Arizona Priority Care™

One Goal. One Priority. Your Healthcare.

QUALITY IMPROVEMENT PROGRAM

2019

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Chief Medical Officer
QI Committee Chair

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ARIZONA PRIORITY CARE STRUCTURE

Arizona Priority Care will have the Quality Improvement (QI) infrastructure necessary to improve the quality and the safety of clinical care and services we provide to our members.

Arizona Priority Care utilizes the IPA structure to deliver healthcare to our members. The IPA model is an organized system of independent physicians or an association of such physicians. Physicians in this model generally are paid on a modified fee-for-service or capitated basis.

MISSION STATEMENT

Our QI Department has a mission to provide an effective, system-wide, measurable plan for monitoring, evaluating and improving the quality of care and services, in a cost effective and efficient manner to our members and practitioners.

PURPOSE/PROGRAM DESCRIPTION

The QI Program is designed to objectively, systematically monitor and evaluate the quality, appropriateness and outcome of care/services delivered to members. Additionally the program will provide mechanisms that continuously pursue opportunities for improvement and problem resolution.

SCOPE OF PROGRAM

The scope of the QI Program is to monitor care, identify opportunities for improvement of care and services to both members and practitioners, and ensure services meet professionally recognized standards of practice. This is accomplished by assisting with the identification, investigation, implementation and evaluation of corrective actions that continuously improve and measure the quality of clinical and administrative service.

This QI Program covers both clinical and non-clinical care and services for Medicare Advantage (MA) and dual eligible populations.

PROGRAM GOALS AND OBJECTIVES

Goals

1. Ensuring ongoing communication and collaboration between the QI Department and other functional areas of the organization.
2. Ensuring members receive the highest quality of care and services by seeking out and identifying opportunities for improvement.
3. Ensuring members have full access to care and availability of primary care physicians and specialists.
4. Monitoring and evaluating the standards of healthcare practice through evidence-based clinical practice guidelines as the basis for clinical decision making.

5. Monitoring, improving and measuring member and practitioner experience with all aspects of the delivery system and network.
6. Utilizing a multi-disciplinary approach to assess, monitor and improve policies and procedures.
7. Promoting physician involvement in the QI Program and activities.
8. Collaborating with contracted hospital practitioners and health delivery organizations to ensure patient quality and safety of care services are provided.
9. Fostering a supportive environment to help practitioners and providers improve the safety of their practices.
10. Assessing and meeting the standards for the cultural and linguistic needs of members.
11. Meeting the changing standards of practice of the healthcare industry by adhering to all state and federal laws and regulations.
12. Adopting, implementing and supporting ongoing adherence with accreditation agency standards.
13. Promoting the benefits of a coordinated care delivery system.
14. Promoting preventive health services and care management of members with chronic conditions.
15. Emphasizing a caring professional relationship between the patient, practitioner and health plan.
16. Ensuring there is a separation between medical and financial decision making.
17. Seeking out and identifying opportunities to improve the quality of care and services provided to members.

Objectives

1. Ensuring that timely, quality, medically necessary and appropriate care and services that meet professionally recognized standards of practice are available to members by the identification, investigation and resolution of problems
2. Focusing on known or suspected issues that are revealed through monitoring, trending and measuring of specific clinical indicators
3. Preventive health services, access to services, and member experience through the use of a total QI philosophy.
4. Systematically collect, screen, identify, evaluate and measure information about the quality and appropriateness of clinical care and provide feedback to contracted IPA physicians and practitioners about their performance and how that affects the network-wide performance.
5. Maintaining a credentialed network based on a thorough review and evaluation of education, training, experience, sanction activity and performance of each healthcare provider.
6. Objectively and regularly evaluating professional practices and performance on a proactive, concurrent and retrospective basis through credentialing and peer review.
7. Ensuring members are afforded accessible healthcare by continually assessing the access to care and availability of network of practitioners and specialists.
8. Designing and developing data systems to support QI monitoring and measurement activities.
9. Assuring compliance with the requirements of regulatory and accrediting agencies including, but not limited to, CMS and NCQA.
10. Ensuring that at all times the QI structure, staff and processes are in compliance with all regulatory and oversight requirements.

11. Actively working to maintain standards for quality of care and accessibility of care and service.
12. Ensuring that mechanisms are in place to support and facilitate continuity of care within the healthcare network and to review the effectiveness of such mechanisms.
13. Identifying potential risk management issues.
14. Effectively interfacing with all interdisciplinary departments and practices for the coordination of QI activities.
15. Providing a confidential mechanism of documentation, communication and reporting of QI issues and activities to the QI Committee and other appropriate involved parties.
16. Assessing the effectiveness of the QI Program and making modifications and enhancements on an ongoing and annual basis.
17. Ensuring that Arizona Priority Care is meeting the members' cultural and linguistic needs at all points of contact.
18. Ensuring members have access to all available services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
19. Ensuring mechanisms are in place to identify, support and facilitate patient safety issues within the network and review the effectiveness of these mechanisms.

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

All QI activities, including correspondence, documentation and files, are protected by State Confidentiality Statutes, the Federal Medical Information Act SB 889 and the Health Information Portability and Accountability Act (HIPAA) for patients' confidentiality. All persons attending the QI Committee(s) or related sub-committee meetings will sign a confidentiality statement on an annual basis. All personnel are required to sign a confidentiality agreement upon employment. Only designated employees, by the nature of their position, will have access to member health information.

