

2016 Quality Improvement Program Description



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Quality Improvement Program Description

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Quality Improvement Program Description

1. Mission Statement

Community Health Group is dedicated to maintaining and improving the health of our members by providing access to quality care and offering exceptional service to diverse populations.

2. Authority and Accountability

Community Health Group's (CHG) Board of Directors (Board) assumes ultimate responsibility for the Quality Improvement Program (QIP) and has established the Quality Improvement Committee to oversee this function. The Board passed a resolution defining the QIP as an organization-wide commitment. This resolution supports the Board playing a central role in monitoring the quality of health care services provided to members and striving for quality improvement in health care delivery. The Board authorizes and designates the Chief Executive Officer (CEO) as the individual responsible for the implementation of the QIP. The CEO has delegated oversight of the day-to-day operations of the QIP to the CMO.

Performance accountability of the Board of Directors includes:

- A. Annual review and approval of the QIP Description, Quality Improvement (QI) Work Plan and QIP Evaluation.
- B. Review status of the QIP quarterly.
- C. Evaluate effectiveness of QI activities and provide feedback to the QIC as appropriate.
- D. Establish direction and strategy for the QIP.

The Quality Program is based on on-going data analysis to identify the clinical needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of its members. The CMO is charged with identifying appropriate interventions and resources necessary to implement the QIP. Such recommendations shall be aligned with federal and state regulations, contractual obligations, and fiscal parameters.

Role of CHG Officers

The CEO allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the CMO, the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIC satisfies all remaining requirements of the Quality Management & Improvement (QI) Plan, as specified in the State and Federal Contracts.

The CMO serves as the Chairperson for the Quality Improvement Committee and is responsible to report to the Board of Directors at least quarterly on the QIP including reports, outcomes, opportunities for improvement and corrective actions and communicating feedback from the Board to the committees as applicable. The CMO is responsible for day to day oversight and management of quality improvement, health care services and peer review activities. The CMO is also responsible for communicating information and updates regarding the QIP to CHG leadership and staff via General Staff meetings, senior management team meetings, and other internal meetings.

The Chief Information Officer is responsible to make certain that clinical and service data is valid, timely and readily available to business leaders conduct analysis, monitor, and review and drive improvements.

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The Chief Compliance Officer is responsible to monitor and drive interventions so that CHG and its delegated entities and vendors meet the requirements set forth by DHCS, CMS, and DMHC. The Compliance staff works in collaboration with the CHG QI and other Health Care Services departments to refer any potential sustained non-compliance issues or trends encountered during audits of health networks, provider medical groups, and other functional areas as well to maintain CHG's fraud, waste, and abuse (FWA) program.

3. Purpose

The QIP provides a formal process to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety, and effectiveness of care and service utilizing a multidimensional approach. This approach enables CHG to focus on opportunities for improving operational processes as well as health outcomes and satisfaction of members and practitioners/providers. The QIP promotes the culture of quality and accountability to all employees and affiliated health personnel to provide quality of care and services to members.

The QIP incorporates continuous QI methodology that focuses on the specific needs of multiple customers (members, health care providers, and community agencies):

- A. It is organized to identify and analyze significant opportunities for improvement in care and service.
- B. It fosters the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals.
- C. It is focused on QI activities carried out on an ongoing basis to promote efforts support the identification and correction of quality of care issues.

4. Goals

Quality improvement goals are to monitor, evaluate, and improve:

- A. The quality of clinical care and services provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
- B. The important clinical and service issues facing the Medi-Cal and Medicare population relevant to its demographics, high-risks, and disease profiles for both acute and chronic illnesses, and preventive care.
- C. The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners.
- D. The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population.
- E. The qualifications and practice patterns of all individual providers in the network to deliver quality care and service.
- F. Member and provider satisfaction, including the timely resolution of complaints and grievances.
- G. Risk prevention and risk management processes.
- H. Compliance with regulatory agencies and accreditation standards.
- I. The effectiveness and efficiency of internal operations, management, and governance.
- J. The effectiveness, efficiency, and compliance of operations associated with functions delegated to the contracted medical groups.
- K. The effectiveness of aligning ongoing quality initiatives and performance measurements with the organization's strategic direction in support of its mission, vision, and values.
- L. Compliance with clinical practice guidelines and evidence-based medicine.
- M. Compliance with regulatory agencies and accreditation standards.

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5. Functions

The QIP functions include, but are not limited to:

- A. Implement a multidimensional and multi-disciplinary QIP that effectively and systematically monitors and evaluates the quality and safety of clinical care and quality of service rendered to members.
- B. Improve health care delivery by monitoring and implementing corrective action, as necessary, for access and availability of provider services to members.
- C. Improve health outcomes for all members by incorporating health promotion programs and preventive medicine services into all the primary care delivery sites.
- D. Evaluate the standards of clinical care and promote the most effective use of medical resources while maintaining acceptable and high standards. This includes an annual evaluation of the QIP.
- E. Support quality processes and effectiveness of continuous quality improvement activities across the organization.
- F. Conduct effective oversight of delegated entities.
- G. Maintains a process for monitoring, identifying, and investigating potential quality issues and taking appropriate action to correct quality of care problems for all provider entities.

6. Objectives

- A. Drive the quality improvement structure and processes that support continuous quality improvement, including measurement, trending, analysis, intervention, and re-measurement.
- B. Support practitioners with participation in quality improvement initiatives of CHG and all governing regulatory agencies.
- C. Establish clinical and service indicators that reflect demographic and epidemiological characteristics of the membership, including benchmarks and performance goals for continuous and/or periodic monitoring and evaluation.
- D. Measure the conformance of contracted practitioners' medical records against CHG's medical record standards at least once every two years. Take steps to improve performance and re-measure to determine organization-wide and practitioner specific performance.
- E. Develop studies or quality activities for member populations using demographic data. Studies and/or activities are designed to identify barriers to improved performance and/or validate a problem or measure conformance to standards. Oversee delegated activities by:
 1. Establishing performance standards;
 2. Monitoring performance through regular reporting; and
 3. Evaluating performance annually
- F. Evaluate under and over-utilization, continuity, and coordination of care through a variety of methods and frequencies based upon members' needs. These methods include, but are not limited to, an annual evaluation of:
 1. Medical record review;
 2. Rates of referral to specialists;
 3. Hospital discharge summaries in office charts;
 4. Communication between referring and referred-to physicians;
 5. Quarterly analysis of member complaints regarding difficulty obtaining referrals;
 6. Identification and follow-up of non-utilizing members;
 7. Profiles of physicians;
 8. Rates of referrals per 1000 members; and
 9. Performance measurement of practice guidelines.

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- G. Coordinate QI activities with all other activities, including, but not limited to, the identification and reporting of risk situations, the identification and reporting of adverse occurrences from UM activities, and the identification and reporting of potential quality of care concerns through complaints and grievances collected through the Member Services Department.
- H. Evaluate the QIP Description and Work Plan at least annually and modify as necessary. The evaluation addresses:

A description of completed and ongoing QI activities that address the quality and safety of clinical care and the quality of services;

Trending of measures to assess performance in quality and safety of clinical care and the quality of service indicator data;

1. Analysis of the results of QI initiatives, including barrier analysis that evaluates the effectiveness of QI interventions for the previous year (demonstrated improvements in the quality and safety of clinical care and in the quality of services);
 2. An evaluation of the overall effectiveness of the QIP, including progress toward influencing safe clinical practices throughout the network that determines the appropriateness of the program structure, processes, and objectives;
 3. Recommendations that are used to re-establish a Work Plan for the upcoming year which includes a schedule of activities for the year, measurable objectives, and monitoring of previously identified issues, explanation of barriers to completion of unmet goals, and assessments of goals.
- I. Implement and maintain health promotion activities and disease management programs linked to QI actions to improve performance. These activities include, at a minimum, identification of high-risk and/or chronically ill members, education of practitioners, and outreach programs to members.
 - J. Maintain accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting body as appropriate.

