Arizona Priority Care™

One Goal. One Priority. Your Healthcare.

2024 Quality Program Description

AZPC Quality Improvement Committee Approved – May 2024

ARIZONA PRIORITY CARE STRUCTURE

Arizona Priority Care ('AZPC') 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.

In addition, AZPC utilizes a Medicare Accountable Care Organization – Realizing Equity, Access, and Community Health (REACH ACO). This QI Program and Workplan is applicable to the REACH ACO in as far as the care delivery model extends.

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. In addition, the QI 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 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 AZPC QI Department and the other areas of the organization, including, but not limited to: Customer Service, Care Management, and Behavioral Health providers and staff.
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. Adhering to the highest standards of healthcare practice through evidence-based Clinical Practice Guidelines ('CPG') as the basis for clinical decision-making.
5. Monitoring, improving and measuring member and practitioner experience with all aspects of the local 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. Monitoring our compliance to regulatory agency and health plan standards through annual oversight audits and survey activities
13. Adopting, implementing and supporting ongoing adherence with accreditation agency standards.
14. Promoting the benefits of a coordinated care delivery system.
15. Promoting preventive health services and care management of members with chronic conditions.
16. Emphasizing a caring professional relationship between the patient, practitioner and health plan.
17. Ensuring there is a separation between medical and financial decision-making.
18. Seeking out and identifying opportunities to improve the quality of care and services provided to members and providers.

Objectives:

1. Maintaining a credentialed network based on a thorough review and evaluation of education, training, experience, sanction activity and performance of each healthcare provider
2. Ensuring members are afforded accessible healthcare by continually assessing the access to care and availability of network of practitioners and specialists.
    a. AZPC is required to meet network adequacy standards established by Federal and State agencies as well as accreditation organizations such as the National Committee on Quality Assurance ('NCQA').
    b. Network adequacy standards are intended to ensure that provider networks offer consumers access to sufficient numbers and types of providers.
3. Assuring compliance with the requirements of regulatory and accrediting agencies including, but not limited to, CMS and NCQA as demonstrated with any and all auditing activity
4. Ensuring that at all times the QI structure, staff and processes are in compliance with all regulatory and oversight requirements by passing all audits and submitting required reports in a timely manner.
5. Actively working to maintain standards for quality of care and accessibility of care and service by ensuring that office telephone answer times and total office wait times are within required standards and validated annually through random sampling
6. Ensure physician compliance with AZPC requirements by requiring regular and scheduled provider education in order to improve provider availability and telephone access based on the result of annual sampling.
7. Ensuring that mechanisms are in place to support and facilitate continuity of care within the AZPC network and to review the effectiveness of such mechanisms on a regular basis and addressing issues as they rise.
8. Assess our performance against Federal and State standards for PCP, SCP, High Volume, High Impact Specialists to ensure member access to highly coordinated and managed care.
9. Assure the highest levels of quality care for Medicare beneficiaries by maintaining STARS ratings of 4.0 or better in all measured areas.
10. Identify potential risk management issues and respond to all potential quality issues raised.

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 securely housed within the Clinical Services 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 Arizona State Confidentiality Statutes, the Federal Medical Information Act SB 889 and the Health Information Portability and Accountability Act ('HIPAA') for patient confidentiality. All persons attending the QI Committee('s') or any 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, including the committee chair, sign a Statement of this understanding.

AZPC ensures that all member care is:

1. Consistent with professionally recognized standards of practice
2. Not withheld or delayed for any reason
3. Reviewed by appropriate clinical staff
4. Void of any influence or oversight by the finance department

Therefore, we do not penalize providers for discussing medically necessary or appropriate patient care regardless of the patient's benefits. We do not pressure providers to render care beyond the scope of their training or experience. 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:
AZPC's governing body is the Executive Committee. The Executive Committee grants AZPC's QI Committee ('QIC') authority. The QIC appoints a senior-level medical director to act as a facilitator for all QI activities, and they are the entities responsible for the oversight of the QI Program.

The Executive Committee directs the establishment of the QIC, which will evaluate and monitor the quality of patient care and address concerns about support services. The Senior-level Medical Director, Medical Director('s'), and Clinical Services Directors will report all QI activities to the Executive Committee. The Executive Committee formally reviews and approves all QI activities quarterly, semi-annually, and annually and directs operations on an ongoing basis.

The Executive Committee will ensure sufficient staff and resources for the QI Program to achieve its objectives. These resources will include staff, data sources, and analytical resources such as statistical expertise and programs. AZPC ensures its contracted practitioners are deemed competent to meet regulatory and accreditation standards during our initial oversight survey and annual oversight audits thereafter.