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

Arizona Priority Care ensures that all member care is consistent with professionally recognized standards of practice, is not withheld or delayed and all treatment decisions rendered by appropriate clinical staff are void of any influence or oversight by the finance department. Therefore:

1. We do not penalize practitioners or providers for discussing medically necessary or appropriate patient care regardless of the patient's benefits.

2. We do not pressure practitioners or providers to render care beyond the scope of their training or experience.
3. We do not exert economic pressure on institutional providers to grant privileges to healthcare providers that would not otherwise be granted.

PROGRAM STRUCTURE

Governing Body

Arizona Priority Care's governing body is the Executive Committee. Arizona Priority Care's QI Committee authority is granted by the Executive Committee. The QI Committee appoints the Chief Medical Officer (CMO) and Vice President Clinical Services to act as facilitators for all QI activities and they are the responsible entities for the oversight of the QI Program.

The Executive Committee directs the establishment of the QI Committee which will evaluate and monitor the quality of patient care and address support services concerns. The Chief Medical Officer and Vice President Clinical Services will report all QI activities to Executive Committee. The Executive Committee formally reviews and approves all QI reports on a semi-annual basis and directs operations on an ongoing basis.

The Executive Committee will ensure sufficient staff and resources to the QI Program to achieve its objectives. These resources will include staff, data sources, and analytical resources such as statistical expertise and programs.

Chief Medical Officer

The Chief Medical Officer is a physician who holds a current license to practice medicine with the Medical Board of Arizona. The Chief Medical Officer is the Executive Committee's designee responsible for implementation of QI Program activities. The Chief Medical Officer works in conjunction with the Medical Director and Clinical Services Directors to develop, implement, and evaluate the QI Program. The Chief Medical Officer is Chairperson of the QI Committee. Responsibilities include but not limited to:

1. Implementing the QI Plan and having substantial involvement in the assessment and improvement of QI activities.
2. Ensuring that medical decisions are rendered by qualified medical personnel, unhindered by fiscal or administrative management.
3. Ensuring that the medical care provided meets the community standards for acceptable medical care.
4. Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
5. Developing and implementing medical policies.
6. Actively participate in the leveling and resolution of grievance.
7. Providing support and clinical guidance to the program and to all physicians in the network.
8. Assuring compliance with the requirements of regulatory and accrediting agencies including, but not limited to, CMS, NCQA, and the contracted health plans.

9. Ensuring that the QI and Clinical Services Departments interface appropriately to maximize opportunities for QI activities.
10. Directing the implementation of the QI process.
11. Overseeing the formulation and modification of comprehensive policies and procedures that support the QI operations.
12. Analyzing QI data.
13. Reviewing pertinent clinical grievances and quality of care concerns, assigning severity levels, and directing corrective actions to be taken including peer review, if required.
14. Reviewing QI Program, Work Plan, Annual Evaluation and Semi-Annual Reports.
15. Directing credentialing activities.
16. Analysis of quality (HEDIS) studies.

Medical Director

AZPC shall employ, contract or designate a Medical Director who holds an Arizona unrestricted license to practice medicine issued pursuant to Arizona Revised Statute (ARS); 32-1421 – 32-1439.

The Medical Director is fully credentialed and serves as the designated physician who is involved in all aspects of QI Program development, evaluation, provides clinical oversight of all QI activities, supports the various committees, staff, resources, and makes recommendations based on clinical care and administrative data. The Medical Director shall be available for assistance with member QI procedures and processes, complaints, development of guidelines, recommendations on service and safety, provide QI statistical data, follow-up on identified issues, and attend the QI Committee Meeting quarterly, at a minimum.

The AZPC Medical Director will work in conjunction with the Director of Care Coordination, Director of Clinical Services Operations, and Director of Quality, Credentialing, and Compliance to develop implement .and evaluate all aspects of the QI Program. The Medical Director helps to plan, develop, organize, monitor, communicate, and recommend modifications to the QI Program and all QI policies and procedures. The Medical Director reports any areas of concern to the CMO and/ or the QI Committee. Responsibilities include but are not limited to:

1. Ensuring that medical decisions are reviewed by qualified personnel, unhindered by fiscal or administrative management.
2. Ensuring that the health care provided meets the community standards for acceptable medical care.
3. Ensuring that protocols are followed.
4. Actively participating in the functioning and resolution of the grievance procedures.
5. Providing support and clinical guidance to the program and to all physicians in the network.
6. Assuring compliance with the requirements of regulatory agencies and accrediting, including but not limited to CMS, NCQA and the contracted health plans.
7. Ensuring that the QI and UM Departments interface appropriately to maximize opportunities for QI activities.
8. Directing the implementation of the QI process.
9. Overseeing the formulation, modification, and implementation of comprehensive policies and procedures that support the QI operations.
10. Analyzing QI data.
11. Reviewing pertinent grievances, quality of care concerns, assigning severity levels, and

directing corrective actions to be taken including peer review, if required.
12. Overseeing Credentialing activities.
13. Assisting with the development, conduct, review and analysis of HEDIS studies

