2024 QUALITY IMPROVEMENT AND HEALTH EQUITY (QIHE) PROGRAM DESCRIPTION

QIHEC Review Date: March 2024

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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.

VALUES

***Health** care that puts members at the center of everything we do.*

***Equitable** access to quality services and supports for all members.*

***Advocacy** for members disproportionally impacted by health inequities.*

***Local** health care based in San Mateo county provided in partnership with community resources.*

***Transparency** and accountability achieved through local governance.*

***Honesty** is the core of our service to members, providers, business partners and the community.*

***You** - because 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. 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. The Cal MediConnect plan ended on 12/31/2022. Beginning on January 1, 2023, in alignment with DHCS, HPSM transitioned the CalMediconnect plan to a D-SNP Plan named CareAdvantage. CareAdvantage Dual Eligible Special Needs Plan (D-SNP) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to for HPSM Medi-Cal members who have Medicare Parts A & B.

Consistent with its mission, HPSM operates additional product lines in response to community needs. These include Access and Care for Everyone (ACE) Program and HealthWorx. 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 January 2022, HPSM expanded its service contract with DHCS to include a dental services benefit with the goal of medical and dental service integration.

As of January 2024, HPSM serves approximately 173,000 members or participants under the following lines of business: Medi-Cal, CareAdvantage (D-SNP), HealthWorx, California Children's Services (CCS), and San Mateo County ACE Program (HPSM serves as the third-party administrator).

As of January 2024, HPSM is integrating Health Equity into the QI Program as required by the 2024 DHCS Contract.

1.2 HPSM'S DELIVERY SYSTEM

HPSM can 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. All 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, HealthWorx, CCS, and CareAdvantage (D-SNP) lines of business. Certain services are not covered by HPSM or may be provided by a different agency:

- Specialty Mental Health services and substance abuse services are administered by the San Mateo County Behavioral Health and Recovery Services (BHRS) for all lines of business but Medi-Cal behavioral health is managed by HPSM and is not delegated. Behavioral Health Treatment (BHT) is administered by Magellan Health Services.
- 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).
- Beginning January 1, 2022, outpatient pharmacy benefits for HPSM Medi-Cal members were transitioned from HPSM to fee-for-service (FFS) Medi-Cal. As of that date, these services were no longer managed by HPSM. Instead, they are administered by the California Department of Health Care Services (DHCS) in partnership with its contracted pharmacy benefits manager (PBM), Magellan.

2. QUALITY IMPROVEMENT AND HEALTH EQUITY PROGRAM

2.1 PURPOSE

The Quality Improvement and Health Equity (QIHE) Program provides a formal process to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety, equity, 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 and high levels of member and practitioner/provider satisfaction. The QIHE Program promotes the accountability of all employees and affiliated health personnel for the quality and equity of care and services provided to our members. HPSM communicates the standards and norms included in this program through a variety of methods, including but not limited to provider training, direct outreach to individual or groups of providers, HPSM's website, the Provider Manual, and provider newsletters.

2.2 GOALS

The goals of the QIHE Program are to:

- Provide timely access to high-quality healthcare for all members, through a cost-effective, safe, equitable, 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, health equity, and safety; and
- Resolve identified problems in a timely manner.

2.3 OBJECTIVES

- Design and maintain the quality improvement and health equity structure and processes that support continuous quality improvement and health equity, including measurement, trending, analysis, intervention and re-measurement.
- Meet the cultural and linguistic needs of the membership.
- Comply, communicate, and coordinate with all governmental agency requirements.
- Support practitioners with participation in quality improvement and health equity 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; and
    - 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 full delegated subcontractor and downstream fully delegated subcontractor activities by:
    - establishing performance standards consistent with the QIHE Program,
    - monitoring performance through regular reporting, and
    - evaluating performance and addressing deficiencies regularly.
- 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/dental record review
    - utilization of physical and behavioral health care
    - 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
    - encounter data
    - identification and follow-up of non-utilizing members
    - profiles of physicians, and
    - measurement of compliance with practice guidelines
    - reports on the number and type of services, denials, deferrals, and modifications, appeals and grievances
- Uses the methods above for equity-focused interventions
- Coordinate QIHE 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 Grievance and Appeals Department.
- Implement and maintain health promotion activities and disease management programs linked to QIHE initiatives to improve performance. These activities include, at a minimum, identification of high-risk and/or chronically ill members, the education of practitioners, and outreach campaigns to members.
- Create and maintain the infrastructure to achieve accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting body for HPSM, fully delegated subcontractors and downstream fully delegated subcontractors, including the annual reporting with copies of reports, accreditation status, survey type, level, results, recommended actions/improvements, corrective action plans, summaries and accreditation expiration dates, as appropriate.
- Methods to address EQRO technical reports and evaluation report recommendations.
- Ensure community engagement with commitment to member and family focused care, and uses consumer advisory committee (CAC) findings, member listening sessions, focus groups/surveys, and uses that information to inform policies.
- Utilization of performance improvement plan (PIP) findings and outcomes, consumer satisfaction surveys, and collaborative initiatives.
- Perform disease surveillance pursuant to California state regulation Title 17 CCR 2500 et seq. including the reporting of diseases and conditions to local and state public health authorities and ensure directives from local and state public health authorities are implemented across HPSM

through coordination with the Chief Medical Officer and Chief Health Officer, and other Leadership Team members.

