
# CalViva Health
## Quality Improvement (QI) Program Description

**201~~7~~8**

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# I.

# Introduction and Background

# A. *Health Plan Products and Membership*

The Fresno-Kings-Madera Regional Health Authority (RHA) is a local public agency, created through a joint exercise of powers agreement by the Counties of Fresno, Kings, and Madera. Under California's Medi-Cal managed care program, the RHA dba CalViva Health ("CalViva") is designated as the Local Initiative. CalViva is contracting with Health Net Community Solutions (HNCS or Health Net), a National Committee for Quality Assurance (NCQA) accredited Medi-Cal managed care plan, for capitated provider services, network, and administrative services to be provided for the majority of CalViva's membership.

CalViva recognizes the challenges posed by the diverse ethnic, cultural and health needs of Medi-Cal beneficiaries in the Fresno-Kings-Madera Region. CalViva in conjunction with HNCS has the network, staff, knowledge, systems, infrastructure and cultural and linguistic competence to serve members in the Fresno-Kings-Madera Region and meet those challenges. CalViva's collaborative health plan partner, HNCS, has over ~~15~~20 years' experience in Fresno County since 1997 when the Two-Plan model was implemented. As such, CalViva is well prepared to serve Medi-Cal beneficiaries in Fresno, Kings and Madera Counties with quality care through evidence-based practices that emphasizes preven~~ta~~tive care and encourages self-management for healthy behaviors.

The RHA may also contract with other entities or health plans to provide or arrange services for CalViva members enrolled with CalViva in the Service Area.

The CalViva Quality Improvement Program (QI Program) provides members with access to network-wide safe clinical practices and services and assures they are given the information they need to make better decisions about their healthcare choices. The QI Program is designed to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis and to support identification and pursuit of opportunities to improve health outcomes, services and member and provider satisfaction. Opportunities for improvement are identified through continuous monitoring of clinical outcomes, safety, access and service. The QI Program employs an organizational structure that reports to the RHA Commission and is led by committed decision-makers. The QI Program functions in collaboration with multiple departments that have QI-related functions. CalViva also collaborates externally with network physicians, other provider types and community partners for effective QI integration process.

CalViva works with stakeholders in each county to develop unique programs tailored to the county's needs and continues to interact with the families, health care providers and county administrators to assure the programs achieve their goal of providing access to needed health care services.

# B. *Provider Network*

In the Fresno-Kings-Madera Region, CalViva partners with HNCS and other entities to maintain contracts with a full range of providers and vendors including acute care hospitals, home health care companies, infusion therapy and dialysis companies, durable medical equipment vendors, outpatient surgery facilities, radiology/imaging centers, skilled nursing facilities, acute and sub-acute rehabilitation facilities, laboratory services, outpatient pharmacies, and hospices. HNCS and other entities also arrange health care through direct contracts with certain health care providers. In Fresno, Kings and Madera counties, all of the provider contracts are a mix of fee-for-service (FFS) capitated delegated and capitated non-delegated models.

# C. *Information Systems and Analysis*

HNCS Information Systems consist of various integrated sub-data systems that support the QI Program. The major sources of data utilized for QI activities are obtained from the following subsystems:

| | |
|---|---|
| Accounts Receivable | Membership |
| Claims and Encounters | Credentialing |
| Benefits | Member Complaints ~~Provider Network Management~~ |
| Grievance and Appeals | ~~Member Complaints~~Provider Network Management |
| Billing | Remittance |
| Medical Management | Customer Call Centers |
| ~~Claims~~ | |

Analytical resources are available within the HNCS QI Department and will be made available to CalViva. The manager and director of the QI Research and Analysis Department ha~~s~~ve~~-~~ Masters Degrees with SAS and programming skills. Additional resources are available from regional and corporate departments: Information Systems, Health Care Services, Pharmacy Operations, Medical Informatics, Healthcare Effectiveness Data and Information Set (HEDIS®) Measurement and Reporting, Actuary, Finance, Strategic Planning, and Marketing. Additional sources of information also come from the HEDIS®, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), appointment access and provider availability surveys, practitioner after-hours telephone access surveys.

# II.

# Purpose and Goals

# A. *Mission*

CalViva mission is:

"To provide access to quality cost-effective healthcare and promote the health and well-being of the communities we serve in partnership with health care providers and our community partners."

The mission of the CalViva QI Program is:

To help CalViva members stay healthy, secure and comfortable by providing access to quality care and services and information to make better decisions about their healthcare choices.

The vision of CalViva QI Program is to:

- Provide access to quality health care that helps CalViva members achieve improved health outcomes.
- Provide understandable, reliable and affordable products and services that exceed expectations.
- Monitor and promote the delivery of accessible, appropriate, compassionate and comprehensive health care and service.
- Offer wellness services that minimize adverse outcomes or improve health care status.
- Foster member-focused partnerships with physician groups and other health care practitioners and providers.

# B. *Purpose*

The CalViva QI Program establishes standards for both the quality and safety of clinical care and service, as well as monitors and evaluates the adequacy and appropriateness of health care and administrative services on a continuous and systematic basis. The QI Program also supports the identification and pursuit of opportunities to improve health outcomes, and both member and provider satisfaction.

~~**The purpose and goals of the CalViva QI Program are to:**~~

# C. *Goals*

1. Support CalViva's strategic business plan to promote safe, high quality care and services while maintaining full compliance with regulations or standards established state regulatory and accreditation agencies.

2. Objectively and systematically monitor and evaluate services provided to CalViva members to ensure conformity to professionally recognized standards of practice and codes of ethics.
3. Provide an integrative structure that links knowledge and processes together throughout the organization to assess and improve the quality and safety of clinical care with quality service provided to members.
4. Develop and implement an annual quality improvement work plan and continually evaluate the effectiveness of plan activities at improving/maintaining performance of target measures, and takes action, as needed, to improve performance.
5. Support a partnership among members, practitioners, providers, regulators and employers to provide effective health management, health education, disease prevention and management, and facilitate appropriate use of health care resources and services.
6. Design, implement and measure organization-wide programs that improve member, practitioner and provider satisfaction with CalViva's clinical delivery system. These programs are population-based ongoing clinical assessments and are evaluated to determine the effectiveness of clinical practice guidelines, preventive health guidelines and disease management programs.
7. Monitor and improve CalViva's performance in promoting quality of service to improve member, practitioner and provider satisfaction through the use of -satisfaction surveys, focused studies, and analysis of administrative data; emphasizing administrative, primary care, high-volume specialists/specialty services, and behavioral health/chemical dependency services.
8. Promote systems and business operations that provide and protect the confidentiality, privacy and security of member, practitioner and provider information while ensuring the integrity of data collection and reporting systems. This is done in accordance with state and federal requirements and accreditation guidelines.
9. Anticipate, understand and respond to customer needs, be customer-driven and dedicated to a standard of excellence in all customer relationships.
10. Provide a means by which members may seek resolutions of perceived failure by practitioners/providers or CalViva personnel to provide appropriate services, access to care, or quality of care. Identify, review and investigate potential quality of care issues and take corrective action, when appropriate.

- 
- ~~CalVivaCalVivaImplement organization-wide programs that continually measure and improve member, practitioner and provider satisfaction with services and clinical delivery systems.~~

- ~~Develop and implement population-based, ongoing clinical studies focused on high risk and high frequency criteria that incorporate current public health goals.~~

- ~~Design, implement and measure the effectiveness of clinical practice guidelines, preventive health guidelines and health management programs that meet professionally recognized standards of practice for the high volume/high risk population issues.~~

- ~~Promote systems and business operations that provide and protect the confidentiality, privacy and security of member, practitioner, and provider information in accordance with state and federal requirements and accreditation guidelines.~~

- ~~Maintain full compliance with the requirements of federal, California regulatory and Medi-Cal contractual requirements. These include, but are not limited to, the Centers for Medicare and Medicaid Services (CMS), California Department of Health Services (DHCS), and the California Department of Managed Health Care (DMHC).~~

- ~~Promote safe clinical practices through member, practitioner and provider education, including the Initial Health Assessment (IHA), and preventive services in accordance with national and specialty society standards.~~

- ~~Promote safe clinical practices and better outcomes for members through improved practitioner relationships and promotion of evidence-based health care.~~

- ~~Provide efficient, simple and high quality administrative services that minimize duplication and errors and produces effective outcomes that result in improved member and practitioner satisfaction.~~

- ~~Anticipate, understand and respond to customer and community needs, be customer- and community-driven and dedicated to a standard of excellence in all customer and community relationships.~~

# III.

# Scope

# A. *Scope of QI Program*

The CalViva QI Program includes the development and implementation of standards for clinical care and service. CalViva ensures that there are no financial incentives or gain, including financial gain to providers, vendors, or facilities, to delay or withhold appropriate care. The QI Program provides oversight to ensure that RHA Commission and CalViva providers exert no economic pressure on facilities to grant privileges to providers. Facilities have in place Policies and Procedures for credentialing and re-credentialing. These processes are not subject to CalViva intervention.

