



**Care1st Quality Improvement Program
Medi-Cal San Diego 2016
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1. MISSION STATEMENT

Care1st Quality Improvement Department has a mission to providing the highest quality of care and excellent in service to all members, providers and employees, with an assurance of basic and ethical values driven by integrity, honesty and respect.

Care1st's QI Program is committed to promoting continuous and coordinated care in a patient-centered environment that recognizes the positive relationship between health education, a culture of wellness, an emphasis on prevention and a cost-effective healthcare.

Care1st Health Plan is accredited by NCQA for both Medicare and Medicaid, and certified for MA Deeming.

2. PURPOSE/PROGRAM DESCRIPTION

The Quality Improvement Program is designed to objectively and systematically monitor and evaluate the quality, appropriateness and outcomes of care and services delivered to our members. The QI Program provides mechanisms that continuously pursue opportunities for improvement and problem resolution. In addition, the QI Program utilizes a population management approach to members and providers and collaborates with local, state and federal public health agencies and programs as well as with providers and other health plans.

3. SCOPE OF PROGRAM

The QI Program addresses full-service Knox-Keene requirements, DHCS, as well as Cal MediConnect, and Waiver provisions.

The scope of the Quality Improvement Program is to monitor care and identify opportunities for improvement of care and services to both our members and Practitioners. This is accomplished by evaluating data, and assisting with the identification, investigation, implementation, and evaluation of corrective actions that continuously improve and measure the quality of clinical and administrative service. This Quality Improvement Program covers all San Diego Medi-Cal members. Behavioral Health Care was a carved out service for this Medi-Cal line of business. A formal evaluation of the Quality Improvement Program is performed annually. Specific elements of the Quality Improvement Program may include but not limited to:

- Practitioner accessibility and availability
- Practitioner satisfaction
- Continuity and coordination of care
- Clinical measurement and improvement monitoring
- State Quality Improvement Projects (QIPs)
- Member safety
- Member satisfaction/grievances
- Credentialing and Recredentialing
- Peer Review
- IPA/MSO Oversight
- Clinical practice guidelines
- Under and over utilization
- Adverse outcomes/sentinel events
- Medical record keeping practices
- Facility site reviews
- Timeliness of handling claims
- High risk and high volume services
- Meeting regulatory requirements and reporting
- Medication Therapy and Management
- Predictive Modeling
- Compliance with regulatory requirements and reporting

4. GOALS AND OBJECTIVES

A. Goals

- Ensuring members receive the highest quality of care and services.
- Ensuring members have full access to care and availability of primary care physicians and specialists.
- Monitoring, improving and measuring member and practitioner satisfaction with all aspects of the delivery system and network.
- Utilizing a multi-disciplinary approach to assess, monitor and improve our policies and procedures.
- Promoting physician involvement in our Quality Improvement Program and activities.
- Fostering a supportive environment to help practitioners and providers improve the safety of their practices.
- Meet and assess the standards for cultural and linguistic needs of our members.
- Meeting the changing standards of practice of the healthcare industry and adhere to all state and federal laws and regulations.
- Adopting, implementing and supporting ongoing adherence with NCQA standards.
- Promoting the benefits of a managed care delivery system.
- Promoting preventive health services and case management of members with chronic conditions.
- Emphasizing a caring professional relationship between the patient, Practitioner and health plan.
- Ensuring there is a separation between medical and financial decision making.
- Seeking out and identifying opportunities to improve the quality of care and services provided to our members.
- Seeking out and identifying opportunities to improve the quality of services to our Practitioners.

B. Objectives

- Ensuring that timely, quality, medically necessary and appropriate care and services that meet professionally recognized standards of practice are available to members by the identification, investigation and resolution of problems, focusing on known or suspected issues that are revealed through monitoring, trending and measuring of specific clinical indicators, preventive health services, access to services and member satisfaction, through the use of a total quality improvement philosophy.
- Systematically collecting, screening, identifying, evaluating and measuring information about the quality and appropriateness of clinical care and provide feedback to IPA/PMG's and Practitioners about their performance and also the network-wide performance.
- Maintaining a credentialed network based on a thorough review and evaluation of education, training, experience, sanction activity and performance.
- Objectively and regularly evaluating professional practices and performance on a proactive, concurrent and retrospective basis through Credentialing and peer review.
- Ensuring our members is afforded accessible health care by continually assessing the access to care and availability of our network of Practitioners and specialists.
- Designing and developing data systems to support Quality Improvement monitoring and measurement activities.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and L.A. Care.
- Ensuring a full-time medical director whose responsibility is direct involvement in the implementation of the QI activities, in accordance with Title 22 CCR Section 53857.
- Appropriately overseeing Quality Improvement activities of our contracted IPA/PMGs.
- Ensuring that at all times the Quality Improvement structure, staff and processes are in compliance with all regulatory and oversight requirements.
- Ensuring accountability through involvement of the governing body, designation of the Medical Services Committee with oversight and performance responsibility, delegation of the Medical

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Director with supervision of QI activities, and inclusion of contracting practitioners and providers in the QI process and performance review.

- Actively working to maintain standards for quality of care and accessibility of care and service.
- Establishing and conducting focused review studies, with an emphasis on preventive services, high-volume Practitioners and services and high-risk services with implementation of processes to measure improvements.
- Ensuring that mechanisms are in place to support and facilitate continuity of care within the healthcare network and to review the effectiveness of such mechanisms.
- Identifying potential risk management issues.
- Effectively interfacing with all interdisciplinary departments and practices for the coordination of quality Improvement activities.
- Providing a confidential mechanism of documentation, communication and reporting of Quality Improvement issues and activities to the Medical Services Committee, Board of Directors and other appropriate involved parties.
- Assessing the effectiveness of the Quality Improvement Program and make modifications and enhancements on an ongoing and annual basis.
- Ensuring that Care1st is meeting the members cultural and linguistic needs at all points of contact.
- Ensuring members have access to all available services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
- Ensuring mechanisms are in place to identify, support and facilitate patient safety issues within the network and review the effectiveness of these mechanisms.
- Monitoring, evaluating, and taking effective action to address any needed improvements in the quality of care delivered to Seniors and People with Disabilities (SPD).
- Assuring availability and access to care clinical services and care management of SPD members.
- Ensuring provision of case management, coordination and coordination of care services to SPD members.
- Continuously reviewing the quality of care provided to all SPD members to ensure that:
 - ✓ A level of care meets professionally-recognized standards of practice is being delivered to all SPD enrollees;
 - ✓ Quality of care problems are identified and corrected for all provider entities;
 - ✓ Physicians who provide care are integral part of the QI Program;
 - ✓ Appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the providers and/or others;
 - ✓ Care1st 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 and experience.
- Utilizing a system or process to maintain and improve quality of care with respect to Medicaid-based services under Cal MediConnect.
- Delivering quality care that enables enrollees to stay healthy, get better, manage chronic illness and/or disabilities, and maintain/improve the quality of life of Cal MediConnect members.
- Applying the principles of Continuous Quality Improvement (CQI) to all aspects of Care1st's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:
 - Quantitative and qualitative data collection and data-driven decision making;
 - Evidence-based practice guidelines;
 - Feedback from enrollees and providers;
 - Rapid cycle quality improvement;
 - Issues identified by Care1st and regulatory entities;

- Addressing all aspects of health care, including specific reference to behavioral health, non-emergency medical transportation, and Long Term Services and Supports (LTSS), with respect to monitoring and improvement efforts, and integration with physical health care.

5. CONFIDENTIALITY AND CONFLICT OF INTEREST

All information related to the Quality Improvement process is considered confidential. All Quality Improvement data and information, inclusive of but not limited to, minutes, reports, letters, correspondence, and reviews, are housed in a designated, secured area in the Quality Improvement Department. All aspects of quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee.

All Quality Improvement activities including correspondence, documentation and files are protected by State Confidentiality Statutes, the Federal Medical Information Act SB 889 and the Health Information Portability and Accountability Act (HIPAA) for patient's confidentiality. All persons attending the Medical Services Committee or its related committee meetings will sign a Confidentiality Statement. All Care1st personnel are required to sign a Confidentiality Agreement upon employment. Only designated employees by the nature of their position will have access to member health information as outlined in the policies and procedures.

No persons shall be involved in the review process of Quality Improvement issues in which they were directly involved. If potential for conflict of interest is identified, another qualified reviewer will be designated. There is a separation of medical/financial decision making and all committee members, committee chair and the Chief Medical Officer sign a statement of this understanding.

6. PROGRAM STRUCTURE

A. Governing Body

The Plan's Governing Body is the Care1st Board of Directors. The Board of Directors is responsible for the establishment and implementation of the Plan's Quality Improvement Program. The Board of Directors appoints the Chief Medical Officer and Medical Services Committee as accountable entities for oversight of the Quality Improvement Program. The Chief Medical Officer reports all Quality Improvement activities monthly and the Medical Services Committee reports all Quality Improvement activities to the Board every quarter. The Board of Directors formally reviews and approves all Quality Improvement activities quarterly and directs these operations on an ongoing basis.

B. Chief Medical Officer

The Chief Medical Officer is a physician who holds a current license to practice medicine with the Medical Board of California. The Chief Medical Officer is the Board of Directors designee responsible for implementation of Quality Improvement Program activities. The Chief Medical Officer works in conjunction with the Director of Quality Improvement to develop implement and evaluate the Quality Improvement Program. The Chief Medical Officer is Chairperson of the Medical Services, Credentials/Peer Review and Pharmacy & Therapeutics Committees.

Responsibilities include but not limited to:

- Ensuring that medical decisions are rendered by qualified medical personnel, unhindered by fiscal or administrative management.
- Ensuring that the medical care provided meets the community standards for acceptable medical care.
- Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
- Developing and implementing medical policy.
- Actively participating in the functioning and resolution of the grievance procedures.
- Providing support and clinical guidance to the program and to all physicians in the network.

