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I. MISSION STATEMENT
Care1st Quality Improvement 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.

II. PURPOSE/PROGRAM DESCRIPTION
The Quality Improvement Program is designed to objectively and systematically monitor and evaluate the quality, appropriateness and outcome of care and services delivered to our members and to provide mechanisms that continuously pursue opportunities for improvement and problem resolution.

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

- Practitioner accessibility and availability
- Practitioner satisfaction
- Continuity and coordination of care
- Clinical measurement and improvement monitoring
- Chronic Care Improvement Program (CCIP)
- Member safety
- Member satisfaction/grievances
- Credentialing and Recredentialing
- Peer Review
- IPA/MSO Oversight
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- Under and over utilization
- Adverse outcomes/sentinel events
- Medical record keeping practices
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IV. GOALS AND OBJECTIVES
A. Goals
- Ensuring members receive the highest quality of care and services.
- Ensuring members have full access to care and availability of primary care physicians and specialists.
• Monitoring, improving and measuring member and practitioner satisfaction with all aspects of the delivery system and network.
• Utilizing a multi-disciplinary approach to assess, monitor and improve our policies and procedures.
• Promoting physician involvement in our Quality Improvement Program and activities.
• Fostering a supportive environment to help practitioners and providers improve the safety of their practices.
• Meet and assess the standards for cultural and linguistic needs of our members.
• Meeting the changing standards of practice of the healthcare industry and adhere to all state and federal laws and regulations.
• Adopting, implementing and supporting ongoing adherence with NCQA standards.
• Promoting the benefits of a managed care delivery system.
• Promoting preventive health services and case management of members with chronic conditions.
• Emphasizing a caring professional relationship between the patient, Practitioner and health plan.
• Ensuring there is a separation between medical and financial decision making.
• Seek out and identify opportunities to improve the quality of care and services provided to our members.
• Seek out and identify opportunities to improve the quality of services to our Practitioners.

B. Objectives
• Ensuring that timely, quality, medically necessary and appropriate care and services that meet professionally recognized standards of practice are available to members by the identification, investigation and resolution of problems, focusing on known or suspected issues that are revealed through monitoring, trending and measuring of specific clinical indicators, preventive health services, access to services and member satisfaction, through the use of a total quality improvement philosophy.
• Systematically collect, screen, identify, evaluate and measure information about the quality and appropriateness of clinical care and provide feedback to IPA/PMG’s and Practitioners about their performance and also the network-wide performance.
• Maintaining a credentialed network based on a thorough review and evaluation of education, training, experience, sanction activity and performance.
• Objectively and regularly evaluate professional practices and performance on a proactive, concurrent and retrospective basis through Credentialing and peer review.
• Ensuring our members are afforded accessible health care by continually assessing the access to care and availability of our network of Practitioners and specialists.
• Designing and developing data systems to support Quality Improvement monitoring and measurement activities.
• Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, HCFA, NCQA and L.A. Care.
• Appropriately oversee Quality Improvement activities of our contracted IPA/PMGs.
• Ensuring that at all times the Quality Improvement structure, staff and processes are in compliance with all regulatory and oversight requirements.
• Actively work to maintain standards for quality of care and accessibility of care and service.
• Establish and conduct focused review studies, with an emphasis on preventive services, high-volume Practitioner and services and high-risk services with implementation of processes to measure improvements.
• Ensuring that mechanisms are in place to support and facilitate continuity of care within the healthcare network and to review the effectiveness of such mechanisms.
• Identifying potential risk management issues.
• Effectively interface with all interdisciplinary departments and practices for the coordination of quality Improvement activities.
• Providing a confidential mechanism of documentation, communication and reporting of Quality Improvement issues and activities to the Medical Services Committee, Board of Directors and other appropriate involved parties.
• Assessing the effectiveness of the Quality Improvement Program and make modifications and enhancements on an ongoing and annual basis.
• Ensuring that Care1st is meeting the members cultural and linguistic needs at all points of contact.
• Ensuring members have access to all available services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
• Ensuring mechanisms are in place to identify, support and facilitate patient safety issues within the network and review the effectiveness of these mechanisms.

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

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

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

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

B. **Chief Operating Officer**
The Chief Operating Officer has overall responsibility for assuring adequate resources and staffing is available for the Quality Improvement Department.

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

**Responsibilities include but not limited to:**
- Ensuring that medical decisions are rendered by qualified medical personnel, unhindered by fiscal or administrative management.
- Ensuring that the medical care provided meets the community standards for acceptable medical care.
- Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
- Developing and implementing medical policy.
- Actively participating in the functioning and resolution of the grievance procedures.
- Providing support and clinical guidance to the program and to all physicians in the network.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, HCFA, NCQA and L.A. Care.
- Ensuring that the Quality Improvement and Utilization Management Departments interface appropriately to maximize opportunities for quality improvement activities.
- Directing the implementation of the Quality Improvement process.
- Overseeing the formulation and modification of comprehensive policies and procedures that support the Quality Improvement operations.
- Analyzing Quality Improvement data.
- Reviewing all clinical grievances, PQIs, QCIs; assign severity levels; and direct corrective actions to be taken, including peer review, if required.
- Reviewing Quality Improvement Program, Work Plan, Annual Evaluation and Quarterly Reports.
- Directing Health Education and Credentialing activities.
- Assisting with the development, conduct, review and analysis of HEDIS and IQIP studies.

