2019 QUALITY IMPROVEMENT PROGRAM DESCRIPTION

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HPSM MISSION STATEMENT

The Health Plan of San Mateo provides San Mateo County's vulnerable and underserved residents access to high quality care services and supports that help them live the healthiest lives possible.

We have a vision, that healthy is for everyone.

1. INTRODUCTION

1.1 BACKGROUND

The Health Plan of San Mateo (HPSM) was created in 1987 by a coalition of local elected officials, hospitals, physicians, and community advocates to serve the needs of Medi-Cal eligible beneficiaries. As a County Organized Health System (COHS), HPSM is authorized by state and federal law to administer Medi-Cal (Medicaid) benefits in San Mateo County. Based within the community it serves, HPSM is sensitive to, and its operation reflects, the unique health care environment and needs of San Mateo County's Medi-Cal beneficiaries. In 1998, HPSM began a Healthy Families (HF) program that served low income children that didn't qualify for Medi-Cal. Beginning April 2014, HPSM began its Cal MediConnect (CMC) Medicare-Medicaid Plan to further serve dually eligible individuals with the goal of providing members with access to high quality services delivered in a cost-effective and compassionate manner.

Consistent with its mission, HPSM operates additional product lines in response to community needs. These include Healthy Kids and HealthWorx. Healthy Kids serves low income children who don't qualify for Medi-Cal, while the latter serves In-Home Supportive Services (IHSS) workers. By taking on these additional groups and a state-licensed Medicare program under a competitive, risk-based contract with the Centers for Medicare and Medicaid Services (CMS), HPSM has expanded and reaffirmed its commitment to providing health care to San Mateo County's most vulnerable residents.
Effective February 2010, HPSM expanded its service contract with the Department of Health Care Services (DHCS), to include Long Term Care (LTC). This expansion includes facility charges in LTC facilities, sub-acute and intermediate care facilities (ICFs). In July 2012, Community-Based Adult Services (CBAS) was added to HPSM's DHCS' contract. In 2013, beneficiaries in the Healthy Families Program have been transitioned to Medi-Cal, as part of phased transition throughout the State of California.

As of December 2018, HPSM serves approximately 140,000 members under the following lines of business: Medi-Cal, CareAdvantage Cal-MediConnect (CA CMC), Healthy Kids, HealthWorx, ACE and California Children's Services (CCS). All HPSM Dual eligible members of CA CMC and Medi-Cal Seniors and Persons with disabilities (SPDs) will be eligible for Coordinated Care Initiative Medi-Cal services.

1.2 HPSM'S DELIVERY SYSTEM

HPSM is able to fulfill its mission in San Mateo County because of its successful partnership with its outstanding healthcare delivery partners. Medical services are delivered to our members through our directly-contracted provider network. HPSM's network includes over 800 primary care providers and over 2,000 specialists. In addition, HPSM's network includes 8 hospitals and medical centers located in San Mateo County and in neighboring San Francisco. While HPSM does not contract directly with its pharmacy network, HPSM's delegates this responsibility to its contracted pharmacy benefits manager, Argus. All pharmacy and medical service authorizations under HPSM's scope of service for each line of business are performed by HPSM licensed clinical staff.

1.3 SCOPE OF SERVICES

HPSM provides a comprehensive scope of acute and preventive care services for its members through its Medi-Cal, Healthy Kids, HealthWorx, CCS, and CareAdvantage Cal MediConnect (MMP) lines of business. Certain services are not covered by HPSM or may be provided by a different agency:

- Mental Health services (Mild to Moderate mental health services) are administered by the San Mateo County Behavioral Health and Recovery Services for all lines of business. Behavioral Health Treatment (BHT) is administered by Magellan Health Services.
- Delta Dental contracts with HPSM to provide services for Healthy Kids and CareAdvantage members.
- California Children's Services (CCS) is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS authorizes care and in San Mateo County, HPSM pays for the specific medical services and equipment provided by CCS-approved specialists. The CCS program is funded with State, County, and Federal tax monies, along with some fees paid by parents or guardians.
- Health Plan of San Mateo works with community programs to ensure that members with special health care needs, high risk or complex medical and developmental conditions receive additional services that enhance their medical benefits. These partnerships are established through special programs and specific Memorandums of Understanding (MOUs) with certain community agencies including the San Mateo County Health Services Agency (HSA), California Children's Services (CCS), and the Golden Gate Regional Center (GGRC).

2. QUALITY IMPROVEMENT PROGRAM

2.1 PURPOSE

The Quality Improvement (QI) Program provides a formal process to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety, and effectiveness of care and service utilizing a multidimensional approach. This approach enables HPSM to focus on opportunities for improving operational processes and health outcomes, ensuring cultural and linguistically appropriate services and high levels of member and practitioner/provider satisfaction. The QI Program promotes the accountability of all employees and affiliated health personnel for the quality of care and services provided to our members.

2.2 GOALS

The goals of the QI Program are to:

- Provide timely access to high-quality healthcare for all members, through a cost-effective, safe, linguistically, and culturally appropriate health care delivery system that objectively and systemically monitors and evaluates quality and appropriateness of health care and services.
- Pursue opportunities to improve health care, services and safety; and
- Resolve identified problems in a timely manner.

2.3 OBJECTIVES

- Design and maintain the quality improvement structure and processes that support continuous quality improvement, including measurement, trending, analysis, intervention and re-measurement.
- Meet the cultural and linguistic needs of the membership.
- Comply and coordinate with all governmental agency requirements.
- Support practitioners with participation in quality improvement initiatives of HPSM and all governing regulatory agencies.

- Establish clinical and service indicators that reflect demographic and epidemiological characteristics of the membership, including benchmarks and performance goals for continuous and or periodic monitoring and evaluation.
- Maintain an on-going up-to-date credentialing and re-credentialing system that compiles with HPSM standards, including primary verification, the use of quality improvement, and other performance indicators in the re-credentialing process.
- Measure availability and accessibility to clinical care and service.
- Measure member satisfaction, identify and address areas of dissatisfaction in a timely manner through:
    - quarterly analysis of trended member complaint data;
    - member satisfaction surveys; and
    - solicitation of member suggestions to improve clinical care and service
- Continue to develop, adopt, and adapt practice guidelines (including preventive health) reflective of the membership.
- Measure the conformance of contracted practitioners' medical records against HPSM medical record standards at least once every three years. Take steps to improve performance and re-measure to determine organization-wide and practitioner specific performance.
- Develop studies or quality activities for member populations using demographic data. Studies and/or activities are designed to identify barriers to improved performance and/or validate a problem or measure conformance to standards.
- Oversee delegated activities by:
    - establishing performance standards,
    - monitoring performance through regular reporting, and
    - evaluating performance annually
- Evaluate under and over-utilization, continuity, and coordination of care through a variety of methods and frequencies based upon members' needs. These methods include but are not limited to an annual evaluation of:
    - medical record review
    - rates of referral to specialists
    - hospital discharge summaries in office charts
    - communication between referring and referred-to physicians
    - quarterly analysis of member complaints regarding difficulty obtaining referrals
    - identification and follow-up of non-utilizing members
    - profiles of physicians
    - rates of referrals per 1000 members and
    - measurement of compliance with practice guidelines
- Coordinate QI activities with all other activities, including, but not limited to, the identification and reporting of risk situations, the identification and reporting of adverse occurrences from UM activities, and the identification and reporting of quality of care concerns through complaints and grievances collected through the Greivance and Appeals Department.
- Implement and maintain health promotion activities and disease management programs linked to QI actions to improve performance. These activities include, at a minimum, identification of high-risk and/or chronically ill members, education of practitioners, and outreach programs to members.
- Create and maintain the infrastructure to achieve accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting body as appropriate.

2.4 EVALUATION OF THE QI PROGRAM (QI 1, A, 7)

The QI Program is evaluated on an annual basis. Findings from the annual evaluation are used to make modifications to the QI Program Description and QI Work Plan as necessary.

The annual QI Program Evaluation includes:

- A description of completed and going QI activities that address the quality and safety of clinical care and quality of services
- Trending of measures to assess performance in quality and safety of clinical and the quality of service indicator data
- Analysis of the results of the QI initiatives, including barrier analysis that evaluates the effectiveness of QI interventions for the previous year (demonstrated improvements in the quality and safety of clinical care and in the quality service);
- An evaluation of the overall effectiveness of the QI program, including progress toward influencing safe clinical practices throughout the network that determines the appropriateness of the program structure, processes, and objectives

2.4.1 MONITORING OF PREVIOUSLY IDENTIFIED ISSUES (QI 1, A, 7)

Recommendations that are used to re-establish a Work Plan for the upcoming year which includes a schedule of activities for the year, measurable objectives, and monitoring of previously identified issues, explanation of barriers to completion of unmet goals and assessments of goals.

2.5 SCOPE OF QUALITY IMPROVEMENT PROGRAM

The QI Program provides for review and evaluation of all aspects of health care, encompassing both clinical care and services provided to external and internal customers. External and internal customers are defined as members, practitioners, governmental agencies, and Health Plan of San Mateo employees.
All departments participate in the quality improvement process. The Chief Medical Officer integrates the review and evaluation of components to demonstrate the process is effective in improving health care. Measuring clinical and service outcomes and member satisfaction is used to monitor the effectiveness of the process.

- The scope of quality review will be reflective of the health care delivery systems, including quality of clinical care and quality of service.
- All activities will reflect the member population in terms of age groups, disease categories and special risk status including those members with particularly complex needs.

The scope of services include, but are not limited to services provided in institutional settings including acute inpatient, long term care, skilled nursing, ambulatory care, home care and behavioral health (as provided by product line); and services provided by primary care, specialty care and other practitioners.

2.6 QI PROGRAM STRUCTURE (QI 1, A,1)

Oversight of the Quality Improvement Program is provided through a committee structure, which allows for the flow of information to and from the San Mateo Health Commission.

2.5.1 QI PROGRAM FUNCTIONAL AREAS AND RESPONSIBILITIES (QI 1, A, 1)

The Quality Improvement Department is responsible for implementing a multidimensional and multi-disciplinary QIP that effectively and systematically monitors and evaluates the quality and safety of clinical care and service rendered to members.

The Quality Improvement Program functions include, but are not limited to:

- Improve health outcomes for all members by incorporating health promotion programs and preventive medicine services into all the primary care delivery sites.
- Ensure effectiveness of continuous quality improvement activities across the organization.
- Evaluate the standards of clinical care and promote the most effective use of medical resources while maintaining acceptable and high standards. This includes an annual evaluation of the Quality Improvement Program.
- Improve health care delivery by monitoring and implementing corrective action, as necessary, for access and availability of provider services to members.
- Conduct effective oversight of delegated providers.
- Ensure strong collaboration between QI and other HPSM departments, such as Care Coordination, Pharmacy and Provider Services, as needed, to ensure the most effective action is being taken on various QI intiatives.

2.5.2 QUALITY IMPROVEMENT DEPARTMENT

The Quality Improvement Department reports to the Chief Medical Officer. Responsibilities of the department include:

- Provide staff support to the Quality Improvement Committee, Clinical Quality Improvement Committee (CQC); and Services Quality Improvement Committee;
- Develop initial drafts of the QI Program documents for review and approval by the QIC;
- Develop a work plan identifying the responsibilities of the operations that support the program implementation;
- Review and evaluate the work plans and quarterly reports of the sub-committees reporting to the CQC;
- Assist in the review and evaluation of delegates reports;
- Assist in data collection for selected components of contractual reporting requirements for external review agencies;
- Develop and implement systematic data collection methodologies;
- Assist in the development of research design and methodologies for disease management and health promotion programs;
- Monitor the QI Program to assure compliance with regulatory and accrediting agency requirements; and
- Assist in the development of company-wide policies and procedures related to Quality Improvement.

