Inland Empire Health Plan

Quality Management Program Description

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Introduction

IEHP supports an active, ongoing and comprehensive Quality Management (QM) Program with the primary goal of continuously monitoring and improving the quality of care, access to care, patient safety, and quality of services delivered to IEHP Members. The QM Program provides a formal process to systematically monitor and objectively evaluate, track and trend the health plan's quality, efficiency and effectiveness. IEHP is committed to assessing and continuously improving the care and service delivered to Members. IEHP has created a systematic, integrated approach to planning, designing, measuring, assessing, and improving the quality of care and services provided to Members. This comprehensive delivery system includes patient safety, behavioral health, care management, culturally and linguistically appropriate services, and coordination of care. These initiatives are aligned with IEHP's mission and vision.

Mission and Vision

The mission of IEHP is to organize and improve the delivery of quality, accessible and wellness-based healthcare services for our community. The organization prides itself in five (5) core values:

- *Health and Quality before Costs:* We believe in placing Member's health care needs above all else.
- *Team Culture:* We are a dedicated and cohesive team focused on Member care and supporting our Providers.
- *Think and Work LEAN:* We strive to continuously improve our daily operations and delivery of health care services.
- *Partner with Providers:* We recognize the necessity of a strong working relationship with our providers based on mutual respect and collaboration.
- *Stewardship of Public Funds:* We are accountable to the public and strive for transparency and prudent fiscal management.

Section 1: QM Program Overview

1.1 QM Program Purpose

The purpose of the QM Program is to provide operational direction necessary to monitor and evaluate the quality and appropriateness of care, identify opportunities for clinical, patient safety, and service improvements, ensure resolution of identified problems, and measure and monitor intervention results over time to assess any needs for new improvement strategies. The purpose of the QM Program Description is to provide a written outline of quality improvement goals, objectives, and structure. IEHP will utilize this document for oversight, monitoring, and evaluation of Quality Management activities to ensure the QM Program is operating in accordance with standards and processes as defined in this Program Description.

1.2 QM Program Scope

The Quality Management Committee approves the QM Program annually. This includes review and approval of the QM Program Description, QM Work Plan, and QM Annual Evaluation to ensure ongoing performance improvement. The QM Program is designed to improve all aspects of care delivered to IEHP Members in all health care settings by:

1. Defining the Program structure;
2. Assessing and monitoring the delivery and safety of care;
3. Assessing and monitoring behavioral health services, care management and disease management programs provided to Members;
4. Supporting Practitioners and providers to improve the safety of their practices;
5. The QM Committee's oversight of IEHP QM functions;
6. Involvement of designated physician(s) in the QM Program;
7. Involvement of a behavioral healthcare Practitioner in the behavioral aspects of the Program;
8. Identifying opportunities for quality improvement initiatives;
9. Implementing and tracking quality improvement initiatives that will have the greatest impact on Members;
10. Measuring the effectiveness of interventions and using the results for future quality improvement planning;
11. Establishing specific role, structure and function of the QM Committee and other committees, including meeting frequency;
12. Reviewing resources devoted to the QM Program;
13. Assessing and monitoring delivery and safety of care for Members with complex health needs and Seniors and Persons with Disabilities; and
14. Assessing and monitoring processes to ensure the Member's cultural and linguistic needs are being met.

1.3 QM Program Goals:

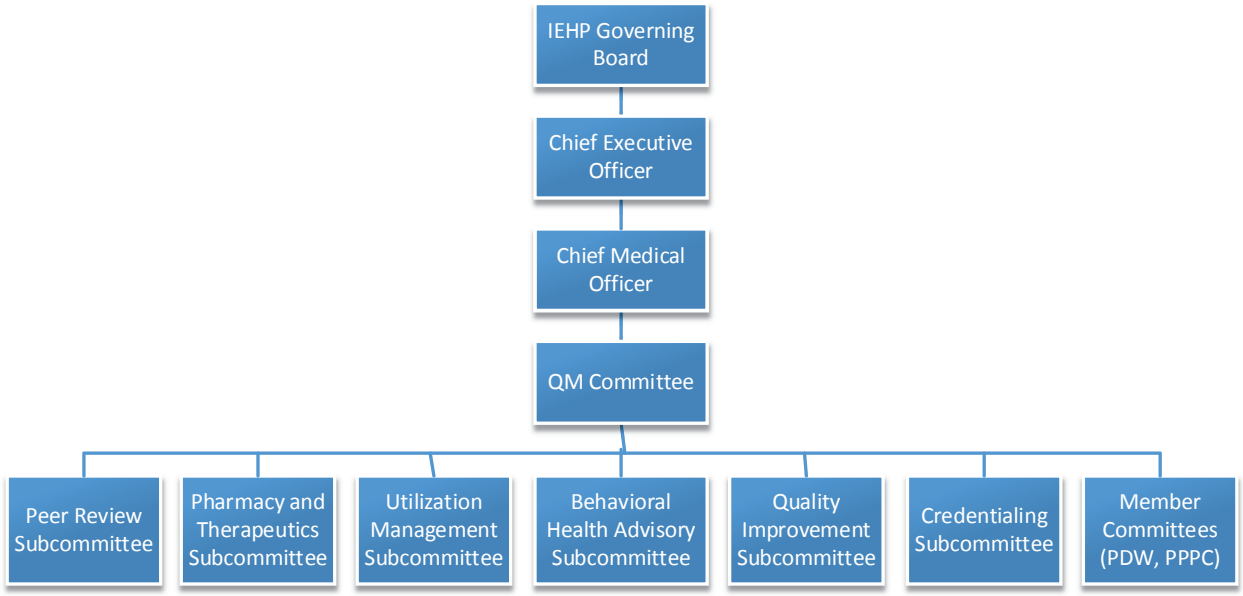
The primary goal of the QM Program is to continuously monitor and improve the quality of care, services, and safety of clinical care delivered to IEHP Members. The overall program goals are to:

1. Improve quality of care, improve Member satisfaction, and reduce cost.
2. Identify clinical and service-related quality and patient safety issues, and develop and implement improvement plans as needed;
3. Share the results of the initiatives to stimulate awareness and change;
4. Empower all staff to identify quality improvement opportunities and work collaboratively to implement changes that improve the quality of all IEHP programs;
5. Implement quality programs designed to improve targeted health conditions;

6. Identify quality improvement opportunities through internal and external audits, Member and Practitioner feedback, and the evaluation of Member grievances and appeals;
7. Monitor over-utilization and under-utilization and access to assure appropriate care;
8. Utilize accurate quality improvement data to ensure program integrity; and
9. Annually review the effectiveness of the QM Program and utilize the results to plan future initiatives.

Section 2: Authority and Responsibility

The QM Program includes tiered levels of authority, accountability, and responsibility related to quality of care and services provided to Members. The line of authority originates from the Governing Board and extends to Practitioners through a number of different subcommittees. Further details can be found in the IEHP organizational chart.



2.1 IEHP Governing Board

IEHP was created as a public entity as a result of a Joint Powers Agency (JPA) agreement between Riverside and San Bernardino Counties to serve eligible residents of both counties. Two (2) Members from each County Board of Supervisors and three (3) public Members selected from the two (2) counties sit on the Governing Board.. The Governing Board is responsible for oversight of health care delivered by contracted Providers and Practitioners. The Board provides direction for the QM Program; evaluates QM Program effectiveness and progress; and evaluates and approves the annual QM Program Description and Work Plan. The QM Committee reports delineating actions taken and improvements made are reported to the Board through the Chief Medical Officer.

The Board delegates' responsibility for monitoring the quality of health care delivered to Members to the Chief Medical Officer and the QM Committee with administrative processes and direction for the overall QM Program initiated through the Chief Medical Officer or Medical Director designee.

2.2. Role of the Chief Executive Officer (CEO)

Appointed by the Governing Board, the CEO has the overall responsibility for IEHP management and viability. Responsibilities include but are not limited to: IEHP direction, organization and operation; developing strategies for each Department including the QM Program; position appointments; fiscal efficiency; public relations; governmental and community liaison; and contract approval. The CEO reports to the Governing Board and is an ex-officio Member of all standing Committees. The CEO interacts with the Chief Medical Officer regarding ongoing QM Program activities, progress toward goals, and identified health care problems or quality issues requiring corrective action.

2.3 Role of the Chief Medical Officer (CMO)

The Chief Medical Officer (CMO) has ultimate responsibility for the quality of care and services delivered to Members, and has the highest level of oversight for IEHP's QM Program. The CMO must possess a valid Physician's and Surgeon's Certificate issued by the State of California and certification by one of the American Specialty Boards. The Chief Medical Officer reports to the CEO and Governing Board. As a Participant of various Subcommittees, the CMO provides direction for internal and external QM Program functions and supervision of IEHP staff.

The CMO participates in quality activities as necessary; provides oversight of IEHP delegated credentialing and re-credentialing activities and approval of IEHP requirements for IEHP Direct Practitioners; reviews credentialed Practitioners for potential or suspected quality of care deficiencies; provides oversight of coordination and continuity of care activities for Members; oversight of patient safety activities; and incorporates quality outcomes into operational policies and procedures on a proactive basis.