D. **Vice President, Quality Improvement**
The Vice President, Quality Improvement is a Registered Nurse with a current California licensure and oversees the operations of the Quality Improvement Department and is responsible for the execution and coordination of all Quality Improvement activities. The Vice President, Quality Improvement, reports to the Chief Medical Officer (CMO). The Vice President helps to plan,
develop, organize, monitor, communicate, and recommend modifications to the Quality Improvement Program and all Quality Improvement policies and procedures. It is the Vice President, Quality Improvement’s responsibility to interface with other departments on Quality Improvement issues. The Vice President reports any areas of concern to the CMO and/or the Medical Services Committee. Additional responsibilities include but not limited to:

- Performing statistical analysis relevant to quality improvement functions and goals.
- Developing and/or revising annually the Quality Improvement Annual Evaluation and Work Plan and presenting for review and approval.
- Developing quarterly Quality Improvement activity progress reports.
- Developing and/or revising annually Quality Improvement policies and procedures.
- Ensuring that quality trends and patterns are monitored, quality issues are identified and corrective action plans are developed.
- Monitoring and reporting to the Medical Services Committee the resolution of quality improvement activities in accordance with the Quality Improvement Program.
- Overseeing compliance required by regulatory agencies.
- Interfacing with all internal departments to ensure compliance to the Quality Improvement Program and policies and procedures.
- Acting as a liaison with each delegated IPA/PMG and ancillary provider and facility regarding Quality Improvement issues.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, HCFA, NCQA and L.A. Care.
- Serving as liaison with Regulatory Agencies for Quality Improvement activities.
- Monitoring and follow up with all applicable Quality Improvement activities.
- Ensuring that staff collects and monitors data and report identified trends to the CMO and Medical Services Committee.
- Ensuring that HEDIS and IQIP studies are conducted appropriately.
- Overseeing the Facility Site Review Program.
- Ensuring Member and Practitioner Satisfaction Surveys are conducted annually.
- Managing the Credentials process.
- Managing the Practitioner database modification process.
- Identifying compliance problems and formulating recommendations for corrective action.
- Ensuring that Focused Review Studies are conducted appropriately.
- Interfacing with the Chief Medical Officer for clinical quality of care and service issues.
- Maintaining a comprehensive PQI/QCI database to track pertinent case data that facilitates capturing, tracking and trending of this data.
- Assuring the department adheres to HIPAA compliance standards.
- Overseeing member clinical grievance case files and the process for the Chief Medical Officer’s action.
- Preparing peer review case files for the Chief Medical Officer’s action.
- Reviewing potential risk management issues and reports them to the Chief Medical Officer.
- Serving as liaison with DHCS, DMHC and other regulatory agencies for investigation, collaboration and resolution of clinical grievances.
- Developing policies and procedures in conjunction with the Chief Medical Officer.
- Collecting, monitoring and reporting data for tracking and trending.
- Serving as a Liaison with departments for investigation, collaboration and resolution of all identified internal quality of care issues.
• Preparing PQI/QCI and grievance reports for management, Board of Directors, Medical Services Committee, Joint Operating Committee and Delegated Oversight Committee meetings
• Collaborating with Member Services Administrative Grievance Coordinator to identify quality of care issues.
• Overseeing the pre-contractual and annual Due Diligence audit process.
• Monitoring delegated Quality Improvement activities to ensure proper performance of Quality Improvement functions in compliance with regulatory and delegation requirements.
• Submitting a written report summarizing each pre-contractual or annual review.
• Tracking compliance with reporting requirements and provide reports for Delegated Oversight Committee and Joint Operating Committee meetings.
• Reviewing Quality Improvement corrective action plans and other Quality Improvement reports for compliance to standards.
• Reporting IPA/PMG findings of non-compliance to the CMO and Delegated Oversight Committee.

