

**Lovelace Health Plan  
And  
Lovelace Insurance Company**

**2011 Quality Management  
Program Description**

## 2010 Quality Management Program Description

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# 2010 QUALITY MANAGEMENT PROGRAM DESCRIPTION

The Lovelace Health Plan and Lovelace Insurance Company (herein referred to as the *Company*) Quality Management Program (QMP) establishes standards that encompass quality management activities within the health plan and is an integral component of the health plan's delivery of services to its members and providers. The Quality Management Program Description (QMPD) is the primary document that establishes the *Company's* commitment to quality management and quality improvement and enables all parties to have a clear definition of the Quality Management (QM) structure, goals and objectives within the organization. The *Company* follows a mission, vision and guiding values in attaining our QM program goals.

## **Mission Statement**

Lovelace Health Plan and Lovelace Insurance Company are premier providers of health care services, delivered with compassion for members; with respect for employees, employers, physicians and other health professionals; with accountability for our fiscal and ethical performance, and with responsibility to the communities we serve.

## **Vision Statement**

Lovelace Health Plan and Lovelace Insurance Company will be the providers of choice for health care benefits and services for our members, beneficiaries, employees, employers, physicians and other health professionals by consistently performing at a superior level, while maintaining sound ethical standards and returning a fair value to our partners.

## **Guiding Values**

- We are dedicated to meeting the health care needs of our *members*.
- We treat *members*, employees, employers, physicians and others with respect and compassion.
- We partner with health care professionals to provide the best care possible for our *members*.
- We work to foster a fulfilling and challenging workplace for all.
- We continuously seek ways to improve the quality of care and service delivered to our *members*.
- We act with responsibility and accountability in the communities we serve.
- We expect 100 percent compliance with ethical and regulatory standards.
- We are dedicated to providing a fair value for our partners.

The QMP supports continuous quality improvement in all phases of our business. This is achieved by adhering to quality principles regarding delivery of valued services to our members and participating providers in addition to providing our employees with an environment that supports high standards of performance.

All QMP activities are considered privileged and confidential consistent with state and federal laws. Upon request, the organization makes non-proprietary and non-confidential information about its QMP available to its practitioners and members, including this description of the Quality Program and a report on the organization's progress in meeting its goals.

## **PROGRAM GOALS AND OBJECTIVES**

### **PROMOTE AND BUILD QUALITY INTO THE HEALTH PLAN'S ORGANIZATIONAL STRUCTURE AND PROCESS.**

1. Facilitate a partnership of members, providers, vendors and health plan leaders and staff for the continuous improvement of quality health care delivery.
2. Improve communication and education about the QMP to support these efforts.
3. Develop meaningful effective quality committees and an annual work plans to guide quality programs.

**PROVIDE EFFECTIVE MONITORING AND EVALUATION OF PATIENT CARE AND SERVICES TO ENSURE THAT CARE AND SERVICE PROVIDED TO THE HEALTH PLAN MEMBERS MEETS ACCEPTED AND APPROPRIATE MEDICAL PRACTICE STANDARDS AND IS POSITIVELY PERCEIVED BY HEALTH PLAN MEMBERS AND HEALTH CARE PROFESSIONALS.**

1. Support and enable providers to provide quality care by reviewing and distributing nationally recognized guidelines of medical practice, including preventive health and physical and behavioral health clinical practice guidelines.
2. Facilitate achievement of public health goals in the areas of health promotion, prevention and early detection, treatment and disease management.
3. Develop medical care administrative services related to quality management activities such as access and availability, credentialing and recredentialing, quality of care review, appeals and grievances and confidentiality.
4. Survey health plan members' and health care professionals' satisfaction with the quality of services provided.
5. Develop, define and maintain data systems adequate to support care and service measurement and quality improvement activities as well as participate in national data sharing and comparison initiatives.
6. Conduct an annual review of the effectiveness of the quality program.

**ENSURE PROMPT IDENTIFICATION AND ANALYSIS OF OPPORTUNITIES FOR IMPROVEMENT WITH IMPLEMENTATION OF ACTIONS AND FOLLOW-UP.**

1. Identify and assess important issues and concerns of health care services provided to health plan members and ensure coordination and continuity of care across and between general medical and behavioral care services, sites, and providers.
2. Continually improve the health plan Quality Management Program. Respond timely to audit findings and continually strive to achieve levels of performance above minimums established by accreditation and regulatory bodies.
3. Provide periodic feedback and education to health plan employees, providers, practitioners and members regarding status of quality management initiatives and applicable measurements.