2.4 EVALUATION OF THE QIHE PROGRAM

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

The annual QIHE Program Evaluation includes:

- A description of completed and going QIHE activities that address the quality, health equity, and safety of clinical care and quality of services
- Trending of measures to assess performance in quality, health equity, and safety of clinical and the quality of service indicator data
- Analysis of the results of the QIHE initiatives, including barrier analysis that evaluates the effectiveness of QIHE interventions for the previous year (demonstrated improvements in the quality, health equity, and safety of clinical care and in the quality service)
- An evaluation of the overall effectiveness of the QIHE 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

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 AND HEALTH EQUITY PROGRAM

The QIHE Program provides for review and evaluation of all aspects of health care, encompassing clinical care, health equity, 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 and Chief Health Officer integrate the review and evaluation of components to demonstrate the process is effective in improving health care. Measuring clinical and service outcomes, health equity, 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, health equity, 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 including dentists. The scope also includes coordination and cooperation with the External Quality Review Organization as designated by DHCS, and detailed in policy QI-120 Coordination with the EQRO.

2.6 QIHE PROGRAM STRUCTURE

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

2.6.1 QIHE PROGRAM FUNCTIONAL AREAS AND RESPONSIBILITIES (QI 1.A.1)

The Quality Improvement and Health Equity Departments are responsible for implementing a multidimensional and multi-disciplinary QIHE Program that effectively and systematically monitors and evaluates the quality and safety of clinical care, health equity, and service rendered to members.

The Quality Improvement and Health Equity 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 and health equity 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.
- Ensure care is not withheld or delayed for any reason, including potential financial gain or incentives to HPSM providers. This includes ensuring HPSM does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, and pressure health care providers or institutions to render care beyond the scope of their training or expertise.
- Improve health care delivery and health equity by monitoring and implementing corrective action, as necessary, for access and availability of provider services to members.
- Conduct effective oversight of fully delegated and downstream fully delegated providers.
- Ensure strong collaboration between QI, HE, and other HPSM departments, such as Utilization Management, Population Health, Integrated Care Management, Pharmacy, Provider Services, Marketing & Communications, and Customer Support as needed, to ensure the most effective action is being taken on various QI initiatives.

2.6.2 QUALITY IMPROVEMENT DEPARTMENT (QI 1.A.1)

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

- Provides the systematic monitoring and measurement of health outcomes, patient safety and member satisfaction and identifies areas of improvement.
- Provide staff support to the Quality Improvement and Health Equity Committee (QIHEC) and Clinical Quality Improvement Committee (CQC).
- Develop initial drafts of the QI Program documents for review and approval by the QIHEC.
- 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.
- Assist in the development of company-wide policies and procedures related to Quality Improvement.

2.7 POPULATION HEALTH MANAGEMENT (PHM) PROGRAM OPERATIONS & OVERSIGHT

The Population Health Management (PHM) team maintains the oversite of the PHM Program Strategy and is responsible for associated reporting. PHM and Health Promotion team leads many PHM initiatives and programs especially those programs aimed at keeping members healthy, managing emerging risk, and improving outcomes across settings/patient safety. The PHM team is also responsible for conducting ongoing population assessments and impact analysis to better inform PHM programming. Several other PHM program operations such as those focused on delivery support systems and complex case management are integrated throughout various HPSM departments. Collectively, PHM Strategy operations and various programs are integrated throughout the following units:

- Health Promotion/Health Education
- Culturally & Linguistically Appropriate Services
- Care Coordination
- Complex Case Management
- Care Transitions
- Behavioral Health & Integrated Services
- Pediatric Health
- Pharmacy Services
- Provider Services

Depending on the topic, PHM reports and program updates are provided regularly to MEC, CQC, QIHEC, committees annually.

Please refer to HPSM's Population Health Management (PHM) Program Strategy for more detailed description of the various programs**.**

2.8 BEHAVIORAL HEALTH SERVICES (QI 1, A, 2)

HPSM's behavioral health management strategy provides behavioral healthcare services to members in order to achieve the best possible clinical outcomes with the most efficient use of resources. Timely, high-quality care, delivered by the appropriate provider in the least restrictive treatment setting is the key to achieving that objective. Behavioral Health Program supports members achieving and maintaining healthy, productive lifestyles.

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

HPSM staff work closely with San Mateo County BHRS 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 behavioral 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.