Sr. Medical Director:
The Sr. Medical Director, or designee, is a physician with a current medical license. The Senior-level Medical Director is the Executive Committee's designee responsible for the implementation of QI Program activities. The Sr. Medical Director works with the Medical Director('s') and Clinical Services Directors to develop, implement, and evaluate the QI Program. The Sr. Medical Director is the Chairperson of the QIC. Responsibilities include but not limited to:

1. Implement the QI Plan and have 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 and behavioral healthcare 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 grievances.
7. Providing support and clinical guidance to the program and 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, modification, and implementation of comprehensive policies and procedures that support the QI operations.
12. Analyzing QI data.
13. Review pertinent clinical grievances and quality of care concerns, assign severity levels, and direct corrective actions to be taken, including peer review, if required.
14. Review the QI Program, Work Plan, Annual Evaluation, and Quarterly or Semi-Annual Reports.
15. Directing health education and credentialing activities.
16. Assisting with the development, conduct, review, and analysis of quality ('HEDIS') studies.

Designated Physician:
AZPC shall employ, contract or designate a Medical Director with an unrestricted medical license. Note that effective April 10, 2019, the State of Arizona recognizes equivalent occupational or professional licenses for all other States within the United States, pursuant to requirements listed in Arizona HB 2569 – A.R.S. 32-4302 out-of-State applicants; residents; military spouses; licensure; certification; exceptions.

The Medical Director is fully credentialed and serves as the designated physician involved in all aspects of QI Program development and evaluation, provides clinical oversight of all QI activities, supports the various committees, staff, and resources, and makes recommendations based on clinical care and administrative data. The Senior-Level 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 QIC quarterly, at a minimum.

The designated physician will work with the Senior Director of Care Coordination, VP of Clinical Services, Director of UM Operations, and Director of Quality, HEDIS and Clinical Compliance to develop,

implement and evaluate all aspects of the QI Program. The designated physician helps to plan, develop, organize, monitor, communicate, and recommend modifications to the QI Program and all QI policies and procedures. 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 healthcare 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 and 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 HEDIS, Clinical Compliance & Quality Management Services:
The Director of HEDIS & Quality Management Services oversees the clinical and administrative day-to-day operations of QI activities and reports directly to the Sr. Medical Director. It is the Director's responsibility to interface with all clinical services 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 Senior-level 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 Sr. Medical Director the resolution of QI activities in accordance with the QI Program.
5. Interfacing with all internal departments to ensure compliance with the QI Program and policies and procedures.
6. Acting as a liaison with network practitioners, ancillary providers, facilities, health plans, and regulatory agencies regarding QI issues.
7. Monitoring and follow up with all applicable QI activities.
8. Ensuring staff collects and monitors data and reports identified trends to the senior-level Medical Director 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 Senior-level Medical Director and/or Medical Director designee.
14. Oversee the preparation of peer review case files for the senior-level medical director'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 QIC 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 selecting and applying 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. Develop and oversees the Credentialing process

Senior Director of Clinical Services:

1. Overseeing the facility site review activities, when applicable
2. Ensuring that focused reviews are conducted as identified.
3. Interfacing with the Senior-level Medical Director 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 collaborating with designated behavioral health practitioner and/or Medical Director designee.
5. Serving as liaison with CMS, health plans, and other regulatory agencies for investigation, collaboration, and resolution of clinical grievances.
6. Assisting the Senior-level 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:

AZPC has multidisciplinary staff to address all aspects of the department functions. AZPC has staff and resources to conduct statistical and data analysis sufficient to establish quality controls and improvement

projects. Staff can develop access databases relevant to specific functions and pull appropriate information relevant to specific studies.

QUALITY IMPROVEMENT COMMITTEE ('QIC')

The QIC is a standing committee responsible for developing, overseeing, guiding, and coordinating all quality improvement activities. The QIC is designated and has been delegated the responsibility of providing an effective QI Program for members and providers. The QIC 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 review and approve the QI Program, work plan, and annual evaluation.
8. Overseeing and keeping staff and providers informed regarding QI and performance improvement projects, QI requirements, activities, updates or revisions, performance measures and results, utilization data, and profiling results.
9. Review and approve QI policies, procedures, guidelines, and protocols.
10. 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.
11. Conducting peer review, assigning severity levels, and making recommendations for corrective actions, as needed.
12. Review and evaluate reports regarding any/all critical incidents, reportable events, and sentinel events.
13. Reviewing and evaluating reports submitted by each health plan.
14. Evaluating and giving recommendations concerning audit results, member experience surveys, practitioner experience surveys, access audits, and any QI studies.
15. Evaluating and giving recommendations from monitoring and tracking reports.
16. Ensuring follow-up, as appropriate.
17. Providing a confidential mechanism of documentation, communication, and reporting of QI issues and activities to the Executive Committee, QIC, and other appropriate involved parties.
18. Assessing the effectiveness of the QI Program and making modifications and enhancements as necessary on an ongoing and annual basis.
19. Ensuring that AZPC and its contracted providers are meeting the members' cultural and linguistic needs at all points of contact.
20. Ensuring members have access to all available services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, gender identity, marital status, sexual orientation, health status, or disability.
21. Ensuring mechanisms are in place to identify and evaluate patient safety issues within the network and systems are established to facilitate effective resolutions.

