HERITAGE PROVIDER NETWORK

&

LAKESIDE MEDICAL GROUP

QUALITY IMPROVEMENT PROGRAM 2025

Approval Signature:

Dr. Ian Drew, Committee Chair

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Date:

CONTENTS

HERITAGE PROVIDER NETWORK STRUCTURE

Heritage Provider Network Inc. (HPN) and its affiliated Medical Groups have the Quality Improvement (QI) infrastructure necessary to improve the quality and safety of clinical care and services we provide to our members.

An affiliated Medical Group is a subsidiary company with operations under the control and oversight by the larger corporation, namely HPN.

HPN and its affiliated Medical Groups vary in model and structure used to deliver health care to our members. The model may be singular or a combination of the following delivery system types:

Network model: HPN contracts with multiple independent practice associations, staff model, and mixed model organizations to provide health care services.

Staff model: The physicians are salaried employees of HPN, or its affiliated Medical Groups. Medical services are delivered in owned medical facilities that generally are open only to our members. The physicians adopt the principles of HPN and its affiliated Medical Groups.

IPA (independent or individual practice association) model: 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: The affiliated Medical Groups uses a combination of staff model and the IPA model described above.

MISSION STATEMENT

Our QI Departments have a mission to provide an effective, system-wide, measurable plan for monitoring, evaluating and improving the quality of care and services and continuity of care provided to our members and practitioners.

PURPOSE/PROGRAM DESCRIPTION

The QI Program is designed to objectively monitor and evaluate the quality, appropriateness and outcome of care and services delivered to our members. Further, the QI Program will identify opportunities for improvement in care delivery and services to both our members and practitioners, ensuring they meet professionally recognized standards of practice. This is accomplished by the identification, investigation, implementation and evaluation of corrective actions that continuously improve and measure the quality of clinical and administrative services.

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 QI Program covers both clinical and non-clinical care and services, for our Commercial, Medicare Advantage, Medicaid, Exchange, and Applicable Integrated Plan populations. This includes an infrastructure

to provide quality monitoring and evaluation of utilization management (UM) services to ensure appropriate delivery and coordination of care across the care continuum.

GOALS AND OBJECTIVES

GOALS

1. Ensuring ongoing communication and collaboration between the QI Department and the other functional areas of the organization, including but not limited to: Utilization Management (UM), Member Services (MS), Behavioral Health (BH), Case Management (CM), and Credentialing (CR).
2. Ensuring members receive the highest quality of care and services.
3. Ensuring that the quality of UM services is continually monitored and evaluated through analytical methods to ensure performance metrics are met.
4. Ensuring members have full access and availability to qualified and credentialed primary care physicians and specialists.
5. Ensuring that practitioner credentialing is performed accurately and timely according to the standards set forth in the HPN Credentialing Plan.
6. Ensuring that credentialing performance is analyzed using the SMART goal indicators outlined in the HPN Credentialing Plan.
7. Ensuring poor provider performance is reported to and reviewed by a peer review body.
8. Ensuring that health plan member concerns are addressed and responded to according to the standards set forth in the HPN Grievance and Appeals Program.
9. Adhering to the highest standards of health care practice through the use of evidence-based guidelines (Practice Guidelines) as the basis for clinical decision-making.
10. Monitoring and evaluating the care provided by each contracting provider group to ensure the care provided meets professionally recognized standards of practice.
11. Monitoring, improving and measuring member and practitioner satisfaction with all aspects of the delivery system and network.
12. Fostering a supportive environment to help practitioners and providers improve the quality and safety of their practices.
13. Assessing and meeting the cultural and linguistic needs of our members.
14. Meeting the changing standards of practice of the healthcare industry by adhering to all state and federal laws and regulations.
15. Monitoring our compliance with regulatory agency standards through annual oversight audits and survey activities
16. Adopting, implementing and supporting ongoing adherence with accreditation agency standards.
17. Promoting the benefits of a coordinated care delivery system.

18. Promoting preventive health services and care management of members with chronic conditions.
19. Emphasizing a caring and therapeutic relationship between the patient and practitioner; and a professional and collaborative relationship between the practitioner and health plan.
20. Ensuring there is a separation between medical and financial decision making.
21. Ensuring there is no economic pressure to cause institutions to grant privileges to providers that would not otherwise be granted.
22. Ensuring providers or institutions are not pressured to render care beyond the scope of their training or experience.
23. Seeking out and identifying opportunities to improve the quality of care and services provided to our members.
24. Seeking out and identifying opportunities to improve the quality of services for our Practitioners.