The CMO or Medical Director designee, provides direction to the QM Committee and associated Subcommittees; provides assistance with study development; and facilitates coordination of the QM Program in all areas to provide continued delivery of quality health care for Members. The CMO assists the Chief Network Officer with provider network development, contract design, and product design. In addition, the CMO works with the Chief Financial Officer to ensure that financial considerations do not influence the quality of health care administered to Members.

The CMO acts as primary liaison to regulatory and oversight agencies including, but not limited to, the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Centers for Medicare and Medicaid Services (CMS), and the National Committee for Quality Assurance (NCQA), with support from Medical Services staff as necessary.

2.4 The Quality Management (QM) Committee

The QM Committee reports to the Governing Board and retains oversight of the QM Program with direction from the Chief Medical Officer. The QM Committee promulgates the quality improvement process to participating groups and physicians, Providers, Subcommittees, and internal IEHP functional areas with oversight by the Chief Medical Officer.

1. **QM Committee Structure:** Network Practitioners, Specialists, and Medical Directors are voting members of the QM Committee and related Subcommittees. These individuals provide expertise and assistance in directing the QM Program activities.

2. **Role**: The QM Committee is responsible for continuously improving the quality of care for IEHP Membership.

3. **Structure:** The QM Committee is composed of IPA Medical Directors who are representative of network Practitioners. Practicing Pharmacists and Public Health Department Representatives from Riverside and San Bernardino Counties may also be in attendance. A designated Behavioral Healthcare Practitioner is an active Member of the IEHP QM Committee to assist with behavioral healthcare related issues. IEHP attendees include multi-disciplinary representation from multiple IEHP Departments including but not limited to:

    a. Quality Management;

    b. Utilization Management;

    c. Care Management;

    d. Pharmaceutical Services;

    e. Behavioral Health;

    f. Member Services;

    g. Health Administration;

    h. Health Education;

    i. Grievances and Appeals;

    j. Quality Informatics;

    k. Independent Living and Diversity Services;

    l. Compliance; and

    m. Provider Services.

4. **Function**: The QM Committee meets quarterly and reports findings, actions, and recommendations to the IEHP Governing Board annually. The QM Committee seeks methods to increase the quality of health care for the served population; recommends policy decisions; analyzes and evaluates QI activity results; institutes and directs needed actions; and ensures follow-up as appropriate. The Committee provides oversight and direction for Subcommittees, related programs, activities, and reviews and approves Subcommittee recommendations, findings, and provides direction as applicable. Committee findings and recommendations are reported through the Chief Medical Officer to the IEHP Governing Board on an annual basis.

5. **Quorum**: Voting cannot occur unless there is a quorum of voting Members present. For decision purposes, a quorum can be composed of one (1) of the following:

    a. The Chairperson or IEHP Medical Director and two (2) appointed Committee Members.

b. A Behavioral Health Practitioner must be present for behavioral health issues. Non-physician Committee Members may not vote on medical issues.

6. **External Committee Members:** QM Committee members must be screened to ensure they are not active on either the Office of Inspector General (OIG) or General Services Administration (GSA) exclusion lists.

   a. Per the guidance laid out in Chapters 9 and 21 of the Medicare Managed Care Manual (50.5.8 – OIG/GSA Exclusion), "Medicare payments may not be made for items or services furnished or prescribed by an excluded provider or entity".

      1) IEHP utilizes the OIG Compliance Now (OIGCN) vendor conducts the screening of covered entities on behalf of IEHP.

      2) In the event that any member of the QM Committee, or prospective member, is found to be excluded per OIGCN, the Compliance Department will notify the QM department so that they may take immediate action.

   b. QM Committee members must be screened before being confirmed and on a monthly basis, thereafter.

   c. The Compliance department and QM department collaborate to ensure committee members undergo an OIG/GSA exclusion screening prior to scheduled QM committee meetings.

   d. QM notifies the Compliance department of any membership changes in advance of the QM Committee meeting so that a screening can be conducted prior to the changes taking effect.

7. **Confidentiality:** All QM Committee minutes, reports, recommendations, memoranda, and documented actions are considered quality assessment working documents and are kept confidential. IEHP complies with all DHCS and HIPAA regulatory requirements for confidentiality. All records are maintained in a manner that preserves the integrity in order to assure Member and Practitioner confidentiality is protected.

   a. All members, participating staff, and guests of the QM Committee and Subcommittees are required to sign the Committee/Subcommittee Attendance Record, including a statement regarding confidentiality.

   b. The confidentiality agreements are maintained in the practitioner files as appropriate.

   c. All IEHP staff members are required to sign a confidentiality agreement upon hiring. The confidentiality agreements are maintained in the employee files as appropriate.

   d. All peer review records, proceedings, reports, and Member records are maintained in a confidential manner in accordance with state, federal and regulatory requirements to ensure confidentiality.

   e. IEHP maintains oversight of Provider and practitioner confidentiality procedures.

1) IEHP has established and distributed confidentiality standards to contracted Providers and practitioners in the IEHP Provider Policy and Procedure Manual.

2) All Provider and practitioner contracts include the provision to safeguard the confidentiality of Members' medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and federal laws.

3) As a condition of participation in the IEHP network, all contracted Providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of Members to their practitioners.

4) IEHP monitors contracted Providers and practitioners for compliance with IEHP's confidentiality standards during Delegation Oversight Annual Audits and practitioner Site and Medical Records Reviews.

8. **Enforcement/Compliance:** The QM Department is responsible for monitoring and oversight of the QM Program including enforcement of compliance with IEHP standards and required activities. Activities can be found in sections of manuals related to the specific monitoring activity. The general process for obtaining compliance when deficiencies are noted, and CAPs are requested, is delineated in internal policies.

9. **Data Sources and Support:** The QM Program utilizes an extensive data system that captures information from claims and encounter data, enrollment data, Utilization Management (UM) and QM activities, pharmaceutical data, grievances and appeals, and Member Services, among others.

10. **Affirmation Statement**: The QM Program assures that utilization decisions made for IEHP Members are based solely on medical necessity. IEHP does not compensate or offer financial incentives to Practitioners or individuals for denials of coverage or service or any other decisions about Member care. IEHP does not exert economic pressure to Practitioners or individuals to grant privileges that would not otherwise be granted or to practice beyond their scope of training or experience.

11. **Availability of QM Program Information**: Member and Practitioner Information on QM Program Activities – IEHP has developed an overview of the QM Program and related activities. This overview is on the IEHP web site at www.iehp.org and a paper copy is available to all Members and/or Practitioners upon request by calling IEHP Member Services Department. Members are notified of the availability through the Member Handbook. Practitioners are notified in the Provider Manual. The IEHP QM Program Description and Work Plan are available to IPAs and Practitioners upon request. A summary of QM activities and progress toward meeting QM goals is available to Members, Providers, and Practitioners upon request.

12. **Conflict of Interest**: IEHP monitors IPAs for policies and procedures and signed conflict of interest statements at the time of the Delegation Oversight Annual Audit.

2.5 QM Subcommittees

Subcommittee and functional reports are submitted on a quarterly and ad hoc basis. The following Subcommittees, chaired by the IEHP Chief Medical Officer or designee, report findings and recommendations to the QM Committee:

1. Quality Improvement Subcommittee;
2. Peer Review Subcommittee;
3. Credentialing Subcommittee;
4. Pharmacy and Therapeutics Subcommittee;
5. Utilization Management Subcommittee; and
6. Behavioral Health Advisory Subcommittee.

2.5.1 Quality Improvement Subcommittee

The Quality Improvement (QI) Subcommittee is responsible for quality improvement activities for IEHP.

1. **Role:** The QI Subcommittee reviews reports and findings of studies before presenting to QM Committee, and works to develop action plans in an effort to improve quality and study results.
2. **Structure:** The QI Subcommittee is composed of representation from multiple IEHP internal Departments including, but not limited to: Quality Management, Care Management, Utilization Management, Compliance, Behavioral Health, Health Administration, Health Education, HealthCare Informatics, Member Services, and Provider Services.
3. **Function**: The QI Subcommittee analyzes and evaluates QI activities and report results; develops action items as needed; and ensures follow-up as appropriate. All action plans are documented on the QI Subcommittee Work Plan.
4. **Frequency of Meetings:** The QI Subcommittee meets every other month with ad hoc meetings conducted as needed.

2.5.2 Peer Review Subcommittee

The Peer Review Subcommittee is responsible for peer review activities for IEHP.

1. **Role:** The Peer Review Subcommittee reviews Provider, Member or Practitioner grievances and/or appeals; Practitioner related quality issues; and other peer review matters. The Subcommittee performs oversight of IPAs who have been delegated credentialing and re-credentialing responsibilities and evaluates the IEHP Credentialing and Re-credentialing Program with recommendations for modification as necessary.
2. **Structure:** The Peer Review Subcommittee is composed of IPA Medical Directors or designated physicians representative of network Practitioners. A behavioral health Practitioner and any other specialist, not represented by committee Members, serve on an ad hoc basis for related issues.
3. **Function**: The Peer Review Subcommittee serves as the committee for clinical quality review of Practitioners; evaluates and makes decisions regarding Member or Practitioner grievances and clinical quality of care cases referred by the CMO or Medical Director

designee.