Reporting:
The QI Department shall submit a summary report of quality activities and actions for review and approval to the QIC quarterly and/or semiannually. QIC's approval completes reporting during the quarterly and/or semi-annual meeting.

Composition:
A Senior-level Medical Director shall chair the QIC, and his/her primary responsibilities may include but are not limited to:

1. Directing the QIC meetings.
2. Reporting QIC activities to the Executive Committee.
3. Acting on the committee's behalf for issues arising 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 Senior-level Medical Director, as the chairperson of the QIC, may designate a designee only when unable to attend the meeting.

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

1. Medical Director(s)
2. Director of Quality
3. Director of PA/UM and Credentialing
4. Senior Director of Clinical Services
5. Directors/Managers of Health Education
6. Director of Provider Relations
7. Director of Contracting/Network Strategy
8. Behavioral Health Practitioners
9. Representation of network physicians serving our members to include Primary Care and Specialty Care Practitioners
10. Appropriate clinical representatives
11. Other members are appointed at the discretion of the Chairperson

Committee members who are employees of AZPC 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 the continuity of the committee functions by the Committee Chair. 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 and may include the Committee Chair. All actions are approved by a majority vote and/or motion 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 QIC may not vote but shall attend the meetings and provide support to the deliberations. If the QIC cannot 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 QIC meets no less than quarterly but can meet more frequently if circumstances require or to accomplish the committee's objectives. The Committee Chair 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 QIC must ensure that each of its members or attending guests is aware of the requirements related to confidentiality and conflicts of interest by having signed Statements on file and/or QIC sign-in sheets with requirements noted on them. An affirmation statement of confidentiality and conflict of interest presented at the start of any QIC meeting shall have the effect of each member/attendee attesting to this requirement.

Breach of confidentiality may result in disciplinary action, including termination. Activities and minutes of the QIC are for the sole and confidential use of AZPC and are protected by State and Federal laws and the Healthcare Portability and Accountability Act ('HIPAA').

Recording of Meeting and Dissemination of Action:
All QIC minutes are contemporaneous, dated, and signed, reflecting all committee decisions.

All QIC meetings are recorded by taking minutes, which are signed and dated and reflect all committee decisions. Meeting minutes and all documentation used by the QIC are the sole property of AZPC and are strictly confidential. When quality issues are identified, the QIC meeting minutes must 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 QIC meeting conducted:

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

The dissemination of QIC 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. Newsletters;
4. Provider Relations and physician reports;
5. Quarterly and/or semi-annual reports to the Executive Committee.
6. AZPC's Website

Credentialing Committee:
The Credentialing Committee consists of physicians who may be on AZPC's QIC panel. A minimum of three physician members is required for a quorum, which is inclusive of the Chairperson and two practicing physicians. The Credentialing Committee**:**

1. Has final authority to approve or disapprove applications by providers for AZPC participation or delegate such authority to the Senior-level Medical Director 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. Access appropriate clinical peer input when discussing standards of care for a particular organizational provider.
4. Review files for organizational providers that do not meet the AZPC's established criteria.
5. Review files for State survey and licensing deficiencies of organizational providers.
6. Review files for reported potential quality of care issues, reportable events, sentinel events, critical incidents, complaints, and/or if a regulatory agency has sanctioned the facility.
7. Maintains minutes of all committee meetings and documents all actions.
8. Provide guidance to AZPC staff on the overall direction of the Credentialing Plan.
9. Evaluate and report to AZPC management on the effectiveness of the plan.
10. Review and approve 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

AZPC utilizes a QI process to identify opportunities to improve both the quality of care and the quality of service for all members or Beneficiaries. AZPC adopts and maintains clinical guidelines, criteria, quality screens, audit tools and other standard surveys for measuring quality of care, access, and service.

AZPC's Quality Program will accomplish its mission and promote its vision through the implementation of an outcomes-oriented, continuous quality improvement program. To support this approach, AZPC's Quality Program Description will be used as a dynamic document that is responsive to the voices of all stakeholders, flexible in its actions, and readily modifiable as conditions warrant. Employing systematic quality improvement processes such as Lean Six Sigma methodologies, the quality program obtains input from a broad spectrum of stakeholders and uses the Define, Measure, Analyze, Improve, Control ('DMAIC') cycle process to insure the timely identification of critical variables and their root causes (barriers.) DMAIC process outcomes are used to develop measurable interventions that lead to improvement. A graphical representation of AZPC's quality processes is presented below.