2.5.3 BEHAVIORAL HEALTHCARE SERVICES (QI 1, A, 2)

HPSM behavioral health management philosophy is to provide behavioral healthcare services to members in order to achieve the best possible clinical outcomes with the most efficient use of resources. It is our philosophy that timely, high-quality care, delivered by the appropriate provider in the least restrictive treatment setting is the key to achieving that objective. The goal of our Behavioral Health Program is to return our members to healthy, productive lifestyles as quickly as possible and to maintain that level.
Behavioral health benefits are structured as follows:

- Members with Serious Mental Illness are served by San Mateo County Behavioral Health and Recovery Services (BHRS) under the carve out of Specialty Mental Health Services
- Medi-Cal members with mild to moderate behavioral health conditions are served by Behavioral Health and Recovery Services which functions as a delegated entity under HPSM
- Medi-Cal members requiring Applied Behavioral Analysis (ABA) are served by Magellan Health Services which functions as a delegated entity under HPSM. Medi-Cal members under 21 years old receive

medically necessary BHT services whether or not the member has an autism diagnosis under the EPSDT benefit.

- Medi-Cal members under 21 receive even more comprehensive services under the Early and Periodic Screening, Diagnostic and Treatment benefit including mental health, developmental and specialty services.
- Members covered under other lines of business are also served by Behavioral Health and Recovery Services which is a delegated entity under HPSM
- Addiction treatment services are largely carved out and are managed by Behavioral Health and Recovery Services.

HPSM staff work closely with San Mateo County Behavioral Health and Recovery Services to oversee and monitor the behavioral health benefit. These activities include, but are not limited to assessing member satisfaction with behavioral health services; ensuring the network is of sufficient size and location for routine behavioral health services (emergency services are carved out); and studying efforts to improve clinical outcomes for members with depression who are screened and treated in the primary care setting. HPSM regularly monitors the continuity and coordination of care between medical and behavioral health practitioners, including facilitating interdisciplinary care teams and conducting case reviews for members with behavorial health conditions and complex medical needs as necessary. HPSM also measures and reviews access to behavioral health services, such as timely follow-up with behavioral health after hospitalization or emergency department visit for mental health condition.

2.6 QI PROGRAM AUTHORITY AND RESPONSIBILITY

The San Mateo Health Commission (Commission) assumes ultimate responsibility for the Quality Improvement Program (QIP) and has established Quality Improvement Committee (QIC) to oversee this function. The Commission plays a key role in monitoring the quality of health care services provided to members and improving quality services delivered to our members. The Commission authorizes and designates the Chief Executive Officer (CEO) as the individual responsible for the implementation of the QIP. The CEO has delegated oversight of the day-to-day operations of the QIP to the Chief Medical Officer (CMO).
The Quality Improvement Committee (QIC) and the Chief Medical Officer have the responsibility for planning, designing, implementing, evaluating and coordinating the patient care and clinical quality improvement activities. The QIC reports on QIP activities to the Commission.
Performance accountability of the Commission includes:

- Annual review and approval of the Quality Improvement Program description, Quality Improvement Work Plan and the Quality Improvement Program Evaluation.
- Review status of QIP and annual work plan at least quarterly.
- Evaluate effectiveness of QI activities and provide feedback to the QIC as appropriate.
- Establish direction and strategy for the QIP.

2.6.1 ROLE OF THE CHIEF MEDICAL OFFICER (QI 1, A, 4)

The Chief Executive Officer (CEO) has appointed the Chief Medical Officer (CMO) as the designated physician to support the Quality Improvement Committees outlined in this program by providing day-to-day oversight and management of all quality improvement activities. The Chief Medical Officer is responsible for:

- All activities requiring day-to-day physician involvement. The Chief Medical Officer may delegate performance of any of these responsibilities to other physicians within the Health Plan.
- Directing the Health Services Department and the various functions under its umbrella, including Quality Improvement, Credentialing, Utilization Management, Complex Care Coordination, Behavioral

Health Services (as covered by product line) and Pharmacy. The Chief Medical Officer consults with a contracted psychiatrist (designated behavioral health care practitioner), as necessary, for behavioral health issues.

- Communicating with the San Mateo Health Commission (Commission) information from the Quality Improvement Committee (QIC), the Clinical Quality Improvement Committee (CQC), the Credentialing Sub-Committee, the Utilization Management Committee (UMC), the Service Quality Improvement Committee (SQIC) and the Pharmacy and Therapeutics Committee (P&T).
- Communicating feedback from the Commission to the above listed committees.
- Serving as chair for the QIC, CQC, and the Credentialing/Peer Review/Physician Advisory Committee.
- Serving as the co-chair for the UMC and P&T.
- Overseeing meeting preparations for the above committees, educating committee members regarding the principals of quality improvement, keeping the committees and corporation current with the regulations and standards of the California Department of Health Care Services, Center for Medicare and Medicaid Services (CMS) and NCQA.
- Participating in the Service Quality Improvement Committee (SQIC) as a member and serving as an advisor to the committee.
- Ensuring that the goals, objectives and scope of the QIP are interrelated in the process of monitoring the quality of clinical care, clinical safety and services to members. The Chief Medical Officer will not be influenced by fiscal motives in making medical policy decisions and establishing medical policies.
- Ensuring that a review and evaluation of the components of the QIP are performed annually in order to demonstrate that the process is effective in improving member care, safety and services.
- Providing oversight to the implementation of the Quality Improvement Program (QIP).
- Guiding the formulation of quality indicators and clinical care guidelines in collaboration with network practitioners.
- Providing direct oversight of the credentialing and re-credentialing process.
- Developing or approving policies and procedures for quality improvement, credentialing, preventive health, utilization management, pharmacy management and behavioral health.
- Reviewing aggregated outcomes from member complaints and grievances, member satisfaction surveys and practitioners' satisfaction surveys.
- Overseeing the development of member and practitioner education relation to QIP issues.
- Ensuring that quality of care is a component in all policy development related to health care services.
- Communicating directly with practitioners on any issues of the QIP to include quality of care; peer review; credentialing; or clinical care guidelines.
- Assisting the senior management team in the analysis, design and implementation of interventions to improve health care service delivery.
- Communicating information and updates regarding the QIP to HPSM leadership and staff via general staff, senior management team meeting, and other internal meetings.
- Delegating staff from other divisions to perform QI Program activities by agreement of appropriate division chief.

2.6.2 ROLE OF PARTICIPATING PRACTITIONERS

Participating practitioners serve on the QIP Committees as necessary to support and provide clinical input. Through these committees' activities, network practitioners:

- Review, evaluate and make recommendations for credentialing and re-credentialing decisions;
- Review individual medical records reflecting adverse occurrences;

- Participate in peer review activities;
- Review and provide feedback on proposed medical guidelines, preventive health guidelines, clinical protocols, disease management programs, quality and HEDIS results, new technology and any other clinical issues regarding policies and procedures;
- Review proposed QI study designs; and
- Participate in the development of action plans and interventions to improve levels of care and service.

2.6.3 INVOLVEMENT OF DESIGNATED BEHAVIORAL HEALTH PRACTITIONER (QI 1, A, 5)

Health Plan of San Mateo has designated a behavioral health practitioner, a psychiatrist, for the QIP. The designated behavioral health practitioner advises the Quality Improvement Committee (QIC) to ensure that the goals, objectives and scope of the QIP are interrelated in the process of monitoring the quality of behavioral health care, safety and services to members.

HPSM also employs a Director of Behavioral Health and Substance Use Disorder Programs, a clinical psychologist, who is responsible for leading the clinical and administrative management of HPSM's behavioral health and substance use disorder programs across all lines of business. Their key functions include, but are not limited to:

- Management and oversight of key delegated relationships with BHRS and the BHT administrator
- Review and guadiance in the development and monitoring of quality improvement metrics, studies and interventions for behavioral health and substance use conditions and related services;
- Participation in the Clinical Quality Improvement Committee (CQC);
- Development of behavioral health and substance use clinical criteria;
- Review of potential quality incidences (PQIs) involving behavioral health and substance services, facilities or practitioners;
- Creation and review of quality improvement, care coordination and utilization mamagment policies and procedures for behavioral health and substance use services

2.6.4 RESOURCES AND ANALYTIC SUPPORT (QI 1, A, 1)

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

- Encounter data
- Claims data
- Pharmacy data
- Laboratory data
- Medical records
- Utilization data
- Utilization case review data
- Practitioner, provider and member complaint data
- Practitioner, provider and member survey results
- Appeals and grievance information
- Statistical, epidemiological and demographic member information
- Authorization data
- Enrollment data
- HEDIS data

- Behavioral Health data
- Risk Management data

In addition, Health Plan of San Mateo staff and analytical resources include, but are not limited to:

- Quality Improvement
- Health Education
- Utilization Management
- Member Services
- Case Management
- Provider Services
- Informatics
    - Quality Data Analyst
    - Information Systems Analysts
    - Biostatistician
    - Statistical Analysis System (SAS) software suite – a comprehensive system for analyzing data

The Quality Improvement Committee uses the above data and resources to fully evaluate the concern by objective or quantitative methods in order to define the specific problem. The Committee must proceed to implement a problem solving action based on its findings and the objective parameters measured. After adequate time has been permitted for problem resolution, a re-evaluation is performed using the same quantitative measures. The Committee bases the re-evaluation time frame (1 month, 3 months, 6 months, etc.) on the severity of the problem identified. The steps outlined below must be supported by adequate documentation of a problem-oriented approach to quality improvement:

- Define of specific indicators of performance through monitoring process
- Collect and analysis of appropriate data
- Identify opportunities to improve performance
- Implementation of interventions and/or guidelines to improve performance
- Measure effectiveness of interventions and/or conformance to guidelines
- Re-evaluate for further potential performance improvements with the same quantitative measures

2.6.5 DELEGATED QI ACTIVITIES (QI 1, A, 1)

Health Plan of San Mateo may delegate Utilization Management, Quality Improvement, Credentialing, Member Rights and Responsibilities, Medical Record and Facility Review, Claims payment and Preventive Health activities to Health Plans, County entities, and/or vendors who meet the requirements as defined in a written delegation agreement and delegation policies and according to NCQA accreditation and regulatory standards.

To ensure that delegates meet required performance standards, HPSM:

- Provides oversight to ensure compliance with federal and state regulatory standards, and NCQA standards for accreditation.
- Reviews and approves program documents, evaluations, and policies and procedures relevant to the delegated activities.
- Conducts required pre-delegation activities
- Conducts annual oversight audits
- Review reports from delegated entities
- Collaborates with delegated entities to continuously improve health service quality

The Delegation Oversight Committee oversees the delegate's compliance with delegation agreements/documents. HPSM monitors delegated compliance through an annual oversight review. Review includes appropriate policies and procedures, programs, reports and files may be reviewed at this time. Should an improvement action plan be required of the delegate, HPSM will review and approve the plan and perform follow-up tracking of compliance in accordance with stated time frames. If the delegated activities are not being carried out in accordance with the terms of the delegation agreement and/or improvement action plan, corrective action (up to and including revocation of delegated status) may be implemented.
Delegated oversight review results are reported to the QIP committees as appropriate and to the QIC.

2.6.6 COLLABORATIVE QI ACTIVITIES (QI 1, A, 1)

Collaborative activities. If the organization collaborates with other organizations on QI activities:

- It includes information about the collaborative and QI activities performed in the QI program description.
- It has communication and feedback mechanisms between the collaborative group and its internal QI Committee.

If the collaborative group has its own QI committee for carrying out functions, the organization may consider it to be a subcommittee of the QI Committee.

