



QUALITY IMPROVEMENT (QI) PROGRAM 2019

Approval Signature:

A handwritten signature in black ink, appearing to read "M. Hoffing", is written over a horizontal line.

Marc A. Hoffing, M.D., Medical Director
Chair, Quality Improvement Council

02/15/2019

Date:

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PROGRAM STRUCTURE

Desert Oasis Healthcare (DOHC) will have the QI infrastructure necessary to improve the quality and safety of clinical care and services we provide to our members.

DOHC uses mixed model structure to deliver health care to our members. The delivery system types are as follows:

Staff model: The physicians are salaried employees of DOHC. Medical services are delivered in owned medical facilities that generally are open only to our members. The physicians adopt the principles of DOHC.

IPA (independent or individual practice association) model: Is an organized system of independent, private-practice physicians or an association of such physicians. Physicians in this model generally are paid on a modified fee-for-service or capitated basis.

Mixed model: A combination of staff model and the IPA model described above.

MISSION STATEMENT

Our QI Department has a mission to provide an effective, system-wide, measurable plan for monitoring, evaluating and improving the quality of care and services, in a cost-effective and efficient manner to our members and practitioners.

PURPOSE/PROGRAM DESCRIPTION

The QI Program is designed to objectively, systematically monitor and evaluate the quality, appropriateness and outcome of care/services delivered to our members. In addition, to provide mechanisms that continuously pursues opportunities for improvement and problem resolution.

SCOPE OF PROGRAM

The scope of the QI Program is to monitor care and identify opportunities for improvement of care and services to both our members and practitioners, and ensure our services meet professionally recognized standards of practice. This is accomplished by assisting with the identification, investigation, implementation, and evaluation of corrective actions that continuously improve and measure the quality of clinical and administrative service.

This QI Program covers both clinical and non-clinical care and services, for our Commercial, Medicare Advantage, Medicaid, and dual-eligible populations.

GOALS AND OBJECTIVES

A. Goals

1. Ensuring ongoing communication and collaboration between the QI Department and the other functional areas of the organization, such as, but not limited to: Utilization Management, Clinical Services, Behavioral Health and Case Management.
2. Ensuring members receive the highest quality of care and services.
3. Ensuring members have full access to care and availability of primary care physicians and specialists.
4. Monitoring and evaluation of the standards of health care practice through evidence-based guidelines (Practice Guidelines) as the basis for clinical decision-making.
5. Monitoring, improving and measuring member and practitioner satisfaction with all aspects of the delivery system and network.
6. Utilizing a multi-disciplinary approach to assess, monitor and improve our policies and procedures.
7. Promoting physician involvement in our QI Program and activities.
8. Collaboration with contracted hospital practitioner and health delivery organizations to assure the quality and safety of services provided.
9. Fostering a supportive environment to help practitioners and providers improve the safety of their practices.
10. Assess and meet the cultural and linguistic needs of our members.
11. Meeting the changing standards of practice of the healthcare industry by adhering to all state and federal laws and regulations.
12. Monitoring our compliance to regulatory agency standards through annual oversight audits, and survey activities
13. Adopting, implementing and supporting ongoing adherence with accreditation agency standards.
14. Promoting the benefits of a coordinated care delivery system.
15. Promoting preventive health services and care management of members with chronic conditions.
16. Emphasizing a caring and therapeutic relationship between the patient and practitioner; and a professional and collaborative relationship between the practitioner and health plan.
17. Ensuring there is a separation between medical and financial decision making.
18. Seek out and identify opportunities to improve the quality of care and services provided to our members.
19. Seek out and identify opportunities to improve the quality of services to our practitioners.

B. Objectives

1. Ensuring that timely, quality, medically necessary and appropriate care and services that meet professionally recognized standards of practice are available to members by the identification, investigation and resolution of problems; focusing on known or suspected issues that are revealed through monitoring, trending and measuring of specific clinical indicators; preventive health services; access to services; and, member experience through the use of a total QI philosophy.
2. Systematically collect, screen, identify, evaluate and measure information about the quality and appropriateness of clinical care provided and provide feedback to affiliates, employed and IPA physicians and practitioners in relation to performance findings and the corresponding impact on patient outcomes and network-wide performance.

3. Maintaining a credentialed network based on a thorough review and evaluation of education, training, experience, sanction activity and performance of each healthcare provider.
4. Objectively and regularly evaluate professional practices and performance on a proactive, concurrent and retrospective basis through Credentialing and peer review.
5. Ensuring our members are afforded accessible health care by continually assessing member access to care and the availability of our network of practitioners and specialists.
6. Designing and developing data systems to support QI monitoring and measurement activities.
7. Assuring compliance with the requirements of regulatory and accrediting agencies, including but not limited to CMS, DHCS, DMHC, and NCQA.
8. Appropriately oversee QI activities of our practitioners, contracted IPA physicians, and facility providers.
9. Ensuring that at all times the QI structure, staff and processes are in compliance with all regulatory and oversight requirements.
10. Actively work to maintain standards for quality of care and accessibility of care and service.
11. Establishing and conducting focused review studies, with an emphasis on preventive and high-risk services and programs and on services provided by our high volume practitioners with implementation of processes to measure improvements.
12. Ensuring that mechanisms are in place to support and facilitate continuity of care within the healthcare network and to review the effectiveness of such mechanisms.
13. Identifying potential risk management issues.
14. Effectively interface with all interdisciplinary departments and practices for the coordination of QI activities.
15. Providing a confidential mechanism of documentation, communication and reporting of QI issues and activities to the QI Council, and other appropriate involved parties.
16. Assessing the effectiveness of the QI Program and making modifications and enhancements as necessary on an ongoing and annual basis.
17. Ensuring that Desert Oasis Healthcare is meeting the members cultural and linguistic needs at all points of contact.
18. Ensuring members have access to all available services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
19. Ensuring mechanisms are in place to identify, and evaluate patient safety issues within the network, and systems are established to facilitate effective resolutions.

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

All QI activities including correspondence, documentation and files are protected by State Confidentiality Statutes, the Federal Medical Information Act SB 889 and the Health

Information Portability and Accountability Act (HIPAA) for patient's confidentiality. All persons attending the QI Council or its related sub-committee meetings will sign a Confidentiality Statement. All personnel are required to sign a Confidentiality Agreement upon employment. Only designated employees by the nature of their position will have access to member health information as outlined in the policies and procedures.

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

DOHC ensures that all member care is consistent with professionally recognized standards of practice, and is not withheld or delayed for any reason, and all treatment decisions rendered by appropriate clinical staff, are void of any influence or oversight by the finance department. Therefore:

1. We do not penalize practitioners or providers for discussing medically necessary or appropriate patient care regardless of the patient's benefits.
2. We do not pressure practitioners, or providers to render care beyond the scope of their training or experience.
3. We do not exert economic pressure on institutional providers to grant privileges to health care providers that would not otherwise be granted.

PROGRAM STRUCTURE

A. Heritage Provider Network (HPN) Governing Body

DOHC'S Governing Body is the HPN Executive Committee. The QI Council is responsible for the establishment and implementation of the QI Program. The QI Council appoints the QI Medical Director, the VP of Quality & Compliance, and the Director of Quality Improvement to act as facilitator for all QI activities and they are the responsible entities for the oversight of the QI Program.

The QI Council evaluates and monitors the quality of patient care and addresses support services concerns. The QI Medical Director, the VP Quality & Compliance, and the Director of Quality Improvement will report all QI activities to the HPN QI Committee every quarter. The HPN QI Committee formally reviews and approves all QI activities quarterly and directs these operations on an ongoing basis.

The HPN QI Committee will ensure sufficient staff and resources to the QI Program to achieve its objectives. These resources will include staff, data sources, analytical resources such as statistical expertise and programs. Desert Oasis Healthcare ensures its contracted Medical Group/Independent Practice Association is deemed competent to meet regulatory and accreditation regulations during our initial oversight survey and our annual oversight audits thereafter.

B. Chief Operating Officer

The Chief Operating Officer has overall responsibility for assuring adequate resources and staffing is available for the QI Department.

C. QI Medical Director

The QI Medical Director is a physician who holds a current license to practice medicine with the Medical Board of California. The QI Medical Director is the QI Council's designee responsible for implementation of QI Program activities. The QI Medical Director works in conjunction with the VP of Quality & Compliance, the QI Director and Management to develop implement and evaluate the QI Program. The QI Medical Director is Chairperson of the QI Council.

Responsibilities include but not limited to:

1. Implementation of the QI Plan for which they must have substantial involvement in the assessment and improvement of QI activities.
2. Ensuring that medical decisions are rendered by qualified medical personnel, unhindered by fiscal or administrative management.
3. Ensuring that the medical care provided meets the community standards for acceptable medical care.
4. Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
5. Developing and implementing medical policy.
6. Actively participating in the functioning and resolution of the grievance procedures.
7. Providing support and clinical guidance to the program and to all physicians in the network.
8. Assuring compliance with the requirements of regulatory and accrediting agencies, including but not limited to CMS, DHCS, DMHC, NCQA and the contracted Health Plans.
9. Ensuring that the QI and Utilization Management Departments interface appropriately to maximize opportunities for QI activities.
10. Directing the implementation of the QI process.
11. Overseeing the formulation and modification of comprehensive policies and procedures that support the QI operations.
12. Analyzing QI data.
13. Reviewing pertinent clinical grievances, and Quality of Care concerns; assigning severity levels; and directing corrective actions to be taken, including peer review, if required.
14. Reviewing QI Program, Work Plan, Annual Evaluation and Quarterly Reports.
15. Directing Health Education and Credentialing activities.
16. Assisting with the development, conduct, review and analysis of quality (HEDIS) studies.