E. Director, Quality Improvement
The Quality Improvement Director oversees the managers in the administrative day to day operations of the Quality Improvement Department and is responsible for the execution of Quality Improvement activities. The Quality Improvement Director reports to the Vice President, Quality Improvement. It is the Director of Quality Improvement’s responsibility to interface with other departments on day to day Quality Improvement processes and issues. Additional responsibilities include but not limited to:
• Assisting the Vice President, Quality Improvement in developing and/or revise annually the Quality Improvement Annual Evaluation and Work Plan and presenting for review and approval.
• Assisting in collecting information for quarterly Quality Improvement activity progress reports.
• Assuring that all staff members are adhering to company standards of conduct.
• Ensuring that quality trends and patterns are monitored, quality issues are identified and corrective action plans are developed.
• Monitoring and reporting to the Vice President, Quality Improvement the resolution of quality improvement activities in accordance with the Quality Improvement Program.
• Interfacing with all internal departments to ensure compliance to the Quality Improvement Program and policies and procedures.
• Acting as a liaison with each delegated IPA/PMG and ancillary provider and facility regarding Quality Improvement issues.
• Serving as liaison with Regulatory Agencies for Quality Improvement activities.
• Monitoring and follow up with all applicable Quality Improvement activities.
• Ensuring that staff collects and monitors data and report identified trends to the CMO and Medical Services Committee.
• Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, HCFA, NCQA and L.A. Care.
• Assisting in all HEDIS and IQIP studies.
• Ensuring appropriate resources and materials are available and ordered to meet the department’s needs.
• Overseeing the Managers in the Reviewing of daily staff time clock logs and ensuring compliance with company standards.
• Assisting in the development of Focused Review Studies.
• Interfacing with the Vice President, Quality Improvement and Chief Medical Officer for clinical quality of care and service issues.
• Ensuring the maintenance of the PQI/QCI database to track pertinent case data that facilitates capture, tracking and trending of quality data.
• Overseeing member clinical grievance case files and the process for the Vice President, Quality Improvement and Chief Medical Officer.
• Overseeing the preparation of peer review case files for the Chief Medical Officer’s action.
• Collecting, monitoring and reporting data for tracking and trending.
• Serving as a Liaison with departments for investigation, collaboration and resolution of all identified internal quality of care issues.
• Overseeing the preparation of PQI/QCI and grievance reports for management, Board of Directors, Medical Services Committee, Joint Operating Committee and Delegated Oversight Committee meetings
• Overseeing the collaboration with Member Services Administrative Grievance Coordinator to identify quality of care issues.
• Monitoring delegated Quality Improvement activities to ensure proper performance of Quality Improvement functions in compliance with regulatory and delegation requirements.
• Tracking compliance with reporting requirements and provide reports for Joint Operating Committee meetings.
• Reviewing Quality Improvement corrective action plans and other Quality Improvement reports for compliance to standards.
• Reporting IPA/PMG findings of non-compliance to the Vice President Quality Improvement and CMO.

F. Other Quality Improvement Staff and Resources
The Quality Improvement Department has multidisciplinary staff to address all aspects of the department functions. A full organizational chart is attached to this program description with all appropriate job descriptions. Care1st has staff and resources to conduct statistical and data analysis sufficient to establish quality controls and improvement projects. Data analysts are capable of developing Access databases relevant to specific functions and pulling appropriate information relevant to specific studies. The staff includes but is not limited to:
- Q. I. Project Manager
- Q.I. Manager, Facility Site Review and Credentialing
- Q.I., Manager, HEDIS
- Clinical Nurse Supervisor, RN
- Clinical Quality Review RNs
- Data Analysts
- Credentialing Supervisor and Credentialing Coordinators
- HEDIS Clinical Nurse Supervisor
- HEDIS/Quality Outreach Leads & Coordinators
- Facility Site Review RNs and FSR Coordinator
- Other supporting administrative staff
- Interdepartmental HEDIS support (UM and Pharmacy Coordinators)
VII. MEDICAL SERVICES COMMITTEE

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

B. **Scope (includes but not limited to):**
   - Directing all Quality Improvement activity.
   - Recommending policy decisions.
   - Reviewing, analyzing and evaluating Quality Improvement activity.
   - Ensuring practitioner participation in the QI program through planning, design, implementation and review.
   - Reviewing and evaluating reports of Quality Improvement activities and issues arising from its subcommittees (Credentials/Peer Review, Pharmacy & Therapeutics or Delegated Oversight Committees).
   - Monitoring, evaluating and directing the overall compliance with the Quality Improvement Program.
   - Annually reviewing and approving the Quality Improvement Program, Work Plan, and Annual Evaluation.
   - Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, HCFA, NCQA and L.A. Care.
   - Reviewing and approving Quality Improvement policies and procedures, guidelines, and protocols.
   - Developing and approving preventive health and clinical practice guidelines that are based on nationally developed and accepted criteria.
   - Developing relevant subcommittees for designated activities and overseeing the standing subcommittee’s roles, structures, functions and frequency of meetings as described in this Program. Ad-hoc subcommittees may be developed for short-term projects.
   - Conducting peer review, assigning severity levels and making recommendations for corrective actions, as needed.
   - Reviewing and evaluating reports regarding any/all potentially litigious incidents and sentinel events.
   - Reviewing and evaluating reports submitted by the Plan’s counsel.
   - Developing and coordinating Risk Management education for all Health Plan Practitioners and staff.
   - Responsibility for evaluating and giving recommendations concerning audit results, member satisfaction surveys, Practitioner satisfaction surveys, access audits, HEDIS audits and IQIP studies.
• Responsibility for evaluating and giving recommendations from monitoring and tracking reports.
• Ensuring follow-up, as appropriate.