7. Scope

The QIP provides for the review and evaluation of all aspects of health care, encompassing both clinical care and service provided to external and internal customers. External and internal customers are defined as Members, practitioners, providers, employers, governmental agencies, and CHG employees.

All departments participate in the quality improvement process. The CMO and/or the Director of Corporate Quality integrate the review and evaluation of components to demonstrate the process is effective in improving health care. The measurement of clinical and service outcomes and member satisfaction is used to monitor the effectiveness of the process.

- A. The scope of quality review will be reflective of the health care delivery systems, including quality of clinical care and quality of service
- B. All activities will reflect the member population in terms of age groups, disease categories and special risk status
- C. The scope of the QIP includes the monitoring and evaluation and driving improvements for key areas, including but not limited to the following:
 1. Preventive Services for children and adults
 2. Perinatal Care
 3. Primary Care

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4. Specialty Care
 5. Potential Quality of Care Issues
 6. Quality of Care Reviews
 7. Grievances
 8. Emergency Services
 9. Minor Consent/Sensitive Services
 10. Inpatient Services
 11. Ancillary Services
 12. Continuity and Coordination of Care
 13. Behavioral Health Services
 14. Access to Preventive Care (HEDIS)
 15. Maintenance of Chronic Care Conditions (HEDIS)
 16. Member Experience
 17. Provider Satisfaction
- D. Please refer to the Utilization Management Program and the Utilization Management Work Plan for QI activities related to the following:
1. UM Metrics
 2. Prior authorization
 3. Concurrent review
 4. Retrospective review
 5. Referral process
 6. Medical Necessity Appeals
 7. Case Management
 8. Complex Case Management
 9. Disease Management
 10. California Children's Services (CCS)

8. QI Work Plan

The QIP guides the development and implementation of an annual QI Work Plan and a separate UM Work Plan that includes:

- A. Quality of clinical care
- B. Quality of Service
- C. Safety of clinical care
- D. QIP scope
- E. Yearly objectives
- F. Yearly planned activities
- G. Time frame for each activity's completion
- H. Staff member responsible for each activity
- I. Monitoring of previously identified issues
- J. Annual evaluation of the QIP
- K. Priorities for QI activities based on the specific needs of CHG's organizational needs and specific needs of CHG's populations for key areas or issues identified as opportunities for improvement
- L. Priorities for QI activities based on the specific needs of CHG's populations, and on areas identified as key opportunities for improvement
- M. Ongoing review and evaluation of the quality of individual patient care to aid in the development of QI studies based on quality of care trends identified
- N. The Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QIP and applicable policies and procedures

9. Annual Evaluation

The Board of Directors, through the QIC structure, conducts an annual written evaluation of the QIP and makes information about the QIP available to members and practitioners.

The Plan conducts an annual written evaluation of the QIP and activities that include the following information

1. A description of completed and ongoing QI activities that address quality of care and safety of clinical care and quality of service
2. Trending of measures to assess performance in the quality and safety of clinical care and quality of services
3. Analysis and evaluation of the overall effectiveness of the QIP and of its progress toward influencing network wide safe clinical practices

The evaluation addresses the overall effectiveness of the QIP, including progress toward influencing network-wide safe clinical practices and will include:

1. Adequacy of QIP resources
2. QIC structure
3. Practitioner participation in the QIP and review process
4. Leadership involvement in the QIP and review process
5. Identify needs to restructure or revise the QIP for the subsequent year

Practitioners and members are advised of the availability of a summary of the QIP posted on the Plan's web site and that the summary is also available upon request. This summary includes information about the QIP's goals, processes, and outcomes as they relate to member care and service.

10. QI Organizational Structure

The Quality Improvement Department

The Department supports and makes certain that processes and efforts of the organizational mission, strategic goals, and processes to monitor, evaluate and act on the quality of care and services that are members receive.

- A. Monitor, evaluate and act on clinical outcomes for members
- B. Conduct review and investigations for potential or actual quality of care matters
- C. Conduct review and investigations for clinical grievances, including Potential Quality Issues (PQIs).
- D. Design, manage and improve work processes, clinical, service, access, member safety, and quality related activities
 1. Drive improvement of quality of care received
 2. Minimize rework and costs
 3. Minimize the time involved in delivering patient care and service
 4. Empower staff to be more effective
 5. Coordinate and communicate organizational information, both division and department-specific, and system-wide
- B. Support the maintenance of quality standards across the continuum of care and all lines of business
- C. Maintain company-wide practices that support accreditation by the National Commission Quality Assurance (NCQA)

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Chief Medical Officer

The Chief Medical Officer (CMO) serves as the Chairperson for the Quality Improvement Committee and is responsible to report to the Board of Directors at least quarterly on the QIP including reports, outcomes, opportunities for improvement and corrective actions and communicating feedback from the Board to the committees as applicable. The CMO is responsible for day to day oversight and management of quality improvement, health care services and peer review activities. The CMO is also responsible for communicating information and updates regarding the QIP to CHG leadership and staff via General Staff meetings, senior management team meetings, and other internal meetings.

Medical Director

The Medical Director(s) have an active unrestricted license in accordance with California state laws and regulations to serve as medical director to oversee and be responsible for the proper provision of core benefits and services to members, the quality management program, the utilization management program, and the grievance system. The Medical Director, reporting to the CMO, is key in the review of potential quality of care cases or potential quality issues.

The Medical Director(s) is required to supervise all medical necessity decisions and conducts medical necessity denial decisions. A Medical Director and CMO, who are California-licensed physicians with an unrestricted license, are the only Plan persons authorized to make a clinical denial based on medical necessity, with the exception of pharmaceutical services decisions by a pharmacist acting under the auspices of and pursuant to criteria established by the CMO, in collaboration with the Pharmacy and Therapeutics Committee.

Director of Corporate Quality

The Director of Corporate Quality is a registered nurse or other qualified person with experience in data analysis, barrier analysis, and project management as it relates improving the clinical quality of care and quality of service provided to Plan members. The Director of Corporate Quality reports to the CMO and is responsible for directing the activities of the Plan's quality management staff in monitoring and auditing the Plan's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. The Director of Corporate Quality assists the Plan's senior executive staff, both clinical and non-clinical, in overseeing the activities of the Plan operations to meet the Plan's goal of providing health care services that improve the health status and health outcomes of its members. Additionally, the Director of Corporate Quality coordinates the Plan's QIC proceedings in conjunction with the CMO; reports to the Board relevant QI activities and outcomes, support corporate initiatives through participation on committees and projects as requested; reviews statistical analysis of clinical, service and utilization data and recommend performance improvement initiatives while incorporating best practices as applicable.

