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SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY (QIHE)

QUALITY IMPROVEMENT AND HEALTH EQUITY (QIHE) OVERVIEW

Health Plan offers a constellation of care, programs and services designed to meet Quality, Equity and Population Health standards set forth by the DHCS contract to improve 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. In order to deepen the commitment to health equity and reducing health disparities, Health Plan is pursuing NCQA Health Equity Accreditation in 2025.

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

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

DEFINITION OF QUALITY

Our definition of quality is an extension of Health Plan's vision that is "**STEEEP**" in Quality.

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

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.

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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. 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, specialty mental health services or substance use disorders are referred to County Behavioral Health for services that are carved out from Health Plan.

SCOPE OF THE QIHE PROGRAM

The QIHE program monitors and improves an array of indicators to measure critical clinical and service processes and outcomes while removing barriers to care and meeting the cultural, linguistic diverse preferences and needs of Members. Components addressed include:

The QIHE 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.

QIHE 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 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.
    - 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
    - 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 disengagement 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 member 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

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

Other areas that have impact on the QIHE Program include:

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

QUALITY IMPROVEMENT AND HEALTH EQUITY (QIHE) PROCESS

The QIHE process 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.

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 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
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.

The QIHE Program includes a comprehensive array of clinical and service indicators that provide information about the systems, processes, and outcomes of clinical care and service delivery. The quality indicators emphasize areas representing risk and need across the continuum of care. Indicators are developed with input from the Chief Medical Officer (CMO) and the Quality Improvement and Health Equity (QIHE) Committee which include key Members of the Provider community. These indicators include, but are not limited to:

- All cause hospital readmissions
- Emergency room (ER) utilization
- Ambulatory care utilization
- Primary and Urgent care utilization

QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE (QIHEC) AND SUBCOMMITTEES

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

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

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

- Approves the annual QIHETP Description, Annual Plan and Evaluation
- Recommends policy decisions or oversees recommendations and revisions to the Quality
- Improvement and Health Equity Activities
- Reviews, analyzes, evaluates, and makes recommendations regarding the progress and outcome of quality improvement QI and Health Equity projects and activities
- Ensures that quality performance standards are met and makes recommendations for improvements
- Institutes actions to address performance deficiencies, identifies necessary actions and ensures follow-up according to plan
- Assists in establishing the strategic direction for all quality and healthy equity initiatives
- Receives subcommittee reports, identifies performance improvement opportunities, and makes recommendations to be incorporated into the QIHETP work plan
- Ensures Provider communication, education and follow-up related to Quality of Care issues
- Ensures Provider participation in the QIHETP through planning, design, implementation, or review
- Confirms and reports to the Commission that Health Plan activities comply with all state, federal, regulatory, and NCQA standards
- Reports to the Commission any variance from quality performance goals and the plan to correct
- Submits to the Commission approved, signed minutes reflecting the committee decisions and actions of each meeting
- Presents to the Commission an annual reviewed and approved *QIHETP Description and Work Plan* and prior year evaluation
- Annually reviews and approves medical review criteria and *Clinical Practice Guidelines*
- Oversees QI and Health Equity activities that validate quality management effectiveness through customer feedback reporting including:
- Provider and Member satisfaction/experience surveys
- Reviews and approves the annual Healthcare Effectiveness Data and Information Set (HEDIS) and Managed Care Accountability Set (MCAS) rates and provides feedback about improvement initiatives
- Reviews and approves the annual Consumer Assessment of Health care Providers and Systems (CAHPS) survey results and provides feedback about improvement initiatives

- Reviews and approves the annual Behavioral Health Member Experience survey results and provides feedback about improvement initiatives.
- Promotes education activities and continuing education unit (CEU) programs on QI for Providers
- Maintains compliance with standards for mandated reporting of diseases or conditions to the local health department
- Review and provide feedback on Quality and Equity policies

Committee Members include:

- Physicians specializing in:
    - Obstetrics/Gynecology
    - Podiatry
    - Family Practice
    - General Surgery
    - Psychiatry
    - Pediatrics
    - Internal Medicine
- Practitioners:
    - RN Clinical Director Regional Center
- Community Partners
    - Deputy Director, Standards & Compliance San Joaquin General Hospital
- Health Plan Staff:
    - Compliance Officer
    - Executive Director, Clinical Operations
    - Executive Director, Quality and Equity
    - Director, Pharmacy
    - Director, Provider Relations
    - Director, Customer Service
    - Director of Delegate and Provider Relations
    - Director, Compliance
    - Director, HEDIS and Accreditation
    - Director, Utilization Management
    - Director, Case Management
    - Director, Clinical Analytics

- HEDIS and NCQA Manager(s)
- Quality Manager(s)
- Manager of Case Management
- Concurrent Review Manager
- Health Education and Population Health Manager
- Quality Supervisors
- Utilization Management Supervisor
- Administrative Assistant

Quality & Health Equity Operations Committee (QHEOC)

The QIHEOC is designated by Health Plan's executive team to provide oversight and guidance for organization-wide quality activities performed by Health Plan's Quality Improvement and Health Equity Transformation Program sub-committees to the Quality Improvement and Health Equity Committee. The QIHEOC develops and recommends policies, analyzes and evaluates the progress, results, and outcomes of all quality improvement activities, implements needed actions, and ensures appropriate and timely follow-up.

