**2024**

**Quality Improvement and Health Equity Program**

**CHPIV Quality Improvement and Health Equity Program Description**

**Purpose**

The Quality Improvement and Health Equity (QIHE) Program works to establish standards for the quality and safety of clinical care and service. The Program ensures the monitoring and evaluation of the adequacy and appropriateness of health care and administrative services. The QIHE Program supports opportunities to improve health outcomes, reduce health disparities and enhance member and provider satisfaction.

**Goals**

1. Ensure promotion of safe, high-quality care and services while maintaining full compliance with standards established by regulatory and accreditation agencies.
2. Systematically monitor services provided to Members to ensure adherence to professionally recognized standards of practice.
3. Support partnership between Members, Practitioners, Providers, Regulators and Employers to provide effective health management and facilitate appropriate use of healthcare resources and services.
4. Ensure the development of programs that improve Member, Practitioner, and Provider satisfaction.
5. Ensure promotion of operations that provide and protect confidentiality, privacy, and security of Member, Practitioner, and Provider information.
6. Ensure provision of means by which Members may seek resolution of perceived failure by Practitioners, Providers, and staff to provide appropriate services, access to care, or quality of care.
7. Ensure the development of strategies and processes designed to improve health equity and mitigate health disparities.
8. Develop and implement an annual QIHE work plan and continually evaluate the effectiveness of plan activities aimed at improving and maintaining performance of target measures.

**Scope**

1. Overview

The QIHE Program is responsible for the development and implementation of standards for clinical care and service, the measurement of compliance to the standards, and implementation of actions to improve performance. These activities support opportunities to improve health outcomes, reduce health disparities and enhance member and provider satisfaction The scope of these activities considers Members’ demographics and health risk characteristics, as well as current national, state, and regional public health goals.

1. Delegation

The Community Health Plan of Imperial Valley (CHPIV) delegates the Quality Improvement and Health Equity Program to an external Managed Care Organization partner, hereby designated as “The Plan”. CHPIV delegates several other health services functions to the Plan: Appeals and Grievances, Utilization Management, Care Management, Population Health, Pharmacy, Behavioral Health. CHPIV also delegates Members Services as well as Provider Network development to the Plan.

CHPIV evaluates the Plan’s ability to perform Quality Improvement and Health Equity functions by means of a robust delegate oversight process. In its delegate oversight process, CHPIV performs continuous monitoring and regular audits. CHPIV has designated Quality Improvement/Health Equity (QIHE) auditors specially trained to perform these evaluation functions. QIHE auditors evaluate and monitor delegated entities annually, or more frequently if needed, to ensure compliance with Federal, State, Contractual, and applicable National Committee on Quality Assurance (NCQA) standards. When the monitoring and auditing process identifies gaps between performance targets and actual performance, root cause analysis will be completed, and corrective action plans (CAP) created. Follow up monitoring and auditing are performed to ensure the CAPs are completed and performance gaps are resolved.

1. Impact

The QIHE program impacts:

1. Members
2. Network Providers and Practitioners
3. Aspects of Care – including level of care, health promotion, wellness, chronic conditions management, care management, continuity of care, appropriateness, timeliness, and clinical effectiveness of care and service
4. Health Equity - supporting activities and initiatives that improve the delivery of health care services, patient outcomes, and reduce health inequities.
5. Communication = meeting the cultural and linguistic needs of all members.
6. Practitioner/Provider Performance - relating to professional licensing, accessibility and availability of care, quality and safety of care and service, including practitioner and office associate behavior, medical record keeping practices, environmental safety and health, and health promotion.
7. Services covered by CHPIV - including preventive care, primary care, specialty care, telehealth, ancillary care, emergency services, behavioral health services, diagnostic services, pharmaceutical services, skilled nursing care, home health care, Health Homes Program (HHP), long term care (LTC), Long Term Services and Supports (LTSS): Community Based Adult Services (CBAS)
8. Internal Administrative Processes – relating to service and quality of care, including customer services, enrollment services, provider relations, practitioner and provider qualifications and selection, confidential handling of medical records and information, care management services, utilization review activities, preventive services, health education, information services and quality improvement.
9. Functional Areas
10. Preventive Screening Guidelines