A systematic methodology for ongoing monitoring and evaluation is performed to assess conformance to the standards. Corrective actions are recommended to improve performance, and follow up is planned when actions are taken to evaluate effectiveness. These efforts maintain compliance with federal and state regulations and contractual requirements as appropriate. The scope of these activities is determined in an annual assessment of the enrolled populations' demographics and health risk characteristics, as well as current national, state and local public health goals. The scope of the program includes:

- Health promotion, wellness and preventive care including the Initial Health Assessment
- Chronic care improvement/disease management
- Monitoring and evaluating access, availability, satisfaction and service
- Integrated Complex Case Management (CICMCCM)
- Quality and safety of care
- Monitoring and evaluating care coordination for medical and behavioral conditions, ensuring coordination of care with other county and state programs
- Practitioner satisfaction
- Practitioner site and facility inspection including physical accessibility reviews of PCP and high-volume specialist provider sites.
- Medical record and documentation standards
- Practitioner and provider qualifications and selection through a careful credentialing and peer review process
- Utilization Management
- Credentialing & recredentialing
- Delegation Oversight
- Health Plan Clinical and Service Performance
- Member Rights & Responsibilities
- Communication to meet cultural and linguistic needs of all members
- Ensure SPD members undergo annual risk stratification, Health Risk Assessment (HRA), care plan preparation and distribution to the PCP

CalViva's QI Program has mechanisms to monitor the quality of care provided in an inpatient setting to ensure that providers utilize equipment and facilities appropriate to the care through the concurrent review process. The Plan's Health NetVNet Provider Network Management staff ensures hospital and outpatient facilities are certified by appropriate oversight agencies. Physician reviewers during the Provider Dispute Resolution process additionally review for appropriate standards of care, including but not limited to, ensuring appropriate specialty care referrals are made, ensuring surgical care is not delayed, ensuring usual standards of care are met, and ensuring physicians in training have oversight of clinical decision making, exams and orders. The QI Program also has mechanisms to monitor the quality of care provided in an inpatient setting to ensure that appropriate referral procedures are in place and utilized for services not customarily provided by a hospital.

The QI Program is prepared annually by the CalViva Chief Medical Officer for presentation to the CalViva QI/UM Committee during the first quarter of each year. The QI/UM Committee, which includes primary care and specialist providers engaged in clinical practice, approve or modify the QI Program annually, based on goals and initiatives for the year, taking into consideration new legislation, regulation and needs of the membership and provider community. Once approved, the CalViva Chief Medical Officer presents the finalized QI Program to the RHA Commission for its approval at its next scheduled RHA Commission meeting. After the RHA Commission has approved the QI Program, the CalViva Chief Medical Officer, as a licensed physician and the QI/UM Committee Chair collaborates with the QI/UM Committee to monitor the full scope of clinical services rendered on a scheduled basis, including a full review at mid-year. During the first quarter of the next year, an annual review of the QI and UM Work plan progress and completion is conducted by the CalViva Chief Medical Officer and QI/UM Committee following the completion of a calendar year.

Each CalViva delegate has established and implemented policies and procedures regarding approval, modification, delay or denial of services as well as the timeliness of those decisions (within the requirements outlined in UM-002 -Precertification and Prior Authorization Requests). As part of the pre-delegation audit and annual audit, CalViva verifies that each delegate has policies and procedures regarding authorization, modification, denial or delay of services, as well as policies regarding the timelines of those decisions.

# B. *Preventative Health Screening Guidelines ( PSGs)*

CalViva adopts nationally recognized preventive health guidelines for health maintenance, improvement and early detection of illness and disease. The guidelines are reviewed, adopted and updated on an annual basis or more frequently when new scientific evidence or national standards are published prior to the scheduled review. CalViva along with HNCS medical directors with various medical specialties are involved in the adoption of the guidelines through the Medical Advisory Council (MAC). New members receive the Preventive Health Screening guidelines in new member welcome packet and new providers receive this information with orientation materials within 10 days of becoming authorized to see CalViva members. It is also available to all members and existing practitioners and providers online and by calling the Health Education Department at 1-800-804-6074.Updates, when applicable, are distributed to all practitioners via Provider Updates.

Preventive services that are relevant to CalViva's membership are monitored through participation in HEDIS® and other programs as specified in the QI Work Plan. In collaboration with HNCS, physicians and providers, CalViva encourages members to utilize health promotion and preventive care services.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

# C. *Health Promotion Programs*

CalViva Health provides health education programs, services and resources to Medi-Cal members to help manage their health and reach their goals. A whole person approach is used with a focus on removing barriers to care and providing health education and guidance. Interventions are tailored to meet the member's clinical, cultural and linguistic needs.

CalViva offers a variety of health education programs, services and resources that are free to CalViva members. Examples include:

- The Health Education Information Line – The Health Education Information Line (1-800-804-6074) allows members to request health education materials and find out about health education programs available.
- Weight Management Programs – Members have access to a comprehensive Fit Families for Life-*Be In Charge!*$^{sm}$ suite of programs. The Fit Families for Life-Home Edition is a 5-week home-based program to help families learn and set weekly nutrition and physical activity goals to achieve a healthy weight. Overweight children and adult can also access telephonic coaching through Raising Well and Adult Weight Management programs respectively.
- Disease Management Program – At risk m~~M~~embers with asthma, diabetes, and chronic heart failure are ~~enrolled into~~offered enrollment into the *Be In Charge!*$^{sm}$ Disease Management program to help them control their condition. Members receive educational resources and have unlimited 24 hour access to a nurse to address their medical concerns
- ~~Pregnancy Matters®~~ Healthy Pregnancy Program – Pregnant members receive educational resources ~~which~~ including telephonic case management for high risk pregnancies to help them achieve a successful pregnancy and healthy baby. ~~materials on monitoring the baby's movement and handbooks on planning a healthy pregnancy, caring for your baby, and teen parenting~~.
- California Smokers' Helpline – The California Smokers' Helpline (1-800-NO-BUTTS) is a free statewide quit smoking service operated by the University of California San Diego Moore's Cancer Center. The Helpline offers self-help resources, referrals to local programs, and one-on-one telephone counseling to quit smoking.
- Nurse Advice Line – Members may speak to a nurse 24~~–~~hours a day, 7 days a week in the member's preferred language about any health related concerns. Pre-recorded information about a variety of diseases and health issues is also available via the Nurse Advice Line as part of the Audio Health Library.
- Healthy Hearts, Healthy Lives – Members have access to a heart health prevention toolkit (educational booklet, tracking journal and fitness DVD) and access to community classes to learn how to maintain a healthy heart.
- Electronic Health Education – Teens from 13 years old and adults may participate in electronic health education campaigns and programs available through T2X's website, text messaging and mobile app. T2X engages members in discussing health topics that are important to them. T2X interventions guide participants in learning how to access credible health education information and seek preventive health care services.
- Community and Telephonic Health Education Classes – Free classes are offered to members and the community. Classes are available in various languages. Topics vary by county and are determined by the community's needs.
- Member Newsletters – Newsletters are mailed to members on a quarterly basis and covers various health topics and the most up-to-date information on health education programs and services.

- Health Education Materials - Members have access to culturally appropriate health education brochures, flyers, newsletter, and screening guidelines on 25 health topics and up to 3 threshold languages.

## ~~D.~~MemberConnections® Program

MemberConnections is a special educational and outreach 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/link/intermediary between the health plan/providers and members.

More specifically, MCRs:

- conduct assessments to better understand members' needs such as the Health Risk Screening
- facilitate access to health services by scheduling medical appointments, helping members find doctors and specialists and checking the status of referral authorizations
- assist with removing barriers to health care by arranging transportation and language services through the health plan vendors
- connect members to case management and disease management to better manage their chronic and/or complex health conditions
- address social needs by linking members to county and community resources
- help reduce health care costs by promoting preventive practices and educating members on how to use their benefits and appropriate utilization of health services

# D. *Clinical Practice Guidelines*

Clinical practice guidelines (CPG) are developed and/or adopted to reduce variation in practice and improve the health status of members. CalViva adopts nationally recognized, evidence-based clinical practice guidelines. CalViva, Medical Directors, and network practitioners are involved in the review and update process for clinical practice guidelines. Specialty input on guidelines is obtained, when indicated. Guidelines are evaluated for consistency with CalViva's benefits, utilization management criteria, and member education materials.