OBJECTIVES

1. Maintaining a credentialed network based on a thorough review and evaluation of education, training, experience, sanction activity and performance of each healthcare provider every three years upon credentialing/re-credentialing.
2. Ensuring our members are afforded accessible health care by continually assessing member access to care and the availability of our network practitioners and specialists. Provider Groups are required to meet network adequacy standards established by Federal and State Agencies as well as accreditation organizations such as the National Committee on Quality Assurance (NCQA). Network adequacy standards are intended to ensure that provider networks offer consumers access to sufficient numbers and types of providers.
3. Assuring compliance with the requirements of regulatory and accrediting agencies, including but not limited to CMS, DHCS, DMHC, and NCQA as demonstrated by compliance with any and all auditing activity.
4. Appropriately overseeing QI activities of its affiliated Medical Groups, employed practitioners, and contracted IPA physicians.
5. Ensuring that at all times the QI structure, staff and processes are in compliance with all regulatory and oversight requirements by passing all audits and submitting required reports in a timely manner.
6. Actively working to maintain standards for quality of care and accessibility of care and service by ensuring that office telephone answer times and total office wait times are within required standards and validated annually through sampling of selected encounters.
7. Ensuring physician compliance with affiliated Medical Group requirements through regular and scheduled provider education in order to improve provider availability and telephone access based on the result of annual sampling.
8. 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 as evidenced by ratings > 75th percentile in Overall Ratings of Doctor & Healthcare.

9. 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 on a regular basis and addressing issues as they arise.
10. Assessing our performance against Federal and State Standards for PCP, SCP, High Volume, High Impact Specialists-to ensure member access to highly coordinated and managed care.
11. Assuring the highest quality levels of care for Medicare beneficiaries by seeking 5 Star ratings in all measured areas.
12. Identifying potential risk management issues and responding to all potential quality issues raised to the QI/QM Department.
13. Evaluating the consistency with which physician and non-physician reviewers apply the utilization management criteria in decision making through annual inter-rater reliability auditing per policy.
14. Ensuring timely notification to providers and members for utilization management determinations.

QI PROGRAM STRUCTURE

GOVERNING BODY

HPN's Governing Body is the Executive Committee. The Executive Committee is responsible for the establishment and implementation of the QI Program. The Executive Committee appoints the Chief Medical Officer and the VP of Clinical Services to act as facilitator for all QI activities and they are the responsible entities for the oversight of the QI Program.

The Executive Committee directs the establishment of the QI Committee and oversees compliance with all applicable laws, statues, and regulations in addition to identification and follow-up on quality related issues and appropriate actions. The Executive Committee receives quarterly reports on all QI activities.

The Executive Committee will ensure sufficient administrative and clinical staff support with sufficient knowledge and experience, and resources for the QI Program to achieve its objectives. These resources will include staff, data sources, analytical resources such as statistical expertise and programs. HPN ensures its contracted Medical Groups are deemed competent to meet regulatory and accreditation regulations during the initial oversight survey and annual oversight audits thereafter.

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 Executive Committee's designee responsible for implementation of QI Program activities. The Chief Medical Officer works in conjunction with the Vice President of Clinical Services to develop implement and evaluate the QI Program. The Chief Medical Officer is Chairperson of the QI Committee.

Responsibilities include but are not limited to:

1. Oversees and directs the medical/clinical operations for HPN, Inc.
2. Oversees and directs the HPN Clinical Services Department.
3. Oversees the QM, UM, and Credentialing Programs.
4. Works with HPN and medical group leadership to meet the requirements of all health plan deliverables.
5. Provides insight and guidance regarding clinical processes and policies.
6. Serves on HPN Advisory Boards and Health Care Coalitions.

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.

DESIGNATED BEHAVIORAL HEALTH PRACTITIONER

HPN will designate a behavioral healthcare practitioner to implement and evaluate the behavioral health aspects of the UM and QI Programs. This individual may be a physician or have a clinical PhD or PsyD, and may be a medical director, clinical director, or participating practitioner from the organization. Affiliate Medical Groups may utilize HPN's designated behavioral health care practitioner or may contract with a vendor or provider meeting similar requirements. The behavioral health practitioner 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. The behavioral health practitioner must attend the QI Committee Meeting quarterly, at a minimum.

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

Responsibilities include but are not limited to:

1. Oversees the behavioral healthcare aspects of clinical operations, including the UM, CM, and QI functions and related programs for HPN and its affiliated Medical Groups, if requested.

2. Provides leadership and support to HPN's Medical Groups, designated senior-level physicians and staff regarding HPN's programs and the implementation of the behavioral healthcare aspects of delegated UM, CM, and QI functions.

3. Performs functions or responsibilities of the Designated Behavior Healthcare Provider as outlined in the UM and QI program descriptions.

4. Ensures that the process by which HPN's Medical Groups review and approve, modify, or deny behavioral healthcare requests prior to, retrospectively, or concurrent with the provision of health care services to members, based in whole or in part on medical necessity or on benefit coverage, complies with regulatory, accreditation, and policy requirements, including but not limited to state and federal mental health parity laws.

5. Ensures compliance with applicable federal and state regulatory requirements (e.g., CMS, DMHC,

DHCS) as well as accreditation standards (e.g., NCQA) for behavioral health care. Involved in setting goals and benchmarks, reviewing performance reports, and in evaluating, identifying and implementing opportunities for improvement in HPN's behavioral healthcare aspects of clinical programs.