D. Designated Behavioral Health Practitioner

The behavioral healthcare practitioner must be doctoral-level. They must hold a current license to practice in the State of California and may be a Medical Director, Clinical Director, or participating practitioner from the Medical Group, or our contracted Behavioral Health Care Organizations.

They shall be involved in all behavioral aspects of the QI program, and assist with member behavioral health complaints, development of behavioral health guidelines, development of programs, recommendations on service and safety, provide behavioral health QI statistical data and follow-up on identified issues. They must attend the QI Council Meeting quarterly, at a minimum.

The behavioral health practitioner works in conjunction with the Vice President of Quality & Compliance, and the QI Director to develop implement and evaluate the Behavioral Health aspects of the QI Program.

Responsibilities include but not limited to:

1. Ensuring that medical decisions are rendered by qualified behavioral health personnel, unhindered by fiscal or administrative management.
2. Ensuring that the behavioral health care provided meets the community standards for acceptable medical care.
3. Ensuring that behavioral health protocols and rules of conduct for plan behavioral health personnel are followed.
4. Assisting in the development and implementation of behavioral health policy.
5. Actively participating in the functioning and resolution of the grievance procedures.
6. Providing support and clinical guidance to the program and to all physicians in the network.
7. Assuring compliance with the requirements of regulatory agencies and accrediting, including but not limited to CMS, DHCS, DMHC, NCQA and the contracted Health Plans.
8. Ensuring that the QI and Utilization Management Departments interface appropriately to maximize opportunities for QI activities.
9. Directing the implementation of the QI process for behavioral health.
10. Overseeing the formulation and modification of comprehensive behavioral health policies and procedures that support the QI operations.
11. Analyzing behavioral health QI data.
12. Reviewing pertinent behavioral health grievances, and Quality of Care concerns; assigning severity levels; and directing corrective actions to be taken, including peer review, if required.
13. Directing Behavioral Health Education and Credentialing activities.
14. Assisting with the development, conduct, review and analysis of HEDIS studies.

E. Vice President of Quality and Compliance

The Vice President of Quality & Compliance is a Registered Nurse with current California licensure, who oversees the operations of the Quality Department and is responsible for the execution and coordination of all QI activities. The VP of Quality & Compliance reports to the Chief Medical Officer.

Responsibilities include but are not limited to:

1. Developing and/or revising annually the QI Annual Evaluation and Work Plan and presenting for review and approval.
2. Developing and/or revising QI policies and procedures.
3. Ensuring that quality trends and patterns are monitored, quality issues are identified and corrective action plans are developed.

4. Ensuring monitoring and reporting to QI Council of the resolution of quality improvement activities, in accordance with the QI Program.
5. Overseeing compliance activities required by regulatory agencies.
6. Interfacing with all internal departments to ensure compliance to the Quality Improvement Program and policies and procedures.
7. Acting as a liaison with each contracted IPA/PCP and ancillary provider and facility regarding QI issues.
8. Assuring compliance with the requirements of regulatory agencies and accrediting, including but not limited to CMS, DHCS, DMHC, NCQA and the contracted Health Plans.
9. Serving as liaison with Regulatory Agencies for QI activities.
10. Monitoring and follow-up with all applicable QI activities.
11. Ensuring that staff collects and monitors data and reports identified trends to the CMO and QI Committee.
12. Ensuring that HEDIS and Quality studies are conducted appropriately.
13. Overseeing Facility Site Review activities.
14. Ensuring Member and Practitioner Satisfaction Surveys are conducted annually.
15. Develops and oversees the Credentials process.
16. Identifying compliance problems and formulating recommendations for corrective action.
17. Ensuring that Focused Review Studies are conducted appropriately when necessary.
18. Interfacing with the Chief Medical Officer for clinical quality of care and service issues.
19. Maintaining a comprehensive grievance and appeals database to track pertinent case data that facilitates capturing, tracking and trending of this data.
20. Ensuring oversight of member clinical grievance case files and the process for the Medical Director's action.
21. Assuring the department adheres to HIPAA compliance standards.
22. Serving as liaison with CMS, DHCS, DMHC, Health Plans and other regulatory agencies for investigation, collaboration and resolution of clinical grievances.
23. Developing policies and procedures in conjunction with the Chief Medical Officer.
24. Overseeing the collecting, monitoring and reporting of data for tracking and trending.
25. Serving as a liaison with departments for investigation, collaboration and resolution of all identified internal quality of care issues.
26. Ensuring preparation of grievance and appeals reports for management, Executive Committee, and QI Council meetings.
27. Monitoring delegated QI activities to ensure proper performance of QI functions in compliance with regulatory and delegation requirements.
28. Ensuring tracking of compliance with reporting requirements, and ensuring reports are provided for the QI Council meetings.
29. Reviewing QI corrective action plans and other QI reports for compliance to standards.
30. Reporting findings of non-compliance to the CMO and QI Council.

F. QI Director

The QI Director is a Registered Nurse with current California licensure. He/she oversees the operations of the QI Department and is responsible for the execution and coordination of all QI activities. If the QI Director is not an RN, they must have significant work experience and credentials to ensure they are qualified to perform the tasks listed assigned. The QI Director reports to the Vice President of Quality & Compliance.

The QI Director helps to plan, develop, organize, monitor, communicate, and recommend modifications to the QI Program and all QI policies and procedures. It is the QI Director's responsibility to interface with other departments on QI issues. The QI Director reports any areas of concern to the VP of Quality & Compliance and/or the QI Council. Additional responsibilities include but not limited to:

1. Performing statistical analysis relevant to QI functions and goals.
2. Developing and/or revising annually the QI Program, Annual Evaluation and Work Plan and presenting for review and approval.
3. Developing quarterly QI activity progress reports.
4. Developing and/or revising annually QI policies and procedures.
5. Ensuring that quality trends and patterns are monitored, quality issues are identified and corrective action plans are developed.
6. Monitoring and reporting to the QI Council the resolution of QI activities in accordance with the QI Program.
7. Overseeing compliance required by regulatory agencies.
8. Interfacing with all internal departments to ensure compliance to the Quality Improvement Program and policies and procedures.
9. Acting as a liaison with each contracted IPA/employed practitioner and ancillary provider and facility regarding QI issues.
10. Assuring compliance with the requirements of regulatory agencies and accrediting, including but not limited to CMS, DHCS, DMHC, NCQA and the contracted Health Plans.
11. Serving as liaison with Regulatory Agencies for QI activities.
12. Monitoring and follow up with all applicable QI activities.
13. Ensuring that staff collects and monitors data and reports identified trends to the QI Medical Director and QI Council.
14. Ensuring that HEDIS and Quality studies are conducted appropriately.
15. Overseeing the Facility Site Review Program.
16. Ensuring Member and Practitioner Satisfaction Surveys are conducted annually.
17. Developing and overseeing the Credentialing process.
18. Identifying compliance problems and formulating recommendations for corrective action.
19. Ensuring that Focused Review Studies are conducted appropriately.
20. Interfacing with the VP of Quality & Compliance and QI Chairperson for clinical quality of care and service issues.
21. Maintaining a comprehensive grievance and appeals database to track pertinent case data that facilitates capturing, tracking and trending of this data.
22. Ensuring review of member clinical grievance case files and completion of Medical Director's action.

23. Assuring the department adheres to HIPAA compliance standards.
24. Serving as liaison with CMS, DHCS, DMHC, Health Plans and other regulatory agencies for investigation, collaboration and resolution of clinical grievances.
25. Developing policies and procedures in conjunction with the Medical Director.
26. Collecting, monitoring and reporting data for tracking and trending.
27. Serving as a liaison with departments for investigation, collaboration and resolution of all identified internal quality of care issues.
28. Preparing grievance and appeals reports for management, QI Council meetings.
29. Overseeing ongoing audit and monitoring processes of each MSO department, employed and IPA practitioner.
30. Monitoring QI activities to ensure proper performance of QI functions in compliance with regulatory and delegation requirements.
31. Submission of a written report summarizing activities conducted annually.
32. Tracking compliance with reporting requirements and provide reports for the QI Council meetings.
33. Reviewing QI corrective action plans and other QI reports for compliance to standards.
34. Reporting IPA/employed practitioner findings of non-compliance to the Medical Director and QI Council.

G. Director of Health Care Informatics (HPN)

The Director of Health Care Informatics under the direction of the HPN Vice President of Clinical Services will monitor the Heritage Provider Network and DOHC's data system and provide reliable information and meaningful analysis for those seeking to improve health care quality, affordability, access, and outcomes within our provider network.