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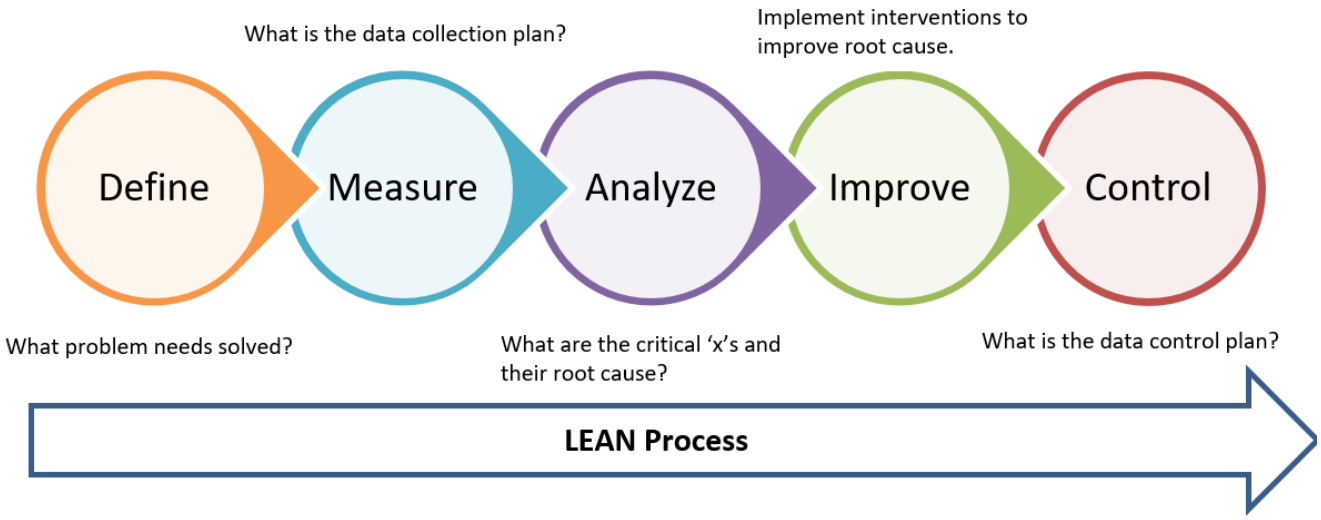
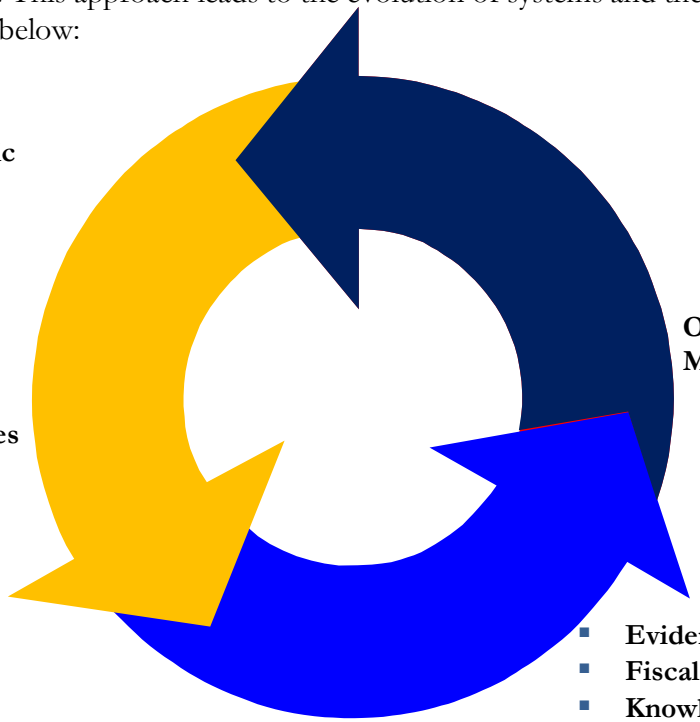


The use of LEAN and DMAIC quality processes propels continuous quality improvement at AZPC while supporting and enhancing the integration of quality and accountability into our Quality Program. All AZPC's QI activities incorporate this approach to solving complex or multifaceted problems logically and systematically, leading to continuous quality improvement to ensure that activities meet or exceed identified measures and goals. All aspects of operations, including member services, audits, provider performance, clinical processes, and outcomes, are appropriate areas for performance improvement. Through the use of DMAIC, stakeholders' expectations can be met.