VICE PRESIDENT, CLINICAL SERVICES

The Vice President, Clinical Services oversees the operations of the Clinical Services Department and is responsible for the execution and coordination of all QI activities. The Vice President, Clinical Services reports to the Chief Medical Officer. He or she helps to plan, develop, organize, monitor, communicate, and recommend modifications to the QI Program and all QI policies and procedures. It is the Vice President's responsibility to interface with other departments on QI issues. The Vice President reports any areas of concern to the Chief Medical Officer and/or the QI Committee.

SENIOR DIRECTOR/DIRECTOR OF QUALITY IMPROVEMENT

The Senior Director/Director of Quality Improvement oversees the administrative day to day operations of the execution of QI activities and reports directly to the Vice President, Clinical Services.

It is the Director's responsibility to interface with the Medical Group on a day-to-day basis on QI processes and issues.

DELEGATION OVERSIGHT QUALITY STAFF (CLINICAL & NON-CLINICAL)

The Delegation Oversight quality staff are responsible for clinical and non-clinical activities that support the administrative day to day operations of the execution of Quality Improvement activities, Health Education, Cultural and Linguistic, Disease Management, and Medicaid QI activities. He or she reports directly to the Director of Quality Improvement.

RESOURCES AND ANALYTICAL SUPPORT

The Clinical Services Department has multidisciplinary staff to address all aspects of the department functions. HPN and its affiliated Medical Groups have staff and resources to conduct statistical and data analysis sufficient to establish quality controls and improvement projects. Data analysts are capable of developing databases relevant to specific functions and pulling appropriate information relevant to specific studies.

HPN and its affiliated Medical Groups will obtain feedback from our members by conducting annual member experience surveys and systematically analyzing the feedback collected. 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.

HPN and its affiliated Medical Groups will evaluate the results of the surveys received. We will develop improvement plans to address areas identified. All results are presented to the QI Committee for review and recommendations.

HPN and its affiliated Medical Groups coordinate services for our members with complex conditions and help them access needed resources, 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.

EFFECTIVENESS OF THE QI PROGRAM

ANNUAL WORK PLAN

QI Work Plans are developed annually outlining QI activities for the year and include UM activities covered by the QI program. The Work Plans will include all activities and tasks for both clinical care and monitoring of access and availability of covered services. The Work Plans are reviewed by the Medical Director and submitted to the QI Committee and Executive Committee 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. Activities should address quality and safety of clinical care, quality of service and the member experience.
2. Beginning and ending dates for all objectives.
3. Methodologies to accomplish measurable goals and objectives.
4. Measurable behavioral health goals and objectives.
5. Measurable utilization management goals and objectives.
6. Staff positions /departments responsible and accountable for the 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. The QI Work Plan will also address how the organization monitors previously identified issues.

An annual evaluation of the QI program will be included as a specific activity on the QI Work Plan, with the stated time frame and listing of staff responsible for the evaluation, listed by title.

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 and Executive Committee for review and comment. Activity reports are submitted quarterly, or as deemed necessary.

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 Chief Medical Officer and submitted to the QI Committee and Executive 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. Grievances
3. Patient Safety
4. Access and Availability

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

1. Completed and ongoing QI activities.
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. This trending will compare results against performance goals and objectives of the QI program.
6. Actions to be taken for the improvement of corrective action plans (CAPs).
7. Analysis and evaluation the effectiveness of the QI program and progress in meeting safe clinical goals. This analysis and evaluation will summarize:
    a. Adequacy of QI program resources
    b. QI Committee Structure
    c. Practitioner participation and leadership involvement in the QI program
    d. Restructuring or change needs in the QI program for the subsequent year
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 Committee review, evaluation, and approval of any changes to the QI plan.
11. An evaluation of the previous year's activities and their overall effectiveness must be submitted as part of the QI Plan after review by the QI Committee.

QI COMMITTEE

Description

The HPN QI Committees is established by the authority of the HPN's Executive Committee as a standing committee and are charged with the development, oversight, guidance and coordination of all improvement. HPN's affiliated Medical Groups also have established QI Committees. Each QI Committee is delegated the responsibility of providing an effective QI Program for our members, and providers. The QI

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.

Responsibilities

The QI Committee's responsibilities include but are 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 regarding practitioner performance.
6. Monitoring, evaluating and directing the overall compliance with the QI Program and identifying needed actions.
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. Reviewing and approving QI policies and procedures, guidelines, and protocols.
10. 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.
11. Conducting peer review, assigning severity levels and making recommendations for corrective actions, as needed.
12. Reviewing and evaluating reports regarding any/all critical incidents, reportable events, and sentinel events.
13. Reviewing and evaluating reports submitted by each Health Plan.
14. Evaluating and giving recommendations concerning audit results, member experience surveys, Practitioner experience surveys, access audits and any QI studies.
15. Evaluating and giving recommendations from monitoring and tracking reports.
16. Ensuring follow-up, as appropriate.
17. Providing a confidential mechanism of documentation, communication and reporting of QI issues and activities to the Executive Committee, QI Committee, and other appropriate involved parties.
18. Assessing the effectiveness of the QI Program and making modifications and enhancements as necessary on an ongoing and annual basis.