The Director of Health Care Informatics will help develop, plan, and produce meaningful analytic reports to leverage our vast data resources. They will analyze large health care-related datasets, including health care claims and enrollment files, and effectively interpret, summarize, and communicate his/her analyses.

Additional responsibilities include, but are not limited to:

1. Independently plan, organize, and prioritize assigned projects, creating and managing work plans that reflect the tasks, timeframes, and processes required to successfully complete each.
2. Assist with development, implementation, and documentation of QI processes to ensure that reported data is accurate and reliable.
3. Design, plan, and produce timely and meaningful analytic reports using a Claims Database, Hospital Discharge Database, and other internal and external data sources.
4. Utilize software programs such as SAS, SQL, Excel and/or other business intelligence tools to analyze large claims, eligibility, and other health care data files.
5. Interpret data accurately and produce clear and comprehensive written analyses, graphics, tables and presentations for diverse internal and external audiences, including the providers, and payers.
6. Participate in the data review of analyses and reports produced by DOHC, and mentor other members of the Analytic Team, as needed.

H. QI Coordinator

The QI Coordinator provides support to the Quality & Compliance Department working under the direction of the Director of Quality Improvement.

The QI Coordinator assists with the preparation of QI Work Plans, organizational charts, QI outcome letters, letter distribution and quarterly or more frequent QI Council meeting minutes. The QI Coordinator is responsible to maintain accurate document system files related to QI.

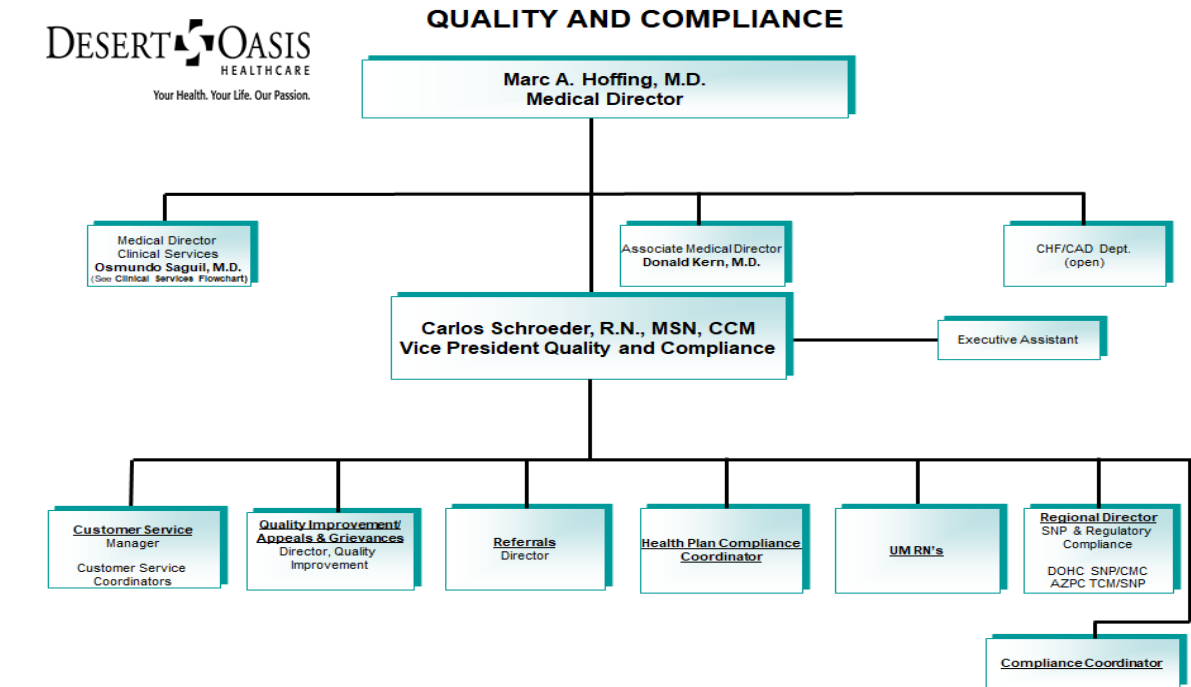
I. Health Education under Administrator of Population Health and Prescription Management

The Administrator of Population Health and Prescription Management oversee the administrative day to day operations of the Health Education Department. He/she reports directly to the Associate VP of Clinical Quality Initiatives.

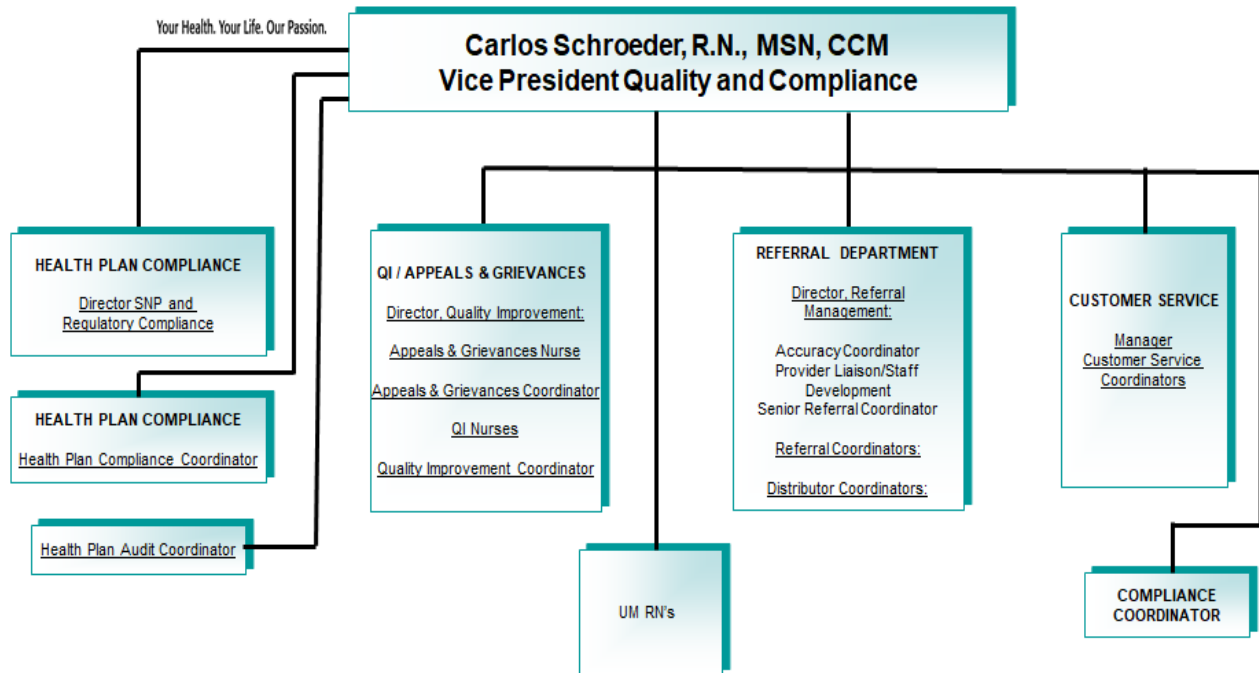
It is the Administrator's responsibility to interface with other department members as needed regarding QI processes and issues. Additional responsibilities and requirements for this position include:

1. Principles of public health education, disease management, to include program planning, implementation, and evaluation.
2. Development of Health Education, Disease Management, teaching materials including teaching methods and curriculum design.
3. Ongoing monitoring, assessment, and evaluation of programs.
4. Oversees a robust diabetes education program.
5. Providing health education training classes and developing cooperative relationships with DOHC and IPA practitioners.

QI Organizational Chart



QUALITY AND COMPLIANCE



DOHC QI COUNCIL

Description

The DOHC QI Council is a standing committee and is charged with the development, oversight, guidance and coordination of all improvement. The QI Council is designated, and has been delegated the responsibility of providing an effective QI Program for our members, and providers. The QI Council monitors provisions of care, identifies problems, recommends corrective action, and guides the education of Practitioners to improve health care outcomes and quality of service.

Scope (includes but not limited to):

1. Directing all QI activity.
2. Recommending policy decisions.
3. Reviewing, analyzing and evaluating QI activity.
4. Ensuring practitioner participation in the QI program through planning, design, implementation and review.
5. Reviewing and evaluating reports of QI activities and issues arising from its subcommittees (Credentials, Pharmacy & Therapeutics Committees).
6. Monitoring, evaluating and directing the overall compliance with the QI Program.
7. Annually reviewing and approving the QI Program, Work Plan, and Annual Evaluation.
8. Overseeing and keeping staff and providers informed regarding: QI Projects and Performance Improvement Projects; QI requirements, activities, updates or revisions; Performance measures and results; Utilization data; and Profiling results.