# E. *Disease Management*

The Disease Management – *Be In Charge!* ℠ Program provides disease specific management for members with Aasthma, Ddiabetes, and Hheart Ffailure (HF) and will transition to Envolve PeopleCare in 2018. ~~In 2017, the program will expand to incorporate members with Chronic Obstructive Pulmonary Disease (COPD) and Coronary Artery Disease (CAD).~~ The goal of the *Be In Charge!* ℠ Program is to improve member knowledge and self-management of these diseases leading to improved quality of life, better functional status and decreased absenteeism. Additionally, the program aim is to empower members to manage their diseases in accordance with national peer-reviewed published guidelines and to ensure that members receive necessary screenings and monitoring services.
Enrolled members in the program are mailed educational materials with action plans, information about the program, and contact numbers for the Nurse Advice Line. Program members receive outbound telephonic interventions and referrals are made to the ~~complex case~~Integrated Case ~~m~~Management program if the member is identified as being at high risk for hospitalizations or poor outcomes.

### Nurse Advice Line

The Nurse Advice Line (NAL) service is a member-centric nurse triage program that combines high-tech, patented, algorithm-based tools with high-touch call center services. The NAL provides immediate symptom assessment, and member education services. In addition to educating members how to better manage their own health, the service recommends callers seek the appropriate level of care, within the appropriate timeframe and at the proper setting. The service is offered 24 hours a day, seven days a week, all year long, in English and Spanish with translation services available for other languages.

Using clinical decision algorithms, the NAL registered nurse listens to each member's chief complaint, identifies member symptoms, and selects the most appropriate algorithm to be used for a thorough assessment. A combination of member input and clinical judgement allow the nurses to answer clinical questions and determine timeliness of care. ~~The~~ Nurse Advice ~~Program~~ Line nurses may access support from a ~~have physicians~~physician when needed as the nurse interacts ~~s~~physicians ~~there to provide support to the nurses as they interact~~ directly with the member. The NAL is URAQ accredited.

- ### Adult Weight Management

Members' ages 18 and older with a BMI of 25 or greater are eligible for the adult weight management program. Individualized care plans are developed based on the member's current health status, presence of co-morbidities, dietary intake, and physical activity limitations. Registered dietitians and exercise physiologists serve as program coaches. Themes introduced include behavior modification for weight loss and weight maintenance, nutritional counseling to assist weight loss goals, food preparation and portion control, food label reading, lifestyle approaches to physical activity, tips for eating out, and more. Members are offered unlimited inbound calls and appropriate educational resources.

### Raising Well-Pediatric Weight Management

Raising Well is a new telephonic weight management program for children and adolescents. Members ages 2–17 with a body mass index (BMI) at or above the 85th percentile are eligible for the program. Participants, including their parents or guardians, are given personalized, telephonic support from health coaches who specialize in weight management. Coaches include registered dietitians, exercise physiologists and nutritionists.

Developed from nationally recognized, evidence-based practices, program components include:

- Behavioral counseling and coping skills.
- Dietary counseling and physical activity education.
- Parent training and modeling.
- Physician visit promotion and tracking.
- Printed educational materials.
- Private social media/Facebook peer support group.
- Readiness to change assessment.
- Unlimited inbound calls.

**Audio Library**

Members can choose from over 1000 health-related topics in the Audio Health Library for a concise overview of any subject of interest. Topics are available in English and Spanish.

# F. ***Transition Care Management Program***

The Transition Care Management (TCM) Program provides a comprehensive, integrated transition process that supports members during movement between levels of care. The TCM Program is a care transition model that utilizes the Coleman Care Transition Intervention (CTI) as the underlying foundation. Care Transition Interventions are focused on coaching the member and the member's support system during the inpatient stay and the immediate post discharge period to ensure timely, safe and appropriate medical care in the most efficient and cost-effective manner. Knowledge of internal and external processes surrounding the inpatient and post discharge stay is essential in navigating the health care continuum and addressing barriers to post discharge success for the member.

The TCM strives to create a smooth transition from one setting to another and to reduce re-hospitalization risks and other potentially adverse events. Using a patient centric approach, the model incorporates three evidenced based care elements of inter-disciplinary communication and collaboration, patient/participant engagement and enhance post-acute care follow-up.

# ~~A.~~G. *Integrated Ca~~r~~se Management (ICM) Program*

CalViva partners with HNCS to provide ~~the~~ Integrated C~~-c~~a~~r~~se M~~m~~anagement (ICM) services. The program targets members identified as being at high risk for hospitalizations or poor outcomes and who have barriers to their care. The program utilizes an evidence-based approach, which is member focused and goal directed in developing, implementing and monitoring an individualized care plan. Trained nurse care managers, in collaboration with a multiple disciplinary team, provide coordination, education and support to the member (family and caregiver) in achieving optimal health, enhancing quality of life and accessing appropriate services. ~~HNCS contracts with a NCQA – accredited case management vendor to deliver these services to the CalVivaCalViva members.~~

The goals of the ICM program are:

- Consistently perform the activities of assessment, planning, facilitation and advocacy for members throughout the continuum of care, in accordance with accreditation standards and standards of practice.
- Collaborate and communicate with the member/family, the physician and other health care providers in the development and implementation of a care plan that is driven by the member's goals for health improvement.
- Accomplish the goals in the individual member's care plan.
- Provide members and their families with the information and education that promotes self-care management.
- Assist in optimizing use of available benefits.
- Improve member and provider satisfaction.
- Promote effective utilization and monitoring of health care resources while ensuring that services are coordinated and appropriate for the member.
- Provide member with tools to empower member to achieve optimal health, independence and functioning in the most proactive and effective way.
- Ensure members with complex conditions receive support and assistance with coordination of care and access to any needed services.

This program seeks to identify and intervene with members:

- Who are at risk of re-admission to hospitals
- With declining health status
- Whose profiles resemble other members with prior poor outcomes
- Who are most likely to engage with case manager (demographics)
- With extensive coordination of care needs, such as members receiving transgender services.

Members for the Integrated Ca~~s~~r~~e~~ Management program are identified proactively using utilization, claims, pharmacy, and encounter data sources. This data is stratified using a predictive modeling and care management analytic tool with a built in proprietary risk stratification algorithm to differentiate members who have higher risk and more complex health needs from those with lower risk. In addition, data gathered through assessments and or screenings is filtered electronically at least monthly to identify members for the program. Members ~~and~~ may also be directly referred by sources including:

- Health information lines
- Any of the Disease management programs
- The concurrent review and discharge planning process
- A member/caregiver request for case management

- A practitioner request for case management

Providers, the Medical Review Unit, internal case management~~management~~~~management, or~~ by self-referral. The risk stratification process incorporates data gathered during the nurse assessments and screenings with daily and monthly electronic filtering to identify members that qualify for the I~~C~~CM program. ~~Members may~~ also be identified for case management programs by direct referral from sources, which may include:

ICM ~~It~~ is a telephonic based program which can provide face-to-face contacts, as needed. ~~Outcomes of this program include:~~

~~The goals of the ICM program are:~~

- ~~Consistently perform the activities of assessment, planning, facilitation and advocacy for members throughout the continuum of care, in accordance with accreditation standards and standards of practice.~~
- ~~Collaborate and communicate with the member/family, the physician and other health care providers in the development and implementation of a care plan that is driven by the member's goals for health improvement.~~
- ~~Accomplish the goals in the individual member's care plan.~~
- ~~Provide members and their families with the information and education that promotes self-care management.~~
- ~~Assist in optimizing use of available benefits.~~
- ~~Improve member and provider satisfaction.~~
- ~~Promote effective utilization and monitoring of health care resources while ensuring that services are coordinated and appropriate for the member.~~
- ~~Provide member with tools to empower member to achieve optimal health, independence and functioning in the most proactive and effective way.~~
- ~~Ensure members with complex conditions receive support and assistance with coordination of care and access to any needed services.~~

~~This program seeks to identify and intervene with members:~~

- ~~1 - Who are at risk of re-admission to hospitals~~
- ~~2 - With declining health status~~
- ~~3 - Whose profiles resemble other members with prior poor outcomes~~
- ~~4 - Who are most likely to engage with case manager (demographics)~~
- ~~5 - With extensive coordination of care needs, such as members receiving transgender services.~~

~~Members are initially identified for participation in the program using data stratification that includes:~~

- ~~Claims and encounter data~~
- ~~Hospital discharge data~~
- ~~Pharmacy data~~
- ~~Information gathered as part of the concurrent review process, as applicable.~~

~~Members may also be identified for case management programs by direct referral from sources, which may include:~~

- ~~Health information lines~~
- ~~Any of the Disease management programs~~
- ~~The concurrent review and discharge planning process~~
- ~~A member/caregiver request for case management~~
- ~~A practitioner request for case management~~

Once members are identified for potential inclusion in the case management program, outreach to the member is completed to assess the care need and the member is invited to participate in case management if they meet

established screening criteria. If the member agrees, the member is assigned to the appropriate program and acuity level to address their care needs. Acuity levels vary from complex to low. Members are also afforded the opportunity to decline participation in the program.

