, and reports on care opportunities, issues and trends; makes appropriate recommendations; develops and implements agreed upon changes
- Oversees the management, planning, and implementation of social service and health navigator quality improvement activities and programs
- Identifies, analyzes, and reports on care opportunities, issues and trends; makes appropriate recommendations; develops and implements agreed upon changes
- Oversees the implementation and monitoring of corrective action plans related to the areas under her management
- Identifies medical service issues that have a negative impact on plan benefits and their administration and develops plans for correction
- Ensures effective continuity and coordination of behavioral and non-behavioral healthcare services
- Assists department managers in resolving medical claims review
- Collaborates with internal and external stakeholders to develop cost effective programs that increase awareness and provide educational opportunities to practitioners/providers and members regarding Health Plan's Case and Utilization Management goals and activities
- Oversees the UM and CM management of quality compliance activities affecting Care and Utilization management
- Develops and implements relevant Disease Management Programs
- Develops and implements relevant health education programs
- Monitors over and underutilization of services, the implementation of relevant interventions, and reports this information to the QIHEC at least annually

- Develops and revises Care and Utilization Management policies and procedures
- Develops, revises, and maintains program descriptions for the complex case management and disease management programs
- Serves on the QIHEC, and Delegation Oversight Committee
- Oversees CM, DM and UM NCQA compliance

Manager Inpatient Services and Care Coordination (Manager ISCCM)

The Manager of ISCCM is responsible for providing oversight of and coordinating daily operations in a manner that ensures that Health Plan, regulatory, and contractual requirements related to Inpatient Concurrent Review, Transition of Care, CCS and Retro Review activities are met. The Manager of ISCCM reports to the Director of UM.

The Manager Inpatient Services and Care Coordination:

- Plans and assigns work; monitors department workload; makes timely and effective adjustments to four teams (Inpatient, Retro Review, CCS and TOC)
- Resolves or facilitates resolution of the highest risk and/or complex medical issues; attends and may make presentation at JOM's
- Investigates identified patient issues, including quality concerns; recommends interventions; implements and monitors corrective action plans
- Monitors and analyzes established metrics; identifies trends and opportunities for improvements; makes recommendations based on findings
- Develops, implements, and maintains standard policies and procedures that comply with applicable regulations, guidelines, NCQA standards, and DMHC and DHCS regulations. Communicates to appropriate individuals in a timely and effective manner
- Assists in the development of department objectives, action plans and budgets; executes and monitors business plans
- Works closely with interdepartmental units to establish and improve workflow and processes; identifies issues and opportunities; resolves issues or makes recommendations as required
- Compiles, develops, and submits routine and ad hoc reports
- Leads internal audits; assists in the development, implementation, and monitoring of corrective action plans
- Prepares for and participates in regulatory audits; gathers information, maintains required reports, develops, and monitors timely and effective corrective actions plans
- Responsible for 6-day weekly coverage of Inpatient Team
- Promotes and maintains and ensures that direct reports promote and maintain an environment that supports Health Plan’s strategy, vision, mission, and values

Director of Case Management (DCM)

The Director of CM reports to the EDCO and is responsible for the strategic direction of the Case Management Department in a manner that promotes the delivery of quality, cost effective services based on medical necessity, contractual benefits, and in a manner that complies with regulatory, NCQA and other accreditation requirements, and Health Plan strategies and objectives.

The Director of Case Management:

- Develops operational objectives and plans; ensures the development and implementation of associated business plans, tactics and documents relevant to case management and transitions of care (TOC)
- Anticipates the need for and develops and implements relevant and effective case management, disease management, and transition of care programs
- Maintains compliance with regulatory and accreditation requirements in areas of responsibility
- Builds strong working relationships with hospital leadership and community providers to support successful member transitions
- Collaborates with agencies and service providers to facilitate case coordination and clinical information sharing
- Works collaboratively with all other areas of medical management and other departments, the providers, and the community to improve members' self-management skills and healthcare engagement
- Oversees the resolution of problematic and/or complex issues that arise during care
- Oversees the review of quality concerns identified through the QI process; implements and monitors corrective action plans
- Oversees the Case Management program and transition of care metrics; identifies trends and opportunities for improvement; makes recommendations based on findings; presents trends, findings and recommendations, including Quality Management/Utilization Management, to the QIHEC
- Develops, implements, and maintains or oversees the development, implementation and maintenance of department policies and procedures that comply with applicable regulations, guidelines and NCQA standards; reviews and updates as needed
- Collaborates with interdepartmental units to establish and improve workflow and processes; identifies issues and opportunities; resolves issues or makes recommendations as required
- Prepares for and participates in regulatory audits; gathers information, maintains required reports, develops, and monitors timely and effective corrective actions plans
- Performs routine and ad hoc internal audits to ensure practices adhere to regulatory requirements, Milliman guidelines, Health Plan criteria and NCQA standards; assists in the development, implementation, and monitoring of corrective action plans
- Oversees the development of relevant, timely, and accurate internal and external reports
- Develops and manages department budgets; implements appropriate interventions
- In collaboration with internal and external stakeholders, ensures the collection, storage and retrieval of relevant data and information
- Develops, implements, and maintains appropriate and required records, documents, policies, and procedures, including relevant program documents such as the program description,
  work plan and evaluation for the CM and DM programs
- Models, promotes, and maintains, and ensures that direct reports model, promote and maintain an environment that supports Health Plan's strategy, vision, mission, and values

Case Management Manager (CMM)

The CMM is responsible for developing and implementing business plans and overseeing resources and department operations in a manger that promotes the delivery of quality, cost effective services based on medical necessity, contractual benefits and complies with State and other regulatory requirements. The CMM reports to the Director of CM.

The Case Management Manager:

- Collaborates with agencies and service providers to facilitate case coordination and clinical information sharing
- Reviews concerns identified through the QI process; implements and monitors corrective action plans
- Monitors and analyzes established Case Management program metrics; identifies trends and opportunities for improvements; makes recommendations based on findings
- Develops, implements, and maintains department policies and procedures that comply with applicable regulations, guidelines and NCQA standards; reviews and updates as needed
- Assists in development of department objectives, action plans, and budgets that align with company-wide and department objectives; monitors progress and implements appropriate interventions based on results
- Works closely with interdepartmental units to establish and improve workflow and processes; identifies issues and opportunities; resolves issues or makes recommendations as required
- Prepares for and participates in regulatory audits; gathers information, maintains required reports, develops, and monitors timely and effective corrective actions plans
- Performs routine and ad hoc internal audits to ensure practices adhere to Milliman guidelines, Health Plan criteria and NCQA standards; assists in the development, or implementation and monitoring of corrective action plans
- Compiles, develops, and submits routine and ad hoc reports, including but not limited to productivity, referral patterns, cost savings, and utilization
- Promotes and maintains, and ensures that direct reports promote and maintain an environment that supports the Health Plan's strategy, vision, mission, and values

Director of Behavioral Health and Social Work (DBHSW)

The DBHSW reports to the EDCO and is responsible for the strategic direction of the Behavioral Health and Social Work functions. The DBHSW provides program development and leadership to support strategic objectives and comply with regulatory requirements.

The Director of Behavioral Health and Social Work:

- Anticipates the need for and develops and implements relevant and effective behavioral health programs and processes
- Collaborates with community partners and key stakeholders to design and develop a comprehensive behavioral health system of care for Health Plan members
- Identifies, develops and implements effective social work programs to address identified needs
- Maintains compliance with regulatory and accreditation requirements in assigned areas of responsibility
- Supports contracting and provider network relations and efforts with health networks and BH providers/vendors
- Develops and maintains a positive relationship with providers, advocates, and state partners, local county and school behavioral health and other agencies, and works to maintain quality outcomes and coordination of care
- Supports clinical practice oversight and operational processes in accordance with regulatory and accreditation requirements

- Represents Health Plan on various community planning bodies and workgroups at the local, state, and national level
- Prepares for and participates in regulatory audits and external review activities; gathers information, maintains required reports, develops and monitors timely and effective corrective actions plans
- Performs routine and ad hoc internal audits to ensure practices adhere to MCG, other nationally accepted evidence-based guidelines, Health Plan criteria and regulatory and accreditation requirements; develops, implements, and monitors corrective action plans
- Develops and manages department budgets; implements appropriate interventions
- Develops, implements, and oversees the development, implementation, and maintenance of appropriate and required documents, policies, and procedures
- In collaboration with internal and external stakeholders, ensures the collection, storage and retrieval of relevant data and information

Social Work Manager (SWM)

The SWM is responsible for developing and implementing department business plans and overseeing department operations in a manner that ensures efficient and quality care and meeting internal and external requirements. The SWM reports to the DBHHSW.

The Social Work Manager:

- Develops department goals based on established objectives, participating with peers to ensure effective integration; oversees the development and implementation of associated action plans
- Identifies, develops, and implements effective social work programs to address identified needs
- Plans and assigns work ensuring that timely and effective adjustments are made
- Monitors and analyzes performance; takes appropriate actions based on findings
- Establishes and recommends changes to policies; ensures implementation of appropriate procedures, guidelines, and other documents
- Works closely with patients with behavioral health issues and autism patients making referrals to the BH vendor
- Assists in the development of department budget; manages budget for area of responsibility
- Identifies the need for and oversees department implementation of system enhancements
- Resolves or assists with the resolution of complex, sensitive, and other service issues
- Prepares for internal and external audits, and in the preparation of recommendations, responses, and reports
- Compiles, develops, and submits internal and external reports with presentations at meetings and at the QIHEC
- Promotes and maintains and ensures that direct reports promote and maintain an environment that supports Health Plan's strategy, vision, mission, and values

Director of Pharmacy (DOP)

The DOP is a pharmacist with an unrestricted license issued by the State of California. The DOP reports to the CMO and is responsible for overseeing the strategy and operations of the pharmacy function in a manner that supports organization, division, and department objectives, and complies with contractual and regulatory requirements.

The Director of Pharmacy:

- Identifies, develops, plans, and executes drug utilization and disease management strategies; ensures the development and implementation of associated business plans, tactics, and policies
- Promotes clinically appropriate prescribing practices which conform to Health Plan as well as national practice guidelines
- Oversees the implementation and administration of Health Plan's pharmacy benefit by contracted PBM: monitors performance; identifies and resolves performance issues
- Monitors and analyzes pharmacy expenses; develops and implements cost-effective pharmacy management programs
- Analyzes pharmacy data for potential fraud and abuse cases; reports suspected cases as required
- Analyzes physician prescribing habits; develops and implements targeted education programs based on results
- Identifies, and analyzes the clinical data of pharmaceuticals for formulary consideration or removal; makes recommendations based on results; oversees implementation of new/removed pharmaceuticals
- Identifies, develops, and implements clinically effective and cost-effective pharmacy management, including but not limited to appropriate use criteria of medications, step edits, PA criteria or quantity limits; monitors and acts based on results
- Leads the Pharmacy and Therapeutics committee in the development, maintenance, and evaluation of the Health Plan's drug formulary, utilization management strategies, and fraud and abuse program
- Oversees pharmacy prior authorization process, conducts clinical review of pharmacy prior authorizations; approves/denies or offers formulary or therapeutic alternatives according to Health Plan's pharmacy criteria
- Supports the identification, development, and implementation of Health Plan's disease management initiatives; compiles and analyzes pharmacy data; identifies related member populations; recommends and develops appropriate interventions; monitors and acts on results
- Develops, implements, and maintains policies and procedures specific to pharmacy management in compliance with Federal and State Department of Health Care Services requirements and regulations

Director of Clinical Analytics (DCA)

The DCA is responsible for developing and monitoring all regulatory required reporting on behalf of the Medical Management department; and developing analytics and business intelligence in support of Medical Management strategic, operational, and corporate objectives. The DCA reports to the CMO.

The Director of Clinical Analytics:

- Leads all aspects of analytics and reporting necessary to ensure regulatory compliance with all Medical Management-owned regulatory reports
- Identifies and leads initiatives that improve underlying data quality recognizing that quality data is the foundation of strong analytics
- Identifies, develops, plans, and executes analytics and business intelligence in partnership with peers and others to ensure effective operational performance and initiative implementation

- Leads the development of analytics that support benchmarking for all functions within the Medical Management department
- Conducts analyses of medication therapy management programs, disease management programs, care management programs, and any other Medical Management led clinical programs
- Collaborates with business owners to develop analytical understanding of high-cost drivers and establishes analytics reporting systems to determine their effectiveness
- Leads and supervises quantitative and qualitative analyses/evaluation; collaborates with medical directors and others to identify opportunities for improving cost effectiveness and quality of care and services, and to monitor and evaluate performance and to evaluate outcomes of programs
- Develops and prepares effective decision support tools and models for accurate evaluation of performance and to assist in management decision-making

Director of Special Projects (DSP)

The Director of Special Projects reports to the CMO and is responsible for thorough market, legislative, regulatory, and community capacity research and development of innovative strategies; products and services to improve healthcare delivery; and professional project management of the implementation of key strategies, products, and services to include the planning and coordination of pilot projects.