19. Ensuring that HPN and its affiliated Medical Groups are meeting the members cultural and linguistic needs at all points of contact.
20. 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.
21. Ensuring mechanisms are in place to identify and evaluate patient safety issues within the network and systems are established to facilitate effective resolutions.

Reporting

The HPN QI Committee shall submit a summary report of quality activities and actions for review and approval to the HPN Executive Committee on a quarterly basis. This is completed by the approval of the QI quarterly report that is sufficiently detailed to include findings and actions taken as a result of the QI program and to identify those internal or contracting provider components which the QI program has identified as presenting significant or chronic quality of care issues.

Composition

Chairperson

The Chief Medical Officer shall chair the HPN QI Committee and his/her primary responsibilities may include but are not limited to:

1. Directing the QI Committee meetings.
2. Reporting QI Committee activities to the Executive Committee.
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.

The Chief Medical Director as the chairperson of the QI Committee may designate the Associate Medical Director as his/her designee only when the Medical Director is unable to attend the meeting.

Membership

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

1. Medical Group Medical Directors
2. Clinical Services VP/Directors
3. Quality Management/Improvement VP/Directors
4. Utilization Management VP/Directors
5. Health Education Directors/Managers
6. Care Management VP/Directors
7. Provider Relations/Contracting VP/Directors

8. Member Services VP/Directors
9. Behavioral Health Practitioner
10. Representation of contracted or affiliated providers serving our members to monitor the scope of the clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. This may include primary care practitioners, an appropriate range of specialty care practitioners, or other appropriate licensed professionals
11. Appropriate clinical representatives
12. Other members appointed at the discretion of the Chairperson

Committee members that are employees of HPN or its affiliated Medical Groups 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 Chief Medical Officer. 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 by a majority vote, and/or motioned for approval by two voting physician members without challenge.

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 QI Committee may not vote but shall attend the meetings and provide support to the deliberations. In the event that the QI 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.

Meetings

The QI 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.

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. The QI Committee 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 Committee 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 Committee are for the sole and confidential use of HPN.

Recording of Meeting and Dissemination of Action

All QI Committee meetings are recorded by the taking of minutes, which are signed and dated and reflect all Committee decisions. Meeting minutes and all documentation used by the QI Committee are the sole property of HPN and are strictly confidential. When quality issues are identified, the QI Committee 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 Committee meeting:

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 issues/action items are tracked in the minutes until resolved.
4. The minutes and all case-related correspondence must be maintained in the Clinical Services Department.
5. The minutes must be available for review as required to appropriate representatives from contracted health plans and regulatory and accrediting agencies. Representatives must adhere to applicable confidentiality and conflict of interest statements.

The dissemination of QI Committee 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 be limited to:

1. Informal one-on-one meetings
2. Formal medical educational meetings
3. HPN Newsletters
4. Provider Relations and Physician Reports
5. Quarterly Reports to the Executive Committee

COLLABORATIVE QI ACTIVITIES

PHARMACY AND THERAPEUTICS COMMITTEE

Description

The HPN Pharmacy and Therapeutics (P&T) Committee is responsible for managing the HPN preferred drug list and adherence to health plan formularies. It is composed of actively practicing physicians and pharmacists 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 provides guidance to the medical staff and organizational administration in all matters pertaining to the use of medications and drug therapies (including investigational or experimental treatments). Other responsibilities of the P&T Committee include evaluating the efficacy of upcoming or newly approved medications, medication use evaluation, adverse-drug-event monitoring and reporting, medication-error prevention, and development of clinical care plans and guidelines. See the P&T Committee charter for more information on committee composition.

Reporting

The Pharmacy and Therapeutics Committee shall report to the QI Committee and through this Committee to the HPN Executive Committee.

Composition

Chairperson

A Medical Officer 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 and the Executive Committee.
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 organization's key department/disciplines:

1. Chief Medical Officer.
2. Pharmacists from each affiliated Medical Group, or a designated Medical Director.
3. VP, Clinical Services, or their 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 Executive 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 semi-annually and may conduct ad- hoc meetings when needed. The Medical Officer, or his or her 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.
4. Activities and minutes of the Pharmacy and Therapeutics Committee are for the sole and confidential use of HPN 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 meetings are recorded by the taking of minutes, which are signed and dated and reflect all Committee decisions.
2. Meeting minutes and all documentation used by the Pharmacy and Therapeutics Committee are the sole property of HPN 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 issues/action items are tracked in the minutes until resolved.
7. The minutes will be prepared and maintained.
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 are not limited to:

1. HPN Newsletters
2. Physician Reports
3. Quarterly Reports to the QI Committee and Executive Committee

HEDIS COMMITTEE (CLINICAL QUALITY MEASURES)

Description

The HEDIS Committee is established by the authority of the HPN Executive Committee as a standing committee. The HEDIS Committee will strive to improve customer health through intensive practitioner and member outreach programs.