2.7 ANNUAL REVIEW AND UPDATE OF QUALITY IMPROVEMENT PROGRAM

The purpose of the annual QI Program Evaluation by the QIC is to determine if quality improvement processes and recommendations made throughout the year result in demonstrated quality improvements in health care, disease prevention and the delivery of health care services to members.
The annual evaluation assesses whether the QIP activities are systematically tracking improvement projects, resulting in improved clinical care and services, and providing appropriate follow-up of corrective actions to monitor their effectiveness. The QIC is responsible for assessing reports, analyzing study and survey findings, and identifying areas of care, which demonstrate improvement and other areas, which may still require interventions. Once a determination is made, the program plan is evaluated to see if certain processes require modification. A final report, including QIP program recommendations is submitted to the Commission for annual approval. The following aspects of the Quality Department activities are assessed during the annual plan evaluation:

- Ongoing surveillance of quality indicators for the year
- Quality improvement projects (goals and objectives) for the year
- Tracking of previously identified issues requiring continued surveillance
- Quality improvement review of the QIP and outcome results from the previous year
- Evaluation and modification, if necessary, of the QIP for the upcoming year
- Implementation of the quality improvement strategy
- Promotion of the development of an effective quality improvement program based on quality improvement strategies
- Completion of the work plan in a timely basis
- Determination if additional resources are necessary to accomplish the quality improvement strategy, and
- Recommendations for needed changes in the quality improvement program or administration

Practitioners and members are notified annually that a summary of the QIP is available upon request. This summary included information about the QIP's goals, processes, and outcomes are they relate to member care and service.

2.8 ANNUAL QUALITY IMPROVEMENT WORK PLAN

Annually the QI department develops a QI Work Plan for the calendar year. The Work Plan integrates QI reporting, studies from all areas of organization (clinical and service) and includes requirements for external reporting. The QI Work Plan is also based on the results of the annual program evaluation.

The Work Plan includes the following elements:

- Measurable objectives for each QI activity planned for the year, including patient safety
- Program scope
- Activities planned for the year, the quality, and safety of clinical care and service indicators, benchmarks, performance goals and previous year results
- Timeframe within which each activity is to be completed.
- The person responsible for initiation, implementation, and management of each activity
- Planned monitoring and follow-up activities from previously identified issues
- Time frame for evaluation of the effectiveness of the QI Program.

Planned Additions to the QI Work Plan include:

- Scheduled reports to the QIC and the Commission
- Scheduled reporting to external regulators (i.e. DHCS)
- The oversight of reporting delegated activities
- Schedules of all planned quality activities (i.e. member satisfaction surveys, practitioner compliance surveys)

2.9 APPROVAL OF THE QUALITY IMPROVEMENT PROGRAM

Annually, following each review and update, the Quality Improvement Program description and work plan is reviewed and approved by the Quality Improvement Committee, the Chief Medical Officer and the San Mateo Health Commission. The approval process includes the authorized signatures at each level of review.

3. QUALITY IMPROVEMENT PROGRAM COMMITTEES

QI PROGRAM COMMITTEE MEETINGS

The Quality Improvement Committee (QIC) and subcommittees convene at regularly scheduled meetings, or more often is the chairperson deems it necessary; minimum frequency for QIC meetings will not extend beyond a quarterly basis. Meetings may be held in person or via teleconference.

A quorum consisting of either four members or 50% of the members, whichever is less, must be present for any QIP committee to conduct business, unless the chairperson has attempted to reschedule and notify participants of the meeting and a quorum still does not exist.

If a quorum cannot be assembled within thirty (30) minutes of the scheduled meeting, those in attendance will select an alternate date and time. If at the alternate meeting, a quorum is still not present and cannot be obtained within thirty (30) minutes, the committee may either elect to meet and conduct business or adjourn. If the committee elects to meet, action items may be voted upon via email following the meeting.

The chairperson, with the assistance of the co-chair, is ultimately responsible for notifying committee members about the meeting schedules. Reminder phone calls will be placed to the committee members a minimum of

three (3) days prior to the scheduled meeting to encourage participation. An agenda and any necessary reading materials will be mailed to participants in advance to expedite the meeting time and prepare for discussion.

QI PROGRAM COMMITTEE MINUTES

Comprehensive, accurate minutes are prepared and maintained for each QI Program regular or ad hoc meetings. Minutes include at a minimum, the name of the committee, date, list of members present, and the names and titles of guests, if applicable. The minutes reflect all decisions and recommendations, including rationale for each, the status of any activities in progress, and a description of the discussions involving recommended studies, corrective action plans, responsible person, follow-up and due date. Minutes of the QI Program committees meetings are provided for review to the:

- Committee members
- San Mateo Health Commission, and
- Regulatory bodies (as required and applicable).

QI PROGRAM COMMITTEE AGENDAS

The QIP Committees agendas shall follow the basic outline:

- Review of Minutes
- Unfinished Business
- Ongoing Reports
- Review of Protocols/Policies
- New Business

Copies of all minutes, reports, data, medical records and other documents used for quality or utilization review purposes, are maintained in a manner that will ensure confidentially of the members and providers involved in each case. Access to these records is restricted to the QIP committees' members and selected administrative personnel as deemed necessary (i.e., CEO, legal staff/counsel, Commission). All sensitive information, medical records and QIC findings are maintained in secure files.
QIP reports, minutes, audit results and other Quality Improvement documentation are only distributed for review to the:

- Chief Medical Officer
- Chief Executive Officer
- San Mateo Health Commission
- QIP Committee members
- Regulatory bodies (as required and applicable)

All distributed copies are collected and destroyed after review; originals are maintained in secured files by committee chair and/or co-chair.

QI PROGRAM COMMITTEE RESPONSIBILITIES AND FUNCTIONS

- Review the QI Program Description that establishes strategic direction for HPSM and forward to the Commission for approval.

- Evaluate the Quality Work Plans, which includes providing feedback and recommendations to the appropriate sub-committee department and forward to the Commission for approval.
- Evaluate the effectiveness of the QI Program with input from other committees and departments annually.
- Receive, review and analyze status reports on the implementation of Work Plans, including aggregate trend reports and analysis of clinical and service indicators.
- Appoint subcommittees and ad hoc committees as needed.
- Ensure that system-wide trends are identified and analyzed.
- Ensure that quality improvement efforts are prioritized, resources are appropriate, and resolutions occur.
- Prioritize quality improvement efforts and assure that resources are allotted.
- Approve Quality Improvement Program policies.
- Ensure appropriate oversight of delegated activities.
  Ensure integration, coordination, and communication among committees reporting to QIC.

QI PROGRAM COMMITTEE MEMBERS (QI 1, A, 1)

For staff participants, qualifications and term of service as a Committee member is determined by the duration of time a staff member holds the position, which initially qualified him/her for Committee membership (i.e., term of service continues as long as the Quality Improvement Director holds his/her position which is also a designated position on the QIC).

Selected contracted practitioners and providers are invited to serve as members of a QI Program Committee by the chairperson or co-chair. Selection is based on the following attributes:

- Availability/accessibility
- Board certification
- Communication skill/diplomacy
- Credentials/re-credentials verification
- Interest/enthusiasm
- Knowledge/expertise
- Managed care knowledge/experience
- Medical/surgical experience
- Peer/personal recommendation
- Previous quality committee experience
- QM audit results greater than average
- Reputation/ethical standards
- Specialty type

A practitioner representative selected to participate on any QI Program Committee continues to serve as long as he/she continues to qualify as a contracted practitioner whose specialty is required on the Committee panel and meets acceptable standards of behavior, with the following exceptions:

- Practitioner requests voluntary removal or
- Involuntary request for removal may be made when a provider:
  - Is no longer qualified
  - Is repeatedly unavailable (unexcused absences from three consecutive meetings)

- Develops a conflict of interest
- Behavior is disruptive and not conducive to effective, professional discussions and performance of business
- Fails to meet QIP expectations

REPORTING RELATIONSHIPS OF QI DEPARTMENT STAFF AND THE QI PROGRAM COMMITTEES (QI 1, A, 1)

Methods of communication include, but are not limited to, quality improvement reports, oral presentations and discussions, memorandums, policies and procedures and meeting minutes. HPSM monitors providers through quality monitors and on-site inspections and audits. The Quality Improvement Manager is the focal point for convergence of quality improvement related activities and information.

The QI Manager is responsible for the coordination and distribution of all QI Program related data and information. The Quality Improvement Committee (QIC) reviews, analyzes, makes recommendations, initiates actions, and/or recommends follow-up based on the data collected and presented. The Chief Medical Officer communicates the QIC's activity to the Commission. The Commission reviews QI activities. Any concerns of the Commission are communicated back to the source for clarification or resolution.

CONFLICT OF INTEREST

Health care providers serving on any QI Program Committee, who are/were involved in the care of a member under review by the committee, are not allowed to participate in discussions and determinations regarding the case. In addition, committee members cannot review cases involving family members, providers with whom they have a financial or contractual affiliation or other similar conflict of interest issues. Prior to participating in any QIP activities, committee members are required to sign a Conflict of Interest statement, which is maintained on file in the Quality Department.

CONFIDENTIALITY

Because of the goals and objectives of the QIP, sensitive and confidential information is often discussed during CQC and Credentialing Sub-Committee meetings. All participants understand that information and parties under investigation or discussion by the Committee members are considered confidential. Prior to participating in CQC and Credentialing activities, committee members are required to sign a Confidentiality Statement which is kept on file in the Quality Department.

3.1 QUALITY IMPROVEMENT COMMITTEE OVERSIGHT (QIC) (QI 1, A, 6)

The Quality Improvement Committee (QIC) establishes strategic direction, recommends policy decisions, analyzes and evaluates the results of QI activities, and ensures practitioner participation in the QI program through planning, design, implementation, or review. The QIC ensures that appropriate actions and follow-up are implemented and evaluates improvement opportunities. The QIC meets and reports at least quarterly to the Commission. The QIC is a multi-disciplinary committee, the membership includes:

- At least one Commission member, (Current chair)

- Medical Director, (Current co-chair)
- Quality Improvement Director
- Practicing network physicians
- Support staff and guests will be invited to attend the meetings as reporting requirements dictate.

3.2 CLINICAL QUALITY COMMITTEE (CQC)

The Clinical Quality Committee advises QIP program activities and procedures performed to monitor and evaluate the quality, safety, and appropriateness of health care. The CQC meets at least quarterly and reports up to the QIC.

CQC RESPONSIBILITIES

- Analyzing demographic and epidemiological data.
- Identifying risk member populations.
- Selecting disease management clinical practice guidelines and quality activities.
- Developing, communicating and implementing clinical practice guidelines based on current medical standards of care. These guidelines include, but not limited to, standards instituted and approved by the following:
    - American Academy of Family Physicians
    - American Board of Internal Medicine
    - American Academy of Pediatrics
    - American Academy of Ophthalmology
    - American College of Obstetricians and Gynecologists
    - California's Child Health and Disability Prevention Program
    - Health Care Effectiveness Data and Information Set (HEDIS)
    - United States Preventive Services Task Force
- Identifying sub-optimal care through the analysis of data referred from all departments.
- Reviewing and approving identified trends and opportunities for improvement and recommendation for strategies to prevent adverse outcomes.
- Identifying practitioners/providers not complying with HPSM medical care standards, service standards, guidelines and/or policies and proceduresReviewing and approving action plans for practitioners/providers in collaboration with company-wide departments.

CQC MEMBERS

The Clinical Quality Committee consists of the representatives listed below. Additional participants and staff representatives provide useful information and/or serve as liaisons to their respective departments.

- Chief Medical Officer, co-chair
- Quality Improvement Director, co-chair
- Medical Directors
- UM Manager
- Provider Relations representative
- Care Coordination Manager
- Pharmacy Services Director

- Director of Behavioral Health and Substance Use Disorder Programs

CQC MAJOR RESPONSIBILITIES

CHIEF MEDICAL OFFICER:

- Serves as the Committee co-chairperson
- Reports CQC activities to QIC and Commission

QUALITY IMPROVEMENT DIRECTOR:

- Serves as the Committee co-chairperson
- Reports CQC activities to the QIC, in the absence of the Chief Medical Officer
- Conducts literature searches to help develop potential indicators based on accepted standards of care
- Develop mechanisms to collect, store and profile data
- Reports summaries of site inspections, quality indicator screens, medical records audits, member complaints and grievances, environmental health and safety/infection control issues, risk management issues and other issues as indicated to the Committee

3.3 CREDENTIALING, PEER REVIEW AND PHYSICIAN ADVISORY COMMITEE

The committee is responsible for the review of credentialing files and makes decisions regarding credentialing and re-credentialing of practitioners. The Credentialing Committee makes decisions regarding provider organizational credentialing/re-credentialing. The committee is responsible for the review of performance data at the time of re-credentialing and making on-going contract recommendations as a result of re-credentialing.