**ENCOURAGE PATIENT SAFETY.**

1. Distribute information to members that improve his or her knowledge about clinical safety.
2. Facilitate informed decision-making.
3. Collaborate with network practitioners and providers and the greater health care community, as appropriate, to establish mechanisms to support and promote safe clinical practices and delivery of care.
4. Organize activities to collect providers' information on actions to improve safety.
5. Develop activities to communicate patient safety performance data to practitioners and members.

**MAINTAIN COMPLIANCE WITH LOCAL, STATE, AND FEDERAL REGULATORY REQUIREMENTS AND ACCREDITATION STANDARDS.**

1. Monitor regulatory requirements for quality management and compliance and respond as needed.
2. Ensure the reporting system provides adequate information for meeting the regulatory external review and accreditation requirements of mandatory and voluntary review bodies.

## **PROGRAM AUTHORITY AND ACCOUNTABILITY**

### **LOVELACE HEALTH PLAN HMO EXECUTIVE ADVISORY GROUP**

The Lovelace Health Plan HMO Executive Advisory Group delegates' operational quality improvement functions to the Health Plan Quality Council (HPQC). The board shall retain oversight of quality functions. All activities of both the HMO Executive Advisory Group and all documents and minutes are considered privileged and confidential pursuant to state and federal laws.

The HMO Executive Advisory Group is responsible for promoting the goals and objectives of the Quality Management Program by:

1. Demonstrating at a senior corporate level a commitment to quality and to the organization's programs for quality management.
2. Requiring that objective measures be used to gauge the quality of care, services and patient safety provided.
3. Ensuring that quality management programs are in place and work effectively to monitor and improve quality.
4. Overseeing the health plan's QMP. Authority and responsibility for the daily operational activities of the QMP are delegated to the HPQC and the Medical Director.
5. Recommending policy to guide the QMP in establishing priorities and objectives.
6. Reviewing and approving annually the written QMPD and evaluation..
7. Monitoring quality improvement in the delivery of member health care and service and network provider satisfaction.
8. Evaluating written reports of quality management activities. Written reports are submitted to the Executive Advisory Group on a regular basis.

### **Lovelace Health Plan HMO Executive Advisory Group Membership**

Lovelace Health Plan Chief Executive Officer  
Lovelace Health Plan Vice President of Sales and Service  
Lovelace Health Plan Associate Vice President of Programs and Compliance Officer  
Lovelace Health Plan Chief Financial Officer  
Lovelace Health Plan Chief Operating Officer  
Lovelace Health Plan Associate Vice President of Business Development  
Community Member(s)

### **Meeting Frequency**

The Executive Advisory Group meets on a regular basis, typically twice a year and more frequently as needed. A quorum composed of the majority of the voting membership is necessary to conduct a meeting.

### **LOVELACE INSURANCE COMPANY BOARD OF DIRECTORS**

The Lovelace Insurance Company (LINC) Board of Directors delegates' operational quality improvement functions to the Health Plan Quality Council (HPQC). The board shall retain oversight of quality functions. All activities of the Board of Directors and all documents and minutes are considered privileged and confidential pursuant to state and federal laws.

The LINC Board of Directors is responsible for promoting the goals and objectives of the Quality Management Program by:

1. Demonstrating at a senior corporate level a commitment to quality and to the organization's programs for quality management.
2. Requiring that objective measures be used to gauge the quality of care, services and patient safety provided.
3. Ensuring that quality management programs are in place and work effectively to monitor and improve quality.
4. Overseeing the QMP. Authority and responsibility for the daily operational activities of the QMP are delegated to the HPQC and the Medical Director.
5. Recommending policy to guide the QMP in establishing priorities and objectives.
6. Reviewing and approving annually the written QMPD, evaluation, and annual work plan.
7. Monitoring quality improvement in the delivery of member health care and service and network provider satisfaction.

8. Evaluating written reports of quality management activities. Written reports are submitted to the Board of Directors on a regular basis.

### **Board of Directors Membership**

The membership of the LINC Board of Directors includes the following:

Lovelace Insurance Company President  
Lovelace Health System CEO and Vice President  
Ardent Health Services Senior VP and General Counsel  
Ardent Health Services VP Finance

### **Meeting Frequency**

The LINC Board of Directors meets on a regular basis, typically twice a year and more frequently as needed. A quorum composed of the majority of the voting membership is necessary to conduct a meeting.