4. **Frequency of Meetings:** The Peer Review Subcommittee meets every other month with ad hoc meetings as needed.

2.5.3 Credentialing Subcommittee

The Credentialing Subcommittee performs credentialing functions for Practitioners who either directly contract with IEHP or for those submitted for approval of participation in the IEHP network by IPAs that have not been delegated credentialing responsibilities.

1. **Role:** The Credentialing Subcommittee is responsible for reviewing individual Practitioners who directly contract with IEHP and denying or approving their participation in the IEHP network.

2. **Structure:** The Credentialing Subcommittee is composed of multidisciplinary participating primary care physicians or specialty physician representative of network Practitioners. A Behavioral Health Practitioner, and any other specialist not represented by committee Members, serves on an ad hoc basis for related issues.

3. **Function:** The Credentialing Subcommittee provides thoughtful discussion and consideration of all network Practitioners being credentialed or re-credentialed; reviews Practitioner qualifications including adverse findings; approves or denies continued participation in the network every three years for re-credentialing; and ensures that decisions are non-discriminatory.

4. **Frequency of Meetings:** The Credentialing Subcommittee meets every month with ad hoc meetings conducted as needed.

2.5.4 Pharmacy and Therapeutics (P&T) Subcommittee

The P&T Subcommittee performs ongoing review and modification of the IEHP Formulary and related processes; conducts oversight of the pharmacy network including medication prescribing practices by IEHP Practitioners; assesses usage patterns by Members; and assists with study design, clinical guidelines and other related functions. The Subcommittee is responsible for reviewing and updating clinical practice guidelines that are primarily medication related.

1. **Role**: The P&T Subcommittee is responsible for maintaining a current and effective formulary, monitoring medication prescribing practices by IEHP Practitioners, and under- and over-utilization of medications.

2. **Structure:** The P&T Subcommittee is composed of clinical pharmacists and designated Physicians representative of network Practitioners. A behavioral health Practitioner and any other specialist not represented by committee Members, serve on an ad hoc basis for related issues.

3. **Function**: The P&T Subcommittee serves as the committee to objectively appraise, evaluate, and select pharmaceutical products for formulary inclusion and exclusion. The Subcommittee provides recommendations regarding protocols and procedures for pharmaceutical management and the use of non-formulary medications on an ongoing basis. The Subcommittee ensures that decisions are based only on appropriateness of care and services. The P&T Subcommittee is responsible for developing, reviewing, recommending, and directing the distribution of disease state management or treatment

guidelines for specific diseases or conditions that are primarily medication related.

4. **Frequency of Meetings:** The P&T Subcommittee meets quarterly with ad hoc meetings conducted as needed.

2.5.5 Utilization Management (UM) Subcommittee

The UM Subcommittee performs oversight of UM, activities in all clinical departments conducted by IEHP and delegated IPAs to maintain high quality health care as well as effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services. The Subcommittee reviews UM criteria, new technologies, and new applications of existing technologies for consideration as IEHP benefits and is responsible for reviewing and updating preventive care and clinical practice guidelines that are not primarily medication related.

1. **Role:** The UM Subcommittee directs the continuous monitoring of all aspects of UM, Care Management (CM), Disease Management (DM) and Behavioral Health (BH) administered to Members.

2. **Structure:** The UM Subcommittee is composed of IPA Medical Directors, or designated physicians representative of network Practitioners. A behavioral health physician and any other specialist, not represented by committee Members, may serve on an ad hoc basis for related issues.

3. **Function**: The UM Subcommittee reviews and approves the Utilization Management, Care Management, Disease Management and Behavioral Health Programs annually. The Subcommittee monitors for over-utilization and under-utilization; ensures that UM decisions are based only on appropriateness of care and service; and reviews and updates preventive care and clinical practice guidelines that are not primarily medication related.

4. **Frequency of Meetings:** The UM Subcommittee meets quarterly with ad hoc meetings conducted as needed. Issues that arise prior to the UM Subcommittee that require immediate attention are reviewed by the Medical Director(s) and reported back to the UM Subcommittee at the next scheduled meeting.

2.5.6 Behavioral Health Advisory Subcommittee

The BH Advisory Subcommittee will serve as a multidisciplinary BH specialty advisory committee. The subcommittee will review the UM and Quality Improvement (QI) activities and reports for BH services as well as review and approval of BH clinical criteria, BH clinical guidelines, new BH technology and treatment innovations.

1. **Role:** The BH Advisory Subcommittee directs the continuous monitoring of all aspects of BH services administered to Members.

2. **Structure**: The BH Advisory Subcommittee is composed of licensed clinicians from IEHP's BH network and contracted consulting clinicians.

3. **Function**: The BH Advisory Subcommittee reviews and approves the Behavioral Health Program annually. The Subcommittee monitors for over-utilization and under-utilization; ensures that BH decisions are based only on appropriateness of care and service; and reviews and updates preventive care and clinical practice guidelines.

4. **Frequency of Meetings:** The BH advisory Subcommittee meets quarterly with ad hoc meetings conducted as needed.

2.6 QM Support Committees/Workgroups

IEHP also has Committees and/or Workgroups that are designed to provide structural input from providers and Members. These Committees and Workgroups report directly through the Quality Management Committee, Compliance Committee or through the CEO to the Governing Board. Any potential quality issues that arise from these Committees would be referred to the QM Committee by attending staff. The Committees and Workgroups include:

1. Provider Advisory Councils (PAC)
2. Public Policy Participation Committee (PPPC)
3. Persons with Disabilities Workgroup (PDW)
4. Nurse Advice Line (NAL) Steering Committee
5. Delegation Oversight Committee
6. Compliance Committee
7. Grievance & Appeals Trend Review Committee (GATRC)

2.6.1 Provider Advisory Councils (PAC)

The PAC was established to provide a forum for Providers and Practitioners to give input and advice on relevant IEHP policies and programs. Based on input from the PAC, the CEO makes recommendations on relevant IEHP policies and programs that may impact Providers and Practitioners.. The PAC meets every other month prior to an IEHP Governing Board Meeting.

2.6.2 Public Policy Participation Committee (PPPC)

The PPPC is a standing Member committee with the majority of Members drawn from IEHP Membership. The PPPC provides a forum to review and comment on operational issues that could impact Member quality of care including, but not limited to, new programs, Member information, access, cultural and linguistic, and Member Services. The PPPC meets quarterly with ad hoc meetings conducted as needed.

2.6.3 Persons with Disabilities Workgroup (PDW)

The PDW is an ad-hoc Member workgroup made up of IEHP Members with disabilities and Members from community based organizations that provide recommendations on provisions of health care services, educational priorities, communication needs, and the coordination of and access to services for Members with disabilities. The PDW meets at least quarterly.

2.6.4 Nurse Advice Line (NAL) Steering Committee

The NAL Steering Committee is an internal committee responsible for making recommendations and reporting oversight activities to IEHP's UM Subcommittee. The NAL Steering Committee provides advice to the Director of Health Administration in support of day-to-day management of the IEHP/NAL contract. The committee reviews NAL utilization and performance reports on a monthly basis. The NAL Steering Committee meets quarterly.

2.6.6 Delegation Oversight Committee

The Delegation Oversight Committee is an internal committee that monitors the operational activities of contracted IPAs and other delegate's activities including Claims Audits, Pre-Service and Payment universe metrics, Financial Viability, Electronic Data Interchange (EDI) transactions, Care Management, Utilization Management, Grievances and Appeals, Quality Management, Credentialing/Re-credentialing activities, and other provider-related issues. The committee provides oversight necessary to monitor and evaluate the operational activities of contracted IPAs and Delegates. The Delegation Oversight Committee reports directly to the Compliance Committee. The Delegation Oversight Committee meets on a bi-monthly basis.

2.6.7 Compliance Committee

The Compliance Committee oversees the organizational Compliance Program, which includes compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and subsequent updates; the Fraud Waste and Abuse (FWA) Program to prevent, detect, investigate, manage, and report incidents of suspected fraud; and ethical considerations including the entity's Code of Conduct. The Compliance Committee oversees all aspects of IEHP's compliance with regulatory bodies. The Compliance Committee is composed of DHCS Medi-Cal fraud investigators and IEHP staff. The Compliance Committee meets at least quarterly with ad hoc meetings conducted as needed.

2.6.8 Grievance & Appeals Trend Review Committee (GATRC)

The Grievance & Appeals Trend Review Committee provides oversight to grievance trends providing the direction necessary to monitor and evaluate grievance-related data. The committee is chaired by the Associate Medical Director and provides guidance in identifying trends and develops action plans to resolve grievance trends and focus on improvement activities. The Committee meets monthly and committee members include representation from Medical Directors, the Chief of Medical Services, QM, Compliance, Provider Services, Member Services, and Grievance and Appeals. The Grievance & Appeals Trend Review Committee meets on a quarterly basis with ad hoc meetings conducted as needed.

Section 3: Organizational Structure and Resources

IEHP has designated internal resources to support, facilitate, and contribute to the QM Program. The Organization Chart provides further details on support staff.