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Corporate Quality Nurse (RN)

The Corporate Quality Nurses report to the Director of Corporate Quality and oversee the investigation of member grievances, support HEDIS reviews, investigate and prepare cases for potential quality of care (QOC) reviews and PQIs for the medical director or CMO review. The Corporate Quality Nurse also assist with ongoing QI studies and reviews which include, but are not limited to, Performance Improvement Projects (PIP) and Chronic Care Improvement Projects (CCIP).

Corporate Quality Analyst (RN)

The Corporate Quality Analyst is a Master Trainer who oversees and coordinates facility site reviews, physical site reviews, medical record reviews, monitors compliance with Initial Health Evaluations (IHEs), and assists with other QI activities at the direction of the Director of Corporate Quality.

Corporate Quality Coordinator

Corporate Quality (CQ) Coordinators are highly trained clinical or non-clinical staff with significant experience in a health care setting and experience with data analysis and/or project management. CQ Coordinators report to the Director of Corporate Quality and their scope of work may include medical record audits, data collection for various quality improvement studies and activities, data analysis and implementation of improvement activities and complaint response with follow up review of risk management and sentinel/adverse event issues. A CQ Coordinator may specialize in one area of the quality process or may be cross trained across several areas. The CQ Coordinator collaborates with other departments as needed to implement corrective action or improvement initiatives as identified through Plan's quality improvement activities and quality of care reviews.

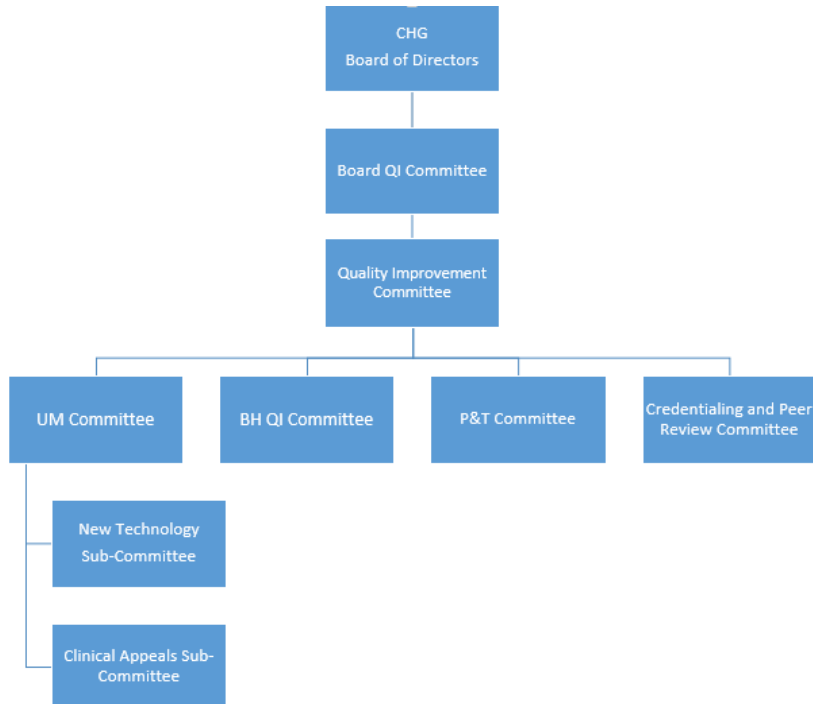
11. Committee Structure

Oversight of the QIP is provided through a committee structure, which allows for the flow of information to and from the Board of Directors.

CHG involves a contracted network licensed behavioral specialist to serve on the QIC and the UM Committee and as an advisor to the QIP structure and processes. The designated behavioral health practitioner advises the Clinical Quality Improvement Committee to support efforts that goals, objectives and scope of the QIP are interrelated in the process of monitoring the quality of behavioral health care, safety and services to members.

- A. Each committee is driven by a Committee Charter which outlines the following; Voting members
- B. CHG support staff
- C. Quorum
- D. Meeting frequency
- E. Meeting terms
- F. Goals
- G. Objectives

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Work Groups that report through a committee to directly to the QIC include: HEDIS work group, Medicare Stars work group, and Grievances work group.

Board of Directors

The Board of Directors is responsible to review, act upon and approve the overall QIP, Work Plan, and annual evaluation. The Board of directors receives at least quarterly progress and status reports from the QIC describing interventions and actions taken, progress in meeting objectives, and improvements achieved. The Board shall also make recommendations additional interventions and actions to be taken when objectives are not met.

The Director of Corporate Quality is responsible for the coordination and distribution of all quality improvement related data and information. The QIC reviews, analyzes, makes recommendations, initiates action, and/or recommends follow-up based on the data collected and presented. The CEO or the CMO communicates the QIC's activities to the Board. The Board reviews the QI activities. Any concerns of the Board are communicated back to the source for clarification or resolution.

Quality Improvement Committee (QIC)

The QIC is the foundation of the QIP. The QIC assists the CMO and administration in overseeing, maintaining, and supporting the QIP and Work Plan activities.

The purpose of the QIC is to monitor and assess that all QI activities are performed, integrated, and communicated internally and to the contracted network and partners to achieve the end result of improved care and services for members. Although delegation oversight is overseen by the Plan's Delegation Oversight Committee, the QIC oversees the performance of delegated functions and contracted provider and practitioner partners. The composition of the QIC includes a participating behavioral health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review as needed, and identification of opportunities to improve care.

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The QIC provides overall direction for the continuous improvement process and evaluates that activities are consistent with CHG's strategic goals and priorities. It supports efforts that an interdisciplinary and interdepartmental approach is taken and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to Quality Improvement Projects (QI Projects), activities, and initiatives. In addition, and most importantly, it makes certain that members are provided the highest quality of care. HEDIS activities and interventions are reviewed, and reported through the QIC.

Providers', practitioners', and contracted groups practice patterns are evaluated, and recommendations are made to promote practices that all members receive medical care that meets CHG standards.

The QIC shall develop, oversee, and coordinate member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to CHG-contracted providers and practitioners, and contracted groups.

The QIC provides overall direction for the continuous improvement process and monitors that activities are consistent with CHG's strategic goals and priorities. It promotes efforts that an interdisciplinary and interdepartmental approach is taken and adequate resources are committed to the program and drives actions when opportunities for improvement are identified.

Utilization Management Committee (UMC)

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary, and provides a comprehensive approach to support the Utilization Management Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UM Committee monitors the utilization of health care services by CHG and its delegated entities to identify areas of under or over utilization that may adversely impact member care. The UMC oversees inter-rater reliability testing to support consistency of application in criteria for making determinations, as well as development of evidence based clinical practice guidelines and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. The UM Committee meets quarterly and reports to the QIC.

Pharmacy & Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost effective pharmaceutical care for all CHG members and reviews anticipated and actual drug utilization trends, parameters, and results on the basis of specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T Committee reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CHG's members. The P&T Committee includes practicing physicians and pharmacists. A majority of the members of the P&T Committee are physicians (including both Plan employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties including a behavioral health practitioner, in order to adequately represent the needs and interests of all plan members. The Committee provides written decisions regarding all formulary development and revisions. The P&T Committee meets at least quarterly, and reports to the QIC.

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Credentialing and Peer Review Committee

The Credentialing and Peer Review Committee provides guidance and peer input into the CHG practitioner and provider selection process, and determines corrective actions as necessary to support that all practitioners and providers that serve CHG members meet generally accepted standards for their profession or industry. The Committee reviews, investigates, and evaluates the credentials of all internal CHG medical staff for membership, and maintains a continuing review of the qualifications and performance of all external medical staff. The Committee's review and findings are reported to the QIC, with recommendations for approval or denial of credentialing. All approved providers and practitioners are presented to Board on a quarterly basis as part of the CMO's report.