Director of Quality, Compliance, and Credentialing

The Director of Quality, Credentialing, and Compliance oversees the administrative day to day operations of the execution of QI activities and reports directly to the Medical Director. It is the Director's responsibility to interface with the behavioral health staff and/ or contracted providers on a day-to-day basis on QI processes and issues. Additional responsibilities include but not limited to:

1. Assisting the Medical Director and all Clinical Services Directors in developing and/or revising the QI Program Description, Policies and Procedures, Annual Evaluation and Work Plan and presenting them for review and approval.
2. Collecting information for quarterly QI activity progress reports.
3. Ensuring that quality trends and patterns are monitored, and that quality issues are identified.
4. Monitoring and reporting to the Medical Director the resolution of QI activities in accordance with the QI Program.
5. Interfacing with all internal departments to ensure compliance to the Quality Improvement Program and policies and procedures.
6. Acting as a liaison with network practitioners, providers, ancillary providers, facilities, health plans, and regulatory agencies regarding QI issues.
7. Monitoring and follow up with all applicable QI activities.
8. Ensuring that staff collects and monitors data and report identified trends to the CMO and QI Committee.
9. Assuring compliance with the requirements of regulatory and accreditation agencies, including but not limited to CMS, NCQA and contracted health plans.
10. Ensuring appropriate resources and materials are available and ordered to meet the department's needs.
11. Overseeing the QI staff ensuring compliance with company standards.
12. Maintaining a comprehensive grievance and appeals database to track pertinent case data that facilitates capturing, tracking, and trending of quality data.
13. Overseeing member clinical grievance case files and the process for the Chief Medical Officer and/or Medical Director designee.
14. Overseeing the preparation of peer review case files for the Chief Medical Officer's action, as needed.
15. Collecting, monitoring, and reporting data for tracking and trending.
16. Serving as a liaison with departments for investigation, collaboration, and resolution of all identified quality of care issues.
17. Overseeing the preparation of grievance, compliance, and quality reports for management, Executive Committee, and QI Committee meetings.
18. Monitoring network QI activities to ensure proper performance of QI functions in compliance with regulatory and health plan delegation requirements.
19. Oversee and participate with regulatory audit(s) preparation and coordination.
20. Reviews Quality Improvement Plans (QIP)/Corrective Action Plans (CAP) for appropriateness, as needed.
21. Provides guidance and assistance to department heads, organization staff and/or contractors in

the selection and application of continuous QI tools and data collection methodologies to achieve compliance.

22. Engages department heads and organization staff to assess compliance and identify opportunities for improving compliance.
23. Ensuring member and provider experience surveys are conducted annually.
24. Develops and oversees the Credentialing process

Director of Clinical Services Operations

1. Performing statistical analysis relevant to QI functions and goals.
2. Assisting the Medical Director and all Clinical Services Directors in developing and/or revising the QI Program Description, Policies and Procedures, Annual Evaluation and Work Plan and presenting them for review and approval.
3. Assuring compliance with the requirements of regulatory and accreditation agencies, including but not limited to CMS, NCQA and contracted health plans.
4. Interfacing with all internal departments to ensure compliance to the Quality Improvement Program and policies and procedures.
5. Serving as liaison with Regulatory Agencies for QI activities.
6. Assisting all Clinical Services Directors in monitoring and follow up with all applicable QI activities.
7. Tracking compliance with reporting requirements and provide reports for the QI Committee meetings.

Director of Care Coordination

1. Overseeing the facility site review activities, when applicable
2. Ensuring that focused reviews are conducted as identified.
3. Interfacing with the Chief Medical Officer and/or Medical Director designee for clinical quality of care and service issues.
4. Serving as a liaison with regard to member clinical grievance case files and collaborates with Designated Behavioral Health Practitioner and/or Medical Director.
5. Serving as liaison with CMS, health plans and other regulatory agencies for investigation, collaboration and resolution of clinical grievances.
6. Assisting the Medical Director and all Clinical Services Directors in developing and/or revising the QI Program Description, Policies and Procedures, Annual Evaluation and Work Plan and presenting them for review and approval.
7. Collecting, monitoring, and reporting data for tracking and trending.
8. Serving as a liaison with departments for investigation, collaboration, and resolution of all identified quality of care issues.
9. Identifying compliance problems, formulating recommendations for corrective action, and reviewing QI corrective action plans.
10. Collaborating with network provider offices and facility staff to identify and address quality of care issues, as needed.

QI Staff and Resources

The Quality Department has clinical and non-clinical staff to address all aspects of the department functions.

QUALITY IMPROVEMENT COMMITTEE

The QI Committee is a standing committee and is responsible for the development, oversight, guidance and coordination of all quality improvement activities. The QI Committee is designated and has been delegated the responsibility of providing an effective QI Program for members and providers. The QI Committee monitors provisions of care, identifies problems, recommends corrective actions and guides the education of practitioners to improve healthcare outcomes and quality of service.