The Case Management Program includes an initial assessment, the use of evidence-based care plans and algorithms, documentation of member preferences, resources, barriers, goals, progress and ongoing evaluation of members needs with adjustments of interventions as needed. In addition, an in-home assessment is preferred for the highest risk complex members.

Each year the program is evaluated for its effectiveness using both established metrics and documented measures of member satisfaction.

# ~~B.~~H. Behavioral Health Services

CalViva's provider network arrangements to deliver covered mental health services to the majority of members are administered through a contract Health Net holds with its affiliate MHN Services ("MHN"). MHN contracts directly with psychiatrists ~~and other~~ as well as non-MD behavioral health specialists and is delegated to perform certain functions (e.g. credentialing, claims, utilization management, etc.).

CalViva Health, HNCS and MHN are taking a collaborative approach to educate providers and members on the importance of:

- Coordination of care and exchange of information between medical and behavioral health providers and county mental health plans
- Diagnosis, treatment, and referrals of members with mental health and substance use disorders to network specialists, county mental health plans, County Drug and Alcohol Programs and other resources as appropriate
- Appropriate uses of psychopharmacologic medications and treatment adherence
- Managing coexisting conditions and behavioral health preventive programs

These areas are measured through the following sources to identify new initiatives or opportunities to enhance existing interventions.

- Member survey to assess satisfaction with and access to covered mental health services
- Provider survey to assess satisfaction with the timeliness and usefulness of information from behavioral health practitioners, ~~-~~along with their experience with coordination of care
- Network availability and adequacy of behavioral health providers
- Member quality of care and service complaints investigation
- Evaluation of behavioral health HEDIS® measures and other QI behavioral health initiatives. ~~such as the Screening for Clinical Depression and follow-up plan (CDF) HEDIS initiative.~~
- ~~Behavioral health HEDIS® measures.~~

## ~~C.~~I. *Credentialing / Recredentialing*

CalViva has established policies and standards to ensure the selection of qualified and credentialed practitioners and providers.

Compliance issues are reported to CalViva's Chief Medical Officer. The Chief Medical Officer will work with CalViva Chief Compliance Officer and CalViva's QI/UM Committee to address such compliance issues.

All providers undergo a quality process of credentialing prior to finalizing contract agreements and are recredentialed every three years. All providers are monitored monthly for Medicare/Medicaid plan sanctions, license expirations, quality of care and service incidents, and any other adverse actions. Trendable actions and any high severity leveled cases are reported to the Peer Review Committee where further actions are taken.

# ~~D.~~J. *Continuity and Coordination of Care*

A major ~~aspect~~focus of CalViva's QI program is ensuring that the care members receive is seamless and integrated. ~~continuity and coordination of care, including coordination activities:~~These activities can be divided into three main areas:

- Across medical care settings that include (but are not limited to) inpatient, residential, ambulatory and other locations where care may be rendered
- Continuity and coordination between~~Between~~ medical care locations and public health agencies,
- ~~Between~~ medical care providers, behavioral health care providers and county mental health plans
- Transition of care when benefits end or practitioners leave the network, between practitioners or changes in setting

CalViva, in conjunction with HNCS, identifies opportunities for improvement in continuity and coordination of care through various methodologies, including but not limited to:

- Member satisfaction surveys
- Appeals & Grievance data analysis
- Provider satisfaction surveys
- HEDIS® measures
- Medical record review

Mechanisms are implemented to monitor and facilitate continuity and coordination of care for members. These activities include, but are not limited to:

- Integrated Case ~~Complex case m~~Management
- Pharmacy programs
- Utilization and Case Management Programs
- Member Services functions
- Communication and data exchange that is appropriate and compliant with state and federal privacy and security regulations
- Information will be posted on the Plan website for advising providers, contractors, members, and the public ~~-~~how they can obtain information about~~-~~ the UM processes and guidelines used to authorize, modify, or deny health care services under the benefits provided by CalViva.
- For all members with identified complex health needs, CalViva supports their continuity and coordination of care through an ~~i~~integrated healthcare model that provides the level of care management the member needs based on acuity and includes the care management of behavioral health conditions. Other programs such as disease management and nurse advice line are also available to members and can help those with complex needs manage their conditions. Provider groups also support members through their coordination of care programs.

# ~~E.~~K. Delegation

CalViva has delegated certain functions (e.g. credentialing and recredentialing, utilization management, and claims administration, etc.) to HNCS and other entities as specified in written agreements between CalViva and the entities. CalViva will institute corrective action and/or may revoke delegation when it determines that HNCS or other entities are unable or unwilling to carry out the delegated responsibilities.

CalViva has established delegation policies and processes to address oversight. HNCS and other entities must demonstrate the capability, proficiency and experience to manage the delegated responsibilities. An annual evaluation of the delegates programs may include as appropriate for the function under review: an analysis of the program documents, reports, audit of related files, and periodic on-site review of their operations. HNCS and other entities are required to report activities and key performance data to CalViva in accordance with agreement requirements, CalViva policies and regulatory requirements. CalViva is responsible for oversight of delegated functions, final approval and monitoring of such delegated activities.

The CalViva QI Program incorporates input from appropriate professionals into the designs of its corrective action plans or QI Programs. Should Corrective Action Plans (CAP) be required and implemented, CalViva utilizes physicians and registered nurse's input and other Plan compliance staff, as applicable to the delegated function, to define the CAP, approve the CAP, and monitor progress and resolution of the CAP. Such CAP is reviewed by CalViva's Chief Medical Officer and/or Chief Compliance Officer as applicable with summary reports of actions taken and progress toward resolution reported to the QI/UM Committee or other appropriate Plan Committees.

CalViva requires that each delegate have a written description of the UM program that includes structure, scope, criteria, processes, and policies and have a designated medical director who is responsible for UM program oversight and holds an unrestricted license to practice medicine in California. As part of the annual delegation audit and pre-delegation audit by CalViva, CalViva verifies the status of the Medical Directors and Registered Nurses for the delegate and verifies that the delegate's UM program has oversight by medical directors licensed in California.

CalViva assesses the capability of each delegated entity by performing a capability assessment prior to delegation specifically with regard to technical expertise and review of budgetary resources. As part of the delegation audit, HNCS and other delegated entities must demonstrate they have adequate clinical staffing to provide timely determinations.

Each CalViva delegate will ensure that emergency health care services are available and accessible, that providers are reimbursed for care necessary to stabilize an emergency condition, and that denials of payment for emergency care meets requirements. As part of the pre-delegation audit, and annual audits CalViva ensures that each subcontracted delegate, including HNCS, has policies and procedures that ensure access to emergency services, and that emergency services are not subject to prior authorization or denial. The delegates may review for medical necessity and appropriateness of care following the triage exam when there is no emergency condition, or following stabilization of an emergency condition. Additionally, claims payment policies are reviewed to ensure that delegates are providing payment for emergency services. Delegates may review records and any other clinical information to determine emergency versus non-emergency condition as a condition of determining payment. These standards are audited during claims audits. The QI/UM Committee monitors appeal and grievance data to ensure issues involving inappropriate denial of emergency claims or inappropriate billing of members are addressed in a timely and complete manner to prevent future similar occurrences.