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- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and L.A. Care.
- Ensuring that the Quality Improvement and Utilization Management Departments interface appropriately to maximize opportunities for quality improvement activities.
- Directing the implementation of the Quality Improvement process.
- Overseeing the formulation and modification of comprehensive policies and procedures that support the Quality Improvement operations.
- Analyzing Quality Improvement data.
- Reviewing all clinical grievances, PQIs, QCLs; assign severity levels; and direct corrective actions to be taken, including peer review, if required.
- Reviewing Quality Improvement Program, Work Plan, Annual Evaluation and Quarterly Reports.
- Directing Health Education and Credentialing activities.
- Assisting with the development, conduct, review and analysis of HEDIS and IQIP studies.

C. Medical Director, Quality Improvement

The Medical Director of Quality Improvement, oversees the operations of the Quality Improvement Department and is responsible for the administrative execution and coordination of all Quality Improvement activities. The Medical Director, Quality Improvement, reports to the Chief Medical Officer (CMO). The Medical Director helps to plan, develop, organize, monitor, communicate, and recommend modifications to the Quality Improvement Program and all Quality Improvement policies and procedures. The Medical Director reports any areas of concern to the CMO and/or the Medical Services Committee:

Responsibilities include but not limited to:

- Overseeing the operations of the Quality Improvement Department and is responsible for the execution and coordination of all Quality Improvement activities.
- Overseeing and performs statistical analysis relevant to quality improvement functions and goals.
- Overseeing the development and or revisions annually to the Quality Improvement Annual Evaluation and Work Plan and presents for review and approval.
- Overseeing the development of quarterly Quality Improvement activity progress reports.
- Oversees the development and/or revising annually of the Quality Improvement policies and procedures.
- Overseeing the QI Directors in ensuring that quality trends and patterns are monitored, quality issues are identified and corrective action plans are developed.
- Monitoring and reports to the Medical Services Committee the resolution of quality improvement activities in accordance with the Quality Improvement Program.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and L.A. Care.
- Along with the QI Directors, interfaces with all internal departments to ensure compliance to the Quality Improvement Program and policies and procedures.
- Acts as a liaison with each delegated IPA/PMG and ancillary provider and facility regarding Quality Improvement issues.
- Along with the QI Directors, ensures compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and L.A. Care.
- Serving as liaison with Regulatory Agencies for Quality Improvement activities’.
- Monitors and oversees follow up with all applicable Quality Improvement activities
- Ensuring that HEDIS and QIP studies are conducted appropriately
- Ensuring Member and Practitioners Satisfaction Surveys are conducted annually
- Managing the Practitioner database modification process
- Identifying compliance problems and formulating recommendations for corrective action.
- Ensuring that Focused Review Studies are conducted appropriately.
- Ensuring the department adheres to HIPAA compliance standards.’

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- Overseeing the pre-contractual and annual Due Diligence audit process.
- Monitoring delegated Quality Improvement activities to ensure proper performance of Quality Improvement functions in compliance with regulatory and delegation requirements.
- Submitting a written report summarizing each pre-contractual or annual review.
- Tracking compliance with reporting requirements and provide reports for Delegated Oversight Committee and Joint Operating Committee meetings.
- Reviewing Quality Improvement corrective action plans and other Quality Improvement reports for compliance to standards.
- Reporting IPA/PMG findings of non-compliance to the CMO and Delegated Oversight Committee.

D. Vice President, Performance Improvement

The Vice President of Performance Improvement is a Registered Nurse with a current California licensure and oversees the operations of the companies Quality Performance Metrics and Improvement Programs and is responsible for the execution and coordination of all Performance Improvement activities. The Vice President of Performance Improvement reports to the Medical Director of Quality Improvement. The Vice President helps to plan, develop, organize, monitor, communicate, and recommend modifications to Performance Improvement Projects and the Quality Improvement Program. It is the Vice President of Performance Improvement's responsibility to interface with other departments on Performance Improvement issues. The Vice President reports any areas of concern to the QI Medical Director and/or the Medical Services Committee. Additional responsibilities include but not limited to:

- Performing statistical analysis relevant to quality improvement functions and goals.
- Developing and/or revising annually the Performance Improvement functions of the Annual Evaluation and Work Plan and presenting for review and approval.
- Developing quarterly Performance Improvement activity progress reports.
- Developing and/or revising annually Performance Improvement policies and procedures.
- Ensuring that quality trends and patterns are monitored, quality issues are identified and corrective action plans are developed.
- Monitoring and reporting to the Medical Services Committee the status of Performance Improvement interventions and in accordance with the Quality Improvement Program.
- Overseeing compliance required by regulatory agencies.
- Interfacing with all internal departments to ensure compliance to the Performance Improvement activities and policies and procedures.
- Assist the liaison with each delegated IPA/PMG and ancillary provider and facility regarding Performance Improvement issues.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and L.A. Care.
- Serving as liaison with Regulatory Agencies for Performance Improvement activities.
- Monitoring and follow up with all applicable Performance Improvement activities.
- Ensuring that staff collects and monitors data and report identified trends to the QI Medical Director and Medical Services Committee.
- Ensuring that HEDIS, QIP, PIP, PDSA, and IP studies are conducted appropriately.
- Ensuring Member and Practitioner Satisfaction Surveys are conducted annually.
- Identifying compliance problems and formulating recommendations for corrective action.
- Ensuring that Focused Review Studies are conducted appropriately.
- Interfacing with the QI Medical Director and Chief Medical Officer for clinical quality of care and service issues.
- Assuring the department adheres to HIPAA compliance standards.
- Reviewing potential risk management issues and reports them to the QI Medical Director and Chief Medical Officer.
- Developing policies and procedures in conjunction with the QI Medical Director and Chief Medical Officer.

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- Collecting, monitoring and reporting data for tracking and trending.
- Monitoring delegated Quality Improvement activities to ensure proper performance of Quality Improvement functions in compliance with regulatory and delegation requirements.
- Reviewing Quality Improvement corrective action plans and other Quality Improvement reports for compliance to standards. Reporting IPA/PMG findings of non-compliance to the QI Medical Director, CMO and Delegated Oversight Committee

E. AVP, Quality Improvement

The Quality Improvement Director is a Registered Nurse with a current California licensure and oversees the managers in the administrative daily operations of the Quality Improvement Department and is responsible for the execution of Quality Improvement activities listed below. The Quality Improvement Director reports to the Medical Director Quality Improvement. It is the Director of Quality Improvement's responsibility to interface with other departments on daily Quality Improvement processes and issues.

Additional responsibilities include but not limited to:

- Writing and collecting information for quarterly QI activity progress reports as they apply to FSR, PQI, Credentialing and Appeals & Grievances.
- Assuring that all staff members are adhering to company standards of conduct.
- Ensuring that quality trends and patterns are monitored, quality issues are identified and corrective action plans are developed.
- Ensuring that staff collects and monitors data and report identified trends to the CMO and Peer Review and Medical Services Committee.
- Ensuring appropriate resources and materials are available and ordered to meet the department's needs.
- Overseeing the Managers in the Reviewing of daily staff time clock logs and ensuring compliance with company standards and acting as department liaison with Human Resources (HR) on all HR issues.
- Assisting in the development of Focused Review Studies.
- Interfacing with the Medical Director, QI and Chief Medical Officer for clinical quality of care and service issues.
- Ensuring the maintenance of the PQI/QCI database to track pertinent case data that facilitates capture, tracking and trending of quality data.
- Overseeing member clinical grievance case files and the process for the Chief Medical Officer and Medical Director.
- Overseeing the preparation of peer review case files for the Chief Medical Officer's action.
- Collecting, monitoring and reporting data for tracking and trending.
- Serving as a Liaison with departments for investigation, collaboration and resolution of all identified internal quality of care issues.
- Overseeing the preparation of PQI/QCI and grievance reports for management, Board of Directors, Medical Services Committee, Joint Operating Committee and Delegated Oversight Committee meetings
- Overseeing the collaboration with Member Services Administrative Grievance Coordinator to identify quality of care issues.
- Reporting IPA/PMG findings of non-compliance to the Medical Director, QI and CMO.

F. HEDIS and Stars Team

Under the direction of the Vice President, of Performance Improvement, HEDIS and Stars Team's primary responsibilities range from oversight of medical record review, data extraction, maintaining data systems leading the physician/physician office staff as it relates to HEDIS and other intervention programs initiated through the Quality Improvement Department

Additional responsibilities include but not limited to:

- Provides oversight and support and expertise for interventions initiated by the Quality Improvement Department and Quality Outreach programs, including medical record abstraction for HEDIS, Outreach Education and STAR rating projects.
- Effectively leverages available resources (financial, people, time) to accomplish project objectives and contribute to the successful implementation of QI Outreach programs.
- Oversight of the field teams educational and data collection efforts with possible traveling to assigned Physician/IPA office sites.
- Ability to oversee the annual HEDIS Compliance audit including submission and dissemination to HSAG and CMS and other regulatory agencies. Extensive education, validation, and documentation of physician and physician's office staff regarding HEDIS measures, compliance guidelines.
- Oversight of the HEDIS data abstraction processes to ensure we adhere to NCQA standards for data abstraction.
- Knowledge and experience with HEDIS Technical Specifications, NCQA Survey and Outcome Measures and be able to write a HEDIS Road Map.
- Must be skilled and knowledgeable with the Minimum Performance Levels (MPL's).
- Ensures physicians and physician's office staff meets the HEDIS requirements by concurrent and ongoing evaluation.
- HEDIS Team consists of nurses and coordinators who educate physician and physician's office staff to use various QI Outreach incentive programs.
- Empowers physician/physician's office staff, promotes physician/physician's office staff relationships, and ensures client satisfaction.
- Concurrent and ongoing assessment of physician offices' current practices and streamlining the process as per the QI Outreach implementation project plans.
- Develops new interventions and corrective action plans for physician office sites that fall below the QI Outreach measurement benchmarks.
- Promotes a team and positive work environment, and quality assurance of QI Outreach team.
- Makes appropriate decisions in the face of ambiguity. Anticipates and resolves barriers while managing multiple priorities.
- Provides support to the CMO and Medical Director, under Quality Improvement to work as part of the Quality Improvement Management Team on projects pertaining to HEDIS. Oversees the PCP and IPA QI report card mailings.
- Attends annual HEDIS certification classes.
- Assists in the annual preparation of the Baseline Assessment Tool and audit process.
- Prepares audit result reports, graphs and presentations.
- Other duties as assigned by the Medical Director, Quality Improvement and as needed to assist the Quality Improvement Department with HEDIS related Accreditation Projects.