2.9 QIHE PROGRAM AUTHORITY AND RESPONSIBILITY

The San Mateo Health Commission (Commission) assumes ultimate responsibility for the Quality Improvement (QIHE) Program and has established Quality Improvement and Health Equity Committee (QIHEC) 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 QIHE Program to the Chief Medical Officer (CMO) and Chief Health Officer (CHO).

The Quality Improvement and Health Equity Committee (QIHEC), the Chief Medical Officer and Chief Health Officer have the responsibility for planning, designing, implementing, evaluating and coordinating patient care, clinical quality improvement, and health equity activities. The QIHEC reports on QIHE Program activities to the Commission.

Performance accountability of the Commission includes:

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

2.9.1 ROLE OF THE CHIEF MEDICAL OFFICER (QI 1.A.3)

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 Case Management, Behavioral Health Services (as covered by product line) and Pharmacy (as covered by product line). The Chief Medical Officer may consult 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 Committee (CQC), the Credentialing Sub-Committee, the Utilization Management Committee (UMC), and the Pharmacy and Therapeutics Committee (P&T).
- Communicating feedback from the Commission to the above listed committees.

- Serving as chair for the QIHEC, and the Credentialing/Peer Review/Physician Advisory Committee.
- Providing clinical oversite to the Clinical Quality Committee (CQC)
- 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 organization current with the regulations and standards of the California Department of Health Care Services, Center for Medicare and Medicaid Services (CMS) and NCQA.
- Ensuring that the goals, objectives and scope of the QIHE Program 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 QIHE Program 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 and Health Equity Program (QIHEP).
- 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 QIHE Program 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 QIHEP 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 QIHE Program to HPSM leadership and staff via general staff, senior management team meeting, and other internal meetings.
- Delegating staff from other divisions to perform QIHE Program activities by agreement of appropriate division chief.

2.9.2 ROLE OF PARTICIPATING PRACTITIONERS

Participating practitioners serve on the QIHE Program 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/dental 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 QIHE study designs; and
- Participate in the development of action plans and interventions to improve levels of care and service.

2.9.3 INVOLVEMENT OF DESIGNATED BEHAVIORAL HEALTH PRACTITIONER (QI 1.A.4)

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

HPSM's current CMO is a board certified psychiatrist. HPSM also employs a Chief Health Officer, a clinical psychologist, who is responsible for leading the clinical and administrative management of HPSM's Behavioral Health Integrated Services 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 guidance 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 management policies and procedures for behavioral health and substance use services

2.9.4 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 QIHE Program. These sources include, but are not limited to, the following:

- Encounter data
- Claims data
- Pharmacy data
- Laboratory data
- Medical records
- Dental 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/Health Promotion
- Population Health Management
- Utilization Management
- Customer Support
- Case Management

- Provider Services
- Health Information Managment
    - Health Data Analysts
    - Information Systems Analysts
    - Biostatisticians
    - Statistical Analysis System (SAS) software suite – a comprehensive system for analyzing data

The Quality Improvement and Health Equity Committee uses the above data and resources to fully evaluate and develop objectives 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

2.9.5 DELEGATED QIHE ACTIVITIES (QI 1.A.1)

Health Plan of San Mateo may delegate Utilization Management, Quality Improvement and Health Equity, 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 QIHEP committees as appropriate and to the QIHEC.

2.9.6 COLLABORATIVE QIHE ACTIVITIES (QI 1.A.1)

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

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

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

2.9.7 ANNUAL REVIEW AND UPDATE OF QUALITY IMPROVEMENT AND HEALTH EQUITY PROGRAM

The purpose of the annual QIHE Program Evaluation by the QIHEC is to determine if quality improvement and health equity processes and recommendations made throughout the year result in demonstrated quality improvements in health care, health equity, disease prevention and the delivery of health care services to members.

The annual evaluation assesses whether the QIHEP 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 QIHEC 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 QIHEP program recommendations is submitted to the Commission for annual approval. The following aspects of the Quality and Health Equity Departments 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 QIHEP and outcome results from the previous year
- Evaluation and modification, if necessary, of the QIHEP 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 QIHEP is available upon request. This summary included information about the QIHEP's goals, processes, and outcomes as they relate to member care and service.

2.9.8 ANNUAL QUALITY IMPROVEMENT AND HEALTH EQUITY WORK PLAN

Annually the QI and HE departments develop QIHE Work Plans for the calendar year. The Work Plans integrates QIHE reporting, studies from all areas of organization (clinical and service) and includes requirements for external reporting. The QIHE Work Plans are based on the results of the annual program evaluation.

The Work Plans include the following elements:

- Measurable objectives for each QIHE 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 QIHE Program.