The DMAIC quality process promotes continuous quality improvement at AZPC while supporting and enhancing the integration of quality and accountability within operations and in delivering quality services and care for consumers. This approach leads to the evolution of systems and the development of a culture of quality, as illustrated below:

- **Established committees**
- **Performance metrics**
- **AZ Connect and electronic interfaces for AZPC processes**
- **Policies, procedures & standards**



Quality Structures

- **Clinical yield**
- **Stakeholder involvement**
- **Satisfaction surveys**
- **Utilization reporting**
- **Process & network measures**

Outcome Management

Quality Processes

- **Evidence-based and best practices**
- **Fiscal accountability**
- **Knowledge transfer processes**
- **External validation & accreditation**

Health/Clinical Service Contracting:
AZPC contracts with individual practitioners and providers, including those making UM decisions, specify that contractors cooperate with its QI Program to improve the quality of care and services and the members' experience. This shall include the collection and evaluation of data and participation in the QI Program.

A practitioner is a licensed or certified professional who provides behavioral healthcare or medical care services.

An organizational provider is an institution or organization that provides services for members, such as a hospital, residential treatment center, home health agency, or rehabilitation facility.

For the purpose of this section, practitioners and organizational providers will be known as "providers".

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

1. Providers cooperate with QI activities.
2. Providers maintain the confidentiality of member information and records and shall keep member information confidential and secure.
3. Providers allow the plan to use their performance data. This shall include allowing the collection of performance measurement data, evaluating the data, and assisting the organization in improving clinical and service measures.
4. Providers will provide access to medical records as permitted by State and Federal law.
5. Providers will give timely notification to members affected by their termination.
6. 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 include an affirmative Statement indicating that providers may freely communicate with patients about the treatment options available, 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 the preferences and the special and cultural needs of our members or Beneficiaries. AZPC will ensure the practitioner network has sufficient numbers and types of practitioners to meet the needs and preferences of membership by effectively:

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

ethnic and linguistic needs and preferences.

Arizona Priority Care establishes the 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 high-volume and high-impact 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, behavioral healthcare, hospital based, and ancillary practitioners.
5. Facilitating transportation for members as needed, as delegated.
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/Beneficiary 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 access and care
6. Telephone service

AZPC'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:
Members are administered a Member Experience Survey based on encounter data. 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 that impact satisfaction. Surveys are conducted throughout the year. The results of the surveys are evaluated and improvement plans are developed to address problem areas identified. All available results are presented to the QIC for review and recommendations semi-annually.

Member Experience Surveys – CCM and SNP Programs:
AZPC 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.

AZPC will evaluate the results of the surveys received. Improvement plans will be developed to address areas identified. All results are presented to the QIC for recommendations and interventions.

Complex Care Management ('CCM' or 'High Risk'):
AZPC coordinates services for members/Beneficiaries 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.

CCM is the coordination of care and services provided to members/Beneficiaries 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/Beneficiaries eligible for CCM may include those with physical or developmental disabilities, multiple chronic conditions or severe injuries.

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

The goal of CCM is to help members/Beneficiaries 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 CCM:

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, AZPC will assess the entire population. Based on the findings, the CCM process and resources will be reviewed and updated in order to meet members/Beneficiaries' needs effectively.

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 QIC. 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:
AZPC is accountable for adopting and disseminating clinical practice guidelines relevant to members/Beneficiaries for the provision of preventive, acute or chronic medical and behavioral health services.

AZPC uses evidenced-based guidelines to help practitioners and members/Beneficiaries make decisions about appropriate healthcare for specific clinical circumstances and behavioral health services. AZPC will distribute guidelines to their practitioners by posting them on our website or through the provider web portals. Notification of online availability will be faxed to our network providers within 30 days of QIC approval. In addition, if changes or revisions are made, a notice will be sent to the practitioners by fax blast within 30 days of QIC approval.

AZPC adopts nationally recognized Clinical Practice Guidelines ('CPGs') that include professional medical associations, voluntary health organizations, and NIH Centers and Institutes. If the guidelines are not from a recognized source, they are created with the involvement of a board-certified practitioner. Selected CPGs are presented to the QIC 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.

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

Preventive Health Guidelines:
AZPC will adopt and disseminate Preventive Health Guidelines ('PHGs') for our population.

AZPC approves, adopts, and disseminates these Preventive Health Guidelines in an effort to improve healthcare quality and reduce unnecessary variation in care. AZPC will distribute guidelines to our contracted providers by posting them on the website. Notification of online availability will be faxed to our network providers within 30 days of QIC approval. In addition, if changes or revisions to the guidelines occur, a notice will be sent to the practitioners by fax blast within 30 days of QIC approval.

AZPC adopts nationally recognized Preventive Health Guidelines ('PHGs') from the U.S. Preventive Services Task Force for adults. AZPC may include other guidelines from professional medical associations, voluntary health organizations, and NIH Centers and Institutes. 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 QIC for discussion and recommendations. PHGs are reviewed and approved by the QIC at least every two years and as needed if changes are made.