G. Additional Quality Improvement Staff and Resources

The Quality Improvement Department has multidisciplinary staff to address all aspects of the department functions. A full organizational chart is attached to this program description with all appropriate job descriptions. Care1st has staff and resources to conduct statistical and data analysis sufficient to establish quality controls and improvement projects. Data analysts are capable of developing Access databases relevant to specific functions and pulling appropriate information relevant to specific studies. The staff includes but is not limited to:

- Director, Performance Improvement & Accreditation
- PI/NCQA Clinical Specialist and PI/QI Specialists & Coordinator
- QI Manager, Facility Site Review, and PQI
- Facility Site Review Nurses & Coordinators
- FSR Auditors
- IHA Coordinator

- QI/FSR Senior Project Coordinator
- Sr. QI Nurse Specialist, Case Finding
- PQI Clinical Supervisor
- Sr. PQI Nurses & PQI Nurse Specialists
- Lead PQI Coordinator & PQI Coordinators
- Director, Appeals and Grievance
- Manager, Appeals and Grievance
- Supervisor, Appeals and Grievance
- Manager, Credentialing
- Sr. Credentialing Auditor & Credentialing Auditors
- Credentialing Coordinators
- HEDIS Outreach Supervisor
- Sr. Data Analysts
- HEDIS Provider Network Specialist
- HEDIS Data Specialist
- HEDIS/Quality Outreach Leads & Coordinators
- Sr. Medicare Services Analyst
- Medicare Revenue Management Supervisor
- HCC Auditing Specialists
- Other support staff

7. MEDICAL SERVICES COMMITTEE

A. Description

The Medical Services Committee is established by the authority of the Care1st Board of Directors as a standing committee and is charged with the development, oversight, guidance and coordination of all Medical Services Department activities, including Quality Improvement and Utilization Management. The Medical Services Committee has a specific portion of the meeting designated for the Quality Improvement Program. The Medical Services Committee has been delegated the responsibility of providing an effective Quality Improvement Program. The Medical Services Committee monitors provisions of care, identifies problems, recommends corrective action, and guides the education of Practitioners to improve health care outcomes and quality of service. The Medical Services Committee is also responsible for Utilization Management activities as outlined in the Utilization Management Program.

B. Scope (includes but not limited to):

- Directing all Quality Improvement activity.
- Recommending policy decisions.
- Reviewing, analyzing and evaluating Quality Improvement activity.
- Ensuring practitioner participation in the QI program through planning, design, implementation and review.
- Reviewing and evaluating reports of Quality Improvement activities and issues arising from its subcommittees (Credentials/Peer Review, Pharmacy & Therapeutics or Delegated Oversight Committees).
- Monitoring, evaluating and directing the overall compliance with the Quality Improvement Program.
- Annually reviewing and approving the Quality Improvement Program, Work Plan, and Annual Evaluation.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and L.A. Care.
- Reviewing and approving Quality Improvement policies and procedures, guidelines, and protocols.
- Developing and approving preventive health and clinical practice guidelines that are based on nationally developed and accepted criteria.

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- Developing relevant subcommittees for designated activities and overseeing the standing subcommittee's roles, structures, functions and frequency of meetings as described in this Program. Ad-hoc subcommittees may be developed for short-term projects.
- Conducting peer review, assigning severity levels and making recommendations for corrective actions, as needed.
- Evaluating reports regarding any/all potentially litigious incidents and sentinel events.
- Evaluating reports submitted by the Plan's counsel.
- Developing and coordinating Risk Management education for all Health Plan Practitioners and staff.
- Responsibility for evaluating and giving recommendations concerning audit results, member satisfaction surveys, Practitioner satisfaction surveys, access audits, HEDIS audits and IQIP studies.
- Responsibility for evaluating and giving recommendations from monitoring and tracking reports.
- Ensuring follow-up, as appropriate.

C. Reporting

The Medical Services Committee shall submit a summary report of quality activities and actions for review and approval to the Care1st Board of Directors on a quarterly basis. This is completed by the approval of the Quality Improvement quarterly report.

D. Composition

1. **Chairperson**

The Chief Medical Officer shall chair the Committee and is primarily responsible for but not limited to:

- Directing the Medical Services Committee meetings
- Reporting Medical Services Committee activities to the Board
- Acting on behalf of the committee for issues that arise between meetings
- Ensuring all appropriate QI activity and reports are presented to the committee
- Ensuring there is a separation between medical and financial decision making

2. **Membership**

Membership is assigned and will include representatives from the following disciplines:

- Primary Care Practitioners
- Specialty Care Practitioners
- IPA/PMG Medical Directors
- VP, Utilization Management, Medical Services
- Director, Medical Services
- Medical Directors
- VP, Performance Improvement
- AVP, Quality Improvement
- Director, PI & Accreditation
- QI, Manager
- Manager, Credentialing
- Director, Health Education
- Member Services and Provider Relations (as needed)
- Other members appointed at the discretion of the Chairperson

Committee members are appointed on an annual basis or as vacancies arise and are staggered to protect continuity of the committee functions. Representatives of DHCS, DMHC and LA Care may attend upon request.

E. Quorum and Voting

Only physician members are allowed to vote. A quorum consists of a minimum of three physicians. All approval of actions is by a majority vote. A committee member with a conflict of interest, which might impair objectivity in any review or decision process, shall not participate in any deliberation involving such issues and shall not cast a vote on any related issue. Non-Physician members of the Medical Services Committee may not vote, but shall attend the meetings and provide support to the deliberations. In the event that the Medical Services Committee is unable to constitute a quorum for voting purposes because of conflicts of interest, alternate committee member(s) will be selected as needed, at the discretion of the Chairperson. Representatives and other guests may attend the meetings upon invitation and prior approval.

F. Meetings

The Medical Services Committee meets at least four times per year but can meet more frequently if needed to accomplish the committee's objectives. The Chief Medical Officer may act on the Committee's behalf on issues that arise between meetings.

G. Confidentiality

All committee members and participants, including network Practitioners, consultants and others, will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. All employees are required to sign a Confidentiality Statement. All members and invited guests to Medical Services Committee meetings annually sign a Confidentiality Statement that is kept on file in the Quality Improvement Department. Breach of confidentiality may result in disciplinary action, up to and including termination. Activities and minutes of the Medical Services Committee are for the sole and confidential use of Care1st Health Plan and are protected by State and Federal laws (1157 of the California Code of Evidence, Federal Information Act SB 889 and the Healthcare Portability and Accountability Act (HIPAA)).

H. Recording of Meeting and Dissemination of Action

- All Medical Services Committee minutes are contemporaneous, dated and signed and reflect all committee decisions made.
- Meeting minutes and all documentation used by the Medical Services Committee are the sole property of Care1st Health Plan and are strictly confidential.
- A written agenda will be used for each meeting.
- Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
- The minutes are recorded in a nationally recommended format.
- All unresolved issue/action items are tracked in the minutes until resolved.
- The minutes and all case related correspondence are maintained in the Quality Improvement Department.
- The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

The dissemination of Medical Services Committee information and findings to physicians may take various forms. These methods may include but not limited to:

- Informal one-on-one meetings
- Formal medical educational meetings
- Care1st Newsletters
- Provider Relations and Physician Reports
- Quarterly Reports to the Board of Directors

In addition, Medical Services Committee meeting minutes are submitted to DHCS quarterly.

8. OTHER MEDICAL SERVICES COMMITTEES

A. Credentials Committee

1. **Description**

The Credentials Committee was established by the Board of Directors. The Credentials Committee is delegated the responsibility of monitoring credentialing and recredentialing activities for Practitioners.

2. **Scope (includes but not limited to):**

- Reviewing, recommending, approving or denying initial credentialing and recredentialing of the direct-contracted Practitioner network.
- Reviewing and approving Credentialing policies and procedures and ensure they are carried out.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and L.A. Care.
- Ensuring appropriate reports, including 805, NPDB, etc, are made, as required.
- Ensuring Fair Hearing Procedures are offered and carried out in accordance with approved policies and procedures.

3. **Reporting**

The Credentials Committee shall report monthly to the Care1st Board of Directors. Practitioner network updates are reported regulatory agencies as per contract requirements.

4. **Composition**

Chairperson

The Chief Medical Officer shall chair the Committee and is primarily responsible for but not limited to:

- Overseeing the credentialing program
- Directing the Credentials Committee meetings
- Reporting Credentials Committee activities to the Board of Directors
- Reviewing credentials and recredentials applications
- Reviewing requested changes to credentialing status or specialty
- Acting on behalf of the committee for issues that arise between meetings
- Ensuring all appropriate credentials activity is presented to the committee
- Ensuring there is a separation between medical and financial decision making

Membership

Membership is assigned and will include representatives from the following disciplines:

- Primary Care Practitioners
- Specialty Care Practitioners
- Medical Director, Quality Improvement
- Quality Improvement Director
- Credentialing Manager

Committee members are appointed on an annual basis or as vacancies arise and are staggered to protect continuity of the committee functions. Representatives of DHCS, DMHC and LA Care may attend upon request.

5. Quorum and Voting

Only physician members are allowed to vote. A quorum consists of a minimum of three physicians. All approval of actions is by a majority vote. A committee member with a conflict of interest, which might impair objectivity in any review or decision process, shall not participate in any deliberation involving such issues and shall not cast a vote on any related issue. Non-Physician members of the Credentials Review Committee may not vote, but shall attend the meetings and provide support to the deliberations. In the event that the Credentials Committee is unable to constitute a quorum for voting purposes because of conflicts of interest, alternate committee member(s) will be selected as needed, at the discretion of the Chairperson. Representatives and other guests may attend the meetings upon invitation and prior approval.

The Practitioner (PCP or Specialist) for any case under review may attend the meeting addressing the case to present and defend. That Practitioner will not vote nor engage in the Committee's discussion occurring in Executive Session. No Practitioner member of the Committee will vote on any case in which he/she has been a participant.

