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**2009-2010**

**QUALITY ASSESSMENT AND  
IMPROVEMENT PROGRAM**

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## **ORGANIZATION**

### ***Background***

The Health Plan of San Mateo (HPSM) was created in the mid 1980s by a unique and dedicated coalition of local elected officials, hospitals, physicians, and community advocates. It is a County Organized Health System (COHS) authorized by state and federal law to administer Medi-Cal (Medicaid) benefits in San Mateo County. Because it is based within the community it serves, HPSM is especially sensitive to, and its operation reflects, the unique health care environment and needs of San Mateo County's Medi-Cal beneficiaries. In 2006, HPSM became a Medicare Special Needs Plan (SNP) called CareAdvantage, which allows HPSM to offer Medicare and Medi-Cal benefits under one umbrella to dual eligible individuals. HPSM's mission is to improve the health of our members through high quality and preventive care.

Since opening its doors in October 1987, HPSM has greatly improved access to healthcare for San Mateo County beneficiaries. At its inception, the organization's primary focus was to serve the health care needs of San Mateo County Medi-Cal beneficiaries including nearly all Medi-Cal eligible individuals in the county, with membership including people receiving Total Aid to Needy Families as well as older adults and disabled recipients.

Over the years, HPSM has added additional product lines in response to community needs. Healthy Families and Healthy Kids serve low income children. HealthWorx serves the County of San Mateo's low-income workers (in the In-Home Supportive Services program), and some cities' part-time workers. HPSM's CareAdvantage program serves dual eligible Medicare/Medi-Cal recipients in San Mateo County. It offers a network of doctors, specialists, hospitals, and pharmacies for these members. In 2008, HPSM became the third-party administrator for San Mateo County's Coverage Initiative program, "San Mateo Access to Care for Everyone" (San Mateo ACE), which serves a portion of the county's indigent population. This line of business further expanded on January 1, 2009 with the inclusion of San Mateo County's WELL program as the ACE/County component of the ACE program. With this expansion, HPSM is now the TPA for almost all indigent participants who receive county coverage. In 2009, with these programs, HPSM's membership/participant covered lives increased to almost 90,000.

By taking on these additional groups, including a Medicare program under a competitive, risk-based contract with the Centers for Medicare and Medicaid Services (CMS), HPSM has expanded and reaffirmed its commitment to providing health care to San Mateo County's most vulnerable residents. In 2010, HPSM's involvement in the care of its members will deepen further, as HPSM becomes responsible for the Long Term Care benefit of its Medi-Cal members.

### ***HPSM's Delivery System***

HPSM is able to fulfill its mission in San Mateo because of its successful partnership with its committed providers who serve as primary care case managers for their patients who are HPSM members. Members in all HPSM lines of business select or are assigned a primary care physician (PCP) and then can directly access a full range of primary care services. PCPs have case management responsibility for their caseloads. HPSM contracts with San Mateo based providers certified by Medi-Cal, in good standing with the state Medi-Cal program, and who meet HPSM's credentialing criteria. This policy has ensured that HPSM's provider network is a mix of public and private providers located throughout the county.

Contracting providers are part of the medical “mainstream” in the county. HPSM's provider network includes independent providers practicing as individuals, small and large group practices, an independent community clinic with two sites, and San Mateo Medical Center (SMMC), which operates multiple clinic sites. SMMC clinics are located in the northern, central, and southern parts of the county and therefore provide access throughout the county. “Other services” are delivered by non-physician providers such as podiatrists and chiropractors. Overall the network includes providers geographically located throughout the county.

### ***Contracted Provider Network Profile***

HPSM's network is made up of the following providers:

<b>Number of Providers</b>	<b>Type of Provider</b>
847	Primary care physicians (individuals, small and large group practices and San Mateo Medical Center clinics)
1,859	Referral (specialty) physicians in solo, group, clinic and university practices
9	Hospitals (contracted facilities in San Mateo, Santa Clara and San Francisco counties)
235	Pharmacies (independent pharmacies and chains with multiple locations)
459	Other services (non-physician providers)

### **San Mateo County Safety Net Clinics**

<b>Clinic</b>	<b>City</b>	<b>Location</b>
Fair Oaks Adult Clinic	Redwood City	South County
Sequoia Teen Wellness Center	Redwood City	South County
Fair Oaks Children's Clinic	Redwood City	South County
Daly City Clinic – Adult and Pediatric	Daly City	North County
Primary Care Clinic – Main Campus	San Mateo	Central County

Pediatric Clinic – Main Campus	San Mateo	Central County
Willow Clinic—Adult and Pediatric	Menlo Park	South County
Daly City Youth Health Center	Daly City	North County
Ravenswood Community Clinic	E. Palo Alto	South County
Belle Haven Clinic (part of Ravenswood)	Menlo Park	South County
South San Francisco Clinic—Adult and Pediatrics	SSF	North County

The following chart lists the hospitals in HPSM's network:

#### Hospital Providers and Access Location

Safety Net Hospitals		Location	Traditional Hospitals		Location
San Mateo Medical Center (SMMC)		San Mateo	Seton Medical Center		Daly City
St. Luke's Hospital		San Francisco	Peninsula Hospital		Burlingame
			Sequoia Hospital		Redwood City
<b>Children's Hospital</b>		<b>Location</b>	Chinese Hospital		San Francisco
Lucile Packard Children's Hospital		Palo Alto	California Pacific Medical Center (3 campuses - California, Davies, and Pacific)		San Francisco
			St. Mary's Hospital		San Francisco

#### Lines of Business

As of December 31, 2008, HPSM served 87,244 members/participants in six lines of business

##### 1. CareAdvantage

HPSM is a licensed Special Needs Plan (SNP) for dually eligible residents in San Mateo County under a contract with the Centers for Medicare and Medicaid Services (CMS). Under this program, dual eligible persons who elect HPSM receive all health care services within a contracted network of providers. As of December 31, 2009, HPSM served 7,817 CareAdvantage members.

##### 2. Healthy Families

In 1998, HPSM received a Knox-Keene license to serve children in Healthy Families, California's S-CHIP program. The Healthy Families program offers low cost insurance for children and teens up to age 19. It provides health, dental and vision coverage to children who meet the program rules, but do not qualify for no-cost Medi-Cal. HPSM is one of two plans currently participating in Healthy Families in San Mateo County. As of December 31, 2009 HPSM served approximately 6,046 children in Healthy Families.

### 3. HealthWorx

HealthWorx is a healthcare product offered to San Mateo County In-Home Supportive Services (IHSS) workers, sometimes known as "independent providers." San Mateo Extra Help employees and the City of San Mateo part-time workers. Coverage is for individuals only (no dependents). The product was licensed in 2001 and as of December 31, 2009 served approximately 1,028 workers.

### 4. Healthy Kids

In 2002, HPSM was licensed to provide low cost health benefits to children living in San Mateo County who are ineligible for full scope Medi-Cal or Healthy Families. This locally financed program has covered approximately 5,908 children as of Dec 31, 2009. Its aim is to provide insurance for all children living in homes with a family income of 400% or less of the federal poverty level. This was San Mateo County's first step at reducing the uninsured in our county. According to follow-up studies, it has reduced the number of uninsured children significantly since the program was initiated.

### 5. Medi-Cal

As of December 31, 2009, HPSM served approximately 53,700 Medi-Cal beneficiaries.

### 6. San Mateo Access to Care for Everyone (San Mateo ACE) Program

The San Mateo ACE Program was launched by the County of San Mateo in 2007, with HPSM as third party administrator. San Mateo ACE serves low-income adults who do not qualify for other public coverage programs and who meet certain eligibility requirements. As of December 31, 2009, San Mateo ACE served 20,200 participants.

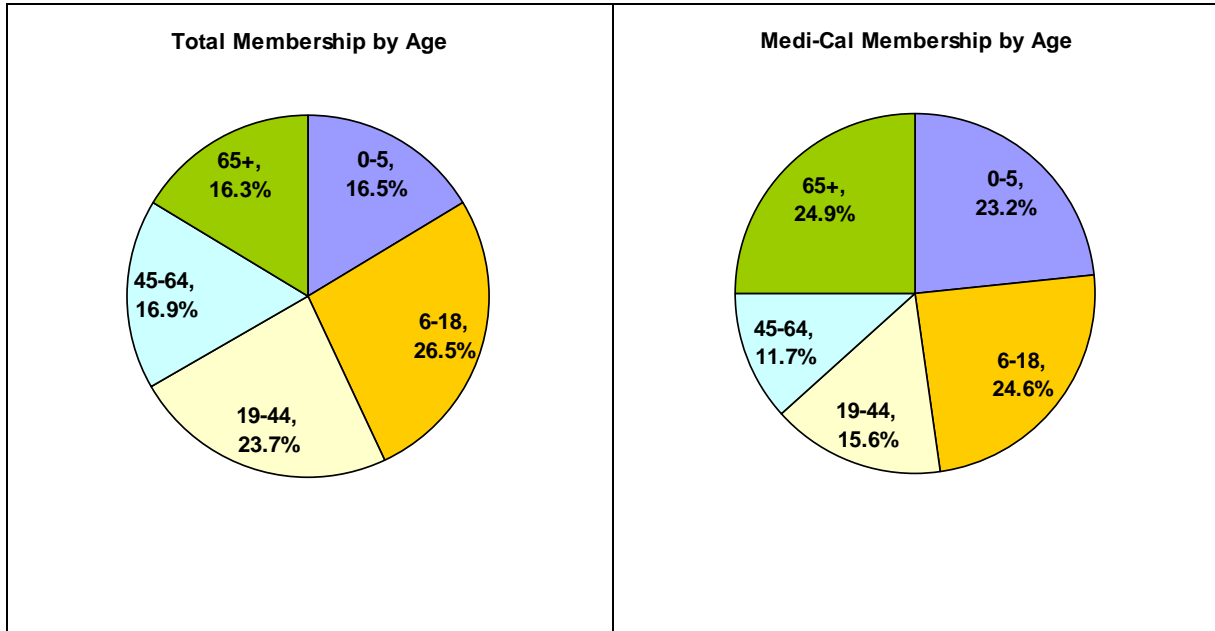
The following chart summarizes the membership in HPSM's current lines of business as of December 31, 2009:

<b>CareAdvantage</b>	<b>Medi-Cal</b>	<b>Healthy Families</b>	<b>HealthWorx</b>	<b>Healthy Kids</b>	<b>San Mateo ACE</b>	<b>Total Members</b>
7,817	46,245 excluding members also enrolled in CareAdvantage	6,046	1,028	5,908	20,200	87,244
<b>9.0%</b>	<b>53.0%</b>	<b>6.9%</b>	<b>1.2%</b>	<b>6.8%</b>	<b>23.1%</b>	<b>100.0%</b>

## Population Served

### Age

HPSM members are representative of all ages. The following charts describe HPSM's member population.



### Culture and Language

HPSM serves a culturally diverse population. The largest cultural designations for HPSM Medi-Cal members are Latino (44%), Asian/Pacific Islander (21%), Caucasian (18%), African American (7%), Alaskan/Native/American Indian (0.2%) and Other/Unknown (10%). English and Spanish are the most common languages spoken by HPSM Medi-Cal members. In Healthy Families and Healthy Kids 82% report their primary language as Spanish. Because of the high percentage of Spanish speaking members, all member materials are available in English and Spanish.

HPSM also serves a culturally diverse membership in CareAdvantage. For this reason, all CareAdvantage materials are available in the following 5 languages: English, Spanish, Tagalog, Russian and Chinese. HPSM providers meet the needs of this diverse population. Among the primary care providers in HPSM's network who supplied information on languages spoken by themselves or their staff, 80% employ staff able to communicate with members in a language other than English. Over 40% have internal Spanish-speaking staff and almost half have Tagalog-speaking capabilities. In addition, approximately one half employ staff who speak a language other than English, Spanish or Tagalog. Languages include French, Vietnamese, Russian, Cantonese, Mandarin, Farsi, Arabic, Greek, German and Italian. In addition, all providers have access to HPSM's Language Line service which offers interpreter services in 140 languages and is paid for by HPSM. Thus, it is free to all members and any provider seeing HPSM members who are Limited English Proficient (LEP).

## **Scope of Services**

HPSM provides a comprehensive scope of acute and preventive care services for San Mateo County's Medi-Cal, CareAdvantage, Healthy Families, Healthy Kids, HealthWorx and San Mateo ACE programs. Certain services are not covered by HPSM or may be provided by a different agency. These are as follows:

- Mental Health services are administered by the San Mateo County Behavioral Health and Recovery Services (BHRS) program, formerly County Mental Health for Medi-Cal, and are carved out of HPSM's Medi-Cal contract. HPSM contracts directly with BHRS for services for its other lines of business.
- Dental services are provided through California's Denti-Cal program for Medi-Cal members, and are carved out of HPSM's contract. Delta Dental contracts with HPSM to provide services for Healthy Families and Healthy Kids members. In addition CareAdvantage offers comprehensive dental services via Delta Dental for our members to address concerns by members that Denti-Cal services are not as accessible as desired. In addition, with the State's decision to eliminate optional coverage of dental services, and thus preventive dental care for adults with Medi-Cal, members with CareAdvantage expressed the importance of coverage for preventive dental care.
- California Children's Services (CCS) is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. For Medi-Cal members, CCS services are carved into the HPSM contract. Thus, CCS authorizes care and HPSM pays for the specific medical services and equipment provided by CCS-approved specialists. The program is funded with State, County and Federal tax monies, along with some fees paid by parents or guardians. Over 2009 and 2010, CCS and HPSM continue to work to integrate their activities to optimize care coordination for these special needs children.
- The Child Health and Disability Prevention (CHDP) program is managed at the County level. These services are carved out of HPSM's Medi-Cal contract. HPSM coordinates with San Mateo County's Department of Health to ensure that HPSM's Medi-Cal providers who serve our pediatric patients are CHDP providers or the equivalent thereof. It is anticipated that in 2010, these services will be carved into the HPSM Medi-Cal contract.
- Vaccines for Children (VFC) program is a federal program that provides vaccines for Medi-Cal members under age 19 via their primary care providers. Vaccines for members not eligible for VFC are covered by HPSM.

Health Plan of San Mateo works with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions receive additional services that enhance their medical benefits. These partnerships are established through special programs and specific Memoranda of Understanding (MOU) with certain community agencies including the San Mateo County Human Services Agency (HSA), California Children's Services (CCS), the Golden Gate Regional Center (GGRC), San Mateo County Health System and San Mateo Medical Center (SMMC).