Planned Additions to the QIHE Work Plans include:

- Scheduled reports to the QIHEC 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)

2.9.10 APPROVAL OF THE QUALITY IMPROVEMENT AND HEALTH EQUITY PROGRAM

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

3. QUALITY IMPROVEMENT AND HEALTH EQUITY PROGRAM COMMITTEES

QIHE PROGRAM COMMITTEE MEETINGS

The Quality Improvement and Health Equity Committee (QIHEC) and subcommittees convene at regularly scheduled meetings, or more often is the chairperson deems it necessary; minimum frequency for QIHEC meetings will not extend beyond a quarterly basis.

A quorum consisting of either four members or 50% of the members, whichever is less, must be present for any QIHE Program committee to conduct business. If a quorum cannot be assembled within thirty (30) minutes of the scheduled meeting, those in attendance will select an alternate date and time. The committee members in attendance may decide to continue the meeting for discussion items only, holding all action items or business until a quorum is assembled, or elect to adjourn.

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 emailed to participants in advance to expedite the meeting time and prepare for discussion.

QIHE PROGRAM COMMITTEE MINUTES

Comprehensive, accurate minutes are prepared and maintained for each QIHE 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 QIHE Program committees' meetings are provided for review to the:

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

QIHE PROGRAM COMMITTEE AGENDAS

The QIHE Program 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 QIHE Program committees' members and selected administrative personnel as deemed necessary (i.e., CEO, legal staff/counsel, Commission). All sensitive information, medical records and QIHEC findings are maintained in secure files.
QIHE Program reports, minutes, audit results and other Quality Improvement and Health Equity documentation, including a written summary of HPSM's QIHEC activities, findings, recommendations, and actions prepared after each meeting, are distributed for review to the:

- Chief Medical Officer
- Chief Health Officer
- Chief Executive Officer
- San Mateo Health Commission
- QIHEC Committee members
- Regulatory bodies (as requested, required, and applicable)
- Public through HPSM's website on at least a quarterly basis (written summary of QIHEC activities, findings, recommendations, and actions, only; including summaries fully delegated subcontractors and downstream fully delegated subcontractors QIHEC).

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

QIHE PROGRAM COMMITTEE RESPONSIBILITIES AND FUNCTIONS

- Review the QIHE Program Description that establishes strategic direction for HPSM and forward to the Commission for approval.
- Evaluate the Quality and Health Equity 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 QIHE 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 and health equity efforts are prioritized, resources are appropriate, and resolutions occur.

- Prioritize quality improvement and health equity efforts and assure that resources are allotted.
- Approve Quality Improvement and Health Equity Program policies.
- Ensure appropriate oversight of delegated activities.
- Ensure integration, coordination, and communication among committees reporting to QIHEC.

QIHE 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 QIHEC).

Selected contracted practitioners and providers are invited to serve as members of a QIHE 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
- Serves one or more of the following member populations:
    - Members affected by health disparities
    - Limited English Proficiency (LEP) members
    - Children with Special Health Care Needs (CSHCN)
    - Seniors and Persons with Disabilities (SPD)
    - Persons with chronic conditions
- *HPSM utilizes findings from the annual population needs assessment (PNA) to ensure that committees reflect varied perspectives across race, ethnicity, language, gender identity, sexual orientation, and disability status. The committee chair will present HPSM member demographic information following the completion of the annual PNA and whenever a committee position becomes available. HPSM will utilize PNA findings to identify and invite diverse candidates to apply for open committee seats, ensuring ongoing diversity within our committees.*

A practitioner representative selected to participate on any QIHE 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 QIHEP expectations

REPORTING RELATIONSHIPS OF QIHE STAFF, FULLY DELEGATED SUBCONTRACTORS AND DOWNSTREAM FULLY DELEGATED SUBCONTRACTORS, AND THE QIHE PROGRAM COMMITTEES (QI 1.A.1)

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

The QI Director and PH Director are responsible for the coordination and distribution of all QIHE Program related data and information, including that of any fully delegated subcontractors and downstream fully delegated subcontractors. The Quality Improvement and Health Equity Committee (QIHEC) reviews, analyzes, makes recommendations, initiates actions, and/or recommends follow-up based on the data collected and presented. The Chief Medical Officer and Chief Health Officer communicates the QIHEC's activity to the Commission. The Commission reviews QIHE activities. Any concerns of the Commission are communicated back to the source for clarification or resolution.

Fully delegated subcontractors and downstream fully delegated subcontractors are required to maintain a QIHEC in compliance with DHCS contract section Exhibit A, Attachment III, Section 2.2.3.E, and to report to HPSM's QIHEC on at least a quarterly basis.