6. Meetings

The Credentials Committee meets not less than quarterly but can meet more frequently if circumstances require or to accomplish the committee's objectives. The Chief Medical Officer may act on the Committee's behalf on issues that arise between meetings

7. Confidentiality

All committee members and participants, including network Practitioners, consultants and others, will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. All employees are required to sign a Confidentiality Statement. All members and invited guests to Credentials Committee meetings annually sign a Confidentiality Statement that is kept on file in the Quality Improvement Department. Breach of confidentiality may result in disciplinary action, up to and including termination. Activities and minutes of the Credentialing/Peer Review Committee are for the sole and confidential use of Care1st Health Plan and are protected by State and Federal laws (1157 of the California Code of Evidence, Federal Information Act SB 889 and the Healthcare Portability and Accountability Act (HIPAA).

8. Recording of Meeting and Dissemination of Action

- All Credentials Committee minutes are contemporaneous, dated and signed and reflect all committee decisions made.
- Meeting minutes and all documentation used by the Credentials Committee are the sole property of Care1st Health Plan and are strictly confidential.
- A written agenda will be used for each meeting.
- Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
- The minutes are recorded in a nationally recommended format.
- All unresolved issue/action items are tracked in the minutes until resolved.
- The minutes and all case related correspondence are maintained in the Credentials Department.
- The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

The dissemination of Credentials Committee information and findings to physicians may take various forms. These methods may include but not limited to:

- Informal one-on-one meetings
- Formal medical educational meetings
- Monthly reports to the Board of Directors

B. Peer Review Committee

1. Description

The Peer Review Committee was established by the Board of Directors. The Peer Review Committee is delegated the responsibility of monitoring peer review of Practitioners.

2. Scope (includes but not limited to):

- Reviewing, recommending, taking action and monitoring the clinical practice activity of the Practitioner network and mid-level practitioners.
- Providing appropriate Peer Review that meets the level of practice of the Practitioners and specialists they are reviewing.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and L.A. Care.
- Ensuring appropriate reports, including 805, NPDB, etc, are made, as required.
- Ensuring Fair Hearing Procedures are offered and carried out in accordance with approved policies and procedures.

3. Reporting

The Peer Review Committee shall report to the Care1st Board of Directors.

4. Composition

Chairperson

The Chief Medical Officer shall chair the Committee and is primarily responsible for but not limited to:

- Directing the Credentialing/Peer Review Committee meetings
- Reporting Credentialing/Peer Review Committee activities to the Medical Services Committee
- Acting on behalf of the committee for issues that arise between meetings
- Ensuring a separation between medical and financial decision making
- Ensuring all appropriate Quality Improvement activity and reports are presented to the committee

Membership

Membership is assigned and will include representatives from the following disciplines:

- IPA Medical Directors
- Primary Care Practitioners
- Specialty Care Practitioners
- Medical Director, Quality Improvement
- Director, Quality Improvement
- Accreditation Manager, and QI Special Projects
- Manager (PQI), Quality Improvement

Committee members are appointed on an annual basis or as vacancies arise and are staggered to protect continuity of the committee functions. Representatives of DHCS, DMHC and LA Care may attend upon request.

5. Quorum and Voting

Only physician members are allowed to vote. A quorum consists of a minimum of three physicians. All approval of actions is by a majority vote. A committee member with a conflict of interest, which might impair objectivity in any review or decision process, shall not participate in any deliberation involving such issues and shall not cast a vote on any related issue. Non-Physician members of the Peer Review Committee may not vote, but shall attend the meetings and provide support to the deliberations. In the event that the Peer Review Committee is unable to constitute a quorum for voting purposes because of conflicts of interest, alternate committee member(s) will be selected as needed, at the discretion of the Chairperson. Representatives and other guests may attend the meetings upon invitation and prior approval.

The Practitioner (PCP or Specialist) for any case under review may attend the meeting addressing the case to present and defend. That Practitioner will not vote nor engage in the Committee's discussion occurring in Executive Session. No Practitioner member of the Committee will vote on any case in which he/she has been a participant.

6. Meetings

The Peer Review Committee meets not less than quarterly but can meet more frequently if circumstances require or to accomplish the committee's objectives. The Chief Medical Officer may act on the Committee's behalf on issues that arise between meetings

7. Confidentiality

All committee members and participants, including network Practitioners, consultants and others, will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. All employees are required to sign a Confidentiality Statement. All members and invited guests to Peer Review Committee meetings annually sign a Confidentiality Statement that is kept on file in the Quality Improvement Department. Breach of confidentiality may result in disciplinary action, up to and including termination. Activities and minutes of the Peer Review Committee are for the sole and confidential use of Care1st Health Plan and are protected by State and Federal laws (1157 of the California Code of Evidence, Federal Information Act SB 889 and the Healthcare Portability and Accountability Act (HIPAA).

8. Recording of Meeting and Dissemination of Action

- All Peer Review Committee minutes are contemporaneous, dated and signed and reflect all committee decisions made.
- Meeting minutes and all documentation used by the Peer Review Committee are the sole property of Care1st Health Plan and are strictly confidential.
- A written agenda will be used for each meeting.
- Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
- The minutes are recorded in a nationally recommended format.
- All unresolved issue/action items are tracked in the minutes until resolved.
- The minutes and all case related correspondence are maintained in the Quality Improvement Department.
- The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

The dissemination of Peer Review Committee information and findings to physicians may take various forms. These methods may include but not limited to:

- Informal one-on-one meetings
- Formal medical educational meetings
- Reports to the Board of Directors

C. Behavioral Health Sub-Committee Description

The Behavioral Health Medical Services Subcommittee (BH MSC) is established by the authority of the Medical Services Committee as a subcommittee and is charged with the development, oversight, guidance and coordination of all Behavioral Health Services Department activities, including Quality Improvement and Utilization Management. The BH MSC reports to the Medical Services Committee. The BH MSC monitors provisions of care, identifies problems, recommends corrective action, and guides the education of Behavioral Health Practitioners through our Managed Behavioral Health Organizations (MBHO's) to improve health care outcomes and quality of service.

1. Scope (includes but not limited to):

- Directing Behavioral Health Quality Improvement activity.
- Recommending policy decisions.
- Reviewing, analyzing and evaluating Quality Improvement activity.
- Ensuring MBHO participation in the QI program through planning, design, implementation and review.
- Reviewing and evaluating reports of Quality Improvement activities and issues arising from its subcommittees (Credentials/Peer Review, Pharmacy & Therapeutics or Delegated Oversight Committees).
- Monitoring, evaluating and directing the overall compliance with the Quality Improvement Program.
- Annually reviewing and approving the Quality Improvement Program, Work Plan, and Annual Evaluation of our MBHO's
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, CMS, DHCS, DMHC, and NCQA.
- Reviewing and approving Quality Improvement policies and procedures, guidelines, and protocols.
- Reviewing and evaluating reports regarding any/all potentially litigious incidents and sentinel events related to behavioral health..
- Reviewing and evaluating reports submitted by the Plan's counsel.
- Evaluating and giving recommendations concerning audit results, member satisfaction surveys, Practitioner satisfaction surveys, access audits
- Evaluating and giving recommendations from monitoring and tracking reports.
- Ensuring follow-up, as appropriate.

2. Reporting

The BH MSC shall submit a summary report of quality activities and actions for review and approval to the Medical Services Committee no less than three times per year.

3. Composition

Chairperson

The Chief Medical Officer and Behavioral Health Director shall co-chair the subcommittee and are primarily responsible for but not limited to:

- Directing the BH MSC meetings
- Reporting BH MSC activities to the Medical Services Committee.
- Acting on behalf of the committee for issues that arise between meetings
- Ensuring all appropriate QI activity and reports are presented to the committee
- Ensuring there is a separation between medical/behavioral health and financial decision making

4. Membership

Membership is assigned and will include representatives from the following disciplines:

- Vice President, Utilization Management
- Director, Medical Services
- Medical Director, Quality Improvement
- VP, Performance Improvement AVP, Quality Improvement
- Director, Performance Improvement & Accreditation
- MBHO's representatives
- Other members appointed at the discretion of the Chairperson

Committee members are appointed on an annual basis or as vacancies arise and are staggered to protect continuity of the committee functions.

5. Quorum and Voting

Only Care1st members are allowed to vote. A quorum consists of a minimum of three Care1st members. All approval of actions is by a majority vote. A committee member with a conflict of interest, which might impair objectivity in any review or decision process, shall not participate in any deliberation involving such issues and shall not cast a vote on any related issue. In the event that the BH MSC is unable to constitute a quorum for voting purposes because of conflicts of interest, alternate committee member(s) will be selected as needed, at the discretion of the Chairperson. Representatives and other guests may attend the meetings upon invitation and prior approval.

6. Meetings

The BH MSC meets as often as is needed to accomplish the subcommittee's objectives. The Co-chairpersons may act on the subcommittee's behalf on issues that arise between meetings.

7. Confidentiality

All committee members and participants, consultants and others, will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. All employees are required to sign a Confidentiality Statement. All members and invited guests to BH MSC meetings annually sign a Confidentiality Statement that is kept on file in the Quality Improvement Department. Breach of confidentiality may result in disciplinary action, up to and including termination. Activities and minutes of the Medical Services Committee are for the sole and confidential use of Care1st Health Plan and are protected by State and Federal laws (1157 of the California Code of Evidence, Federal Information Act SB 889 and the Healthcare Portability and Accountability Act (HIPAA).

8. Recording of Meeting and Dissemination of Action

- All BH MSC minutes are contemporaneous, dated and signed and reflect all committee decisions made.
- Meeting minutes and all documentation used by the BH MSC are the sole property of Care1st Health Plan and are strictly confidential.
- A written agenda will be used for each meeting.
- Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
- The minutes are recorded in a nationally recommended format. All unresolved issue/action items are tracked in the minutes until resolved.
- The minutes and all case related correspondence are to be maintained in the Medical Services Committee.
- The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

D. MOC & Quality Improvement Committee

1. Internal Quality Performance Process

The Chief Medical Officer (CMO) who functions as the Chair of the MOC & QI Committee has the direct reporting responsibility to the CEO and the Board of Directors. The CMO, through the Board of Directors, is given all necessary decision making authority to ensure that the MOC program is implemented as developed and that it meets the quality thresholds that have been established. The CMO is also responsible for ensuring that corrective action plans are implemented for any measures not meeting established thresholds.