## **Strategic Goals and Objectives**

HPSM's Quality Assessment and Improvement Program systematically manages the provision of and continuous improvement in the quality of care and services provided to HPSM members in support of our mission. This is accomplished through the development and implementation of comprehensive quality management systems that begin prospectively and extend across the continuum of care. The HPSM QAIP encompasses providers contracted with HPSM. Measures of quality of care and service include:

- Access to care
- Appropriateness of care
- Health outcomes
- Member and provider satisfaction

The strategic goal areas are incorporated throughout the organization. Performance towards goals is evaluated on an ongoing basis as determined by the target dates for completion of related initiatives. Annually an evaluation is conducted, and strategies for continuous improvement for the coming year are established. Our ultimate goal is to ensure all HPSM members receive high quality care and to help optimize their health status.

## **AUTHORITY, ACCOUNTABILITY AND RESPONSIBILITY**

The San Mateo Health Commission (SMHC) has ultimate accountability and responsibility for the quality of care and services provided to HPSM members. The responsibility to oversee the program is delegated by the SMHC to HPSM's Executive Director. The Commission holds the Executive Director and Medical Director accountable and responsible for the quality of care and services provided to members. The Executive Director and Medical Director ensure separation of medical services from fiscal and administrative management to assure that medical decisions will not be unduly influenced.

The Executive Director has organizational responsibility and accountability for the overall implementation of the Quality Assessment and Improvement Program and provides for adequate resources and staffing. HPSM's Senior Managers oversee and provide direction to HPSM's internal QAI activities and ensure that the QAI Program objectives are coordinated, integrated, and accomplished. In addition, the Executive Director allocates financial and employee resources to fulfill program objectives.

The Medical Director is the Executive Director's designee in the day-to-day implementation of the Quality Assessment and Improvement Program and is responsible for ensuring that the program is properly developed, implemented and coordinated. The Medical Director works in conjunction with the Executive Director to develop and implement quality studies, and follows up on identified quality of care issues. The Medical Director is assisted in these functions by the Associate Medical Director.

As part of the role in the day-to-day implementation of the Quality Assessment and Improvement Program, the Medical Director chairs the Quality Improvement Projects and Initiatives (QIPI) meeting that coordinates the program's Quality Studies. The Medical Director and quality team report activities and recommendations about QIPs to the Senior Managers monthly via the Quality Management Oversight Committee (QMOC). In addition to monthly updates on quality projects and initiatives, QMOC receives quarterly updates on grievance and appeals, provider-related issues (access, credentialing) and utilization management.

The Medical Director oversees credentialing/re-credentialing of providers, provider review issues, grievance and appeals issues that are clinical in nature, all clinical quality concerns, clinical practice guidelines, and issues regarding standards of practice. At least quarterly, reports on QAIP activities encompassing QMOC and external provider quality meetings are provided to the SMHC.

The Director of Planning and Evaluation (P and E) Services is responsible for the overall coordination of planning and evaluation services, including contract requirements and coordination of external quality review requirements. As part of this function, the Director ensures that HPSM meets the requirements set forth by the Department of Health Care Services (DHCS), Department of Health Care Services Medi-Cal Managed Care Division (DHCS/MMCD), Department of Managed Health Care (DMHC), Centers for Medicare and Medicaid Services (CMS), and the Managed Risk Medical Insurance Board (MRMIB). The compliance staff works in collaboration with the HPSM QAI Department and other functional areas, such as Utilization Management, Credentialing and Grievance and Appeals (which is part of P and E), to evaluate the results of performance audits and to determine the appropriate course of action to achieve desired results. In addition, this Director oversees the development and amendment of HPSM policies and procedures to ensure adherence to state and federal requirements and functions as HPSM's Compliance Officer. Lastly, functions relating to fraud investigations, referrals, and prevention are in the Planning and Evaluation Division.

## **QUALITY IMPROVEMENT PROGRAM PURPOSE**

The purpose of HPSM's Quality Improvement Program is to design and implement quality projects that improve the quality of care received by and the health status of all HPSM members. Through the QAIP, in collaboration with HPSM providers, HPSM strives to continuously improve the structure, processes, and outcomes of its health care delivery system.

HPSM's QAIP has a commitment to quality that relies on senior management oversight and accountability, and integrates the activities of all departments in meeting program goals and objectives. Thus, specific initiatives take into account the need to improve member access, assess member satisfaction, develop programs in response to member grievances, and so forth, incorporating the varied aspects of quality issues as part of quality improvement efforts.

HPSM's QAIP incorporates methodology that focuses on the specific needs of HPSM customers (members, providers, community agencies, regulators). It is organized to identify and analyze significant opportunities for improvement in care and service, to develop improvement strategies, and to systematically track whether these strategies result in progress towards established benchmarks or goals. Focused QAIP activities are carried out on an ongoing basis to ensure quality of care issues are identified and corrected. The plan-do-study-act model is used to ensure continuous quality improvement of quality initiatives (see "Methodology," below for further details.). Quality studies and monitoring activities are reported at least quarterly to the San Mateo Health Commission, and to the Department of Health Care Services (DHCS), per HPSM Contract 08-85213, Exhibit A, Attachment 4, Provision 4.