CONFLICT OF INTEREST

Health care providers serving on any QIHE 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 QIHE Program 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 QIHE Program, 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 AND HEALTH EQUITY COMMITTEE OVERSIGHT (QIHEC) (QI 1, A, 5)

The Quality Improvement and Health Equity Committee (QIHEC) establishes strategic direction, recommends policy decisions, analyzes and evaluates the results of QIHE activities, including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other QIHE Program Committees, and ensures practitioner participation in the QIHE program through

planning, design, implementation, or review. The QIHEC ensures that appropriate actions and follow-up are implemented and evaluates improvement opportunities. The QIHEC meets and reports at least quarterly to the Commission. The QIHEC is a multi-disciplinary committee, the membership includes at least one Commission member, (Current chair & co-chair) and a broad range of practicing network physicians. Facilitating staff include the Chief Medical Officer, Chief Health Officer, Quality Improvement Director, Population Health Director, and Dental Director. 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 QI 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

- Clinical Oversight
    - Provide clinical oversite and guidance on quality, population health and community support programs and initiatives throughout development, monitoring, and ongoing evaluation phases. Including:
    - Analyzing demographic and epidemiological data.
    - Identifying at-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.
    - Identifying sub-optimal care through the analysis of data referred from all departments.
    - Reviewing and approving identified trends, opportunities for improvement and recommendations for strategies to prevent adverse outcomes.
    - Identifying practitioners/providers not complying with HPSM medical care standards, service standards, guidelines and/or policies and procedures.
    - Reviewing and approving action plans for practitioners/providers in collaboration with company-wide departments.

- Evaluation Guidance & Review
    - Provide oversite and guidance on the evaluation of clinical, population health and community support programs planning and execution to foster a culture of continuous quality improvement.
- Compliance
    - Ensure HPSM's compliance with regulatory requirements that govern clinical programs, clinical quality initiatives, population health management, and community support programs and initiatives
    - Oversee the development of policies, activities and procedures that meet requirements provided by State and Federal regulators and the National Committee for Quality Assurance.
    - Delegation Oversite for Quality Improvement and Population Health Management Functions:
        - establishing performance standards,
        - monitoring performance through regular reporting, and
        - evaluating performance annually
        - provide findings and recommendations to the Delegation Oversight Committee for action for the delegate as needed

CQC MEMBERS

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

- Chief Medical Officer
- Chief Health Officer
- Medical Directors
- Dental Director
- Director of Quality Improvement
- Director of Provider Services
- Director of Pharmacy
- Director of Health Information Management
- Director of Behavioral Health
- Director of Integrated Care
- Director of Population Health
- Director of Medicare
- Manager, Clinical Oversight & Monitoring
- Manager, Integrated Care Management
- Manager, Population Health
- Clinical Quality Improvement Manager
- Manager, Integrated Programs

CQC MEMBER RESPONSIBILITIES

CHIEF MEDICAL OFFICER:

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

QUALITY IMPROVEMENT DIRECTOR:

- Serves as the Committee co-chairperson
- Reports CQC activities to the QIHEC, in the absence of the Chief Medical Officer
- Develop mechanisms to collect, store and profile data
- Reports summaries of site inspections, quality indicator screens, medical records audits, environmental health and safety/infection control issues, risk management issues and other issues as indicated to the Committee

3.3 CREDENTIALING AND PEER REVIEW 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 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 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 Pharmacy & Therapeutic (P&T) Committee meets and reports to the Commission 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 Commission 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
- Dental Director
- UM Manager
- Director of Pharmacy
- Director of Health Services Analytics
- Director of Behavioral Health
- Director of Integrated Care
- Manager, Clinical Oversight & Monitoring
- Manager, Integrated Care Management
- Manager, Population Health

- Manager, Integrated Programs
- 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 QIHEC
- Formalizes UM policies and procedures
- Monitoring of delegated UM; monitoring of CAPs for delegated UM
- 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 MEMBER EXPERIENCE AND ENGAGEMENT COMMITTEE (MEC)

The Member Experience and Engagement Committee(MEC) was established in 2019 as an interdisciplinary committee to assess and enhance efforts to improve member experience, as well as ensure the quality, safety, and appropriateness of services provided through HPSM to members. The Member Experience and Engagement Committee meets monthly. The Director of Population Health Management is the chairperson.

The MEC membership includes representation from the following departments:

- Behavioral Health & Integrated Services
- Care & Transitions Coordination
- Customer Support
- Population Health Management
- Health Information Management
- Marketing & Communications
- Grievance and Appeals

MEC RESPONSIBILITIES AND FUNCTIONS

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

- Reporting on Complaints and grievances
- Member and Provider Appeal trends
- Member satisfaction survey data
- Telephone and turnaround time standard performance
- Access and availability
- Enrollment service standards
- Plan operations
- Member satisfaction/dissatisfaction with providers

4. PATIENT SAFETY

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

- Informing and educating members and providers of issues affecting member safety
- Developing strategies to identify safety issues and promote reporting

HPSM also has a Potential Quality Issues (PQI) program that identifies deviations from expected provider performance or clinical care, as well as issues with the outcome of care. This is accomplished through the systematic evaluation of a variety of sources, such as grievances, utilization, medical/dental record and facility site reviews. Potential Quality Issues can also be referred by HPSM staff and providers. The reporting and processing of PQIs determines opportunities for improvement in the provision of care and services to HPSM members. Appropriate actions for improvement will be taken based on PQI outcomes.