### **HEALTH PLAN QUALITY COUNCIL (HPQC)**

Both the Lovelace Health Plan HMO Executive Advisory Group and the Lovelace Insurance Company Board of Directors delegates the authority and responsibility for daily operational activities of the QMP to the HPQC and the health plan Senior Medical Director. The HPQC is responsible for providing oversight of the *Company's* Quality Management Program. The ongoing evaluation and monitoring by the HPQC facilitates continuous quality improvement of comprehensive health care and services and patient safety provided to health plan members as well as provider satisfaction with services.

### **Functions**

The HPQC is responsible for providing guidance and direction for the health plan's QMP and for promoting its goals and objectives by:

1. Centralizing and coordinating the integration of all quality management activities.
2. Reviewing and distributing policies for medical practice and nationally recognized preventive and clinical practice guidelines or reviewing and approving actions taken by a defined subcommittee related to such guidelines and policies.
3. Organizing and overseeing the QMP goals and objectives related to patient safety.
4. Analyzing and evaluating summary data from the following quality management activities and making recommendations for improvement:
  - Accreditation or state or federal regulatory agency review
  - Ambulatory medical record review
  - Appeal and grievance review
  - Compliance review
  - Credentialing and recredentialing review
  - Health and disease management review
  - Enrollment and disenrollment review
  - HEDIS performance measure review
  - Member and provider satisfaction survey review
  - Member service metrics review
  - Pharmacy and therapeutics review
  - Provider access and availability review
  - Quality improvement activity review
  - Utilization management review
5. Reviewing and approving the annual Quality Management Program Evaluation, Work Plan, and updates to the Quality Management Program Description.
6. Monitoring the quality of health plan delegates.

## **HPQC Membership**

The membership of the HPQC includes the following:

- Senior Medical Director (Chair)
- Medical Director(s)
- Associate Medical Director
- Director of Behavioral Health
- Participating Network Physicians
- Health Plan Chief Operating Officer
- Health Plan Chief Sales and Service Officer
- Chief Compliance Officer
- Quality Accreditation Program Manager
- Other members as appointed

Physician members serve a two-year term and may be re-appointed for subsequent terms by the committee chair. To provide consistency from year to year, only 50% of the participating provider membership may be transitioned off the committee.

## **Meeting Frequency**

The HPQC meets at least four times per year and more often if necessary. A quorum composed of a majority of the voting membership is necessary to conduct a meeting. Written signed minutes documenting HPQC proceedings are filed in the Quality Management Department.

## **OTHER QUALITY COMMITTEES (Attachment B)**

Specified health plan committees are accountable to the HPQC regarding quality management and improvement functions of the health plan. It is the responsibility of these committees to assist the HPQC in performing its duties. The health plan Senior Medical Director or designee chairs all quality committees.

## **Functions, Membership and Meeting Frequency**

Other quality committees provide regular reports to HPQC related to quality management and improvement activities for evaluation, guidance and recommendations. Committee minutes are taken at each meeting, and are considered confidential quality management documents. Minutes are maintained in a secure location accessible only to authorized health plan representatives. Membership of the committee(s) may include Specialists and/or Primary Care Physicians as deemed appropriate by the HPQC, the Medical Director, the *Company's* Management, the *Company's* Staff, or as stated in the Committee Description.

## **HEALTH PLAN PERSONNEL RESPONSIBLE FOR IMPLEMENTATION AND INTEGRATION OF THE QUALITY MANAGEMENT PROGRAM ACTIVITIES**

The CEO of the health plan is responsible for oversight of the implementation of the QMP at an operational level.

### **Chief Medical Officer**

The Chief Medical Officer (CMO) is responsible for providing executive leadership, oversight and direction for the QMP.

### **Senior Medical Director**

The Senior Medical Director is responsible for providing direction for the development and implementation of the QMP within the health plan. The Senior Medical Director is the chairperson of the HPQC and the designated medical practitioner for QM activities for the organization.

### **Medical Director(s)**

The Medical Directors support the Senior Medical Director in providing direction for the development and implementation of the QMP within the health plan, including responsibility for specific oversight of QI and QM functions as assigned.