9. Assuring compliance with the requirements of regulatory and accreditation agencies, including but not limited to CMS, DHCS, DMHC, NCQA and contracted Health Plan policies.
10. Reviewing and approving QI policies and procedures, guidelines, and protocols.
11. Developing and approving preventive health and clinical practice guidelines that are based on nationally developed and accepted criteria.
12. Developing relevant subcommittees for designated activities and overseeing the standing subcommittee's roles, structures, functions and frequency of meetings as described in this Program. Ad-hoc subcommittees may be developed for short-term projects.
13. Conducting peer review, assigning severity levels and making recommendations for corrective actions, as needed.
14. Reviewing network practitioner and provider availability, and the number of credentialed, re-credentialed, and termed providers. We shall adjust the network based on our findings.
15. Reviewing and evaluating reports regarding any/all critical incidents, reportable events, and sentinel events.
16. Reviewing and evaluating reports submitted by each Health Plan.
17. Responsibility for evaluating and giving recommendations concerning audit results, member experience surveys, Practitioner experience surveys, access audits and any QI studies.
18. Responsibility for evaluating and giving recommendations from monitoring and tracking reports ensuring follow-up, as appropriate.

Reporting

The QI Department shall submit a summary report of quality activities and actions for review and approval to the Desert Oasis Healthcare QI Council on a quarterly basis.

Composition

Chairperson

The QI Medical Director shall chair the Council and be primarily responsible for but not limited to:

1. Directing the QI Council meetings.
2. Reporting QI activities to the QI Council.
3. Acting on behalf of the Council for issues that arise between meetings.
4. Ensuring all appropriate QI activity and reports are presented to the Council.
5. Ensuring there is a separation between medical and financial decision making.

The Chairperson of the QI Council may designate an Associate Medical Director as his/her designee only when the Chairperson is unable to attend the meeting.

Membership

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

1. IPA/PMG Medical Directors
2. Quality & Compliance VP/Directors
3. Care Management VP/Directors
4. Member Services VP/ Directors

5. Provider Relations / Contracting VP/Director
6. Behavioral Health Practitioner
7. Representation of contracted or employed providers serving our members to include:
Primary Care Practitioners and Specialty Care Practitioners
8. Appropriate clinical representatives
9. Other members appointed at the discretion of the Chairperson

Council members that are employees of DOHC are permanent members unless reassigned, or employment ends. Independent Physicians are assigned on a bi-annual basis or as vacancies arise and are staggered to protect continuity of the committee functions by the QI Medical Director. Representatives of regulatory agencies and Health Plans may attend upon written request and chair approval.

Quorum and Voting

Only physician members are allowed to vote. A quorum consists of a minimum of three physicians. All approval of actions is made by a majority vote, and/or motioned for approval by two voting physician members without challenge.

A council member with a conflict of interest, which might impair objectivity in any review or decision process, shall not participate in any deliberation involving such issues and shall not cast a vote on any related issue.

Non-Physician members of the QI Council may not vote, but shall attend the meetings and provide support to the deliberations. In the event that the QI Council is unable to constitute a quorum for voting purposes because of conflicts of interest, alternate committee member(s) will be selected as needed, at the discretion of the Chairperson. Representatives and other guests may attend the meetings upon invitation and prior approval.

Meetings

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

Confidentiality

All Council members and participants, including network Practitioners, consultants and others, will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. The QI Council must ensure that each of its members, or attending guests, are aware of the requirements related to confidentiality and conflicts of interest by having signed statements on file and/or QI Council sign-in sheets with requirements noted on them. Breach of confidentiality may result in disciplinary action, up to and including termination. Activities and minutes of the QI Council are for the sole and confidential use of Desert Oasis Healthcare and are protected by State and Federal laws.

Recording of Meeting and Dissemination of Action

All QI Council minutes are recorded by the taking of minutes which are dated and signed and reflect all council decisions made. Meeting minutes and all documentation used by the QI

Council are the sole property of Desert Oasis Healthcare and are strictly confidential. When quality issues are identified, the QI Council Meeting Minutes must clearly document discussions of the following:

1. Identified issues.
2. Responsible party for interventions or activities.
3. Proposed actions.
4. Evaluation of the actions taken.
5. Timelines including start and end dates.
6. Additional recommendations or acceptance of the results as applicable.

For each QI Council conducted:

1. A written agenda will be used for each meeting.
2. Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
3. The minutes are recorded in a nationally recommended format. All unresolved issue/action items are tracked in the minutes until resolved.
4. The minutes and all case related correspondence must be maintained in the QI Department.
5. The minutes must be available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

The dissemination of QI Council information and findings to physicians may take various forms. Practitioners and providers must be informed of information related to their performance. These methods may include but not limited to:

1. Informal one-on-one meetings
2. Formal medical educational meetings
3. Desert Oasis Healthcare Newsletters
4. Provider Relations and Physician Reports
5. Quarterly Reports to the QI Council

OTHER QI COUNCIL ACTIVITIES

A. Pharmacy and Therapeutics (P&T) Committee

Description

The Pharmacy and Therapeutics Committee is established by the authority of the HPN QI Committee as a standing committee and is responsible for managing the delegated formulary system. It is composed of actively practicing physicians, pharmacists and other health care professional who participate in the medication-use process. The P&T Committee is responsible for overseeing policies and procedures related to all aspects of medication use within our organization. The P&T committee serves in an evaluative, educational, and advisory capacity to the medical staff and organizational administration in all matters pertaining to the use of medications (including investigational medications). Other responsibilities of the P&T committee include medication use evaluation (MUE), adverse-drug-event monitoring and reporting, medication-error prevention, and development of clinical care plans and guidelines.

Reporting

The Pharmacy and Therapeutics Committee shall report to the HPN QI Committee and through this committee to the Desert Oasis Healthcare QI Council.

Composition

Chairperson

The HPN QI Medical Director or his/her Physician Designee is the chair of the Committee and is primarily responsible for:

1. Directing the Pharmacy and Therapeutics Committee meetings.
2. Reporting Pharmacy and Therapeutics Committee activities to the QI Committee/Council.
3. Acting on behalf of the committee for issues that arise between meetings.
4. Ensuring all appropriate QI activity and reports are presented to the committee.
5. Ensuring there is a separation between medical and financial decision making.

Membership

Membership includes representatives from the organizations key department/disciplines:

1. Chief Medical Officer
2. Pharmacists from each HPN Affiliated Group or a designated Medical Director.
3. VP, Clinical Services, or his/her designee.

Quorum and Voting

This is an internal committee and approval of programs, clinical guidelines, resources and interventions are made by the QI Committee and reported to the QI Committee:

1. A quorum is three members/departments
2. Decisions are made by a majority vote of those present

Meetings

The Pharmacy and Therapeutics Committee will meet minimally each quarter, and may conduct ad-hoc meetings when needed. The QI Medical Director, or Physician Designee may act on the Committee's behalf on issues that arise between meetings.

Confidentiality

1. All committee members and participants will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information.
2. All employees are required to sign a Confidentiality Statement annually.
3. All members and invited guests to Pharmacy and Therapeutics Committee meetings annually sign a Confidentiality Statement that is kept on file in the QI Department.
4. Activities and minutes of the Pharmacy and Therapeutics Committee are for the sole and confidential use of Heritage Provider Network and are protected by State and Federal laws and the Healthcare Portability and Accountability Act (HIPAA).

Recording of Meeting and Dissemination of Action

1. All Pharmacy and Therapeutics Committee minutes are recorded by the taking of minutes which are dated and signed, and reflect all committee decisions made.

2. Meeting minutes and all documentation used by the Pharmacy and Therapeutics Committee are the sole property of Heritage Provider Network and are strictly confidential.
3. A written agenda will be used for each meeting.
4. Meeting minutes will be comprehensive, timely, show indicators, document discussion, recommendations, follow-up and evaluation of activities.
5. The minutes are recorded in a nationally recommended format.
6. All unresolved issue/action items are tracked in the minutes until resolved.
7. The minutes and all case related correspondence will be prepared and maintained by the HPN Clinical Services Department.
8. The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

The dissemination of Pharmacy and Therapeutics Committee recommendations and findings may take various forms. These methods may include but not limited to:

1. HPN Newsletters.
2. Physician Reports.
3. Quarterly Reports to the HPN QI Committee, and DOHC QI Council.

B. Credentialing Committee

The Credentialing Committee is integrated into the QI Council. The provider selection includes Primary Care Providers, Specialists, and Credentialing Directors/Management/Staff.

The Credentialing Committee:

1. Has final authority to approve or disapprove applications by providers for participation or delegate such authority to the senior clinical staff person for approving clean applications, provided that such designation is documented and provides reasonable guidelines.
2. Discusses whether organizational providers are meeting reasonable standards of care.
3. Accesses appropriate clinical peer input when discussing standards of care for a particular type of organizational provider.
4. Reviews files for organizational providers that do not meet the HPN's established criteria.
5. Reviews files for State Survey and Licensing deficiencies of organizational providers.
6. Reviews files for reported potential quality of care issues, reportable events, sentinel events, critical incidents, complaints, and/or for a facility that has been sanctioned by a regulatory agency.
7. Maintains minutes of all committee meetings and documents all actions.
8. Provides guidance to Medical Group staff on the overall direction of the credentialing program.
9. Evaluates and reports to Medical Group management on the effectiveness of the program.
10. Reviews and approves credentialing policies and procedures at least annually.
11. Meets as often as necessary to fulfill its responsibilities, but no less than quarterly.
12. Has the authority to delegate authority to the senior clinical staff person, such as another medical director or other equally qualified provider for approving clean applications for continuing participation.