Behavioral Health Quality Improvement Committee (BHQIC)

The BHQIC promotes timely and satisfactory behavioral health care services, enhancing continuity and coordination between physical health and behavioral health care providers, and guiding CHG towards the vision of bi-directional behavioral health care integration.

The BHQIC is responsible for monitoring key areas of service to members and providers through review of reports and presentations, identifying quality concerns, trends or systemic issues and opportunities for improvement, and communicating to QIC its findings and recommendations.

The designated Chairman of the BHQIC is the Designated Behavioral Health Care Practitioner

Technology Assessment Sub-Committee

The Technology Assessment Sub-Committee (TASC), a sub-committee of the Utilization Management (UM) Committee, meets at least annually, with ad hoc meetings as necessary, or called by the chairperson. TASC reviews and assesses existing and emerging medical technologies, drugs, procedures and therapeutic modalities on an as-needed basis.

Member Appeal Sub-Committee

The Appeals sub-committee serves to protect the rights of our members, and to promote the provision of quality health care services and enforces that the policies of CHG are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The Appeals Sub-committee serves to provide a mechanism to resolve member appeals expeditiously. And protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of member appeals. The Appeals Subcommittee meets monthly and reports to the Quality Improvement Committee.

12. Pharmacy Services

Pharmacy services and medication management processes are overseen by the Pharmacy & Therapeutics (P&T) Committee. The P&T Committee oversees the development, maintenance, and improvement of CHG's formularies. The P&T Committee recommends policy on all matters related to the use of drugs to promote the clinically appropriate use of pharmaceuticals based on sound clinical evidence. The P&T Committee reports organizationally to CHG's QIC.

CHG has adopted its PBM's Medicare Advantage formulary and associated prior authorization criteria, step edits and step criteria, and quantity limits. The maintenance and updating of the Medicare formulary has been delegated to the Pharmacy Benefits Manager's (PBM's) national P&T Committee based on Medicare requirements and guidelines. However, CHG's P&T Committee is responsible for the oversight of the delegation for the formulary review process and maintains responsibility for maintaining a formulary that complies with Medicare standards and regulation.

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The scope of coverage, classes of pharmaceuticals, co-payment policies, exclusions and limitations, policies and procedures may be affected by contractual and regulatory requirements. CHG's Medi-Cal Formulary is influenced by the state of California's Medi-Cal List of Contracted Drugs. The P & T Committee reviews additions, deletions, and changes to the Medi-Cal List of Contracted Drugs as they are announced in the Medi-Cal Pharmacy Provider Bulletins. The Committee may elect to adopt, modify, or reject the actions taken by the state but at all times, maintains a Medi-Cal formulary that is comparable to the Medi-Cal List of Contract Drugs.

Current versions of CHG's formularies are posted on CHG's web site and are accessible to both members and practitioners. CHG's pharmaceutical management procedures are included within the formulary as well as in the *Member Guide* (Combined Evidence of Coverage and Disclosure Form) and Provider Manual. Members, prescribers, and pharmacies may receive a printed copy of the formularies upon request.

CHG develops its own medical exception review criteria and/or adopts its PBM's criteria for the Medi-Cal line of business. The P&T Committee reviews and approves each set of criteria (both CHG- developed and PBM-developed criteria) prior to use and performs an annual review of all criteria. When applying the criteria in a review of a request, CHG's criteria are applied when they exist. When CHG-developed criteria does not exist, the PBM's criteria will be applied.

Member safety is integrated into all components of the Plan's QIP, and is especially applicable to Pharmacy Services who conducts monitoring and evaluation and takes interventions when application while reviewing processes

CHG's pharmaceutical quality improvement process includes measures and reporting systems to address the identification and reduction of medication errors and adverse drug interactions. The PBM's utilization review (DUR) edits provide on-line messaging to dispensing pharmacists. The PBM identifies drug-drug interactions based on three severity levels supported by nationally recognized references (e.g., First Data Bank, NDDF Plus, and National Drug Data File). Eight (8) on-line DUR edits are used and send a message to the dispensing pharmacist when "triggered":

- Drug Interaction
- Drug dosage
- Ingredient duplication
- Age precaution
- Pregnancy precaution
- Gender conflict
- Therapeutic duplication
- Late refill

There is also a "Sound Alike" drug edit to help prevent confusion between similar drug names. A message back to the dispensing pharmacist prompts the pharmacist to check the drug with the name of the drug with which it is most commonly mistaken.

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The PBM identifies and notifies CHG of members and prescribers affected by a Class II recall or voluntary drug withdrawals from the market for safety reasons. CHG uses these reports to notify affected physicians and members within 30 calendar days of the FDA notification. An expedited process is followed for prompt identification and notification of members and prescribing practitioners affected by a Class I recall. When the FDA recalls a drug, the product is immediately removed from CHG's formularies and active prior authorizations are terminated.

CHG also conducts retrospective drug utilization of pharmacy claims and other records, through computerized drug claims processing and information retrieval systems to identify patterns of inappropriate or medically unnecessary care among members or associated with specific drugs or groups of drugs.

CHG, through its contracted PBM pharmacy network, ensures that patient counseling is offered to members, when appropriate and that network pharmacies implement a method for maintaining up-to-date member information, such as but not limited to, member demographic information and allergy information (food and drug).

CHG monitors and implements processes to prevent over-utilization and under-utilization of prescribed medications, including but not limited to the following elements:

- Compliance programs designated to improve adherence/persistency with appropriate medication regimens;
- Monitoring procedures to discourage over-utilization through multiple prescribers or multiple pharmacies;
- Quantity versus time edits;
- Early refill edits.

13. Behavioral Health Services

CHG will monitor and improve the quality of behavioral health care and services provided through based on applicable contract requirements. The QIP includes services for behavioral health and review of the quality and outcome of those services delivered to the members within our network of practitioners and providers. The quality of Behavioral Health services may be determined through, but not limited to the following:

- A. Access to Care
- B. Availability of practitioners
- C. Coordination of care
- D. Medical record and treatment record documentation
- E. Complaints and grievances
- F. Appeals
- G. Utilization Metrics
 1. Timeliness
 2. Application of criteria
 3. Bed days
 4. Readmissions
 5. Emergency Department Utilization
 6. Inter-rater reliability
- H. Compliance with evidence-based clinical guidelines
- I. Language assistance

Designated Behavioral Health Care Practitioner

The Designated Behavioral Health Care Practitioner reports to the CMO and shall be involved in the behavioral aspects of the QIP. The Designated Behavioral Health Practitioner shall be available for assistance with member behavioral health complaints, development of behavioral health guidelines, recommendations on service and safety, provide behavioral health QI statistical data, and follow-up on identified issues. The Designated Behavioral Health Care Practitioner shall serve as the chairperson of the BHQIC which is sub-committee of the CHG QIC.

The behavioral health practitioner serving as a voting member of the Plan's QIC must be a psychiatrist.

14. QI Methodology

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- A. Areas for improvement identified through continuous monitoring activities, including, but not limited to, (a) potential quality concern review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) satisfaction surveys, (f) HEDIS results, and (g) other subcommittee unfavorable outcomes
- B. Measures required by DHCS for Medi-Cal members

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, and ancillary care services.