## ~~F.~~L. *Safety*

CalViva is committed to ongoing collaboration with network practitioners, providers and external agencies to build a safer health system. This is accomplished through quality initiatives that promote best practices, track outcomes, educate members, educate practitioners and providers, and ensure coordination of care. Measures to ensure that the goals of the member safety and quality data collection program are met include but are not limited to:

- Informing and educating health care professionals on safety issues
- Identifying and evaluating strategies for reducing errors and improving member safety
- Promoting the dissemination of effective strategies and best practices throughout the health care industry
- Making performance data publicly available for members and practitioners
- Current member safety activities include~~,~~ but are not limited to: Conducting PCP facility site/medical record reviews and physical accessibility reviews of PCP and other high~~-~~volume provider sites.
- Conducting a rigorous credentialing and recredentialing process to ensure only qualified practitioners and organizational providers provide care in the network.
- Monitoring quality of care indicators on a quarterly basis to identify patterns and/or trends
- Conducting pharmacy system edits to assist in avoiding medication errors.
- Working with contracted pharmacies to assure a system is in place for classifying drug-drug interactions and/or notifying dispensing providers of specific interactions when they meet CalViva's severity threshold.
- Monitoring narcotic prescribing carefully and ensuring a narcotic contract is in place for any member on narcotic medication in excess of DHCS determined or nationally recommended quantity limits
- Analysis of member quality of care complaints, potential quality of care, and provider preventable conditions cases to identify patterns and trends
- Care coordination for high risk patients
- Member education
- Assuring that affected members and providers are notified of FDA and voluntary drug safety alerts and recalls
- Nurse Advice and Triage Line available 24 hours a day, 7 days a week, every day of the year

Mechanisms for communication include:

- CalViva website
- Provider Updates
- Drug safety, refill history and dosage alerts
- Letters to individual practitioners, providers, or members
- Member and Provider Newsletters
- Regular provider and member communications
- Automated reminder calls to members
- Prior Authorization process for Pharmacy and Medical Services

## ~~G.~~M. Health Plan Performance

CalViva conducts ongoing monitoring of health plan performance by participating in annual HEDIS® measurement, member and practitioner satisfaction assessments, monitoring of appeals and grievances, and evaluating the accessibility and availability of medical services. CalViva's QI Program also has established metrics for key operational processes, such as Claims and Customer Service, and monitoring for service improvement opportunities.

CalViva adopts and maintains a broad range of key performance metrics to monitor clinical and service quality in Medical Management, Appeals & Grievances, Disease Management, Case Management, Concurrent Review and the Medical Review Unit. CalViva's QI Program also monitors key performance metrics for Pharmacy.

## ~~H.~~N. Satisfaction

QI activities focusing on access, availability, satisfaction, and service rely on multi-departmental involvement. Service activities involve CalViva and HNCS staff in the Health Care Services, Customer Contact Center, QI, Appeals & Grievances, Pharmacy, Claims, Credentialing, Provider Network Management, Delegation Oversight, and Marketing departments.

An important aspect of satisfaction and service to members is providing details of the benefit plan to prospective members and enrollees. Member materials are assessed to ensure that prospective member and enrollment information includes details on the benefit plan, how to obtain primary, specialty, and behavioral health care, how to voice complaints and appeals, and how to obtain information on translation and interpretative services. In addition, members receive various communications that highlight general medical information and other focused activities.

Information used to assess and monitor member satisfaction with service and clinical care include the following: CAHPS®, SWBHC (Satisfaction With Behavioral Health Care), grievance and appeal data, member call data, including reasons for transfers between practitioners or member disenrollment. Practitioners and providers are informed of the results of member satisfaction analyses and any opportunities for improvement that have been identified through Provider Updates and Committees with external participants. Opportunities for improvement are shared internally through quality committees.

# ~~I.~~O. *Access and Availability*

To ensure CalViva has a network that is sufficient and adequate to provide its members appropriate access to, and availability of, practitioners, providers, and health care services and to ensure CalViva's members have appropriate access to health care services within a reasonable period of time, CalViva has established access to care standards for medical services including primary, specialty, and behavioral health care appointment access, after-hours access and instruction, emergency care and telephone access; and standards for availability of practitioners, providers and health care facilities including primary care physicians, specialty care physicians, high volume specialty care physicians, hospitals, ERs, pharmacies, laboratory/radiology facilities, skilled nursing facilities, home health agencies and ambulatory clinics.

CalViva does not pressure providers or facilities to render care beyond the scope of their training or experience.

Access standards are communicated to network practitioners and providers via the online Provider Operations Manual, and Provider Updates.

CalViva measures, evaluates, and reports compliance with access and availability standards using the following methods:

- Member Satisfaction Surveys: HEDIS® CAHPS® and SWBHC (Satisfaction With Behavioral Health Care) Surveys.
- Provider After-Hours Access Survey (PAHAS) : Annual provider telephone survey assessing after- hours ER information and physician afterhours access.
- Provider Appointment Availability Survey(PAAS): Annual provider appointment survey to assess member access to care and service. Specific elements include preventive care, routine care, and urgent care for medical and behavioral care.
- Member Grievances: Grievance data related to access is tracked and trended to identify issues with access.
- Geo Access Analysis: Geographic distribution of PCPs, SCPs, high volume SCPs, hospitals, emergency services, ambulatory clinics and ancillary (laboratory, radiology, and pharmacy) providers.
- Hospital Bed Capacity: Ratio of members per hospital beds in the contracted hospital network.
- Ratio of Members to Practitioner/Provider: Assessment of the ratio of members to PCPs, SCPs, and high volume SCPs.
- Network Open Access Report: Presents the percentage of PCPs accepting new members by line of business.

Results are analyzed to identify opportunities for improvement through corrective actions. Plan-level results and applicable actions for improvement are communicated to the CalViva QI/UM Committee, Access Workgroup or appropriate CalViva or HNCS staff for review, recommendations and approval, and to practitioners and/or providers through the CalViva QI/UM Committee.

# ~~J.~~P. *Member Rights and Responsibilities*

CalViva has established a list of member rights and responsibilities that ensure members are treated with dignity and have full access to information about their care and benefits. These rights and responsibilities are reviewed and approved annually by the appropriate CalViva staff. Members are informed of their rights and responsibilities through the member Evidence of Coverage (EOC) and other member communications.

Member rights include, the right to:

- be treated with respect, dignity, and courtesy;
- privacy and confidentiality;
- receive information about your health plan, its services, its doctors and other providers;
- choose a Primary Care Physician and get an appointment within a reasonable time;
- participate in making decisions and have a candid discussion with practitioners regarding appropriate or medically necessary treatment options;
- decide in advance how you want to be cared for in case you have a life-threatening illness or injury;
- voice complaints or other feedback about the Plan or the care provided without fear of losing your benefits;
- appeal if you don't agree with a decision;
- request a State Fair Hearing;
- receive emergency or urgent services whenever and wherever you need it;
- services and information in your language;
- receive information about your rights and responsibilities; and
- make recommendations regarding the organization's members' rights and responsibilities policies.

Member responsibilities include:

- acting courteously and respectfully toward doctors and staff and being on time for visits;
- providing up-to-date, accurate and complete information;
- following the doctor's advice and participating in the treatment plan;
- using the Emergency Room only in an emergency; and
- reporting health care fraud or wrong doing.

CalViva has established policies that address member grievances and appeals. Grievances and appeals are resolved in a timely manner. Trends are monitored on a regular basis to assess opportunities to improve health plan processes.

## ~~K.~~Q. *Medical Records*

CalViva 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.

CalViva's 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.

CalViva monitors both medical record keeping and medical record systems to assess the quality of medical record documentation and compliance with standards through medical record audits as part of the Medi-Cal Managed Care Division Department of Healthcare Services PCP Full Scope Facility Site and Medical Record Review process.

At least annually, the PCP Facility Site and Medical Record Review results are analyzed and reported to the QI/UM Committee to identify opportunities for improvement. ~~and a~~Actions ~~is~~are taken when compliance issues are identified. Appropriate interventions are implemented based on compliance rates established for each standard. Interventions may include Corrective Action Plan, sending Provider Updates, revising the Provider Operations Manual, sending educational or reference materials to practitioners or providers, and creating template medical record forms. Follow up is conducted to evaluate the effectiveness of the corrective actions.

# ~~L.~~R. *Cultural and Linguistic Needs*

CalViva Health is contracted with Health Net Community Solutions (HNCS) to provide cultural and linguistic services and programs for the majority of CalViva Health's membership. CalViva Health ("CalViva" or "Plan") may also contract with other entities or health plans to provide or arrange cultural and linguistic services and programs for members enrolled with CalViva Health. CalViva Health, in collaboration with Health Net Community Solutions (HNCS), is committed to improving health outcomes by providing cultural and linguistic services and programs that facilitate effective communication between a diverse membership, provider networks, and CalViva Health and HNCS.

The C&L Services Department, on behalf of CalViva Health, provides resources, materials, trainings, and in-services on a wide range of C&L topics that impact health and health care. ~~Cultural competency training addresses members with limited English proficiency, diverse cultural and ethnic backgrounds and disabilities, including topics on gender, sexual orientation and gender identity.~~ The cultural competency training program covers non-discrimination based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. Services offered include cultural and language information for providers and their staff, as well as for Plan staff; trainings on language assistance requirements imposed by state and federal regulatory agencies; interpreter support for members and providers; culturally appropriate translation and review of member materials; and cultural responsiveness education. C&L also analyses the needs of its membership by reviewing various sources of ~~date~~data~~e~~~~date~~ which may include membership demographic data, call center data, appeals and grievance information, and geo-access analysis of provider network language capabilities.