C. Peer Review

The sole purpose of peer review is to improve the quality of the medical and behavioral health care provided to our members by practitioners and providers. DOHC cannot delegate the function of peer review to another entity.

The peer review scope includes cases where there is evidence of deficient quality, or the omission of the care or service provided by a participating, or non-participating health care professional or provider.

The peer review committee is a sub-committee reviewing potential of quality care issues, resulting in a serious member negative outcome.

At a minimum, the peer review is accomplished with:

1. The Credentialing Medical Director and/or appointed physician designee;
2. Providers of the same or similar specialty participate in review and recommendation of individual peer review cases. If the specialty being reviewed is not represented on the, we may utilize peers of the same or similar specialty through external consultation.
3. A Behavioral Health provider must be part of the peer review when a Behavioral Health specialty is being reviewed.

Peer Review Functions

1. Peer review committee members shall sign a confidentiality and conflict of interest statement at each meeting.
2. Committee members must not participate in peer review activities if they have a direct or indirect interest in the peer review outcome.
3. The Peer Review Committee must evaluate the case referred to peer review based on all information made available through the QI Management process.
4. The Peer Review Committee is responsible for making recommendations and must determine appropriate action which may include, but is not limited to: peer contact, education, credentials, and limit on new member enrollment, sanctions, or other corrective actions. The Credentialing Medical Director is responsible for ensuring that the corrective actions are implementing.
5. The Peer Review Committee is responsible for making referrals to Child Protective services, Adult Protective Services, the appropriate regulatory agency or board, and State agency for further investigation or action if not already referred during the QPI process. Notification must occur when the committee determines care was not provided according to community standards. Initial notice may be verbal but must be followed by a written report.
6. All information used in the peer review process is kept confidential and is not discussed outside of the peer review process. The reports, minutes, documents, recommendations, and participants must be kept confidential except for implementing recommendations made.
7. Peer Review at DOHC is not a separate committee. Peer review is accomplished at both the QI quarterly meetings and the quarterly Credentialing Committee meetings. Peer

review issues are identified through both of these areas and the issues are communicated between the two Council/Committees.

Peer Review meetings are protected by State and Federal Law, documents from the proceedings must not leave the room and shall be collected by staff at the meeting closure. Any member copies, hand-written notes, post-it notes, or other material that is not to be retained in the case file must be destroyed at the end of the session.

We must make peer review documentation available to State and Federal agencies upon request. Providers and practitioners must be informed regarding the peer review process and peer review grievance procedures.

COMPLIANCE OVERSIGHT (HPN)

Heritage Provider Network(HPN), assumes responsibility for specific functional activities for the delivery of care and service to its members. HPN maintains accountability and responsibility for the associated activities by overseeing performance in the following areas: Quality Management, Clinical Services/Utilization Management, Credentialing, Care Coordination and Management, Culture and Linguistics, and Health Education. Oversight functions include, but are not limited to, preventive health services, health education activities, clinical practice guidelines, access standards, clinical studies, clinical grievances, appeals, HEDIS/QIP studies, facility site/medical record reviews, access studies, Health Education materials development and review, member and Practitioner satisfaction surveys. DOHC has a functioning quality assurance program in place following Federal, State, and NCQA standards.

QI PROCESS

DOHC utilizes a QI Process to identify opportunities to improve both the quality of care and quality of service for all members. DOHC adopts and maintains clinical guidelines, criteria, quality screens, audit tools, and other standard surveys for which quality of care, access, and service can be measured.

A. Health Service Contracting

DOHC contracts with individual practitioners and providers, including those making Utilization Management decisions, specify that contractors cooperate with its QI program to improve the quality of care and services, and the members' experience. This shall include the collection and evaluation of data, and participation in our QI Program.

*A **practitioner** is a licensed or certified professional who provider behavioral healthcare, or medical care services.*

*A **provider** is an institution or organization that provides services for our members, such as a hospital, residential treatment center, home health agency, or rehabilitation facility.*

Our contracts will foster open communication and cooperation with all QI activities. Our contracts with practitioners and providers will specifically require that:

1. Practitioners and providers cooperate with QI activities,

2. Practitioners and providers maintain the confidentiality of member information and records, and shall keep member information confidential and secure;
3. Practitioners and providers allow the plan to use their performance data. This shall include allowing collection of performance measurement data, evaluation of the data, and assisting the organization to improve clinical and service measures.
4. Practitioner and provider will provide access to medical records as permitted by state and federal law.
5. Practitioners and providers will give timely notification to members affected by their termination.
6. Practitioners and providers shall not discriminate against any Beneficiary in the provision of Contracted Services whether on the basis of the beneficiary's coverage under a Benefit program, age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, handicap, health status, source of payment, utilization of medical or mental health services, equipment, pharmaceuticals or supplies, or other unlawful basis including, without limitation, the filing by such Beneficiary of any compliant, grievance, or legal action against the provider or payer.

Contracts with practitioners and providers include an affirmative statement indicating that practitioners may freely communicate with patients about the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

B. Availability of Practitioners

In creating and developing our delivery system of practitioners, DOHC takes into consideration the preferences and the special and cultural needs of our members. We will ensure that our practitioner network has sufficient numbers and types of practitioners to effectively meet the needs, and preferences of our membership by:

1. Annually assessing the cultural, ethnic, racial and linguistic needs of our members.
2. Annually assessing the number and geographic distribution of each type of practitioner providing primary care, specialty care, behavioral healthcare, hospital based, and ancillary practitioners to our members.
3. Adjusting the availability of practitioners within our network based on the community served, the delivery system, and considering clinical safety.
4. Linking members with practitioners who can meet members' cultural, racial, ethnic, and linguistic needs and preferences.

DOHC establishes availability of primary care, specialty care, behavioral healthcare, hospital based, and ancillary practitioners by:

1. Ensuring that standards are in-place to define practitioners who serve as primary care practitioners (Pediatrics, Family Practice, General Practice, and Internal Medicine).
2. Ensuring that standards are in-place to define specialty care practitioners. (obstetrics/gynecology, cardiologists, dermatologist, ophthalmologist, orthopedic surgeons, gastroenterologists)
3. Ensuring that standards are in place to define high-volume behavioral healthcare practitioners. (Psychiatrists, clinical psychologists, clinical social workers, etc.)

4. Ensuring a database is in place which analyzes practitioner availability and ability to meet the special cultural need of our members.
5. Ensuring a database is in place which analyzes the geographic distribution of our members to our primary care, specialty care, behavioral healthcare, hospital based, and ancillary practitioners.
6. Providing members with transportation as needed.
7. Providing processes for member requests for special cultural and language needs.
8. Annually reviews and measures the effectiveness of these standards through specialized studies.

C. Access to Service

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

1. Preventive care appointments
2. Regular and Routine care appointments
3. Urgent care appointments
4. Emergency care
5. After-hours care
6. Telephone service

DOHC shall comply with all Federal and State accessibility guidelines. We will conduct annual access to care audits using the standards to implement and measure improvements made in performance. DOHC contracted with a new after-hours answering service with Nurses available for questions/triage to provide improved member service. Our contracted behavioral healthcare practitioners conduct annual access to care audits, and quarterly telephone screening and triage audits.

D. Member Experience

Grievance Process

DOHC clinical grievance process assesses the member experience with the services provided by our affiliates, and our practitioners. Each quarter we evaluate our member complaints and appeals by collecting data for each of the five (5) categories:

1. Quality of Care
2. Access
3. Attitude and Customer Service
4. Billing and Financial Issues
5. Quality of Practitioner Office Site

The data collected is further aggregated, and evaluated by the total population served. Sufficient data is collected to identify areas of dissatisfaction on which we can act. The rates are computed over time by reason, and related to the total member population. Annually we conduct a quantitative and causal analysis of our aggregate results and trends over time, and compare our results against a standard goal. We identify opportunities for improvement based on our analysis, and their significance to our members.

Member Experience Survey (Consumer Assessment Health Plan Service (CAHPS) and Patient Assessment Survey (PAS))

Medicare and Medicaid members are administered the CAHPS survey. Commercial members are administered the PAS survey. Surveys are conducted to monitor members' experience with health care services, accessibility of care, continuity of care, quality of care and service, cultural and linguistic issues, and to identify and pursue opportunities to improve member satisfaction and the processes which impact satisfaction. Surveys are conducted at least annually. We receive survey results from our contracted Health Plans or vendors. The results of the surveys are evaluated, and we develop improvement plans to address problem areas identified. All results are presented to the QI Council for recommendations and interventions.

DOHC also contracts with an outside independent vendor, MTS, for a member experience/satisfaction survey that includes Primary Care Practitioners, some Specialty Care Practitioners, Imaging and Laboratory Providers. This survey is done annually and provides a means of comparison for the PAS survey.