The functions of the HEDIS Committee are as follows:

1. Directing all HEDIS Committee QI activity.
2. Recommending policy decisions.
3. Reviewing, analyzing and evaluating HEDIS interventions, and actions.
4. Ensuring practitioner involvement in the program through planning, education, monitoring, and oversight activities.
5. Reviewing and evaluating HEDIS Committee report scores.
6. Monitoring, evaluating and directing overall compliance with the regulatory technical specifications.
7. Assuring compliance with the requirements of CMS and contracted Health Plan policies.
8. Reviewing and evaluating reports submitted by each Health Plan.
9. Responsibility for evaluating and giving recommendations concerning audit results, member experience surveys, Practitioner experience surveys, grievances, HEDIS validation audits and any QI studies.
10. Responsibility for evaluating and giving recommendations from monitoring and tracking reports.
11. Ensuring follow-up, as appropriate.

Responsibilities

The HEDIS Committee's responsibilities include but are not limited to:

1. Developing measurable internal improvement activities throughout the organization with a focus on improving our processes to meet the needs of our members and providers.
2. Developing education and training material to ensure practitioner and office manager compliance to standards.
3. Developing and giving recommendations on practice guidelines that are based on nationally

developed and accepted criteria and present them to the QI Committee for approval.

4. Assuring that appropriate specialty providers are involved to give recommendations concerning improvement activity functions
5. Discussing and adopting improvement activity rationale, methodology, data sources, sampling, measurement, analysis, intervention and follow-up.
6. Directing all internal HEDIS QI activities throughout the organization.
7. Reviewing and evaluating HEDIS QI activity reports and providing recommendations.
8. Providing guidance, monitoring, evaluating and directing overall compliance to Federal Standards.
9. Reporting findings and recommendations to the QI Committee and/or the Executive Committee as appropriate.

Reporting

The HEDIS Committee shall report to the QI Committee and through this Committee to the HPN Executive Committee.

Composition

Chairperson

The Chief Medical Officer or his or her Physician Designee is the chair of the Committee and is primarily responsible for:

1. Directing the HEDIS Committee meetings
2. Reporting HEDIS Committee activities to the QI Committee and the Executive Committee.
3. Acting on behalf of the Committee for issues that arise between meetings
4. Ensuring all appropriate HEDIS QI activity and reports are timely presented to the Committee

Membership

Membership shall include representatives from the organization's key department/disciplines:

1. Chief Medical Officer, or Physician Designee
2. Vice President, Clinical Services
3. Director of Healthcare Informatics
4. HEDIS Project Manager
5. Affiliate Medical Directors, or designees
6. Key leaders, and executives
7. Department leaders and assigned staff
8. Specialist Physicians, as deemed necessary

9. Other key members as directed by the Committee
10. Representatives of contracted Health Plans, CMS, DHCS, DMHC and other Regulatory Agencies may attend upon written request and chairperson approval

Meetings

The HEDIS Committee will meet at least quarterly or as needed.

Confidentiality

All Committee members and participants will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. Activities and minutes of the HEDIS Committee are for the sole and confidential use of HPN and are protected by State and Federal laws and HIPAA.

Recording of Meeting and Dissemination of Action

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

Committee recommendations and findings may take various forms. These methods may include but are not limited to:

1. Informal one-on-one meetings
2. Formal medical educational meetings
3. HPN Newsletters
4. Physician Report
5. Quarterly Reports to the Quality Committee and Executive

CREDENTIALING COMMITTEES

Credentialing Committee activities are performed at the medical group level. These Credentialing Committees consist of physicians, practitioners, and other staff qualified to evaluate practitioner performance and the selection of Primary Care Providers and Specialists that are contracted with their perspective medical group and are in good standing with regulatory agencies and the communities they serve.

The Credentialing Committees:

1. Have 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. Discuss whether providers meet reasonable community standards of care.
3. Access appropriate clinical peer input when discussing standards of care for a particular type of organizational provider.
4. Review files for providers that do not meet the HPN's established criteria.
5. Reviews files for State Survey and Licensing deficiencies of organizational providers
6. Review files when there are reported potential quality of care issues, reportable events, sentinel events, critical incidents, complaints, and/or the facility has been sanctioned by a regulatory agency.
7. Maintain minutes of all Committee meetings and documents all actions.
8. Provides guidance to staff on the overall direction of the credentialing program.
9. Evaluates the effectiveness of the program.
10. Review and approve credentialing policies and procedures at least annually.
11. Meet as often as necessary to fulfill its responsibilities, but no less than quarterly.
12. Are peer review protected by State and Federal Law. Peer review documents must not leave the room and must be collected by staff at the meeting closure. Any Committee member copies, hand-written notes, post-it notes, or other material that will not be retained in the case file must be destroyed at the end of the session.
13. Must provide peer review documentation to State and Federal agencies upon request. Providers and practitioners must be informed regarding the peer review process and peer review grievance procedures.
14. 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.
15. Reviews aggregate data and trends regarding the accuracy and timeliness of credentialing files as well as data regarding practitioner complaints.