3.1 Clinical Oversight of QM Program

Under the direction of the Chief Medical Officer or Medical Director designee, the Medical Directors are responsible for clinical oversight and management of the QM, UM, BH, and CM Program activities, participating in QM functions and overseeing credentialing functions. The designated Medical Directors must possess a valid Physician's and Surgeon's Certificate issued by the State of California and certification by one of the American Specialty Boards. Principal accountabilities include: developing and implementing medical policy for UM and CM activities and QM functions; reviewing current medical practices ensuring that medical protocols and medical personnel of IEHP follow rules of conduct; ensuring that assigned Members are provided health care services and medical attention at all locations; ensuring that medical care rendered by Practitioners meets applicable professional standards for acceptable medical care and quality that equals or exceeds the standards for medical practice developed by IEHP and approved by DHCS and other regulatory entities; developing and implementing medical policy for utilization activities for the IEHP Direct line of business; overseeing reporting and UM profiling of Direct physicians; and ensuring the appropriate and timely use of UM criteria and guidelines. The Medical Directors actively participate in the QM Program for IEHP and its Practitioners.

3.2 Quality Systems Department

The Quality Systems Department operates under the direction of the Senior Director of Quality Systems. The Senior Director of Quality Systems is responsible for integrating quality resources across multiple units including Quality Management, Quality Informatics, HealthCare Informatics, HealthCare Analytics and Grievance and Appeals. Together, these departments initiate, develop, implement, and report on quality studies, demographic analysis, and other research projects. Areas of accountability include: developing research or methodologies for quality studies; producing detailed criteria and processes for research and studies to ensure accurate and reliable results; designing data collection methodologies or other tools as necessary for research or study activities; implementing research or studies in coordination with other IEHP functional areas; ensuring appropriate collection of data or information; performing analysis, including barrier analysis of results; managing the Quality Systems staff to ensure high productivity and high quality output; and working with other IEHP staff involved in research or study processes.

Staff support for the Senior Director of Quality Systems consists of clinical and/or non-clinical Directors, Managers, Supervisors, Analysts, and administrative staff.

3.3 Quality Management Department

The Quality Management Department operates under the direction of the Senior Director of Quality Systems. Under the direction of the Senior Director of Quality Systems, the he Clinical Director of Quality Programs assists in developing, coordinating, and maintaining the QM Program and its related activities; oversees the quality process; and monitors for health care improvement. Activities include the ongoing assessment of Provider and Practitioner compliance with IEHP requirements and standards monitoring Provider trends and report submissions, and oversight of facility inspections. The Clinical Director of Quality Programs monitors and evaluates the effectiveness of IPA QM systems. The Clinical Director of Quality Programs coordinates information for the annual QM Program Evaluation and Work Plan; prepares audit results for presentation to the QM Committee, associated Subcommittees, and the Governing Board; and acts as liaison regarding medical issues for Providers, Practitioners, and Members.

The Senior Director of Quality Systems and Clinical Director of Quality Programs oversee staff consisting of clinical and/or non-clinical Managers, Analysts, and administrative staff.

3.4 Pharmaceutical Services Department

The Pharmaceutical Services Department operates under the Senior Director of Pharmaceutical Services. The Senior Director of Pharmaceutical Services reports to the Chief Medical Officer. The Pharmaceutical Services Department is responsible for pharmacy benefits and pharmaceutical services, including pharmacy network, pharmacy benefit coverage, formulary management, drug utilization program, pharmacy quality management program and pharmacy disease management program. The Senior Director of Pharmaceutical Services is responsible for developing and overseeing the IEHP Pharmaceutical Services Program.

Staff support for the Senior Director of Pharmaceutical Services consists of clinical and/or non-clinical Directors, Managers, Supervisors, and administrative staff.

3.5 Behavioral Health Department

The Behavioral Health (BH) Department operates under the direction of the Executive Director of Population Health and a Medical Director of Behavioral Health, Under the direction of the Chief Medical Officer, the Executive Director of Population Health and Medical Director of Behavioral Health are responsible for clinical oversight and management of the IEHP Behavioral Health and Care Management Programs and participates in the quality management, grievance, utilization and credentialing functions and activities related to Behavioral Health and Care Management services.

The Executive Director of Population Health and Medical Director of Behavioral Health oversee BH and CM Staff with the required qualifications to perform BH and CM care coordination activities in a managed care environment. BH and CM staff may have experience in behavioral health, social work, utilization management, utilization review, care management, quality assurance, training, and customer or provider relations. BH and CM staff positions may include: clinical and/or non-clinical Directors, Managers, Supervisors, and administrative staff.

3.6 Utilization Management Department

The UM Department operates under the direction of the Chief of Medical Services and Chief Medical Officer. The Directors of Utilization Management report to the Chief of Medical Services and are responsible for developing and maintaining the UM Program structure and assisting Providers and Practitioners to provide optimal UM services to Members. The Directors of Utilization Management are responsible for oversight of non-delegated and IEHP Direct UM activities. Additional responsibilities include the development and implementation of internal UM services, processes, policies and procedures. The Directors of Utilization Management are responsible for oversight and direction of IEHP UM staff and provides support to the IEHP QM Committee and Subcommittees.

The Directors of Utilization Management oversee UM staff with the required qualifications to perform UM in a managed care environment. The required qualifications for UM staff positions may consist of experience in utilization management or care management. Staff positions may include: clinical and/or non-clinical Directors, Managers, Supervisors, and administrative staff.

3.7 Health Education Department

The Health Education Program operates under the direction of the Medical Director for Family and Community Health and the Director of Health Education. Primary responsibilities include oversight of the Health Education Department for Member health education and Employee Wellness Program. The Medical Director coordinates with other departments to ensure Member health education materials meet state requirements in readability format, cultural and linguistic relevance. Health Education department leadership facilitates effective communication and coordination of care among Utilization Management, Care Management, Pharmaceutical Services, and Health Education departments. Leadership works with other departments to develop and coordinate policies and procedures for medical services (e.g., medical procedures, denials, pharmaceutical services) that incorporate Member participation in health education programs. The Medical Director ensures compliance with all accreditation and regulatory standards for health education, and acts as the primary liaison between IEHP and providers/external agencies for health education. The Medical Director of Family and Community Health provides oversight of the Employee Wellness Program and co-chairs the Employee Wellness Advisory Committee to plan and monitor activities to enhance wellness among IEHP Team Members.

The Medical Director of Family and Community Health oversees various levels of staff consisting of clinical and/or non-clinical management, and administrative staff.

3.8 Health Administration Department

The Health Administration Department operates under the direction of the Director of Health Administration. In this capacity, the Director of Health Administration coordinates and/or manages activities that involve multiple divisions within Medical Services, including contracting with various vendors (e.g. Nurse Advise Line), and coordinates operational planning activities. Under the direction of the Chief Medical Officer, the Director of Health Administration organizes and prepares written responses to requests from regulatory agencies involving Medical Services (e.g. telephone service call reports).

The Director of Health Administration oversees various levels of staff, including the Independent Living and Diversity (ILDS) Services Department.

3.9 Provider Services Department

The Provider Services Department operates under the direction of the Senior Director of Provider Services. Under the direction of the Chief Network Officer, the Senior Director of Provider Services is responsible for Credentialing and Provider Services, including the resolution of Provider and Practitioner issues, education of Providers and Practitioners concerning IEHP policies and procedures, health plan programs, IEHP website training and all other functions necessary to ensure Providers and Practitioners can successfully participate in IEHP's network and provide appropriate, quality care to IEHP Members. The Senior Director of Provider Services is also responsible for IPA oversight and monitoring in conjunction with Departments including Quality Management, Utilization Management, Care Management, and Finance.

IEHP has support staff for the Senior Director of Provider Services including, clinical and/or non-clinical Directors, Managers, Supervisors, and administrative staff.

3.10 Credentialing Department

The Credentialing Department operates under the direction of the Director of Provider Operations, reports to the Senior Director of Provider Services and is responsible for Provider Operations, including Credentialing and Re-credentialing oversight for directly contracted Practitioners, Providers and delegated IPAs, all Credentialing and Re-credentialing functions and resolving credentialing functions and resolving credentialing related Provider issues for directly contracted Practitioners. The Senior Director of Provider Services is responsible for developing and overseeing the IEHP Credentialing and Re-credentialing Program, with input from the Chief Medical Officer.

IEHP has support staff for the Senior Director of Provider Services. This group consists of a Director of Network Development, Director of Operations, Credentialing Manager and Credentialing Coordinators, who are responsible for performing all credentialing and re-credentialing related activities, including primary source verifications, review of applications and other functions for all Practitioners for whom IEHP is responsible for credentialing & re-credentialing. They are also responsible for verifying that Providers and Practitioners meet IEHP requirements for credentialed Practitioners.

3.11 Grievance and Appeals Department

The Grievance and Appeals Department, under the direction of the Director of Grievance & Appeals, reports to the Senior Director of Quality Systems and is responsible for investigation and resolution of grievances and service appeals received from Members, Providers, Practitioners and regulatory agencies. The Grievance and Appeals Department gathers supporting documentation from Members, Providers or contracted entities, and resolves cases based on clinical urgency of the Member's health condition. The Grievance and Appeals Nurse Manager has the primary responsibility for the timeliness and processing of the resolution for all cases. The Chief Medical Officer is the designated officer of the plan that has the primary responsibility for the maintenance of the Grievance and Appeals Resolution System. Staff supporting the Director of Grievance and Appeals include: clinical and/or non-clinical Managers, Supervisors, and administrative staff.