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

D. **Composition**

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

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

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

   • Primary Care Practitioners
   • Specialty Care Practitioners
   • IPA/PMG Medical Directors
   • VP, Utilization Management
   • Director, Medical Services
   • VP, Quality Improvement
   • Director, Quality Improvement
   • Quality Improvement Project Manager
   • Member Services
   • Health Education
   • Provider Relations
   • Other members appointed at the discretion of the Chairperson

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

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

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

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

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

The dissemination of Medical Services Committee information and findings to physicians may take various forms. These methods may include but not limited to:
- Informal one-on-one meetings
- Formal medical educational meetings
- Care1st Newsletters
- Provider Relations and Physician Reports
- Quarterly Reports to the Board of Directors
VIII. OTHER MEDICAL SERVICES COMMITTEES

A. Credentials Committee

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

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

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

4. Composition

Chairperson
The Chief Medical Officer shall chair the Committee and is primarily responsible for but not limited to:
- Overseeing the credentialing program
- Directing the Credentials Committee meetings
- Reporting Credentials Committee activities to the Board of Directors
- Reviewing credentials and recredentials applications
- Reviewing requested changes to credentialing status or specialty
- Acting on behalf of the committee for issues that arise between meetings
- Ensuring all appropriate credentials activity is presented to the committee
- Ensuring there is a separation between medical and financial decision making

Membership
Membership is assigned and will include representatives from the following disciplines:
- Primary Care Practitioners
- Specialty Care Practitioners
- Vice President, Quality Improvement
- Director, Quality Improvement
- Credentialing Supervisor
Committee members are appointed on an annual basis or as vacancies arise and are staggered to protect continuity of the committee functions. Representatives of DHCS, DMHC and LA Care may attend upon request.

5. **Quorum and Voting**

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

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

6. **Meetings**

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

7. **Confidentiality**

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

8. **Recording of Meeting and Dissemination of Action**

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

The dissemination of Credentials Committee information and findings to physicians may take various forms. These methods may include but not limited to:
• Informal one-on-one meetings
• Formal medical educational meetings
• Monthly reports to the Board of Directors

B. Peer Review Committee

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

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

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

4. Composition

Chairperson
   The Chief Medical Officer shall chair the Committee and is primarily responsible for but not limited to:
   • Directing the Credentialing/Peer Review Committee meetings
   • Reporting Credentialing/Peer Review Committee activities to the Medical Services Committee
   • Acting on behalf of the committee for issues that arise between meetings
   • Ensuring a separation between medical and financial decision making
   • Ensuring all appropriate Quality Improvement activity and reports are presented to the committee
Membership
Membership is assigned and will include representatives from the following disciplines:

- IPA Medical Directors
- Primary Care Practitioners
- Specialty Care Practitioners
- Vice President, Quality Improvement
- Quality Improvement Director
- Quality Improvement Manager

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

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

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

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

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

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

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

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

C. **Quality Improvement Activity Steering Committee**

1. **Description**

   The QIA Steering Committee is established by the authority of the Care1st Board of Directors as a standing committee and is charged with the development, oversight, guidance and coordination of all Quality Improvement Activities, including but not limited to the measurement, analysis, intervention development, and follow-up of planned QIAs throughout the organization.

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

   - Developing measurable internal QIAs throughout the organization with a focus on improving our processes to meet our members and providers needs.
   - Developing and giving recommendations on preventive health and clinical practice guidelines that are based on nationally developed and accepted criteria and present them to the Medical Services Committee for approval.
   - Establishing and overseeing relevant Ad-hoc task force meetings to address specific Quality Improvement Activities which may be established for short-term QIAs.
   - Assuring that appropriate specialty providers are involved to give recommendations concerning QIA functions (i.e., Endocrinology review of diabetes clinical practice guidelines).
   - Discussing and adopting QIA rationale, methodology, data sources, sampling, measurement, analysis, intervention and follow-up.
   - Directing all internal Quality Improvement Activities throughout the organization.
   - Reviewing and evaluating all QIA activity reports and providing recommendations.
• Providing guidance, monitoring, evaluating and directing the overall compliance with the State mandated and other QIA requirements.
• Ensuring that all QIAs include both qualitative and quantitative analysis.
• Directing the written summary of QIA activities to the Medical Services Committee for discussion and recommendation as necessary.
• Reporting findings and recommendations to the Medical Services Committee and/or the Board of Directors as appropriate.

3. Reporting
The QIA Steering Committee shall report to the Medical Services Committee and through this committee to the Care1st Board of Directors.

4. Composition

Chairperson
The Chief Medical Officer is the Chair of the Committee and is primarily responsible for:
• Directing the Steering Committee meetings
• Reporting QIA Steering Committee activities to the Medical Services Committee and the Board of Directors
• Acting on behalf of the committee for issues that arise between meetings
• Ensuring all appropriate QIA activity and reports are presented to the committee
• Ensuring there is a separation between medical and financial decision making

Membership
Membership includes representatives from the organizations key department and disciplines:
• Chief Medical Officer
• Medical Director
• Vice President, Quality Improvement
• Director, Quality Improvement
• Quality Improvement Manager
• Quality Improvement Project Manager
• Vice President, Medical Services
• Director, Medical Services
• Pharmacy Director
• Member Services Director
• Provider Network Operations Director
• Health Education Manager
• Grievance Manager
• UM Manager
• Culture and Linguistics
• Other key areas as directed by the committee
• Representatives of DHCS, DMHC and other Regulatory Agencies may attend upon request
5. **Quorum and Voting**
   - This is an internal committee and approval of programs, clinical guidelines, resources and interventions are made by the Medical Services Committee and reported to the Board of Directors
   - A quorum is three members/departments
   - Decisions are made by a majority vote of those present

6. **Meetings**
   - The QIA Steering Committee will meet on a monthly basis, as needed, but not less than quarterly and can meet more frequently if circumstances require accomplishing the committee’s objectives.
   - The Chief Medical Officer may act on the Committee’s behalf on issues that arise between meetings.