The Director of Special Projects:

- Conducts extensive needs analysis and coordinates cost and/or benefit analyses to determine areas of the healthcare delivery system that can be improved through new technology or innovative strategies
- Leads research and development of innovative or pilot programs, services, products, and ventures as directed by the Vice President of Network Management
- Develops and implements the plan's frameworks for opportunity exploration, partnering with executive team members and external stakeholders
- Provides strategic and tactical support to the Vice President of Network Management to coordinate and help drive the development strategic plans
- Researches, analyzes, and documents relevant market assessment, industry standards, and input from internal and external sources
- Works with internal and external resources to develop financial models, feasibility analysis, and other key critical targets
- Manages multiple, sometimes disparate, innovation and strategic projects
- Takes an active role in building the plan's innovation culture and mindset
- Serves as the key content expertise for innovative strategies, technologies, and projects
- Socializes understanding of new initiatives and strategies among the plan's executive team members, directors, and other key stakeholders
- Actively participates in industry trade associations as appropriate for strategic and innovation projects currently in process
- Develops positive and energetic relationships with internal and external stakeholders
- Promotes and maintains an environment that supports the plan's strategy, vision, mission, and values
- Represents Health Plan in a highly professional manner that promotes a positive image of the plan in the community; serves on internal and external committees and other leadership forums

Director of Special Projects, Quality (DSPQ)

Leads research and development of quality initiatives and projects especially those related to Quality improvement initiatives that impact the HEDIS and MCAS measures as directed by the CMO.

The Director of Special Projects, Quality:

- Defines project's objective, scope, and success measures in collaboration with CMO, senior Quality & Health Equity leadership and directors
- Leads the identification and prioritization of quality projects within Medical Management; oversees or manages project implementations
- Identifies, secures, and manages, oversees, or assists with the identification, securing and management of internal and external project resources
- Leads development, implementation, and maintenance of best practice methodology, including but not limited to technology, policies, procedures, processes, tools, and standards; ensures their dissemination and understanding among stakeholders Develops, implements, and maintains, or oversees the development, implementation and maintenance of the appropriate and required quality data, records, reports, and other documentation related to the projects being managed
- Works with the key content experts for the quality projects and ensures leadership for the
- project from inception to implementation and evaluation
- Represents Medical Management and HPSJ in a manner that promotes a positive image of
- HPSJ in the community
- Serves on internal and external committees as needed
- Promotes and maintains an environment that supports HPSJ's strategy, vision, mission and
- Values

Chief Compliance Officer (CCO)

The CCO reports to the CEO and is responsible for establishing and implementing an effective Compliance Program, including Fraud, Waste and Abuse, to prevent illegal, unethical, or improper conduct consistent with applicable laws, regulatory and accreditation standards, and the plan's policies.

The Chief Compliance Officer:

- Coordinates and oversees all compliance efforts for the organization
- Designs and implements internal controls, policies, and procedures to assure compliance with applicable local, state, and federal laws and regulations and third-party guidelines to prevent illegal, unethical, or improper conduct
- Manages audits and investigations into regulatory and compliance issues
- Responds to requests for information from regulatory bodies
- Collaborates with Quality Management and other department leaders to direct compliance issues to appropriate existing channels for investigation and resolution
- Consults with the corporate attorney as needed to resolve difficult legal compliance issues
- Plans for and oversees annual external audits; responds to, logs and tracks deficiencies; develops and monitors corrective action plans
- Serves as the Plan's contact for regulatory agency inquiries and issues; ensures that communication and responses are accurate and consistent

- Oversees the identification, preparation, maintenance, and monitoring of appropriate and required data, records, reports and other documentation; includes regulatory filings
- Oversees the reviews and responses to requests and subpoenas for protected health information

Director of Compliance (DCO)

The DCO reports to the CCO and is responsible for developing and overseeing the implementation of strategic and operational objectives and plans according to best practices, internal and external requirements, with a focus on DHCS and DMHC, and in support of organizational strategy.

The Director of Compliance:

- Coordinates and oversees all compliance efforts for the organization
- Identifies, develops, plans and executes strategies, participating with peers and others to ensure effective integration; oversees the development and implementation of department goals and actions plans
- Monitors and tracks organization-wide compliance, including program metrics, structure and processes; identifies and communicates risks; develops actions plans to address deficiencies
- Serves as the subject matter expert for management and staff on the conditions and terms of DHCS and DMHC contracts, and other external laws and regulations; collaborates to ensure compliance and alignment
- Performs validation reviews and risk assessments to evaluate compliance contract requirements and business processes; ensures appropriate documentation in compliance systems
- Conducts or oversees investigations relative to FWA, HIPAA violations, enrollment activities and other compliance issues or violations as required; oversees the implementation and completion of corrective action plans and other activities
- Manages the internal and external audit program, including risk assessment preparation and facilitation; monitors results, escalation issues, notices of non-compliance, warning letters, corrective action plans, fines, penalties, and/or sanctions
- Establishes and leads the Compliance Committee; ensures meeting minutes are completed and archived
- Assists in the development of, and oversees implementation of policies, procedures and practices designed to ensure compliance with the requirements set forth by DHCS and DMHC contracts, laws, regulations, and health care program requirements
- Develops and manages department budget
- Oversees the development, implementation, and maintenance of the appropriate and required data, records, reports, and other documentation
- Promotes and maintains and ensures that direct reports promote and maintain an environment that supports Health Plan's strategy, vision, mission and values
- Hires, develops, supervises and retains, and ensures direct reports hire, develop, supervise and maintain, an adequate and competent staff

Credentialing Specialists (CS)

The Credentialing Specialists report to the QMM and are responsible to review and verify credentials and documentation submitted by practitioners and providers seeking to participate or to continue participating in the Health Plan network.

The Credentialing Specialists:

- Coordinate and support Peer Review committees
- Ensure the confidentiality of practitioner/provider information protected under the Welfare and Institution Code Section 14087.3 (q).
- Collect, review and verify credentialing documentation submitted by practitioners/providers including but not limited to:
    - State professional licensure
    - Board certification
    - Education
    - Malpractice insurance
    - Malpractice history
    - Legal sanctions
    - Medicare and Medicaid sanctions
    - Sanctions on licensure

Grievance Coordinators (GC)

The Grievance Coordinators report to the QM Supervisor and are responsible in supporting the provision of high quality, efficient care by ensuring the accurate and timely processing of grievances, in a manner that meets NCQA standards as well as internal and external requirements.

The Grievance Coordinator:

- Receives logs and conducts the initial research of member appeals and grievances to determine the validity of the appeal or grievance
- Tracks, trends, and reports appeals and grievance data
- Sorts and distributes logged grievances for processing by QM Supervisor or designee
- Develops grievance acknowledgement and resolution letters
- Prepares case files for Independent Medical Review and State Fair Hearings
- Reviews grievance documentation for accuracy and conformance with standards; researches using a variety of methods including internal and external resources
- Identifies appropriate actions; makes or recommends adjustments
- Sends out member communications according to mandated timeframes
- Monitors and tracks grievances to ensure resolution within mandated timeframes
- Serves as a contact person during state audits related to grievances; may interact with State directly on individual cases
- Compiles, formats and prepares routine reports for distribution to internal and external stakeholders, coordinates review and distribution

Health Information and Data Reporting Resources

Commented [KC16]: Factor 1: Resources and analytical support.

Commented [KC17R16]: provides details on analytical resources such as Clinical Analytics and Business Intelligence teams, which provide data and reports necessary for quality improvement projects. These resources include software tools and data systems like HEDIS, care management, and claims processing system

The Quality Program is supported by management information systems and health information resources sufficient to ensure necessary and timely reporting to regulatory entities and recognition program requirements and to enable the delivery of high-quality care.

The Health Information and Data Reporting Resources:

- Maintain the systems that support high quality care
- Ensure data vendor systems and software are performing optimally and assist with troubleshooting when needed. This includes but is not limited to:

    - Warehouse and Processing systems to support integrating:
        - Medical, Behavioral and Pharmacy Claims and Encounter Processing and Payment Data
        - Medical Record Information including Laboratory results
        - Medical and Behavioral Utilization Data
        - Member Enrollment, Demographic and Characteristic Information
    - Care Management Systems to support integrating:
        - Authorization and Referral Data
        - Health Appraisals, Screening and Assessment data
        - Health Service Programs Data
- Cultural and Linguistic:
    - Care Management, Case and Disease Management
- Care Management System Data
- Program Reporting Data
- Provider Demographic and Credentialing Information
- Printing and reproduction vendors
- Member Experience vendors
- Outreach and engagement vendors
- Document management systems
- Health Plan enterprise productivity software Supplemental Data systems including registries and referral parties.
- Electronic Health Record Data
- Admission, Discharge, Transfer Data and Health Information Exchange Data
- Data from Contracted Partners
- Customer Service Data
- Quality Performance Data
- Registry and Supplemental Data
- APCD, Fee for Service and Historical Claims Data

Quality Management and Improvement Resources

The QIHETP Program has staff and analytical resources available to achieve program objectives. The Quality Management and Improvement Department has overall responsibility for all QIHETP activities. The Department has adequate staff to fulfill its role. Departments within the Health Plan provide significant amounts of time for QIHETP activities and responsibilities. Leadership ensures adequate resources to implement and maintain all QIHETP Program activities. Additional external resources such as quality improvement consultants, HEDIS auditors for medical record review and data abstraction and analysis, and accreditation readiness are available as needed. The organization chart showing Medical Management resources is included as an attachment at the end of the QIPD.

The following Health Plan FTE positions are 100% dedicated to QIHETP.

Position/Title

- Chief Health Equity Officer (1)
- Executive Director of Quality and Equity (1)
- Director of Special Projects, Quality (1)
- Director of Quality Management (1)
- Manager of Quality Management (2)
- Quality Coordinator (1)

Commented [KC18]: Factor 1: Resources and analytical support

Commented [KC19R18]: provides details on analytical resources such as Clinical Analytics and Business Intelligence teams, which provide data and reports necessary for quality improvement projects. These resources include software tools and data systems like HEDIS, care management, and claims processing system

- Quality Management Supervisor (2)
- Trainer, Quality Improvement (1)
- Quality Management Nurse (13)
- Grievance Coordinators (7)
- Grievance Coordinator Lead (1)
- Appeals and Grievances Nurse (7)
- Appeals Nurse Senior (1)
- Credentialing Specialists (4)
- Credentialing Specialist Lead (1)
- HEDIS and NCQA Accreditation Director (1)
- HEDIS and Quality Reporting Manager (1)
- NCQA Accreditation Manager (1)
- HEDIS and Accreditation Coordinators (7)
- Health Education and Population Health Manager (1)
- Health Educator Senior (1)
- Health Education Specialists (2)
- Health Promotion Specialist (3)
- Population Health Supervisor (1)
- Patient Health Navigator Lead (1)
- Health Education Patient Health Navigators (16)

The following Health Plan FTE positions have a portion of their time allocated to the QIHETP Program:

- Chief Medical Officer
- Chief Operations Officer
- Chief Financial Officer
- Director of Fiscal Operations
- Medical Director (3)
- Executive Director of Clinical Operations
- Director of Utilization Management
- Director of Case Management
- Director of Pharmacy
- Director of Clinical Analytics
- Director of Special Projects
- Director of Compliance or designee

All Health Plan departments collaborate with the Quality Management and Health Equity departments for QM and HE-related improvement activities:

- Customer Service
- Provider Services
- Provider Contracting/Network Development.
- Compliance/Delegation Oversight
- Privacy and Security
- Claims
- Finance
- Information Technology/Configuration
- Pharmacy
- Utilization Management

- Case and Disease Management
- Health Education
- Marketing/Creative, Community Relations, Marketplace, and Member Engagement (CRME/CMME) [Formerly Marking/External Affairs (OERU)]
- Clinical Analytics

Functional Areas and Their Responsibilities

Commented [KC20]: Factor 1: Functional Areas and their responsibilities

Commented [KC21R20]: outlines various functional areas, including Clinical Quality, Behavioral Health, Utilization Management, and Population Health. These areas are responsible for activities like improving care quality, managing grievances, and coordinating long-term care.

The CMO leads the functional areas of Clinical Quality, Clinical Operations, Utilization Management, Case Management, Behavioral Health and Social Work, Long Term Care, Inpatient and Outpatient Utilization Management, Quality, Equity, HEDIS, Accreditation, Population Health, Health Education, Culture and Linguistics, Credentialing, and Grievance and Appeals, and Member Experience Surveys. Quality improvement activities undertaken are conducted in collaboration with other departments to integrate quality improvement activities at all levels of the organization. Many other functional areas are involved in aspects of, and provide support to, the QIHETP Program, and are outlined below.

Customer Service

The QIHETP Program provides interaction with Customer Services to assure maintenance and adequacy of practitioner/provider availability and access to care, and evaluation of satisfaction feedback that is used to develop and improve quality management processes, program effectiveness, and health care delivery processes.

The Customer Service Department is responsible for:

- Serving as first point of contact for member inquiries and resolving issues when possible or if not possible, for forwarding issues to designated department 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 by the CSR; and the appropriate complaint or appeal category
- Immediately referring potential quality of care, clinically urgent, and member safety issue complaints and appeals to designated Grievance queue for Quality review
- Measuring average speed of telephone answer and abandonment rate; analyzing results in collaboration with the Quality team and other stakeholders; taking action when performance does not meet standard; and reporting results to the Quality Operations Committee and to the Quality Management and Utilization Management Committee

Provider Services

The QIHETP Program is a foundation for planning and structuring provider/practitioner education and support efforts. Provider Services staff communicate provider satisfaction feedback from physicians, allied and ancillary health practitioners and used to develop and improve quality management processes, program effectiveness, medical review and clinical guideline criteria.