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

- National Committee for Quality Assurance (NCQA) Health Plan and Health Equity Accreditation
- HEDIS, MCAS and HEQMS
- Quality Improvement Projects (QIP), and Plan Do Study Act (PDSA) initiatives
- DHCS Quality and Health Equity (QIHE) initiatives
- Review and approval of all quality improvement corrective action plans (CAP)
- Wellness and preventive health programs
- Health Education, and Health promotion actions
- Population Health Management
- Member and Provider experience survey results
- Provider access and availability
- Network adequacy
- Grievances and Appeals
- Performance Improvement Projects (PIP)
- Wellness and preventative health programs
- Health education standards/guidelines

- Policy and procedures
- Network adequacy
- Appeals and grievances
- Facility Site Reviews and Credentialing
- Feedback and annul review process of the Health Plan Provider Manual and any new or revised policies and procedures.

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

The QIHEOC is chaired by the Executive Director of Quality and Equity or Designee. The Committee Chair facilitates and manages the committee meetings. The Chief Medical Officer (CMO) serves as the committee sponsor.

Committee Members include, but are not limited to:

- Chief Medical Officer (CMO)
- Compliance Director
- Medical Director or designee
- Director of Delegate and Provider Relations
- Directors of Utilization and Case Management
- Directors of Clinical, Analytics, and Pharmacy
- Director of HEDIS and Accreditation
- Director of Customer Service
- Quality Manager(s)

Ad Hoc Members of the QOC include:

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

Peer Review and Credentialing Committee (PRCC)

The PRCC is a “Medical Peer Review” committee. PRCC Members are appointed by the Commission to which the committee also reports. The PRCC is chaired by the CMO and is composed of Providers representing primary and specialty care, as well as other health care practitioners. The Committee meets at least quarterly and reports to the QMUM Committee.

The PRCC:

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

Grievance and Appeals (G&A) Committee

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

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

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

- Pharmacy

The G&A Committee:

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

Clinical Operations Committee (Clinical Ops)

- The Clinical Ops Committee is chaired by the Executive Director of Clinical Operations and the Chief Medical Officer and reports to the QIHEC. Clinical Ops Committee members include:
    - Director of Utilization Management
    - Director of Behavioral Health and Social Work
    - Director of Case Management
    - Manager of Health Education
    - Manager of Cultural and Linguistics
    - Medical Director(s)
- The committee provides oversight of quality improvement efforts focused on Continuity and Coordination of Medical and Behavioral Care, Disease Management, Case Management, Complex Case Management, Utilization Management, Timeliness of UM decisions, grievances and appeals, interrater reliability, referrals, over and underutilization, and member and provider satisfaction with the utilization management process.

Compliance Committee (CC)

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

Ad Hoc Members of the CC include:

- Security Officer
- Marketing

- Human Resources
- Claims Operations
- Compliance
- Audits and Oversight
- Information Technology
- External Affairs
- Customer Service
- Finance
- Pharmacy
- Provider Services/Contracting
- Quality Management
- Utilization/Care Management
- HEDIS/NCQA

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

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

Community Advisory Committee (CAC)

CAC Members (including a Commissioner, a Provider, and Health Plan Members) are selected by CAC coordinators and reviewed with the Commission. Factors such as racial ethnic representation, language, demography, occupation, and geography are considered in the selection of the committee's Members. At least fifty percent (50%) of the CAC is comprised of Health Plan Members.

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

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

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

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

Health Plan solicits feedback including but not limited to the Community Advisory Committee and Quality Improvement Committee to inform the development of Provider manual and review policies and procedures.

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

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

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

Pharmacy and Therapeutics Advisory (P&TA) Committee

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

The P&TA Committee:

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

- Submits to the Commission approved, signed minutes reflecting the committee decisions and actions of each meeting

NETWORK PROVIDER COMMITTEE PARTICIPATION

Contracted Providers are expected to cooperate with Health Plan's quality improvement and health equity activities to improve the quality of care and service, to reduce health disparities and to improve Member experience. Cooperation includes collection and evaluation of data and participation in Health Plan's QIHE programs. Practitioners understand that Health Plan may use practitioner performance data for quality improvement activities.

All Providers who participate on our QIHE committees or subcommittees receive a stipend for each meeting attendance. If you have an interest in being a participant on one of these committees, please call the CMO at 1-209-461-2276.