### **Director of Behavioral Health**

The Director, Behavioral Health, assures that coordination of care decisions comply with behavioral health standards, appropriateness, and contract benefits. The Behavioral Health Director is responsible for interacting directly with the providers when necessary regarding interpretation of benefits, appropriateness and medical necessity of care. The Behavioral Health Director is responsible for assisting with the oversight of all Behavioral Health quality activities pertaining to the care of the *Company's* members and, serves as the designated practitioner for QM activities related to behavioral health.

**Chief Operating Officer**

The Chief Operating Officer is responsible for assuring the quality of health plan operations and for assuring organizational effectiveness and process improvement related to claims, enrollment and project management.

**Chief Sales and Service Officer**

The Chief Sales and Services officer is responsible for all sales and marketing programs for the health plan. The position is responsible for the quality and performance of service delivered by the customer care center.

**AVP Ethics and Compliance**

This position oversees all lines of business program management, compliance and regulatory requirements for the health plan, and directs health plan required activities relating to fraud and abuse monitoring and the New Mexico Insurance Division compliance and reporting. The officer is responsible for the implementation and administration of all HIPAA regulations. The position ensures appropriate training is provided to employees to ensure their compliance with all regulation and facilitates member requests for personal health information, and maintains reports and logs as needed to manage the program. Compliance staffs coordinate required public program audits and reporting requirements.

**AVP Network Operations**

The Network Operations AVP is responsible for all network provider contracting and provider services functions. This position is responsible for ensuring all provider contracts reflect appropriate regulatory and accreditation requirements, and that there is adequate network access. The Network Operations AVP is responsible for assuring appropriate management of the provider database and production of the provider directory.

**AVP Health Services**

AVP Health Services is responsible for the overall direction of the health services department. The position is responsible for care management including complex case management, disease management, health management, utilization management and coordination and continuity of care functions. The positions establish policies and departmental goals and work as liaisons between department and other internal departments. The AVP participates in the Medical Directors Committee and is responsible for developing and overseeing the Care Management and Utilization Management Program, work plan and annual evaluation of UM program effectiveness.

**AVP Quality Management**

The AVP for Quality Management has daily operating authority for the QM program. The AVP is responsible for overseeing the advancements of the health plan's goals for quality by implementing quality programs for care and service and assuring the evaluation of these programs on an ongoing basis. The AVP of QM is responsible for the credentialing program, the HEDIS and CAHPS performance measurement programs and supports the CMO and Senior Medical Director with provider performance recognition programs related to quality improvement.

**AVP Operations**

The AVP for Operations is responsible for the oversight of claims and enrollment processing and process improvement for these areas. This position is accountable for the oversight of claims or payment administration outsourced to contracted vendors by the Health Plan and is responsible for oversight and process improvement of enrollment and eligibility functions for the Health Plan. This position monitors the timing and accuracy of eligibility loaded into various systems and is responsible for ensuring compliance of administrative guidelines with the Oklahoma Insurance Division and other state and federal regulatory agencies.

**Medicaid Director**

The Medicaid Director is responsible for the operational elements of the Lovelace Medicaid product, including maintaining the relationship with the Human Services Department (HSD), Medicaid program financial oversight, legislative management and oversight and management of delegated Medicaid entities.

**Medicare Director**

The Medicare Director is responsible for the operational elements of the Medicare Plan including maintaining the relationship with CMS for financial oversight, legislative management and oversight and management of any delegated Medicare entities.

**Customer Care Director**

The Customer Care Director plans and directs the customer service operations for the Customer Care Center including the Call Center. This position maintains compliance with multiple complex products in meeting both federal and state mandated requirements and accreditation standards regarding resolution of complaints and appeals and quality of care concerns; oversees the maintenance of a quality program including improvement initiatives to measure and assure excellent quality of service and regularly reports customer service measures and performance to the HPQC.

**Project Management Director**

The Project Management Director is responsible for directing and organizing the activities of the Project Management Office and assuring timely and efficient implementation of strategic initiatives identified by the organization that require project management oversight.

### **Credentialing Manager**

The Credentialing Manager is responsible for the operations of the Credentialing department assuring compliance with regulatory and accrediting body standards for the credentialing and recredentialing of practitioners and providers. The Credentialing Manager provides oversight of delegated credentialing through monitoring of delegates. The Credentialing Manager maintains the functioning of the Credentialing Committees and reports their activities to the HPQC. The position is responsible for the development of policies that ensure the organization is in compliance with standards set forth by regulatory and accreditation bodies.