To ensure compliance with applicable Medi-Cal contractual requirements, state and federal rules and regulations and other requirements of the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC), the C&L Services Department:

a) Develops and implements Policies and Procedures (P&Ps) related to the delivery of culturally and linguistically appropriate services
b) Utilizes and implement the Culturally and Linguistically Appropriate Services (CLAS) Standards developed by the Office of Minority Health, to address Health Care disparities
c) Collects and analyzes C&L information and requirements as identified by DMHC and DHCS and other regulatory or oversight entities
d) Collects, analyzes and reports membership language, race and ethnicity data in reports such as the ~~annual~~ Group Needs Assessment (GNA) ~~and annual GNA updates~~
e) Informs members of interpreter services via the member newsletter, the Member Handbook/Evidence of Coverage (EOC), and other communication sources at least once annually
f) Maintains information links with the community through Public Policy Committee (PPC) meetings, Group Needs Assessment (GNA) ~~and annual GNA updates,~~ and other methods
g) Informs contracted providers annually of the C&L services available via Provider Updates, online newsletter articles, the Provider Operations Manual, in-services, trainings, conferences, and other communication sources
h) Engage community-based organizations, coalitions, and collaborative in counties where CalViva Health members reside and be a resource for them on C&L issues
i) Participate actively and leverage resources from community and government committees including Health Industry Collaboration Effort (ICE), ~~Office of Patient Advocate (OPA),~~ America's Health Insurance Plans (AHIP), and California Association of Health Plans (CAHP)~~, and National Health Plan Collaborative (NHPC)~~
~~j)~~ Provide C&L services that support member satisfaction, retention, and growth

~~k)~~j)

Additionally, C&L performs the following activities to ensure staff and providers have C&L resources available to provide culturally competent services to CalViva Health members:

a) Provide C&L information and support for HNCS and CalViva Health staff in their efforts to provide excellent customer relations and services
b) Collaborate with other departments, where appropriate, to further the mutual attainment of culturally and linguistically appropriate healthcare services received by members, e.g. work with the Appeals and Grievance department on culture and language related grievances
c) Support efforts of contracted providers to deliver culturally and linguistically appropriate health care services by providing informative materials, cultural competency workshops, and in-services
d) Promote effective communication by staff and contracted providers with LEP members by providing them with easy access to culturally and linguistically appropriate materials, high quality translations of member-informing materials, high quality interpreter services, and culturally responsive staff and health care providers
e) Deliberately address health equity through collaborating to develop and implement an organizational and member level strategic plan to improve health disparities
f) Sustain efforts to address health literacy in support of CalViva Health members
g) Assess bilingual capabilities of bilingual staff and provide ongoing education and support
h) Increase cultural awareness of Plan staff through trainings, newsletter articles, annual "Heritage" events~~day~~, and other venues.

# *IV.*

# *QI Process*

# A. *Confidentiality / Conflict of Interest*

CalViva Health's Compliance Department is responsible to review, approve and disseminate confidentiality policies and practices regarding the collection, appropriate and legitimate use, storage and disclosure of medical information in order to protect the privacy and confidentiality rights of members, employees, providers and the company. CalViva Health's contracts require that providers and practitioners maintain the confidentiality of member's information and records. Information or copies or records may be released only to authorized individuals as permitted by state and federal law.

As a public entity, the Plan's QI/UM Committee is subject to the "open meeting" rules of the California Brown Act. Confidential matters presented to the Committee are discussed in a closed session, otherwise all other matters discussed at Committee meetings are open to the public and materials presented in the public portion of meetings are available to the public. Within CalViva's internal operations, QI activities that will not be presented in the public Committee meetings are conducted and discussed under a code of confidentiality. All documents~~document~~ created as part of the QI Program are maintained in accordance with federal and state law. Materials pertaining to confidential QI Review will be marked "confidential" and kept in a locked area. CalViva Health, its providers, vendors and contracted or delegated entities are responsible for safeguarding all confidential materials.

CalViva fully complies with the Health Insurance Portability and Accountability Act (HIPAA), which regulates the privacy of protected health information (PHI). CalViva strictly prohibits any unlawful and unauthorized access to, use or disclosure of member or provider information. Members are informed of these rights through the distribution of the Notice of Privacy Practices.

CalViva has policies and procedures for the collection, handling, storage and release of confidential information to protect the privacy and confidentiality rights of members, employees, providers and the company, and to ensure the appropriate and legitimate use of information. CalViva and HNCS contracts require that practitioners and providers maintain the confidentiality of member information and records. Information or copies of records may be released only to authorized individuals as permitted by state and federal law. Prior to participation in the QI Program or its non-public committees (Credentialing and Peer Review Sub-Committees), participants are educated regarding confidentiality requirements. The CalViva Chief Compliance Officer is responsible to review, approve and disseminate confidentiality policies and practices regarding the collection, use and disclosure of medical information.

**Conflict of Interest**
No person(s) will be assigned or selected for a QI Committee where a conflict of interest exists. Physician members will not review or participate in the review of their own care, referrals, or of other practitioners they are in direct competition with or are associated with through financial arrangements. All Peer Review case presentations are blinded as to member and practitioner identification prior to committee review.

# B. *QI Process*

CalViva's quality and performance improvement activities are implemented and documented in accordance with applicable state, federal, and accreditation regulations and standards. CalViva, in conjunction with HNCS, identifies opportunities for improvement through continuous monitoring of important aspects of care and service. CalViva's QI process includes the following:

- Establishment of quantitative and qualitative measures to assess performance and identify and prioritize areas for improvement
- Establishment of goals or benchmarks for each measure using nationally recognized, evidence-based standards of practice if applicable
- Identification of appropriate methodology to identify the targeted population or sample and ensure the validity and reliability of the collected data
- Performance of a quantitative and qualitative (identification of barriers) analysis of the data collected for each measure
- Identification of opportunities for improvement
- Implementation of appropriate interventions to improve practitioner, provider, and plan performance
- Measurement of the effectiveness of the interventions and corrective actions
- Quality of care problems or grievances are identified and can be submitted by the member, member's family, or provider on behalf of the member and can include problems or grievances about any type of medical or behavioral health service including, without limitation, care in a physician's office, clinic, hospital, ER, outpatient facility, home health agency, rehabilitation office, retail pharmacy, dialysis center, laboratory facility, hospice, imaging center. The full range of medical providers and their facilities under contract or providing medical care to CalViva members are included in and covered by the Appeal and Grievance process.

Areas for focused performance improvement are identified based on but not limited to the following:

- HEDIS®, CAHPS®, and SWBHC, rates, national and regional benchmarks and goals
- Local and state required improvement projects
- Concordance with plan initiatives (e.g., disease management programs)
- QI programs identified through community collaborative activities
- Patterns of inappropriate utilization
- Cultural or linguistic makeup of membership causing gaps in care
- Health Outcome disparities
- Appeals and grievance / customer service rates
- Member and provider survey results regarding satisfaction, access and availability, and coordination of care

Selection of topics takes into account:

- Relevance to the health plan population
- Prevalence of a condition among, or need for a specific service, by plan membership
- Demographic characteristics and health risks

Data collected to support the CalViva QI process include:

- Claims and encounter data
- Membership and Pharmacy data

- Reports of key indicators and sentinel events
- Demographic factors generally associated with risk such as age and sex or special health care needs status
- Cultural and linguistic makeup of membership
- Federal and state-reported quality and administrative data
- Clinical quality data collected by the plan, including recognized quality indicators such as HEDIS® and HEDIS®-like measures
- CAHPS® Survey
- SWBHC
- Medical Record Review
- Member & Practitioner Complaint & Inquiry Reports
- Appeals Reports

Information about CalViva's QI Program, including program description, activities and projects, and progress toward goals is available, upon request, to members and practitioners. CalViva notifies members of the availability of information about the QI program through regular member communications, committee meetings, and CalViva's website. Practitioners and providers are notified of the availability of information about the QI program via Provider Updates, committee meetings, new practitioner welcome letters, the Provider Operations Manual and CalViva's website.