Continuity and Coordination of Care:
AZPC ensures the continuity and coordination of care for our members/Beneficiaries. The members/Beneficiaries may select a Primary Care Provider ('PCP'), or the health plan may assign a PCP to the members/Beneficiaries with the primary responsibility for coordinating the members/Beneficiaries' overall healthcare. AZPC must:

1. Identify members with special healthcare needs.
2. Ensure an appropriate healthcare professional assesses the ongoing needs of each member identified as having special healthcare needs or conditions.
3. Identify medical procedures and/or behavioral health services to address and/or monitor the need or condition.
4. Ensure adequate care coordination among providers, as necessary.
5. 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 act on an annual basis and as necessary to improve continuity and coordination of care across the healthcare network. AZPC identifies opportunities to improve the coordination of medical care through routine medical record reviews, potential quality of care reviews, grievances received from a 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/Beneficiaries' 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, AZPC may notify members affected by the termination of a practitioner or practice group. This is applicable to general medicine, family practice, internal medicine, or pediatrics at least sixty days for MA plans prior to the effective termination date and help 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, AZPC's policy specifies circumstances in which affected members may continue access to the practitioner and duration of continued care. AZPC 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 major component of the QI Program is the identification and review of potential quality issues and the implementation of appropriate corrective action to address confirmed quality of care issues. 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.

Sentinel Events / Critical Incidents:
A sentinel event or critical incident is "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, 'or risk thereof' includes any process variation for which a recurrence carries a significant chance of a serious adverse outcome."

A major component of the QI Program is the use of sentinel events to monitor important aspects of care, accessibility and service in medical and behavioral healthcare. These events are called "sentinel" because they signal the need for immediate investigation and response. As such, all sentinel events must be

monitored, tracked, and investigated.

Serious Reportable Adverse Events:
A Serious Reportable Adverse Event ('SRAE') is an incident involving death or serious harm to a patient resulting from a lapse or error in a healthcare facility. It is broken down into three major categories by the Centers for Medicare & Medicaid Services:

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

AZPC will ensure our compliance with all Federal and State guidelines. All serious reportable adverse events will be monitored, tracked, and investigated.

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

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

PEER REVIEW COMMITTEE

The Peer Review Committee's sole purpose is to improve the quality of the medical and behavioral healthcare provided to our members by practitioners and providers. AZPC cannot delegate the function of peer review to another entity.

The Peer Review Committee's scope includes the review of cases where there is evidence of deficient quality or the omission of the care or service provided by a participating or non-participating healthcare professional or provider.

The Peer Review Committee meetings are held as needed. The Peer Review Committee is a sub-committee represented by members of the Credentialing Committee that reviews the potential of quality care issues, resulting in serious members/Beneficiaries negative outcome. At a minimum, the Peer Review Committee shall include:

1. The Medical Director and/or appointed physician designee.
2. A behavioral health provider when a behavioral health specialty is being reviewed. The committee

may utilize peers through external consultation.

Peer Review Committee Functions:

1. Peer Review Committee members shall sign a confidential and conflict of interest statement at each meeting.
2. Committee members must not participate in peer review activities if they have a direct or indirect interest in the peer review outcome.
3. The Peer Review Committee must evaluate the case referred to peer review based on all information made available through the QI Management process.
4. The Peer Review Committee is responsible for making recommendations to the BH Medical Director. Together they must determine appropriate action which may include, but is not limited to peer contact, education, credentials, limits on new member enrollment, sanctions, or other corrective actions. The BH Medical Director is responsible for ensuring that the corrective actions are implemented.
5. The Peer Review Committee is responsible for making recommendations to the Medical Director and referrals to the Department of Child Safety, Adult Protective Services, the appropriate regulatory agency or board, and State agency for further investigation or action if not already referred during the PQI process. Notification must occur when the committee determines care was not provided according to community standards. Initial notice may be verbal but must be followed by a written report.
6. All information used in the peer review process is kept confidential and is not discussed outside of the peer review process. The reports, meetings, minutes, documents, recommendations, and participants must be kept confidential except for implementing recommendations made by the Peer Review Committee.

Peer Review meetings are protected by State and Federal law. Documents from the proceedings must not leave the confines of the meeting and shall be retained by staff at the meeting closure. Any committee member copies, hand-written notes, post-it notes, or other material that will not be retained in the case file must be destroyed at the end of the session.

Peer review documentation must be provided to State and Federal agencies upon request.
Providers and practitioners must be informed regarding the peer review process and peer review grievance procedures.

CLINICAL MEASUREMENT ACTIVITIES AND QUALITY PERFORMANCE REPORTING

AZPC adheres to all regulatory standards for quality performance reporting. AZPC will cooperate and assist regulators and their contracted QI Organizations ('QIO'). AZPC uses data collection and analysis to track clinical issues that are relevant to the population. AZPC 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:
AZPC actively takes part in the 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.