2. Roles and Responsibilities of MOC & QI Committee:

The MOC & QI Committee has the accountability for implementing and overseeing the performance of the MOC Program to ensure that it meets the established goals. The Subcommittee establishes direction, recommends changes, and evaluates results of ongoing clinical and service improvement activities. Roles and responsibilities include but are not limited to the following:

- Approves the scope of improvement activities as documented in the MOC program description annually.
- Reviews the progress as documented in the work plan and makes recommendations as needed every quarter.
- Ensures adequate practitioner participation in planning, implementing, and evaluating the MOC program.
- Communicates the results of the MOC program quarterly to Medical Services Committee, CEO, and the Board of Directors.
- Annually reviews and approves the annual evaluation, program description and work plan for the subsequent year.
- Responsibility for evaluating and giving recommendations, concerning audit results, member satisfaction surveys, Practitioner satisfaction surveys, access audits, HEDIS audits, and QIP studies.
- Review and approves other ad-hoc reports and studies as needed

3. Frequency

The MOC & QI Committee meets at least three times per year but can meet more frequently if needed to accomplish the committee’s objectives.

4. Composition

The Model of Care and QI Committee is a multi-disciplinary committee that includes the following members:

Chair: Chief Medical Office (CMO)	
• Corporate Medical Director	• Director of Provider Relations
• QI Medical Director	• VP of Medical Services
• VP, Performance Improvement	• Director of Member Services
• Director of Social Services	• Director of Behavioral Health Services
• Quality Improvement Specialist/Analyst	• Director of Pharmacy Services
Community Providers/ Practitioners and other personnel as needed	

9. DELEGATION

A. Independent Practice Association/Primary Medical Groups (IPA/PMG)

Care1st delegates responsibility for specific functional activities for the delivery of care and service to its members to IPA/PMGs. Care1st does not delegate Quality Improvement activities to contracted IPA's and Medical Groups. Care1st maintains accountability and ultimate responsibility for the associated activities by overseeing performance in the following areas: Utilization Management, Credentialing, Quality Improvement, Culture and Linguistics and Health Education. Delegated functions include, but are not limited to, preventive health services, health education activities, clinical practice guidelines, access standards. Non-delegated functions include clinical studies, clinical grievances, appeals, HEDIS/IQIP studies, facility site/medical record reviews, access studies, Health Education materials development and review, member and Practitioner satisfaction surveys. Delegated IPAs will be expected to have a functioning quality assurance program in place. Care1st retains the right to revoke any delegated function if compliance with standards is not met.

Care1st has a process in place to assess and ensure the IPA/PMG's ability to perform the delegated functions which is part of the Utilization Management Department. . NCQA, DMHC, DHCS and LA Care regulations and requirements are used to evaluate and determine the IPA/PMG's potential for delegation. An initial assessment is conducted pre-contractually to determine the IPA/PMG's ability to provide delegated services and at least annually thereafter. Care1st's UM Delegation and Credentialing Departments are responsible for oversight of the IPA/PMGs and reporting which is presented to Compliance Delegation Oversight Committee (CDOC). CDOC activity is reported to the Board of Directors for final review and approval.

B. Availability of Practitioners

In creating and developing our delivery system of practitioners, Care1st takes into consideration assessed special and cultural needs and preferences of our members. Care1st establishes availability of primary care, specialty care, hospital based and ancillary Practitioners by:

- Ensuring that standards are in-place to define practitioners who serve as primary care practitioners (Pediatrics, Family Practice, General Practice, Internal Medicine, etc.).
- Assigning each member to a Practitioner with-in five (5) miles of their home unless specially requested by the member or family.
- Referring each member should be referred to a specialist within (15) fifteen miles of their home unless specially requested by the member or family.
- Ensuring a database is in-place which analyzes practitioner availability and ability to meet the special cultural need of our members.
- Ensuring members are within (15) fifteen miles or (30) thirty minutes from a contracted hospital and ancillary service.
- Providing members with transportation as needed.
- Proving member requests of special cultural and language needs.
- Annually reviewing and measuring the effectiveness of these standards through specialized studies.

Behavioral Health Access to Care and Availability

Care1st contracts with an NCQA Accredited MBHO and delegates the following functions to ensure BH access to care and geographical availability to ensure access and availability of BH Practitioners:

1. BH Access to Care
2. BH Telephone Access to Care
3. BH Geographical Availability
4. Annual BH CAHPS (Member Experience)
5. Annual BH CAHPS opportunities for improvement

10. QUALITY IMPROVEMENT PROCESS

Care1st utilizes a Quality Improvement Process to identify opportunities to improve both the quality of care and quality of service for all Plan members. Care1st adopts and maintains clinical guidelines, criteria, quality screens and other standards against which quality of care, access, and service can be measured.

A. Standards of Practice

1. The standards of practice used as criteria, measures, indicators, protocols, practice guidelines, review standards or benchmarks in the Quality Improvement process are based on professionally recognized standards. Sources for standards include but not limited to:
 - a. National and local medical professional associations
 - b. Local professionally recognized practices
 - c. Review of applicable medical literature
 - d. Available medical knowledge
 - e. State and federal requirements
2. Standards are used to evaluate quality of care of Practitioners.
3. Standards are incorporated into policies and procedures.
4. Thresholds and targets derived from these standards and norms and accepted for will be:
 - a. Measurable
 - b. Achievable
 - c. Consistent with national/community standards
 - d. Consistent with requirements of regulatory agencies and legal guidelines Valuable to the assessment of quality or the potential improvement of quality for our member population
5. Standards are communicated to Practitioners through the Plan in a systematic manner in ways that may include but not limited to:
 - Care1st Provider Manual
 - Newsletters
 - Bulletins

B. Access to Service

Care1st has established standards and mechanisms to assure the accessibility of primary care, specialty care, and behavioral health and member services. Standards include but not limited to:

- Preventive care appointments
- Regular and Routine care appointments
- Urgent care appointments
- Emergency care
- After-hours care
- Wait times
- Member Services by Telephone

Care1st conducts an annual access to care audit using the standards to implement and measure improvements made in performance (please refer to QI Policy and Procedure for Access to Service).

(Refer to our Quality Improvement Policies and Procedures for Availability of Practitioners)

C. Member Satisfaction

1. Grievance Process

Under the QI departmental structure the Appeals and Grievance and PQI Departments adheres to the following process:

The Grievance and Appeals Department receives from Member Services a typed call text of every call-in grievance to the company. A grievance is described as any indication of dissatisfaction from a member. These grievances can also be submitted in writing. A Registered Nurse in the PQI department reviews each grievance as they are received by the Grievance and appeals department for clinical urgency and if indicated, forwards the case information to the CMO or QI Medical Director for review and further direction. The RN assigns an Issue code based on the content of the grievance. This process is housed in the Grievance Database.

A RN in the PQI Department then evaluates each closed grievance utilizing available information and determines if there is a potential quality of care issue. All of those that receive that determination are forwarded to the PQI department where a nurse reviews and prepares the case to be reviewed by the QI Medical Director and is ultimately assigned a Severity Level.

Care1st's grievance process provides members a means by which they can report and seek resolution of concerns regarding practitioners' or Care1st's ability to provide appropriate health care services, access to care, cultural and linguistic issues or quality of care or service issues. (Refer to the Quality Improvement Policy and Procedure for Grievance Process.)

2. Member Satisfaction Survey (CAHPS)

Care1st contracts with vendors to conduct an annual child and adult CAHPS survey. These CAHPS surveys are conducted to monitor members' satisfaction with health care services, accessibility of care, continuity of care, quality of care and service, cultural and linguistic issues, and to identify and pursue opportunities to improve member satisfaction and the processes which impact satisfaction. Member Satisfaction surveys are conducted at least annually. Care1st evaluates the survey results annually and develops an improvement plan to address areas identified. Care1st does a drill down analysis of the CAHPS survey results at the medical group and IPA level to identify high and low performing groups. This analysis helps Care1st to learn best practices from high performing groups and work with low performing groups to improve performance. Care1st evaluates the survey results annually and develops and improvement plant to address areas identified. (Refer to the Member Satisfaction Survey Policy and Procedure.)

3. Public Policy Meetings

Our Care1st Member Services Department holds a quarterly Public Policy meeting where members have the opportunity to voice any opinions or concerns about the services provided to them. This meeting is an open forum and has educational purposes for the members who attend. (Refer to the Member Services Program for a detailed description).

D. Health Management Systems

Care1st identifies members with chronic conditions such as hypertension, asthma, diabetes and offers appropriate services and programs to assist in the management of these conditions. The Quality Improvement Department identifies these conditions through several ways but not limited to:

1. Clinical Practice Guidelines

Care1st adopts nationally recognized Clinical Practice Guidelines (CPGs), which are reviewed and approved annually through our committees and overseen by our Utilization Management Department.

2. Potential Quality Issues (PQI)

A major component of the Quality Improvement Program is the identification and review of potential quality issues and the implementation of appropriate corrective action to address confirmed quality of care issues. (Refer to Quality Improvement Policy and Procedure for identification and handling of PQIs.)

- A PQI is a deviation or suspected deviation from expected Practitioner performance, clinical care or outcome of care that cannot be determined to be justified without additional review. Such issues must be referred to the Quality Improvement Department for review and investigation.

3. Peer Review

Peer review is conducted in any situation where peers are needed to assess the appropriateness or necessity of a particular course of treatment, to review or monitor a pattern of care provided by a specific practitioner or to review aspects of care, behavior or practice, as may be deemed inappropriate:

- The Chief Medical Officer is responsible for authorizing the referral of cases for peer review.
- All Peer Review consultants (including members of the Credentials/Peer Review or ad-hoc Peer Review Committees) are duly licensed professionals in active practice.
- At least one consultant will be a Practitioner with the same or similar specialty training as the Practitioner whose care is being reviewed, except in those cases where there is no applicable board certification for the specialty.
- The Chief Medical Officer can send cases out for a specialty review and consultation to be used for the peer review process.
- The Chief Medical Officer will confirm that the peer review consultants have the necessary experience and qualifications for the review at hand.
- The AVP, Quality Improvement Director and Quality Improvement Manager prepare all materials for review by the Peer Review Committee and conduct all follow-ups, as required by the Committee. (Refer to Peer Review Policy and Procedure.)