### **Appeal & Grievance Manager**

The Appeal and Grievance Manager is responsible for the development of and maintenance of company policies and procedures for proper function of department. This position ensures proper investigation and resolution of member and provider grievances and appeals and maintains compliance with federal and state appeal and grievance regulations and accreditation standards.

### **Accreditation Program Managers**

The Accreditation Program Managers are responsible for ensuring compliance with quality management regulatory requirements and NCQA accreditation. The positions also manage, develop and execute the implementation of an accreditation program. The positions manage and monitor state and federal regulations and accreditation standard of national quality entities in which the health plan participates. The positions provide leadership, inter-departmental facilitation and technical assistance on content and structure of health plan programs as regards compliance with quality management accreditation and regulatory matters.

### **Disease Management Manager**

The Disease Manager has the responsibility for clinical quality improvement activities associated with disease management. These activities include identifying areas for improvement, developing and implementing interventions, and ensuring that evaluation occurs. The DM Manager works collaboratively with Care Management, the Medical Directors, other program managers, data analysts, and clinical pharmacists to help coordinate activities and facilitate standardization, consistency and timeliness of interventions.

### **Wellness Manager**

Responsible for preventive health, health promotion and wellness the promotion of health management programs to members and employer groups. This position is accountable for assessing the health management needs of the employer group population and all members of the health plan.

### **Quality of Care Program Manager**

The Quality of Care (QOC) Program Manager is responsible for the review of clinical quality of care concerns and evaluation of review findings. The QOC Manager works with the medical directors to assure appropriate corrective actions are taken based on review findings and that follow-up related to each concern is addressed.

## **SCOPE OF THE QUALITY PROGRAM**

In order to fulfill the goals and objectives of this program and to efficiently utilize resources, the Quality Management Program functions as an integrated activity within the health plan, providing a mechanism for the coordination of both quality improvement and quality management activities. This includes, but is not limited to, interactions with Medical Directors, Care Management, Utilization Management, Disease Management, Contracting, Network Operations, Provider Services, Member Services, Credentialing, Sales and Outreach, Claims, Appeals and Grievance, Project Management, and Compliance personnel. Special attention is given to high volume, high-risk areas of care and service for our member populations and to major demographic groups. Identified opportunities are acted upon and results of program activities are reported back to program participants.

Activities include review and subsequent reporting of the following:

- Performance against key indicators for quality improvement as identified in the quality program description and activities as identified in the quality work plan and reported in the Quality Management Evaluation.
- Quality and utilization of clinical care and services, including both inpatient and outpatient, provided by hospitals, practitioners, and ancillary providers.
- Evaluation of continuity and coordination of care, as well as, under-utilization and over-utilization of services and pharmaceuticals.
- Monitoring and evaluation of member and provider satisfaction information.
- Review of indicators measuring outcome of care to members.
- Surveying and evaluating access to routine, urgent and emergent care and behavioral health care against established health plan standards.

## **QUALITY MANAGEMENT PROGRAM ACTIVITIES**

Quality Management activities include a variety of mechanisms and procedures to measure, evaluate and improve the total scope of services provided to health plan members and providers. The following activities and processes, listed alphabetically, are used to either conduct reviews or support improvement in areas that reflect important aspects of quality care and service.

### **AMBULATORY MEDICAL RECORD REVIEW**

Ambulatory Medical Record Reviews (AMRR) are conducted for PCP, OB-GYN and high volume behavioral health provider records pursuant to policy and a defined methodology for selecting records. The objectives are to: 1) evaluate the structural integrity of the medical record, 2) evaluate the completeness and appropriateness of information necessary to provide safe clinical care to members; 3) reflect that continuity and coordination of care is documented; 4) monitor adherence to Preventive Health Guidelines, which are distributed by the Health plan, and 5) improve performance in documentation of the clinical care delivered to our members.

Clinical reviewers trained in the use of the AMRR instrument collect data. The scores of practitioners are aggregated, analyzed, and indicators are individually trended. Overall study results and opportunities for improvement are reported to HPQC. Feedback of AMRR results and areas for improvement are disseminated to the Primary Care Physicians, OB-GYNs and high volume behavioral health specialists. Follow-up reviews are conducted as necessary.