7. **Confidentiality**
   - All committee members and participants will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information.
   - All employees are required to sign a Confidentiality Statement annually.
   - All members and invited guests to QIA Steering Committee meetings annually sign a Confidentiality Statement that is kept on file in the Quality Management Department.
   - Activities and minutes of the QIA Steering Committee are for the sole and confidential use of Care1st Health Plan and are protected by State and Federal laws and the Healthcare Portability and Accountability Act (HIPAA).

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

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

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

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

Care1st has a process in place to assess and ensure the IPA/PMG’s ability to perform the delegated functions. NCQA, DMHC, DHCS and L.A. Care regulations and requirements are used to evaluate and determine the IPA/PMG’s potential for delegation. An initial assessment is conducted pre-contractually to determine the IPA/PMG’s ability to provide delegated services and at least annually thereafter. The Care1st Audit Team consists of representatives from The IPA Compliance Department, Utilization Management, Credentialing, Quality Improvement, Health Education and Cultural and Linguistics Departments. The results of each IPA/PMG audit are reviewed with the Care1st Chief Medical Officer and then presented to the Contracts Committee for review and recommendation for delegation status. Recommendations are then reported to the Board of Directors for final review and approval.

The Care1st IPA Compliance Department continuously monitors IPA/PMG compliance with required submission of all corrective action plans, reports, audits, studies, and evaluations. All submissions are reviewed for quality, timeliness, and completeness of required information. It is the responsibility of the appropriate Care1st department to monitor implementation of corrective action plans. Care1st maintains individual IPA/PMG files to document all submissions and correspondence and a database to maintain on-line information with IPA/PMG report submission compliance.

Care1st promotes a collaborative, supportive, relationship with its contracted IPA/PMGs. The Care1st IPA Compliance Department works closely with each IPA/PMG to facilitate effective delegation oversight. Any compliance issues are reported to the Contracts Committee for recommendations and action.

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

- Ensuring that standards are in-place to define practitioners who serve as primary care practitioners (Pediatrics, Family Practice, General Practice, Internal Medicine, etc.).
• Each member must be assigned to a Practitioner within five miles of their home unless specially requested by the member or family.
• Each member should be referred to a specialist within ten miles of their home unless specially requested by the member or family.
• Ensuring a database is in-place which analyzes practitioner availability and ability to meet the special cultural need of our members.
• Ensuring members are within 15 miles or 30 minutes from a contracted hospital and ancillary service.
• Care1st provides members with transportation as needed.
• Care1st has processes in-place for member requests of special cultural and language needs.
• Care1st will annually review and measure the effectiveness of these standards through specialized studies.

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

X. QUALITY IMPROVEMENT PROCESS
Care1st utilizes a Quality Improvement Process to identify opportunities to improve both the quality of care and quality of service for all Plan members. Care1st adopts and maintains clinical guidelines, criteria, quality screens and other standards against which quality of care, access, and service can be measured. Compliance with standards is measured using a variety of techniques, including but not limited to:

A. Standards of Practice
1. The standards of practice used as criteria, measures, indicators, protocols, practice guidelines, review standards or benchmarks in the Quality Improvement process are based on professionally recognized standards. Sources for standards include but not limited to:
   a. National and local medical professional associations
   b. Local professionally recognized practices
   c. Review of applicable medical literature
   d. Available medical knowledge
   e. State and federal requirements
2. Standards are used to evaluate quality of care of Practitioners.
3. Standards are incorporated into policies and procedures.
4. Thresholds and targets derived from these standards and norms and accepted for will be:
   • Measurable
   • Achievable
   • Consistent with national/community standards
   • Consistent with requirements of regulatory agencies and legal guidelines
   Valuable to the assessment of quality or the potential improvement of quality for our member population
5. Standards are communicated to Practitioners through the Plan in a systematic manner in ways that may include but not limited to:
   • Care1st Provider Manual
   • Newsletters
   • Bulletins
B. **Access to Service**
Care1st has established standards and mechanisms to assure the accessibility of primary care, specialty care, behavioral health and member services. Standards include but not limited to:
- Preventive care appointments
- Regular and Routine care appointments
- Urgent care appointments
- Emergency care
- After-hours care
- Wait times
- Member Services by Telephone

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

C. **Member Satisfaction**

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

2. **Member Satisfaction Survey (CAHPS)**
Care1st contracts with vendors to conduct an annual child and adult CAHPS survey. These CAHPS surveys are conducted to monitor members’ satisfaction with health care services, accessibility of care, continuity of care, quality of care and service, cultural and linguistic issues, and to identify and pursue opportunities to improve member satisfaction and the processes which impact satisfaction. CAHPS surveys are conducted at least annually and presented to the Medical Services Committee. Care1st evaluates the survey results annually and develops an improvement plan to address areas identified (Refer to the Member Satisfaction Survey Policy and Procedure.)