The Credentialing sub-committee serves as the practitioner Peer Review and Appeals Committee. Peer review issues are presented for review discussion and determination of appropriate improvement action plans. The committee makes a reasonable effort to obtain the facts and conduct – hearing procedures for health care practitioners.

The committee meets at least quarterly. The Chief Medical Officer, or designee, is the chairperson. The functions of the Credentialing Committee are:

- Review, recommend, and approve procedures for practitioner/provider credentialing/re-credentialing.
- Review and provide final decision of practitioner/provider credentials reviewed and presented by the CMO, or designee, that did not meet "clean file" category.
- Review and approve a practitioner/provider profile with input from all departments that analyze performance in conjunction with the re-credentialing process.
- Review and approve credentialing/re-credentialing standards/policy and procedures.
- Review and approve quality of care and service indicators for re-credentialing.
- Review of delegated credentialing performance.

3.4 PHARMACY AND THERAPEUTIC (P&T) COMMITTEE

The P&T Committee meets and reports to the QIC at least quarterly. The Chief Medical Officer and Pharmacy Director serve as co-chairs.

P& T COMMITTEE MEMBERSHIP:

- Chief Medical Officer
- HPSM Pharmacists
- Network primary and specialty care practitioners
- Pharmacy Services Director

P&T COMMITTEE RESPONSIBILITIES AND FUNCTIONS:

- Formulating policies on the evaluation, selection, distribution, use and safety procedures relating to medication therapy.
- Developing and maintaining the Drug Formulary.
- Monitoring activities related to the Formulary Exception Policy.
- Monitoring prescribing practices and drug utilization for appropriateness.
- Submitting quarterly report to the QIC of the status of all activities.

3.5 UTILIZATION MANAGEMENT COMMITTEE (UMC)

The Utilization Management Committee provides direction to and oversight of the Utilization Management Program (UMC). The UMC meets at least quarterly and reports to the QIC quarterly. The Chief Medical Officer serves as the chair.

The UMC is a multi-disciplinary committee whose members include:

- Chief Medical Officer
- Medical Directors
- UM Manager
- Care Coordination Manager
- Quality Improvement staff representative
- Network practitioners as appropriate

UMC RESPONSIBILITIES AND FUNCTIONS

- Reviews and approves the UM Program Description that establishes direction for the organization
- Receives, reviews, and analyzes utilization reports on the progress of the UM Program
- Conducts new technology assessment
- Reviews recommendations for delegation of utilization management and makes recommendations to the QIC
- Formalizes UM policies and procedures
- Reviews, approves, and distributes medical criteria for review at least annually
- Monitors continuity and coordination of care
- Conducts under/over utilization monitoring on practitioner specific and organizational-wide dimensions
- Evaluates satisfaction with the UM Program using member and practitioner input.

3.6 SERVICE QUALITY IMPROVEMENT COMMITTEE (SQIC)

The Service Quality Improvement Committee (SQIC) monitors and evaluates the quality, safety, and appropriateness of non-clinical services to members, practitioners and providers and operations of the

organization. The Service Quality Improvement Committee meets at least quarterly and reports up to the QIC. The Quality Improvement Director is the chairperson.

The Service Quality Improvement membership includes:

- Chief Medical Officer
- Chief Information Officer, or designee
- Claims Director
- UM Manager
- Chief Compliance Officer, or designee
- Member Services Manager
- Grievance and Appeals Manager
- Director of Customer Support

SQIC RESPONSIBILITIES AND FUNCTIONS

Responsibilities of the Service QIC include reviewing and making recommendations for interventions to improve all service activities relative to:

- Complaints
- Grievances
- Member and Provider Appeal trends
- Member satisfaction survey data
- Telephone and turnaround time standard performance
- UM turnaround times
- Access and availability
- Claims services standards
- Enrollment service standards
- Plan operations
- Member and practitioner satisfaction/dissatisfaction as identified by surveys including monitoring of PCP change request and results of access and availability monitoring.

3.7 CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) COMMITTEE

The primary function of the committee is to provide oversight and support to all Culturally and Linguistically Appropriate Services (CLAS) Program activities. HPSM CLAS activities are imbedded into the daily work of each employee at the health plan. Structurally, the CLAS Program is integrated into the Quality Improvement Program. The CLAS Committee meets quarterly and reports to the Service Quality Committee, Clinical Quality Committee, Consumer Advisory Committee and Quality Improvement Committee.

CLAS COMMITTEE COMPOSITION & TERMS

The CLAS Committee is intended to leverage the experience, expertise, and insight of key individuals at HPSM to ensure organizational compliance with regulatory CLAS program requirements. The CLAS Committee is a multidisciplinary team that is comprised of Managers and Supervisors, as well as key staff throughout the organization with direct member interaction.

All members will remain on the committee unless or until replaced by another department representative. Members on the CLAS Committee include representatives from the following units:

CLAS COMMITTEE RESPONSIBILITY AND FUNCTION

The CLAS Committee objectives are also aligned with the National CLAS Standards and are intended to advance healthy equity, improve quality and help eliminate health disparities for HPSM's member population. The CLAS Committee is responsible for reviewing, updating and implementing the Cultural Competency Plan. The CLAS Committee oversees policies, activities and procedures that meet requirements provided by State and Federal regulators. This ensures that all plan members-regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status, or disability have equal access to health care.

4. PATIENT SAFETY (QI 1, A 3)

Health Plan of San Mateo is committed to an ongoing collaboration with network practitioners, providers and vendors to build a safer health system. This is accomplished through established quality initiatives that promote best practices, tracking outcomes and educating patients, providers and members. The goals of the safety program include but are not limited to:

- Informing and educating members, practitioners and providers of issues affecting member safety
- Identifying and evaluating strategies for analyzing events, promoting reporting and improving patient safety

HPSM also has a Potential Quality Issues (PQI) program that identifies deviation from expected provider performance, clinical care, or outcome of care. This accomplished through the systematic review of a variety of data sources, such as grievances, utilization review, medical record and facility site audits, and referrals by plan staff and providers. The reporting and processing of PQIs determines opportunities for improvement in the provision of care and services to HPSM members, and directs appropriate actions for improvement based upon outcome, risk, frequency and severity.

ADMINISTRATIVE PATIENT SAFETY ACTIVITIES

In addition to the activities listed below, HPSM participates in many other patient safety activities. These activities include, but not limited to:

- Conducts office site reviews as a part of the initial practitioners credentialing process, and triennially thereafter
- Conducts a rigorous credentialing and re-credentialing process to ensure only qualified practitioners and organizations provide care in the network
- Establishes a process that monitors the continuity and coordination of care between the medical delivery system and behavioral healthcare, and between the medical delivery system and health delivery organizations.

RISK MANAGEMENT

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

MECHANISMS FOR COMMUNICATION

- HPSM website
- Newsletters
- Drug safety recalls, refill history and dosage alerts
- Safety specific letter to individual practitioners, providers or members

MONITORING AND EVALUATION

Patient safety activities are monitored continuously and will be trended and reported quarterly. The Patient Safety Program will be evaluated annually.

4.1 SAFETY OF CLINICAL CARE ACTIVITIES

4.1.1 FACILITY SITE REVIEWS (FSR)

HPSM conducts provider site reviews for all new Medi-Cal PCP as a pre-contractual requirement prior to initial credentialing. HPSM conducts provider re-credentialing site reviews triennially for Medi-Cal Primary Care Providers, as a requirement of participation in the California State Medi-Cal Managed Care Program, regardless of the status of other accreditation and/or certification. A full scope review is conducted utilizing the criteria and guidelines of California Department of Health Services Medi-Cal Managed Care (MMCD Policy Letter 14-004 Full Scope Site Review Survey and Medical Record Survey Tool, and Policy Letter 12-006).

Full Scope Facility Site Review
New providers are required to have a site review within thirty days of signing a contract with HPSM. If an overall score is less than 90%, a critical element of deficiency is identified, a deficiency is identified in Pharmacy or Infection Control, or a particular review section receive less than 90%, a Corrective Action Plan (CAP) is completed. No members are assigned to the provider until all CAP corrections have been addressed and a passing score has been demonstrated.

HPSM reviews sites more frequently when determined necessary based on monitoring, evaluation or Corrective Action Plan (CAP) follow-up needs. Additional site reviews may be performed pursuant to a request from the Peer Review Committee, the Quality Improvement Committee, and the San Mateo Health Commission. Additional reviews may also be done at the discretion of the Medical Director or the Quality Improvement Nurse if patient safety or compliance with applicable standards is in question.

The same audit criteria applicable for Initial Full Scope Site Review are applicable for subsequent site reviews.

The six areas of focus for the site review are:
- Access/Safety
- Personnel
- Office Management
- Clinical Services
- Preventive Services
- Infection Control.

4.1.2 MEDICAL RECORD REVIEW

Ten (10) medical records are reviewed initially for each PCP as part of the site review process and every three years thereafter. During any medical record survey, reviewers have the option to request additional records for review. If additional records are reviewed, scores must be calculated as outlined in this policy.

Sites where documentation of patient care by multiple PCPs occurs in the same record are reviewed as a "shared" medical record system. Shared medical records are considered those that are not identifiable as "separate" records belonging to any specific PCP. A minimum of 10 records are reviewed if two to three PCPs share records, 20 records are reviewed for four to six PCPs, and 30 records are reviewed for seven or more PCPs.

Medical records of new providers are reviewed within 90 calendar days of the date on which members are first assigned to the provider. An extension of 90 calendar days may be allowed *only if* the new provider does not have sufficient HPSM members assigned to complete a review of 10 medical records. If there are still fewer than 10 records for assigned members at the end of six months, a medical record review is completed on the total number of records available, and the scoring is adjusted according to the number of records reviewed.
The six criteria assessed by Medical Record Review are:

- Format
- Documentation
- Continuity/Coordination
- Pediatric Preventive
- Adult Preventive
- OB/CPSP Preventive

4.1.2 PHYSICAL ACCESSIBILITY REVIEWS (PAR)

Health Plan of San Mateo conducts Physical Accessibility Review (PAR) for all existing and new primary care providers, High-Volume Senior and Person with Disabilities (SPD) Specialist, High- Volume SPDs Ancillary Services and CBAS Centers. Also, those defined with five or more SPD encounters per day. Department of Health Care Services Policy Letter 12-006 and All Plan Letter 15-023 requires Medi-Cal managed care health plan to use FSR Attachments C, D and E appropriate to their provider type in line. Each survey tools comes with the Level of Accessibility and Accessibility Indicators.

PAR are scheduled and performed within 3 years of the provider's office or sites last visit. Providers whom move to a new location must receive a new PAR within 30 calendar days after the date the new site opened for business or HPSM's notification date. If there are no changes to the site and PAR remains the same, a signature and date from the office will be required to indicate of no changes since the last PAR. Changes include physical changes to the parking lots, exterior building, interior building, restrooms, exams rooms, patient's diagnostic/treatment use and participant areas.
Attachment 'C' is used for Providers offices or sites. There are 29 critical elements in this tool. If all 29 Critical elements are met, the provider or the sites will receive "Basic Access" If there is one or more deficiencies the provider or the site will receive "Limited Access". Medical Equipment is determined if the provider office or the site meets ADA equipment requirements.