ADMINISTRATIVE PATIENT SAFETY ACTIVITIES

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

- Conducting office site reviews as a part of the initial practitioners credentialing process, upon office relocation, and triennially thereafter
- Conducting a rigorous credentialing and re-credentialing process to ensure only qualified practitioners and organizations provide care in the network
- Establishing 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 and 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, Customer Support, Pharmacy Services, Provider Services related to risk management will be 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 will be 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 PRACTITIONER COMPLIANCE MONITORING

Health Plan of San Mateo will continue monitoring and evaluating 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, as well as to assist in the implementation of corrective action plans, as indicated.

During each compliance survey, a site facility inspection will be conducted along with a review of medical records. The medical record score is based on a survey standard of at least ten randomly selected records per provider.

Upon completion of the review, the provider will be handed the completed survey tool, a summary of findings and a corrective action plan, if required. A corrective action plan is required for specific deficiencies noted. For compliance rating of "conditional pass" and "not pass" a follow-up survey is conducted.

4.1.1.1 FACILITY SITE REVIEWS (FSR)

HPSM conducts provider site reviews for all new Medi-Cal PCPs 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 accreditations and/or certifications. A full scope review is conducted utilizing the criteria and guidelines of California Department of Health Services Medi-Cal Managed Care (MMCD APL 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review).

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%, there is a deficiency in a critical element, Pharmacy or Infection Control a Corrective Action Plan (CAP) is required to be completed by the provider. The provider will be placed in EPO (established patients only) until all CAP corrections have been addressed.

HPSM will review 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. 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. A Facility Site Review is also required upon relocation of the provider's office.

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

4.1.1.2 MEDICAL RECORD REVIEW (MRR)

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.

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 will be reviewed for an individual PCP or when 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. If there are still a small number of 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 criteria assessed by a Medical Record Review are:

- Format
- Documentation
- Continuity/Coordination
- Pediatric Preventive, Adult Preventive and/or OB/CPSP Preventive

4.1.1.3 PHYSICAL ACCESSIBILITY REVIEWS (PAR)

Health Plan of San Mateo conducts a Physical Accessibility Review (PAR) for all existing and new primary care providers, High-Volume Senior and Person with Disabilities (SPD) Specialists, High- Volume SPDs Ancillary Services and CBAS Centers. Also, those defined with five or more SPD encounters per day. The 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.

Physical Accessibility Reviews are scheduled and performed triennially. Providers who move to a new location will 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 there were 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 rooms 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 are one or more deficiencies the provider or the site will receive "Limited Access." Medical Equipment determines if the provider office or the site meets ADA equipment requirements.

Attachment 'D' is used for Ancillary Services 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 are one or more deficiencies, the site will receive "Limited Access." Medical Equipment determines 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 receive the Physical Accessibility Review results indicating their level of accessibility as well as a list of the accessibility indicators within compliance. Provider Services department will also receive a copy to be published in our HPSM Provider Directory and MMP website. The accessibility level determination is to provide our members with physical limitations with a list of providers that can accommodate their needs, it does not affect the provider's member enrollment.

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

4.1.2 QUALITY ISSUE IDENTIFICATION

To provide overall quality functions, each division and/or department will continually monitor specific important aspects of care. These aspects or activities of care and/or service will include, but is 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, will develop and implement a process that addresses improving member safety. The goal of the process is to foster a supportive environment to aid practitioners and organizational providers improve safety in their practice. Activities that may be included in this process are:

4.2 CARE COORDINATION PROGRAMS

- Will continue to assist in the coordination of managed care efforts to reduce or prevent omission or duplicate orders when multiple providers are involved.
- Will continue to monitor 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, and/or patient non-adherence with a care plan.

4.3 QUALITY MONITORING ACTIVITIES

- In accordance with regulatory requirements and guidance, the QI team maintains quality oversight for services provided to HPSM Medi-Cal members at the following Medi-Cal contracted facilities:
    - Skilled Nursing Facilities/Long Term Care Facilities including Intermediate Care Facilities/Home For Individuals With Developmental Disabilities
    - Regional Centers
    - Subacute Facilities

- At least annually, unless otherwise requested, quality assurance and improvement findings for our the above-listed are retrieved directly from the respective government websites including CA Department of Developmental Services, California Department of Public and Health CDPH, , which includes survey deficiency results, site visit findings, and compliant findings. The QI team also utilizes CMS resources that offer additional insight on the quality of care for our contracted SNFs.

- For the purposes of reporting, and internal quality improvement initiatives, the QI team utilizes claims data, which includes emergency room visits, healthcare associated infections requiring hospitalizations, and potentially preventable readmissions to identify trends and patterns that warrant further investigation on the quality of care being provided at the respective facility . The requested claims data is reported to DHCS via the template provided by DHCS on a quality basis.