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

D. **Disease State Management**
Care1st Health Plan has developed its own proactive Disease Management Program which is overseen by the Utilization Management Department. Additionally, all related policies and procedures and clinical measurements can be found in the Utilization Management Department.
E. Health Management Systems
Care1st identifies members with chronic conditions such as hypertension, asthma, diabetes and offers appropriate services and programs to assist in the management of these conditions. The Quality Improvement Department identifies these conditions through several ways but not limited to:

1. Clinical Practice Guidelines
   Care1st adopts nationally recognized Clinical Practice Guidelines (CPGs), which are taken through our committees for discussion and recommendations. Our committees are comprised of network physicians, medical directors and QI staff but only physicians have voting rights. We assure that all clinical practice guidelines are approved through these committees annually. These CPGs include but are not limited to Asthma, congestive heart failure (CHF), and coronary artery disease (CAD). Additionally, the Utilization Management Department uses nationally developed and accepted review criteria (Milliman, American College of Obstetrics and Gynecology, American Academy of Pediatrics and U.S. Preventive Services Task Force Standards). Locally used criteria sets include the Comprehensive Services Program (CPSP) specifications of Title 22 of the California Code of Regulations, Los Angeles County Department of Health and Human Services Health Care Guidelines and Requirements and L.A. Care Guidelines. Review criteria are updated on an ongoing basis. For nationally recognized criteria sets they will be renewed at least every two years.

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

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

3. Peer Review
   Peer review is conducted in any situation where peers are needed to assess the appropriateness or necessity of a particular course of treatment, to review or monitor a pattern of care provided by a specific practitioner or to review aspects of care, behavior or practice, as may be deemed inappropriate:
   - The Chief Medical Officer is responsible for authorizing the referral of cases for peer review.
   - All peer review consultants (including members of the Credentials/Peer Review or ad-hoc Peer Review Committees) are duly licensed professionals in active practice.
   - At least one consultant will be a Practitioner with the same or similar specialty training as the Practitioner whose care is being reviewed, except in those cases where there is no applicable board certification for the specialty.
   - The Chief Medical Officer can send cases out for a specialty review and consultation to be used for the peer review process.
• The Chief Medical Officer will confirm that the peer review consultants have the necessary experience and qualifications for the review at hand.
• The Quality Improvement Director and Quality Improvement Manager prepare all materials for review by the Peer Review Committee and conducts all follow-ups, as required by the Committee. (Refer to Peer Review Policy and Procedure.)

4. **Continuity and Coordination of Care**
   Our Care1st Quality Improvement Department ensures the continuity and coordination of care that our members receive. This is measured through routine medical record reviews, potential quality of care reviews, grievance reviews and member satisfaction surveys. This collaborative information is tracked and analyzed to identify opportunities for improvement. When a Practitioner discontinues a contract with Care1st the member can continue with that Practitioner for care for the remainder of active treatment or 90 days, whichever is shorter. Members with a second or third trimester pregnancy have access to their discontinued practitioner through the post-partum period. (Refer to Continuity and Coordination of Care Policy and Procedure.)

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

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

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

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

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

   The Quality Improvement Department has initiated new facility site review criteria aimed at improving patient safety in the offices and provide our members with added information that can help them make a decision on what office is best for them. This audit looks at very specific access requirements such as but not limited to: does exam table lower for member
with limitations, does the parking have wheelchair access, doorways wide enough for large wheelchairs, ramps, bathroom access for disabled, scale that accommodates a wheelchair, and etc. The facility site review sub-department performs these safety audits when conducting on-site review of the Practitioners. This information is now being used in our practitioner directory both hard copy and on the web, giving members the opportunity to know if the office site meets their individual needs.

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

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

Care1st uses data collection and analysis to track clinical issues that are relevant to our population. At a minimum, Care1st will adopt and establish quantitative measures to assess performance and to identify and prioritize areas for improvement in (4) Internal Quality Improvement Projects (IQIPs).

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

2. Internal Quality Improvement Projects (IQIPs)
Care1st will conduct and/or participate in four (4) Quality Improvement Projects (QIPs). In addition to a plan-specific QIP Care1st will also collaborate with other Health Plans and partner in the statewide collaborative. Among the QIPs at least one will be non-clinical and one clinical. All QIPs must meet guidelines for preventive care standards. The guidelines include American Academy of Pediatrics (AAP), Advisory Committee on Immunizations Practices, American College of Obstetrics and Gynecology, U. S. Preventive Services Task Force and all other nationally recognized practice guidelines as appropriate.

G. Practitioner/Provider Performance Data
To ensure compliance with National Committee of Quality Assurance, (NCQA), Practitioners and Providers must comply with Care1st policies and procedures and allow the health plan to use their performance data (i.e., HEDIS, clinical performance data).
H. Other Quality Improvement Activities

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

1. Member and Practitioner Satisfaction Surveys

CAHPS surveys are conducted to monitor members’ satisfaction with health care services, accessibility of care, continuity of care, quality of care and service, identify any cultural or linguistic issues and to identify and pursue opportunities to improve member satisfaction and the processes which impact satisfaction. Member satisfaction surveys are conducted at least annually. Care1st annually presents the survey results to the Medical Services Committee. Care1st evaluates the survey results annually and develops an improvement plan to address areas identified (Refer to the Member Satisfaction Survey Policy and Procedure.)