Behavioral Health Care Grievance Process

DOHC will report separate member complaint and appeal assessment results concerning behavioral health care. The reports may be generated by HPN, and/or by our contracted Behavioral Health Care provider. As such, each quarter we will evaluate our member complaints and appeals by collecting data for each of the five (5) categories:

1. Quality of Care
2. Access
3. Attitude and Customer Service
4. Billing and Financial Issues
5. Quality of Practitioner Office Site

The data collected is further aggregated, and evaluated by the total population served. Sufficient data is collected to identify areas of dissatisfaction on which we can act. The rates are computed over time by reason. Annually we conduct a quantitative and causal analysis of our aggregate results and trends over time, and compare our results against a standard goal. We identify opportunities for improvement based on our analysis, and their significance to our members.

Behavioral Health Member Experience Survey

A sample size will be drawn for the members' experience survey and will be sufficient enough to reach conclusions about the services provided to our members by our contracted Behavioral Health Care provider. The experience surveys must consist of the core questions plus additional questions specific to their experience with health care services, accessibility of care, continuity of care, and the quality of care and service.

HPN, DOHC, and our Behavioral Health Care providers evaluate the results of the surveys received. We will develop improvement plans to address areas identified. All results are presented to the QI Council for recommendations and interventions.

Population Health Grievance Process

HPN and DOHC will analyze population health complaints to identify opportunities to improve satisfaction with our program. This will be conducted on a quarterly basis, and is included in our aggregate grievance report. For the purpose of this section, population health refers to the complex care management, disease management, and special needs programs.

Annually the results will be analyzed to identify opportunities to improve satisfaction with our care management program.

Population Health Member Experience Surveys

HPN and DOHC will obtain feedback from our members by conducting focus member experience surveys, and systematically analyzing the feedback we collect at least annually. The surveys may include information about the overall program, program staff, the usefulness of the information disseminated by the primary provider group, and the members' ability to adhere to recommendations. The feedback obtained will be specific to the population health programs.

HPN and DOHC will evaluate the results of the surveys received. We will develop improvement plans to address areas identified. All results are presented to the QI Council for recommendations and interventions.

E. Complex Care Management

DOHC coordinates services for our members with complex conditions and helps them access needed resources. We do this through our Population Health Program. The program includes all information and interventions that our organization implements for a member or provider to improve health care delivery and management and promote quality, cost-effective outcomes.

Complex care management is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Members eligible for complex care management may include those with physical or developmental disabilities, serious mental illness, multiple chronic conditions, or severe injuries.

Since complex management is considered an opt-out program, all eligible members have the right to participate or decline participation.

The goal of complex care management is to help members regain optimum health and improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a patient centered care management plan with performance goals, monitoring and follow-up.

Distinguishing factors of complex care management

1. Degree and complexity of illness or condition is typically severe.
2. Level of management necessary is typically intensive.
3. Amount of resources required for member to regain optimal health and improved functionality is typically extensive.

Annually, DOHC will conduct an assessment of the entire complex care management population, and sub-populations based on the following:

1. Characteristics and needs of our member population and all relevant subpopulations;
2. The needs of children and adolescents;
3. The needs of individuals with disabilities;
4. The needs of individuals with serious and persistent mental illness (SPMI).

Based on the findings we will review and update our complex care management process and resources in order to effectively meet our member's needs.

In addition, DOHC participates in the Special Needs Program and a brief description is provided below.

F. Special Needs Program (SNP)

The Special Needs Program (SNP) is a Medicare program that focuses on three populations, those with chronic conditions, those that are deemed institutional, and those that have Medicare and Medicaid dual benefits. The Care Management departments have written processes for the identification of enrollees with multiple or sufficiently severe chronic conditions that meet the criteria for participation in the program.

All Special Needs Plan members have an annual risk assessment completed where an individualized care plan for that member is generated and completed. The Population Health Program details which chronic conditions are monitored, types of services offered and the types of measures that are used to assess performance.

G. Disease State Management

DOHC works hard to improve the health status of our members with chronic conditions. Our proactive Disease Management Programs is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for chronic medical conditions, i.e. Diabetes and Congestive Heart Failure.

Disease management supports the practitioner-patient relationship and plan of care. It is a multidisciplinary, continuum-based approach to health care delivery which emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as self-management. It continuously evaluates clinical, humanistic and economic outcomes with the goal of improving overall health. Annually we will measure admit and readmission rates for Diabetics and patients with Congestive Heart Failure.

H. Clinical Practice Guidelines

HPN and DOHC is accountable for adopting and disseminating clinical practice guidelines relevant to our members for the provision of preventive, acute, or chronic medical services and behavioral health services.

We use clinical practice guidelines to help practitioners and members make decision about appropriate health care for specific clinical circumstances and behavioral health services. DOHC distributes guidelines to our practitioners by posting them on our website, or through the provider web portals. If changes, or revisions are made a notice will be sent to the practitioners by blast fax.

DOHC adopts nationally recognized Clinical Practice Guidelines (CPGs), and includes professional medical associations, voluntary health organization, and NIH Centers and Institutes. If the guidelines are not from a recognized source, they are created with the involvement of a board certified practitioner. Selected CPGs are taken through our committees for discussion and recommendations. We shall adopt evidence based CPGs for at least two medical conditions, and at least two behavioral conditions, with at least one behavioral guideline addressing children and adolescent care.

At least two of our adopted clinical practice guidelines are the clinical basis for the Disease Management programs, Examples are Diabetes, Heart Failure, Depression, and Anxiety disease.

We assure that all clinical practice guidelines are reviewed and approved through our QI Council at least every two years, and ongoing if updated.

I. Preventative Health Guidelines

DOHC is accountable for adopting and disseminating preventative health guidelines (PHGs) for perinatal care, care for children up to 24 months, care for children 2-19 years old, care for adults 20-64 years old, and care for adults 65 years and older.

We approve, adopt, and disseminate these preventative health guidelines to our primary provider groups in an effort to improve health care quality and reduce unnecessary variation in care. DOHC distributes guidelines to our practitioners by posting them on our website, or through the provider web portals. If changes, or revisions are made a notice will be sent to the practitioners by blast fax.

DOHC adopts nationally recognized Preventative Health Guidelines (PHGs) from the U.S. Preventive Services Task Force for adults, children, and adolescents. We may include other guidelines from professional medical associations, voluntary health organization, and NIH Centers and Institutes. If the guidelines are not from a recognized source, they are created with the involvement of a board certified practitioner.

Selected PHGs are taken through the QI Council for discussion and recommendations. We assure that the preventative health guidelines are reviewed and approved through the QI Council at least every two years, and ongoing if updated.

J. Continuity and Coordination of Care

DOHC ensures the continuity and coordination of care that our members receive. The member may select a primary care provider (PCP), or the Medical may assign a PCP to the member with the primary responsibility for coordinating the member's overall healthcare.

DOHC must:

1. Identify members with special health care needs, including those that would benefit from Disease Management.
2. Ensure an assessment by an appropriate health care professional of ongoing needs of each member identified as having special health care needs or conditions.
3. Identify medical procedures and/or behavioral health services to address and/or monitor the need or condition.
4. Ensure adequate care coordination among providers, including other practitioners, a behavioral health providers, as necessary, and
5. Ensure a mechanism to allow direct access to a Care Coordinator as appropriate for the member's condition and identified special health care needs (e.g., a standing referral or an approved number of visits).

We monitor and take action on an annual basis and as necessary to improve continuity and coordination of care across the health care network. We measure, and identify opportunities to improve coordination of medical care through routine medical record reviews, review of transition of care reports, potential quality of care reviews, grievance reviews and member experience surveys. This collaborative information is tracked and analyzed to identify opportunities for improvement. Actions and interventions are taken to improve our members' experience, and the coordination of their medical care in our delivery system.

Notification of Termination

DOHC will notify members affected by the termination of a practitioner or practice groups in general medicine, family practice, internal medicine, or pediatrics at least thirty days (30 days) prior to the effective termination date, and help them select a new practitioner.

Notification must be in writing and may be distributed via the Internet. Written notification about the availability of information on the Web site and on paper must be mailed to members and a printed copy of the information must be made available upon request. Notice of termination through a member newsletter is not adequate. All communication must include the following information:

1. The practitioner's name and the effective termination date.
2. Procedures for selecting another practitioner.

We are not responsible for notifying members of practitioner relocations or office closures as long as the practitioner remains available to members as part of the organization's network. If a practitioner notifies us of termination less than 30 calendar days prior to the effective date, we should notify the affected members as soon as possible, but no later than 30 calendar days after receipt of the notification.

Continued Access to Practitioners

If a practitioner's contract is discontinued, DOHC will allow affected members continued access to the practitioner, as follows:

We will allow members already undergoing an active course of treatment for acute and serious chronic conditions under a provider whose contract with the medical group/IPA and/or the full-service health plan is ending, to have continued access to that provider for a limited period of time (up to 90 days). This does not apply to providers who voluntarily leave the medical group/IPA and/or health plan. Conditions covered under this policy include but are not limited to:

1. An acute condition requiring prompt medical attention and that has a limited duration (not to exceed the acute phase of the condition when care can be safely transferred to a contracted provider)
2. A serious chronic condition, for the period of time necessary to complete a course of treatment and to arrange for safe transfer of care to a contracted provider (but not to exceed 12 months from the effective date of coverage)
3. Pregnancy, including immediate postpartum period
4. Care of newborn between birth and 36 months (not to exceed 12 months from effective date of coverage)
5. A surgery or other treatment that was previously scheduled to take place within 180 days of the effective date of coverage and which is authorized by the Medical Group
6. Terminal illness

DOHC will help a member transition to other care, if necessary when their benefits end or during transition from pediatric care to adult care.