CHPIV ensures the adoption of nationally recognized guidelines for health maintenance, improvement and early detection of illness and disease for children and adults. Preventive and health maintenance services are monitored through the National Committee of Quality Assurance (NCQA) Health Care Effectiveness Data Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

1. Clinical Practice Guidelines

CHPIV ensures adoption and dissemination of evidenced-based clinical practice guidelines that are relevant to its membership for the provision of preventive and non- preventive health care services, acute and chronic medical services, pharmacy services, and behavioral health services. These clinical practice guidelines assist practitioners, providers, and members to make decisions about appropriate health care for specific clinical circumstances, to improve health care, and help to reduce unnecessary variations in care. The guidelines are communicated to providers through fax and mail and are available to providers on the Health Net websites, and to members upon request. Health Net monitors adherence to guideline recommendations and program outcomes using HEDIS measures.

1. Population Health Management (PHM)

CHPIV ensures evaluation of its Member population at least annually by means of a Population Health Based predictive modeling approach that can identify the characteristics and needs of the Member population, including an analysis of the impact of social determinants of health. The results of this evaluation help to determine if changes are required in PHM programs or resources.

1. Behavioral Health Services

CHPIV ensures Members receive robust behavioral health services that include:

1. Diagnosis, treatment, and referrals of behavioral health disorders, including substance use disorders (SUD)
2. Coordination of care between medical and behavioral health providers
3. Coordination of care between the Plan and Imperial County behavioral health services in the management of serious mental illness (SMI)
4. Pharmacy Services

While pharmacy services for Medi-Cal Members have been carved-out to a state Pharmacy Benefit Manager (PBM) program, CHPIV ensures Members receive appropriate ancillary pharmacy services.

1. Health Plan Performance

CHPIV ensures ongoing monitoring of the Plan’s key performance and operational metrics to monitor clinical and service quality in Appeals and Grievances, Customer Service, Population Health, and Clinical Operations which includes Utilization Management, Care Management, Concurrent Review, and the Medical Review Unit. CHPIV monitors HEDIS rate, access and availability standards, quality of care incidents, and CAHPS results to assess practitioner and provider adherence to best practices and prioritize health plan outreach activities and campaigns.

1. Credentialing and Recredentialing

CHPIV ensures establishment of policies and standards used for the selection and retention of qualified practitioners and providers. The Plans also ensures policies have been developed for oversight of downstream organizations delegated to manage the credentialing of practitioners.

Recredentialing is in initiated and completed within 36 months of the previous committee decision and incorporates a 3 year look back review of peer review and member activity that assists the Credentialing Committee in making an informed decision.

Ongoing monitoring occurs after the practitioner’s initial inclusion in the network and begins and occurs monthly, to ensure the Plan can take immediate action to protect Members and maintain compliance with all regulatory agencies.

CHPIV ensures collaboration among Appeals and Grievances, Credentialing, and Peer Review teams to report on potential and substantiated quality of care issues. All practitioners and providers undergo a quality process of credentialing prior to finalizing contractual agreements and are recredentialed every three years. All practitioners and providers are monitored monthly for Medi-Cal sanctions, license sanctions, limitations and expirations, quality of care and service incidents, and any other adverse actions. Trended issues and high severity leveled cases are reported to a Peer Review Committee for review and determination.

1. Continuity and Coordination of Care

CHPIV works to ensure the care Members receive is as seamless and integrated as possible. This work can be divided into the following main areas:

1. Across medical care settings that include (but are not limited to) outpatient, inpatient, residential, ambulatory, CBAS centers, and other types of locations where care may be provided.
2. Transition between practitioners when practitioners leave the network or changes their health care setting.
3. Continuity and coordination between medical care and behavioral health care.

CHPIV works to ensure the care Members receive is as seamless and integrated as possible. This work can be divided into the following main a

For all Members with identified complex health needs, CHPIV will ensure their continuity and coordination of care is supported through an integrated healthcare model that provides the level of care management the member needs based on acuity or behavioral health conditions.

The nurse advice line also addresses Member triage needs 24 hours a day, seven days a week for all lines of business. Provider groups can also support Members through their coordination of care programs.

1. Delegation

While it as CHPIV main delegate supporting most health plan functions and activities, Health Net may, in turn, delegate certain functions to downstream contractors. CHPIV will ensure monitoring and auditing of Health Net’s delegate oversight process.