QUALITY OF CARE ISSUES

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

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

MONITORING OF QUALITY OF CARE ISSUES

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

REPORTING A POTENTIAL QUALITY OF CARE ISSUES (PQI)

Members, Providers, and Health Plan staff may report PQI issues. A PQI can be reported to a Quality Management Nurse using the Administrative or Clinical PQI report form *Clinical Potential Quality Issue Report Form*. Providers and Members can also report PQI issues by contacting the Customer Service Department at 1-209-942-6320 or 1-888-936-7526.

Processing of PQI

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

Communication to Provider or Party Filing the Complaint

- Each PQI is reviewed by a Medical Director who designates an action code that indicates requirement to complete Provider notification by letter.

HEALTH CARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

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

- Quality of Care
- Effectiveness of Care, Prevention, Screening, Care Coordination
- Access and Availability of Care
- Experience With Care
- Utilization
- Health Plan Descriptive Information

Managed Care Accountability Set (MCAS) and Health Equity, Quality, Measure Set (HEQMS) MCAS and HEQMS are a subset of HEDIS measures coupled with non-HEDIS quality metrics that are generated by DHCS and DMHC for the purpose of holding Health Plan accountable to contractual requirements around quality and equity. These metrics are the highest priority metrics for Health Plan and are prioritized accordingly.

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY (QIHE)

Improving a practice's HEDIS scores has benefits for Providers and Members. Consistently performing well in HEDIS measures can help save Providers time while also potentially reducing health care costs. By proactively managing Members' care, Providers can effectively monitor Members' health, prevent further complications and identify issues that may arise with their care. Providers may also benefit financially because Health Plan currently provides financial incentives based on Provider's HEDIS scores. Health Plan has tools that can be made available to PCPs to increase and improve HEDIS measures. Please contact the Provider Services Department at 1-209-942-6340 for information on HEDIS tools and incentives.

TIPS FOR IMPROVING HEDIS SCORES

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

CLINICAL PRACTICE GUIDELINES

Providers can access *Clinical Practice Guidelines* on Health Plan's website at www.hpsj-mvhp.org. *Clinical Practice Guidelines* are guidelines about a defined task or function in preventive care and clinical practice, such as desirable diagnostic tests or the optimal treatment regimen for a specific diagnosis; generally based on the best available clinical evidence.

MEMBER EXPERIENCE SURVEY

Annually and quarterly, Health Plan administers an industry standard survey instrument utilizing a contracted certified survey vendor targeting a statistically significant number of Members enrolled with Health Plan. The questions are carefully selected to measure access, quality, and satisfaction with Health Plan. The results are then analyzed by Health Plan's HEDIS and Accreditation team and reported to the QIHEOC. Quarterly, surveys are sent to members who have had ambulatory care visits in the prior 6 months. These surveys evaluate the member's experience with care and services provided by individual providers. Quarterly, results are trended and when patterns emerge, action plans are formalized into service expectations which are evaluated quarterly, progress against goals are monitored and activities are prioritized for the following year. The results are then measured each year to document Health Plan's commitment to serving our communities health care needs.

PROVIDER SATISFACTION SURVEY

Each year, Health Plan Providers are surveyed by an independent survey company that surveys all PCPs, and a random selection of Specialists and ancillary Providers. Results are reviewed by both Health Plan leadership and various departments within Health Plan. Action plans are incorporated into goals and objectives for the following year to address issues identified by the Provider community.

PATIENT SAFETY

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

Health Plan defines Patient Safety as "freedom from accidental injury caused by errors in medical care." Medical errors refer to unintentional, preventable mistakes in the provision of care that have actual or potential adverse impact on Members.

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

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

- Evaluation of pharmacy data for Provider alerts about drug interactions, recall, and pharmacy over and under-utilization
- Education of Providers regarding the availability and use of clinical practice guidelines. Members are educated about the use of guidelines using Member facing health education materials.
- Education of Providers regarding improved safety practices in their practice through the Provider newsletter, Member profiles, and Health Plan website
- Evaluation for safe clinic environments during office site reviews and dissemination of information regarding Facility Site Review findings and important safety concerns to Members and Providers
- Education to Members regarding safe practices at home through health education and incentive programs
- Intervention for safety issues identified through case management, care management, and the grievance and clinical case review processes
- Evaluation and analysis of data collected regarding hospital activities relating to Member safety, including but not limited to the rate of hospital-acquired infections and all cause readmissions within thirty (30) days of discharge

- Collaboration and exchanges information between the Hospital and PCP when Members are admitted to and discharged from acute care facilities
- Dissemination of information to Providers and Members regarding activities in the network related to safety and quality improvement
- Monitoring Hospital safety scores using publicly reported *Leapfrog* data: www.leapfroggroup.org/cp

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