Provider Services is responsible for:

- Assisting QM with developing and managing communication with practitioners/providers
- Proposing ways to improve practitioner/provider satisfaction with Health Plan

- Assisting with the coordination of QM educational trainings for practitioner/provider and office staff
- Collaborating on the Physician Partnership Program for the enhancement of Quality initiatives
- Reporting Access and Availability and Provider Satisfaction results
- Collecting, analyzing, and reporting on provider appointment and network availability survey results
- Collaborating with the Quality team and other stakeholders on analysis and action planning of provider service quality metrics

Provider Contracting and Network Development

The QIHETP Program ensures collaboration with Provider Contracting in evaluation of potential and contracted practitioners/providers for appropriateness to meet the care and service needs of our member population.

Provider Contracting and Network Development are responsible for:

- Meeting access and availability standards by contracting with sufficient practitioners and providers
- Ensuring provider contracts are in full compliance with all accreditation and regulatory entities
- Collaborating with Providers by offering programs that will improve quality standards
- Maintaining resources that will assist providers with understanding their responsibility for access and availability requirements
- Resolving provider grievances which are not related to members or claims

Compliance/Delegation Oversight

The QIHETP program reports to Compliance with information or results of any findings of non-compliance by contracted providers, facilities, and internal departments.

The Compliance Department:

- Promotes the guidelines to conduct business in compliance with both Federal and State laws, policies, contractual requirements, and accreditation standards
- Identifies, develops, plans, and executes strategies to track organization-wide compliance to develop actions plans to address
- Provides training and manages the plan's policies and procedures; monitors or conducts internal audits to detect any violation of compliance procedures
- Conducts fraud and abuse detection and prevention activities and reports credible allegation findings to the appropriate State/Federal agencies
- Conducts oversight of Delegated Entities that are contracted with the plan to ensure compliance with Federal, State, and NCQA standards and creates a decision-making forum to recommend and review delegation activities related to Quality, UM, Credentialing, Member Experience, Network and Population Health Management delegates. Input and feedback are collected from internal stakeholders about delegated activities through review and consensus

Claims

Commented [KC22]: Factor 1: Delegated QI activities, if the organization delegates QI activities.

Commented [KC23R22]: describes delegation oversight processes, where certain functions like credentialing are delegated, but oversight remains with the Compliance Department to ensure standards are met

Commented [NB24R22]: This does not actually list what we delegate for QI.

The QIHETP Program provides ongoing claims support services for evaluation of appropriate billing practices and identification of suspected fraud and abuse.

The Claims Department is responsible for:

- Providing data regarding timeliness of claims for care and services according to the member Evidence of Coverage criteria
- Providing data regarding accuracy and timeliness of claim submission
- Investigating and resolving provider grievances or disputes related claims and payments
- Identifying and communicating suspected fraudulent billing practices
- Identifying over utilization of services

Finance

The QIHETP Program coordinates with the Finance Department who manages the financial activities and assists with the development of budget for quality activities and for staffing.

The Finance Department:

- Identifies, develops, plans and executes short, medium and long-range organization and division strategies; ensures the development and implementation of associated business plans, tactics and policies
- Oversees and directs the timely and accurate analysis of budgets, financial reports, medical loss analysis and financial trends
- Oversees the internal and external audit function to ensure the timely and accurate completion of annual fiscal audits and other financial information

Information Technology

The QIHETP Program provides interaction with IT to access and collect standardized, timely, and accurate data to monitor, track and trend, and perform benchmark analysis to develop and improve quality management processes and program effectiveness.

Information Technology is responsible for:

- Providing data to the HEDIS Vendor 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
- Maintaining enrollment and payment systems for collecting and reporting encounter data, REaL (Race, Ethnicity and Language) data, and member demographics
- Running reports and analysis on data systems and supports
- Ensuring healthcare data privacy and security
- Setting up systems that can detect over and under utilization
- Creating reports that gather data from disparate sources for internal quality needs

Pharmacy

The QIHETP Program collaborates with the Pharmacy Department to continuously improve the delivery and quality of drug therapies in compliance with contractual and regulatory requirements.

The Pharmacy Department is responsible for:

- Promoting clinically appropriate prescribing practices in line with national practice guidelines
- Monitoring and analyzing medical benefit medication expenses, developing, and implementing cost-effective pharmacy management programs
- Analyzing provider prescribing habits to develop and implement targeted education programs based on results
- Analyzing pharmacy utilization data for potential fraud and abuse cases and reports cases as required
- Collecting, analyzing, and reporting on pharmacy quality metrics
- Collaborating with the Quality team and other stakeholders on analysis and action planning of pharmacy quality metrics
- Creating clinical programs that target improved medication adherence and help members improve their understanding regarding their disease conditions and medications
- Developing, implementing, and maintaining policies and procedures specific to pharmacy management in compliance with Federal and State requirements and regulations

Utilization Management

The QIHETP Program provides data to profile practitioners/providers; identify opportunities for improving authorization and referral processes, including guideline/criteria development, modification of existing guidelines, benefit interpretations, and the development of disease management programs.

Utilization Management 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 impacting HEDIS/MCAS rates and health plan accreditation standards
- Overseeing case management activities including those for high-risk members and members with complex health needs
- Tracking and analyzing data regarding clinical outcomes
- Tracking and analyzing data regarding over and under-utilization of services
- Collaborating with the Quality team and other stakeholders on analysis and action planning of utilization management quality metrics
- Ensuing outreach and care coordination activities for identified members
- Fostering continuity and coordination of care
- Implementing CalAIM programs like Enhanced Care Management (ECM) and Community Support Services (CSS)

Community, Marketing, and Member Engagement (CMME)

The QIHETP Program provides aggregate data to the CMME Department regarding the effectiveness of practitioner/provider outreach strategies and processes as part of customer engagement.

CMME is responsible for:

- Communicating Health Plan's strengths in terms of its provider network, local access, and other factors

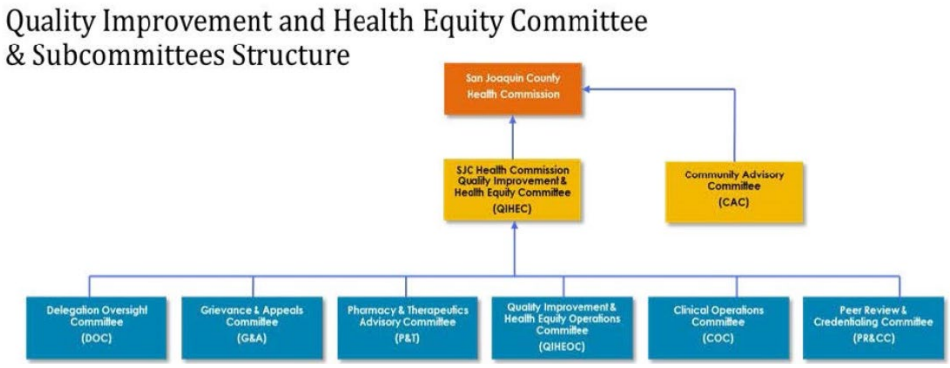
- Engaging potential members at community engagement events and advising on how to contact the state for enrollment information
- Providing the Evidence of Coverage manual in our Post-Enrollment kit

Clinical Analytics

The QIHETP Program works with the Clinical Analytics Department to understand the data and statistics to assist in developing the standard methodologies to achieve targeted and accurate results.

The Clinical Analytics Department is responsible for:

- Providing quantitative and qualitative analyses or evaluation on a variety of complex and diverse strategic and operation issues
- Collaborating with Business Intelligence, Finance and Contracting for data compilation
- Measuring rates and analyzing patterns of utilization to aid in quality improvement projects
- Producing dashboards that are used to measure quality improvement projects, effectiveness of care, utilization, and to provide data for comparison
- Providing ad hoc reporting for quality improvement projects (QIPs) and other analytical needs.



Quality Management and Health Equity Committees 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 are validated, coordinated, aggregated, communicated, reported, and acted upon in a timely, expedient manner to ensure success with all performance improvement and quality initiatives. Regular meetings are held by each respective committee during the year. Written minutes are maintained by each Committee for each meeting. Health Plan has specific participant requirements that all committee members must adhere to:

- Committee members are required to sign a conflict-of-interest statement
- Committee members cannot vote on matters where they have an interest and must abstain until the issue has been resolved

- Committee members are expected to actively participate, contribute, provide expertise, and assistance in directing the QIHETP Program activities

The following are the specific functions of the QIHEC Committee and Subcommittees:

Quality Improvement and Health Equity Committee (QIHEC)

The Quality Improvement and Health Equity Committee reports to the County Health Commission. The QIHEC is co-chaired by the CMO and the Chief Health Equity Officer. The committee is responsible for the implementation and ongoing monitoring of the Quality Improvement and Health Equity Transformation Program. The committee meets at least 5 times each year.

The following are the specific functions of the QIHEC Committee:

- Recommends policy decisions
- Analyzes and evaluates the results of QIHE activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other contractor committees such as the CAC
- Institutes actions to address performance deficiencies, including policy recommendations and ensure appropriate follow up of identified performance deficiencies
- Reviews, analyzes, evaluates, and makes recommendations regarding the progress and outcome of QI projects and Health Equity 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 and health equity initiatives
- Receives subcommittee reports, identifies performance improvement opportunities, and makes recommendations to be incorporated into the QIHETP Work Plan
- Ensures practitioner participation in the QIHETP through planning, design, implementation, and review
- Confirms and reports to the County Health Commission that Health Plan activities comply with all state, federal, regulatory and NCQA standards
- Reports to the County Health Commission on any variance from planned quality performance and reports on health equity interventions, goals, and the plan to course correct
- Submits to the County Health Commission approved and signed minutes reflecting Committee decisions and actions of each meeting
- Presents an annual review of the approved QIHETP Description and Work Plan and prior year evaluation to the County Health Commission
- Annually reviews and approves Medical Review Criteria and Clinical Practice Guidelines
- Oversees Quality Improvement and Health Equity Transformation Program Activities that validate quality management and health equity effectiveness through customer feedback reporting including:
  - Provider and Member satisfaction/experience surveys
  - HEDIS, MCAS and HEQMS rates
  - CAHPS and Behavioral Health surveys
  - CLAS standards
- Promotes education activities and CEU programs on Quality Improvement for practitioners and providers

Commented [KC25]: Factor 5: QI Committee Oversight

Commented [KC26R25]: Role, Function, and Reporting Relationships of the QI Committee: QIHEC reports to the County Health Commission, and it is responsible for overseeing the implementation and monitoring of the QIHETP. The committee includes multiple subcommittees, such as Peer Review, Credentialing, Grievance and Appeals, and others. The QIHEC's role includes recommending policy decisions, reviewing quality improvement projects, and ensuring compliance with regulatory standards

- Maintains compliance with standards for mandated reporting of diseases or conditions to the local health department

The QIHEC Chairs: CMO and CHEO
Required Membership

- The SJC Health Commission – QIHEC is made up of a broad range of participants, including but not limited to: Network Providers including but not limited to:
  - Hospitals
  - Clinics
  - County Partners
  - Physicians
- Network Providers who provide care to HPSJ Members affected by:
  - Health Disparities
  - Limited English Proficiency (LEP)
  - Children with Special Health Care Needs (CSHCN)
  - Seniors and Persons with Disabilities (SPDs)
  - Individuals with chronic conditions

Subcontractors and Downstream Subcontractors

The following subcommittees report to the QIHEC:

- Peer Review and Credentialing
- Grievance and Appeals Committee
- Pharmacy and Therapeutics Advisory (P&TA) Committee
- Quality Operations Committee
- Delegation Oversight Committee
- Health Education Committee
- Community Advisory Committee

Peer Review and Credentialing (PR&C) Committee

The PR&C Committee is a "medical peer review" and credentialing committee. The members of this committee are appointed by the County Health Commission. The PR&C committee is chaired by the CMO and is composed of physicians representing network primary care, various specialty care, and other health care practitioners. The Committee meets every other month and reports to the QIHEC.

The following are the specific functions of the PR&C Committee:

- Make credentialing and recredentialing decisions for all network providers, practitioners, and institutional providers
- Oversee and evaluate Health Plan's credentialing and recredentialing process for evaluating and selecting licensed independent practitioners/providers to provide care to members
- Review the qualifications of new and continuing network practitioners/providers desiring to provide care and services to members
- Ensure a fair and effective peer-review process to make recommendations regarding credentialing decisions
- Review practitioner/provider quality of care, quality of service, and performance data, including member complaints, Facility Site Reviews, access and availability studies and reports, and identifies opportunities for improvement
- Track suspended, excluded, and ineligible providers

Commented [KC27]: Factor 5: QI Committee oversight

Commented [KC28R27]: Involvement of Participating Practitioners in Subcommittees or Task Forces:mentions that network providers and practitioners are part of the QIHEC, with physicians, hospitals, and clinics included as participants. If they are not members of the QIHEC, they participate in subcommittees like Peer Review and Credentialing

- Review Potential Quality of Care issues escalated to the committee for review, determination, and for recommending corrective actions
- Review and make recommendations on actions to be taken for quality of care, quality of service, and other provider and practitioner issues that are identified during the ongoing monitoring of grievance processes
- Review credentialing reports from delegates
- Determine whether health care services were performed in compliance with standards of practice and directs corrective action measures when standards are not met
- Evaluate and make recommendations on all practitioner adverse actions and takes appropriate disciplinary action against practitioners/providers who fail to meet established standards and/or legal requirements as appropriate
- Ensure and oversee a formal and objective practitioner/provider appeal process
- Submit to the County Health Commission approved and signed minutes reflecting committee decisions and actions of each meeting

Grievance and Appeals (G&A) Committee

The Director of QM serves as the chair of the G&A Committee. Committee members are appointed by the Director of QM in collaboration with the Compliance Officer. This Committee meets at least quarterly and, in the format, determined by the committee, and reports to the QIHEC.