AZPC 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 ('when delegated').
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 three months.
7. Annual education and training of practitioners and their office staff
8. HEDIS coordinators work alongside and provide provider relations representatives detailed reports to contact primary care practitioners and discuss the importance of the reports and services not yet captured at a minimum of every three months.

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 QIC. A formal corrective action plan will be developed for 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.

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 AZPC'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 is captured.

A key component of the CMS Star Program is to develop strong and collaborative relationships with practitioners and office staff through 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 (if available), improve patient care, and overall improvement of medical record documentation practices.

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

1. Healthcare Effectiveness Data and Information Set ('HEDIS') and CMS Stars.
2. Improving documentation practices.
3. Providing tools that focus the practitioner's office on specific members requiring services and the use of CMS Star and HEDIS-specific encounter billing and documentation.
4. Identify opportunities to limit barriers between the physician and the health plan.
5. Collaborate on the collection of important diagnosis and procedure codes and service information to limit the intrusion into the physician's office.
6. Inform the physician that Provider Relations/Network staff have the resources to get questions answered and issues resolved quickly.
7. Work toward improvement in members' access to care.
8. Educate the provider's office on the submission of Medicare diagnosis and procedure codes through the encounter/claims systems while utilizing an incentive program.
9. Identify Medicare members who have not been seen or have gaps in care to help them schedule

their needed services with contracted providers and facilities.
10. In-service practitioners and staff on how they can increase revenue through the improvement of documentation and data submission.
11. In-service on how to complete an Annual Wellness Assessment of the Medicare members, including scheduling the member to be seen by the physician for incentive opportunities.

OTHER QI 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. Access to care audits/surveys.
3. Availability audits/surveys.
4. Potential or actual quality of care issues ('PQI').
5. Grievances received from health plans.

AZPC conducts other quality improvement studies deemed necessary to ensure quality of service to members. Follow-up surveys and/or focus audits may be conducted based on our findings, and actions taken as recommended by the QI Committee.

DISSEMINATION OF INFORMATION

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

1. Policies and procedures.
2. Medical record and facility audit reports and trends.
3. Delegation audit results.
4. Member/Practitioner Experience Survey results.
5. Member grievance statistics and trends.
6. Sentinel events.
7. Reportable events.
8. Special study outcomes.
9. Other QI activities.
10. QI Program, work plan, annual evaluation and semi-annual reports.
11. New or changed regulatory and legislative information.

Results of QI activities are communicated to practitioners and providers 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 network practitioners and members/Beneficiaries.

Members and practitioners are notified of the availability of the QI Program through the website, Provider Manual, and newsletters. The results and intervention analysis is available by request for all practitioners and members. The notification of online availability is sent by fax blast to all network providers within 30 days of QI Committee approval.

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 clinical care and monitoring access and availability of covered services. The work plans are reviewed by a Senior-level Medical Director and submitted to the QIC and Executive Committee for review and comment at least annually.

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 measurable goals and objectives.
4. Staff positions/departments responsible and accountable for meeting established goals and objectives.

The QI Work Plan is a fluid document and is revised, as needed, to meet changing priorities and regulatory requirements and identify 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 QIC and Executive Committee for review and recommendations.

Annual Plan Evaluation:
As defined by the QI Work Plan, QI activities will be evaluated annually to measure performance for the year and assist in revising the QI Program and preparing the following year's work plan. The evaluations are reviewed by the senior-level Medical Director and submitted to the QIC and Executive Committee for review and approval. AZPC will maintain and report separately by line of business and health plan, as applicable, for the following measures:

1. Appeals.
2. Complaints/Grievances
3. Potential Quality of Care issues.
4. Reportable Events
5. Sentinel Events

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

1. Title/name of each activity.
2. Measurable goals and/or objectives related to each activity.
3. Department or staff positions involved in the QI activity.
4. Description of communication and feedback related to QI data and activities.
5. An evaluation of baseline data and outcomes utilizing qualitative and quantitative data which must include a Statement describing if the goals were met completely, partially, or not at all.

6. Actions to be taken for the improvement of corrective action plans ('CAPs') and Quality Improvement Plans ('QIPs').
7. Documentation of continued monitoring to evaluate the effectiveness of the actions ('interventions') and other follow-up activities.
8. Rationale for changes in the scope of the QI program and plan or documentation indicating if no changes were made.
9. Necessary follow-up with targeted timelines for revisions made to the QI plan.
10. Documentation of QIC review, evaluation, and approval of any changes to the QI plan.
11. An evaluation of the previous year's activities must be submitted as part of the QI Plan after review by the QIC.