4. Continuity and Coordination of Care

Our Care1st Quality Improvement Department ensures the continuity and coordination of care that our members receive. This is measured through routine medical record review, potential quality of care reviews, grievance reviews and member satisfaction surveys. This collaborative information is tracked and analyzed to identify opportunities for improvement. When a Practitioner discontinues a contract with Care1st the member can continue with that Practitioner for care for the remainder of active treatment or 90 days, whichever is shorter.

Members with a second or third trimester pregnancy have access to their discontinued practitioner through the post-partum period. (Refer to Continuity and Coordination of Care Policy and Procedure.)

As an on-going activity, the organization notifies members affected by the termination of a practitioner or practice group in general, family and internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and helps them select a new practitioner. (Refer to Member Reassignment Provider Terminates with Care1st Health Plan Policy or Member Assignment PCP Changes IPA Affiliation within Care1st Health Plan Policy)

Additionally, as part of the Continuity and Coordination of Care process, the organization assists with a member's transition to other care, if necessary, when benefits end (refer to Transition of Care When Benefits End Policy).

5. Sentinel Events

A major component of the Quality Improvement Program is the use of sentinel events to monitor important aspects of care, accessibility and service (Refer to the Sentinel Events Policy and Procedure).

6. Patient Safety Program

Care1st's Quality Improvement Department has developed a patient safety program which identifies supports and facilitates patient safety throughout our network operations. This program evaluates multiple aspects of the patient care process, such as hospital safety, health education, Practitioner office safety and drug utilization safety.

Programs are in place through our Pharmacy Department to identify members who are on medications that are contraindicated (such as drug interactions) or when warnings have been issued. All members that prescribed 10 or more medications are reviewed for patient safety, drug to drug interactions and drug-disease interactions.

The Quality Improvement Department has initiated new facility site review criteria aimed at improving patient safety in the offices and provide our members with added information that can help them make a decision on what office is best for them. This Physical Accessibility Review Survey (PARS) looks at the general areas of Parking, Exterior Building, Interior Building, Restroom, Exam Room(s), and Exam Table/Scale. The facility site review sub-department performs these safety audits when conducting on-site review of the Practitioners. This information is now being used to provide offices with an accessibility level for physically challenged members. The levels are posted in our practitioner directory both hard copy and on the web, giving members the opportunity to know if the office site meets their individual needs.

The Facility Site Review Department also looks at percentage of yes answers in Facility criteria with the initial and periodic reviews for the following criteria which directly impact patient safety: Disabled Parking, Accessible Restroom, Diagrammed Evacuation Routes, and Personnel Trained in Medical Emergency procedures, Emergency Equipment, Emergency Medications and documented preventive equipment maintenance.

The member's grievance system has codes identified to track grievances relating to safety issues. Care1st actively encourages hospitals to have a Leap Frog patient safety survey completed. When hospitals have the Leap Frog survey done, results are disseminated on our web site. Care1st strives to include patient safety specific education in our intervention and program mailings and have educational material available to members through multiple sources. Our Provider Manual documents specific patient safety issues and policies. A full description of our patient safety program can be found as QI P&P # 70.1.1.49

E. Clinical Measurement Activities and Quality Performance Reporting

Care1st Health Plan's Quality Improvement Department adheres to all DHCS standards in accordance with Title 22, CCR, Section 53860 (d) and Title 42, USC, Section 1396a(30)(C) for quality performance reporting. Care1st will cooperate and assist the External Quality Review Organization (EQRO) in the review process.

Care1st uses data collection and analysis to track clinical issues that are relevant to our population. At a minimum, Care1st will adopt and establish quantitative measures to assess performance and to identify and prioritize areas for improvement in (2) Internal Quality Improvement Projects (IQIPs).

1. External Accountability Set (EAS) and Health Plan Effectiveness Data and Information Set (HEDIS®)

Care1st Health Plan actively takes part in annual Health Plan Effectiveness Data and Information Set (HEDIS) measures. HEDIS Studies are conducted for all lines of business and are in accordance with DHCS standards. Care1st cooperates and assists the External Quality Review Organization (EQRO) in the review of quality outcomes and timeliness of services provided. (Refer to QI Policy and Procedure for HEDIS.)

2. Quality Improvement Projects (QIPs) Performance Improvement Projects (PIPs), Plan, Do, Study, and Act (PDSAs), Performance Improvement (PIs)

Care1st conducts and/or participates in several quality improvement projects for all lines of business. In addition to a plan-specific QIPs Care1st will also collaborate with DHCS, DMHC, and CMS on statewide or small group collaborative. The quality improvement projects with regulatory agencies will be selected from the options they list to us annually. Other quality improvement projects are based on rate performance and all those that score below minimum performance levels (25th percentile of the National rate) will be an improvement project the next year. All QIPs will meet guidelines for preventive care standards. The guidelines include American Academy of Pediatrics (AAP), Advisory Committee on Immunizations Practices, American College of Obstetrics and Gynecology, U. S. Preventive Services Task Force and all other nationally recognized practice guidelines as appropriate

Upon request, Care1st will collaborate with LA Care QI Initiatives.

3. Practitioner/Provider Performance Data

To ensure compliance with regulatory agencies (e.g., National Committee of Quality Assurance, (NCQA), Practitioners and Providers must comply with Care1st policies and procedures and allow the health plan to use their performance data (i.e., HEDIS, clinical performance data).

F. Other Quality Improvement Activities

Care1st conducts quality improvement studies and programs to assess quality of service to our members, including the following:

1. Member and Practitioner Satisfaction Surveys

CAHPS surveys are conducted to monitor members' satisfaction with health care services, accessibility of care, continuity of care, quality of care and service, identify any cultural or linguistic issues and to identify and pursue opportunities to improve member satisfaction and the processes which impact satisfaction. Member satisfaction surveys are conducted at least annually.

Care1st does a drill down analysis of the CAHPS survey results at the medical group and IPA level to identify high and low performing groups. This analysis helps Care1st to learn best practices from high performing groups and work with low performing groups to improve performance. Care1st evaluates the survey results annually and develops and improvement plan to address areas identified. Care1st annually presents the survey results to the Medical Services Committee.

Care1st is going to share the results of the CAHPS survey with the groups so they can assess their performance. Care1st also plans to hold joint operations meetings with the large groups to address quality related issues and identify opportunities for improvement. (Refer to the Member Satisfaction Survey Policy and Procedure.)

Practitioner satisfaction surveys are conducted to monitor practitioners' satisfaction with the Plan's delivery of services and to identify and pursue opportunities for improvement. Practitioner satisfaction surveys are conducted at least annually. Care1st annually evaluates the survey results and presents to Medical Services Committee. The Survey Summary analysis is forwarded to the Provider Network Operations Director (Refer to the Practitioner Satisfaction Survey Policy and Procedure.)

2. Facility Site Review (FSR)

- A FSR/MRR is conducted for all PCPs prior to entering the Care1st Medi-Cal and Cal MediConnect provider networks network (and receive a score of 80% or higher) and at least every three years thereafter.
- FSR/MRR reviews include all requirements, as outlined in the DHCS MMCD Policy Letters 14-004 and 12-006, All Plan Letter 15-023, and Dual Plan Letter 14-005 and any revisions as they become available.
- FSR/MRR will also be conducted in response to member complaints and grievances, per NCQA, CMS and MMCP criteria
- FSR/MRR standards and updates are communicated to Providers in provider bulletins, newsletters and the Care1st Provider Manual.
- FSR/MRR are tracked via Healthy Data Systems and various tracking logs, to ensure timely completion of periodic, annual and interim reviews, as well as track required Provider Corrective Action Plans.
- Regulatory reports are generated using Health Data System and are submitted to DHCS and LA Care according to the established reporting schedule. Additional reporting is submitted to the Care 1st Board and Medical Services Committee.

3. Credentialing

Care1st conducts a Credentialing process that is in compliance with all regulatory and oversight requirements. Care1st will credential and recredential all contracted independent practitioners and mid-level practitioners employed in contracted practitioners' offices who see Care1st members. Care1st does not credential hospital-based practitioners, i.e., anesthesiologists, Emergency Medicine physicians, pathologists and radiologists, who see Care1st members solely as patients of the hospital. Care1st does delegate Credentialing functions to contracted IPA/MSOs but retains ultimate responsibility and authority for all credentialing activities. (Refer to the Credentialing Program, Policies and Procedures for details.)

G. Quality Improvement Interventions

The Quality Improvement Department will implement opportunities to improve the delivery and quality of care through the design and implementation of quality improvement interventions. Wherever possible, these interventions are designed to achieve systemic or procedural improvements affecting multiple members, Practitioners or services. Such interventions may include but are not limited to:

- Developing and adopting clinical standards, practice guidelines or administrative standards, with subsequent dissemination of the standards to Practitioners, members or staff as appropriate.
- Educating Practitioners about clinical standards and practice guidelines.
- Monitoring the receipt of and compliance with standards and guidelines by practitioners.
- Providing feedback to practitioners to inform them of specific findings of Quality Improvement reviews pertaining to the Practitioner in question.
- Providing health promotion and health education programs to inform members of ways to improve their health or their use of the health care delivery system.
- Modifying administrative processes to improve quality of care, accessibility and service. These processes may include, but are not limited to, customer services, utilization management and case management activities, preventive services and health education.
- Modifying the practitioner and provider network, including adding practitioners or providers to improve accessibility.
- Taking disciplinary action against practitioners and providers.
- Conducting Joint Operations Committee (JOC) meetings with the delegated IPA/PMGs for the purpose of education and dissemination of new materials, tools and standards.
- Providing information to members in the threshold languages.

1. Severity Levels

The Quality Improvement Department has adopted a system of severity levels to be assigned to PQI cases as reviewed by QI nurses and the QI Medical Director and actual quality of care and service issues. Any severity level that reveals a borderline quality of care issue, or above, is required to have a corrective action plan developed (refer to the Quality Improvement Policy and Procedure for Severity Levels).