The following are the specific functions of the Grievance and Appeals Committee:

- Oversee and ensure the integrity of the grievance and appeal process, including tracking for timeliness and resolution
- Evaluate grievances for potential quality issues (PQI's)
- Review and evaluate G&A trend reports and member communication; identify and make recommendation for improvements
- Ensure compliance with regulatory and contractual requirements
- Discuss member grievances, recommend corrective action plans and review the completion of corrective actions
- Submit to the QHEOC and QIHEC approved and signed minutes reflecting committee decisions and actions of each meeting.

Committee Chair: Director of QM

Committee members include the following:

- Chief Medical Officer
- Medical Director
- Chief Health Equity Officer
- Executive Director of Clinical Operations or designee(s)
- QM Manager
- QM Supervisor
- Grievance Coordinators
- Appeals Nurse
- QM Nurses
- Provider Services Director or designee(s)
- Clinical Analytics Director or designee

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

- Pharmacy
- Claims
- Member Services
- UM
- Compliance

Health Education Work Group (HE)

Health Plan's Health Educator serves as the work group's coordinator. The Health Education work group meets bi-monthly, in the format, as determined by the Work Group, and reports to the QHEOC Committee.

The following are the specific functions of the Health Education Work Group:

- Program Development
    - Plan, develop, and implement Health Plan health education programs
    - These programs are required to comply with State and departmental objectives and regulations
    - These programs will be developed or expanded upon as needs arise and shift within our membership and their communities
- Care Management Support
    - Support Social Work, Case Management, and Disease Management programs by way of educational materials, Health Plan Health Education Programs, and outreach connection to community resources
    - Providing support to other departments in creating, writing, and reviewing health education messages and materials
- Member Communications and Health Messages
    - FOCUS Member Newsletter
    - Health Articles
    - Health Education Promotion Content
    - Seasonal Health Education Messages
- PNA discussion
    - Sharing results of PNA with community partners

Committee Chair: Health Education Specialist

Work Group members include, but are not limited to:

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

Pharmacy and Therapeutics Advisory (P&T) Committee:

The P&T Committee is chaired by the Director of Pharmacy and is comprised of in-house and network pharmacists, primary care physicians and specialists. The P&T Committee meets quarterly and reports to the QIHEC.

The following are the specific functions of the P&T Committee:

- Review, oversee, and approve Health Plan's medical pharmacy benefit
- Identify processes to evaluate pharmacy safety and effectiveness
- Develop, approve, and maintain pharmacy criteria and policies and procedures that ensure safe and effective medical benefit management for medications
- Review pharmacy data and reports and make recommendations for improvement
- Establish and oversee Specialty Advisory Panels, as necessary, to provide expert opinion on clinical matters for P&T Committee consideration
- Develop and approve member and practitioner/provider education to address patient safety
- Submit to the County Health Commission approved and signed minutes reflecting Committee decisions and actions of each meeting

Committee Chair: Director of Pharmacy

Committee members include the following:

- Chief Medical Officer
- Medical Director
- Chief Health Equity Officer
- Executive Director of Clinical Operations or designee(s)
- Clinical Analytics Director or designee
- Network physicians
- Network pharmacists

Quality Improvement and Health Equity Operations Committee (QIHEOC)

The Quality Improvement and Health Equity Operations Committee (QIHEOC) is designated by Health Plan's Executive Team to provide oversight and guidance, analysis, and evaluation of QIHETP Workplan activities, including, but not limited to QIHETP projects, NCQA workplan updates, HEDIS workplan updates, and the functions that are required for NCQA reporting in those workplans. The QHEOC shall recommend policy, analyze, and evaluate the progress, results, and outcomes of all quality improvement activities, implement needed actions, and ensure appropriate and timely follow-up.

The following are specific functions and responsibilities of the Quality Improvement and Health Equity Operations Committee:
The Chairman:

- Provide a summary report on behalf of the Committee directly to the Quality Management, and Utilization Management Committee, no less than once per quarter, regarding the Committee's activities and actions and the status of the items discussed
- Ensure the agenda, together with materials relating to the subject matter of each meeting, is sent to members of the Committee prior to each meeting; and
- Ensure minutes for all meetings are prepared, distributed, and maintained

The Committee:

- Reports to the QIHEC by summary report no less than quarterly. The QHEOC submits to the QIHEC approved and signed minutes reflecting committee decisions and actions of each meeting. In addition, the activities of the committee are as follows:
    - Ensure the implementation and ongoing monitoring of the QIHETP to make quality improvement recommendations to the QIHEC
    - Advise and direct sub-committees on the focus and implementation of the QIHETP program and work plan activities
    - Receive reports from all QIHEC sub-committees and make recommendations, as needed
    - Confirm and report to the QIHEC that plan activities comply with all state, federal, regulatory and NCQA standards

The QIHEOC strives to improve the quality of members' health care and service by developing, implementing, and evaluating processes, programs, and measurement activities.
These include:

- HEDIS, MCAS and HEQMS monitoring and reporting
- NCQA and quality regulatory compliance
- Annual QIHETP description and work plan
- Quality of clinical care, safety of clinical care, quality of service, and effectiveness of the QIHE activities
- Performance Improvement Plans/ Plan Do Study Act/ PIPs
- Quality improvement corrective action plans
- Wellness and preventative health programs
- Procedures with recommendations for policy decisions
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Member experience survey results and Clinic and Group CAHPS (CG-CAHPS)
- Provider access and availability
- Provider Satisfaction
- Encounter Data Validation
- Focused Studies
- Quality of Care for Children
- Timely Access
- Network adequacy
- Facility Site Review
- Data Integrity monitoring
- Call Center Monitoring
- Population Health Management
- Health Education Management
- Grievance Resolution

Governance

The QIHEOC is chaired by the Director of Quality or designee. The Committee Chairs shall facilitate and manage committee meetings. The Chief Medical Officer (CMO) and the Chief Health Equity Officer serve as the committee sponsors.

Committee members include the following:

- Chief Medical Officer (CMO) Medical Director or designee
- Chief Health Equity Officer/Executive Director of Quality and Equity
- Director of Provider Services

- Director of Customer Services
- Director of Utilization Management and Care Management
- Director of Clinical Analytics
- Director of Pharmacy
- Director of Member Services
- Director of Quality Management
- Director of HEDIS and NCQA Accreditation and/or HEDIS
- NCQA Accreditation Manager
- Quality Manager (s)
- Health Education Manager
- Culture and Linguistics Manager
- Quality Supervisor(s)

When the primary attendee is not available, a designee is assigned. Ad hoc membership can include staff from: Compliance, Contracting, Claims, and IT.

Meetings

The Committee will meet at least quarterly, or more frequently as determined by the Committee and in the format determined by the Committee. Other parties may attend meetings at the invitation of the Committee.

The Chair will set the agenda of items to be addressed by the Committee with input from other members of the Committee.

Most of the members of the Committee will represent a quorum of the Committee, and, if a quorum is present, any action by at least most of the Committee members present shall represent the valid action of the Committee. Regular attendance of Committee members is expected for the Committee to function effectively. A voting member may designate a representative on an ad-hoc basis who may vote on the Committee member's behalf. Such designation must be received in writing by the Chair or a designee of the Chair in advance of the meeting or vote.

In those instances where voting is conducted via email, all members of the Committee will be considered present. The only exceptions will be members who are out of the office, as indicated by an out-of-office auto reply and have not designated a representative.

Delegation Oversight Committee

Commented [KC29]: Factor 5: QI Committee oversight

Commented [KC30R29]: Involvement of Organization Staff in Multidisciplinary Workgroups or Subcommittees: organization staff who are not part of the QIHEC directly are involved in various multidisciplinary committees and workgroups. For example, the Delegation Oversight Committee includes members from departments such as Pharmacy, Claims, and Customer Service, ensuring that a broad spectrum of organizational roles is represented

The DOC is responsible for overseeing all Delegate activities and ensuring appropriate actions are taken when Delegates are not meeting State, Federal, and local statutes and regulations, accreditation standards, requirements, or contractual obligations. The DOC ensures that Health Plan remains accountable and compliant when delegating core administrative and management functions through pre-delegation audits, ongoing monitoring, annual performance review and compliance auditing, and ad hoc focused auditing. The DOC reports to the Compliance Committee and the Quality Improvement and Health Equity (QIHEC).

Committee Chair: Manager, Delegation Oversight

Voting Members:

- Director, Compliance
- Director, Provider Contracting or designee

- Director, HEDIS & NCQA Accreditation or designee
- Director, Quality Improvement, or designee
- Supervisor, Quality Improvement
- Manager, Pharmacy Initiatives
- Manager, Claims
- Manager, Processing and Payment Integrity
- Manager, Cultural and Linguistics
- Manager, Case Management
- Manager, Social Work
- Manager, Authorizations and Referrals
- Manager, Inpatient Services and Care Coordination
- Manager, Customer Service

Non-Voting Members:
- Manager, Compliance
- Compliance Analyst
- Senior Compliance Specialist

Meetings

The committee meets every two months, or more frequently as determined by the Committee and in the format determined by the Committee. Other parties may attend meetings at the invitation of the Committee. The Chair will set the agenda of items to be addressed by the Committee with input from other members of the Committee.

A quorum is 50% of the voting members, and, if a quorum is present, any action by at least a majority of the Committee members present shall represent the valid action of the Committee. The Compliance Department maintains copies of all DOC meeting agendas, minutes, and documents presented to the Committee for review.

Compliance Committee

The Compliance Committee is appointed by the Compliance Officer and reports to the CEO.

The following are the specific functions of the Compliance Committee:
- Review and approve the Health Plan Compliance Program including the policies and procedures that support the seven (7) elements of an effective compliance program at least annually, or more frequently depending upon business needs or changes to the Compliance Program requirements
- Promote a compliance culture within the Health Plan environment by allocating resources and time to remediate any deficiencies or findings identified
- Develop strategies to promote compliance and the detection of any potential violations
- Ensure that compliance training and education are effective and appropriately completed
- Authorize and review a compliance risk assessment at least annually, or more frequently as needed
- Review and make recommendations regarding Internal Audit's annual audit work plan
- Assist with the creation and implementation of the Medi-Cal Monitoring Work Plan
- Assist in the creation of effective corrective and preventive action plans and ensure that they are implemented and monitored

- Oversee a system of internal controls designed to ensure compliance with the Compliance Program requirements in daily operations
- Support the CCO's needs for sufficient staff and resources to carry out the Chief Compliance Officer's duties
- Ensure the Health Plan has appropriate and up-to-date compliance P&Ps for the Compliance Program
- Ensure the Health Plan has a system for employees, workforce members, Delegates and business partners to ask Compliance Program questions, and report potential instances of non-compliance
- Ensure members and other interested parties have easily accessible methods to report suspected or actual fraud, waste, abuse, or other non-compliance with the Compliance Program
- Review and address reports of monitoring and auditing of areas in which the Health Plan is at risk for non-compliance or fraud, waste and abuse, and ensures corrective action plans are implemented and monitored for effectiveness
- Escalate compliance deficiencies and ongoing issues of non-compliance to the Chief Compliance Officer and/or other Health Plan executive leadership. Compliance deficiencies and issues of non-compliance regarding Health Equity will be escalated to the Chief Health Equity Officer

Committee Chair: Chief Compliance Officer
Voting Members of the Compliance Committee include:

- **Executive Team Members:**
  - Chief Compliance Officer
  - Chief Financial Officer
  - Chief Information Officer
  - Chief Medical Officer
  - Chief Operating Officer
  - Chief Administrative Officer
  - Chief Health Equity Officer
  - Executive Director, Clinical Operations
  - ~~o~~ Chief Operations Officer
- **Medical Management Representatives:**
  - Director, HEDIS & NCQA Accreditation
  - Director, Pharmacy
  - Director, Quality Improvement/Management
  - Director, Utilization Management
  - Manager, Case Management
  - Director, Clinical Analytics
  - Manager, Social Work
- **Finance & Claims Representatives:**
  - Director, Claims
  - Controller
  - Director, Financial Planning & Analysis
- **Operations Representatives:**
  - Director, Customer Service
  - Director, Provider Services

    - Director, Provider Contracting
    - Director, System Configuration
- **Information Technology Representatives:**
    - Director, Business Intelligence & Applications Development
    - Designated Security Officer
- Administration and Human Resources
    - Director, Community, Marketplace & Member Engagement
    - Manager, Government & Public Affairs
    - Director, Human Resources
    - Director, Employee Relationship
- **Compliance Representatives:**
    - Director, Compliance
    - Manager, Delegation Oversight
    - Manager, C&L
    - Manager, Risk Management

Meetings

The Committee will meet at least quarterly, or more frequently as determined by the Committee and in the format determined by the Committee. Other parties may attend meetings at the invitation of the Committee.