### **ADMINISTRATIVE SERVICES**

Review of internal administrative procedures and services is performed to better meet health care and customer service needs of the membership. Focus is placed on enrollment of members, phone response times, timely claims service, periodic assessment of processes and strategic health plan initiatives, including new products and services. Based on reviewed activities, opportunities for improvement are identified within the health plan and with appropriate internal/external partners. Follow-up is based on the use of continuous quality improvement techniques.

### **APEAL AND GRIEVANCE PROCESS**

The member grievance process includes the intake of member concerns and complaints and their resolution in a satisfactory and timely manner. The appeals process addresses denied claims and/or services relative to the member's benefits. In the event the member is not satisfied with initial resolution of a matter, they may request a Level II hearing. The process affords the member a hearing before an appeal committee to make a final determination. Should the complaint or appeal be of a 'quality of care' nature, which has the potential to adversely affect the member's health; a Quality of Care review process is implemented.

### **BEHAVIORAL HEALTH SERVICES**

Lovelace provides behavioral health services for the commercial and Medicare members. The Quality Improvement Committee (QIC) is responsible for reviewing behavioral health clinical care and service reports, studies and performance measures and identifying opportunities for improvement within the Behavioral Health program. The QIC will assure that appropriate and timely improvement activities occur and that all BH QM activities, as outlined on the annual Work Plan, are complete with final approval by HPQC.

State Coverage Insurance (SCI) Managed Care behavioral health services are administered by Lovelace directly, pursuant to a state mandate. The health plan's "integrated model" combines the administration of behavioral and physical health services. All case managers attend Combined Rounds, which provide a forum to discuss the care of members who are receiving both medical and behavioral health case management services.

Lovelace works with the Statewide Entity (SE) to assure timely and appropriate continuity and coordination of care between the SE and Lovelace for the Medicaid managed care members requiring both types of care. Lovelace works with the SE to address continuity and coordination of care issues through routine meetings.

### **CONTINUITY AND COORDINATION OF CARE**

To enhance continuous and appropriate care for members, and to strengthen continuity between medical and behavioral healthcare, Lovelace monitors continuity and coordination of care among primary, specialty, and behavioral health care practitioners. Examples of this occur when: one practitioner treats the same patient as an organizational provider; one practitioner treats the same patient as another practitioner; and when a practitioner leaves the network or a member completes a continued access period as defined by health plan policy. Assessment of continuity and coordination of care collaboration may include, but is not limited to measurement of the following as demonstrated through the use of surveys, committee discussions reflected in minutes, medical record review, and data analysis:

- Exchange of information in an effective, timely and confidential manner.
- Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care.
- Evaluation of the use of psychopharmacological medication.
- Coordination of timely access for appropriate treatment and follow-up for individuals with coexisting medical and behavioral health disorders.

- Implementation of physical and behavioral health clinical guidelines.
- Movement of members from a termed practitioner.
- Monitoring of members who qualify for continued access to a practitioner termed for other than quality reasons.

### **CONTINUOUS QUALITY IMPROVEMENT PROCESS**

The Continuous Quality Improvement (CQI) process is utilized when an opportunity for improvement is identified through monitoring of either quality of care or quality of service indicators. The steps in the CQI process are documented; results and action plans for improvement are presented to the appropriate health plan committee for review and approval. These steps include: determination of the relevance of the issue to the health plan's population, evaluation of baseline measure(s), analysis to identify an opportunity for improvement, analysis to identify possible root cause or barriers, planning and implementation of actions to eliminate possible root causes or barriers, evaluation of performance and effectiveness of the interventions by remeasurement after implementing actions, analysis to determine how actions impacted performance, and continued remeasurement to determine whether improvements are sustained.

Decision to take actions related to improvement opportunities are generally prioritized based on the following:

- The impact to the member or the organization of not improving;
- Performance below a targeted goal or performance threshold that is not acceptable to the health plan;
- Regulatory or accreditation requirement.

Performance goals or thresholds are generally established based on the following:

- A measure of statistical significance;
- The NCQA minimum effect size methodology (also considered statistical significance);
- Regulatory or accreditation requirement or performance goal;
- Internal performance standards.

Identified opportunities for improvement are documented in the annual QI Work Plan. The annual QI Evaluation documents success of these opportunities or identifies continued opportunities for improvement.