Scope (includes, but not limited to):

1. Directing all QI activity.
2. Recommending policy decisions and revisions.
3. Reviewing, analyzing and evaluating QI activities
4. Ensuring practitioner participation in the QI Program through plan, design, implementation and review.
5. Reviewing and evaluating reports of QI activities and issues arising from its subcommittees (Credentialing Committee, for example).
6. Monitoring, evaluating and directing the overall compliance with the QI Program.
7. Annually reviewing and approving the QI Program, Work Plan and Annual Evaluation.
8. Keeping staff and providers informed regarding QI projects and performance measures and results, utilization data, and profiling results.
9. Assuring compliance with the requirements of regulatory and accreditation agencies including, but not limited to, CMS, NCQA, and contracted health plan policies.
10. Reviewing and approving QI policies and procedures, guidelines and protocols.
11. Developing and approving preventive health and clinical practice guidelines that are based on nationally developed and accepted criteria.
12. Developing relevant subcommittees for designated activities and overseeing the standing subcommittees' roles, structures, functions and frequency of meetings as described in this Program. Ad-hoc subcommittees may be developed for short-term projects.
13. Conducting peer review, assigning severity levels and making recommendations for corrective actions, as needed.
14. Reviewing network practitioners' and providers' availability and the number of credentialed, re-credentialed, and termed providers to adjust the network as needed based upon the findings.
15. Reviewing and evaluating reports regarding any/all critical incidents, reportable events and sentinel events.
16. Reviewing and evaluating reports submitted by each health plan.
17. Evaluating and giving recommendations concerning audit results, member experience surveys, practitioner experience surveys, access audits and any QI studies.
18. Evaluating and giving recommendations from monitoring and tracking reports.
19. Ensuring follow-up, as appropriate.

Reporting

The QI Department shall submit a summary report of quality activities and actions for review and approval to the QIC. Reporting is completed by QIC's approval during the semi-annual meeting.

Composition

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

1. Directing the QI Committee meetings.
2. Reporting QI Committee activities to the Executive Committee.
3. Acting on behalf of the committee for issues that arise between meetings.
4. Ensuring all appropriate QI activities and reports are presented to the committee.
5. Ensuring there is a separation between medical and financial decision making.

The Chief Medical Officer as the chairperson of the QI Committee may designate a designee only when unable to attend the meeting.

Membership

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

1. AZPC Medical Directors
2. Director of Quality, Credentialing, and Compliance
3. Director of Clinical Services Operations
4. Director of Care Coordination
5. Directors/Managers of Health Education
6. Director of Provider Relations
7. Director of Contracting/Network Strategy
8. Director of Customer Service
9. Behavioral Health Practitioners
10. Representation of contracted providers serving our members to include: Primary Care and Specialty Care Practitioners
11. Appropriate clinical representatives
12. Other members appointed at the discretion of the Chairperson

Committee members that are employees of Arizona Priority Care are permanent members unless reassigned or employment ends. Independent physicians are assigned on a bi-annual basis or as vacancies arise and are staggered to protect continuity of the committee functions by the Chief Medical Officer. Representatives of regulatory agencies and health plans may attend upon written request and chair approval.

Quorum and Voting

Only physician members are allowed to vote. A quorum consists of a minimum of three physicians. All approval of actions is made by a majority vote and/or motioned for approval by two voting physician members without challenge.

A committee member with a conflict of interest, which might impair objectivity in any review or decision process, shall not participate in any deliberation involving such issues and shall not cast a vote on any related issue.

Non-physician members of the QI Committee may not vote but shall attend the meetings and provide support to the deliberations. In the event that the QI Committee is unable to constitute a quorum for

voting purposes because of conflicts of interest, alternate committee member(s) will be selected as needed, at the discretion of the Chairperson. Representatives and other guests may attend the meetings upon invitation and prior approval.

Meetings

The QI Committee meets no less than semi-annually but can meet more frequently if circumstances require or to accomplish the committee's objectives. The Chief Medical Officer may act on the committee's behalf on issues that arise between meetings.

Confidentiality

All committee members and participants, including network practitioners, consultants and others, will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. The QI Committee must ensure that each of its members, or attending guests, are aware of the requirements related to confidentiality and conflicts of interest by having signed statements on file and/or QI Committee sign-in sheets with requirements noted on them.

Breach of confidentiality may result in disciplinary action, up to and including termination. Activities and minutes of the QI Committee are for the sole and confidential use of Arizona Priority Care and are protected by state and federal laws and the Healthcare Portability and Accountability Act (HIPAA).

Recording of Meeting and Dissemination of Action

All QI Committee minutes are contemporaneous, dated and signed and reflect all committee decisions made.

Meeting minutes and all documentation used by the QI Committee are the sole property of Arizona Priority Care and are strictly confidential. When deficiencies are noted, the QI Committee meeting minutes must clearly document discussions of the following:

1. Identified issues.
2. Responsible party for interventions or activities.
3. Proposed actions.
4. Evaluation of the actions taken.
5. Timelines including start and end dates.
6. Additional recommendations or acceptance of the results, as applicable.

For Each QI Committee meeting conducted:

1. A written agenda will be used for each meeting.
2. Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
3. The minutes are recorded in a nationally recommended format. All unresolved issues/action items are tracked in the minutes until resolved.
4. The minutes and all case related correspondence must be maintained in the Quality Department.
5. The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

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

1. Informal one-on-one meetings;
2. Formal medical educational meetings;
3. Arizona Priority Care newsletters;
4. Provider Relations and Physician Reports;
5. Semi-Annual Reports to the Executive Committee.