A majority of the members of the Committee will represent a quorum of the Committee, and, if a quorum is present, any action by at least a majority of the Committee members present shall represent the valid action of the Committee. Regular attendance of Committee members is expected in order for the Committee to function effectively.

Policy Review Committee

The Policy Review Committee is overseen by the Compliance Director which stands as the committee chair. This Committee is responsible for ensuring policies and procedures (P&P) and their outcomes, support the mission, values, and strategic goals of Health Plan. This Committee reports to the Compliance Committee.

The following are the specific functions of the Policy Review Committee:

- Hold regularly scheduled meetings
- Satisfy policy review training
- Support the corporate mandate that all P&Ps are reviewed annually
- Assist departments in establishing and modifying P&Ps
- Provide technical assistance to the departments to ensure that P&Ps are compliant with applicable laws and regulations
- Confirm that P&Ps are written in a clear and concise manner

Committee Chair: Director, Compliance
Voting Members, representing specific Health Plan operational areas include:

- Controller -- Accounting
- Care Management Director -- Care Management
- Claims Director -- Claims
- Compliance Director -- Compliance and Privacy, Delegation Oversight, Risk Management

- Customer Service Director -- Customer Service
- Financial Planning & Analysis Director -- Financial Planning & Analysis
- HEDIS and NCQA Director -- Quality Management
- Human Resources Director -- Human Resources
- Pharmacy Director -- Pharmacy
- Clinical Analytics Director -- Clinical Analytics
- Director Core Systems -- IT Ops and Security
- Provider Contracting Director -- Provider Contracting
- Provider Relations Director -- Provider Services
- Quality Management Director -- QM, G&A, and Credentialing
- Utilization Management Director -- Utilization

Meetings

The Committee will meet on a monthly basis, on an established regular schedule, or more frequently as necessary to ensure all Health Plan Policies and Procedures are reviewed and updated on an annual basis. Meeting dates and times will be specified a year in advance. A quorum must be present to act on business before the Committee. There must be at least one (1) meeting per quarter. Meetings may be canceled if there is no business or if a quorum cannot be established. Over 50% of the voting members shall constitute a quorum. Ad hoc and electronic voting meetings may be held for special circumstances, as deemed necessary by the Chairperson.

Diversity, Equity, and Inclusion (DEI) Committee

The Health Plan of San Joaquin (Health Plan) Diversity Equity and Inclusion Committee (DEI) develops strategies and plans to promote equity and inclusion that involves Health Plan members, providers, community partners and staff. Health Plan strives to be a voice for equity and inclusion in the community and take actions to promote change. The CHEO serves as the Executive Sponsor for the DEI Committee. When a permanent candidate is selected, this committee will commence.

The following are the specific functions of the Diversity, Equity, and Inclusion Committee:

- Community support and resources
- Provider education and training
- Member support and programs
- Employee training and activities

Structure and 2023 Committee Members

Committee Chair: Manager, Health Education

The Committee will consist of no less than six and no more than eight committee members. A member of the cultural and linguistic team, member services, community outreach, and medical management departments will participate on the committee. Members of the committee will be appointed by the executive team and must have their managers and director's approval to join the committee. The committee must have a minimum of four members in attendance to have a quorum.

The Chair of the Committee is responsible for being the liaison between the committee and executive leadership. They will obtain approval (when necessary) from the ET and cascade

responses and feedback to the committee. The Chair will schedule and facilitate all committee meetings (unless not able to fulfill duty – backup facilitator to be determined in advance and Secretary will be notified in order to update agenda). The Co-Chair of the DEI Committee is responsible for sub-committee oversight on a biweekly basis. The Secretary of the DEI Committee is responsible for preparing the agenda for each meeting and sending it to committee members a day in advance. The Secretary will also be responsible for taking minutes during the meeting, ensuring all action items are recorded and tracked for completion. Committee Members are responsible for active participation in the work tasked to the committee by organizational leadership. The members will be responsible for the execution and promotion of programs and activities developed by the committee.

Meetings

The Committee will meet every other week or more frequently as needed by the Committee. Meeting dates and location will be scheduled six months in advance; a meeting agenda will be prepared by the Committee Secretary and provided at the beginning of each meeting. The Committee Chair will facilitate all meetings unless Chair asks another to facilitate as back-up.

Community Advisory Committee

The Community Advisory Committee (CAC) seeks to empower Members to become active participants in their care, through processes and channels for engagement for Members, families, and the community. It is designed to encourage participation of consumer, community advocates, traditional and safety net providers. The committee provides recommendations and consumer insights to policy decisions related to Quality Improvement, education, operational, and culture competency issues affecting groups who speak a primary language other than English.

Health Plan makes an effort to include membership from hard-to-reach populations, (e.g., members with physical disabilities) and modifies the CAC membership as the beneficiary population changes. This includes but is not limited to Seniors and Persons with Disabilities (SPD), persons with chronic conditions (such as asthma, diabetes, congestive heart failure), Limited English Proficient (LEP) Members, and Members from diverse cultural and ethnic backgrounds or their representatives are included.

Health Plan makes a good faith effort to include community advocate groups, safety-net providers, and traditional providers that represent hard-to-reach populations, such as, but not limited to, Health Plan members with physical disabilities. Health Plan will ensure a diversity of membership on the CAC that is reflective of respective services area(s) and includes adolescents and/or parents/caregivers of Members under 21 years of age. The CAC reports to both the QIHEC and to the San Joaquin County Health Commission.

The Community Advisory Committee topics may include, but are not limited to:

- Care Coordination in an Emergency
- Community Advisory Committee Charter Review
- COVID – 19 and Flu update
- Health Education Material Review
- Population Needs Assessment (PNA) Introduction
- PNA Workgroup
- Member Portal Website Usability
- Women's Health Education & Webpage Review

- Text Messaging Focus Group
- Health Equity Presentation
- Diabetes Prevention Program
- Tobacco Prevention
- Review Health Plan Resource Guide
- STDs/STIs Presentation
- MCAS Measures
- Grievance data

Committee Chair: Manager, Health Education or Designee(s)
Membership may include:

- **External Participants:**
  - Health Plan members
  - Community Advocate Groups
  - Safety Net providers
  - Traditional providers
  - SJ Health Commission appointed CAC delegate
- **Health Plan Staff:**
  - Departments that may provide representation include:
    - Claims
    - Administration
    - Compliance
    - Customer Service
    - Medical Management
    - Community, Marketplace, and Member Engagement
    - Provider Contracting
    - Provider Services

Meetings
The Committee will meet at least every other month, or more frequently as determined by the Committee and in the format determined by the Committee.

Facility Site Reviews

Facility Site Reviews (FSR) audit processes are in place to ensure that all primary care provider sites utilized by Health Plan for delivery of services to members have sufficient capacity to:

- Provide appropriate primary healthcare services
- Carry out processes that support continuity and coordination of care
- Maintain patient safety standards and practices; and
- Operate in compliance with all applicable federal, state, and local laws and regulations

In compliance with the California statute (Title 22, section 56230) that requires all primary care provider sites contracted with the Health Plan Medi-Cal Managed Care Program to have both initial and periodic site inspections regardless of the status of other accreditation and/or certifications, the FSR serves as the standard for conducting the initial and subsequent periodic reviews of PCP sites. A full scope FSR consists of:

- Facility Site Review (FSR)
- Medical record Review (MRR)

- Physical Accessibility Review Survey (PARS)

As per DHCS All Plan Letter 22-017, Health Plan ensures that FSRs are conducted by a Certified Site Reviewer (CSR), trained and certified by the Health Plan's Master Trainer (MT), and provides necessary education and support to primary care providers and their office staff to facilitate successfully passing the initial and periodic FSR. Technical assistance is provided to PCPs and their staff with identified deficiencies needing improvement or corrections. Health Plan also performs various monitoring reviews to ensure that standards are maintained in areas of care. These are also done to keep PCPs abreast with the latest updates or changes in the guidelines.

These monitoring platforms consist of:

1. All primary care provider (PCP) sites are monitored between required three-year FSRs to maintain patient safety standards and practices and operate in compliance with applicable federal, state, and local laws and regulations.
2. An Interim Review form is sent to all PCP sites mid-way between the periodic full scope reviews (at 18 months). The Interim Review form is faxed to the provider office. It contains a checklist of the nine critical elements and requires that the provider verify that all nine are either in place or are not applicable. Onsite verification is done depending on a PCP's compliance and history of previous audit standing.
3. Monitoring and trending of quality of care, member dissatisfaction, and access issues on an ongoing basis utilizing the following resources:
    - Customer contact logs
    - Utilization Management nurse referrals
    - QIHETP investigations and studies
    - HEDIS measures
4. Focused reviews for critical elements or repetitive deficiencies identified during FSRs that impact patient health and safety.
5. Corrective Action Plans for sites that receive a Conditional Pass (80-89%), or 90% and above with critical element deficiencies and/or deficiencies in pharmacy, infection control. A CAP is required to be established that addresses each of the noted deficiencies. CAP documentation shall identify the following:
    - The specific deficiency
    - Corrective action(s) needed
    - Re-evaluation timelines/dates
    - Responsible person(s)
    - Problems in completing corrective actions
    - Education and/or technical assistance provided by the Health Plan
    - Evidence of the correction(s), completion/closure dates and name/title of reviewer

All CAPS are placed and followed up based on strict timelines determined by MMCD standards and Health Plan's internal policy.

Health Plan also collaborates locally within each Medi-Cal managed care county to establish systems and implement procedures for the coordination and consolidation of site reviews for mutually shared PCPs. Health Plan has equal responsibility and accountability for participation in the site review collaborative process.

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. Also, Health Plan aims to engage with both members and provider to promote and implement safety practices.

The goals of our patient safety initiatives are to:

- Avoid injuries to our members from the care that is intended to help them
    - Health Plan defines Patient Safety as "freedom from accidental injury caused by errors in medical care". Medical errors refers to "unintentional, preventable mistakes in the provision of care that have actual or potential adverse impact on our members".
- Establish and maintain a blame-free environment where members, their families, practitioners, providers, and Health Plan staff, can 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 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 Health Plan web site
- 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 Health Plan web site
- Evaluation for safe clinic environments during FSRs and dissemination of information regarding FSR 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, social worker 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 30 days of discharge
- Collaboration and exchanges of admission notes and discharge summary between hospital and Primary Care Provider (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: http://www.leapfroggroup.org/cp
- Implementing and maintaining procedures for reporting any serious diseases or conditions to both local and State public health authorities and to implement directives from the public health authorities as required by law, including but not limited to, 17 CCR section 2500 et seq.

Health Plan receives information about actual and potential safety issues from multiple sources including member and practitioner grievances, potential quality issues, and pharmacy data, as well as through FSR Corrective Action Plans.

Quality & Health Equity Initiatives

Clinical Quality & Health Equity Improvement

Health Plan's Quality Improvement Department adheres to all DHCS standards in accordance with Title 22, CCR, Section 53860 (d) and Title 42, USC, Section 1396a(30)(C) for quality performance reporting.

On an annual basis, Health Plan cooperates with the appropriate External Quality Review Organization (EQROs) to conduct an onsite or virtual assessment of the quality and performance measure compliance. The plan's administrative data management and processes conform to the technical specifications intended by measure stewards and complies with the annual HEDIS, MCAS, HEQMS and other quality review processes. The plan subsequently complies with mandatory and optional activities described in the EQRO Final Audit Report (FAR). The plan partners with an NCQA certified quality measure rate calculation vendor to assist with data collection, reporting and analysis. The data is used for tracking clinical issues that are relevant to the population. Relevant measures focus on DHCS, DMHC, and NCQA quality measures and relevant equity stratification reports. Quality measures are selected from primarily NCQA HEDIS and Center for Medicare and Medicaid (CMS) Core Measure sets. Results are reported to DHCS, DMHC, and NCQA and through state specific reporting document templates and data reporting portals. Health Plan establishes goals and benchmarks for measures in alignment with DHCS and DMHC Quality and Performance Standards and evaluates the Plan's performance against these goals throughout the year as prospective monthly rate monitoring with no less than quarterly reporting and as regulatory end of calendar reporting which aligns with the timing of the end of the fiscal year.

Based on the findings, Health Plan identifies and prioritizes areas for improvement by developing quality improvement projects. Health Plan also deploys a Quality Outreach Program for practitioners and their office staff, known as the Provider Partnership Program (PPP). PPP reports include provider reports and education. On occasion meetings are held on site to build collaborative relationships with the providers and clinics. The QIHETP program will also monitor areas of over and underutilization of services to improve appropriate utilization of services. The over and underutilization measures will be based on HEDIS, MCAS, and other internally developed utilization measures.

The QI Department implements opportunities to improve quality of care by developing and implementing quality improvement activities/interventions. These interventions promote patient and provider engagement programs, focus on equity, removing barriers to care, promoting partnerships with local government agencies (LGAs) and local education agencies (LEAs) in alignment with Population Health Management activities and may include but are not limited to:

- Developing and adopting clinical standards, practice guidelines or administrative standards, with subsequent dissemination of the standards to physicians, members, or staff as appropriate
- Educating physicians and clinic staff about clinical standards and practice and preventative guidelines
- Providing feedback reports to physicians and clinic staff on their current performance

- Providing health promotion and health education programs to members and educating them on how to improve their health
  Improving internal functions to improve quality of care, accessibility, and service.