Attachment 'D' is used for Ancillary Services in which are referred to Diagnostic and Therapeutic services. There are 34 Critical elements in this tool. If all 34 critical elements are met, the site will receive "Basic Access". If there is one or more deficiencies the site will receive "Limited Access". Medical Equipment is determined if the site meets ADA equipment requirements.

Attachment 'E' is used for Community Based Adult Services (CBAS). There are 24 critical elements. If all 24 Critical elements are met, the site will receive "Basic Access". If there are one or more deficiencies the site will receive "Limited Access".

Accessibility Indicators are the following:

Accessibility Indicator Symbols
P= Parking
EB= Exterior Building
IB= Interior Building
R= Restroom
E=Exam Room
T=Medical Equipment
PD=Patient Diagnostic and Treatment Use
PA= Participant Areas

Providers or the site will received PAR results indicating their level of accessibility as well as accessibility indicators. Provider Services department will also receive a copy to be published in our HPSM Provider Directory and MMP website.

HPSM will submit to DHCS updated SPD high volume provider documentation by January 31st of each year, indicating any changes made to the high-volume benchmarks as a results of the availability of more complete utilization data. If no changes are made, HPSM will respond accordingly to DHCS.

4.1.3 QUALITY ISSUE IDENTIFICATION

To provide overall quality functioning, each division and/or department will continually monitor specific important aspects of care. These aspects or activities of care and/or service include, but are not limited to:

- Access/Availability
- Continuity/Coordination
- Health and Pharmacy Management Systems
- Under/Over Utilization
- Behavioral Healthcare
- Chronic/Acute Care
- High-Risk/High-Volume/Problem Prone Care
- Preventive Healthcare
- Member Satisfaction/Dissatisfaction (Customer Service)
- Member Appeals and Grievances
- Medical Record Documentation
- Clinical Practice Guidelines/Preventive Health Guideline Compliance
- HPSM Service Standards
- Individual Care Review
- Potential Quality Issue Tracking
- Credentialing
- Provider Relations
- Claims Analysis
- Marketing Feedback

The QIC, with input from its reporting committees, develops and implements a process that addresses improving member safety. The goal of the process is to foster a supportive environment to aid practitioners and organizational providers in improving safety in their practice. Activities that may be included in this process are:

4.2 CARE COORDINATION PROGRAMS

- Assists in the coordination of managed care efforts to reduce or prevent omission or duplication of orders when multiple providers are involved
- Monitors Emergency Room utilization beyond a threshold of two or more times in any quarter to identify the lack of primary care, the absence of coordinated care, potential drug interactions, unnecessary testing and treatments, omission or duplication of care, or patient non-adherence with a care plan.

4.3 DRUG SAFETY

HPSM monitors for appropriate medication use to ensure the safety of members. These techniques include, but not limited to:

- Potential drug and drug disease interactions
- Analyzing pharmacy data to identify polypharmacy, potential adverse drug reactions, inappropriate medication usage, excessive controlled substance usage and voluntary drug recalls
- Assuring that affected members and practitioners are notified of FDA or voluntary drug alerts
- Notification and education of members and practitioners of other identified events
- Conducting pharmacy system edits to assist in avoiding medication errors

Working with contracted pharmacies to assure a system is in place for classifying drug-drug interactions and/or notifying dispensing providers of specific interactions when they meet HPSM's severity threshold

4.4 UTILIZATION MANAGEMENT

The concurrent review process has established a medical management process which follows identified participants throughout the healthcare delivery system to ensure optimal delivery of care including transition from acute to subacute, long term care and home settings.

Please refer to Health Plan of San Mateo UM Program Description for more details.

4.5 HEALTH MANAGEMENT PROGRAMS

Work to assist, communicate, and educate patients and practitioners in standard of care in all aspect of specific disease processes. These programs are especially important to help identify over and under-utilization, patient non-compliance, and care that does not meet the standards, thus assisting to reduce adverse medical events. Clinical practice guidelines go hand-in-hand with the disease management programs and addresses patient safety by communicating evidenced based standards of care to practitioners and members.

4.6 QUALITY IMPROVEMENT

- Establishes standards for medical record documentation

- Conducts an on-going medical review process that evaluates key components of documentation to address patient safety
- Establishes a rigorous process for investigation and resolution of complaints, especially quality of service and care complaints against practitioners and providers
- Monitors quality of care indicators to identify patterns and/or trends
- Strives to contract only with hospitals and ancillary providers that are JCAHO accredited or other nationally recognized accreditation organization

5. SERVING MEMBERS WITH COMPLEX HEALTH NEEDS (QI 1, A, 9)

Health Plan of San Mateo (HPSM) ensures that members with complex health needs receive medically necessary services in a timely manner. HPSM is committed to coordinating care for these members and ensuring access to appropriate specialty and primary care. This includes:

- Providing care coordination/case management services for
    - Members who have multiple comorbidities
    - Members with ESRD
    - Members with malignancies, HIV/AIDS, degenerative disorders
    - Members with significant co-existing medical and behavioral issues
- Identifying and addressing any barriers to care for members with complex needs
  Coordinating care across the continuum

6. QUALITY IMPROVEMENT PROGRAM ACTIVITIES

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

PRIORITIZATION

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

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

USE OF COMMITTEE FINDINGS

To the degree possible, quality improvement systems are structured to recognize care for favorable outcomes as well as correcting instances of deficient or sub-optimal practice. The vast majority of practicing physicians provide care results in favorable outcomes. Quality improvement systems explore methods to identify and recognize those treatment methodologies or protocols that consistently contribute to improved health outcomes. Information of such results is communicated to the Commission and providers on a regular basis. Written communication to primary practitioners is the responsibility of the Committee chairperson. Submission of written corrective action plans, as necessary, is required for the Committee's approval. Significant findings of quality improvement activities are incorporated into practitioner educational programs,

the re-credentialing process, and the re-contracting process and personnel annual performance evaluations. All quality improvement activities are documented and the result of actions taken recorded to demonstrate the program's overall impact on improving health care and the delivery system.

PREVENTIVE HEALTH/HEDIS MEASURES

The Clinical Quality Committee will determine aspects of care to be evaluated based on member population and regulatory requirements. At a minimum, HEDIS performance indicators will be monitored annually. These include:

- Adult Body Mass Index (BMI) Assessment
- Adult's Access to Preventive/Ambulatory Health Services
- Ambulatory Care
- Annual Monitoring for Patients on Persistent Medications
- Antibiotic Utilization
- Antidepressant Medication Management
- Asthma Medication Ratio
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Breast Cancer Screening
- Board Certification Status
- Care for Older Adults
- Cervical Cancer Screening
- Childhood Immunization Status – Combo 3
- Children and Adolescent's Access to Primary Care Providers
- Colorectal Cancer Screening
- Comprehensive Diabetes Care
- Controlling High Blood Pressure
- Depression Screening and Follow-Up for Adolescents and Adults
- Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
- Follow-Up After Emergency Department Visit for Mental Illness
- Follow-Up After Hospitalization for Mental Illness
- Hospitalization for Potentially Preventable Conditions
- Identification of Alcohol and Other Drug Services
- Immunizations for Adolescents
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Language Diversity of Membership
- Medication Management for People with Asthma
- Medication Reconciliation Post-Discharge
- Mental Health Utilization
- Non-Recommended PSA-Based Screening in Older Men
- Osteoporosis Management in Women Who Had a Fracture
- Persistence of Beta Blocker Treatment After a Heart Attack
- Pharmacotherapy Management of COPD Exacerbation
- Plan All-Cause Readmissions
- Potentially Harmful Drug-Disease Interactions in the Elderly

- Prenatal and Postpartum Care
- Race/Ethnicity Diversity of Membership
- Standardized Healthcare-Associated Infection Ratio
- Statin Therapy for Patients with Cardiovascular Disease
- Statin Therapy for Patients with Diabetes
- Transitions of Care
- Use of High-Risk Medications in the Elderly
- Use of Imaging Studies for Low Back Pain
- Use of Opioids at High Doses
- Use of Opioids from Multiple ProvidersUse of Services - Acute Hospital Utilization
- Use of Services – Ambulatory Care
- Use of Services – Emergency Department Utilization
- Use of Services – Inpatient Utilization – General Hospital/Acute Care
- Use of Services – Mental Health Utilization
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Weight Assessment/Counseling for Nutrition & Physical Activity for Children/Adolescents
- Well Child Visit in the Third, Fourth, Fifth, and Sixth Years of Life

6.1 POPULATION HEALTH MANAGEMENT PROGRAMS

The Health Services Department staff, Clinical Quality Committee and network practitioners identify members with, or at risk for, chronic medical conditions. The Clinical Quality Committee is responsible for the development and implementation of population health management strategies. Population health management is a framework that utilizes population identification monitoring data, health assessments and risk stratification to develop a continuum of care that includes health interventions both cultural/organizational and tailored to promote positive program outcomes. This is a new program that is being developed to meet the NCQA requirements and more details including PHM activity descriptions can be found in *HPSM's Population Health Management Program Description*. This new program will use strategies to address the health care needs of members across the continuum of care. HPSM will assess the needs of its members to determine the appropriate types of interventions to improve health outcomes. We will work with providers to assist with the population health management program through the use of value-based payment arrangements and data sharing. HPSM will use evidence-based tools to assess member's health and provide interactive self-management tools for members to use to address their identified health issues. For those members with multiple of complex health conditions, HPSM will implement a coordinated care program to ensure access to quality care. All of the population health management programs will be evaluated to assess if they have achieved their goals and determine areas of improvement.

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

Components of complex case management and chronic care improvement programs shall include:

1. Initial assessment of members' health status, including condition-specific issues.
2. Documentation of clinical history, including medications.
3. Initial assessment of the activities of daily living.
4. Initial assessment of behavioral health status, including cognitive functions.
5. Initial assessment of social determinants of health.
6. Initial assessment of life-planning activities.
7. Evaluation of cultural and linguistic needs, preferences or limitations.
8. Evaluation of visual and hearing needs, preferences or limitations.
9. Evaluation of caregiver resources and involvement.
10. Evaluation of available benefits.
11. Evaluation of community resources.
12. Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan.
13. Identification of barriers to member meeting goals or complying with the case management plan.
14. Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals.
15. Development of a schedule for follow-up and communication with members.
16. Development and communication of a member self-management plan.
17. A process to assess member progress against the case management plan.

POPULATION IDENTIFICATION(PHM. 2)

NCQA's Population Health Management standard 2(PHM.2) requires HPSM to conduct an annual analysis of the characteristics and needs of its Medi-Cal population. Its purpose is to identify relevant member subpopulations for a reassessment of their alignment with the health plan's current population health management programs and resources. A Quality Improvement (QI) Specialist collects member data from various internal reports, and interviews program managers for supplemental qualitative data, to prepare two annual reports: the Population Assessment Report and the Population Segmentation Report. Collectively, they describe HPSM's Medi-Cal member subpopulations and their classification into program intervention categories associated with their needs. The QI Specialist presents the reports' findings in a summary presentation to the the Clinical Quality Committee (CQC).

2019 ANNUAL POPULATION ASSESSMENT REPORT (PHM 2.B AND 2.C)

The framework for the content of the Population Asssessment Report reflects NCQA's specifications for identifying the health plan's population characteristics and needs, and for reviewing HPSM's population health management activites and resources that correspond to those needs. Factors include assessing the needs of child and teen members, members with disabilities, and of other relevant member subpopulations. The assessment also includes identifying social determinants of health most common to HPSM's member subpopulations. The QI Specialist uses the following characteristics to identify relevant subpopulations based on member data reports from Informatics.