Credentialing Committee

The Credentialing Committee consists of physicians which are on AZPC's QI Committee panel as well as a minimum three (3) practitioners who are currently contracted with Arizona Priority Care. The Credentialing Committee**:**

1. Has final authority to approve or disapprove applications by providers for AZPC participation or delegate such authority to the senior clinical staff person for approving clean applications, provided that such designation is documented and provides reasonable guidelines.
2. Discusses whether organizational providers are meeting reasonable standards of care.
3. Accesses appropriate clinical peer input when discussing standards of care for a particular type of organizational provider.
4. Reviews files for organizational providers that do not meet the AZPC's established criteria.
5. Reviews files for state survey and licensing deficiencies of organizational providers.
6. Reviews files for reported potential quality of care issues, reportable events, sentinel events, critical incidents, complaints, and/or if the facility has been sanctioned by a regulatory agency.
7. Maintains minutes of all committee meetings and documents all actions.
8. Provides guidance to AZPC staff on the overall direction of the Credentialing Plan.
9. Evaluates and reports to AZPC management on the effectiveness of the plan.
10. Reviews and approves credentialing policies and procedures at least annually.
11. Meets as often as necessary to fulfill its responsibilities, but no less than semi-annually.
12. Has the authority to delegate authority to the senior clinical staff person, such as another medical director or other equally qualified provider for approving clean applications for continuing participation.

QI PROCESS

Arizona Priority Care utilizes a QI process to identify opportunities to improve both the quality of care and quality of service for all members. Arizona Priority Care adopts and maintains clinical guidelines, criteria, quality screens, audit tools and other standard surveys for which quality of care, access, and service can be measured.

Health Service Contracting

Arizona Priority Care contracts with individual practitioners and providers, including those making utilization management decisions, specifying that contractors cooperate with its QI Program to improve the quality of care and services and the members' experience. This shall include the collection and evaluation of data and participation in the QI Program.

*A practitioner is a **licensed or certified professional** who provides behavioral healthcare or medical care services.*
*A provider is an **institution or organization** that provides services for members, such as a hospital, residential treatment center, home health agency, or rehabilitation facility.*

Our contracts will foster open communication and cooperation with all QI activities. Our contracts with practitioners and providers will specifically require that:

1. Practitioners and providers cooperate with QI activities.
2. Practitioners and providers maintain the confidentiality of member information and records and shall keep member information confidential and secure.
3. Practitioners and providers allow the plan to use their performance data. This shall include allowing collection of performance measurement data, evaluation of the data and assisting the organization to improve clinical and service measures.
4. Practitioner and provider will provide access to medical records as permitted by State and federal law.
5. Practitioners and providers will give timely notification to members affected by their termination.
6. Practitioners and providers shall not discriminate against any beneficiary in the provision of contracted services whether on the basis of the beneficiary's coverage under a benefit program, age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, handicap, health status, source of payment, utilization of medical or mental health services, equipment, pharmaceuticals or supplies, or other unlawful basis including, without limitation, the filing by such beneficiary of any complaint, grievance or legal action against the provider or payer.

Contracts with practitioners and providers include an affirmative statement indicating that practitioners may freely communicate with patients about the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

Availability of Practitioners

In creating and developing the delivery system of practitioners, Arizona Priority Care takes into consideration special and cultural needs and preferences of members. AZPC will ensure the practitioner network has sufficient numbers and types of practitioners to effectively meet the needs and preferences of membership by:

1. Annually assessing the cultural, ethnic, racial and linguistic needs of members.
2. Annually assessing the number and geographic distribution of each type of practitioner providing primary care, specialty care, hospital based and ancillary practitioners to members.
3. Adjusting the availability of practitioners within the network based on the community served, the delivery system and considering clinical safety.
4. Linking members with practitioners who can meet members' cultural, racial, ethnic and linguistic needs and preferences.

Arizona Priority Care establishes availability of primary care, specialty care, hospital based and ancillary practitioners by:

1. Ensuring standards are in place to define practitioners who serve as primary care practitioners (pediatrics, family practice, general practice, internal medicine).
2. Ensuring standards are in place to define specialty care practitioners (obstetrics/gynecology, cardiologists, dermatologists, ophthalmologists, orthopedic surgeons, gastroenterologists).
3. Ensuring a database is in place which analyzes practitioner availability and ability to meet the special cultural needs of members.
4. Ensuring a database is in place which analyzes the geographic distribution of members to primary care, specialty care, hospital based and ancillary practitioners.
5. Assisting members with transportation as needed, as delegated or via the health plan.
6. Providing processes for member requests for special cultural and linguistic needs.

Access to Service

Arizona Priority Care has established standards and mechanisms to assure the accessibility of primary care, specialty care and member services. Standards include, but are not limited to:

1. Preventive care appointments
2. Regular and routine care appointments
3. Urgent care appointments
4. Emergency care
5. After-hours care
6. Telephone service

Arizona Priority Care's employed and contracted practitioners and providers shall comply with all state and federal accessibility guidelines. Annual access to care audits will be conducted using the standards to implement and measure improvements made in performance.

Member Experience Survey (Consumer Assessment Health Plan Service (CAHPS)

Medicare members are administered the CAHPS survey. Surveys are conducted to monitor members' experience with healthcare services, accessibility of care, continuity of care, quality of care and service, cultural and linguistic issues, and to identify and pursue opportunities to improve member experience and the processes which impact satisfaction. Surveys are conducted at least annually. Survey results are received from contracted plans or vendors. The results of the surveys are evaluated and improvement plans are developed to address problem areas identified. All available results are presented to the QI Committee for review and recommendations.