1. Safety

CHPIV will ensure a commitment to an ongoing collaboration with network Providers, facilities, and external accrediting agencies to build a safer health system. Current safety initiatives include:

1. Responses to quality of care issues for which an investigation of complaints is conducted, and action taken where applicable. Analyses of overall and individual trends are conducted.
2. Monitoring of reportable hospital events and investigation of quality of care issues as appropriate.
3. Providing educational information to Members and Practitioners on safe health practices.
4. Credentialing and recredentialing to ensure only qualified Practitioners and organizations provide care to members.
5. Practitioner office site reviews in accordance with established criteria to ensure environments are safe, clean and accessible for members.
6. Clinical practice guidelines distributed to network providers; Health Net evaluates and makes decisions on utilization management, member education, coverage of services, and other areas to be consistent with guidelines.
7. Careful review of member complaints and member satisfaction surveys related to member safety to ensure action is taken when applicable.
8. Care Management conducts activities to ensure that continuity and coordination of care are provided for high-risk members.
9. Pharmaceutical information available for practitioners about member- specific topics and new medications. The Pharmacy Department also conducts utilization reviews and develops quality initiatives related to prescription drugs and best practices.
10. Prescription drug information available on the member portal of the Health Net website about generic and brand names, warnings, side effects, precautions, drug-drug interactions, overdose information and what to do if a dose is missed.
11. Member outreach to drive awareness about hospital quality issues and the tools that can support informed decision-making. Particular focus is on patient safety and maternal health.
12. Cultural and Linguistics Needs

CHPIV ensures utilization of the Cultural and Linguistic Appropriate Services (CLAS) Standards, developed by the Office of Minority Health, as a guide for provision of culturally and linguistically appropriate services. CLAS Standards assure that services comply with the Office of Civil Rights Guidelines for culturally and linguistically appropriate access to health care services (Title VI of the Civil Rights Act).

CHPIV’s objective is to ensure effective communication with limited English proficient members by assuring access to culturally appropriate materials, print translations of member informing materials, telephonic and in- person interpreter services, and through culturally responsive Health Net associates and health care practitioners and providers.

At least annually, CHPIV will ensure that Members, Practitioners, and Providers are informed of the availability of the Language Assistance Program (LAP), which offers language assistance services at no cost to members, including how to access the services and their rights to file grievances, in compliance with legal, contractual, regulatory agency, and oversight agency guidelines. Semi-annually, the LAP is monitored; this report includes trend analysis of grievances, and summary of language preference for all product lines. CHPIV ensures that a Quality Improvement program approves the appropriate quality benchmarks, review language preference results, and make recommendations for incorporating language preference into QI programs, follow-up actions or corrective action plans as needed.

1. Health Equity
2. Health Disparities

CHPIV will ensure the implementation of strategies to support the identification and reduction of health disparities in clinical areas.

1. DEI

CHPIV ensures a commitment to supporting diversity, equity, inclusion, and cultural humility and improving health inequities and disparities by working to break down the barriers that prevent access to high-quality health care services.

1. Access and Availability

CHPIV ensures the establishment of access to care standards that will make certain the Provider network has sufficient numbers and diversity to provide all members with appropriate access to and availability of practitioners, providers, health care services, and language assistance services. These standards also ensure Health Net members have appropriate access to medical services including primary care, specialty care, and behavioral care appointment access, after-hours access and instruction, urgent and emergent care, ancillary services access, and telephone customer service within a reasonable distance and time period.

CHPIV monitors the effectiveness of this network to meet the needs and preferences of its membership, and to meet regulatory guidelines through annual access and availability surveys. CHPIV ensures the maintenance of detailed access and availability policies and procedures, which define and discuss the necessary elements for these systems across the continuum of care. Corrective actions are developed for identified performance issues.

1. Member Experience

CHPIV will ensure the monitoring of Member experience throughout the year using CAHPS survey results, mock CAHPS results, and Member pain points including Member appeals and grievances and Call Center reports. Annually, CHPIV will ensure the analysis of collected data and documents and will ensure evaluations of Member Satisfaction are reported various stakeholders to support and improve member experience.