- Eligibility categories for Medi-Cal managed care

- Medi-Cal enrollment by ethnic/racial and age groups
- Eligibility for special needs programs
- Needs related to social determinants of health (need for stable housing and community-based resources for independent living)

HPSM's program structure and PHM strategies for addressing population needs includes active partnerhsips with community agencies and organizations. These are partnerships that enable HPSM staff to connect members with complex social needs to social services that provide assistance and support. The QI Specialist reviews HPSM's member enrollment data for social services, which includes following programs/services. She also meets with the Care Coordination Manager to review staff referral activities to the following

- Community Care Settings Pilot
- In-Home Supportive Services
- Multi-purpose Senior Support Program
- Community Based Adult Services
- Aging and adult services
- Golden Gate Regional Center

2019 ANNUAL POPULATION SEGMENTATION REPORT (PHM 2.D)

The population segmentation report describes the stratification of HPSM's entire Medi-Cal membership into three population risk level subsets. It identifies subpopulations within each subset and the specific PHM programs/interventions that correspond to their care needs. Its purpose is to provide a "point-in-time" snapshot report that shows the number of members that are eligibile for each of HPSM's PHM services/resources.

- Low Risk Population Subset– Members targeted for Wellness and Education Interventions
- Moderate Risk Population Subset - Members targeted for Disease or Condition Management Interventions
- High Risk Population Subset – Members targeted for the Care Coordination Progam

6.2 CONTINUITY AND COORDINATION OF CARE

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

- Primary care services
- OB/GYN services
- Behavioral health care services
- Inpatient hospitalization services
- Home health services
- Skilled nursing facility services
- Long Term Care

The continuity and coordination of care received by members include medical and behavioral health care. Health Plan of San Mateo collaborates with Behavioral Health and Recovery Services to ensure the following activities are accomplished:

- Information Exchange – information exchange between medical practitioners and behavioral health practitioners must be member-approved and be conducted in an effective, timely and confidential manner.
- Referral of Behavioral Health Disorders – Primary care practitioners are encouraged to make timely referral treatment of behavioral health disorders commonly seen in their practices, i.e., depression.
- Evaluation of Psychopharmacological Medication – Drug use evaluations are conducted to increase appropriate use, or decrease inappropriate use and to reduce the incidence of adverse drug reactions.
- Data Collection – Data is collected and analyzed to identify opportunities for improvement and collaborate with behavioral health practitioners for possible improvement actions.
- Implementations of Corrective Action – Collaborative interventions are implemented when opportunities for improvement are identified.

6.3 CLINICAL PRACTICE GUIDELINES

HPSM provides its network providers access to evidence-based practice guidelines for assistance in making decisions about appropriate health care for specific clinical circumstances, including preventive care. Web links to specific guidelines developed by nationally recognized medical organizations, expert task forces, and health professional societies are posted on the provider section of the HPSM website. Some links connect to the expert organization websites and others are direct links to practice guideline documents . Quality and Provider Services work together to make certain that the provider newsletter promotes awareness of the clinical guidelines on the HPSM website, in at least one of its quarterly newsletters.

HPSM's Quality department leads an annual review process of the of the posted guidelines to ensure they reflect the most up-to-date available clinical evidence, and remain relevant to health conditions common in the member population. A summary of the currently posted guidelines noted with their publication dates and source organizations, is prepared and presented to the Quality Improvement Committee (QIC) for review, discussion, and approval at one of its quarterly meetings. Prior to presenting the summary to the QIC, a Quality Improvement Specialist goes online to the source organization website for each posted guideline to check the published date of the last systematic evidence review. In general, guidelines that have been reviewed and updated within the past 3 – 5 years are considered up-to-date and are maintained on the HPSM website. Guidelines with publication dates older than 5 years that remain active on the source organization's website, and have a proposed date for a future review are noted for discussion by the QIC. Members of the QIC comment on the posted guidelines, and advise on any necessary additions or removals. QIC chairs lead a vote to approve the posted guidelines and any decisions for changes.

HPSM's currently posted guidelines are listed in the Appendix A

6.4 NURSE ADVICE LINE (NAL)

DMHC's Timely Access standard requires HPSM to ensure that its member population (all LOBs) has access to telephone triage and screening services 24/7, 365 days a year. This means that members must be able to reach a qualified health profressional during after-hours, including weekends, if and when they cannot reach their PCP for advice about an urgent medical concern. HPSM complies with this standard through its contract with TeamHealth Medical Call Center to provide triage services 24/7 to members who call the toll free number for HPSM's Nurse Advice Line (NAL). HPSM encourages members to call the NAL when they cannot reach their PCP for advice about an urgent health concern.

NAL OVERSIGHT

HPSM designates oversight of NAL services to the Quality Improvement Department. A Quality Improvement Specialist serves as HPSM's liason with TeamHealth and as the primary internal contact for other HPSM departments. The lead QI Specialist for the NAL is responsible for collecting and reviewing TeamHealth monthly and quarterly reports on member utilization, triage call summaries, and telephone triage service metrics. The QI Specialist uses the TeamHealth reports to monitor member access and various indicators of quality of service. An analysis of triage services provided, which includes the following, is presented to the Services Quality Improvement (SQIC) Committee.

- Quarterly reports/dashboards on member call volume during after hours and daytime
- Call count by acuity level and average response time by acuity level
- Triage outcome summary (breakdown of clinical disposition categories)
- Post triage referrals to contracted urgent care clinics
- Average response time for callbacks by triage nurse

In 2019, HPSM Quality will track implementation of a new protocol that enables TeamHealth triage nurses to warm transfer member calls during daytime hours, to their assigned PCP. The protocol will be used only for calls with triage dispostions that advise a member to see their physician within 4 to 24 hours, or to make an appointment to be seen within 2 weeks.

6.5 MEMBER EXPERIENCE (QI 4, C & D)

6.5.1 MEMBER SATISFACTION, COMPLAINT, AND GRIEVANCE/APPEAL MONITORING

An NCQA certified vendor conducts a member satisfaction survey (Consumer Assessment of Healthcare Providers and Systems – CAHPS) annually for the Medicare-Medicaid Plan (MMP) members and triennially for Medi-Cal members. The results of the surveys are reported to the Service QIC, Consumer Advisory Committee, QIC and Commission.

Quarterly summaries of complaints and grievances/appeals are reported to the Service QIC and Consumer Advisory Committee. Reporting is trended by type of complaint, HPSM departments, sites, facilities and physicians as indicated. Cases reviewed by the Chief Medical Officer are included in the quarterly summaries.

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

- The QI Nurse screens it immediately upon receipt for potential quality issues.
- Supporting documentation is requested from primary care sites, hospitals, etc.
- The Chief Medical Officer/designee reviews the complaint and any supporting documentation, categorizes the quality of care concerns, communicates with the primary care provider as indicated

6.5.2 CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS)

HPSM uses the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to assess members experience with the health plan. CAHPS is conducted annually for Medicare and every 3 years for Medicaid (only Medicare in 2017). The survey is conducted in the first half of 2017 and measures members'

experiences over the previous 6 months. The survey sample is drawn from all members who have been enrolled for at least 6 months. The CAHPS survey asks members to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services. The acronym "CAHPS" is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)(https://www.ahrq.gov/cahps/about-cahps/index.html).

6.6 PRACTITIONER COMPLIANCE MONITORING

Health Plan of San Mateo monitors and evaluates practitioners' compliance with policies and procedures through on-site provider compliance surveys. The purpose of this monitoring is to ensure compliance with established protocols and policies and assist in the implementation of corrective action plans, as indicated.

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

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

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

7. MEMBER HEALTH EDUCATION/PROMOTION & WELLNESS PROGRAM

The Health Education program is reviewed annually to assess that there is an appropriate allocation of health education resources to address the health education needs and gaps of HPSM members. This assessment includes completing required readability and suitability checklists for health education materials; reviewing and presenting consumer survey results; soliciting health educational requests information from other HPSM department staff; conducting on-site evaluations of classes offered in the community; analyzing encounter data and other relevant data sources; and identifying other intervention activities to accomplish the objectives in the work plan.

Health education programs are offered to the member at no cost directly and/or through subcontractors or other formal agreement with providers that have expertise in delivering health education services.

HPSM conducts targeted outreach to members that his heavily based on mailings to educate them about resources available to them in the community. The Health Educator will monitor the availability and accessibility through self-referral or referral from of provider for these programs.

HEALTH EDUCATION RESPONSIBILITY AND AUTHORITY

- The Chief Medical Officer is responsible for overseeing and monitoring overall compliance for the health education activities at HPSM.

- Under the direction of the Chief Medical Officer, the Health Educator is responsible for managing the health education system.

HEALTH EDUCATION PROGRAM SCOPE

HPSM will provide health education interventions, materials and programs that address a wide variety of health topics, including, but not limited to, the following: effective use of managed health care services, risk-reduction and healthy lifestyles, and self-care and management of health conditions, like pregnancy, asthma, diabetes, hypertension, smoking cessation, nutrition, weight control, dental care and physical activity.

HPSM's Health Educator ensures the successful delivery of health education programs using educational strategies, methods, and materials that are appropriate for the member population and effective in achieving behavioral change for improved health outcomes.

OBJECTIVE 1: All relevant health education materials will be updated and reviewed to ensure that an updated Readability and Suitability checklist has been completed as well as that they are available in the four threshold languages.

7.1 HEALTH EDUCATION CLASSES AND RESOURCES

The Health Educator will evaluate specific health education classes, submit articles to member and provider newsletters and compile a community resource binder for staff to make referrrals to to our members. The top five topics that members identified that they want to know more about in the most recent Group Needs Assessment (GNA) were healthy eating, exercise, weight loss, healthy teeth and healthy aging. Information and community resources related to these topics will be regularly updated and compiled in a resource binder for HPSM staff to provide to members. In addition, articles in the member and provider newsletters will address these topics more generally throughout the year. When necessary, the health information section of the HPSM website will be updated with current class schedules and/or new health education information.

7.2 HEALTH EDUCATION MATERIALS

As mentioned above, the top 5 topics identified from the GNA survey results will be updated and be available in the form of a community resource binder to HPSM departments that directly interact with members. All new health education materials will be evaluated for readability and suitability and translated accordingly in our four threshold languages. New content areas will be solicited from other HPSM departments to respond to additional needs of members. Newly purchased materials will be used for home visits and/or sent to members upon request. All new materials will be purchased from an approved vendor.

OBJECTIVE 2: Collaborate with external partners to offer, promote and evaluate health education programs, i.e. Weight Watchers, etc. that are tailored to our members.

7.3 DIABETES PREVENTION PROGRAM (DPP)

DPP is a program designed to assist Medi-Cal/Medicare beneficiaries diagnosed with prediabetes in preventing or delaying the onset of type 2 diabetes. The program consists of peer-coaching session, which are provided to target weight loss and healthy lifestyle behaviors. It is an evidence-based, lifestyle change program designed

to assist HPSM members diagnosed with prediabetes in preventing or delaying the onset of type 2 diabetes. The program is consistent with the federal Centers for Disease Control and Prevention's (CDC's) guidelines for DPP curricullum. The Diabetes Prevention Program (DPP) is a covered benefit for both CareAdvantage and Medi-Cal members.

Eligible Population:
Medicare or Medi-Cal eligible beneficiaries that are pre-diabetic and meets the following criteria:

- Have a body mass index (BMI) of at least 25, or at least 23 if self-identified as Asian
- Meet 1 of the 3 blood test within the 12 months of the 1st core session:
  - ♣ hemoglobin A1c test with a value between 5.7 and 6.4% , or
  - ♣ A fasting plasma glucose of 110-125 mg/dL, or A 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test
- Have no previous diagnosis of type 1 or type 2 diabetes (other than gestational diabetes)
- Do not have end-stage renal disease (ESRD)
- + 18 or older and not pregnant
- + If doesn't meet the blood test requirements: a positive screening for prediabetes based on the CDC Prediabetes Screening Test.

7.4 WEIGHT WATCHERS

Weight Watchers is a weight loss program available to adult Medi-Cal members with a BMI over 30. The objectives of this program are 1) By December 2018, 25 adult members with a BMI > 30 will participate in at least 10 Weight Watchers meetings; 2) by December 2018, 15 adult members with a BMI >30 participating in Weight Watchers will lose 10% of their body weight.