Member Experience Surveys – CCM and SNP Programs

Arizona Priority Care will obtain feedback from members by conducting focus member experience surveys and systematically analyzing the feedback we collect at least annually. The surveys may include information about the overall program, program staff, the usefulness of the information disseminated by the primary provider group, and the members' ability to adhere to recommendations. The feedback obtained will be specific to the CCM and SNP Programs, when delegated.

Arizona Priority Care will evaluate the results of the surveys received. Improvement plans will be developed to address areas identified. All results are presented to the QI Committee for recommendations and interventions.

Complex Care Management (CCM)

Arizona Priority Care coordinates services for members with complex conditions and helps them access needed resources. The program includes all information and interventions that the organization implements for a member or provider to improve healthcare delivery and management and promote quality, cost-effective outcomes.

Complex Care Management is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Members eligible for Complex Care Management may include those with physical or developmental disabilities, multiple chronic conditions or severe injuries.

Since complex management is considered an opt-out program, all eligible members have the right to participate or decline participation.

The goal of Complex Care Management is to help members regain optimum health or improved functional capability in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition, determination of available benefits and resources, and development and implementation of a patient centered care management plan with performance goals, monitoring and follow up.

Distinguishing factors of Complex Care Management

1. Degree and complexity of illness or condition is typically severe.
2. Level of management necessary is typically intensive.
3. Amount of resources required for member to regain optimal health or improved functionality is typically extensive.

Annually, Arizona Priority Care will conduct an assessment of the entire population. Based on the findings, the Complex Care Management process and resources will be reviewed and updated in order to effectively meet members' needs.

Special Needs Program (SNP)

The Special Needs Program (SNP) is a Medicare program that focuses on three populations: those with chronic conditions, those that are deemed institutional, and those that have Medicare and Medicaid dual benefits. The Care Management departments have written processes for the identification of enrollees with multiple or sufficiently severe chronic conditions and meet the criteria for participation in the program, when delegated by the health plan.

When delegated, all Special Needs Program members have an annual risk assessment completed where an individualized care plan for that member is generated and completed. The criteria are developed, reviewed and approved through the QI Committee. The Program details which chronic conditions are monitored, types of services offered and the types of measures that are used to assess performance.

Clinical Practice Guidelines

Arizona Priority Care is accountable for adopting and disseminating clinical practice guidelines relevant

to members for the provision of preventive, acute or chronic medical services.

Clinical practice guidelines are used to help practitioners and members make decisions about appropriate healthcare for specific clinical circumstances. AZPC will distribute guidelines to practitioners by posting them on their website or through the provider web portals. If changes or revisions are made, a notice will be sent to the practitioners by blast fax.

Arizona Priority Care adopts nationally recognized Clinical Practice Guidelines (CPGs) and includes professional medical associations, voluntary health organizations, and National Institutes of Health. If the guidelines are not from a recognized source, they are created with the involvement of a practitioner. Selected CPGs are taken through committees for discussion and recommendations. Evidence based CPGs for at least two medical conditions shall be adopted, e.g., diabetes, heart failure, COPD, Coronary Heart Disease. Evidence based CPGs for at least two behavioral health conditions shall be adopted.

We ensure all clinical practice guidelines are reviewed and approved through the QI Committee at least every two years and as needed if changes are made.

Preventive Health Guidelines

Arizona Priority Care will adopt and disseminate preventive health guidelines (PHGs) for our population.

These preventive health guidelines are approved, adopted and disseminated to practitioners in an effort to improve healthcare quality and reduce unnecessary variation in care. AZPC distributes guidelines to practitioners by posting them on the website. If changes or revisions are made, a notice will be sent to the practitioners by blast fax.

Arizona Priority Care adopts nationally recognized Preventive Health Guidelines (PHGs) from the U.S. Preventive Services Task Force for adults. Other guidelines from professional medical associations, voluntary health organizations and NIH Centers and institutes may be included. If the guidelines are not from a recognized source, they are created with the involvement of a board certified practitioner.

Selected PHGs are taken to the QI Committee for discussion and recommendations. The Preventive Health Guidelines are reviewed and approved by the QI Committee at least every two years and as needed if changes are made.

Continuity and Coordination of Care

Arizona Priority Care ensures the continuity and coordination of care that AZPC members receive. The member may select a Primary Care Provider (PCP) or the health plan may assign a PCP to the member with the primary responsibility for coordinating the member's overall healthcare. AZPC must:
Identify members with special healthcare needs.

1. Ensure an assessment by an appropriate healthcare professional of ongoing needs of each member identified as having special health care needs or conditions.
2. Identify medical procedures and/or behavioral health services to address and/or monitor the need or condition.
3. Ensure adequate care coordination among providers, as necessary.
4. Ensure a mechanism to allow direct access to a specialist as appropriate for the member's

condition and identified special healthcare needs.

We monitor and take action on an annual basis and as necessary to improve continuity and coordination of care across the healthcare network. AZPC measures and identifies opportunities to improve coordination of medical care though routine medical record review, potential quality of care review, grievances received from health plan and member experience surveys. This collaborative information is tracked and analyzed to identify opportunities for improvement. Actions and interventions are taken to improve members' experience and the coordination of their medical care in AZPC's delivery system.