1. Provider Satisfaction

CHPIV will ensure the monitoring of Provider satisfaction with annual assessment using valid survey methodology and a standardized comprehensive survey tool. The survey tool is designed to assess practitioner and provider satisfaction with the network, claims, quality, utilization management, cultural, linguistic, and disability access services and other administrative services. Survey results will be reviewed the QIHEC with specific recommendations for performance improvement interventions or actions.

1. Health & Wellness Promotion

CHPIV ensures oversight over Health Net’s Health Education Department. The Health Education Department provides health education resources, materials, and services to CHPIV Members. These services are based on community health, cultural, and linguistic needs to encourage members to practice positive health and lifestyle behaviors, to use appropriate preventive care and primary health care services, and to follow self- care regimens and treatment therapies. Health education services may include individual, group and community-level education, and are supported by trained health educators to encourage positive health and lifestyle behaviors. Health Education resources, services and materials vary by membership type but generally include:

1. Weight Management Programs
2. “Smart Start for your Baby”
3. “Kick it California”
4. Diabetes Prevention Program
5. Behavioral Health Programs
6. Adverse Childhood Experiences (ACEs)
7. Flu Prevention
8. Healthy Hearts Healthy Lives
9. Digital Health Programs
10. Community and Telephonic Health Education Classes
11. Community Health Fairs
12. Member Incentive Programs
13. Health Education Resources
14. Prevention Screening Guidelines
15. Member Newsletter
16. Telehealth Services

CHPIV will provide delegate oversight over Health Net’s Telehealth Services program. Health Net supports members access to their care through telehealth programs by connecting them to California-licensed clinicians through leading and global providers of virtual care such as Babylon Health and Teladoc Health. Virtual providers schedule members with clinic-based general medical and behavioral health virtual visits with various pediatric and adult primary care and specialty providers.

Members access the mobile apps to connect to providers anytime, anywhere by phone, video, or app. Remote consultations with doctors and mental health care professionals are provided via a secure HIPAA-compliant, videoconferencing and voice over internet protocol (VOIP) software. Medically trained, certified interpreters are available on-demand to limited English proficiency (LEP) membership across 27 high demand and threshold languages including Spanish and American Sign Language.

The goals of the telehealth program are to:

1. Enhance member and provider experiences.
2. Address critical provider shortages.
3. Optimize care coordination.
4. Decrease the incidence of medical errors.
5. Reduce overall health care costs.
6. Provide equitable health care access to Limited English Proficiency members.

Electronic Consultation is a concurrent exchange between a primary care physician (PCP) and a specialist. A PCP can consult with a specialist through a secure electronic message to initiate care for a non-urgent, non-procedural patient need. A digital referral, along with clinical information, images, lab results, and other content from the medical record, is sent directly to a specialist. In 70% 75% of cases, an eConsult will result in PCP management which helps prevent unnecessary/low value diagnostic testing and in-person appointments with specialists. Most eConsults reviewed by the specialist and responded to within 72-hours, which improves timely access for patients and removes potential geographic or language barriers that may occur during in person visits.

1. MemberConnections Program

MemberConnections is an educational and outreach Medi-Cal program, designed to help members navigate the health care system, promote preventive health practices, and connect them to health and community social services. MemberConnections representatives (MCRs) extend the reach of member engagement and care management efforts by making home visits and providing personalized service to members. MCRs are highly trained, specialized non- clinical members of our integrated care teams. MCRs serve as a liaison or intermediary link between the health plan, providers and members.

1. Medical Records

CHPIV provides oversight over Health Net’s Medical Records Requirements. Health Net requires its practitioners and providers to maintain current organized and detailed medical records. Records must be consistent with standard medical and professional practice and protected health information is handled in accordance with established policies and procedures to safeguard patient confidentiality.

Health Net’ documentation standards address format, documentation, coordination of care and preventive care and includes but is not limited to the following areas: adult preventive care, pediatric preventive care and perinatal care. Standards are distributed on a regular basis and at the request of network providers. Practitioners are required to have systems and procedures to provide consistent, confidential and comprehensive record keeping practices.

Health Net monitors both medical record keeping and medical record systems to assess the quality of medical record documentation and compliance with standards through PPG medical record audits. This occurs during the HEDIS process, DMHC and CMS surveys, and during routine DHCS audits.