PEER REVIEW

Peer Review occurs at the medical group level through the group's Credentialing Committee or their Grievance and Appeals review committee. The committee's purpose is to improve the quality of the medical and behavioral health care provided to our members by practitioners and providers. Neither HPN nor HPN Groups can sub-delegate the peer review to another entity.

Reviews include 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.

Peer Review occurs during the Credentialing Committee meetings held at least quarterly. Reviews may include potential quality of care issues, resulting in a serious member negative outcome.

At a minimum, the Peer Review shall include:

1. A Medical Director and/or appointed physician designee;
2. Providers of the same or similar specialty as the provider involved in the case in question. If the specialty being reviewed is not represented on the Peer Review Committee, the Committee may utilize peers of the same or similar specialty through external consultation.
3. A Behavioral Health provider when a Behavioral Health specialty is being reviewed.

Peer Review Functions

1. Peer Review members sign a confidentially and conflict of interest statement at least annually.
2. Peer Review members must not participate in peer review activities if they have a direct or indirect interest in the peer review outcome.
3. Peer Reviewers must evaluate any case referred for peer review based on all information made available.
4. Peer Reviewers determinations regarding appropriate actions which may include, but are not limited to: Peer contact, education, credentials, limits on new member enrollment, sanctions, corrective actions, or removal from network participation. The Medical Director is responsible for ensuring that the corrective actions are implemented.
5. Peer Reviewers are responsible for making recommendations to the appropriate regulatory agency or board, and State agency for further investigation or action when it is determined that care was not provided according to community standards. Initial notice may be verbal but must be followed by a written report within 10 days.
6. All information used in the peer review process is kept confidential and is not discussed outside of the peer review process. The reports, meetings, minutes, documents, recommendations, and participants must be kept confidential except for implementing recommendations made by the Peer Reviewers.
7. Peer Review documents are protected by State and Federal Law. Documents from the proceedings must not leave the room and must be collected by staff at the meeting closure. Any Committee member copies, hand-written notes, post-it notes, or other material that will not be retained in the case file must be destroyed at the end of the session.
8. Peer Review documentation must be provided to State and Federal agencies upon request. Providers and practitioners must be informed regarding the peer review process and peer review grievance procedures.

QI PROCESS

HEALTH SERVICE CONTRACTING

HPN and affiliated Medical Groups' 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 provides 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. Practitioners and providers will provide access to medical records as permitted by state and federal law.
5. 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.

AVAILABILITY OF PRACTITIONERS

In creating and developing our delivery system of practitioners, HPN 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 health care, hospital-based care and ancillary care to our members.

3. Adjusting the availability of practitioners within our network based on the community served, the delivery system, and clinical safety.
4. Linking members with practitioners who can meet members' cultural, racial, ethnic, and linguistic needs and preferences.
5. HPN establishes availability of primary care, specialty care, behavioral healthcare, hospital based, and ancillary Practitioners by:
6. Ensuring that standards are in place to define practitioners who serve as primary care practitioners (Pediatrics, Family Practice, General Practice, OB/GYN, and Internal Medicine).
7. Ensuring that standards are in-place to define specialty care practitioners (obstetrics/gynecology, cardiologists, dermatologist, HIV/AIDS, Endocrinology, Oncology, ophthalmologist, orthopedic surgeons, and gastroenterologists).
8. Ensuring that standards are in place to define high-volume behavioral healthcare practitioners. (Psychiatrists, clinical psychologists, clinical social workers, etc.)
9. Ensuring a database is in place which analyzes practitioner availability and ability to meet the special cultural needs of our members.
10. 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.
11. Providing members with transportation as needed.
12. Providing processes for member requests for special cultural and language needs.
13. Annual reviews and measurement of the effectiveness of these standards through specialized studies.

ACCESS TO SERVICE

HPN has established standards and mechanisms to assure the accessibility of primary care, specialty care, behavioral health care and member services. Standards include but are 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

HPN's affiliated Medical Groups 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.

MEMBER EXPERIENCE

Grievance Process

The HPN clinical grievance process assesses the member experience with the services provided by its affiliated Medical Groups and our practitioners and supports the health plans in resolving client complaints and issues, including timely response to client concerns. Each quarter we evaluate our member complaints and appeals by collecting data for each of the following 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 Surveys--Consumer Assessment Health Plan Service (CAHPS)

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 Committee for review and recommendations.

CONTINUITY AND COORDINATION OF MEDICAL CARE

HPN and its affiliated Medical Groups ensure the continuity and coordination of care that our members receive. The member may select a primary care provider (PCP), or the Medical Group may assign a PCP to the member with the primary responsibility for coordinating the member's overall healthcare. HPN will ensure that there is continuity and coordination of medical services and will facilitate, across transitions and settings of care, that (1) patients receive care and services they need, and (2) practitioners or providers will get the information they need to provide care the patients need.

HPN will use valid data collection methodology to identify the following:

1. Care transitions between health care practitioners and across settings, based on changing needs, during episodes of acute or chronic illness. HPN will collect data needed to assess coordination of

care during these transitions.