### **CREDENTIALING AND RECREDENTIALING**

The appropriate and regular credentialing of network practitioners and providers, as defined by health plan policies, is a key function of the health plan's Quality Management Program. All practitioners participating with the health plan undergo a review of their qualifications, including education and training, licensure status, board certification, hospital privileges, and malpractice history. All practitioners undergoing initial credentialing and recredentialing are reviewed and approved by the designated health plan quality committee. Credentialing and recredentialing activities, minutes and documents are considered privileged and confidential under state and federal laws.

Recredentialing is performed on a triennial basis, or more frequently, as required by State law. To ensure quality and safety of care between recredentialing cycles, the health plan performs ongoing monitoring for practitioner adverse events, sanctions and complaints. The health plan will review Medicare, Medicaid and state information regarding practitioners who have received sanctions or limitations on licensure within 30 calendar days of its release. Investigation of practitioner-specific complaints will include evaluation of both the specific complaint and the practitioner's history of issues, if applicable. If a practitioner is identified on a sanction report, or there is evidence of poor quality, the practitioner's ability to provide services will be reviewed and assessed by the Credentials Committee and actions taken as needed.

The Credentials Committee also reviews and approves, at a minimum, hospitals, home health agencies, skilled nursing facilities, free standing surgical facilities, free standing birthing centers, and inpatient or ambulatory behavioral health facilities through the Credentialing and Recredentialing process. Health plan staffs conduct a quality assessment for each facility, which includes accreditation status, state licensure status, Medicare/Medicaid sanction status, malpractice coverage and history.

### **CULTURAL COMPETENCY**

The *Company* is dedicated to ensuring that all members, providers and employees are treated with dignity and respect concerning their values, culture, class, race, age, sexual orientation, ethnic background and religion. The health plan recognizes and values the cultural diversity of the membership and the impact it has on the value of care and service provided to each member. The *Company* supports interventions that promote an effective health care encounter between a member and provider where language or cultural values regarding health and healing may vary. Such interventions may include providing culturally appropriate linguistic services to members, providing cultural diversity information for the Lovelace workforce interacting with the membership, and promoting cultural sensitivity training throughout the provider network as evidenced by the Cultural Competency Program Description and Evaluation. The goals of the cultural competency program include:

- Determine cultural competency needs of the health plan's members using community demographics, surveys, and other available information
- Identify key issues and approaches to assure cultural competence while managing and coordinating care
- Understand the role of diverse values, norms, practices, attitudes and beliefs about disease and treatment when coordinating care and developing health plan policy
- Identify linguistic competency issues and provide non and limited English speaking membership with timely, accurate and confidential interpreter services, and quality, relevant and culturally-appropriate written and/or translated materials

- Identify community resources to support culturally competent member care and service delivery
- Respect and support the dignity and perspectives of the member, family and staff to best address the health interests of the member and/or patient
- Promote cultural and linguistic competency planning at the department level to address improvements related to the provision of culturally and linguistically competent care or service
- Ensure systems of recruitment, evaluation, staff development and retention that support a health plan organizational culture and staff that are prepared to provide health care, interactions and coordination of care that meet the cultural and linguistic needs of the greater community
- Identify key issues and approaches to address health care disparities experienced by different cultural and ethnic groups within the health plan membership
- Ensure compliance with contractual requirements and state and federal rules and regulations including CLAS Standards, Title VI of the Civil Rights Act, and State of New Mexico Medical Assistance Division (MAD) requirements

## **ETHICS**

The Quality Program functions as a key component in promotion of integrity and value found in the care and services provided to members. The health plan is committed to maintaining the highest legal and ethical standards in the conduct of its businesses. In maintaining these standards, the health plan places heavy reliance on individual good judgment, honesty, and character. This commitment applies without exception to all activities.

## **FRAUD AND ABUSE**

The Fraud and Abuse program addresses the prevention, detection, and reporting of fraudulent, abusive, or suspicious activities. Many departments facilitate these efforts through participation in Fraud and Abuse workgroup sessions, participation in ongoing training and cooperation with investigative efforts. The Compliance department reports investigative findings to Network Operations, as appropriate, for consideration with contract compliance review and development of provider corrective action plans for improvement or termination for cause.