1. Primary Care Onsite Facility Review

Health Net is subject to the requirements in Statute 22, California Code of Regulations (CCR) for participation in Title 28, CCR, for Knox-Keene licensed health plans to conduct onsite reviews of PCP facility sites. Health Net ensures that the PCP sites are compliant with all applicable local, state, and federal standards. Each provider site, where applicable, must be licensed and accredited by the appropriate agencies and maintain compliance with all licensing standards. Prior to approval for use in providing services to members, all contracted or subcontracted sites where primary health care services are provided are subject to initial onsite inspections, and periodic inspections thereafter, to evaluate the continuing capacity of the sites to support the delivery of quality health care services. These inspections include the following types of audits; facility site review, medical record review, physical accessibility review surveys, onsite grievance visits, PQI audits and Peer Review or Credentialing Committee document/audit requests.

**CHPIV QIHE Program Structure**

1. Board of Commissioners

The CHPIV Board of Commissioners is the governing body with ultimate authority, responsibility, and oversight of the QIHE Program. The Board of Directors has delegated the responsibility for overseeing the development and implementation of CHPIV’s QIHE Program and QIHE functions to the Quality Improvement Health Equity Committee (QIHEC).

Functions:

1. Establish strategic direction for the QIHE Program
2. Receive quarterly updates from QIHEC, and review reports from the QIHEC, delineating actions taken and performance improvements at least annually.
3. Ensure the QIHE Program and Work Plan are implemented effectively.
4. QIHEC Committee Structure

The QIHEC is charged with monitoring medical management, health equity activities, and quality of care and services provided to Members, including identifying and selecting opportunities for improvement, and monitoring and evaluating the effectiveness of interventions. The QIHEC is chaired by the Chief Medical Officer/Chief Health Equity Officer (CMO/CHEO). The QIHEC meets quarterly.

Functions:

1. Review and approve the annual QIHE Program Description and Work Plan.
2. Report to the Board of Commissioners at least annually.
3. Recommend and revise, or oversee policy changes, effective QI program operation and program achievement.
4. Ensure external providers and subcontractors, who are representative of the specialties in the network actively participate in the QI program through planning, design, implementation, or review.
5. Maintain meeting minutes.
6. Review behavioral health care initiatives and outcomes.
7. Address activities and priorities related to the QI and Health Equity Transformation Program (QIHETP).
8. Analyze and evaluate the results of QI and health equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys.
9. Monitor activities and evaluate the results of QI activities, institutes needed actions, and ensures follow up as appropriate.
10. Analyze and evaluate the results of focused audits, studies, quality of care and safety issues and quality of service issues.
11. Monitor for compliance and other quality improvement findings that identify trends and opportunities for improvement.
12. Provide input and recommendations for corrective actions and monitor previously identified opportunities for improvement.
13. Monitor data for opportunities to improve member and practitioner perception of satisfaction with quality of service.
14. Address UM, QI, and health equity activities which affect implementation and effectiveness of the QI Program and interventions. Review, approve, evaluate, and make recommendations for physical accessibility of the practitioners and provider offices.

**Administration Oversight**

1. Chief Medical Officer/Chief Health Equity Officer (CMO/CHEO)

This position has oversight responsibility for the QIHE and Health Services Programs. The CMO/CHEO has oversight of the development, implementation and evaluation of QI projects and population-based care programs. The CMO/CHEO serves as Chairmen of the QIHEC.

1. Senior Director of Health Services

This position reports to and works closely with the CMO/CHEO to provide oversight over CHPIV’s QIHE and Health Services Programs. The Senior Director of Health Services will be responsible for the development of monitoring and auditing tools used in delegate oversight of QIHE activities.

1. Quality Review Nursing Staff

The Quality Review Nurses report to the Senior Director of Health Services and perform many of the day-to-day monitoring and yearly auditing activities.

**Committee Structure**

CHPIV

QIHEC

CHPIV

Local Health Commission

Executive Subcommittee

CHPIV

Local Health Commission

CHPIV

CAC 1

CHPIV

PAC 2

CHPIV

1 Community Advisory Committee

2 Physician’s Advisory Committee

The Plan

QIHEC

Delegation
Oversight

Pharmacy &

Therapeutics

Access and Accessibility

Governance

CAPHS3

Steering

Credentialing &

Peer Review

Health Equity

Governance

The Plan

3 Consumer Assessment of Healthcare Provider & Systems