3.12 Information and Technology (IT)

The IT Department, under the direction of the Directors of IT, who report to the Chief Information Officer. The IT Department is responsible for the overall security and integrity of the data systems that IEHP uses to support Members, Providers and Team Members. IT is

responsible for maintaining internal systems that provide access to beneficiary data, both from regulators and Providers. The system ensures that Team Members have access to data to assist them in providing care and guidance to beneficiaries. The IT Department maintains the Member and Provider portals which are two (2) extensively used tools for communicating.

3.13 Marketing and Communication Department

The Marketing Department operates under the direction of the Senior Director of Marketing, who reports to the Chief Marketing Officer. The Marketing Department is responsible for conducting appropriate product and market research to support the development of marketing and Member communication plans for all products including Member materials (e.g., Member Newsletters, Evidence of Coverage, Provider Directory, website, etc.). The Quality Management Department works closely with the Marketing and Health Education Departments to ensure the aforementioned Member materials are implemented in a timely manner. The Senior Director of Marketing & Product Management is responsible for developing and overseeing the IEHP Marketing and Member Communications programs, under the vision and oversight from the Chief Marketing Officer.

Section 4: Program Documents

In addition to the detailed QM Program Description, IEHP also develops the QM Work Plan and completes a robust annual evaluation of the QM program.

4.1 Quality Improvement Work Plan

Annually, the QM Committee approves a QM Work Plan, which details the current year program initiatives to achieve established goals and objectives including the specific activities, methods, projected time frames for completion, and project leader for each initiative. The scope of the Work Plan incorporates the needs, input, and priorities of IEHP. The Work Plan is used to monitor all the different initiatives that are part of the QM program. These initiatives focus on improving quality of care, Member and Provider satisfaction, and patient safety. Initiatives include, but are not limited to planned monitoring activities for previous initiatives, disease-specific interventions, special projects, quality improvement studies, and the annual evaluation of the QM Program. The QM Committee oversees the prioritization and implementation of clinical and non-clinical Work Plan initiatives, respectively. The Work Plan includes goals and objectives, staff responsible, completion timeframes, monitoring of CAPs and ongoing analysis of the work completed during the measurement year.

4.2 Annual Evaluation

On an annual basis, IEHP evaluates the effectiveness and progress of the QM Program including:

- The QM program structure
- The behavioral healthcare aspects of the program
- How patient safety is addressed
- Involvement of a designated physician in the QM Program

- Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program
- Oversight of QI functions of the organization by the QI Committee
- An annual work plan
- Objectives for serving a culturally and linguistically diverse membership
- Objectives for serving Members with complex health needs

As such, a yearly summary of all completed and ongoing QM Program activities addresses the quality and safety of clinical care and quality of service provided as outlined in the QM Work Plan. The evaluation documents evidence of improved health care or deficiencies, progress in improving safe clinical practices, status of studies initiated or completed, timelines, methodologies used, and follow-up mechanisms is reviewed by QM staff, the Chief Medical Officer (CMO) or Medical Director designee, and Chief of Medical Services. The report includes pertinent results from QM Program studies, Member access to care, IEHP standards, physician credentialing and facility review compliance, Member satisfaction, evidence of the overall effectiveness of the program, and significant activities affecting medical and behavioral health care provided to Members.

Performance measures are trended over time and compared with established performance thresholds to determine service, safe clinical practices, and clinical care issues. The results are analyzed to assess barriers and verify and establish additional improvements. The CMO or designee presents the results to the QM Committee for comments, consideration of performance, suggested program adjustments, and revision of procedures or guidelines as necessary.

4.3 Review and Approval of Program Documents

On an annual basis, the QM Program Description, QM Program Summary, and QM Work Plan, are presented to the Governing Board for review, approval, and assessment of health care rendered to Members, comments, direction for activities proposed for the coming year, and approval of changes in the QM Program. The Governing Board is responsible for the direction of the program and actively evaluates the annual plan to determine areas for improvement. Board comments, actions, and responsible parties assigned to changes are documented in the minutes.

Section 5: Quality Improvement Processes

The planning and implementation of annual QM Program activities follows an established process. This includes development and implementation of the QM Work Plan, IEHP Quality Initiatives, and quality studies. Measurement of success encompasses an annual evaluation of the QM Program.

5.1 IEHP Quality Improvement (QI) Initiatives

QI initiatives are selected based on strategic priorities. Goals and objectives are selected based on relevance to IEHP's Membership and relation to IEHP's mission and vision. Activities reflect the needs of the Membership and focus on high-volume, high risk, or deficient areas for which quality improvement activities are likely to result in improvements in care and service, access,

safety, and satisfaction. Performance measures and customized metrics form the basis for plans and actions developed to improve care and service. Measure data and performance metrics are collected, compiled and analyzed to determine strategic priority direction and to ensure that opportunities for improvement are identified and/or best practices are defined and communicated.

5.5.1 Plan-Do-Study-Act Cycle

The "Plan-Do-Study-Act" (PDSA) Cycle is utilized to implement and test the effectiveness of changes. The model focuses on identifying improvement opportunities and changes, and measuring improvements. Successful changes are adopted and applied where applicable. In general, quality improvement initiatives follow the process below:

1. Find a process to improve, usually by presenting deficient results;
2. Organize a team that understands the process and include subject matter experts (SMEs);
3. Clarify knowledge about the process;
4. Understand and define the key variables and characteristics of the process;
5. Select the process to improve;
6. Plan a roadmap for improvement and/or develop a work plan;
7. Implement changes;
8. Evaluate the effect of changes through measurement and analysis; and
9. Maintain improvements and continue to improve the process.

5.5.2 Data Collection Methodology

Performance measures developed have a specified data collection methodology and frequency. The methodology for data collection is dependent on the type of measure and available data. Data validation is a vital part of the data collection process. Quality assessment and improvement activities are linked with the delivery of health care services. Data is collected, aggregated, and analyzed to monitor performance. When opportunities for improvement are identified, a plan for improvement is developed and implemented. Data is used to determine if the plan resulted in the desired improvement. Data collection is ongoing until the improvement is considered stable. At that time, the need for ongoing monitoring is reevaluated. Data may also indicate the need to abandon an action and reassess options for other action items necessary to drive performance improvement.

5.5.3 Measurement Process:

Quality measures are used to regularly monitor and evaluate the effectiveness of quality improvement initiatives, and compliance with internal and external requirements. IEHP reviews and evaluates, on not less than a quarterly basis, the information available to the plan regarding accessibility and availability. IEHP measures performance against community, national or internal baselines and benchmarks when available, and applicable, which are derived from peer-reviewed literature, national standards, regulatory guidelines, established clinical practice guidelines, and internal trend reviews.

5.5.4 Evaluation Process:

IEHP uses a number of techniques and tools to evaluate effectiveness of QI studies and initiatives. These include conducting a robust quantitative and qualitative analysis. A quantitative analysis includes comparison to benchmarks and goals, trend analysis, and tests of statistical significance. The HCI team selects the appropriate tools to complete the quantitative analysis. The QM Department works closely with the HCI Department and other key stakeholders to complete a robust qualitative analysis. A qualitative analysis includes barrier analysis and attribution analysis. IEHP performs this analysis in focus group like setting using all the key stakeholders.

5.5.5 Communication and Feedback:

Ongoing education and communication regarding quality improvement initiatives is accomplished internally and externally through committees, staff meetings, mailings, and announcements.

1. Providers are educated regarding quality improvement initiatives through on-site quality visits, Provider newsletters, specific mailings, and the IEHP website.
2. Specific performance feedback regarding actions or data is communicated to Providers. General and measure-specific performance feedback is shared via special mailings, Provider newsletters, IEHP's Provider Portal, and the IEHP website.
3. Feedback to Providers may include, but is not limited to, the following:
    a. Listings of Members who need specific services or interventions;
    b. Clinical Practice Guideline recommended interventions;
    c. HEDIS® and CAHPS® results;
    d. Recognition for performance or contributions; and
    e. Discussions regarding the results of medical chart audits, grievances, appeals, referral patterns, utilization patterns, and compliance with contractual requirements.

5.5.6 Improvement Processes:

Performance indicators are also used to identify quality issues. When identified, IEHP QM staff investigates cases and determines the appropriate remediation activities including Corrective Action Plans (CAP). Providers or Practitioners that are significantly out of compliance with QM requirements must submit a CAP. Persistent non-compliance, or failure to adequately address or explain discrepancies identified through oversight activities, may result in freezing of new Member enrollment, a requirement to subcontract out the deficient activities within the Management Services Organization MSO or IPA; de-delegation of specified functions; termination of participation or non-renewal of the agreement with IEHP.

Section 6: Quality Improvement Initiatives

IEHP has developed a number of Quality Improvement Initiatives to improve quality of care, access to care, Member and Provider satisfaction, and patient safety. IEHP assesses the performance of these studies against established thresholds and/or benchmarks.