### **QAIP Goals and Objectives**

To monitor, evaluate and improve:

- The quality of clinical care and services provided by the health care delivery system in all settings.
- The important clinical and service issues facing the HPSM population relevant to its demographics, high-risks and disease profiles for both acute and chronic illnesses, and preventive care.
- The accessibility, availability and, where indicated, the timeliness of appropriate clinical care.
- The qualifications and practice patterns of all individual providers in the HPSM network to deliver quality care and service.
- The use of Clinical Practice Guidelines and evidence based medicine.
- Member and provider satisfaction.
- The effectiveness of aligning ongoing quality initiative and performance measurements with organizational strategic direction in support of HPSM's mission, vision and values.

To guide the development of an annual QAIP Work Plan that includes:

- Specific goals and objectives for the year.
- Priorities for QAIP activities based on the specific needs of the HPSM's population, and on areas identified as key opportunities for improvement.
- Specific action plans for QAIP activities that assign timeframes and staff accountability.
- A comprehensive annual evaluation and planning process that includes review and revision of the QAIP and applicable policies and procedures.

## **COMMITTEE AND KEY GROUP STRUCTURES**

### **Quality Reporting Structure**

The QAIP reports monthly to Senior Managers in the Quality Management Oversight Committee (QMOC) regarding the status of quality initiatives. In addition, the Physician Advisory Group (PAG) and the Quality Assessment Improvement Committee (QAIC) provide insight and recommendations about HPSM quality initiatives. Reports from all these activities are provided at least quarterly to the San Mateo Health Commission (SMHC), HPSM's governing body.

### **Committees**

#### *San Mateo Health Commission*

The San Mateo Health Commission (SMHC) meets monthly. Members are appointed by the San Mateo County Board of Supervisors. SMHC delegates management of the QAIP to HPSM's Executive Director, retaining overall authority and responsibility for program implementation, continuity and effectiveness. SMHC identifies opportunities to improve care and service and directs action to be taken when indicated by QAIP reports.

SMHC monitors Quality Assessment and Improvement actions (strategies, activities) outlined in HPSM's QAIP, Annual Report/Evaluation and Work Plan. SMHC receives quarterly reports about monitoring and evaluation activities performed as a result of the quality assessment and improvement program implementation that are presented for discussion.

#### *Quality Assessment and Improvement Committee*

The Quality Assessment and Improvement Committee (QAIC) meets quarterly as an advisory committee for HPSM. Committee membership includes a physician member of the SMHC, primary care physicians, specialists, a consumer representative, and a pharmacist.

QAIC reviews the quality assessment and improvement program/process to ensure that activities are consistent with the purposes of the program. The committee advises HPSM regarding guidelines for quality of medical care and services; and reviews activities, reports, and outcomes of QIP studies and initiatives. Through its review of the QAIP, the committee identifies and recommends additional opportunities to improve member care. This committee is responsible for evaluating the progress of initiatives at its quarterly meetings.

#### *Physician Advisory Group/Peer Review Committee*

The Physician Advisory Group (PAG) and Peer Review Committee (PRC) meet every other month to provide community physician insight for HPSM on developing and ongoing quality activities. Committee membership is reflective of the provider network and includes HPSM physicians, the majority of whom are primary care physicians from the adult and pediatric community (representing care of adults and children) and specialists representing different disciplines. Additional specialty membership is added as necessary for expert opinion.

The PAG evaluates the QAIP as it relates to providers. The committee reviews and advises HPSM clinical staff on practice guidelines (based on scientific evidence and quality indicators to monitor provider performance); and reviews department quality activities. While QAIC serves to provide more evaluatory and analytic feedback on QAI activities, PAG is HPSM’s provider “focus group.”

The PAG is also the PRC, which serves, at every meeting, to review current credentialing activities. The PRC members offer their external provider insight and knowledge about providers being considered for credentialing. They also serve to address complex or problematic practitioner credentialing and re-credentialing program activities and investigate specific case-based quality of care issues. Any sanctions or actions affecting individual providers are protected by Evidence Code 1157.

## **METHODOLOGY**

HPSM uses a variety of QAIP methodologies depending on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. The protocol follows the Model for Improvement and is structured to answer the following questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in an improvement?

The model has four steps: plan, do, study, and act.

- Plan 1) Identify opportunities for improvement  
2) Define baseline  
3) Describe root cause(s)  
4) Develop an action plan
- Do 5) Communicate change plan  
6) Implement change plan
- Study 7) Review and evaluate result of change  
8) Communicate progress
- Act 9) Reflect and act on findings  
10) Standardize process and celebrate success

Data Collection for QAIP includes:

Collect (Baseline Tracking Sheet/Survey)	→	Aggregate (Summary Sheet)	→	Calculate (Report form)
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## **Project Selection and Prioritization**

Improvements in work processes, quality of care and service are derived from all levels of the organization. Staff, administration and physicians provide vital information necessary to ensure continuous performance is occurring at all levels of the organization. Individuals and administrators initiate improvement projects within their area of authority which support the strategic goals of the organization. Other prioritization criteria include the expected impact on performance and the identification of items deemed to be a high risk, high volume or problem prone processes. Project coordination occurs through the leadership structures that include the San Mateo Health Commission, management, and quality committees, previously described, based upon the scope of work and impact of the effort. These improvement efforts are often cross functional and require dedicated resources to assist in data collection, analysis, and implementation. Outcomes are shared through communication that occurs within the previously described quality committees.