- A. Access to and availability of services, including appointment availability, as described in the Utilization Management Program and in policy and procedure
- B. Case Management
- C. Coordination and continuity of care for seniors and persons with disabilities
- D. Provisions of chronic and complex care management services
- E. Access to and provision of preventive services

Improvements in work processes, quality of care, and service are derived from all levels of the organization.

- A. Staff, administration, and physicians provide vital information necessary to support continuous performance is occurring at all levels of the organization
- B. Individuals and administrators initiate improvement projects within their area of authority, which support the strategic goals of the organization
- C. Other prioritization criteria include the expected impact on performance, (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes
- D. Project coordination occurs through the various leadership structures: Board of Directors, CHG management, QI and UM Committees, etc., based upon the scope of work and impact of the effort
- E. These improvement efforts are often cross functional, and require dedicated resources to assist in data collection, analysis, and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups

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QI Project Quality Indicators

Each QI Project will have at least one (and frequently more) quality indicator(s). While at least one quality indicator must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Quality indicators will measure changes in health status, functional status, member satisfaction, and activities of delegated entities, or system performance. Quality indicators will be clearly defined and objectively measurable. Standard indicators from HEDIS measures are acceptable.

Quality indicators may be either outcome measures or process measures where there is strong clinical evidence of the correlation between the process and member outcome. This evidence must be cited in the project description.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Data Warehouse will be utilized.

For studies and measures that require data from sources other than administrative data (i.e., medical records), sample sizes will be a minimum of 411 (with 5 to 10% over sampling), so as to allow performance of statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411, and for certain HEDIS studies whose sample size is reduced from 411 based on CHG's previous year's score. Measures that rely exclusively on administrative data utilize the entire target population as a denominator.

CHG also uses a variety of QI methodologies dependent on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:

- Plan** 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan
- Do** 5) Communicate change/plan
6) Implement change plan
- Study** 7) Review and evaluate result of change
8) Communicate progress
- Act** 9) Reflect and act on learning
10) Standardize process and celebrate success

15. Quality Issue Identification

To provide overall quality functioning, each division and/or department will continually monitor specific important aspects of care.

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Quality Monitors (Sentinel Events) Screening

CHG's Health Care Services staff will continually assess interactions with members' health care systems for potential quality of care issues. Continual quality monitoring of members' health care on a daily basis provides a methodology enabling the Health Care Services staff to identify indicators that may suggest the presence of less than optimal care.

The following monitors identify the minimum health care areas for review of quality care problems:

- A. Unexpected death during hospitalization
- B. Complications of care (outcomes), inpatient and outpatient
- C. Reportable events for long-term care (LTC) facilities include but are not limited to falls, suspected abuse and/or neglect, medication errors, pressure sores, urinary tract infections, dehydration, pneumonia, and/or preventable hospital admissions from the LTC facilities.
- D. Reportable events for community-based adult services (CBAS) centers include but are not limited to falls, injuries, medication errors, wandering incidents, emergency room transfers, and deaths that occur in the CBAS center and unusual occurrences reportable pursuant to adult day health care licensing requirements.
- E. Reportable events for non-emergency medical and non-medical transport include but are not limited to falls, injuries, and accidents.

Protocol for Using Quality Monitors Screens

Case Management and Referrals staff apply the quality monitor screens to each case reviewed during pre-certification and concurrent review. Contracted LTC facilities, CBAS centers, and non-emergency medical and non-medical transport must report all identified reportable events to the Director of Utilization Management. All potential quality issues are routed to the Corporate Quality Department.

Corporate Quality staff access information in the case and utilization management systems to obtain information to evaluate quality of care grievances and PQIs. The Corporate Quality staff, under the supervision of the Director of Corporate Quality, determines the need for additional documentation, inpatient or ambulatory care, in evaluating the cause of potential quality of care.

When it is decided that medical records are required, the Corporate Quality staff contacts the appropriate inpatient facility/ambulatory care site to obtain copies of the medical record. It may be necessary for a Corporate Quality staff member to visit the facility/site to review the record.

When a case is identified to have potential quality of care issues, the Corporate Quality staff will present the case to the Medical Director or CMO for review. If the CMO identifies no quality of care problem, the case requires no further review. The case is routed back to the Corporate Quality staff who initiated the review for closure of the case.

When the CMO agrees that a quality of care problem exists, he/she reviews the case, assigns a priority level, initiates corrective action, or recommends corrective action as appropriate. For case of neglect or abuse, follow-up/corrective action may include referrals to Child or Adult Protective Services.

The case is then forwarded to the QIC. The QIC reviews the case, the priority rating, and recommendations or actions implemented for corrective action and follow-up. The QIC either approves the rating and recommended corrective actions or assigns a new rating and recommends additional or different corrective action and follow-up.

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In-Home Supportive Services (IHSS) Quality Monitoring

CHG will participate in the stakeholder workgroup established by the Department of Health Services, the State Department of Social Services, and the California Department of Aging to develop the universal assessment process, including a universal assessment tool, for home- and community-based services, as defined in subdivision (a) of Section 14186.1. The stakeholder workgroup shall include, but not be limited to, consumers of IHSS and other home- and community-based services and their authorized representatives, the county, IHSS, Multipurpose Senior Services Program (MSSP), and CBAS providers, and legislative staff. The universal assessment process will be used for all home- and community-based services, including IHSS. In developing the process, the workgroup shall build upon the IHSS uniform assessment process and hourly task guidelines, the MSSP assessment process, and other appropriate home- and community-based assessment tools.

In developing the universal assessment process, a universal assessment tool will be developed that will facilitate the development of plans of care based on the individual needs of the recipient. The workgroup shall consider issues including, but not limited to, how the results of new assessments would be used for the oversight and quality monitoring of home- and community-based services providers.

CHG will work closely with the San Diego County IHSS Agency to develop an appropriate monitoring and oversight plan to adhere to quality assurance provisions and individual data and other standards and requirements as specified by the State Department of Social Services including state and federal quality assurance requirements. Referrals will also be made to appropriate agencies for follow-up and/or referrals will be made to local Adult and Child Protective Services agencies or law enforcement agencies (when appropriate).

Quality Improvement Activities Related to Long-Term Services and Supports (LTSS) and Transportation Services

Monitoring of the quality of care provided to CHG members related to long term care facilities, CBAS centers and non-emergency medical and non-medical transport includes, but is not limited to, the following:

- Member complaint and/or grievance trends.
- Provider complaint and/or grievance trends.
- Case review of potential quality of care issue referrals triggered by quality monitors (sentinel events), or utilization management activities.
- Member satisfaction surveys.
- Focused review of topics, including those specifically related to special needs populations such as members residing in LTC facilities and receiving services at CBAS centers.
- Quarterly review of facility rating as listed on the California Health Care Foundation's CalQualityCare.org website.

Topics for review are identified through the monitoring process. Proposed study indicators shall be reviewed by the Clinical Quality Improvement Committee and approved prior to commencing the study. Initiation of quality improvement projects will be directed to the identified needs of members residing in LTC facilities. Focused quality improvement audits for members residing in LTC facilities are performed by the Concurrent Review Case Managers, or Corporate Quality Analysts, during on-site facility visits.