2. Corrective Action Plans

The Quality Improvement Department when conducting any activity that reveals any opportunity for improvement will have a corrective action plan developed. The corrective action plans can be developed from issues arising from but not limited to:

- Member/Practitioner satisfaction surveys
- Access to care audits
- Availability studies
- Potential or actual quality of care issues
- Grievances focused review studies

3. Dissemination of Information

All Quality Improvement activities are presented and reviewed by the Medical Services Committee. Communication to the Medical Services Committee may include but is not limited to:

- Member grievance statistics and trends
- Sentinel events
- HEDIS Summary
- Access to Care (Appointment Availability, After Hours & Ancillary)
- CAHPS Summary
- Study outcomes (Geo Access Distance and Language)
- Policies and Procedures
- Medical record and facility audit reports and trends
- Delegation audit results
- Satisfaction survey results
- Utilization Management referral statistics and trends
- Quality Improvement activities
- Quality Improvement Program, Work Plan, Annual Evaluation and Quarterly Reports
- Regulatory and legislative information

Results of Quality Improvement activities are communicated to Practitioners in the most appropriate manner, including but not limited to:

- Correspondence with the Practitioner showing individual results and a comparison to the group
- Correspondence with the IPA/PMGs showing results and comparisons to the net-work
- Newsletter articles
- Fax updates
- Provider Manual updates

The Quality Improvement Program description is made available to all practitioners and members. Members and Practitioners are notified of the availability of the Quality Improvement Program through the Member Handbook and Provider Manual, respectively.

H. Language Services

Effective July 1, 2008, Care1st completed the required filing for SB 853 that demonstrates compliance with DMHC Title 28, Section 1300.67.04 Language Assistance Programs. The QI Program will provide its written Language Assistance Program policies and procedures. For specific details on the Language Assistance requirements, please refer to the C & L policies and procedures.

I. Quality Outreach Program

The Quality Outreach Program will have the responsibility of reaching out to practitioners and their office staff by a site visit that provides intensive education and incentives. In addition, practitioners can obtain the Quality Outreach Program tools/information via the recently implemented Provider Portal. The Quality Outreach Program was implemented to make change at the “point of care” and ensure members received required annual services.

A key component of the Quality Outreach Program is to develop strong and collaborative relationships with Practitioners and office staff through the outreach efforts. In addition, through this educational mechanism staff will emphasize compliance as it relates to Healthcare Effectiveness Data and Information Set (HEDIS) Measures and the completion of encounter forms; improve patient care, and overall improvement of medical record documentation practices.

As part of the Quality Outreach Program, staff will routinely visit the office site offering intensive education in the following areas:

1. Provider Portal Orientation
2. Healthcare Effectiveness Data and Information Set (HEDIS).
3. Improving documentation practices.
4. Providing tools that focus practitioners’ office on specific members requiring services and the use of HEDIS specific encounter forms.
5. Suggestions and assistance in the development of office processes that limit the possibility of these services being missed.
6. Identify opportunities to limit barriers between the physician and the health plan.
7. Clinical care resources such as Disease Management Programs and how to refer patients.
8. Collaborate on the collection of important diagnosis and service information to limit the intrusion on the physician office.
9. Inform the physician that you are the resource to get questions answered and issues resolved quickly.
10. Work toward improvement in access to care for our members.
11. Offer practice management suggestion that would limit barriers to care.
12. Look for opportunities to free up physician time so additional time can be spent with the patient.
13. Provide in-service reminders that will be placed on the member’s medical record (i.e., on the next visit this member needs a Mammogram and Colorectal Cancer Screening completed).

Physician and Office Staff Incentives

As a part of the QI Outreach process, participating practitioners will be offered incentives to complete specific HEDIS related services. The provider’s office staff will earn small incentives, such as movie tickets, food and gift cards for using the web portal, filing medical record HEDIS reminders and contacting member to schedule them for specific services.

Quality Outreach Tool-Kit consists of:

Physician Profile Report	The report details their specific rates compared to their peers (i.e., pediatricians are compared to pediatricians), national benchmarks and health plan’s overall rates.
Member Listing	Physicians are supplied a listing of their assigned members that based on administrative data, have not obtained the required services.
Health Risk Assessment	This Progress Note Form contains a complete comprehensive Risk, functional, pain and health history assessment, including meeting several other HEDIS related components. Providers are offered incentives for completing these assessments on our Medicare members.

The Quality Outreach Program sustainability is attributed to the following two factors:

- Ensuring that Providers understand the requirements.
- The better the office understands the measures, the higher the probability to reach an improvement over time Outreach Staff become an additional resource to practitioner’s offices.

Provider Web Portal

In 2010, our web based Provider Portal was implemented and contains the essential Quality Outreach Program tools which are available to practitioners. By integrating the tools electronically for practitioners to use that include: Physician Profile Report, Assigned Members Listing, Member and other tools; these will improve data collection from provider offices. Due to new requirements by NCQA pertaining to encounter data, Care1st has revised our web site.

With the Provider Portal implementation, we have eliminated hard copy encounter forms which has increased the turnaround time, further streamlined the internal clinical review, HEDIS record/data collection process and practitioner payment process. Please refer to the Provider Portal/QI Data Information Exchange Policy.

The Quality Outreach Program sustainability is attributed to the following two factors:

- Ensuring that Providers understand the requirements. The better the office understand the measures, the higher the probability to reach an improvement over time.
- Outreach Staff become a permanent resource to practitioner’s offices.

J. Care1st Pay For Performance Program

A new Quality Incentive Bonus Grant program was planned to be implemented in 2015. The new program created a bonus program based on how well each IPA/MG’s measured rates for 6 HEDIS measures compared with their peers and how they compared with the county wide rates.

K. Serving Members with Complex Needs

The Complex Case Management Program Description outlines the organization’s approach to address members with complex needs. Members with complex needs can include individuals with physical or developmental disabilities, multiple chronic conditions and severe mental illness.

L. Seniors and Persons with Disabilities (SPD)

As a result of the Seniors and Persons with Disabilities (SPD) Act, effective June 2011, which is a federal waiver granted under Section 1115(a) of the Social Security Act which permits mandatory enrollment of Medi-Cal only Seniors and Persons with Disabilities into Medi-Cal managed care. The purpose is so that the “waiver” allows DHCS to achieve care coordination, better manage chronic conditions, and improve health outcomes for the SPD population via contacted health plans.

As part of the quality improvement process, the QI department will analyze HEDIS performance measures applicable to the SPD population to evaluate if there are needed interventions.

M. Under and Over-Utilization

As part of the Quality Improvement process, the QI Department will monitor Under and Over Utilization through HEDIS Use of Services measures that include but not limited to:

- Frequency of Selected Procedures: back surgery, bariatric weight loss surgery, lumpectomy, and mastectomy
- Inpatient Utilization: General Hospital/Acute Care - utilization of acute inpatient services in categories
- Ambulatory Care: Includes outpatient visits and emergency department visits

N. Behavioral Health Program

Care1st Health Plan is contracted with Managed Behavioral Healthcare Organizations (MBHOs) that have a comprehensive Behavioral Health Program (BHP). The MBHOs are fully delegated to coordinate and administer Care1st behavioral health benefits.

Behavioral Health Program for the Medi-Cal Population

Effective 1/1/2014, the following behavioral health services for members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder have been integrated into Medi-Cal Managed Care:

- Individual/group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Psychiatric consultation for medication management
- Outpatient laboratory, supplies and supplements
- Screening and Brief Intervention and Referral to Treatment (SBIRT) for alcohol misuse
- Drugs, excluding anti-psychotic drugs (which are covered by Medi-Cal FFS)

Care1st’s MBHO’s Behavioral Health (BH) Director’s responsibilities:

Care1st’s BH Director is a doctoral-level behavioral healthcare practitioner involved in all the behavioral health aspects of the QI and UM Programs and is responsible for, but not limited to, the following functions:

- Ensuring that the process by which the MBHO reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of behavioral health services to enrollees, complies with the requirements in State Federal regulatory and accrediting entities, as they apply to LOB.
- Providing substantial involvement in MBHO’s QI and UM Program operations through significant time devoted to UM activities, clinical oversight, and guidance to QI staff.
- Providing substantial involvement in Care1st’s Medical Services Committee and other sub-committees through collaboration with MBHO’s Behavioral Health Director. .
- Establishing QI and UM policies and procedures relating to behavioral healthcare
- Participating in activities related to continuity and coordination of care between medical and BH practitioners

11. EFFECTIVENESS OF THE QUALITY IMPROVEMENT PROGRAM

A. Quality Improvement Work Plans

A Quality Improvement Work Plan is developed annually outlining Quality Improvement activities for the year. The Work Plan will include all activities not completed during the previous year, unless identified in the Annual Evaluation as issues that are no longer relevant or feasible to pursue. The Work Plan is reviewed by the Chief Medical Officer and QI Medical Director and submitted to the Medical Services Committee and Board of Directors for review and comment.

The Quality Improvement Work Plan is a fluid document and is revised, as needed, to meet changing priorities, regulatory requirements and identified areas for improvement.

B. Quarterly Reports

Quarterly reports are an evaluation of the progress of the Quality Improvement activities, as outlined in the Work Plan, and are submitted to the Medical Services Committee and Board of Directors for review and comment each quarter.

C. Annual Plan Evaluation

Quality Improvement activities, as defined by the Quality Improvement Work Plan, will be annually evaluated to measure the Plan's performance for the year and to assist in revising the Quality Improvement Program and preparing the following year's Work Plan. The Evaluations are reviewed by the Chief Medical Officer and QI Medical Director submitted to the Medical Services Committee and Board of Directors for review and approval.

12. RESOURCES, QI PERSONNEL AND INTERDEPARTMENTAL INTERFACE

A. Pharmacy Department

The Pharmacy Department and Quality Improvement Department work collaboratively on disease management and study projects. The Pharmacy Department supports the process of obtaining grants and conducting pharmacy reports.

B. Utilization Management Department

The Utilization Management and Quality Improvement Departments are part of the Medical Services Department. The Utilization Management Department frequently identifies potential risk management and quality of care issues and health education needs through case management, inpatient review, utilization review, referrals, etc. The Quality Improvement Department can refer cases to the Utilization Management Department for active Case Management of members with identified chronic conditions.