# V.

# Program Structure and Resources

# A. *QI Committees*

## *Governing Body/RHA Commission*

The RHA Commission is the governing body with ultimate authority and responsibility for the oversight of the CalViva QI Program. The RHA Commission has delegated the authority and responsibility for development and implementation of the QI Program to the CalViva QI/UM Committee.
RHA Commission functions:

- Establish strategic direction for the QI/Utilization Management/Credentialing/ Peer Review Program
- Annually review and approve the QI Program Description, QI Workplan and QI Workplan Evaluation
- Review quarterly reports regarding the QI program, delineating actions taken and improvements made
- Ensure the QI Program and Work Plan are implemented effectively to provide improvements in care and service
- Provide feedback to the CalViva QI/UM Committee, as appropriate following each review
- Assess and recommend resources, as needed, to implement QI activities

## *CalViva Quality Committees: CalViva Quality Improvement/Utilization Management (QI/UM) Committee and its Peer Review and Credentialing Sub-Committees*

The CalViva QI/UM Committee meets at least quarterly and monitors the quality and safety of care and services rendered to CalViva members and maintain records of its quality improvement activities. Quality of care and service is defined as medical care and service which is accessible, meets CalViva standards of performance, is provided in the most timely and appropriate setting, and results in a high level of member satisfaction and improved health outcomes. This Committee identifies opportunities for improvement, recommends policy decisions, evaluates the results of QI activities, institutes needed actions, and ensures follow up as appropriate. The Committee also ensures practitioners participate in the planning, design, implementation and review of the CalViva QI Program. This Committee is accountable to and provides reporting to the RHA Commission on a quarterly basis. Membership of the CalViva QI/UM Committees includes practicing practitioners.

CalViva QI/UM Committee has the following subcommittees:

Credentialing and Peer Review Sub-Committees

## *Credentialing and Peer Review Sub-Committees*

The RHA Commission has final authority for the Credentialing and Peer Review Programs. The CMO receives recommendations regarding policies, processes and standards from the Credentialing and Peer Review Sub-Committees. The Chairperson of the Credentialing and Peer Review Sub-Committees is responsible for the Credentialing and Peer Review Sub-Committees operations, including, but not limited to, communicating committee decisions to network practitioners and providers, maintaining committee protocol, and signing and enacting credentialing and peer review policies. The CalViva QI/UM Committee, through annual approval of the Credentialing Program and quarterly reports supplied by the Credentialing and Peer Review Sub-Committees, provides program oversight.

The RHA Commission provides oversight of the QI/UM Committee and Credentialing and Peer Review Subcommittees, through annual approval of the Credentialing Program and quarterly reports supplied by the Credentialing and Peer Review Sub-Committees. The RHA Commission has final decision-making responsibility and authority to monitor, suspend, terminate or deny practitioners or organizational providers who have a direct contract with CalViva Health. CalViva retains the right to request in writing any modifications to a Health Net contracted participating providers' status in the CalViva network, including, without limitation, a request to terminate a participating provider's contract.

Furthermore, in the interest of protecting the safety and welfare of CalViva members, the Credentialing and Peer Review Sub-Committees also review summary reports of member Quality of Care (QOC) grievances and Potential Quality Issues (PQIs) cases that may be initiated by members, providers, CalViva or HNCS staff, or other sources. The Peer Review Sub-Committee may conduct an assessment of a practitioner's professional competence and conduct. If the Credentialing and Peer Review Sub-Committees decide to take disciplinary action against a practitioner that would be reportable to any outside agency, as a result of a practitioner's professional competence and/or conduct not meeting participation criteria or community care standards, all case materials are handled in accordance with CalViva Credentialing/Peer Review policies and procedures.

# B. *QI Workgroups*

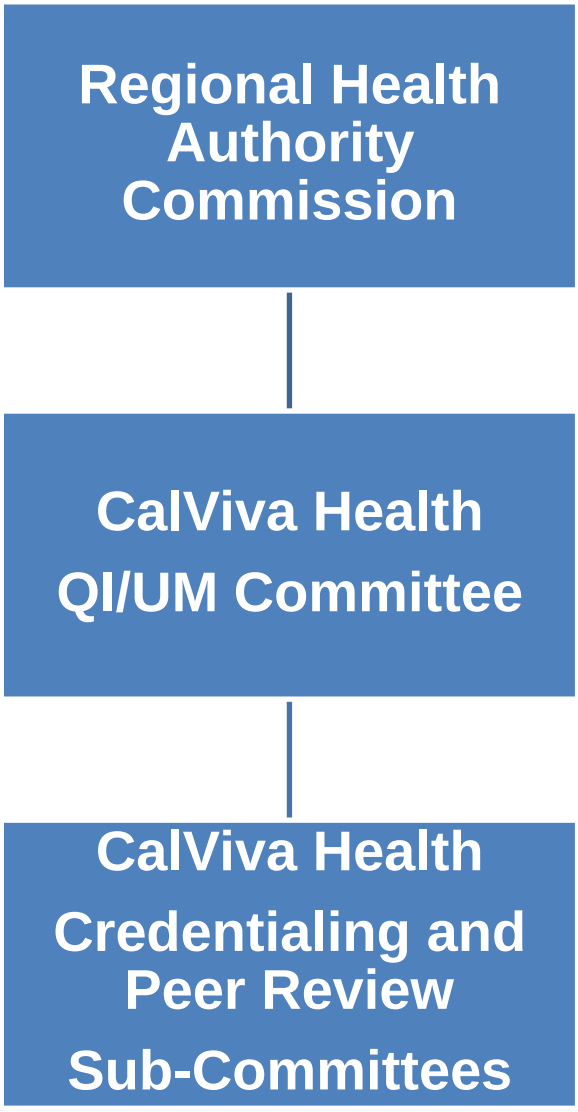
## *QI/UM Operational Workgroup*

The QI/UM Operational Workgroup is designed to monitor and evaluate the adequacy and appropriateness of health and QI/UM related services on a continuous and systematic basis. The Workgroup supports the identification and pursuit of opportunities to improve health outcomes, safety, access, services and member and provider satisfaction. The Workgroup consists of CalViva Health and Health Net Community Solutions core staff including CalViva Health's Chief Medical Officer, Director of Medical Management, Chief Compliance Officer, and ~~QI~~Medical Management ~~Analyst~~Specialist. Health Net Community Solutions staff includes designated Medical Directors, Quality Improvement staff, Utilization Management staff, Appeals and Grievance staff, Credentialing, Provider Network, and ad-hoc members pertinent to the report or discussion topic. The Workgroup process includes performance improvement review and discussion of monitoring activities, findings, barriers, and interventions to develop and implement actions. The QI Operational Workgroup meets weekly and reports significant findings and ensures follow up to the QI/UM Committee.

## *Access Workgroup*

The CalViva Access Workgroup brings together representatives from CalViva and HNCS multiple departments that have access and network adequacy related functions. The function of the workgroup is to review findings from ongoing monitoring of access to Health Plan services, identify gaps, and develop and evaluate implementation of activities in collaboration with HNCS representatives to improve access to care services. The Access Workgroup will report recommendations and findings to the QI/UM Workgroup.

***Committee Organizational Chart***


Regional Health Authority Commission
CalViva Health QI/UM Committee
CalViva Health Credentialing and Peer Review Sub-Committees

C.

# ~~D.~~ Staff Resources and Accountability

### CalViva Chief Medical Officer

The CalViva Chief Medical Officer's responsibilities include assuring that the QI and Utilization Management Programs are compatible and interface appropriately with the provider network, overseeing compliance with regulatory standards and reporting requirements; and achieving consistency in QI/Utilization Management operations. This position makes recommendations to the RHA Commission to initiate major program revisions and communicates the RHA Commission's directives to both internal and external stakeholders.

### Regional Medical Director

The Regional Medical Directors (RMDs), who are provided through HNCS, assist in the clinical focus of the QI, utilization and case management programs for CalViva's Medi-Cal members. The RMDs communicate with providers on a day-to-day basis to ensure the provider performance meets established CalViva, DHCS, DMHC, and NCQA standards. The RMDs will participate in DHCS clinical improvement workgroups and other CalViva QI activities, such as provider training, grievance and appeals review, and collaboration with network physicians and other providers to facilitate improved health outcomes for Medi-Cal members.

### Department Resources

- CalViva staff, with assistance from HNCS interdisciplinary staff, contributes to the success of the CalViva QI Program. These administrative and clinical staff works with CalViva's Chief Medical Officer to carry out QI activities for CalViva's Medi-Cal members and provider network. The resources and responsibilities of departments most involved in the QI process are described below.

### QI Team

The QI team will include a Chief Medical Officer, Director of Medical Management Services, who is a Registered Nurse, and a Medical Management Specialist~~-~~ to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. CalViva and HNCS will ensure that staff involved with the Quality Program are appropriately trained and experienced in Quality Improvement and Safety, Public Health, Health Administration, and Case Management.