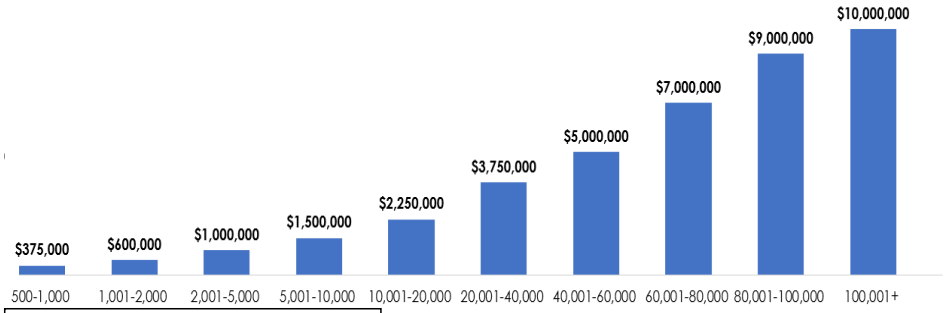
As part of Health Plan's QIHETP, Health Plan is heavily invested in rolling out DHCS's Equity and Practice Transformation (EPT) to selected small and medium primary care practices. Qualifications for program enrollment is guided by DHCS. In addition to providing full assessment and application preparation support to qualifying contracted practices, Health Plan is fully committed to supporting and partnering with Federally Qualified Health Centers (FQHCs) by sharing information about eligibility, and the application process. Other equity focused activities include identifying and acting on health disparities in the MCAS and HEQMS measure rate performance in order to meet DHCS Quality Bold Goals and other relevant measure rates designed to identify subpopulations that may benefit from equity activities.

Equity Practice Transformation Payments Program (EPT Payments Program)

The Department of Health Care Services is implementing a one-time $700 million primary care provider practice transformation program to advance health equity and reduce COVID-19-driven care disparities by investing in up-stream care models and partnerships to address health and wellness and funding practice transformation. These efforts aligned with value-based payment models will allow Medi-Cal providers to better serve the state's diverse Medi-Cal enrollee population. To align with the goals of the DHCS Comprehensive Quality Strategy and Equity Roadmap, these funds will pay for delivery system transformation payments to primary care practices (pediatrics, family practice, adult medicine primary care, primary care OB/GYN, and behavioral health providers in primary care settings) focused on advancing DHCS' equity goals in the "50 by 2025: Bold Goals" Initiative and to prepare them to participate in alternative payment models.

Allocation of Funds:

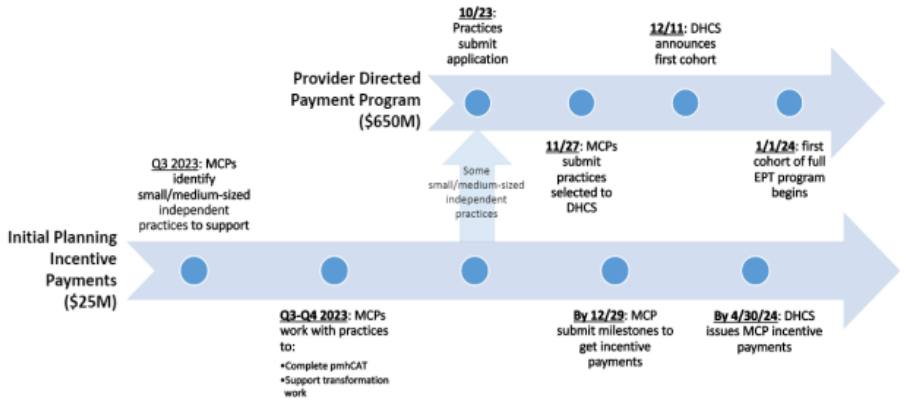
- Payments will be disbursed upon achievement of specific activities and milestones
- Practices must commit to certain activities, some of which are required and others which are optional. Practices can receive $375,000 to $10 million depending on the number of Medi-Cal members assigned



Timeline of the EPT Payment Program:

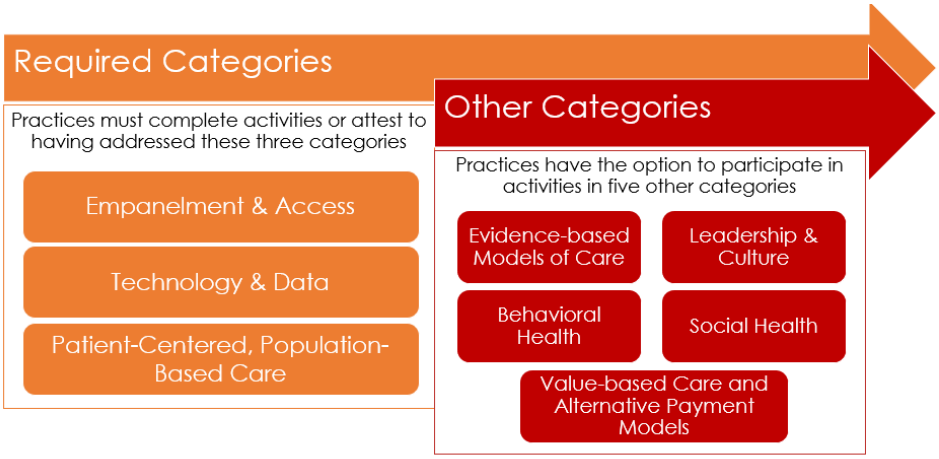
The EPT Payment Program is a 5-year initiative of DHCS, which incorporates three main phases from development to evaluation.

1. 2023: Phase I: initial planning phase, managed care plans assist small, independent practices apply for the grant
2. 2024 – 2028: Phase II and III
    - Phase II: Provider Directed Payments Phase, practices implement processes and infrastructure to support quality improvement initiatives
    - Phase III: Statewide Learning Collaborative, to summarize the successes and challenges of the EPT Payments Program.



EPT Payment Program Activities:
The EPT program will fund transformation activities that will help practices improve quality, close gaps in care, and prepare for value-based care. Per DHCS application guidelines, there are required and optional activities that applying practices will need to consider. Required activities that practices will need to complete or attest out of are a.) Empanelment and Access, b.) Technology and Data, c.) Patient-Centered, and Population-Based Care. In addition, practices may commit to optional activities, such as:

- Evidence-Based Models of Care
- Leadership & Culture
- Behavioral Health
- Social Health, and
- Value-Based Care and Alternative Payment Models



The Provider Partnership Program

The Provider Partnership Program is an initiative launched by Health Plan in 2016 with the main purpose of increasing the delivery of preventive services and disease management services to its members. Through the years, this program has adhered to its purpose and goals which are:

- Improve the collaboration between Health Plan and our network providers to improve the quality of care and services provided to our members
- Share comparative quality measure data and performance and when appropriate, share comparative cost data
- Communicate value-based payment program progress against goals
- Share best practices for access and service and to follow up on opportunities for improvement
- Build a partnership to improve quality metrics such as HEDIS and MCAS for various BH and Medical preventive services and disease states
- Improve the administrative communication between the Health Plan and the physician's office
- Improve the delivery of preventative and treatment services to the members
- Increase HEDIS and MCAS measure compliance rates in both San Joaquin and Stanislaus Counties
- Develop a collaborative approach, share best practices, share resources, and share tools to improve care delivery for members
- Ensure that the PPP engages a significant number of providers and provider groups to influence the care for the majority of the Health Plan membership
- Share best practices and other relevant provider practitioner supports
- Partner with the provider network to remove barriers to care and to identify and remediate health inequities

The core of the program revolves on performance measurement of:

- HEDIS Measures
    - Access/Availability of Care

    - Effectiveness of Care survey results
    - Experience of care
    - Utilization
    - Equity Measures
- MCAS measures
    - Children's Health Measures
    - Reproductive Health Measures
    - Acute and Chronic Disease Management Measures
    - Behavioral Health Measures
    - Cancer Prevention Measures

The Provider Partnership Program has a multidisciplinary team for provider support that includes plan representatives on a regular and ad hoc basis from:

- Executive leadership
- Provider Services
- Quality Operations
- Claims
- HEDIS and NCQA
- Clinical Quality

The partnership also includes some other areas of the Medical Management Department as needed which are:

- Disease Management and Care Management
- Transition of Care
- Continuity of Care
- Prior Authorization
- Pharmacy
- Social Work
- Health Education
- Clinical Analytics

As the program continues to evolve, it welcomes new providers regardless of empanelment numbers, to work hand-in hand with the providers implementing the program's purpose and goals. In future years, the program team will expand collaboration with the Health Education Department and with the Population Health team to ensure effective population health program implementation with an eye towards building a constellation of entities that will provide an expanding net of care and services to members. Furthermore, QI also plans on closer collaboration with other ad hoc teams for collective and streamlined initiatives.

Network Adequacy

The Knox-Keene Act requires Health Plan to maintain practitioner networks that are sufficient to ensure that all covered health care services are readily available to each member consistent with good professional practice. In addition, Health Plan is required to monitor and maintain networks sufficient to provide members access to covered health care services within specific appointment wait time standards and to meet network adequacy requirements set forth within the Knox-Keene Act. To demonstrate compliance with these requirements, Health Plan is required to annually submit certain information to the DMHC and undergo a Network Adequacy Validation audit.

Health Plan has established standards to ensure members have access to primary, high-volume and high impact specialist practitioners, and behavioral practitioners. Health Plan monitors performance areas affecting and reflecting practitioner network availability and accessibility on at least an annual basis for San Joaquin and Stanislaus counties. Quantitative analysis is conducted to assess results with the availability and accessibility performance standards. Qualitative analysis is conducted for results that do not meet performance goals to determine the root causes driving performance results. Root causes are listed in rank order, based on their importance to member access and their likelihood as a contributing factor. Staff responsible for executing network processes for members and practitioners and other subject matter experts participate in the qualitative analysis.

Availability

Health Plan annually collects data from available sources on members' cultural, ethnic, racial and linguistic needs. To assess for any unmet member needs relative to our network, Health Plan also collects and analyzes the same data for our practitioner network. Member and practitioner data is analyzed to determine if any adjustments (e.g., number, type, geographic location of practitioners) are needed to the network. Health Plan continues to seek solutions to address challenges associated with obtaining member and practitioner level data related to cultural, ethnic, racial, and linguistic characteristics.
Health Plan has established availability standards for the number and geographic distribution of the following practitioner types:

- Primary Care
- High Volume Specialty Practitioners
- High Impact Specialty Practitioners
- Behavioral Health Practitioners

Primary care practitioners include:

- Family Medicine and General Practitioners
- Internal Medicine
- Pediatrics
- Obstetrics and Gynecology (DHCS requirement)

Behavioral health practitioners include:

- Licensed Professional Clinical Counselors
- Marriage and Family Therapists
- Psychologists
- Licensed Clinical Social Workers
- Psychiatrists

High volume specialty practitioners include:

- Cardiology/Interventional Cardiology
- Gastroenterology
- General Surgery
- Obstetrics & Gynecology
- Ophthalmology

High impact specialty practitioners include:

- HIV/AIDS Specialists/Infectious Diseases

- Neurological Surgery
- Oncology
- Orthopedic Surgery

Network availability data is collected via GeoAccess for each of the practitioner types listed above at least annually for San Joaquin and Stanislaus counties.

Accessibility

Health Plan has established appointment accessibility performance standards for different appointment types for the network practitioner types outlined in the Availability section. Appointment accessibility is monitored at least annually for San Joaquin and Stanislaus counties using surveys that are administered by an external survey vendor.

- Primary care: Regular and routine care, urgent care, and after-hours appointments
- High-volume and high-impact: Routine care, and urgent care
- Behavioral health: Care for a non-life-threatening emergency, urgent care, initial visit for routine care, and follow-up routine care

Comprehensive Network Adequacy Assessment

On an annual basis, Health Plan conducts a comprehensive assessment of network adequacy. This assessment involves an analysis of behavioral and non-behavioral data and results for San Joaquin and Stanislaus counties for the following:

- Member experience: Grievances and appeals, survey results from CAHPS and ECHO
- Utilization data: Requests for and utilization of out-of-network practitioners
- Accessibility: Appointment accessibility results
- Availability: Numeric and geographic distribution results

Stakeholders from various departments conduct and document the comprehensive analysis report and include the Director, HEDIS & NCQA; Director, Practitioner Services; Director, Corporate Analytics; Manager, Accreditation; Manager, Practitioner Services; Manager, Quality; and Manager, Practitioner Network Program. The analysis includes an assessment of the effectiveness of interventions with improving network accessibility and availability. Previous measurement period results compared to current year results are used as the measurement of intervention effectiveness. Opportunities for improvement are identified and prioritized by importance to member need and risk to member access to behavioral and nonbehavioral services. Interventions are determined in alignment with the prioritized opportunities and the root causes. Lead persons and due dates are assigned to each intervention to ensure the timely implementation and completion of improvement actions.

Access to Care

Health Plan has established standards and mechanisms to assure the accessibility of primary care, specialty care, and behavioral health care. The Plan will continue to work with providers and clinics to develop interventions to improve access.