Results of quality improvement activities are presented to the Corporate Quality Department for review, analysis and summarizing. LTC facilities are notified if there is a need to execute corrective action plans

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(CAPs). Follow-up reviews will be conducted at LTC facilities when CAPs are executed. CHG assists in the identification and communication of potential quality of care issues with other agencies directly involved in coordination of services for CHG members in LTC facilities, including the San Diego County Regional Center, Licensing and Certification, Medi-Cal Operations Division and the Ombudsman's Office. Referrals will also be made to appropriate agencies for follow-up and/or referrals will be made to local Adult and Child Protective Services agencies or law enforcement agencies (when appropriate).

16. QIP Activities

The QIP's scope includes implementation of QI activities or initiatives. The QIC and the subcommittees select the activities that are designed to improve performance on selected high volume and/or high-risk aspects of clinical care and member service.

Prioritization

Certain aspects of clinical care and service data may identify opportunities to maximize the use of quality improvement resources. Priority will be given the following:

- A. The annual analysis of member demographic and epidemiological data
- B. Those aspects of care which occur most frequently or affect large numbers of members
- C. Those diagnoses in which members are at risk for serious consequences or deprivation of substantial benefit if care does not meet community standards or is not medically indicated
- D. Those processes involved in the delivery of care or service that, through process improvement interventions, could achieve a higher level of performance

Use of Committee Findings

To the degree possible, quality improvement systems are structured to recognize care for favorable outcomes as well as correcting instances of deficient practice. The vast majority of practicing physicians provides care resulting in favorable outcomes. Quality improvement systems explore methods to identify and recognize those treatment methodologies or protocols that consistently contribute to improved health outcomes. Information of such results is communicated to the Board of Directors and providers on a regular basis. Written communication to primary practitioners is the responsibility of the Committee chairperson. Submission of written corrective action plans, as necessary, is required for the Committee's approval. Significant findings of quality improvement activities are incorporated into practitioner educational programs, the re-credentialing process, and the re-contracting process and personnel annual performance evaluations. All quality improvement activities are documented and the result of actions taken recorded to demonstrate the program's overall impact on improving health care and the delivery system.

Clinical Practice Guidelines

CHG utilizes evidence-based practice guidelines to establish requirements and measure performance on a minimum of three practice guidelines (acute, chronic and behavioral health) annually to strive to reduce variability in clinical processes. Practice guidelines are developed with representation from the network practitioners. The guidelines are implemented after input from participating practitioners of the Clinical Quality Improvement, Utilization Management and Pharmacy and Therapeutics Committees. Guidelines will be reviewed and revised, as applicable, at least every two years.

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Preventive Health/HEDIS® Measures

The Quality Improvement Committee will determine aspects of care to be evaluated based on member population and regulatory requirements. At a minimum, HEDIS performance indicators will be monitored annually based on product type, i.e. Medi-Cal or Medicare.

Disease Management Programs

The health care services staff, QIC and network practitioners identify members with, or at risk for, chronic medical conditions. CHG's clinical team is responsible for the development and implementation of disease management programs for identified conditions. Disease management programs are designed to support the practitioner-patient relationship and plan of care. The programs will emphasize the prevention of exacerbation and complications using evidence-based practice guidelines. The active disease management programs and their components will be identified in the annual UM work plan.

Complex case management and chronic care improvement are major components of the disease management program. Specific criteria are used to identify members appropriate for each component. Member self-referral and practitioner referral will be considered for entry into these programs. Following confidentiality standards, eligible members are notified that they are enrolled in these programs, how they qualified, and how to opt-out if they desire. Case managers and care coordinators are assigned to specific members or groups of members and defined by stratification of the complexity of their condition and care required. The case managers'/care coordinators help members navigate the care system and obtain necessary services in the most optimal setting.

Continuity and Coordination of Care

The continuity and coordination of care that members receive is monitored across all practice and provider sites. As meaningful clinical issues relevant to the membership are identified, they will be addressed in the quality improvement work plan. The following areas are reviewed for potential clinical continuity and coordination of care concerns.

- A. Primary care services
- B. OB/GYN services
- C. Behavioral health care services
- D. Inpatient hospitalization services
- E. Home health services
- F. Skilled nursing facility services

The continuity and coordination of care received by members includes medical care in combination with behavioral health care. CHG collaborates with behavioral health practitioners to promote the following activities are accomplished:

- A. Information Exchange – Information exchange between medical practitioners and behavioral health practitioners must be member-approved and be conducted in an effective, timely, and confidential manner.
- B. Referral of Behavioral Health Disorders – Primary care practitioners are encouraged to make timely referral for treatment of behavioral health disorders commonly seen in their practices, i.e., depression.
- C. Evaluation of Psychopharmacological Medication – Drug use evaluations are conducted to increase appropriate use, or decrease inappropriate use, and to reduce the incidence of adverse drug reactions.

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- D. Data Collection – Data is collected and analyzed to identify opportunities for improvement and collaborate with behavioral health practitioners for possible improvement actions.
- E. Implementations of Corrective Action – Collaborative interventions are implemented when opportunities for improvement are identified.

Risk Management

The purpose of the Risk Management component of the QIP is to prevent or reduce risk due to adverse member occurrences associated with care or service. The risk management function involves identifying potential areas of risk, analyzing the cause and designing interventions to prevent or reduce risk. The activities of Quality Improvement, Utilization Management, Member Services, Provider Relations and Risk Management are coordinated.

17. Care of Members with Complex Needs

CHG is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- A. Standardized mechanisms for member identification through use of data
- B. Documented process to assess the needs of member population
- C. Multiple avenues for referral to case management and disease management programs
- D. Management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- E. Ability of member to opt out
- F. Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g. diabetes, asthma) through health education
- G. Use of evidenced based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)
- H. Development of individualized care plans that include input from member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary
- I. Coordinating services for members for appropriate levels of care and resources
- J. Documenting all findings
- K. Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services
- L. Ongoing assessment of outcomes

18. Cultural and Linguistics

CHG will monitor that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds, disabilities, gender, sexual orientation or gender identity.

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CHG is committed to “member centric” care that recognizes the beliefs, traditions, customs and individual differences of the diverse population we serve. Identified needs and planned interventions involve member input and are vetted through the Public Policy Committee prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- A. Analyze significant health care disparities in clinical areas
- B. Use practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- C. Consider outcomes of member grievances and complaints
- D. Conduct patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/language specific risks
- E. Identify and reduce a specific health care disparity with culture and race
- F. Provide information, training and tools to staff and practitioners to support culturally competent communication

All individuals providing linguistic services to CHG members shall be adequately proficient in the required language to both accurately convey and understand the information being communicated. This policy applies to CHG staff, providers, provider staff, and professional translators or interpreters.

Interpreter services are provided to the member at no charge to the member.

CHG offers programs and services that are culturally and linguistically appropriate by:

- A. Using practitioner and provider chart reviews and interviews to understand the differences in care provided and outcomes achieved to reduce health care disparities in clinical areas
- B. Conducting patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/language specific risks to improve cultural competency in materials
- C. Conducting focus groups or key informant interviews with cultural or linguistic minority members to determine how to better meet their needs to improve cultural competency communications
- D. Providing information, training and tools to staff and practitioners to support culturally competent communication to improve network adequacy to meet the needs of underserved groups.