C. Member Services Department

When a Member Services representative identifies a potential quality of care issue from a member's call, it is forwarded to the Quality Improvement Department for investigation and resolution. The Member Services Department records all incoming calls by specific indicators for tracking, trending and reporting.

D. Credentialing Department

The Credentialing Department is part of the Quality Improvement Department. Quality Improvement information is provided to the Credentialing Department for inclusion in the Credentialing/recredentialing process. The Quality Improvement Department provides the Credentialing Department with Facility Site Review and Medical Record audit scores and any sanction activity related to those reviews and with identified QCIs, as appropriate. The Quality Improvement Manager works with the Credentialing Department to take peer review cases, as directed by the Chief Medical Officer, to the Peer Review Committee for review and action.

E. Provider Relations/Contracting Department

The Provider Relations/Contracting Department assists the Quality Improvement Department in obtaining Quality Improvement information from and disseminating information to practitioners. In addition, the Provider Relations/Contracting Department:

- Serves as a liaison between the Quality Improvement Department and Practitioners to facilitate education and compliance with approved Care1st standards.
- Schedules Joint Operating Committee meetings.
- Serves as a liaison with delegated IPA/PMGs.
- Assists the Quality Improvement Department with Practitioners who do not comply with requests from the Quality Improvement Department.
- Ensures contracted ancillary providers and facilities meet regulatory and accreditation requirements.

F. Health Education Department

The goal of the Health Education Program is to improve the health status of members and to educate Practitioners and Providers in a variety of modalities to help them educate their patients. Education modalities may include preventive health literature, educational classes and wellness programs. (Refer to the Health Education Program and Policies and Procedures).

The Health Education Department and Quality Improvement Department work together on projects related to Practitioner and member education. The Health Education Department is part of the Medical Services Department. Educational opportunities identified through grievances, quality of care issues, facility site review audits, focused review studies, etc., are forwarded to the Health Education Department. The Quality Improvement Department also works with the Health Education Department on preventive service guidelines, 120-Day Initial Health Assessment and Staying Healthy Assessment compliance.

G. Claims Department

The Quality Improvement Department utilizes claims data to identify potential quality of care issues and sentinel diagnosis. The Quality Improvement Department is able to obtain certain medical records from the Claims Department as available.

H. Cultural and Linguistic Department

The Quality Improvement Department utilizes the Health Education and C&L Department to review materials for reading level and cultural appropriateness before submitting to members. Additionally, C&L coordinates the process of sending materials to qualified vendors for translation. All materials must be approved by CMS prior to utilization. The C&L Department uses QI to analyze studies and identify any areas for improvement by using cultural and linguistic breakdowns. In addition, the C & L Department has objectives for serving a culturally and linguistically diverse population.

I. Appeals and Grievances:

The QI department utilizes data from the appeals and grievances databases to analyze for patterns of complaints and problems being reported by members. These analyses are done the A&G Division that is part of the QI department. The A&G division works with other departments to resolve grievances and appeals and for preventing reoccurrences.

13. POLICIES AND PROCEDURES

Quality Improvement

- 10.1.1.2 Reporting to LA Care
- 70.1.1.1 Confidentiality of QI Information
- 70.1.1.3 Internal Quality Improvement Projects (IQIP's)
- 70.1.1.5 Assigning a Quality Improvement Severity Level
- 70.1.1.7 Clinical Grievance Process
- 70.1.1.8 Access to Care Standards and Monitoring Process
- 90.1.1.8 Access to Care Standards and Monitoring Process
- 70.1.1.9 Potential Quality of Care and Quality of Care issues
- 70.1.1.10 Peer Review
- 70.1.1.11 Sentinel Events
- 90.1.1.11 Sentinel Events
- 70.1.1.12 Practitioner Request to Terminate Patient/Practitioner Relationship
- 70.1.1.14 Initial Health Assessment – IHEBA's
- 70.1.1.22 Confidentiality and Release of Patient Medical Information
- 70.1.1.24 Medical Record Keeping
- 70.1.1.25 Member Satisfaction Survey – CAHPS and ProActive CAHPS
- 90.1.1.25 Member Satisfaction Survey – CAHPS and ProActive CAHPS
- 70.1.1.26 Practitioner Satisfaction Survey
- 70.1.1.28 Cultural and Linguistic in QI
- 70.1.1.29 Availability of Practitioners (PCP, SPEC, Hospitals & Ancillary)
- 70.1.1.30 Continuity and Coordination of Care
- 70.1.1.31 Over and Under Utilization
- 90.1.1.38 Availability of Specialty Care Practitioners
- 70.1.1.44 Reporting Diseases and Conditions to Public Health Agencies
- 70.1.1.45 Dissemination of QI Activities and Outcomes to Network Practitioners
- 70.1.1.49 Patient Safety Program
- 80.1.1.50 Interactive Voice Response (IVR) System
- 70.1.1.51 QI Outreach Program
- 70.1.1.52 Over and Under Utilization of Specific Services
- 90.1.1.52 Over and Under Utilization of Specific Services
- 50.1.1.55 Reporting to CMS
- 90.1.1.55 Reporting to CMS
- 80.1.1.56 Reporting to DHCS
- 70.1.1.57 Grievance Tracking Process
- 70.1.1.58 Provider Portal Data/QI Data Information Exchange
- 70.1.1.59 Continuity and Coordination between Medical and Behavioral Health Care
- 90.1.1.59 Continuity and Coordination between Medical and Behavioral Health Care
- 50.1.1.60 CMS Chronic Care Improvement Program (Clinical Initiative)
- 50.1.1.61 CMS Quality Improvement Project (QIP)
- 90.1.1.63 Community Based Adult Services (CBAS) and LTSS Quality Monitoring

HEDIS

- 70.1.2.1 HEDIS Studies and QISMC Studies Reporting
- 90.1.2.1 HEDIS Studies and QISMC Studies Reporting
- 70.1.2.2 HEDIS Medical Record Abstraction Process
- 70.1.2.3 HEDIS Oversight Audit Process
- 90.1.2.3 HEDIS Oversight Audit Process
- 70.1.2.4 HEDIS Reporting and Dissemination of Results
- 70.1.2.5 HEDIS Corrective Actions and Interventions
- 90.1.2.5 HEDIS Corrective Actions and Interventions
- 70.1.2.6 Internal HEDIS Tracking Database and Collection Process
- 70.1.2.7 Healthy Start Program
- 70.1.2.8 HEDIS Provider Incentive

Credentialing

- 70.1.3.1 Credentialing Committee
- 70.1.3.2 Minimum Credentialing Criteria for Practitioners
- 90.1.3.2 Minimum Credentialing Criteria for Practitioners
- 70.1.3.3 Credentialing Verification
- 90.1.3.3 Credentialing Verification
- 70.1.3.4 Re-Credentialing Cycle Length
- 90.1.3.4 Re-Credentialing Cycle Length
- 70.1.3.5 Sanction Review
- 90.1.3.5 Sanction Review
- 70.1.3.7 Adverse Events
- 70.1.3.8 Practitioner Rights
- 70.1.3.9 Confidentiality of Credentials Information
- 70.1.3.10 Fair Hearing Plan
- 90.1.3.10 Fair Hearing Plan
- 70.1.3.11 Non-Physician Medical Practitioner Initial Credentialing
- 90.1.3.11 Non-Physician Medical Practitioner Initial Credentialing
- 70.1.3.12 Non-Physician Medical Practitioner Re-Credentialing
- 70.1.3.13 Credentialing Policies
- 90.1.3.13 Credentialing Policies
- 70.1.3.14 Delegation of Credentialing
- 90.1.3.14 Delegation of Credentialing
- 70.1.3.15 PCP Practice Requirements
- 70.1.3.16 Chief Medical Officer's Responsibilities for Credentialing
- 70.1.3.17 Reporting Sanction Activity to State and Federal Agencies
- 90.1.3.17 Reporting Sanction Activity to State and Federal Agencies
- 70.1.3.18 Credentialing of Health Delivery Organizational Providers
- 90.1.3.18 Credentialing of Health Delivery Organizational Providers
- 70.1.3.19 Provider Database Modification Changes
- 70.1.3.20 HIV Specialist Credentialing Criteria
- 90.1.3.20 HIV Specialist Credentialing Criteria
- 70.1.3.21 Guidelines for Physicians Supervising Non-Physician Medical Practitioners
- 90.1.3.21 Guidelines for Physicians Supervising Non-Physician Medical Practitioners
- 50.1.3.22 Medicare Opt-Out Practitioners
- 90.1.3.22 Medicare Opt-Out Practitioners
- 70.1.3.23 Mid Cycle License and Expired Documents
- 70.1.3.24 LOA Credentialing Process

Facility Site Review

- 70.1.4.1 Facility Site Review/Medical Record Review Process
- 70.1.4.2 Facility Site Review/Medical Record Review Auditor Training
- 70.1.4.3 Facility Site Review/ Primary Care Physician Access Requirements
- 70.1.4.4 Full Scope FSR Corrective Action Plan
- 70.1.4.5 FSR/ Reviewer Certification & Inter-Rater Reliability
- 70.1.4.6 FSR/Medical Record Review Score Notification to L.A. Care
- 70.1.4.7 FSR /Medical Record Review & Physical Access Review Practitioner Feedback Process
- 70.1.4.8 FSR Survey Health Plans Collaborative Process
- 80.1.4.9 Scoring/Facility & Medical Record Review Collaborative Process
- 80.1.4.10 Consolidated Medical Record Review Process
- 70.1.4.11 FSR Interim Review of Facility and Medical Records
- 70.1.4.12 Member Complaint-Focused Site Review
- 50.1.4.14 Facility Site Review Delegation
- 70.1.4.15 Facility Site Review -Staying Health Assessment Tool
- 90.1.4.16 FSR American Disabilities Act Physical Access Compliance
- 70.1.4.17 FSR Health Care Delivery Organization
- 90.1.4.17 FSR Health Care Delivery Organization

14. APPENDIX

- Appendix A Committee Structure
- Appendix B Meeting Minutes
- Appendix C Quality Improvement Calendar/Work Plan (sample)
- Appendix D Quarterly Reports (sample)