2. Movement of members between practitioners. This includes inception/cessation of patient care by a practitioner and coordination of care across practitioners who are concurrently or intermittently providing care to member
3. Member movement across settings which includes moving from home to hospital, or from hospital to a rehabilitation facility.
4. After conducting quantitative and causal analysis of data to identify improvement opportunities, HPN will identify and select opportunities for improvement. These initiatives will be a direct result of data collected and analysis performed for 1.-3., above.
5. HPN will then act annually to improve coordination of medical care by acting on the opportunities noted above, and also by annually measuring the effectiveness of improvement actions taken for the first three opportunities. The effectiveness of these actions will be measured twice and results of each of those remeasurements analyzed. HPN will define variables in order to measure performance of identified issues and collect data on at least one of the following:
    a. Activities;
    b. Events;
    c. Occurrences; and
    d. Outcomes
6. Measures are based on practice guidelines and accepted standards of care and will include objective clinical criteria from authoritative sources (i.e. Clinical literature, consensus panels or HEDIS measures).
7. Quantitative analysis will define the (1) numerator; (2) denominator; (3) sampling methodology; (4) sample size calculation; and (5) measurement periods and seasonality effects and HPN will perform a causal analysis if stated goals are not met.

The Medical Groups must:

1. Identify members with special health care needs, including those that would benefit from Disease Management.
2. Ensure an appropriate health care professional assesses the 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 provider, as necessary, and
5. Ensure a mechanism to allow direct access to a specialist as appropriate for the member's condition and identified special health care needs (e.g., a standing referral or an approved number of visits).

Notification of Termination

HPN and its affiliated Medical Groups will notify members affected by the termination of a practitioner or practice groups as stated in policy.

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, when delegated:

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.

Continued Access to Practitioners

If a practitioner's contract is discontinued, the HPN and its affiliated Medical Groups will allow affected members continued access to the practitioner, as follows:

The contracted, delegated medical groups 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 12 months). This does not apply to members 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. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by the Group Medical Director in consultation with the Member and the Terminated Provider or Out-of-network Provider and consistent with good professional practice. Completion of covered services under this subsection shall not exceed 12-months from the contract termination date or 12-months from the effective date of coverage for a newly covered Member.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period (six (6) weeks). Completion of covered services shall be provided for the duration of the pregnancy. For purposes of an individual who presents written documentation of being diagnosed

with a maternal mental health condition from the individual's treating health care provider, completion of covered services for the maternal health condition shall not exceed 12-months from the diagnosis or from the end of pregnancy, whichever occurs later.

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new Member.
5. The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered Member.
6. Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the Provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered Member.

CONTINUITY AND COORDINATION BETWEEN MEDICAL CARE AND BEHAVIORAL HEALTHCARE

HPN and its affiliated Medical Groups collaborate with our contracted behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare.

HPN, working with its affiliated Medical Groups, monitors the quality and coordination of behavioral health services. We must ensure 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 specialists, organizational providers or other relevant medical delivery systems. HPN will collect data on this process that measures any or all of the following:
    a. Accuracy of information
    b. Sufficiency of information
    c. Timeliness of information
    d. Clarity of information
    e. Frequency of information
2. Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care settings. HPN will collect data on
    a. Behavioral disorders that may have been misdiagnosed or treated improperly; OR
    b. Referrals that were unnecessary, to early, to late or to the incorrect type of behavioral

healthcare practitioner

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 treatment access and follow up for patients with coexisting medical and behavioral conditions and there is a need for management across the continuum of care.
5. Primary education programs will be developed after data collection on preventable issues such as prevention of substance abuse, stress management, depression management, bereavement counseling, and nutrition and body image programs for adolescents.
6. Development and adoption of secondary preventative programs will be based on data collection on preventable issues for behavioral healthcare, such as 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).
7. Development and adoption of programs to meet the needs to members with severe and persistent mental illness. HPN will collect data on specific issues around the continuity and coordination of services for these members.

We measure and identify opportunities to improve coordination and continuity of care between medical and behavioral health providers through specific collaborative activities.

After HPN conducts a quantitative analysis of data that incorporates aggregate results and trends over time, these results will be compared against a standard. HPN will then conduct collaborative causal analysis if stated goals are not met.

HPN will then collaboratively identify, select and take action on opportunities to improve coordination of care between medical and behavioral healthcare. Annually, HPN will measure the effectiveness of two (2) selected opportunities. The effectiveness of these actions will be measured twice and results of each of those remeasurements analyzed. HPN will define variables in order to measure performance of identified issues and collects data on at least one of the following:

1. Activities;
2. Events;
3. Occurrences; and
4. Outcomes

Measures are based on practice guidelines and accepted standards of care and will include objective clinical criteria from authoritative sources (i.e. Clinical literature, consensus panels or HEDIS measures).

Quantitative analysis will define the (1) numerator; (2) denominator; (3) sampling methodology; (4) sample size calculation; and (5) measurement periods and seasonality effects and HPN will perform a causal analysis if stated goals are not met.