CHG has designated the COO to provide oversight for meeting the objectives of service to a culturally and linguistically diverse population through the following:

- A. Translation services
- B. Interpretation services
- C. Proficiency testing for bilingual Spanish staff
- D. Cultural competency trainings such as:
- E. Medical Interpreting Workshops
- F. Interpreter Services In-service
- G. Older Adult Sensitivity Workshops
- H. Cultural Competency Workshops
- I. Provider newsletter articles on a variety of cultural and linguistic issues
- J. Health education materials in different languages and appropriate reading levels
- K. Provider office signage on the availability of interpretation services

Member Health Education

CHG makes materials available to providers to educate members on the health risk behaviors and

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refers members to additional resources and programs. The materials include member tip sheets corresponding to each age-specific assessment; talking points for the provider to initiate discussions of risks identified, and brief counseling points for the provider.

CHG has several processes in place to remind members, and provide education and outreach, about the importance of receiving recommended preventive care services.

19. Data Integrity

Quality Improvement is a data driven process. CHG maintains an information data system appropriate to provide tracking of multiple data sources for implementing the QIP. These sources include, but are not limited to, the following:

- A. Encounter data
- B. Claims data
- C. Pharmacy data
- D. Medical records
- E. Utilization Management data
- F. Practitioner, provider and member complaint data
- G. Practitioner, provider and member surveys results
- H. Appeals and grievance information
- I. Enrollment data
- J. HEDIS data
- K. Behavioral Health data

In addition, Community Health Group's staff and analytical resources include, but are not limited to:

- A. Quality Improvement
- B. Preventive Health and Education
- C. Utilization Management
- D. Member Services
- E. Case Management
- F. Provider Relations
- G. Information Systems Programmers
- H. Information Systems Analysts

The Quality Improvement Committee uses the above data and resources to fully evaluate the concern by objective or quantitative methods in order to define the specific problem. The QIC must proceed to implement a problem solving action based on its findings and the objective parameters measured. After adequate time has been permitted for problem resolution, a re-evaluation is performed using the same quantitative measures. The Committee bases the re-evaluation time frame (one month, three months, six months, etc.) on the severity of the problem identified. The steps outlined below must be supported by adequate documentation of a problem-oriented approach to quality improvement.

- A. Define specific indicators of performance through monitoring process.
- B. Collection and analysis of appropriate data.
- C. Identify opportunities to improve performance.
- D. Implement interventions and/or guidelines to improve performance.
- E. Measure effectiveness of interventions and/or conformance to guidelines.
- F. Re-evaluate for further potential performance improvements with the same quantitative measures.

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Health Information Systems

The primary information management functions of the Information Systems Division are: Application Development and Management, Reporting, Systems Administration, Technical Support, and Database Administration. These functions are performed by Department Managers and support staff under the direction of the Informatics Manager.

Reporting and Informatics

CHG provides exceptional service to its members, practitioners, regulatory agencies, and other customers. The Information Systems Division's internal and external customers make business decisions every day that depend on timely, valid and accurate data. Therefore, software-driven report generation capabilities are utilized to their fullest extent. Standard and ad hoc reports are routinely generated from the core application databases.

CHG's reporting subsystem consists of standard reports and flexible, ad hoc report creation tools. The Information Systems Division is responsible for the coordination, development, and production of these reports. Reports are generated from three major sources – claims, membership, and medical management. Most operational reports are generated from these sources. All other utilization, quality and decision support reports are generated from the data warehouse. These reports include HEDIS®, provider profiling, and other statistical and quality measures.

Data Warehouse Reporting

The data warehouse stores key member, provider, utilization, case, quality, outcome, encounter, pharmacy and claims data in a common format in a single location. The warehouse enhances this raw data by automatically creating "views" and "objects" to summarize the data into key reporting. The types of reports include:

- Population Information - Data on enrollee characteristics relevant to health risks or utilization of clinical and non-clinical services, including age, sex, race, ethnicity, language, and disability or functional status.
- Performance Measures - Data on the organization's performance as reflected in standardized measures, to be compared when possible to: Local, State, or national information on performance of comparable organizations.
- Other Utilization, Diagnostic, and Outcome Information - Data on utilization of services, procedures, medications and devices; inpatient and ambulatory diagnoses; adverse incidents (such as deaths, avoidable admissions, or readmissions); and patterns of referrals or authorization requests.

External Data Sources

Data from outside organizations, including Medicare or Medicaid managed care data, data from other managed care organizations, and local or national public health reports on conditions or risks for specified populations is collected for comparison and benchmarking.

20. Credentialing Standards and Activities

The comprehensive credentialing process is designed to provide on-going verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status, and judgment, thus ensuring the competency of practitioners working within the CHG contracted delivery system. Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, DMHC, CMS, and NCQA). The scope of the credentialing program includes all licensed M.D.s, D.O.s, allied health and midlevel practitioners, which include, but are not limited to; behavioral health practitioners, Certified Nurse Midwives, Nurse Practitioners, Optometrist, etc., both in the delegated and Direct contracts.

Healthcare Delivery Organizations:

CHG performs credentialing and re-credentialing of ancillary providers and Health Delivery Organizations (HDOs), including, but are not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc., upon initial contracting, and every 36 months thereafter. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with State and Federal regulatory agencies.

Use of Quality Improvement Activities in the Recredentialing Process:

Findings from quality improvement activities are included in the recredentialing process

Monitoring for Sanctions and Complaints:

CHG has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, state or federal sanctions, restrictions on licensure, or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between re-credentialing periods.

21. Facility Site Review, Medical Record and Physical Accessibility Review

CHG does not delegate Primary Care Practitioner (PCP) site and medical records review, however, this function is carried out in collaboration with the Health San Diego Medi-Cal Managed Care health plans in accordance with standards set forth by MMCD Policy Letter 02-02. CHG assumes responsibility and conducts and coordinates/medical record review (MRR) for the delegated medical groups. CHG retains coordination, maintenance, and oversight of the facility site review (FSR)/MRR process. CHG collaborates with the Healthy San Diego Medi-Cal Managed Care health plans to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for shared PCPs. Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full scope site review performed by another health plan in the last three years, in accordance with MMCD Policy Letter 02-02 and CHG policies. Medical records of new providers shall be reviewed within ninety (90) calendar days of the date on which members are first assigned to the provider. An additional extension of ninety (90) calendar days may be allowed only if the provider does not have sufficient assigned members to complete review of the required number of medical records.

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)

CHG conducts an additional DHCS-required facility audit for American with Disabilities Act compliance for Seniors and Persons with Disabilities (SPD) members, which includes access evaluation criteria to

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determine compliance with ADA requirements.

Medical Record Documentation Standards

CHG requires that its contracted medical groups make certain that each member medical record is maintained in an accurate and timely manner that is current, detailed, organized, and easily accessible to treating practitioners. All patient data should be filed in the medical record in a timely manner (i.e., lab, x-ray, consultation notes, etc.) The medical record should also promote timely access by members to information that pertains to them.

The medical record should provide appropriate documentation of the member's medical care, in such a way that it facilitates communication, coordination, and continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by state and federal laws and regulations, and the requirements of CHG's contracts.

The medical record should be protected in that medical information is released only in accordance with applicable Federal and/or state law.

Practitioner Compliance Monitoring

CHG monitors and evaluates practitioners' compliance with policies and procedures through on-site provider compliance surveys (FSR/MRR). The purpose of this monitoring is to measure compliance with established protocols and policies and assist in the implementation of corrective action plans, as indicated.

During each compliance survey, a site facility inspection is conducted and a review of medical records per physician per age group (adults/pediatrics) for members being treated is performed. The medical record score is based on a survey standard of ten randomly selected records per provider. All ten records surveyed are from adult, obstetric or pediatric preventive care areas. For sites with only adult, only obstetric, or only pediatric members, all ten records surveyed are only in that preventive care area.