6.1 Quality of Care

IEHP monitors a number of externally and internally developed clinical quality measures and

tracks the quality of care provided by IEHP. In order to evaluate these measures IEHP collects data from a number of different sources that include, but are not limited to, the following:

- Annual Healthcare Effectiveness Data and Information Set (HEDIS®) submission for Medi-Cal and IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)
- State/Federal required Quality Improvement Plans (QIPs) and Performance Improvement Projects (PIPs)
- Claims and encounter data from contracted Providers (e.g. Primary Care Providers, Specialists, labs, hospitals, IPAs, Vendors, etc.)

Measuring and reporting on these measures helps IEHP to guarantee that its Members are getting care that is safe, effective, and timely. The clinical quality measures discussed below are used to evaluate multiple aspects of Member care including:

- Performance with healthcare outcomes and clinical processes;
- Adherence to clinical and preventive health guidelines;
- Effectiveness of disease and case management programs; and
- Member satisfaction with care received.

6.1.1 HEDIS® Measures

HEDIS® is a group of standardized performance measures designed to ensure that information is available to compare the performance of managed health care plans. IEHP has initiatives in place that focuses on a number of key HEDIS® measures that cover its entire Membership, including, priority measures that relate to children, adolescents and Members with chronic conditions.

IEHP develops a number of Member and Provider engagement programs to improve HEDIS® rates. Interventions include a combination of incentives, outreach and education, Provider level reports and gaps in care reports, and other activities deemed critical to improve performance. These interventions are tracked by IEHP's HEDIS® Improvement Workgroup is monitored in the QI Work Plan and presented at the QI Subcommittee. In addition, IEHP's performance on HEDIS® measures is reported and discussed annually at the QM Committee. The QM Committee provides guidance on prioritizing measures for the subsequent year(s). IEHP's goal is to continually develop and implement interventions that are aimed at improving HEDIS® rates and quality of care for its Members.

The HEDIS® Improvement Workgroup is chaired by the designated Medical Director, and its Committee Members meets monthly (at a minimum). The HEDIS® Improvement Workgroup sets goals for HEDIS® improvement by establishing various intervention strategies/activities to achieve HEDIS goals and measures during the calendar year (CY). The committee continually does the following:

- Monitors HEDIS® rates and progress/success toward the set goals;
- Discusses barriers and potential intervention strategies;
- Monitors all implementation strategies;
- Develops intervention timeframes; and

- Makes necessary changes to existing programs.

6.1.2 Quality Improvement Projects/Performance Improvement Projects (DHCS and CMS)

IEHP implements a number of Quality Improvement Projects (QIPs), Performance Improvement Projects (PIPs), and HEDIS® PDSA QIPs) that are required by regulatory agencies (DHCS and CMS).

- QIPs - initiatives that focus on one (1) or more clinical or non-clinical area(s) with the aim of improving health outcomes and beneficiary satisfaction. This project is to be implemented over a three (3) year period.
- PIPs- performance improvement projects that focus on testing interventions on a small scale using the PDSA cycle. The PIP process is structured into four (4) phases and includes Modules 1 to 5.
- HEDIS® PDSA QIPs- conducted for each HEDIS® External Accountability Set (EAS) measure with a rate that does not meet the Minimum Performance Level (MPL) or is given an audit result of "Not Reportable." IEHP evaluates ongoing quality improvement efforts on a quarterly basis.
- NCQA Quality Activities – quality improvement activities conducted to satisfy NCQA standards.

The Quality Management Department, under the direction of the Medical Director(s), is responsible for monitoring these programs and implementing interventions to make improvements. For 2018, IEHP is focusing on the following studies:

Study Name	Reporting Agency	Type of Study
All-Cause Readmissions - Statewide Collaborative QIP measure (non-HEDIS® measure) Charter Healthcare Group (CHG) Transition Care Services Study - addressing reduction of hospital readmission rates.	NCQA	Quality Activity
Disparity Performance Improvement Project – Childhood Immunization Status (CIS) Combo 10	DHCS	PIP
Asthma Medication Ratio (AMR)	DHCS	PIP
Individualized Care Plan	CMS, DHCS	PIP

6.1.3 Continuity and Coordination of Care Studies

Continuity and coordination of care are key determinants for overall health outcomes. Comprehensive coordination of care improves patient safety, avoids duplicate assessments, procedures or testing, and results in better treatment outcomes. IEHP evaluates continuity and coordination of care on an annual basis through multiple studies. The purpose of these studies is to assess the effectiveness of the exchange of information between:

- Medical care providers working in different care settings.
- Medical and behavioral healthcare providers.

The results of these studies are presented and discussed the QI subcommittee and QM committee. Based on the findings, the committee Members recommend opportunities for improvement that are implemented by the QM Department.

6.1.4 Disease Management Program

IEHP has implemented Asthma (Breathe) and Diabetes (Journey) Disease Management programs to engage Members diagnosed with these conditions and their managing Practitioners. As a part of the DM programs Members receive relevant educational materials that give them a better understanding of the disease condition and ways to better manage their health. The programs also help facilitate Members' access to disease management services, health education programs, care management, and other healthcare services. Members in the DM program can access health education programs to prevent co-morbidities or mitigate their effects. The DM Program is a component of IEHP's Member-centric care. IEHP evaluates the effectiveness of both these programs using the appropriate process and outcome measures that are part of the HEDIS® submission. The annual evaluation is reported and discussed at the QM committee.

6.1.5 Improving Quality for Members with Complex Needs

IEHP has multiple programs at no cost to the Member that focus on improving quality of care and services provided to Members with complex medical needs (i.e., chronic conditions, severe mental illness) and Seniors and Persons with Disabilities (SPD), including physical and developmental. These programs include, but are not limited to, the following:

Complex Case Management (CCM) Program

The CCM program was established for Members with poorly controlled chronic diseases and/or complex conditions. The goal of the CCM program is to optimize Member wellness, improve clinical outcomes, and promote self-efficacy and appropriate resource management across the care continuum, through efficient care coordination, education, referrals to health care resource, and advocacy. IEHP assesses the performance of the CCM program annually using a number of established measures and quantifiable standards. These reports are presented to the QI Subcommittee and QM Committee for discussion and next steps. Based on the committee recommendations, the Case Management Department collaborates with other Departments within the organization to implement improvement activities.

Transition of Care (TOC) Program

IEHP has developed a system to coordinate the delivery of care across all healthcare settings, Providers, and services to ensure all hospitalized Members are evaluated for discharge needs to provide continuity of care and coordination of care. Multiple studies have shown that the poor transition between care settings have resulted an increase in mortality and morbidity. Transitioning care without assistance for Members with complex needs (e.g. SPD Members that very often have three (3) or more chronic conditions) can be complicated by several other health and social risk factors. IEHP's TOC program has been designed to provide solutions to these challenges. Through the TOC program, IEHP makes concerted efforts to coordinate care when Members move from one setting to another. This coordination ensures quality of care and minimizes risk to patient safety. IEHP also works with the Member or their caregiver to ensure

they have the necessary medications/supplies to prevent readmissions or complications. The goals of the TOC program include the following:

- Avoiding of hospital readmissions post discharge
- Improvements in health outcomes post discharge from inpatient facilities
- Improving Member and caregiver experience with care received

Facility Site Review

IEHP requires all Primary Care Physician (PCP) sites that do not have Medi-Cal Members to undergo an initial Site Review and Medical Record Review (MRR) Survey performed by a Certified Site Reviewer (CSR), utilizing a combined Site and Medical Record Review Checklist, prior to the PCP site participating with IEHP. Focused site visits or Physical Accessibility Review Surveys are conducted if a Member complaint is received about the quality of a practitioner's office related to physical accessibility, physical appearance, appearance safety, adequacy of room space, availability of appointments, and adequacy of record keeping or any other issue that could impede quality of care. Sites will be monitored every six (6) months until all deficiencies are resolved. The Quality Management Department is responsible for oversight of PARS activities. Additionally, the Quality Management Department is responsible for providing training should physical access issues or deficiencies be identified. The QM Committee reviews an annual assessment of PARS activities to ensure compliance.

6.1.6 Other Clinical Measures and Studies

Initial Health Assessment Monitoring

IEHP also monitors the rate of Initial Health Assessments (IHA) performed on new Members. The timeliness criteria for an IHA is within 120 days of enrollment for Members. This rate is presented to QI Subcommittee for review and analysis. IEHP has a number of Member and Provider outreach programs to improve the IHA rate.

Evidence-Based Clinical Practice Guidelines (CPGs) and Preventive Services Guidelines

Clinical practice guidelines are "Statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options (Institute of Medicine, 2011)."

To make health care safer, higher quality, more accessible, equitable and affordable, IEHP has adopted evidence-based clinical practice guidelines for prevention and chronic condition management. In addition, IEHP considers recommendations for Adult and Pediatric Preventive Services per DHCS contractual requirements which include criteria for the following;

1) FSR/MRR Documentation;
2) Select United States Preventive Task Force (USPTF) recommendations;
3) Bright Futures from American Academy of Pediatrics (AAP);
4) IEHP/Advisory Committee on Immunization Practices (ACIP) Immunizations Schedule.