K. Continuity and Coordination of Between Medical Care and Behavioral Healthcare

DOHC collaborates with our contracted behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare.

DOHC monitors the quality and coordination of behavioral health services. We must insure timely updates from primary care providers to behavioral health providers regarding a member's change in health status. The update must include but is not limited to: diagnosis of chronic conditions, support for the petitioning process for long term care, and all medication prescribed.

Annually we collect data about opportunities for collaboration, and assess for:

1. Exchange of information between behavioral healthcare and primary care practitioners, medical/surgical Care Managers, organizational providers or other relevant medical delivery systems.
2. Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care settings.
3. Appropriate use of psychotropic medications and consistent guidelines for prescribing by behavioral and medical practitioners. (HEDIS Antidepressant Medication Management, and/or Follow-Up Care for children prescribed ADHD Medication)
4. Screening and managing of patients with coexisting medical and behavioral conditions.
5. Consultations of medical or surgical inpatients with secondary mental illness or substance abuse disorder.
6. Development and adoption of primary prevention programs for behavioral healthcare.

7. Primary education programs to promote prevention of substance abuse, stress management programs, depression management programs, bereavement counseling, and nutrition and body image programs for adolescents.
8. Development and adoption of secondary preventive programs for behavioral healthcare, i.e. screening of children for developmental delays, ADHD screening of children in primary care settings, screening for eating disorders for female adolescents in primary care setting and behavioral health consultations for targeted medical or surgical conditions. (Depression post CABG, Post-Partum depression; depression associated with exacerbation of Diabetes Mellitus)
9. Development and adoption of programs to meet the needs of members with severe and persistent mental illness.

We measure, and identify opportunities to improve coordination and continuity of care between medical and behavioral health providers through routine medical and treatment record reviews, review of behavioral healthcare referrals, review of behavioral healthcare consultations, HEDIS antidepressant medication studies, grievance reviews, and member experience surveys. This collaborative information is tracked and analyzed to identify opportunities for improvement. Actions and interventions are taken to improve our members' experience, and the coordination and continuity of care between our primary care physicians, and the behavioral healthcare providers.

L. Patient Safety Program

Heritage Provider Network's Clinical Services Department has developed a patient safety program which identifies supports and facilitates patient safety throughout our network operations. This program evaluates multiple aspects of the patient care process, such as hospital safety, health education, practitioner office safety and drug utilization safety.

Poly-pharmacology

Programs are in place through our EHR systems to identify members who are on medications that are contraindicated (such as drug interactions) or when warnings have been issued. All members that are prescribed ten (10) or more medications are reviewed for patient safety, drug to drug interactions and drug-disease interactions by their primary care provider.

Medication Reconciliation

1. A complete list of a patient's current medications, allergies, and medication sensitivities will be obtained and documented upon admission to all relevant sites of care and all settings within our Network of practitioners and providers. This is updated at all visits whenever medications are administered, prescribed, or the response to the care or service provided to the patient could be affected by medications.
2. All new medications prescribed or administered will be reconciled against this list during the patient's care. Inpatients transferred between services or levels of care will have all medications reconciled. If a new medication is prescribed (or changes are made to the current regimen), the patient's electronic medication list is then updated and a copy of the updated list is provided to the patient.
3. A complete list of medications will be given to the patient upon discharge, and communicated to the next known provider or service when the patient is referred or

transferred to another setting, service, practitioner or level of care within or outside the organization.

Patient Adverse Outcomes

DOHC will track and trend the number of Grievances, Appeals, Sentinel Events, and Reportable Events received by category, sub-category, provider type, and be level of severity. We take these events seriously and a full-investigation shall occur to ensure that safe care is provided to our member across our network.

Documenting and investigating Serious Reportable Events—Critical incidents, Sentinel Events, and CMS Reportable Events, is essential. Analysis of information from these events can enhance coordination of program services, improve processes, and prevent recurrence of events in the future.

Facility Site Reviews

The QI Department has initiated new facility site review criteria and implemented a comprehensive audit tool aimed at improving patient safety in the offices and providing our members with added information that can help them make a decision on what office is best for them.

M. Potential Quality Issues (PQI)

A major component of the QI Program is the identification and review of potential quality issues and the implementation of appropriate corrective action to address confirmed quality of care issues.

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

N. Peer Review

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

1. The QI Medical Director or designee is responsible for authorizing the referral of cases for peer review.
2. All peer review consultants (including members of the Credentials/Peer Review or ad-hoc Peer Review Committees) are duly licensed professionals in active practice.
3. At least one consultant will be a Practitioner with the same or similar specialty training as the Practitioner whose care is being reviewed, except in those cases where there is no applicable board certification for the specialty.
4. The QI Medical Director can send cases out for a specialty review and consultation to be used for the peer review process.
5. The QI Medical Director will confirm that the peer review consultants have the necessary experience and qualifications for the review at hand.

6. The Credentialing Manager and QI Director prepare all materials for review by the Peer Review Committee to conduct all follow-ups, as required by the Committee.

O. Sentinel Events / Critical Incidents

A sentinel event or critical incident is “an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, ‘or risk thereof’ includes any process variation for which a recurrence carries a significant chance of a serious adverse outcome.”

A major component of the QI Program is the use of sentinel events to monitor important aspects of care, accessibility and service in medical and behavioral healthcare. These events are called "sentinel" because they signal the need for immediate investigation and response, as such all sentinel events must be monitored, tracked, and investigated.

P. Serious Reportable Adverse Events

A serious reportable event (SRAE) is an incident involving death or serious harm to a patient resulting from a lapse or error in a healthcare facility and is broken down into three major categories by the Center for Medicare and Medicaid Services:

1. Never Events;
2. Hospital Acquired Condition (HAC); and
3. Provider Preventable Condition.

DOHC will ensure our compliance with all Federal and State guidelines. All serious reportable adverse events will be monitored, tracked, and investigated.

CLINICAL MEASUREMENT ACTIVITIES AND QUALITY PERFORMANCE REPORTING

DOHC’s QI Department adheres to all regulatory standards in accordance with Title 42 CFR Part 422, Subpart D, Social Security Act, Title 22, CCR, Section 53860 (d) and Title 42, USC, Section 1396a(30)(C) for quality performance reporting. Desert Oasis Healthcare will cooperate and assist regulators and their contracted QI Organizations (QIO).

DOHC uses data collection and analysis to track clinical issues that are relevant to our population. At a minimum, DOHC will adopt and establish quantitative measures to assess performance and to identify and prioritize areas for improvement in at least (2) QI Projects Annually (QIPs), and as prescribed in our service agreement with the full-service Health Plan.

A. Health Plan Effectiveness Data and Information Set (HEDIS®) and Structure and Process Measures

DOHC actively takes part in annual Health Plan Effectiveness Data and Information Set (HEDIS) and Structure and Process measures. HEDIS Studies and Structure and Process measures are conducted for all lines of business with 30 or more members and are in accordance with CMS and NCQA standards.

DOHC collects HEDIS and Structure and Process measure data through multiple sources:

1. Claims and encounter data
2. Proactive medical record review
3. Population Health Program-- Disease Management, Complex Care Management, and Special Needs Programs
4. Proactive Measure Review
5. Specialized software program that runs each measure proactively every month during the measurement year.
6. Member listings of services that have not been captured are provided to primary care practitioners at a minimum of every six months
7. Annual education and training of practitioners, and their office staff by physician champions.
8. Quality Outreach Nurses and Coordinators contact primary care practitioners offices at a minimum of every six months to discuss the importance of these services
9. Primary care practitioners are provided a report card at a minimum of every six months detailing their specific rates compared to their peers, their Medical Group's overall and National benchmarks (Report in April-May details previous year, report in September details status of current year).
10. Medical record reminder sheets or boarding passes are provided to PCPs to be placed in the member's record reminding the practitioner and member on the next visit the specific services that are required.

Every measure is compared to National benchmarks (or if a benchmark is not available a goal is established) and final rates are reported through the QI Council. All measures that do not meet minimum performance levels (25th percentile of the National rate, or not meeting goal) or have a significant drop in rate will have a formal corrective action plan developed. A written plan will detail specific actions or processes aimed at improving rates.

B. Center for Medicaid and Medicare Services 5 Star Program

The Center for Medicaid and Medicare Services Star Program has the responsibility of reaching out to practitioners and their office staff and providing them with intensive education and incentives. In addition, practitioners can obtain the program tools/information via the Medical Groups Provider web portals. The CMS Star Program was implemented to make changes at the "point of care" and ensure members received required annual services, and that appropriate use of diagnosis codes is captured.