The site's contact person is provided with an exit summary at the end of the inspection and copies of the completed survey tools.

The formal summary report is presented to the QIC for review and recommendations and then sent to the CMO of the site surveyed with copies to the site administrator and/or contact person.

A corrective action plan is required for deficiencies noted and a follow-up survey is conducted for compliance ratings of 'Conditional Pass' and 'Not Pass.' The follow-up visit is scheduled from the time the formal summary report is provided to the site.

Site and Medical Records (*Adults, Pediatrics, & Obstetrics*) Review Compliance Ratings – Compliance ratings standards are determined by the California Department of Health Care Services.

Facility

Exempted Pass: 90% or above, *without* deficiencies in critical elements or deficiencies in infection control or pharmacy – No Corrective Action Plan (CAP) required.

Conditional Pass: 80-89%, or 90% or above *with* deficiencies in critical elements – CAP required

Not Pass: Below 80% - CAP required.

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Medical Records

Exempted Pass: 90% or above – No Corrective Action Plan (CAP) required.

Conditional Pass: 80-89% – CAP required.

Not Pass: Below 80% - CAP required.

22. Role of Participating Practitioners

Participating practitioners serve on the QIP Committees as necessary to each committee's function. Through these committees' activities, network practitioners:

- Review, evaluate and make recommendations for credentialing and recredentialing decisions
- Review individual cases reflecting actual or potential adverse occurrences
- Review and provide feedback on proposed medical guidelines, preventive health guidelines, clinical protocols, disease management programs, quality and HEDIS results, new technology and any other clinical issues regarding policies and procedures
- Review proposed QI study designs
- Participate in the development of action plans and interventions to improve levels of care and service
- Are involved with policy setting
- Participate with the following committees
 - Quality Improvement Committee
 - Pharmacy and Therapeutics Committee
 - Utilization Management Committee
 - Credentialing and Peer Review Committee
 - Additional committees as requested by the Plan

23. Member Safety

Member (Patient) safety is very important to CHG; it aligns with CHG's mission statement dedicated to maintaining and improving the health of our members. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed members and families are vital members of the health care team.

Member safety is integrated into all components of member enrollment and health care delivery organization continuum oversight and is a significant part our quality and risk management functions. Our member safety endeavors are clearly articulated both internally and externally, and include strategic efforts specific to member safety, including:

- A. Identification and prioritization of patient safety-related risks for all members, regardless of line of business and contracted health care delivery organizations
- B. Operational objectives, roles and responsibilities, and targets based on the risk assessment
- C. Health Education and Promotion
- D. Over- and under- Utilization monitoring
- E. Medication Management
- F. Case Management and Disease Management activities

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Drug Safety

CHG monitors for appropriate medication use to support the safety of members. These techniques include, but are not limited to:

- A. Potential drug and drug disease interactions
- B. Analyzing pharmacy data to identify polypharmacy, potential adverse drug reactions, inappropriate medication usage, excessive controlled substance usage and voluntary drug recalls
- C. Adopting processes that allow for affected members and practitioners are notified of FDA or voluntary drug alerts
- D. Notification and education of members and practitioners of other identified events
- E. Conducting pharmacy system edits to assist in avoiding medication errors
- F. Working with contracted pharmacies to assure a system is in place for classifying drug-drug interactions and/or notifying dispensing providers of specific interactions when they meet CHG's severity threshold.

Member safety prevention, monitoring and evaluation includes:

- A. Distributing member information that improves their knowledge about clinical safety in their own care; for example, member brochures, which outline member concerns or questions that they should address with their practitioners for their care
- B. Collaborating with practitioners in performing the following activities: improving medical record documentation and legibility, establishing timely follow-up for lab results; addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance patient safety
- C. Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- D. Utilizing facility site review, Physical Accessibility Review Survey (PARS), and medical record review results from practitioner and healthcare delivery organization at the time of credentialing to improve safe practices, and incorporating ADA (Americans with Disabilities Act), and SPD site review audits into the general facility site review process
- E. Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

24. Conflict of Interest

Health care providers serving on any QIP Committee, who are/were involved in the care of a member under review by the committee, are not allowed to participate in discussions and determinations regarding the case. Committee members cannot review cases involving family members, providers, or suppliers with whom they have a financial or contractual affiliation or other similar conflict of interest issues. All employees and committee participants sign a Conflict of Interest statement on an annual basis. Fiscal and clinical interests are separated. CHG's QIP promotes care which is consistent with professionally recognized standards of practice and monitors that care is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan or providers. CHG does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor to pressure health care providers or institutions to render care beyond the scope of their training or experience. Furthermore, CHG and its delegates do not specifically reward

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practitioners or other individuals conducting utilization review for issuing denials of coverage, services, or care. There are no financial incentives for UM decision-makers that could encourage decisions that result in under-utilization.

25. Confidentiality

CHG has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CHG employees, including contracted professionals who have access to confidential or member information, sign a written statement delineating responsibility for maintaining confidentiality.

In addition, all Committee members of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the Quality Improvement Committee and other QI committees, related to member- or practitioner-specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The medical groups hold all information in strictest confidence. Members of the Quality Improvement Committee and the subcommittees sign a "Confidentiality Agreement." This Agreement requires the member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any Quality Improvement reports required by law or by the State Contract.

26. Member Satisfaction

CHG contracts with an NCQA certified vendor to conduct member satisfaction surveys (Consumer Assessment of Healthcare Providers and Systems – CAHPS) annually by all product lines. The Health Outcomes Survey (HOS) for the Medicare line of business will be added for Medicare dual-eligible plans. A behavioral health satisfaction survey is also conducted for those members who receive behavioral health care through contracted vendors.

The results of the surveys are reported to the QIC and the Public Policy Committee. Additionally, the behavioral health satisfaction results are reported to the Behavioral Health Advisory Committee.

Quarterly summaries of complaints and grievances and appeals are reported to the QIC. Reporting is trended by type of complaint, CHG departments, sites, facilities and physicians as indicated. Cases reviewed by the CMO are included in the quarterly summaries.

Any complaint that has a potential quality of care issue receives medical review as follows:

- The QI Specialist screens it immediately upon receipt for potential quality issues.
- Supporting documentation is requested from primary care sites, hospitals, etc. or obtained through information available throughout CHG's utilization and case management systems.
- The CMO reviews the complaint and any supporting documentation, categorizes the quality of care concerns, communicates with primary care provider as indicated and provides an acknowledgement letter to the member within 30 days of receiving a medical quality of care grievance.

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27. Delegation Oversight

CHG may delegate those Utilization Management, Credentialing, , and Claims activities to IPAs, medical groups and plan partners who meet the requirements as defined in a written delegation agreement and delegation policies.

The Delegation Oversight Committee oversees the delegation of activities and the QIP reviews regular reporting received from the delegates.

There are policies and procedures in place to monitor, evaluate and drive improvement of delegates' compliance with the defined policies and standards applicable to delegated activities. Delegation of activities is based on an initial assessment and on-going monitoring and oversight. CHG retains accountability for all delegated functions. If the delegated activities are not being carried out in accordance with the terms of the delegation agreement and/or improvement action plan, corrective action (up to and including revocation of delegated status) may be implemented.

CHG does not delegate Quality Improvement activities. All practitioners, IPAs/Medical Groups are expected to participate in CHG's QI activities.