Over-utilization and Under-utilization

IEHP monitors over-utilization and under-utilization of services at least annually. The QM and

UM departments work collaboratively to capture utilization trends or patterns. The results are compared with nationally recognized thresholds. Under-utilization of services can result due to a number of reasons that include but are not limited to the following:

- Access to health care services based on geographic regions.
- Demographic factors also impact over-utilization and under-utilization of services/care:
    - Race, ethnicity, and language
    - Knowledge and perceptions regarding health care which are largely driven by cultural beliefs.
    - Income and socioeconomic status

IEHP reviews trends of ER utilization, pain medications prescriptions, and potential areas of over-utilization on an annual basis.

The purpose of the analysis is to:

- Identify the dominant utilization patterns within the population.
- Identify groups of high and low utilizers and understand their general characteristics.

6.2 Access to Care

With the rapid expansion of the managed care programs in California, access to health care services within the State has been negatively impacted over the last few years and is now considered unreliable. Based on a number of statewide studies, there are many Members who do not receive appropriate and timely care. With the rapid growth in IEHP's Membership, access to care is a major area of concern for the plan and hence the organization has dedicated a significant amount of resources to measuring and improving access to care. This analysis is presented to the QI Subcommittee and QM Committee for discussion and recommendations as needed.

6.2.1 Availability of PCPs by Language

IEHP monitors network availability based on threshold languages annually. IEHP understands the importance of being able to provide care to Members in their language of choice and the impact it has on a Member-Practitioner relationship. In order to ensure adequate access to Primary Care Practitioners, IEHP has established quantifiable standards for PCPs for its threshold languages, which are English and Spanish. These two (2) languages cover over 98% of the Membership. The primary objectives are to evaluate network availability against the establish language standards and identify opportunities for improvement.

6.2.2 Availability of Practitioners

IEHP monitors the availability of PCP, Specialists and Behavioral Health Practitioners and assesses them against established standards at least annually or when there is a significant change to the network. The performance standards are based on State, NCQA, and industry benchmarks. IEHP has established quantifiable standards for both the number and geographic distribution of its network of Practitioners. IEHP uses a geo-mapping application to assess the geographic distribution. Considering the size of the service area, IEHP evaluates the distribution of Providers based on geographic regions since there may be significant gaps in some of the more rural areas covered by IEHP.

6.2.3 Appointment Access

IEHP monitors appointment access for PCPs, Specialists and Behavioral Health Providers and assesses them against established standards at least annually. There is significant evidence that timely access to health care services results in better health outcomes, reduced health disparities, and lower spending, including avoidable emergency room visits and hospital care. In order to measure performance, IEHP collects the required appointment access data from Practitioner offices using a timely access to care survey. IEHP also evaluates the grievances and appeals data quarterly to identify potential issues with access to care. A combination of both these activities helps IEHP identify and implement opportunities for improvement.

6.2.3 After-hours Access to Care

IEHP monitors after-hours access to PCPs at least annually. One of IEHP's key initiatives is to reduce inappropriate ER utilization. Ensuring that Members have appropriate access to their primary care Practitioner outside of regular business hours can result in reduced ER rates which can subsequently result in reduced inpatient admissions. The criteria for appropriate after hours care is that the physician or designated on-call physician be available to respond to the Member's medical needs beyond normal hours. PCP offices can use a professional exchange service or automated answering system that allows the Member to connect to a live party or the physician by phone. It is also required that any after-hours system or service that a physician uses provide emergency instructions in the event that the Member is experiencing a life-threatening emergency.

6.2.4 Telephone Access to IEHP Staff

IEHP monitors access to its Member Services Department on quarterly basis. IEHP has established the following standards and goals to evaluate access to Member services by telephone.

Standards of Care for Telephone Access	
Standards	**Goal**
% Of Calls answered by a live voice within 30 seconds	80 %
Calls Abandoned Before Live Voice is Reached	≤ 5%

6.3 Member and Provider Satisfaction

6.3.1 CAHPS®

IEHP conducts a comprehensive CAHPS® survey and analysis annually to assess Member satisfaction with the services and care received. CAHPS® is a set of standardized surveys that ask health care consumers to report on and evaluate their care experience. The survey focuses on key areas like getting care needed; getting appointments to PCPs and SCPs; satisfaction with IEHP and its Practitioners; and other key areas of the Plan operations. CAHPS® surveys serve as a means to provide usable information about quality of care received by the Members. IEHP uses this tool as one of its key instruments to identify opportunities for improvement. As part of the annual evaluation, IEHP reviews the CAHPS® results to identify relative strengths and weaknesses in performance, determines where improvement is needed, and tracks progress with interventions over time.

6.3.2 Internal Member Satisfaction Studies

1. **DualChoice Member Satisfaction Survey**: IEHP conducts an internal survey for DualChoice Members to evaluate their satisfaction with the services received. The survey focuses on key areas like getting care needed; getting appointments to PCPs and SCPs; satisfaction with IEHP staff and network of Medicare Practitioners; and other key areas of the Plan operations. The goal of the satisfaction study is to identify and implement opportunities to improve overall Member satisfaction.

2. **Disease Management (DM) Member Satisfaction Survey:** The DM program provides educational materials to Members to help with achieving self-management skills for their asthma or diabetes, respectively. Members are enrolled into one of the programs via an opt-in enrollment methodology. IEHP monitors Member satisfaction with the DM programs annually. IEHP has established standards to evaluate satisfaction with different components of the DM program. The survey includes questions on usefulness of the program materials, program staff, Member's experience in adhering to treatment plans, and overall satisfaction with the DM program. The goal of the satisfaction study is to identify and implement opportunities to improve Member satisfaction.

3. **BH Member Satisfaction Survey**: IEHP surveys Members who are receiving behavioral care services at least annually to evaluate their satisfaction with the services received. The survey focuses on key areas like getting care needed; getting appointments to BH Practitioners; satisfaction with IEHP staff and network of BH Practitioners; and other key areas of the Plan operations. The goal of the satisfaction study is to identify and implement opportunities to improve overall Member satisfaction.

4. **CCM Member Satisfaction Survey**: The CCM assists Members with complex needs get the care they need to better manage their health. Members are enrolled into the program based upon meeting specific clinical criteria. IEHP monitors Member satisfaction with the CCM program annually. IEHP has established standards to evaluate satisfaction with different components of the CCM program. The survey includes questions on usefulness of the program materials, program staff, Member's ability for adhering to recommendations, and overall satisfaction with the CCM program. The goal of the satisfaction study is to identify and implement opportunities to improve overall Member satisfaction.

6.3.3 Grievances and Appeals

IEHP monitors performance areas affecting Member experience. IEHP has established categories and quantifiable standards to evaluate grievances received by Members. All grievances are categorized in a number of different categories including but not limited to the following:

- Quality of Service
- Quality of Care
- Access
- Compliance
- Benefits/Coverage
- Enrollment/Eligibility

The organization's goal is to resolve all grievances within 30 days of receipt. IEHP calculates the grievance rate per 1000 Members on a quarterly basis and presents this information to the QI Subcommittee and QM Committees. IEHP's goal is to maintain the overall complaint rate below thresholds as established by regulatory agencies such as DHCS, DMHC, and CMS.

6.3.4 Provider Satisfaction

IEHP monitors performance areas affecting provider satisfaction annually. This study assesses the satisfaction experienced by IEHP's network of PCPs, SCPs, and Behavioral Health Providers. Information obtained from these surveys allows plans to measure how well they are meeting their Providers' expectations and needs. This study examines the satisfaction of the Provider network in the following areas: overall satisfaction, all other plans, finance issues, utilization and quality management network, coordination of care, pharmacy, Health Plan Call Center Service Staff, and Provider relations. Based on the data collected, IEHPs reports the findings to the QI Subcommittee and QM Committee. The committees review the findings and make recommendations on potential opportunities for improvements.

6.4 Patient Safety

IEHP recognizes that patient safety is a key component of delivering quality health care and focuses on promoting best practices that are aimed at improving patient safety. IEHP engages Members and Providers in order to promote safety practices. IEHP also focuses on reducing the risk of adverse events that can occur while providing medical care in different delivery settings. Some of the IEHP's safety initiatives include:

6.4.1 Appropriate Medication Utilization

IEHP monitors pharmaceutical data to identify patient safety issues on an ongoing basis. Drug Utilization Review (DUR) is a structured, ongoing program that evaluates, analyzes, and interprets drug usage against predetermined standards and undertakes actions to obtain improvements. The DUR process is designed to assist pharmacists in identifying potential drug related problems by assessing patterns of medication usage. The goal of the DUR process is to identify potential drug-to-drug interactions, over-utilization and under-utilization patterns, high/low dosage alerts, duplication of medications, and other critical elements that can affect patient safety. The DUR study data is collected via an administrative data extraction of paid pharmaceutical claims. Actual prescribing patterns of PCPs, Behavioral Health Practitioners, and Specialists are compared to IEHP standards. The results of the quantitative analysis are presented to IEHP's Pharmacy and Therapeutics (P&T) Subcommittee and QM Committee for discussion and action, as necessary.