- In addition to the claims data, Potential Quality Issues (PQIs) received for care provided at the above listed facilities are reviewed and included in the quality review. The PQIs are identified through a systematic review of a variety of data sources as applicable, including but not limited to the following sources :
    1. Information gathered through concurrent, prospective, and retrospective utilization review
    2. Referrals by health plan staff or providers
    3. Claims and encounter data
    4. Site reviews
    5. HEDIS medical record abstraction
    6. Medical/dental record audits
    7. Pharmacy utilization
    8. Phone log detail
    9. Grievances

- In efforts to prevent, detect, and remediate identified critical incidents, any identified trends/patterns in the quality of care being provided at our contracted provider sites/facilities Clinical Quality Committee (CQC) on a bi-annual basis.

- As needed, QI will readily collaborate with internal teams to assess the quality and appropriateness of care furnished to members and the efforts provided to support member's community integration.

4.4 DRUG SAFETY

HPSM will continue monitoring for appropriate medication use to ensure the safety of members. These techniques include, but are 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

4.5 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.

4.6 HEALTH MANAGEMENT PROGRAMS

HPSM will continue working 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.

4.7 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

Health Plan of San Mateo (HPSM) continuously 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. SERVING A DIVERSE MEMBER POPULATION

HPSM's DEI training program is a core part of our efforts to advance health equity for our members. It supports us in creating a better relationship and connectivity with HPSM's diverse member population. "Healthy is for everyone" means striving for equitable access to high quality health care services for every person in San Mateo County. The reality is that systemic injustices persist, and health care experiences are not equal for all. HPSM is committed to working towards improvements in this system through our health equity approach. Ongoing education fosters an inclusive environment within HPSM and externally with Network Providers, and other community-based contractors. We empower San Mateo County's residents to live their healthiest lives by building awareness and strong community partnerships. The DEI training program includes sensitivity, diversity, cultural competency and cultural humility, and health equity training programs.

The DEI training program implementation and evaluation progress will be reported to Quality Improvement and Health Equity Committee including at a minimum: training program materials; compliance reports; and any adjustments made to the training program. For more details on the DEI training program, reference HPSM's Culturally and Linguistically Appropriate Services (CLAS) program description.

7. QUALITY IMPROVEMENT AND HEALTH EQUITY PROGRAM ACTIVITIES

The QIHE Program's scope includes implementation of QIHE activities or initiatives. The QIHEC 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. Most 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's Access to Preventive/Ambulatory Health Services
- Ambulatory Care
- Antibiotic Utilization
- Antidepressant Medication Management
- Asthma Medication Ratio
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Breast Cancer Screening
- Care for Older Adults
- Cervical Cancer Screening
- Childhood Immunization Status – Combo 10
- Colorectal Cancer Screening
- Comprehensive Diabetes Care
- Controlling High Blood Pressure
- Depression Screening and Follow-Up for Adolescents and Adults
- 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
- Lead Screening in Children
- Mental Health Utilization
- Non-Recommended PSA-Based Screening in Older Men
- Oral Evaluation, Dental Services
- 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
- Statin Therapy for Patients with Cardiovascular Disease
- Statin Therapy for Patients with Diabetes
- Topical Fluoride for Children
- Transitions of Care

- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- 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 Providers
- Use 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
- Well Child Visits (ages 0-15 months)
- Well Child Visits (16-30 months)
- Well Child and Adolescent Visits (3-21)

7.1 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 and health promotion services that includes health interventions to promote positive health outcomes across the entire membership population. HPSM's PHM Strategy was developed to meet the NCQA requirements. Detailed descriptions of PHM initiatives and programs can be found in *HPSM's Population Health Management Program Description*. 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 using 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 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.

7.2 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
- Dental services

The continuity and coordination of care received by members include medical, dental, and behavioral health care. Health Plan of San Mateo collaborates with San Mateo County 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.

7.3 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. Provider Services will make certain that the provider newsletter promotes awareness of the clinical guidelines on the HPSM website, in at least one of its quarterly newsletters or news alerts in 2023.

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 staff 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.

7.4 MEMBER EXPERIENCE

7.4.1 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 D-SNP members and for Medi-Cal members. The results of the surveys are reported to the MEC, Consumer Advisory Committee, QIHEC and Commission.

Quarterly summaries of complaints and grievances/appeals will be reported to the Member Experience and Engagement Committee (MEC), and Consumer Advisory Committee. Report will be trended by type of complaint, HPSM departments, sites, facilities and physicians as indicated. Cases that will be reviewed by the Chief Health Officer will be included in the quarterly summaries.

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

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

7.4.2 CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS)

HPSM uses the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to assess member experience with the health plan. CAHPS is conducted annually for Medicare and Medi-Cal populations. The survey is conducted in the first half of the calendar year 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.