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

2. Facility Site Review (FSR)

- A facility site review is conducted for all PCPs in the Care1st network prior to entering the network and at least every three years thereafter.
- FSRs include all requirements, as outlined in the DHCS MMCD Policy Letter 96-06 and Policy Letter 02-02.
- The standards for FSRs are communicated to Practitioners in Practitioner bulletins, newsletters and the Care1st Provider Manual.
- In addition, with a recent FSR Database implementation, the purpose is to streamline/automate the FSR process. With this cross-functional database/tracking system, it will improve Quality Improvement’s ability to track and trend quality issues and establish programs. Furthermore, it will ensure compliance with DHCS, improve data collection efforts and lead to positive hits for HCC, HEDIS and QIFs.

(Refer to the Quality Improvement Facility Site Review/Medical Record Review Policies and Procedures)

3. Medical Record Audit

Another component of the Quality Improvement Program is the review of medical record keeping practices. Medical record audits are conducted in conjunction with the FSR process. In addition, Care1st conducts follow-up audits with Practitioners who fail the medical record portion of the FSR audit. (Refer to the Quality Improvement Facility Site Review/Medical Record Review Policies and Procedures.)

4. Credentialing

Care1st conducts a Credentialing process that is in compliance with all regulatory and oversight requirements. Care1st will credential and recredential all contracted independent practitioners and mid-level practitioners employed in contracted practitioners’ offices who see Care1st members. Care1st does not credential hospital-based practitioners, i.e., anesthesiologists, Emergency Medicine physicians, pathologists and radiologists, who see

2013 QI Program Plan MCL (LA)
Care1st members solely as patients of the hospital. Care1st does delegate Credentialing functions to contracted IPA/MSOs but retains ultimate responsibility and authority for all credentialing activities. (Refer to the Credentialing Program, Policies and Procedures for details.)

I. **Intervention and Follow-Up for Clinical Issues**

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

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

1. **Severity Levels**

The Quality Improvement Department has adopted a system of severity levels to be applied by the Chief Medical Officer to any and all grievances, potential quality of care and service issues and actual quality of care and service issues. Any severity level that reveals a borderline quality of care issue, or above, is required to have a corrective action plan developed (refer to the Quality Improvement Policy and Procedure for Severity Levels).

2. **Corrective Action Plans**

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

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

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

- Member grievance statistics and trends
- Sentinel events
- Study outcomes
- Policies and Procedures
- Medical record and facility audit reports and trends
- Delegation audit results
- Satisfaction survey results
- Utilization Management referral statistics and trends
- Quality Improvement activities
- Quality Improvement Program, Work Plan, Annual Evaluation and Quarterly Reports
- Regulatory and legislative information

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

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

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

J. **Language Services**

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

K. **Quality Outreach Program**

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

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

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

Collection of HCC Diagnosis related to MCR Members
14. Educate 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).
14. In-service practitioner and staff on how they can increase revenue through the improvement of documentation and data submission.
15. Ins-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.

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

**Physician Profile Report:** The report details their specific rates compared to their peers (i.e., pediatricians are compared to pediatricians), national benchmarks and health plan’s overall rates.

**Member Listing:** Physicians are supplied a listing of their assigned members that based on administrative data, have not obtained the required services.

**Medical Record Reminder:** A member-specific medical record reminder sheet which is filed in the member’s record.

**Encounter Form:** The Encounter Form contains all the HEDIS related measures and a practitioner documents the service provide, date of service and submits form for reimbursement. All Encounter Forms are reviewed and approved by clinical nurses validating that it meets the HEDIS criteria

**Health Risk Assessment:** This Progress Note Form contains a complete comprehensive Risk, functional, pain and health history assessment, including meeting several other HEDIS related components. Providers are offered incentives for completing these assessments on our Medicare members.

**Provider Web Portal**
In 2010, our web based Provider Portal was implemented and contains the essential Quality Outreach Program tools which are immediately available to practitioners. By integrating the tools electronically for practitioners, the Physician Profile Report, Assigned Members Listing, Member Medical Record Reminder(s) and the Encounter Form are easily accessible.

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

The Quality Outreach Program sustainability is attributed to the following two factors:
- Ensuring that Providers understand the requirements. The better the office understand the measures, the higher the probability to reach an improvement over time.
- Outreach Staff become a permanent resource to practitioner’s offices.
L. **Serving Members with Complex Needs**
The Complex Case Management Program Description outlines the organization’s approach to address members with complex needs. Members with complex needs can include individuals with physical or developmental disabilities, multiple chronic conditions and severe mental illness.

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

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

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

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

XI. **EFFECTIVENESS OF THE QUALITY IMPROVEMENT PROGRAM**

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

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

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

C. **Annual Plan Evaluation**
Quality Improvement activities, as defined by the Quality Improvement Work Plan, will be evaluated annually to measure the Plan’s performance for the year and to assist in revising the Quality Improvement Program and preparing the following year’s Work Plan. The Evaluations are reviewed by the Chief Medical Officer and submitted to the Medical Services Committee and Board of Directors for review and approval.
XII. RESOURCES, QI PERSONNEL AND INTERDEPARTMENTAL INTERFACE