Notification of Termination

Depending upon the delegated contract with the health plan, Arizona Priority Care may notify members affected by the termination of a practitioner or practice groups in general medicine, family practice, internal medicine, or pediatrics at least sixty days (60 days) for MA plans prior to the effective termination date and help them select a new practitioner.

Notification must be in writing and may be distributed via the internet. Written notification about the availability of information on the website and on paper must be mailed to members and a printed copy of the information must be made available upon request. All communication must include the following information:

1. The practitioner's name and the effective termination date.
2. Procedures for selecting another practitioner.

AZPC is not responsible for notifying members of practitioner relocations or office closures as long as the practitioner remains available to members as part of the organization's network. If a practitioner notifies AZPC of termination less than 30 calendar days prior to the effective date, AZPC should notify the affected members as soon as possible but no later than 30 calendar days after receipt of the notification.

Continued Access to Practitioners

If a practitioner's contract is discontinued, Arizona Priority Care's policy specifies circumstances in which affected members may continue access to the practitioner and duration of continued care. Arizona Priority Care will help a member transition to other care, if necessary, when their benefits end or during transition from pediatric care to adult care.

Potential Quality Issues (PQI)

A component of the QI Program is the identification and review of potential quality issues and the implementation of appropriate corrective actions to address confirmed quality of care issues. A PQI is a deviation or suspected deviation from expected practitioner performance, clinical care or outcome of care that cannot be determined to be justified without additional review. Such issues must be referred to the QI Department.

Peer Review

1. Peer review is conducted in any situation where peers are needed to assess the appropriateness or necessity of a particular course of treatment, to review or monitor a pattern of care provided by a specific practitioner or to review aspects of care, behavior or practice, as may be deemed

inappropriate.

2. The Chief Medical Officer or Arizona Priority Care Medical Director (or designee) is responsible for authorizing the referral of cases for peer review.
3. All peer review consultants (including members of the Credentialing/Peer Review or ad-hoc Peer Review Committees) are duly licensed professionals in active practice.
4. At least one consultant will be a practitioner with the same or similar specialty training as the practitioner whose care is being reviewed, except in those cases where there is no applicable board certification for the specialty.
5. The Chief Medical Officer can send cases out for a specialty review and consultation to be used for the peer review process.
6. The Chief Medical Officer will confirm that the peer review consultants have the necessary experience and qualifications for the review at hand.
7. The QI Director prepares all materials for review by the Peer Review Committee to conduct all follow ups as required by the committee.

CLINICAL MEASUREMENT ACTIVITIES AND QUALITY PERFORMANCE REPORTING

Arizona Priority Care adheres to all regulatory standards in accordance with Title 42 CFR Part 422, Subpart D, and Social Security Act for quality performance reporting. Arizona Priority Care will cooperate and assist regulators and their contracted QI Organizations (QIO). Arizona Priority Care uses data collection and analysis to track clinical issues that are relevant to the population. Arizona Priority Care will adopt and establish quantitative measures to assess performance and to identify and prioritize as appropriate.

Health Plan Effectiveness Data and Information Set (HEDIS®) and Structure and Process Measures

Arizona Priority Care actively takes part in annual Health Plan Effectiveness Data and Information Set (HEDIS) and Structure and Process measures. HEDIS Studies and Structure and Process measures are conducted for all lines of business with 30 or more members and are in accordance with CMS and NCQA standards.

Arizona Priority Care facilitates collection of HEDIS measure data through multiple sources:

1. Claims and encounter data.
2. Proactive medical record review.
3. Complex Care Management and Special Needs Programs.
4. Proactive measure review.
5. Specialized software program that runs each measure proactively every month during the measurement year.
6. Member listings of services that have not been captured are provided to primary care practitioners at a minimum of every six months.
7. Annual education and training of practitioners and their office staff by physician champions.
8. HEDIS coordinators contact primary care practitioners' offices at a minimum of every six months to discuss the importance of these services.

HEDIS measure outcome data is compared to national benchmarks (or if a benchmark is not available, a goal is established) and final rates are reported through the QI Committee. All measures that do not meet minimum performance levels (25th percentile of the national rate or not meeting goal) or have a significant drop in rate will have a formal corrective action plan developed. A written plan will detail specific actions or processes aimed at improving rates.

Center for Medicaid and Medicare Services 5 Star Program

The Center for Medicaid and Medicare Services 5 Star Program has the responsibility of reaching out to practitioners and their office staff and providing them with intensive education and incentives. In addition, practitioners can obtain the program tools/information via Arizona Priority Care's provider web portal. The CMS Star Program was implemented to make changes at the "point of care" and ensure members received required annual services and that the appropriate use of diagnosis codes are captured.