7.4.3 HEALTH OUTCOMES SURVEY (HOS)

HPSM participates in the Medicare Health Outcomes Survey (HOS) to gather valid, reliable, and clinically meaningful health status data from the CareAdvantage program to use in quality improvement activities, pay for performance, program oversight, public reporting, and to improve health (https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HOS/).

This self-report survey of plan members is conducted in English, Spanish, & Chinese. Baseline results of HOS are intended to help plans identify potential areas for improvement and evaluate the physical and mental health of members. The reporting is done within specific cohorts with a follow-up 2 years later.

8. 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; soliciting health educational request 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 is heavily based on mailings to educate them about resources available to them in the community. The Health Promotion Program Specialists monitor the availability and accessibility of programs/resources through self-referral or referral from provider for these programs/resources.

See Health Promotion Program Description for further details.

9. QUALITY IMPROVEMENT INTERVENTIONS

9.1 INITIAL HEALTH APPOINTMENT (IHA)

The Initial Health Appointment (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 22-030) 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. It is required that health plan's reach a 100% compliance rate ensuring every member enrolled is seen by their primary care physician within the first 120 days of enrollment with the plan.

2024 IHA ACTION PLAN

IHA completion will continue to be incentivized for Medi-Cal PCPs under HPSM's Pay for Performance (P4P) program. As part of P4P, monthly reports are sent to PCPs detailing level of performance.

The IHA CAP required by DHCS due to less than 100% of members receiving an IHA will be implemented and completed. CAP actions include:

1. Updating HPSM's website to contain updated information for Providers and revising the IHA training document for providers
2. Create IHA requirement attestations to be used to educate providers during Site Reviews.
3. Continue pay-for-performance(P4P) monetary incentive for PCPs for timely IHA completion in 2024 Under the Benchmark P4P IHA remains a payment metric for Family Practice and Adult track providers and reporting-only for Pediatric providers. This is based on prioritization in assigned quality metric sets. As part of P4P, monthly reports are sent to PCPs detailing level of performance.
4. HPSM is also incentivizing both the scheduling of the IHA and timely completion with inclusion of the IHA in its new Care Gap P4P. Care Gap P4P utilizes an interactive platform that allows PCPs to readily view and filter for their assigned members in need of an IHA.

HPSM QI RNs will continue to audit for IHA completion with regular Facility Site Review Medical Record Review audits. Any deficient IHA documentation is addressed at the time of the Facility Site Review by site review nurses. Consistently underperforming PCPs will be investigated and may be subject to a focused medical record review based on the identified deficiency(ies). The PCP may be given a corrective action plan based on the findings of the investigation and/or medical record review.

Members will continue to be informed through the evidence of coverage and a IHA reminder in new Medi-Cal member welcome packets.

9.2 DHCS WELL-CHILD VISITS IN THE FIRST 15 MONTHS HEALTH EQUITY PIP

Starting in 2024, the Quality Improvement Department will implement a disparity performance improvement project (PIP) on the Well-Child Visits in the First 15 Months of Life measure which requires six or more well-child visits in the first 0 to 15 months of life. (W30 6+)) The PIP will focus on the Hispanic population.

PIP Topic: Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) measure rates for the Hispanic American population.

Program Area Goal: Implement targeted interventions to improve the percentage of Hispanic members who complete 6 or more well child visits in the first 15 months of life.

2024 HEALTH EQUITY **PIP** ACTION PLAN

For 2024, W30 6+ will be a key area of focus for HPSM and based on findings from barrier analysis and intervention planning, HPSM staff will conduct the following activities.

1. The County Home Visiting Program will conduct health education home visits to Hispanic members to provide culturally and linguistic appropriate health education regarding the importance of completing 6 well child visits by the 15th month of life.
2. Population Health will provide a quarterly report that includes all members reached out to by County Home Visiting and the result of the outreach to QI.
3. Qi will use the report to validate which members complete their well child visits,
4. QI will submit an annual evaluation of the PIP results to DHCS in the Fall of 2024.

9.2.1 DHCS NON CLINICAL PIP

Starting in 2024, the Quality Improvement Department will implement a 3 year non-clinical performance improvement project (PIP) on the Follow Up after Mental Health(FUM) and /Follow Up After Substance Abuse(FUA) HEDIS Measures.

PIP TopicProvider notifications for members with SUD/SMH diagnoses following or within 7 days of emergency department (ED) visit.

Program Area Goal: Implement a process and improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 7 days of emergency department (ED) visit.

2024 NON CLINICAL PIP ACTION PLAN

For 2024, FUM, FUA will be a key area of focus for HPSM and based on findings from barrier analysis and intervention planning, HPSM staff will conduct the following activities.

- Implement a process to provide notifications to providers when a patient is seen in the ED for SUD/SMH diagnosis.
- Provide the notification within 7 days of the ED visit.
- Track the percentage of notifications provided within 7 days of the ED visit.
- Submit an annual evaluation of the PIP results to DHCS in the Fall of 2024.