RESOURCES, QI PERSONNEL AND INTERDEPARTMENTAL INTERFACE

Resources Allocated to AZPC's QI Program

As AZPC's products and services are dynamic and can change throughout the year, QI support demonstrates flexibility to provide support for new workflows and business. The following table outlines the staff resources in terms of FTEs allocated to meet the needs of the Quality Program.

AZPC Team Member	Percent of FTE Allocated to QI
Sr. Medical Director	55%
Medical Director(s)	40%
Chief Operations Officer	20%
Member Services Representatives	20%
Director, Customer Service	30%
Director, HEDIS & Quality Management Services	100%
Clinical Administrative Coordinator	40%
Quality and Compliance Specialist	60%
Director, Prior Auth and Credentialing	60%
Credentialists	60%
Sr. Director of Care Management	60%
VP Provider Experience	60%
Associate Director, Provider Relations	40%
Provider Relations Representative	30%
Director, Network Contracting	60%
Network Contracting Manager/Coordinator	40%
Director, HEDIS & STARS	70%
HEDIS and STARS Coordinator	60%
Care Managers (TCM and CCM)	40%
VP, Clinical Service	70%
Director, Claims	70%
Claims Personnel	40%

AZPC Team Member	Percent of FTE Allocated to QI
VP Finance	40%
IT Staff	40%
Compliance Officer (AZPC)	55%
Clinical Reporting Director	70%
Clinical Reporting Manager/Coordinator	40%
Coordinator/Manager of Care Management	60%
Home Wellness Providers/Team Members	40%

Technical Resources
Clinical Information System
q.HMO
AZ Connect
Business Solutions
Document Management
Survey Tools
Network Shared Locations
Claims System
EZ-CAP
Other Technical Resources
Microsoft® Office Suite
Visio® Basic
Microsoft® Project
QI Macros (StatPak)
SQL Server Reporting Services
Network Credentialing Application(s)

Analytical Resources
Staff backgrounds in:
Computer programming
Healthcare data analysis
Research methodology
Clinical Providers/Staff

Utilization Management Department:
The Utilization Management ('UM') Department frequently identifies potential risk management, 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 UM 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 assisted with initiating contact with the respective health plan. The issue is then forwarded to the QI Department for tracking. The Customer Service Department records all incoming calls by specific indicators for tracking, trending, and reporting.

Credentialing Department:
The Credentialing Department is part of the QI 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 medical record audit scores and any sanction activity related to those reviews and with identified Quality of Care Issues ('QICs')/Potential Quality Issue ('PQIs') as appropriate. The Director of Quality, Credentialing, and Compliance will take peer review cases, as directed by the Senior-level Medical Director, to the Peer Review Committee for review and action.

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

1. Serve as liaisons between the QI Department and practitioners to facilitate education and compliance with approved Arizona Priority Care standards.
2. Assist the QI Department with practitioners who do not comply with requests from the QI Department.
3. Ensure 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, including critical incidents, reportable events, and sentinel event diagnoses. The QI Department is able to obtain certain medical records from the Claims Department as available.

Health Informatics Department:
The AZPC QI Department works collaboratively with HPN's Health Informatics Department to collect, analyze, and integrate data into the AZPC QI process. The AZPC QI Department works with Health Informatics to ensure that data is accurate and complete. Specialized and standardized reports are generated through the various systems and programs so data elements can be continuously monitored. Through this department, data is maintained for regulatory agency review. The data is also used to conduct annual review of the overall AZPC QI Program. Specialized databases have been built by Informatics to track grievances, complaints and potential quality issues for tracking and corrective actions. Data being submitted from outside vendors or being sent out of our organization goes through the Informatics Department and the Information Systems Department to ensure all HIPAA regulations are being met. No file containing member specific information is sent out of the QI Department without meeting all HIPAA requirements

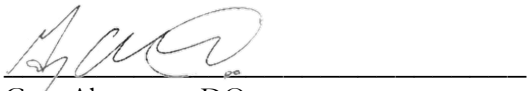
DELEGATION OF QUALITY IMPROVEMENT

AZPC 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. Describe the delegated activities and the responsibilities of the health plan and AZPC.
3. Requiring at least semi-annual reporting by AZPC.
4. Describing the process by which the health plan will evaluate AZPC's performance.
5. Describing the remedies available to the health plan if AZPC does not fulfill their obligations up to and including revocation of the delegation agreement.

APPROVAL

This AZPC Quality Program Description was approved on the sixteenth of May, 2024 at the Quality Management Meeting. The affixed signatures below endorse approval. Approval is valid for, at maximum, of one year



Greg Alaestante, DO
Clinical Services Medical Director
AZ Priority Care

5/16/2024
Date

Doug Mitchell, PhD(c), RN, BC, CPHQ, CPHRM
Director, HEDIS, Clinical Compliance & Quality Management Services
AZ Priority Care

2/15/2024
Date

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