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

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

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

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

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

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

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

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

G. **Claims Department**

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

H. **Cultural and Linguistics Department**

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

I. **Informatics Department**

The Informatics Department is a key operational department that manages data being submitted from providers and contracted vendors. The Informatics Department also includes the Encounter Department, where encounter submission are data entered into our repository. The Informatics department assists the QI Department to retrieve, gain accessibility to all clinical and administrative data in a way that we can incorporate into cross-functional projects to achieve our operational goals. Additionally, the Informatics Department is responsible for storing data in a way that QI staff can access or retrieve for various operational purposes and project implementations which includes the following databases: PQI, MSFE (Provider Database), HEDIS Encounter, Provider Satisfaction, Credentialing Master, Credentialing HDO, California Medical Board, and FSR.
XIII. POLICIES AND PROCEDURES

Quality Improvement

70.1.1.1 Confidentiality of QI Information
10.1.1.2 Reporting to LA Care
70.1.1.3 Internal Quality Improvement Projects (IQIP’s)
70.1.1.5 Assigning a Quality Improvement Severity Level
70.1.1.6 Clinical Practice Guidelines
70.1.1.7 Clinical Grievance Process
70.1.1.8 Access to Care Standards and Monitoring Process
70.1.1.9 Potential Quality of Care and Quality of Care issues
70.1.1.10 Peer Review
70.1.1.11 Sentinel Events
70.1.1.12 Practitioner Request to Terminate Patient/Practitioner Relationship
70.1.1.14 Initial Health Assessment – IHEBA’s
70.1.1.22 Confidentiality and Release of Patient Medical Information
70.1.1.24 Medical Record Keeping
70.1.1.25 Member Satisfaction Survey – CAHPS and ProActive CAHPS
70.1.1.26 Practitioner Satisfaction Survey
70.1.1.28 Cultural and Linguistics in QI
70.1.1.29 Availability of Primary Care Practitioners
70.1.1.30 Continuity and Coordination of Care
70.1.1.31 Over and Under Utilization
70.1.1.38 Availability of Specialty Care Practitioners
70.1.1.39 Availability of Hospitals and Ancillary Care Facilities
70.1.1.44 Reporting Diseases and Conditions to Public Health Agencies
70.1.1.45 Dissemination of QI Activities and Outcomes to Network Practitioners
70.1.1.49 Patient Safety Program
80.1.1.50 Interactive Voice Response (IVR) System
70.1.1.51 QI Outreach Program
70.1.1.52 Over and Under Utilization of Specific Services
80.1.1.56 Reporting to DHCS
70.1.1.57 Grievance Tracking Process

HEDIS

70.1.2.1 HEDIS Studies and QISMC Studies Reporting
70.1.2.2 HEDIS Medical Record Abstraction Process
70.1.2.3 HEDIS Oversight Audit Process
70.1.2.4 HEDIS Reporting and Dissemination of Results
70.1.2.5 HEDIS Corrective Actions and Interventions
70.1.2.6 Internal HEDIS Tracking Database and Collection Process
70.12.7 Healthy Start Program
Credentialing

70.1.3.1 Credentials Committee
70.1.3.2 Minimum Credentialing Criteria for Practitioners
70.1.3.3 Practitioner Initial Credentialing Process
70.1.3.4 Practitioner Re-Credentialing Process
70.1.3.5 Sanction Review
70.1.3.6 Physicians in Rehabilitation
70.1.3.7 Summary Suspension of a Practitioner’s Privileges
70.1.3.8 Practitioner Rights
70.1.3.9 Confidentiality of Credentials Information
70.1.3.10 Fair Hearing Plan
70.1.3.11 Non-Physician Medical Practitioner Initial Credentialing
70.1.3.12 Non-Physician Medical Practitioner Re-Credentialing
70.1.3.13 Scope of Credentialing
70.1.3.14 Delegated Credentialing
70.1.3.15 PCP Practice Requirements
70.1.3.16 Chief Medical Officer’s Responsibilities for Credentialing
70.1.3.17 Reporting Sanction Activity to State and Federal Agencies
70.1.3.18 Credentialing of Health Delivery Organizational Providers
70.1.3.19 Practitioner Network Database Changes
70.1.3.20 Minimum Credentialing Criteria for Standing Referral to HIV Specialist
70.1.3.21 Guidelines for Physicians Supervising Non-Physician Medical Practitioners
50.1.3.22 Medicare Opt-Out Practitioners

Facility Site Review

70.1.4.1 Facility Site Review/Medical Record Review Process
80.1.4.2 Facility Site Review/Medical Record Review Auditor Training
70.1.4.3 Facility Site Review/Medical Record Review PCP Access Requirements
70.1.4.4 Facility Site Review/Medical Record Review Corrective Action Plans
70.1.4.5 Facility Site Review/Medical Record Review Inter-Rater Reliability
10.1.4.6 Facility Site Review/Medical Record Review Score Notification to L.A. Care
70.1.4.7 Facility Site Review/Medical Record Review Practitioner Feedback Process
80.1.4.8 Collaborative FSR Process
80.1.4.9 FSR Scoring Collaborative
80.1.4.10 Medical Record Collaborative
80.1.4.11 FSR Interim Review of Facility and Medical Records
80.1.4.12 Member Complaint-Related Office Visit
50.1.4.13 Medicare Facility Site Review Process
50.1.4.14 Facility Site Review Delegation

XIV. APPENDIX

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