## **Key Business Processes/Functions/Important Aspects of Care and Service**

HPSM provides comprehensive acute and preventive care services based on the philosophy of a medical “home” for each member. The primary care provider is the medical “home” for members. The Institute of Medicine describes the concepts of primary care and community oriented primary care, which apply to the HPSM approach:

*Primary Care by definition is accessible, comprehensive, coordinated and continual care delivered by accountable providers of personal health services.*

*Community Oriented Primary Care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.*

The important aspects of care and service around which key business processes are designed include:

Clinical Care and Service:

- Patient-Centered Medical Home
  - Accessible
  - Family Centered
  - Continuous
  - Coordinated/Case Management
  - Compassionate
  - Culturally Effective
  
- Providing
  - Evidence based medical care
  - High quality care
  - Self management guidance
  - Preventive services (including Initial Health Risk Assessment, Initial Health Education and Behavioral Assessment)

- Safe, secure technology to promote access to personal health information
- Practice participation in quality assurance evaluations
- Patient Diagnosis, Care and Treatment of acute and chronic conditions
- Drug Utilization
- Patient Safety
- Health Education
- Over/Under Utilization
- Operational Aspects of Care and Service

Administrative Oversight:

- Delegation Oversight
- Member Rights and Responsibilities
- Organizational Ethics
- Effective Utilization of Resources
- Management of Information
- Financial Management
- Management of Human Resources
- Regulatory and Contract Compliance
- Customer Satisfaction
- Fraud and Abuse\* as it relates to quality of care
- HIPAA Privacy and Security

\*HPSM has adopted a zero tolerance policy for fraud and abuse as required by applicable laws and its regulatory contracts. The prevention and detection of fraud and abuse is a key function of the HPSM Compliance Program.

**Performance Measurement, Assessment and Evaluation Process**

Performance improvement and resource management reflect structural, process and outcome indicators as determined by an analysis of the important aspects of care and scope of services provided. Process and outcome indicators consist of numerators and denominators when it is appropriate. Each department creates its own indicators based on the mission and strategic goals or success factors. However, HPSM ensures inter and intra connectivity in the organization. Internally, departments monitor their activities and report to Senior Managers since each department’s activities and achievements are integrally linked to the other HPSM departments. Additionally, HPSM recognizes its dependence on our health care partners for the successful delivery of health care to a very vulnerable population in our community. A comprehensive work plan is developed annually and revised as needed.

As part of its overall performance improvement, in 2009, HPSM instituted a company “report card,” with various measures for each department to be followed and reported to the SMHC on a periodic basis. The quality measures are a few selected HEDIS measures.

The specific QAIP improvement process consists of identifying a population to be monitored, selecting a proper sample size, determining the frequency of monitoring,

defining responsibility for data collection and analysis, establishing a reporting schedule, and developing recommendations and a follow-up reporting mechanism.

Targets for compliance, goals, comparisons or benchmarks are established for the indicators. When appropriate, indicators will be analyzed using statistical process control to distinguish random variation from assignable or special cause in the performance. Performance targets are set by reviewing past performance, regulatory requirements, comparable benchmarks, best practices, public or national expectations or targets and clinical expertise. Contract-required HEDIS measurements and HPSM performance in relation to state and federal expectations guide HPSM in identifying areas in need of improvement. Goals are compared to current performance. Gaps are analyzed when performance goals are not met and priorities are set and action taken to close those gaps.

## **PEER REVIEW PROCESS**

Peer Review is coordinated through the QAI Department with oversight by the Medical Director. The HPSM Medical Director or Associate Medical Director reviews clinical quality of care cases, to determine if there is an opportunity to improve care and service. These cases usually come to HPSM's attention through the grievance process. Credentialing cases that have potential concerns are brought to the Medical Directors' attention through Provider Services. Significant cases from both areas are discussed with HPSM deputy county counsel, and then brought to the Peer Review Committee for review to determine the appropriate course of action. Results of peer review action are handled as appropriate, according to HPSM contracts, and state and federal regulations.

## **HPSM Practitioner Standards**

The San Mateo Health Commission has approved the following HPSM Practitioner Standards for practitioners furnishing services to HPSM members. These HPSM Practitioner Standards have been incorporated into the credentialing and peer review processes, and are consistent with the federal and state contracts held by HPSM.