When a fax referral from a provider is received, the member is enrolled into the program. The member completes the pre-program survey and is sent a set of 5 vouchers to attend 5 meetings. A physician referral is not required, and the Health Educator may enroll the member directly into the program through the Health Education phone line. Members must send in their weigh-in logs after each set of 5 visits in order to receive another set of vouchers, and can receive up to 4 sets of vouchers (a total of 20). However, requests for continuation may be granted depending on weigh-in logs, attendance and availability of vouchers. Data from the member logs will be entered into the HPSM's Weight Watchers program data base and used to evaluate the effectiveness of the program.

7.5 SMOKING CESSATION

OBJECTIVE: Increase referrals to the California Smokers' Helpline that offers free services in three of our threshold languages.

HPSM continues to mail out flyers to promote the use of the California Smoker's Helpline. Smokers are identified by ICD-10 codes and prescriptions of tobacco cessation medication on a monthly basis. Flyers are mailed out in English, Spanish, Korean and Chinese. Currently, the California Smoker's Helpline does not

include language services in Tagalog or Russian. Smokers will also receive an additional flyer at the end of the year to urge them to make quitting smoking a new year's resolution.

Also during provider visits, providers will receive the Quality Improvement Provider Toolkit that includes information on the mandatory assessment of the members' smoking status. It also includes resources to encourage them to make referrals to the California Smokers' Helpline.

8. QUALITY IMPROVEMENT INTERVENTIONS

8.1 PRENATAL AND POSTPARTUM CARE PROGRAM

Health Plan of San Mateo's (HPSM) Prenatal and Postpartum Care Program is for pregnant women enrolled in its Medi-Cal line of business. The goal is to improve timely prenatal (within the first trimester) and postpartum (within 21-56 days post-delivery) care. The program incentivizes members for both the prenatal and postpartum appointments with a $50 Target gift card per each visit made within the specified timeframes. Members are identified by the following data sources: prenatal ultrasound visits, first prenatal visit, prenatal vitamins, pregnancy diagnosis codes, and a recent delivery. Members are also identified through P4P Provider Referral Incentive Forms, OB Providers, Family Health Services, and Self-Referral. Once the member is identified as pregnant through the different data sources, the Health Promotion Coordinator conducts outbound calls to this list of members. If the member chooses to participate, the Health Promotion Coordinator enrolls and follows-up with the member throughout her pregnancy. In addition, the Health Promotion Coordinator links the member to community programs such as WIC, BIH (Black Infant Health) and FHS (Family Health Services). For postpartum members, the Coordinator sends reminder text messages through the CareMessage platform.

PROGRAM GOAL: The objective of the program is to increase enrollment in the Prenatal and Postpartum Care Program. High enrollment into HPSM prenatal program reflects higher rates of women getting timely prenatal and postpartum care.

SMART GOAL: By 12/31/2019, improve timely prenatal (within 42 days of enrollment or during the first trimester) care from 83.88% (HEDIS 2018) to 87.06% (Medicaid 2018 75th%tile).

2019 ACTION PLAN

For 2019, we will continue to provide the incentive to increase compliance rates for this program. We will also focus on connecting members to locally available resources and community programs. Postpartum members will also continue to receive text message reminders regarding their appointments.

8.2 CERVICAL CANCER SCREENING OUTREACH PROJECT

In 2019, HPSM Quality will continue implementation of the provider outreach project presented to the QIC in September 2018 and initiated in November. The QI Specialist will aim to schedule site visits with 1 – 2 PCPs per quarter, to gradually increase the number of PCPs targeted for follow-up and ongoing communication on engaging their assigned members due for CCS. The strategy for engaging PCPs will be to link the project's efforts to increasing their P4P bonus payments for the CCS and panel engagement metrics, receiving HPSM support in referring assigned members to outside specialists when members prefer female providers for CCS, and removing inactive assigned members that indicate preference for other PCP. Quality's role will be to offer direct support in calling members that have been inactive on PCP's panels, facilitating warm transfer to

assigned PCP for members that agree to receive CCS, and sending text message reminders to encourage completion of CCS.

Project Goal: Increase the CCS rate among the age-eligible population with continuous enrollment from baseline rate of 59.95% to 60.1%.

2019 PROJECT IMPROVEMENTS

Improvements to the CCS outreach project in 2019 will be the following.

- Communicate to PCPs the potential impact of CCS outreach efforts on increasing their P4P bonus payments.
- Provide Quality staff support in doing phone outreach to assigned inactive members and doing warm transfers to PCP's office to schedule CCS appointment.
- Create a HPSM referral protocol for PCPs to use with members that express preference for receiving CCS from an a female provider outside of PCP's practice.
- Use the CareMessage platform to send follow up text messages that remind members reached through the project, to either schedule a CCS appointment with their provider or attend a scheduled appointment.

8.3 CCS DISPARITY PERFORMANCE IMPROVEMENT PROJECT (PIP)

This PIP addresses the significant disparity in cervical cancer screening rates for Medi-Cal members who indicate English as their language preference, compared to members with other language preferences. The project's intervention planning stages were completed in 2018. Implementation of the intervention will begin in January 2019. Members with English language preference assigned to NorthEast Medical Services (NEMS), and due for CCS, are the intervention's target population which will be identified in monthly reports and tracked for outreach. The SMART Aim goal of this PIP is to increase CCS rate among the target population at NEMS to 67.4% from its baseline rate of 56.7%.

PROJECT ACTIVITIES

Primary activities will focus on generating HPSM monthly reports that use a rolling 12-month timeframe to identify women due for CCS among the target population at NEMS, and using those reports to inform clinic outreach to engage those women in scheduling an appointment at NEMS. The sample of women identified in the monthly reports will be limited to members that have 12 months continuous assignment to NEMS during the rolling 12-month timeframe. The report will also flag "inactive"members, meaning those that have not had a primary care visit at NEMS during the report's timeframe. NEMS staff will track the clinic's outreach attempts and document the outcomes which include scheduling an appointment, appointment declined, or unable to reach among other possible outcomes.The project's secondary activities identified during the planning stages with NEMS, will involve NEMS staff doing warm transfers of outreach calls to HPSM Member Services in cases where members indicate their preference for assignment to another PCP.

2019 ACTION PLAN

Request monthly or bimonthly progress updates from NEMS of clinic documentation of outreach attempts with target population.
• Use progress updates to create dashboard that tracks monthly denominator and numerator for intervention metric.
• Track count of warm transfers to HPSM Member Services and follow up with Member Services on outcomes from warm transfers
• Complete and submit final drafts of Mods 4 and 5 to HSAG by September 20, 2019

8.4 REDUCING 30-DAY READMISSIONS PROJECT

The Quality Improvement Project (QIP) for reducing 30 day readmissions is aimed at reducing member readmission within 30 days across health care settings and practitioners, by decreasing the Plan All Cause (PCR) readmission rate by 2% from the baseline rate of 15.53% to 13.53%. At HPSM there are currently two interventions aimed at reducing 30 day readmissions: Care Transitions and HomeAdvantage (Landmark). Care Transitions Coaches (CTC) visit newly admitted members in the hospital. During their visit the CTCs complete a My Personal Health Record with the member and work with facility discharge planners to ensure a smooth transition from health care facilities. The HomeAdvantage intervention is a home health program that brings health care practitioners to the member's home.

2019 ACTION PLAN

Reducing readmission continues to be a high priority area for HPSM. HPSM will continue to evaluate the current efforts across the organization aimed at reducing readmissions. Part of this includes reevaluation of the current process and conducting a deeper analysis of the population with a readmission within 30 days to identify ways to better tailor the interventions for our membership.

HPSM will continue to work with the Care Transition department on assessing opportunites for improvement. This will include observing, monitoring, and collecting the proper data and updating the dashboard.

8.5 CONTROLLING HIGH BLOOD PRESSURE (CBP) PILOT PROJECT

Starting in 2017 the Health Plan of San Mateo (HPSM) partnered with a Federally Qualified Health Center, North East Medical Services (NEMS), on a project aimed at improving control of high blood pressure among members with hypertension.

Blood pressure monitors are provided to members served at their primary care provider's office. The members who enroll sign a contract verifying acceptance of blood pressure monitor and are taught how to take blood pressure in accordance to each individual's specific needs. The assigned clinician also educates members on signs and symptoms of hypertension, diet, proper medication adherence and use of the blood pressure monitor. The blood pressure monitors need to be connected to a gateway "cloud" device to upload the pressure readings via the internet.

In 2018 HPSM expanded its CBP pilot program by partnering with the San Mateo Medical Center (SMMC)'s 39th Ave Primary Care Clinic. The plan is pilot the project with 50 blood pressure monitors at the clinic. Currently, the pilot with SMMC is in the early stages, with confirmed plans for training with ForaCare.

2019 ACTION PLAN

The QI Specialist will implement the CBP pilot at the SMMC site. The implementation will involve determining the site champion for the project, how outreach will be done, and which patient population will qualify for the program. Additionally, the QI Specialist will continue collecting data from NEMS and SMMC. The data will include the number of members that are participating in the pilot, length of time (in weeks) for a member to achieve the controlled blood pressure, if the member was seen by the health educator at least one time on a quarter, if the member is on hypertensive medications and if the member is compliant with the medications.

The lead physician of the clinic and the clinic's health educator are responsible for training all front and back office staff when members on the the target population list arrive for an appointment. The health educator will then proceed to continue outreach to all identified members with a hypertension diagnosis and who were seen in the clinic in the last year. When a member has an appointment to be seen by a physician, staff will notify the physician and the health educator who will market the benefits of joining the pilot. When the member agrees to participate in the pilot, the health educator will provide a BP (in the language of the member's choice), record baseline BP, review medications and lifestyle changes with physician present and inform the member on how to use and upload BP readings.

The QI Specialist will collect data on a quarterly basis from the clinics for all data on members within the pilot. The information collected will include a list of members who are on hypertension medication and compliant in the pilot and a percentage of how many abnormal blood pressure readings the participant had. Blood pressure readings are collected from the member when they visit their health coach and clinician. Members who have out of control blood pressure have a visit with their health coach and clinician scheduled every 6 weeks. Members who have their blood pressure in control see their clinician and health coach every 3 months.

The QI Specialist will continue to seek out providers and/or clinics that would be candidates in partnering in the pilot program in 2019. The QI Specialist will continue to work with the lead physician, Clinic Operations Manager and health educator to define how the pilot can best benefit the members and work into the processes and workflows of the participating clinic.

8.6 INITIAL HEALTH ASSESSMENT (IHA) OUTREACH

The Initial Health Assessment (IHA) has become a high priority in health plans, primary care and preventative services across California as the Medi-Cal population has a higher prevalence of chronic and/or preventable illnesses. Many of which could be modified through appropriate health behavior change and early detection to promote lifestyle changes. The IHA enables a provider to comprehensively assess the member's chronic, acute and preventative needs and to identify patients whose needs require additional coordination with other resources. The All Plan Letter (APL 08-003) requires all primary care providers to administer an IHA to all Medi-Cal managed care patients as part of their IHA and well care visits. California Department of Health Care Services (DHCS) audits in both November 2014 and November 2015 found that the plan did not ensure that IHAs for new members were completed within 120 calendar days of enrollment. It is required that health plan's reach a 100% compliance rate ensuring every member enrolled is seen by their primary care physician. HPSM will research the efficacy of using a text messaging campaign to further market awareness of seeking early primary care services. Reaching members through text messaging versus mail has the potential to reach more members as studies have shown that populations similar to HPSM's membership has access to a cell phone and messaging services.

2019 ACTION PLAN

For 2019, the QI specialist will work with the facility site review nurses, informatics, provider services and member services to discuss strategies and interventions to boost the IHA compliance rates.