The Plan will also monitor access to care based on the following standards, as outlined by the DHCS and the DMHC:

- Availability of Practitioners (PCP, Specialists and Behavioral Health providers)

- Accessibility through Appointment access (routine and urgent appointments)
- Availability of PCPs by Language
- Language Assistance Services (Telephonic, In-Person Interpreter, Language Line and Hearing Impaired)
- Telephone access
- After-hours access to care
- HealthReach 24/7 Nurse Advice Line
- Transportation services
- Availability of Practitioners via Telehealth

California Advancing and Innovating Medi-Cal (Cal AIM)

The State of California's initiative to improve managed care members' access to care. The primary goals of the Cal-AIM initiative are to:

- Implement a whole-person care approach and address social drivers of health
- Create a consistent, efficient, and seamless Medi-Cal system; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation

Enhanced Care Management provides services to our highest-need Medi-Cal members, primarily through in-person engagement where Health Plan's members live, seek care, and choose to access services.

Community Support Services (also known as "In Lieu of Services") include housing supports, medically tailored meals, respite care, and other services that plan a fundamental role in meeting members' needs for health and health-related services that address social drivers of health.

Transition of institutional long-term care from Medi-Cal Fee-For-Service to managed care to enhance care coordination, simplify administration and provide a more integrated experience.

Collaborative Quality Improvement Initiatives

Child Health Equity Sprint Collaborative

The Institute for Healthcare Improvement (IHI) is partnering with DHCS to continue the work already started by California Advancing and Innovating Medi-Cal (CalAIM). Together, IHI and DHCS have designed a 12-month Child Health Sprint Collaborative that focuses on supporting Managed Care Plans to implement best practices in children's preventive services with their network providers and plan-based teams to provide effective, equitable whole-person pediatric care. Specifically, the focus of the Child Health Equity Collaborative is to improve the completion of well-child visits (WCVs) for infants (0-30 months) and adolescents (15-18 years old). All California Managed Care Plans are required to participate.

Working with DHCS and Managed Care Plans, the IHI is using a comprehensive strategy to reduce equity gaps, improve access, and build capacity across Medi-Cal. Critical elements of the strategy include effective team-based care, automation and effective use of technology, including Electronic Health Records, population health management, and addressing social drivers of health. The Collaborative coordinates regular meetings and training sessions with Managed Care Plans. Health Plan is partnering with Golden Valley Health Center on this important initiative. Health Plan staff

Commented [KC31]: Factor 1: Collaborative QI activities, if any

Commented [KC32R31]: outlines collaborations with external entities such as DHCS and managed care plan through initiatives like the Child Health Equity Sprint Collaborative. It also discusses partnerships with providers to improve care quality

participating in the Sprint include Manager, HEDIS and Quality Reporting; Coordinators for HEDIS and Quality Reporting; Manager, Accreditation, HEDIS, and NCQA; Interim Quality Director; Manager, Cultural and Linguistic; and Manager, Health Education.

The final phase of this work will provide results and analysis of the work completed in the 12-month collaborative. The results will then be used to provide value insight and guidance to IHI and DHCS on how to best scale up and disseminate the key learnings, change ideas, and results in a sustainable and impactful manner.

Population Health Management

Commented [KC33]: Factor 1: How the QI and population health management (PHM) programs are related in terms of operations and oversight.

Commented [KC34R33]: integrates population health management within its quality improvement efforts, using data-driven approaches to assess care needs and monitor PHM program effectiveness in alignment with quality improvement goals

Health Plan develops and maintains a comprehensive population health management program that creates a cohesive framework which will serve as the cornerstone of transformation in the care provided to Health Plan enrollees. The PHM program will be informed by the population needs assessment, DHCS MCAS, DMHC HEQMS and will collaborate with delivery system partners to prioritize members' equitable access to necessary wellness and prevention services, care coordination, and care management. Health Plan assesses each member's needs across the continuum of care based on member preferences, data driven risk stratification, identified gaps in care, and the results of standardized assessments. The PHM program seeks to align with the QIHETP to:

- Improve the care for all members
- Collect data that will assist with accurately identifying member characteristics
- Align resources toward priority groups
- Facilitate safe member transitions
- Provide culturally and linguistically sensitive materials
- Offer language services at key points of contact
- Provide activities which are designed to support practitioners, providers and community partners
- Align with DHCS and NCQA standards for PHM
- Align with Health Plan's and DHCS's Comprehensive Quality Strategy
- Collaborate with internal and external entities and local agencies
- Align priorities with the Population needs Assessment (PNA)
- Incorporate a lens towards health equity and health education and continuous quality improvement
- Engage with the community representatives of diverse cultural and ethnic backgrounds to develop strategies
- Empower members to become active participants in their care by supporting existing channels and creating new channels of engagement
- Facilitate health risk reduction and promote healthy lifestyles, and self-care and management of health conditions.

Collaborative Relationship of PHM and Quality Improvement

The Population Health and Quality Improvement/Health Equity departments reside within the larger and overarching Medical Management structure. The Population Health and Quality teams report directly to the CMO. The CMO and department leaders serve as the primary vehicle for facilitating quality, health equity, and population health activities to promote a focused and cohesive approach to organization wide quality and population health priorities. Committee oversight is provided by the QIHEC with reports related to quality, health equity, and population health provided to the Committee on an ongoing basis.

Population Health and Quality leadership collaborate on activities that include, but are not limited to: data collection, tracking and analyzing quality indicator results (e.g., clinical, utilization, member experience), population identification and assessment, member segmentation and stratification, member-centered initiatives, and measurement of intervention effectiveness. Data and information flow between areas to achieve program objectives. All quality, health equity, and population health activities are conducted collaboratively within an environment of improving health outcomes and racial equity. The Population Health and Quality departments maintain program documents that provide an overview of each area's goals, objectives, functions, and structures. The Annual Quality Work Plan is developed in collaboration with all HPSJ stakeholders and includes Population Health specific quality improvement activities.
The Population Health Management Program and an annual evaluation of effectiveness is reported to the QIHEC Annually.

Continuity and Coordination of Care

Continuity and Coordination of care is a key component of the QIHETP deployed to improve overall health outcomes. Health Plan Utilization Management and Clinical Operations programs focus on a number of key initiatives to improve coordination between providers and support members moving across care settings and programs. Health plan uses data integrated from a variety of sources, and risk stratifies data. The stratified data assists with identifying and defining metrics. Given the stratified data, Health Plan can better act on opportunities to improve access to Early Periodic Screening, Diagnostic, and Treatment services, access to adult and child primary care, specialty care, emergent and inpatient care, behavioral healthcare, including members with mental illness and substance use, ancillary care, and the care and treatment of seniors and persons with disabilities and children with special healthcare needs.

Care Management systems enable staff to monitor the member's condition while focusing on linking members to available resources. The system can be used to create care plans, goals and identify barriers.

The system has alerts programmed to ensure appropriate follow up:

- Outreach and referrals
- Program management
- Transitions across setting and alternate levels of care
- Emerging risk and disease management programs
- Complex Case Management and Enhanced Case Management
- Community resource referrals
- Outreach and communication attempts

Health Plan acts, as necessary to improve continuity and coordination of medical and medical and behavioral healthcare and ensures safe transitions of care. Health Plan uses relevant HEDIS measures to evaluate effectiveness of continuity of care and conducts provider surveys to measure the effectiveness of interventions aimed at improving continuity and coordination of care that involve member movement between practitioners and across settings. Health Plan collaborates with behavioral health practitioners and uses information from its repositories to coordinate medical and behavioral healthcare. In addition, Health Plan makes every effort to ensure that new members can continue with their established provider at the time of enrollment, and that active prior treatment authorizations remain in effect for ninety (90) days after enrollment. If not

possible, Health Plan ensures that the member's care is transitioned to provider with similar skills and abilities.

When a Practitioner terminates their contract with Health Plan, the Plan ensures that members have the ability to request completion of covered services for members with an acute or serious chronic condition or terminal illness. Members with a second or third trimester pregnancy have access to their discontinued practitioner through the post-partum period for up to one year after delivery and children, newborn to thirty-six (36) months, may continue with their provider for up to twelve (12) months.

HSPJ Case Management services and Complex Case Management program are focused on assisting members with complex physical or behavioral health conditions and ensuring supported Transitional Care Services (TCS). When a member's social need is coupled with multiple chronic conditions, Enhanced Case Management (ECM) is offered. Community Supports augment the care provided through ECM.

Delegation Oversight

The DO Program mentioned previously in the QIHETP, oversees functions delegated to contracted entities and is responsible for ensuring delegated activities are performed appropriately and in accordance with State, Federal, and local statutes and regulations, accreditation standards, requirements, and contractual obligations. Health Plan maintains accountability and ultimate responsibility for the associated activities by overseeing performance for the delegated functions. Health Plan retains the right to revoke any delegated function if compliance with standards is not met. Health Plan has a process in place to assess and ensure delegated entities have the capacity and expertise to perform the delegated functions. Please refer to Delegation Oversight Program Description for program details.

Member Experience

In addition to HEDIS clinical measures, the QIHETP supports company-wide efforts to improve the member's experience with the plan's services and the provider network. On an annual basis, the plan uses Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Experience of Care and Health Outcomes (ECHO) or equivalent Behavioral Health survey scores to evaluate member experience. The CAHPS survey complies with the format designated by the Association for Healthcare Research and Quality (AHRQ) and fielded in compliance with and reports to NCQA. In addition, Health Plan is expanding member experience surveys to include the evaluation of the language access program (LAP) in compliance with the DMHC and Knox Keene license requirements. The plan incorporates results from the CAHPS, ECHO, and LAP results into quality and health equity activities.

The plan contracts with NCQA certified vendors to conduct an annual CAHPS to monitor members' satisfaction with health care services, accessibility of care, continuity of care, quality of care and service, cultural and linguistic issues, and to identify and pursue opportunities to improve member satisfaction and the processes, which impact satisfaction. Health Plan fields the ECHO or a similar survey instrument using Health Plan resources.

Health Plan will conduct CAHPS surveys at least annually and the results will be presented to the QHEOC and QIHEC. Once approved by the QIHEC, CAHPS summary level results are posted on the website. When the results of CAHPS and ECHO reports are available from delegated and

Commented [KC35]: Factor 1: Delegated QI activities, if the organization delegates QI activities.

Commented [KC36R35]: describes delegation oversight processes, where certain functions like credentialing are delegated, but oversight remains with the Compliance Department to ensure standards are met

Commented [NB37R35]: This does not actually include what QI activities are delegated

subdelegated entities, their results are also posted to the plan website. The plan will evaluate the survey results to develop an improvement plan to address areas identified.

The plan has a robust grievance and appeals process that monitors patient experience with the plan's benefits, services, and providers on an ongoing basis. Using plan grievances and appeals to identify potential quality issues and as companion data sets for member experience survey analysis, together the plan is better positioned to identify opportunities for improvement. The plan collaborates with the internal and external stakeholders to identify methods to resolve member experience issues on an individual member level and at a system-wide level.

Provider Performance Results

In line with Health Plan's mission of continuously improving the health of the community, the Health Plan's QIHETP aims to:

- Improve the quality and efficiency of health care provided to Health Plan members
- Improve members' experiences with services and care received
- Improve members' health outcomes
- Provide culturally sensitive and linguistically appropriate services
- Promote the safety of all members in all treatment settings
- Ensure timely access and availability of services for all members, including those with complex or special needs, including physical or developmental disabilities, multiple chronic conditions and severe mental illness
- Promote processes to ensure the availability of "safe, timely, effective, efficient, equitable, patient centered care" and provide oversight within the network

The following strategies are being adapted to achieve above goals:

- Focus on managing chronic conditions by adhering to and providing best practices in the care of their condition(s)
- Focus on improving patient safety by ensuring that evidenced-based clinical practice guidelines are followed in providing care and best practices are implemented at inpatient care settings.
- Focus on preventive health for the members by ensuring that they get access to preventive services in a timely manner and by adopting evidence-based medicine in prevention and health promotion
- Focus on improving performance of different quality measures during the measurement year including, but not limited to:
- Healthcare Effectiveness Data and Information Set (HEDIS)
    - The Healthcare Effectiveness Data and Information Set (commonly referred to as HEDIS) is the gold standard in healthcare performance measurement. Health Plan strives to achieve /perform above 50th percentile on all measures imposed.
- Managed Care Accountability Set (MCAS)
    - Focus is on both adult and Child Core Set measures to which the State requires us to accountable for the 50th percentile
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
    - The QIHE program supported companywide efforts to improve the member's experience with our service and our provider network. Health Plan uses CAHPS scores to evaluate member experience.
    - Health Plan is evaluated against the following CAHPS measures:
        - Rating of the Health Plan
        - Customer Service

        - Getting Care Needed
        - Getting Care Quickly
    - In-Network Providers are evaluated against the following CAHPS measures:
        - Rating of Personal Doctor
        - Rating of Health Care Quality
        - Grievance and Appeals
        - Access and Availability
- Clinic and Group CAHPS
    - The QIHETP will be informed by quarterly reporting of member experience using the CG-CAHPS beginning in the third quarter of 2024.
    - CG-CAHPS will identify silos of high performing and low performing provider office sites.
        - Access, Service and Provider and Office Staff Attitude will be evaluated with and eye towards identifying and remediating quality and equity of care issues and is reported through the QIHETP

Credentialing

The Credentialing Department is part of the Quality Improvement Department. Health Plan has a robust credentialing process that includes collaborating with the Quality Improvement staff to obtain Grievances, FSR and MRR audit scores at the time of the initial credentialing and re-credentialing. The Department monitors sanctions and exclusion lists on an ongoing basis to improve the quality of the network. The Credentialing Department also manages the Peer Review process under the direction of the Medical Director/Chief Medical Officer. Health Plan has delegated credentialing to a number of organizations that are part of the network. The credentialing department monitors the performance of these organizations through review of reports and annual audits. The Audits and Oversight Department team in the Compliance Department provides oversight of delegated credentialing activities and reports findings and recommendations to the QIHEC.