- Valid state license to practice medicine or comparable (if not a physician)
- Current professional liability (malpractice) insurance or self-insurance (e.g. trust, escrow accounts, etc.) coverage in the minimum amounts of \$1 million per occurrence and \$3 million aggregate per year.
- Not currently excluded, suspended, or otherwise ineligible to participate in any State or Federal health care programs.
- Never been excluded from participation in Federal and/or State health care programs based on conduct that supports a mandatory exclusion under the Medicare program set forth in 42 U.S.C. § 1396a-7(a) as follows: (1) a conviction of a criminal offense related to the delivery of an item or service under Federal and/or State health care programs; (2) a felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service; (3) a felony conviction related to health care fraud

- No felony conviction in the seven (7) year period prior to the date of the questionnaire.

Practitioners must continue to meet all of the above HPSM practitioner standards during the term of their contract in order to be a provider of good standing for HPSM.

In addition, all HPSM practitioners must meet the following additional standards to become new practitioners credentialed by HPSM:

- Board certified in a nationally recognized specialty by the American Board of Medical Specialties, if a physician, or by their certification board as applicable if not a physician
- If applying to be a contracted primary care provider for children, must be CHDP certified or comparable, and must enroll in VFC

### **Conflict of Interest**

No physician or individual involved in quality assessment and improvement, resource management, or risk management may conduct peer review on any case in which he/she is professionally involved.

### **Peer Review Actions**

*Immediate actions:* Quality and risk management investigations of a serious event or trend with serious implication may call for immediate follow up actions. After consultation with HPSM's deputy county counsel, and review and recommendation by the PRC, the Medical Director collaborates with the Executive Director for immediate action.

*Education:* The ongoing performance assessment and improvement and risk management review process can suggest the need for in-service or continuing medical education. This is monitored through ongoing QAI review.

*Proctoring:* When the monitoring and evaluation results indicate a problem with a practitioner or allied health professional, the Medical Director or PRC may require the individual to be proctored for a specified period of time.

*Limitation/suspension/revocation of a practitioner's or allied health professional's ability to continue as an HPSM provider.* When education, proctoring, and other remedial efforts fail to correct a problem, termination of participation in the Health Plan of San Mateo program may be carried out in accordance with Health Plan of San Mateo's policies, procedures, contracts and applicable laws and regulations.

## **MEDICAL RECORD AND SITE REVIEW PROCESS**

Full scope site reviews are conducted triennially for primary care providers, including pediatricians, and obstetricians/gynecologists. These reviews are done as a requirement of participation in the California State Medi-Cal Managed Care Program, regardless of the status of other accreditation and/or certifications and to assure that providers are in compliance with applicable local, state, federal and HPSM standards. In addition, HPSM conducts provider site reviews for all new providers in all lines of business, including Medicare, as a pre-contractual requirement prior to initial credentialing.

Full scope reviews are conducted utilizing the criteria and guidelines of California Department of Health Services Medi-Cal Managed Care (MMCD Policy Letter 02-02 Dated May 16, 2002 or any superseding Policy Letter). HPSM may also address additional requirements as appropriate for quality studies. A full scope site review is not required automatically as a part of the re-credentialing process. A passing Site Review Survey shall be considered "current" if it is dated within the last 3 years, and need not be repeated until the due date of the next scheduled site review survey or when determined necessary through monitoring activities by the plan. Re-credentialing includes consideration of information from other sources pertinent to the credentialing process such as quality improvement studies and may include medical record reviews. The schedule for performing facility site review is determined by Quality Management staff and the prospective provider. It is based on the prospective credentialing date, as well as provider availability and preference. Site reviews for continuing providers are scheduled and performed within three years of the provider's last site review in compliance with criteria and guidelines of MMCD Policy Letter 02-02 - Site Review. Providers who move to a new site must undergo a full scope site review unless the site has been reviewed with a passing score within the last three (MMCD 02-02) years. The site review must be completed as soon as possible after the provider's move to the site or the provider's notice to HPSM (whichever is later), and not later than 30 calendar days after the date the new site was opened for business (or HPSM's notification date). The site review for relocated offices must also be completed prior to the provider's re-credentialing date. A minimum passing score of 80% on both the Site Review Survey and Medical Record Review Survey is required for a provider to continue as an HPSM provider in good standing. If problems are identified, a Corrective Action Plan (CAP) is requested that must be completed as part of compliance with a provider's HPSM contract.

HPSM reviews sites more frequently when determined necessary based on monitoring, evaluation or Corrective Action Plan (CAP) follow-up needs. Additional site reviews may be performed at the discretion of the Medical Director, using input from the Quality Site Review nurses, if patient safety or compliance with applicable standards is in question. The same audit criteria applicable for Initial Full Scope Site Reviews are applicable for subsequent site reviews.

Providers are required to correct deficiencies identified during the survey and submit a Corrective Action Plan (CAP) that is monitored by the QAI Nurses. Provider Review

issues are reviewed by the Medical Director and may be referred to the PRC for action or follow up.