The Staying Healthy Assessment (SHA) also proves to be a difficult area for providers to comply with. Training has been developed to address this, but the additional questionnaire component in busy practices is hindering. Providers have relayed feedback that they want to modify the questionnaire along with the challenges they face when adding the questionnaire into their electronic health records. The state is aware of the issues and is in the early stages of modifying the questionnaire. Until a modification from DHCS has been made aware to the health plan, training from all touch points to the providers and/or office staff will remain a focus.
For the current IHA text messaging campaign the QI specialist will work in conjunction with our vendor to streamline the processes of the outreach campaign. Additionally, we are considering altering the content of the text messages to see if it will improve rates.

8.7 ASTHMA MEDICATION RATIO (AMR) PERFORMANCE IMPROVEMENT PROJECT

Due to the low HEDIS rates for the Asthma Medication Ratio (AMR) measure in reporting year 2017, HPSM began the planning and initial implementation of a new intervention aimed at improving consistent asthma controller medication adherence (meds dispensed) among members 19-50 with persistent asthma. This topic was selected as the primary focus of our of the Performance Improvement Projects (PIP) with planning and evaluation oversight from the Health Services Advisory Group (HSAG). The Improving Asthma Medication Ratio for Medi-Cal Member ages 19-50 years old project was implemented in October of 2018. The program first highlighted those members that had persistent asthma that were found to be non-compliant (AMR<0.5) and stratified them as either low risk or high risk to put them in touch with the best possible outreach staff. The high risk group was identified as those that had more than 2 ER visits in the previous year, had at least one inpatient stay, and where the difference between controller and reliever meds was greater than three or if they had picked more than 10 reliever meds. Low risk groups were then outreached to by the Health Promotion Coordinator while the Care Coordination team made phone calls to the high risk groups. This outreach was conducted to educate the individuals on the need for control of their asthma as well as the importance of controller medications.Low risk members were encouraged to visit their pharmacy to obtain controller medications and high risk members were encouraged to do the same and visit visit their PCP for any questions or concerns related to their care.

SMART AIM Goal: By 12/31/2019, increase the Medi-Cal Asthma Medication Ratio (AMR) rate of 58.15% (HEDIS 2018) to 62.3% (50th percentile).

2019 ACTION PLAN

HPSM will continue to prioritise outreach to increase the AMR for Medi-Cal members and continue to evaluate and monitor changes in these rates. In 2019, the Health Promotion Coordinator and Care Coordination teams will continue to educate members and HPSM will look to other avenues of impacting this measure. Some additional areas we would look to explore include:

- Partnering with pharmacy to highlight those members who need extra support from their PCP providers and highlight these to PCPs
- Provide greater detail in ER visits to determine how many visits are made due to asthma
- Developing and disseminating an AMR tip sheet for providers to educate them on the importance of the measure and simple ways to impact it.
- Developing partnerships within the community, such as county support services to provide additional support to members
- Developing a pilot asthma education text messaging campaign with CareMessage to boost education about asthma and greater compliance with controller medication

8.8 BREAST CANCER SCREENING (BCS) OUTREACH PROJECT

In 2019, HPSM Quality will integrate breast cancer screening (BCS) outreach efforts with its cervical cancer screening outreach activitites as presented to the QIC in September 2018. Outreach efforts, which were initiated in November 2018, will continue to focus on scheduling and completing site visits with PCPs with low CCS or BCS rates and engaging them in follow up collaborative activities with HPSM. One objective of the site visits is to gather information on PCP's process for identifying and informing members of their need for BCS, referring them to mammography services, and receiving screening results. A second objective is to identify opportunities where HPSM Quality can support PCPs in informing assigned members of their need to get screened through a text message campaign. Similar to the CCS project, the strategy for engaging PCPs will be to link the project's efforts to increasing their P4P bonus payments for the BCS and panel engagement metrics. Collaborative activities with HPSM QualityDepartment will provide PCPs direct support in calling members that have been inactive on their panels and receiving warm transfers of member that agree to receive BCS and remained assigned to PCP.

The goal of the BCS outreach effort in 2019 is to increase the screening rate for Medi-Cal members from 62.8% (HEDIS RY 2018) to 70.29% (90th percentile) and for Medicare members, increase the rate from 67.78% to 72.95% (50th percentile).

2019 Action Plan

• Aim to schedule and complete site visits with 1 -2 PCPs per quarter, that have low BCS rate.
• Pursue PCP agreement to review HPSM report of assigned members in need of BCS to confirm inactive members that will receive outreach call from HPSM Quality.
• Conduct warm transfers to PCP to facilitate member access to appointment with PCP, if member is not established with PCP
• Use CareMessage platform to send text messages to established assigned member to remind them to schedule a mammography screening.

8.9 MMP INDIVIDUALIZED CARE PLAN PERFORMANCE IMPROVEMENT PROJECT (PIP)

Starting in 2018, the Quality Improvement Department began implementing a performance improvement project (PIP) through a collaborative effort with the Care Coordination unit. The PIP focuses on targeted interventions ability to increase the percentage of completed individual care plans (ICP), discussions of care goals, and revisions. This PIP looks at Cal Mediconnect members who meet the elements in the Medicare-Medicaid Capitated Financial Alignment Model Care Coordination sections 1.5 and 1.6.

The data element definitions being addressed for 1.5 is members with a completed ICP who are classified by their pre HRA risk score of high or low risk. High risk members must be enrolled for 90 days or longer as of the end of the reporting period, low risk members must be enrolled for 135 days or longer as of the end of the reporting period, have a correspondence delivered, and completed an ICP. The data elements for 1.6 are members with a documented discussion of care goals in their initial ICP and the number of existing ICP that have been revised.

An evaluation plan was developed involving a key driver diagram and failure modes effects analysis will be used to determine barriers and possible interventions. Two interventions have been selected and will be measured throughout the year and reported for two years after the baseline.

Intervention #1: ILS HRA Call Process and Data Collection Improvements
(*System Level Intervention*)
HPSM members are initially contacted to complete the HRAs by a vendor, Independent Living Service (ILS). ILS provides managed care services, including telephonic and field-based case management, meal delivery & nutritional support, and managed long term services & supports (MLTSS), on behalf of hospitals, health plans and systems of care across the country.

HPSM has narrowed the target population for this PIP to "hard to reach members" which are defined as those that have exhausted their outreach attempts of six calls. In order to accurately identify this target population of hard to reach members, systems level improvements needed to be made to streamline data collected and reporting between ILS and HPSM regarding the call attempts and dispositions.

HPSM has been working with ILS on several process improvements aimed at increasing overall HRA completion rates. Increasing HRA completeness ties into the overarching goal of this PIP as it also improves the quality of ICP completion by providing more comprehensive information to the ICP team regarding member's individual needs.

Intervention #2: Improving Member Engagement through Partner Organizations Current Processes
(*Member Level Intervention*)
1) Identify organizations that are already working with "hard to reach" members through specialized programs.
2) Partner with organizations to improve data sharing and member engagement and the completion of individualized care plans with "hard to reach" members.
3) Implement new process to engage members in HRA completion as a step in the new Care Planning Process. In addition, providers or Case Managers from the partner sites already working with the members will be included in the ICP meeting to provide more comprehensive information regarding member needs.

2019 ACTION PLAN

In 2019 the QI specialist will continue submit HSAG updates on time and to drive the project by addressing the following areas:

- Data transparency

    - Work with informatics, care coordination and management to institute a clear and efficient method of matching the ILS call logs with completed HRAs from MedHOK.
    - The QI specialist will take on the role of tracking the data of completed HRAs from the hard to reach populations at the BHRS sites (Oasis and North County). Additionally, the QI Specialist will work on preparing the necessary documentation for an eventual warm handoff to designated personel responsible for tracking the HRA completion data and outreach results.
- Develop stronger partnerships with pilot sites
    - Communicate and connect with main point of contacts at current BHRS sites and planned GGRC population.
    - Revisit HRA handoff process to ensure that it is efficient and does not negatively affect the workflow of the clinics.
- Assess expansion of project
    - Reinitiate the conversation of expanding the ICP-PIP project to GGRC.

9. SERVING A DIVERSE MEMBERSHIP (QI 1, A, 8)

The Health Plan of San Mateo (HPSM) is committed to delivering culturally and linguistically appropriate services (CLAS) health care services to our diverse membership. HPSM's CLAS Program complies with Title VI of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, and 45 C.F.R. Part 80) and the Cultural and Linguistic Services requirements in accordance to the contractual agreement with the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and the Centers for Medicare and Medicaid Services (CMS).

The goal of CLAS is to ensure that all plan members-regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status, or disability have equal access to health care. Recognizing and having a better understanding of our members' culture and their preferences is key to the development of successful and effective programs. HPSM is committed to accommodating this diversity in a manner that accepts and respects differences while promoting optimal health outcomes.

9.1 CLAS PROGRAM VISION

To plan, develop, implement, support and evaluate the cultural and linguistic services available to HPSM members including those mandated by our contractual obligations with regulatory agencies. The provision of culturally appropriate care and language services are an integral component of effective health care delivery.

9.2 CLAS PROGRAM OBJECTIVES

The CLAS Committee objectives are aligned with the National CLAS Standards and are intended to advance healthy equity, improve quality and help eliminate health disparities for HPSM's member population.

- Promote effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.
- Advance and sustain organizational governance and leadership that promote CLAS and health equity through policy, practice and other resources.

- Create culturally and linguistically appropriate goals, policies, and management accountability, and imbed them throughout HPSM's planning and operations.
- Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
  Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, members, and the provider network.

9.3 CLAS PROGRAM GOALS

1. Report CLAS Program initiatives to the Service Quality Committee, Clinical Quality Committee and Quality Improvement Committee on an ongoing basis to identify areas for improvement and to provide guidance to improvement activities.
2. Ensure compliance with state and federal contract regulation to caring for Limited English Proficiency (LEP) and sensory impaired members.
3. Provide interpreter services to individuals who have limited English proficiency and/or other communication needs, free of charge to them, to facilitate timely access to all health care. This is measured through Language Utilization reports from Member Services and providers, annually.
4. Inform individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
5. Ensure the competences of individuals providing language assistance services, understanding that the use of a professional interpreter is recommended and that the use of a family member or minor should be avoided.
6. Regularly monitor ongoing assessments of the organization's CLAS related activities and integrate CLAS related measures into measurement and continuous quality improvement activities, annually, in the CLAS program evaluation.
7. Ensure quality interpretation and translation of written materials in members' preferred language and format are available and accessible.
8. Establish processes for review of member materials to assess various components of health literacy and cultural appropriateness.
9. Collect and maintain accurate and reliable race/ethnicity/language (REL) data to monitor and evaluate the impact of the CLAS Program on health equity and outcomes and to inform service delivery, annually.
10. Analyze Healthcare Effectiveness Data and Information Set (HEDIS) data and Consumer Assessment of Healthcare Providers and Systems (CAHPS) by REL data to identify disparities in quality of care and member experience, annually.
11. Implement interventions aimed at reducing REL based disparities related to quality of care or member experience, when they exist.
12. Assess member health assets, as well as barriers to care, and use the results to plan and implement services that respond to the cultural and linguistic diversity of the population in the service area.
13. Ensure that both limited English proficient (LEP) and non-LEP members receive the same quality of health care services by providing Cultural and Linguistic Services (oral and written).
14. Ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable to identify, prevent, and resolve cross cultural conflicts or complaints.
15. Ensure annual Staff and Provider Training on culturally and linguistically appropriateness to improve quality of care and workplace environment.

INFORMING MEMBERS (QI 2, B)

HPSM summarizes the information in the annual QI Program Description that includes information about QI program processes, goals and outcomes as they relate to member care and services, in language that is easy to understand, on the HPSM website.

HPSM notifies members of the availability of the information by regular mail. Members are also informed that they can request a hard copy of the summary, QI Program Description and annual Evaluation via mail if they do not have electronic access to the information.