A key component of the CMS Star Program is to develop strong and collaborative relationships with Practitioners and office staff through the outreach efforts. In addition, through this educational mechanism, staff will comply as it relates to CMS Star Technical Specifications, Healthcare Effectiveness Data and Information Set (HEDIS) Measures and the completion of encounter forms; Collection of HCC Diagnosis Codes, Initial Health Risk Assessment related to Medicare members, improvement of patient care, and overall improvement of medical record documentation practices.

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

1. qHMO, (qMetrics for Star, and qHealth for coding), orientation, and training.
2. Healthcare Effectiveness Data and Information Set (HEDIS).
3. Improving documentation practices.
4. Providing tools that focus the practitioners' office on specific members requiring services and the use of CMS Star, and HEDIS specific encounter forms.
5. Suggestions and assistance in the development of office processes that limit the possibility of these services being missed.
6. Identify opportunities to limit barriers between the physician and the health plan.
7. Clinical care resources such as Disease Management Programs and how to refer patients.
8. Collaborate on the collection of important diagnosis and service information to limit the intrusion on the physician office.
9. Inform the physician that we are the resource to get questions answered and issues resolved quickly.
10. Work toward improvement in access to care for our members.
11. Offer practice management suggestion that would limit barriers to care.
12. Look for opportunities to free up physician time so additional time can be spent with the patient.
13. Provide in-service reminders that will be placed on the member's medical record (i.e., on the next visit this member needs a Mammogram and Colorectal Cancer Screening completed).
14. Educate the provider's office on submission of Medicare Diagnosis codes through the encounter/claims systems by utilizing an incentive program.
15. Identification of Medicare members who have not been seen or have gaps in care (i.e., facilitate scheduling members to be seen soon).
16. In-service practitioner and staff on how they can increase revenue through the improvement of documentation and data submission.
17. In-service on how to complete a Risk Assessment of the new Medicare members within ninety(90) days of enrollment, including scheduling the member to be seen by the physician for the incentive.

OTHER QI ACTIVITY

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

Corrective Action Plans

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

1. Member/Practitioner satisfaction surveys
2. Access to care audits
3. Availability studies
4. Potential or actual quality of care issues
5. Grievances focused review studies

Follow-up surveys and/or focus audits may be conducted based on our findings, and actions taken by the Medical Group.

DISSEMINATION OF INFORMATION

All QI activities are presented and reviewed by the QI Council may include but not limited to:

1. Policies and Procedures
2. Medical record and facility audit reports and trends
3. Delegation audit results
4. Member Experience survey results
5. Member grievance statistics and trends
6. Sentinel events
7. Reportable events
8. Study outcomes
9. Referral statistics and trends
10. QI activities
11. QI Program, Work Plan, Annual Evaluation and Quarterly Reports
12. New, or changed regulatory and legislative information

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

1. Correspondence with the Practitioner showing individual results and a comparison to the group
2. Correspondence with the IPA/employed practitioners showing results and comparisons to the net-work
3. Newsletter articles
4. Fax updates
5. Email updates
6. Provider Manual updates

The QI Program description is made available to all practitioners and members. Members and Practitioners are notified of the availability of the QI program through the websites, Provider Manual, and newsletters. The notification of this availability is posted on our website.

EFFECTIVENESS OF THE QI PROGRAM

A. QI Work Plans

The QI Work Plan is developed annually outlining QI activities for the year. The Work Plan will include all activities and tasks for both clinical care and monitoring of access and availability of covered services. The Work Plan is reviewed by the Medical Director and submitted to the QI Council for review and comment.

The work plan must include the following information:

1. A description of all planned activities and tasks for both clinical care, Medical Group monitoring and all other covered services.
2. Beginning and ending dates for all objectives.
3. Methodologies to accomplish measurable goals and objectives.
4. At least three measurable behavioral health goals and objectives.
5. Staff positions /departments responsible and accountable for meeting established goals and objectives.

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

B. Semi-Annual Reports

Semi-annual reports are an evaluation of the progress of the QI activities, as outlined in the Work Plan, and are submitted to the QI Committee for review and comment. Activity reports are submitted quarterly, or as deemed necessary.

C. Annual Plan Evaluation

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

Medical Groups that are contracted with more than one line of business must maintain and report separately by line of business for the following measures:

1. Appeals
2. Complaints
3. Statement of Concerns
4. Potential Quality of Care Issues
5. Reportable Events
6. Sentinel Events
7. NCQA HEDIS

The annual QI evaluation report must contain a summary of all QI activities performed throughout the year, to include:

1. Title/name of each activity.
2. Measurable goals and/or objectives related to each activity.
3. Department or staff positions involved in the QI activity.
4. Description of communication and feedback related to QI data and activities.
5. An evaluation of baseline data and outcomes utilizing qualitative and quantitative data which must include a statement describing if the goals were met completely, partially, or not at all.
6. Actions to be taken for the improvement of corrective action plans (CAPs).
7. Documentation of continued monitoring to evaluate the effectiveness of the actions (interventions) and other follow up activities.
8. Rationale for changes in the scope of the QI program and plan or documentation indicating if no changes were made.
9. Necessary follow-up with targeted timelines for revisions made to the QI plan.
10. Documentation of QI Council review, evaluation, and approval of any changes to the QI plan.
11. An evaluation of the previous year's activities must be submitted as part of the QI Plan after review by the QI Council.

RESOURCES, QI PERSONNEL AND INTERDEPARTMENTAL INTERFACE

A. Clinical Services/Utilization Management Department

The Clinical Services/Utilization Management and QI Departments are integrated, performing coordinated functions. The Clinical Services/Utilization Management Department frequently identifies potential risk management and quality of care issues and health education needs through care management, inpatient review, utilization review, referrals, etc. The QI Department can refer cases to the Clinical Services/Utilization Management Department for active Care Management of members with identified chronic conditions.

B. Customer Service Department

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

C. Credentialing Department

The Credentialing Department is part of the Clinical Quality & NextGen Services Department. QI information is provided to the Credentialing Department for inclusion in the Credentialing/re-credentialing process. The QI Department provides the Credentialing Department with Facility Site Review and Medical Record audit scores and any sanction activity related to those reviews and with identified quality of care issues, as appropriate. The QI Director works with the Credentialing Department, as directed by the QI Chairperson, to identify peer review cases which are reviewed at the QI Council and the Credentialing Committee for peer review and action.

D. Provider Relations/Contracting Department

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

1. Serves as a liaison between the QI Department and practitioners to facilitate education and compliance with approved Desert Oasis Healthcare standards.
2. Serves as a liaison with delegated IPA/PMGs.
3. Assists the QI Department with practitioners who do not comply with requests from the QI Department.
4. Ensures contracted ancillary providers and facilities meet regulatory and accreditation requirements.

E. Health Education Department (Population Health and Prescription Management (PHARxM))

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

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

F. Claims Department

The QI Department utilizes claims data to identify potential quality of care issues, to include critical incidents, reportable events, and sentinel event diagnosis. The QI Department is able to obtain certain medical records from the Claims Department as available.

G. Health Informatics Department

The QI Department collaborative works with the HPN Health Informatics Department to collect, analyze and integrate data into our QI process. The QI Department works with Health Informatics to ensure that data is accurate and complete. Specialized and standardized reports are generated through the Informatics Department so data elements can be continuously monitored. Through this department data is maintained for regulatory agency review. The data is also used to conduct annual review of the overall QI Program. Specialized databases have been built by Informatics to track grievances, complaints and potential quality issues for tracking and corrective actions. Data being submitted from outside vendors or being sent out of our organization goes through the Informatics department and the Information Systems Department to ensure all HIPAA regulations are being met. No file containing member specific information is sent out of the QI Department without meeting all HIPAA requirements.

DELEGATION OF QUALITY MANAGEMENT

DOHC does not delegate Quality Management, and does not permit delegation of QI activities to sub-contracted IPA's and other Medical Groups. For any delegated activity from the Health Plan, there shall be a signed and dated agreement:

1. Stating that it is mutually agreed upon.
2. Describing the delegated activities and the responsibilities of the Health Plan and Desert Oasis Healthcare.
3. Requires at least semiannual reporting by the Medical Group.
4. Describing the process by which the Health Plan will evaluate DOHC's performance.
5. Describing the remedies available to the Health Plan if the DOHC does not fulfill their obligations, up to and including revocation of the delegation agreement.

DOHC must provide to the Health Plan when requested:

1. Member Experience data, when requested; and
2. Clinical Performance data.

If the delegation arrangement includes the use of protected health information (PHI) by DOHC, the delegation agreement will also include the following provisions:

1. A list of the allowed uses of PHI.

2. A description of delegate safeguards that DOHC will use to protect the information from inappropriate use or further disclosure.
3. A stipulation that DOHC will ensure that sub-delegates has similar safeguards.
4. A stipulation that DOHC provide individuals with access to their PHI.
5. A stipulation that DOHC inform the Health Plan(s) if inappropriate use of the information occurs.
6. A stipulation that DOHC ensure that PHI is returned, destroyed, or protected if the delegation agreement ends.

For any new delegation agreements, the Health Plan will evaluate DOHC's capacity to meet NCQA, CMS, and State of California requirements before delegation begins. DOHC will fully cooperate with the Health Plan(s) in the completion of this function.