## **PLAN OF ACTION TO IMPROVE CARE AND SERVICE**

HPSM is evaluated regularly by DHCS/MMCD, the DMHC, and CMS. HPSM views the State and Federal audits as opportunities to identify ways to improve care and services. Deficiencies identified are reviewed at the QIPI and Senior Management meetings. The team develops a corrective action plan to address deficiencies found during the audit.

In addition to using audits, HPSM uses information from reports, HEDIS Studies, Quality Improvement Projects, Grievances and Appeals data, and information from departments to identify opportunities for improvement in programs and services. If HPSM identifies an opportunity for improvement, appropriate action(s) are taken to correct the problem. These include:

- Development of cross-departmental teams utilizing continuous improvement tools to identify root causes, develop and implement solutions and to develop quality control mechanisms to maintain improvements.
- Referral of unresolved issues to the appropriate committee/department for evaluation and, if necessary, action.
- Intensified evaluation when a trigger for evaluation is attained or when further study needs to be designed to gather more specific data, i.e. when the current data is insufficient to fully define the problem.
- Changes in policies and procedures when evaluation indicates a problem can be corrected by changing a policy or procedure.

Provider issues and identified quality of care issues are referred to the Medical Director for review and direction. The issue may warrant discussion of the data/problem with the involved practitioner by the Medical Director or by the Peer Review Committee. This determines if follow up action has resolved the problem or if further observation of the performance via the appropriate clinical monitor is necessary.

### **Performance Improvement Evaluation Criteria for Effectiveness**

The effectiveness of actions taken and documentation of improvements made are reviewed through the monitoring and evaluation process. Additional analysis and action will be required when the desired state of performance is not achieved. Analysis will include use of the statistical control process, use of comparative data, and benchmarking when appropriate.

## **COMMUNICATION OF QAI ACTIVITIES**

Results of performance improvement activities are communicated to the appropriate department, multidisciplinary committee, or administrative team as determined by the nature of the issue. The QAIP reports this summarized information to the QMOC

monthly in order to facilitate communication along the reporting continuum. This information is also reported quarterly to the SMHC.

Communication of QAIP trends to Health Plan of San Mateo's contracted entities and providers is through the following:

- Provider participation in the SMHC committees, provider trainings, informal Medical Director meetings, provider bulletins, HPSM's web site [www.hpsm.org](http://www.hpsm.org), and other ad-hoc meetings.
- Minutes of all QAIP and SMHC Committee meetings are documented and produced within a reasonable time (usually one month or by the next committee meeting). These are provided to and reviewed by members at the next regular meeting.
- HPSM shares confidential information on an as needed basis with law enforcement or other governmental agencies to facilitate the investigation of potential fraud and abuse and promote prosecution for unlawful conduct and curb fraud.

### **Confidentiality Statement**

All records and proceedings of the any HPSM or SMHC committees related to member or provider specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58. This statute renders the records of such proceedings as non-discoverable pursuant to a public records request. All information is maintained in confidential files. Members of the above-outlined committees sign a "Confidentiality Agreement." This agreement requires members to maintain confidentiality of any and all information discussed during the meeting. The Executive Director, in accordance with applicable laws regarding confidentiality, issues any QAIP reports required by law or by the State Contract. Peer review activities are treated as confidential and privileged in accordance with the Health and Safety Code 1370 and Evidence Code 1157.

Confidential data that may be shared with government or law enforcement agencies on an as needed basis to promote prosecution for unlawful acts is protected as a joint effort to curb fraud through joint powers agreements. In addition, the Centers for Medicare and Medicaid Services have agreements with the U.S. Inspector General who utilizes the Federal Bureau of Investigation as the law enforcement arm. The California Bureau of Medi-Cal Fraud and Elder Abuse have agreements with the Attorney General in the Department of Justice.

### **ANNUAL QAIP WORK PLAN**

In the development of the annual QAI Program Work Plan, the following are included:

- Goals, scope projects or activities
- Quality interventions and timelines
- Planned evaluation of the QAI Program

### **Resources for the Program**

Health Plan of San Mateo's budgeting process includes personnel and other administrative costs projected for the QAI Program. The budget is revisited on a regular basis to ensure adequate support for Health Plan of San Mateo's QAI Program.

### **ANNUAL PROGRAM EVALUATION**

The objectives, scope, organization and effectiveness of HPSM's QAI Program are reviewed, evaluated, and approved by the QAIC and the SMHC at least annually. Results of the written annual evaluation are used as the basis for formulating the following year's QAI Work Plan. The evaluation includes:

- An assessment of the accomplishments from the previous year as well as identifying the barriers encountered in implementing the annual plan. Assessments are conducted to prepare for new interventions and areas are identified where improvements in care or service were achieved as a result of QAIP interventions; then activities are continued to sustain improvement.
- A summary of all quality indicators and reporting of significant findings to SMHC
- A review of the organizational resources involved in the QAI Program.
- Updated procedures according to contract guidelines.
- Recommended changes and goals that are identified are included in the revised QAI Program description for the following year.

The QAI Program Evaluation is included in a separate document that details the results of the 2009 QAI program efforts, and outlines plans for the 2010 QAI program.