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

As part of the Quality Outreach Program, staff will routinely visit the office site offering intensive education on the following:

1. Electronic system orientation and training.
2. Healthcare Effectiveness Data and Information Set (HEDIS) and CMS Stars.
3. Improving documentation practices.
4. Providing tools that focus the practitioner's office on specific members requiring services and the use of CMS Star and HEDIS specific encounter forms.
5. Suggestions and assistance in the development of office processes that limit the possibility of these services being missed.
6. Identify opportunities to limit barriers between the physician and the health plan.
7. Collaborate on the collection of important diagnosis and service information to limit the intrusion on the physician office.
8. Inform the physician that staff is the resource to get questions answered and issues resolved quickly.
9. Work toward improvement in access to care for members.
10. Offer practice management suggestion that would limit barriers to care.
11. Look for opportunities to free up physician time so additional time can be spent with the patient.
12. Provide in-service reminders that will be placed on the member's medical record (i.e., on the next visit this member needs a mammogram and colorectal cancer screening completed).
13. Educate the provider's office on submission of Medicare diagnosis codes through the encounter/claims systems by utilizing an incentive program.
14. Identify Medicare members who have not been seen or have gaps in care (i.e., facilitate scheduling members to be seen soon).
15. In-service practitioner and staff on how they can increase revenue through the improvement of

documentation and data submission.

16. In-service on how to complete a Risk Assessment of the new Medicare members within ninety (90) days of enrollment, including scheduling the member to be seen by the physician for the incentive.

OTHER ACTIVITIES

Corrective Action Plans

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

1. Member/practitioner experience surveys
2. Potential or actual quality of care issues
3. Grievances received from health plan

Arizona Priority Care conducts other quality improvement studies deemed necessary to ensure quality of service to members.

DISSEMINATION OF INFORMATION

All QI activities are presented and reviewed by the QI Committee. Communication to the QI Committee may include, but is not limited to:

1. Policies and Procedures
2. Medical record and facility audit reports and trends
3. Member/practitioner satisfaction survey results
4. Special study outcomes
5. Other QI activities
6. QI Program, Work Plan, Annual Evaluation and Semi-Annual Reports
7. New or changed regulatory and legislative information

Results of quality improvement activities are communicated to practitioners in the most appropriate manner including, but not limited to:

1. Correspondence with the practitioner showing individual results and a comparison to the group, when available.
2. Newsletter articles
3. Fax updates
4. Email updates
5. Provider Manual updates

The QI Program description is made available to all practitioners and members. Practitioners and members are notified of the availability of the QI Program through the website, Provider Manual and newsletters.

EFFECTIVENESS OF THE QI PROGRAM

QI Work Plans

A QI Work Plan is developed annually, outlining QI activities for the year. The Work Plans will include all activities and tasks for both clinical care and monitoring of access and availability of covered services. The Work Plans are reviewed by the Chief Medical Officer and submitted to the QI Committee and Executive Committee for review and comment.

The work plan must include the following information:

1. A description of all planned activities.
2. Beginning and ending dates for all objectives.
3. Methodologies to accomplish measureable goals and objectives.
4. Staff positions/department responsible and accountable for the meeting established goals and objectives.

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

Semi-Annual Reports

Semi-Annual reports are an evaluation of the progress of the QI activities, as outlined in the Work Plan, and are submitted to the QI Committee and Executive Committee for review and recommendations.

Annual Plan Evaluation

QI activities, as defined by the QI Work Plan, will be evaluated annually to measure performance for the year and to assist in revising the QI Program and preparing the following year's Work Plan. The evaluations are reviewed by the Chief Medical Officer and submitted to the QI Committee and Executive Committee for review and approval.

Should Arizona Priority Care contract with more than one line of business, AZPC will maintain and report separately by line of business.

RESOURCES, QI PERSONNEL AND INTERDEPARTMENTAL INTERFACE

Clinical Services Department

The Clinical Services Department frequently identifies potential risk management and quality of care issues and health education needs through care management, inpatient review, utilization review, referrals, etc. The QI Department can refer cases to the Clinical Services Department for active care management of members with identified chronic conditions.

Customer Services Department

When a Customer Service Representative identifies a potential quality of care issue or grievance from a member's call, the member is informed of their right to file a grievance and is provided assistance with initiating contact with the respective health plan. The issue is then forwarded to the QI Department for

tracking. The Customer Service Department and QI Department records all incoming calls by specific indicators for tracking, trending and reporting.

Credentialing Department

QI information is provided to the Credentialing Department for inclusion in the credentialing/re-credentialing process. The QI Department provides the Credentialing Department with facility site review and medical record audit scores and any sanction activity related to those reviews and with identified issues, as appropriate.

Provider Relations and Contracting Department

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

1. Serves as a liaison between the QI Department and practitioners to facilitate education and compliance with approved Arizona Priority Care standards.
2. Assists the QI Department with practitioners who do not comply with requests from the QI Department.
3. Ensures contracted ancillary providers and facilities meet regulatory and accreditation requirements.

Claims Department

The QI Department utilizes claims data to identify potential quality of care issues, to include critical incidents, reportable events and sentinel event diagnosis. The QI Department is able to obtain certain medical records from the Claims Department as available.

DELEGATION OF QI

Arizona Priority Care does not delegate QI activities. For any delegated activity from the health plan, there shall be a signed and dated agreement:

1. Stating that it is mutually agreed upon;
2. Describing the delegated activities and the responsibilities of the health plan and Arizona Priority Care;
3. Requiring at least semi-annual reporting by Arizona Priority Care;
4. Describing the process by which the health plan will evaluate Arizona Priority Care's performance;
5. Describing the remedies available to the health plan if Arizona Priority Care does not fulfill their obligations up to and including revocation of the delegation agreement.