### Facility Site Review (FSR)/ Medical Record Review (MRR)/ Physical Accessibility Review Survey (PARS)

CalViva delegates DHCS required PCP Facility Site and Medical Record Reviews and Physical Accessibility Review Surveys (PARS) to HNCS. Per Medi-Cal Managed Care Division (MMCD) Policy Letters ~~02-02~~14-004~~, and~~ 12-006 and APL 15-023, HNCS collaborates with other Medi-Cal Plans to develop and maintain a standardized system-wide process for conducting reviews of Primary Care Physician (PCP) facility sites and medical records. PARS are conducted for PCPs and high volume specialists (including behavioral health)~~,~~ ancillary providers, CBAS providers and hospitals. Collaboration with other Medi-Cal Plans minimizes FSR and PARS duplication and supports consolidation of FSR and PARS surveys. The FSR/PARS process uses evaluation criteria and guidelines in compliance with the DHCS contractual requirements and is applicable to all Health Plans participating in the MMCD process.

The FSR team will include a registered nurse who has oversight responsibility for the PCP facility and medical record audit processes. This oversight process involves conducting initial evaluation, conducting

annual review of activities, identifying areas for improvement, and collaboratively developing action plans to address areas of noncompliance. Results of the annual review are presented to the CalViva Chief Medical Officer and the CalViva QI/UM Committee.

### *Health Education*

CalViva and HNCS staff provide health education programs, materials, and services to CalViva members based on community health, cultural, and linguistic needs in order to encourage members to practice positive health and lifestyle behaviors, and to use appropriate preventive care and primary health care services. Health education services include individual, group and community-level education, and support community needs assessments and work plans based on the results of the assessments. Based on cultural and linguistic needs of the membership, CalViva, with HNCS's assistance, implements preventive care programs, such as weight management, tobacco cessation and prenatal/postpartum education, at varying intervention levels such as individual, group and community-level.

### *Pharmacy Services*

CalViva is responsible for managing the pharmaceutical benefits of CalViva. HNCS will assist CalViva in the establishment and maintenance of the CalViva drug formularies, the education and communication of formularies and non-formulary issues throughout the CalViva practitioners and pharmacy network. This includes the implementation of policies and procedures ensuring the safety, quality and appropriate use and delivery of drug products, as well as review of requests for pre-service, pre-authorized urgent and non-formulary drugs. Analysis includes drug utilization patterns, pharmacy service indicators and cost-effectiveness monitoring of the pharmaceutical care and services provided to CalViva members. Pharmaceutical services reports shall be made to the CalViva QI/UM Committee on a quarterly basis.

### *Grievances and Appeals*

CalViva will process, track and trend member grievances and appeals at the practitioner and plan level. CalViva identifies patterns and/or trends of potential risk exposures via the Potential Quality Incident Referral Form. CalViva staff will report to the CalViva QI/UM Committee and as indicated its Credentialing and Peer Review Sub-Committees to ensure and allow CalViva the ability to review, act, and follow-up on identified clinical and/or service events or trends that are significant at the practitioner or plan level.

### *Credentialing/Recredentialing*

CalViva delegates credentialing/recredentialing of practitioners and organizational providers to HNCS but retains oversight and ultimate authority for such function.

### *Utilization Management/Medical Management*

CalViva's Chief Medical Officer is ultimately responsible for the design, implementation and monitoring of the effectiveness of utilization and medical management programs. A systematic approach is used by CalViva, with the assistance of HNCS staff, to identify and manage members who are currently accessing inpatient or ambulatory health care services. HNCS Healthcare Services Department and medical management team partner with contracted practitioners and member/family and/or caregivers to monitor, to evaluate and to facilitate continuity and coordination of care among CalViva's members. Utilization/Medical Management staff interfaces with the QI staff in development, management and assessment of programs designed to improve the health of CalViva members. HNCS UM Department prepares and presents reports to the CalViva QI/UM committee at each meeting~~,~~ and presents a semi-annual and annual report on the UM Workplan. HNCS seeks input from the CalViva QI/UM committee and RHA Commission prior to preparing the annual Workplan.

### *Customer Contact Centers*

The Customer Contact Centers, operated by HNCS on CalViva's behalf, are responsible for addressing telephone inquiries from members and practitioners. Based on established criteria, the Customer Contact Center refers specific appeals and grievances and expedited requests to appropriate CalViva and HNCS staff for focused evaluation and follow-up for any quality of care or service issues. Quarterly reports of trended member/practitioner service-related issues are compiled and reviewed for action. The analysis of these reports comprises one of the data sources utilized by CalViva's Chief Medical Officer to directly identify and/or confirm opportunities for improvement.

### *Provider Network Management*

CalViva delegates provider network management to HNCS. HNCS Provider Network management staff initiates and directs efforts to recruit and expand hospital, practitioner and ancillary provider networks to serve CalViva Medi-Cal members. The Provider Network Management staff liaison also collaborates with the hospitals, practitioners and other providers for the resolution of contractual, operational, service and medical issues and conducts training sessions to provide contracted practitioners and providers with current CalViva policies and operational and product changes.

### *Delegation Oversight*

CalViva staff is responsible for the development, implementation and monitoring of the delegation program for functions (e.g. utilization management, credentialing, claims and claims administration, etc.) delegated to HNCS and other entities as specified in written agreements between CalViva and the entities. CalViva staff maintains responsibility for the implementation and monitoring of corrective action plans resulting from oversight recommendations.

### *HEDIS® Management and Clinical Reporting*

HNCS provides CalViva with the HEDIS® Management and Clinical Reporting Team which is responsible for HEDIS® and CAHPS® data collection and reporting. This team works collaboratively with CalViva staff to collect and report data.

# *VI. Program Evaluation and Work Plan*

## ~~A.~~B. Review and Oversight

The RHA Commission is responsible for QI and annually receives reviews and approves the CalViva QI Program Description, QI Work Plan and QI Program Evaluation. The CalViva QI/UM Committee submits regular reports to the Commission on quality findings related to monitoring and quality issues identified and activities initiated.

## ~~B.~~C. Annual QI Evaluation

The evaluation of the QI Program and Work Plan is based on the results of a systematic monitoring and assessment of QI efforts. It includes a summary of completed and ongoing QI activities, trending of measures to assess performance, analysis of the results of QI initiatives (including barriers), and evaluation of the overall effectiveness of the QI program, which is conducted during the year. The process identifies program strengths and limitations, improvement opportunities and unfinished business. The QI Evaluation assesses the adequacy of resource allocations needed to plan and implement the QI activities and programs for the upcoming year. The annual QI Program Evaluation and Work plan are reviewed and approved by CalViva QI/UM Committee during the first quarter each year.

## ~~C.~~D. Annual QI Work Plan

The work plan documents the annual QI initiatives and defines goals, objectives, specific actions, responsible parties and time frames targeted for completion or resolution of activities that address quality and safety of clinical care and quality of service. The work plan builds on the recommendations and findings of the previous year's program evaluation. The work plan allows integration of QI reporting and studies from various CalViva and HNCS departments, and includes the requirements for both internal and external reporting. The CalViva and HNCS staff, CalViva QI/UM Committee, and RHA Commission utilize the work plan as a tool for monitoring the effectiveness of the CalViva QI Program. The structure of the work plan outlines the steps necessary to complete the QI cycle: monitoring, planning, implementation, action, assessment and evaluation of outcomes. Each individual department or functional unit retains the responsibility for the implementation and evaluation of their specific activities. It is a dynamic document that CalViva with HNCS assistance updates regularly to reflect progress on QI activities throughout the year. The QI Work Plan documents the annual QI Program initiatives and delineates:

- Objectives, scope and population demographics
- Improvement activities planned for the year covering quality and safety of clinical care, quality of service, and members' experience.
- Timeframes within which each activity is to be achieved and/or reported
- Responsible department(s) and/or person(s) for each activity
- Goals and benchmarks for each activity
- Number of objectives met
- Number of activities met
- Planned monitoring of previously identified issues
- Barriers identified when goals are not achieved
- Follow-up action plan, including continuation status (close, continue, or continue with modifications)

~~The following CalViva and/or HNCS departments/functional units or staff contributes to the annual QI Program Work Plan:~~

~~QI~~
~~Credentialing/ Peer Review~~
~~Delegation Oversight~~
~~Health Education~~
~~Cultural and Linguistics Department~~
~~Grievances and Appeals~~
~~Healthcare Services~~
~~Pharmacy Services~~
~~Customer Contact Center (Member Services)~~
~~Provider Network Management~~
~~Medical Management~~
~~Case Management~~
~~Disease Management~~
~~Compliance Staff~~
~~Public Programs Department~~

# *VII. Approval*

# A. *Fresno-Kings-Madera Regional Health Authority Commission Approval*

The Fresno-Kings-Madera Regional Health Authority Commission has reviewed and approved this Program Description

David Hodge, MD, Fresno County
Regional Health Authority Commission Chairperson

Date

Patrick Marabella, MD, Chief Medical Officer
Chair, CalViva Health QI/UM Committee

Date