PATIENT SAFETY PROGRAM

HPN'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 EMR 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

HPN and its affiliated Medical Groups will track and trend the number of Grievances, Appeals, Sentinel Events, and Reportable Events received by category, sub-category, provider type, and level of severity. We take these events seriously and a full investigation shall occur to ensure that safe care is provided to our members 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 Clinical Services 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.

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. This process identifies and corrects potential quality issues for all provider entities, including physicians, hospitals, and laboratories as applicable.

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 reviewed and investigated.

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 Chief Medical Officer or Medical Group Medical Director Designee is responsible for authorizing the referral of cases for peer review.
2. All peer review consultants (including members of the Credentialing/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 Chief Medical Officer can send cases out for a specialty review and consultation to be used for the peer review process.
5. The Chief Medical Officer will confirm that the peer review consultants have the necessary experience and qualifications for the review at hand.
6. The QI Director and Manager prepare all materials for review by the Peer Review Committee to conduct all follow-ups, as required by the Committee.

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.

SERIOUS REPORTABLE ADVERSE EVENTS

A serious reportable adverse 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 Centers for Medicare & Medicaid Services:

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

HPN and its affiliated Medical Groups 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

HPN's Clinical Services 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. HPN will cooperate and assist regulators and their contracted QI Organizations (QIO).

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

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)

HPN and its affiliated Medical Groups actively take part in annual HEDIS measures in support of its contracted health plans. HEDIS Studies are conducted for all lines of business with 30 or more members and are in accordance with CMS and NCQA standards.

HPN and its affiliated Medical Groups collect HEDIS measure data through multiple sources:

1. Claims and encounter data
2. Proactive medical record review
3. 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 Committee. 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.

CENTERS FOR MEDICARE & MEDICAID SERVICES STAR RATINGS PROGRAM

The Centers for Medicare & Medicaid Services Star Ratings 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 program tools/information via the Medical Groups Provider web portals. The CMS Star Ratings were implemented to make changes at the "point of care" and ensure members received required annual services, and that appropriate use of diagnosis codes are captured.

A key component of the CMS Star Ratings 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 Ratings Technical Specifications, 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 on the following:

1. iStar and iCode orientation, and training
2. HEDIS
3. Improving documentation practices
4. Providing tools that focus the practitioners' office on specific members requiring services and the use of CMS Star Ratings, 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 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).
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

HPN conducts quality improvement studies and programs to assess quality of service to our members. Audits are also conducted to ensure the affiliated Medical Group is compliant with regulatory and accrediting agency requirements. When conducting any activity that reveals any opportunity for improvement, HPN will have a corrective action plan developed. 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

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 results and intervention analysis are available by request for all practitioners and members. The notification of this availability is posted on our website.

DELEGATION OF QUALITY MANAGEMENT/IMPROVEMENT

HPN and its affiliated Medical Groups do not delegate Quality Management/Improvement, and do not permit delegation of QI activities to sub-contracted IPA's and other Medical Groups.

HPN or its affiliated Medical Groups must provide to the Health Plan when requested:

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

QI INFRASTRUCTURE FOR UTILIZATION MANAGEMENT (UM) FUNCTIONS

As a component of the QI program, HPN and its affiliated Medical Groups have an infrastructure for ongoing monitoring of UM activities to ensure established metrics are met and to identify any improvement opportunities. HPN's QIC or UMC will continually evaluate the QI Program through ongoing reporting as well as the appropriate Work Plans which will document goals, objectives, areas of focus, planned monitoring, and action steps to be taken to ensure the appropriateness of the UM activities.

Goals Monitoring and measuring UM activities to ensure the implementation of such activities support positive outcomes and identify opportunities to improve quality of care.

1. Implementing the interrater reliability process to ensure reviewers are applying the UM decision making criteria consistently.
2. Monitoring UM decision making turnaround times through sampled audits.
3. Tracking and trending telephone statistics, including abandonment rates and average speed to answer, to ensure appropriate access to care.
4. Monitoring the process for resolving client complaints and issues, including procedures for responding to concerns timely per policy. **
5. Monitoring appeals handling turnaround times through sampled audits. **

QI Indicators

The following quality indicators are used to monitor and measure UM performance. Each indicator has a metric with an established benchmark to evaluate performance at least semi-annually. A quantitative analysis of the data, activities and performance are tracked and trended within the appropriate QI or UM work plans Assessment of performance, opportunities for improvement and barriers are identified and corrective actions are taken for indicators that do not meet goal. Findings are presented to the appropriate QI or UM Committee.

1. Interrater reliability of UM decision making
2. Turnaround time of UM decision making
3. Telephone statistics, such as call abandonment rates and average speed of answer
4. Client complaint-handling turnaround times**
5. Appeal-handling turnaround times**

**Note: HPN and its Medical Groups are not delegated by any full-service Health Plan to process or resolve member grievances/complaints or appeals. However, any complaints/appeals received will be forwarded to the Health Plan for processing, per agreements and non-delegated status