6.4.2 Review of Inpatient Admissions

IEHP considers the quality of care in the hospitals to be a top priority. To ensure Member safety, IEHP assesses, tracks, and reviews the following measures:

1. Bed Day Reporting
2. Length of stay reports;
3. Post Op wound infection referrals;
4. Sentinel events occurring in inpatient settings;
5. Inappropriate discharges from inpatient settings;

6. Provider Preventable Conditions (PPCs);

7. Potential Quality Incidents (PQI) referrals for any adverse outcome related to an inpatient stay.

Monthly reports are produced using relevant utilization data. These reports are reviewed by the UM and QM staff to identify potential quality incidents. Any significant findings are reviewed by IEHP's Medical Directors and summary reports are provided to the UM Subcommittee and QM Committee. The UM Subcommittee identifies potential quality of care issues and makes recommendations to address them as needed. The committee delegates the implementation of these recommendations to the UM and/or QM Department. The QM Department collaborates with different Departments (e.g. UM, CM, PS, etc.) to implement and monitor the improvement activities.

6.4.3 Potential Quality Incidents Review

The QM Department reviews all Potential Quality Incidents (PQI) for all Practitioners and Providers. Areas of review include but are not limited to primary and specialty care, facilities (Hospital, Long Term Care, Skilled Nursing Facility, and Community-Based Adult Services), In-Home Support Services, Multipurpose Senior Services Program (MSSP) services, Home Health agencies and transportation Providers. The QM Department is responsible for investigating and reviewing the alleged Potential Quality Incidents. The Medical Director(s) review all cases and may refer to the QM Committee and/or Peer Review Subcommittee for further evaluation and review.

6.4.4 Facility Site Review (FSR)

IEHP requires all PCPs undergo a full Facility Site Review at the time of signing with the Plan and at least every three (3) years thereafter. The purpose of these reviews is to meet the IEHP's quality improvement standards and ensure compliance with applicable local, state, and federal laws and regulations. These site reviews are conducted as a part of the initial Provider credentialing process. Additional site reviews are conducted as part of the ongoing Provider re-credentialing process to ensure that each Provider continues to meet the IEHP's site review standards. These are done at least every three (3) years and more often if IEHP has identified any quality of care concerns with the site. A Certified Site Reviewer (CSR), utilizing a combined Site and Medical Record Review Checklist, completes the site audits. Focused site visits or Physical Accessibility Review Surveys are conducted if a Member complaint is received about the quality of a Practitioner's office related to physical accessibility, physical appearance, safety, room space, availability of appointments, and adequacy of record keeping or any other issue that could impede quality of care. Sites will be reevaluated after six (6) months to validate if the deficiencies have been resolved. The Credentialing Subcommittee and QM Committee review the results of the FSR audits.

Physical Accessibility Review Survey (PARS)

IEHP participates in the California FSR collaborative audits, which includes the PARS audit. The purpose of the PARS is to assess the physical accessibility and safety of provider sites using a set of standards established by Department of Health Care Services. PARS are performed on all PCP and high volume Specialty Care Practitioners (SCP), ancillary provider sites, and other Community Based Adult Services (CBAS) centers. The goal of the PARS review is to ensure provider sites that are seeing Members with disabilities don't have any limitations as Members

try to get access to the offices. A PARS audit covers a number of different areas including assessment of parking, office exteriors and interiors, restrooms, examination rooms, and examination tables.

6.4.5 Promoting Safety Practices for Members

IEHP offers various safety programs to Members including the Bicycle Helmet Program for children between 5 to 14 years old and Members who have a child between 5-14 years old. This interactive program assesses childrens' and parents' knowledge on bicycle safety and offers a free helmet to program participants. IEHP also offers the Child Car Seat Program to keep children safe in a car, providing information on the latest car seat laws, and choosing the right car seat. Additionally, Member education materials that cover different health topics are available to Members including immunizations, flu and cold facts, avoiding allergens, medication reconciliation etc. Additional safety initiatives are developed in collaboration with Health Education and Medical Services departments as safety needs are identified.

6.5 Addressing Cultural and Linguistic Needs of Members

IEHP is dedicated to ensure that all medically covered services are available and accessible to all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all covered services are provided in a culturally and linguistically appropriate manner. IEHP strives to reduce health care disparities in clinical areas, improving cultural competency in Member materials and communications, and ensuring network adequacy to meet the needs of underserved groups. Services to address cultural and linguistic services are adjusted based on the annual assessment of Member needs. Further details about cultural and linguistic services provided to Members are seen in the individual reports supporting each of the following studies. The following are the current IEHP Quality Studies that evaluate our ability to serve a culturally and linguistically diverse Membership:

1. Provider Language Competency Study: The purpose of this study is to verify that the PCP, OB/GYN, and vision provider offices that inform IEHP that they have Spanish speaking office staff actually have those services available to Members.
2. Cultural and Linguistic Study: The purpose of the study is to identify the linguistic and ethnic diversity of IEHP's PCP and Member populations. More specifically, they assess the cultural, ethnic, racial, and linguistic needs of Members in accordance with NCQA standards.
3. Ongoing monitoring of interpreter service use: The purpose of this report is to monitor the top languages requested by the Members. IEHP offer face-to-face interpreter services for medical appointments to Members at no cost. The purpose is to provide Members with interpretation services and office excellence in service to Members/callers.
4. Ongoing monitoring of grievances related to language and culture. Grievances are reported to monitor cultural and linguistic services provided to Members.

Section 7: Delegation Oversight

IEHP delegates certain utilization management, care management, credentialing/re-credentialing, and compliance activities to contracted Delegates that meet IEHP delegation requirements and comply with the most current National Committee for Quality Assurance (NCQA), Department

of Health Care Services (DHCS) (when applicable) and IEHP standards. IEHP monitors Delegate performance in QM, UM, CM, credentialing and re-credentialing, compliance, and their implementation of related activities through Delegation Oversight activities.

7.1 Monitoring Activities:

IEHP performs a series of activities to monitor IPAs and other delegated entities:

1. An annual Delegation Oversight Audit is conducted using a designated audit tool that is based on the National Committee for Quality Assurance (NCQA), DMHC and DHCS standards. Delegation Oversight Audits are performed by IEHP Medical Services and Provider Services Staff using the most current NCQA, DHCS, CMS and IEHP standards.
2. Joint Operations Meetings (JOM) – These meetings are called by IEHP as a means of discussing performance measures and findings as needed. The JOM includes representation from the delegate and IEHP Departments as applicable.
3. Review of grievances and other quality information;
4. Specified audits:
    a. Focused Approved and Denied Referral Audits;
    b. Focused Case Management Audits;
    c. Utilization data review (Denial/Approval Rates, timely Member notification, overturn rate; and
    d. Provider Satisfaction Surveys.
5. Member Contracted IPAs are required to submit the following information to the IEHP Provider Services Department:
    a. Utilization Management (UM) Trend Report – Monthly report of utilization data;
    b. Denial Log and Letters – Monthly report of all denials and modifications of requested services;
    c. Care Management (CM) Log – Monthly report of CM activities;
    d. Second Opinion Tracking Log – Monthly report to track Member requested second opinions;
    e. Notice of Medicare Non-Coverage (NOMNC) – Monthly report to track NOMNC compliance for facilities;
    f. Credentialing Activity – Periodic report of any changes to the network at the Delegate level (e.g., terminated PCPs, specialists);
    g. Annual QM and UM Program Descriptions;
    h. Annual QM and UM Work Plans;
    i. Semi-annual reports of quality improvement activities;
    j. Semi-annual reports of utilization management activities; and
    k. Annual QM and UM Program Evaluations.

6. IPAs with deficient scores must submit a Corrective Action Plan (CAP) to remedy any deficiencies. If a delegate is unable to meet performance requirements, IEHP may implement further remediation action including but not limited to:

   a. Conduct a focused re-audit;

   b. Immediately freeze the Delegate to new Member enrollment, as applicable;

   c. Send a 30-day contract termination notice with specific cure requirements;

   d. Rescind delegated status of Delegate, as applicable;

   e. Terminate the IEHP contract with the Delegate; or

   f. Not renew the contract.

7. **Assessment and Monitoring:** To ensure that Delegates have the capacity and capability to perform required functions, IEHP has a rigorous pre-contractual and post-contractual assessment and monitoring system. IEHP's also provides clinical and Member experience data to delegates upon request so they can initiate improvement activities.

8. **Pre-contractual Assessment of Providers**: All Providers desiring to contract with IEHP must complete a comprehensive pre-contractual document and on-site review.

9. **Reporting**: IEHP's Delegation Oversight Committee (DOC) monitors and evaluates the operational activities of contracted Delegates to ensure adherence to contractual obligations, regulatory requirements and policy performance. Elements of delegation are monitored on monthly, quarterly and annual basis for trending and assessment of ongoing compliance. The reporting includes review of monthly assessment packets, encounter adequacy reports and Provider Services highlights. All oversight audits performed on delegates are reported to the DOC. Corrective Action Plan (CAP) activities are implemented as deficiencies are identified. Findings and summaries of DOC activities are reported to the Compliance Committee.

INLAND EMPIRE HEALTH PLAN		
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