Initial Health Assessments

Health Plan recognizes the importance of improving the rate of Initial Health Assessments (IHA) as a key initiative to providing better care to members. The IHA includes a history of the member's physical and mental health, an identification of risks and an assessment of need for preventive screening and health education, and a diagnosis and treatment plan for any diseases. Health Plan notifies new members about the importance of the IHA in the new member mailing. Health Plan has developed training for providers on IHA requirements that are conducted during the in-service. To effectively monitor the accuracy of completed IHAs, Health Plan has also identified the appropriate claims and encounter codes used to identify initial health assessments. In addition, Health Plan reviews a random selection of medical records annually to ensure that providers are accurately completing and documenting all the elements required as part of the IHA in the medical records.

The QM department tracks and trends the IHA rates and findings from the medical record audit and develops interventions as necessary to improve quality of care. IHA's are also tracked and addressed during the FSR and MRR onsite visit of the Provider's office.

Member Engagement and Involvement in the Quality Program

Health Plan has established a Wellness Program, a health promotion program, to provide members with a variety of opportunities to improve health. The purpose of the wellness program is to

provide opportunities for members to improve their health by participating in wellness activities available to them. The Wellness Program is available to all members that are enrolled with the Health Plan. Members have access to all the tools, activities, programs, and incentives that are part of the Wellness Program. All members are informed about the Wellness Program at the time of enrollment and at least annually thereafter. Health Plan also promotes the Wellness Program on the website. The program is evaluated annually for effectiveness.

Several programs have been implemented and are monitored for use by the members on a periodic basis:

- Health Appraisals
- Self-Management opportunities
- Pharmacy benefit inquiries
- 24-hour access to clinical advice and information
- Member outreach:
    - Health Plan contracted with an outside vendor for services and activities to improve MCAS measure rates through member engagement and communications, including timely and efficient incentive distribution. Its focus is on member connection through:
        - Member communication through text, email and outbound calls if needed
        - Cultural investigation
        - Identifying additional phone numbers for non-reachable members
        - Electronic gift card request and redemption for member incentives
- Member Incentives:
    - Health Plan has started rewarding its members for taking steps to be healthier by launching the My Rewards program – an incentive program for members who have not visited their doctors or stayed up to date with their health exams and check-ups. Through this program, members visit their doctors and then verify their visits with Health Plan. Health Plan checks proof and sends an email to the member with a link to the reward/incentive gift card. Members without computer access are sent their incentive card through regular mail.
- Comprehensive Member Portal

Health Plan has worked on driving its members more to use the Health Plan's portal through developing a comprehensive website where member related information and updates can be seen. Health Plan Member Portal offers the following:

- Member Tools
    - Customer Service
    - Creating an Account
    - Provider Directory
    - Medical EOC

        - My Rewards (member incentive program)
        - Formulary
    - Member Information
        - Benefits and Services
        - Grievance and Appeals
        - Medi-Cal Redetermination
        - Medi-Cal Eligibility
        - Rights and Responsibilities
        - Case Management
        - Disease management
        - Health Guidelines
        - Health Resources
    - Health Education
        - Diabetes Education
        - Healthy Smiles
        - Men's Health
        - Prenatal Program
        - Women's Health

Member Portal information is being constantly updated to deliver the latest, most valuable information that may serve its members. For better Health Plan experience, there is also the My HPSJ App that members can download from the APP store or Android Market.

- Social Media Platform
    - Health Plan also facilitates the sharing of ideas, thoughts, and information via Facebook, where its members can follow for identity, conversations, sharing, relationships, presence, and support.

Furthermore, members are actively engaged through our Member Newsletter and Health Plan outreach for preventative services reminders. Members have the chance to provide feedback to Health Plan through our Community Advisory Committee. This committee brings Health Plan personnel, participating community-based organizations (like County Public Health), and participating network providers together with a panel of members in order to discuss health topics, grievance trends, and other important information (please see the Community Advisory Committee, pg. 61)

Provider Participation in the Quality Program

In addition to the QIHETPs' efforts for Provider Engagement, our network providers also contribute directly into the QIHETP. Some of the ways providers contribute include, but are not limited to:

- Key committee involvement, where they provide direct input into the QIHETP:

Commented [KC38]: Factor 4: Involvement of designated behavioral healthcare practitioner

Commented [KC39R38]: specifies that behavioral health practitioners, including psychiatrists and other clinicians, collaborate with primary care providers in integrated behavioral health models. These behavioral health experts help to evaluate and enhance care plans, participate in the QIHEC, and provide guidance in managing both medical and behavioral health conditions

    - Health Commission
    - QIHEC
    - Peer Review and Credentialing Committee
    - Community Advisory Committee

  Provider Partnership Program
- Collaboration for DHCS sanctioned projects
- Collaboration for Health Plan sponsored community events
- Collaboration for various health initiatives, which includes but is not limited to:
    - Behavioral Health Integration project
    - Continuity and coordination of medical and behavioral health quality improvement initiatives

Provider involvement in the QIHETP is essential to continuous quality improvement. Providers receive training upon joining Health Plan's network. Improvements in the quality of care and services delivered by our providers are achieved through continued, bidirectional communications between network providers and Health Plan. This allows the sharing of tools, provision of provider education, sharing of provider input into program development via audits, feedback, and surveys. Some special areas of focus include, but are not limited to:

- Access and Availability of Care
- Coordination of Care
- Communication with members, addressing:
    - Cultural and Linguistic needs
    - Health Equity needs
- Provider involvement for Grievances, Appeals, and Potential Quality Issues (PQIs)
- Patient safety, including provider office safety and medical record documentation
- Participation in focused interventions to improve quality of care for both preventative services and acute/chronic medical and behavioral health conditions
- Direct input into programs through committee participation
- Communication with Health Plan personnel and participation in surveys

The following strategies and tools utilized to promote provider engagement include direct communications with providers and working with them to identify and address challenges, provide tools that include training and education, as well as member engagement materials, and an incentive program. Our Provider Services team plays a critical role in engaging our providers through initial and ongoing provider trainings, regular meetings with network providers, educational tools, various provider communications (e.g., provider alerts, PlanSCAN newsletters, etc.), and providing opportunities for feedback into key quality activities.
The Quality team also has regular interactions with providers and solicits their input into programs and provides support by organizing trainings, auditing and providing feedback/guidance for improvements, and providing educational materials and tools related to member engagement and improvement of care and services.

Provider Engagement

Health Plan's QIHETP works hand in hand with the plan's Provider Services Department for provider involvement/engagement. This department has representatives for providers in both San Joaquin and Stanislaus counties. This team helps ensure that network providers are engaged through:

- Soliciting provider input to the Health Plan for the development and implementation of Health Plan's policies and standards
- Identification of provider needs and gaps

- Assistance on other areas in which provider input and engagement are critical
- Coordination of provider feedback on matters relevant to Health Plan and quality improvement activities that impact providers

QIHETP 's Strategies for Provider Engagement includes:

- Provider collaboration opportunities
- 2024 Health Plan Provider Incentive Program
- Continuing provider incentives for Proposition 56 payments that represent measures not in the overarching performance measure set
- Value Based Payments
- Enhanced Comprehensive Provider Portal (Doctor Referral Express [DRE])
    - Health Plan has worked on driving its network providers more to use the Health Plan's portal through developing a comprehensive website where provider related information and updates can be seen. Health Plan Provider Portal offers the following:
        - Provider Tools
            - ❖ Provider Incentives Program
            - ❖ Cultural Competency Training
            - ❖ HIPAA Training
            - ❖ Anti-Fraud, Waste & Abuse Training
            - ❖ Clinical Practice Guidelines
            - ❖ Forms & Documents
            - ❖ Plan Scan Newsletter
            - ❖ Provider Manual
            - ❖ Member Eligibility
        - Provider Alerts/Provider Information
            - ❖ Benefit Information
            - ❖ Education & Training
            - ❖ Code of Conduct
            - ❖ Our Network
            - ❖ Dispute Resolution
            - ❖ Performance Results
            - ❖ Regulatory Updates
        - Pharmacy and Clinical Updates
            - ❖ Announcements
            - ❖ Coverage Policies
            - ❖ Formulary with link to the DHCS
            - ❖ Prior Authorizations
            - ❖ Referral Status
            - ❖ Guidelines https://www.Health Plan.com/pharmacy-policies-and-procedures/

Health Plan Health Equity Provider Goals:

- Ensure all Network Providers, Subcontractors and Downstream Contractors complete diversity, equity and inclusion training per DHCS 2024 contract requirements

- Increase participation by providers in the Quality Improvement and Health Equity Committee as well as ensure diverse representation of providers that serve populations that have higher risks for health disparities
- Recruit five or more providers to participate in the DHCS Health Equity & Practice Transformation Grant Program (EPT) as determined by DHCS
- Incorporate equity stratifications for practices that participate in EPT funding programs

Meeting Quality Goals: Equity in Practice Transformation Program

As the Equity and Practice Transformation program matures, metrics that guide practice transformation will develop. The participating practices will be focusing on categories that will drive meaningful transformation.

Annual Quality Improvement and Health Equity Program Evaluation

An evaluation of the QIHETP is completed at the end of each fiscal year. The annual evaluation is conducted by the QM staff in conjunction with designated department leaders.

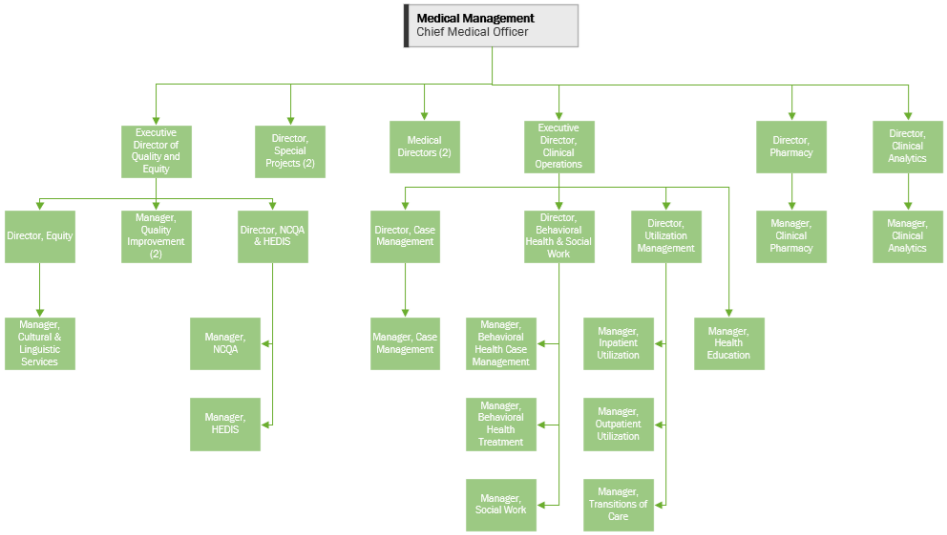
The evaluation includes:

- Adequacy of QIHETP Resources
- QI Committee and subcommittee structure
- Practitioner participation and leadership involvement in the QIHETP
- Need to restructure or change the QIHETP for the subsequent year
- A description of completed and ongoing QI activities, including, but not limited to:
    - Quality Improvement Projects (QIPs)
    - Provider Partnership Program
    - Other quality related initiatives
- Trending of measures to assess performance in quality and safety of clinical care and quality and safety of service
- Assessment of barriers and/or limitations when performance does not meet goals
- Changes in staffing, reorganization, structure, or scope of the program during the year
- Analyses of demonstrated improvements, including assessing whether there was meaningful improvement in a measure
- An analysis of the overall effectiveness of the program, including progress toward influencing network-wide safe clinical practices
- An evaluation of delegated activities, if any
- Recommendations for changes to be incorporated into the subsequent QIHETP Program Description and annual QI work plan

Quality Improvement and Health Equity Program (QIHETP) Work Plan

The QIHETP Work Plan is the schedule of activities for the QIHEC Programs. The QIHETP Work Plan includes the main tasks that cover the scope of the QIHETP 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, as well as a separate document designed for full QIHETP reporting. At any point in time, a full year of activities is visible. QIHETP activities and indicators are ongoing and continuous. They are not discontinuous at the end of the year (both fiscal and calendrical).

The QIHETP work plan is not a static document. It is approved annually by the QIHEC and is revised and developed more fully in response to the ongoing analysis of performance data, interventions, remeasurement timeframes, and the addition and deletion of indicators on an ongoing basis. The reporting document is updated on a quarterly basis by the various business owners and reported to the QHEOC, QIHEC, as well as to the Health Commission.



Attachments

2024-2025 QIHETP Work Plan

Reviewed and Approved:

QIHEC Chairperson _____ _____
Lakshmi Dhanvanthari, MD, Chief Medical Officer Date

Governing Board _____ _____
Greg Diederich, Chairman Date