## **HEALTH PROMOTION, PREVENTIVE CARE and WELLNESS**

The objective of the Health Promotion, Preventive Care and Wellness Outreach program is to assure that members are kept informed about scientifically based, nationally recognized preventive health care guidelines and that they seek services related to these guidelines. The health plan regularly reviews updates to prenatal, pediatric, adolescent, and adult guidelines with input from practicing practitioners, to include behavioral health care components, which have been reviewed and approved by the Health Plan Quality Council. The preventive health guidelines are sent to both practitioners and members for educational and quality enhancement purposes.

The Quality Improvement Committee regularly recommends for distribution current prenatal, pediatric, adolescent and adult preventive health guidelines as updated by nationally recognized preventive health sources including the U. S. Preventive Services Task Force (USPSTF), American Academy of Pediatrics (AAP), American College of OB/GYN (ACOG), Centers for Disease Control (CDC), Adult Treatment Panel III (ATPIII), American Cancer Society (ACS), and American Diabetes Association (ADA). The components are not meant to be comprehensive, but rather provide a basic foundation and reference to improve quality of care. Through the integration of Healthcare Effectiveness Information Data Set (HEDIS) effectiveness of care measures, the health plan can monitor the use of preventive health guidelines annually.

To encourage patients to obtain and follow recognized preventive care, the health plan promotes patient focused educational programs and supports access to healthcare information through various methods. These programs may identify members at risk for specific health problems and involve both members and their practitioners in decisions about the member's health care. Programs are developed to inform members of primary and secondary preventive and screening needs. Certain members may be targeted for management of their illness, condition or risk factors. Members may also access general health information through a variety of health plan sources to encourage wellness. Personal health assessments, health coaching, nurse triage and health information line are made available. Wellness campaigns are organized based on employer group request or the Company's focus for health improvement.

## **HEALTH MANAGEMENT AND DISEASE MANAGEMENT**

The objective of health and disease management activities are to monitor the care received by the member population with certain chronic conditions such as asthma, diabetes, cardiac disease and COPD and seek to improve the members' health status and reduce serious health problems. Lovelace collects relevant data about the health status of its members and develops interventions to assist members and their practitioners in managing targeted chronic conditions. Lovelace implements structured health and disease management programs that are designed to:

- Identify members or member populations with certain chronic conditions;
- Implement appropriate services and programs to assist members in managing their conditions;
- Encourage members to utilize health and disease management programs available to them;
- Inform and educate practitioners about health and disease management programs available to Lovelace members assigned to them;
- Evaluate the clinical outcomes of members with chronic conditions.

## **HEDIS® and CAHPS®**

HEDIS is the Healthcare Effectiveness Data Information Set, which is a comprehensive measurement tool used by the health plan to help with evaluating the performance and effectiveness of its quality program. HEDIS contains multiple measures representing a variety of health care related areas, including effectiveness of care measures, access to care, use of healthcare services, member satisfaction, health plan stability, and health plan descriptive information. Annually, these data are collected, analyzed, evaluated, and compared to regional and national benchmarks. Based on the outcomes of the HEDIS measures, the health plan determines its strategy for quality improvement activities. Two major components of HEDIS that are critical in the evaluation process include clinical outcomes through effectiveness of care measurement and member service outcomes through the member satisfaction survey – Consumer Assessment of Healthcare Providers and Systems CAHPS®.

Note: HEDIS performance results are not submitted to NCQA for non-accredited products administered by the *Company* unless required by a regulatory agency. Where non-NCQA accredited program membership is significant enough to assess HEDIS performance, non-audited HEDIS results will be calculated. When accredited or non-accredited product membership is too small to assess using HEDIS performance measures, the HEDIS performance results for the closest demographic-like membership will be used as a proxy for HEDIS performance.

## **MEDICAID – SALUD! AND STATE COVERAGE INSURANCE (SCI) MANAGED CARE**

This QMPD is designed to meet the quality requirements of the State of New Mexico Medical Assistance Division (MAD) and Centers for Medicare and Medicaid Services (CMS) as specified in the MAD Program Policy Manual. Many of the QI activities described elsewhere in the document pertain to all products, including Salud! and SCI. An ongoing quality assessment and performance improvement program is developed and evaluated annually for these public programs. These programs, as outlined in this document, include conducting performance measurement and reporting, undertaking performance improvement projects, maintaining written policies and procedures that reflect current standards of medical practice, detecting over and under-utilization, making information on quality and outcome measures available to MAD, achieving minimum performance levels established by MAD, and maintaining a health information system.

Clinical performance improvement projects are evaluated and approved by MAD in both medical and behavioral health areas. The medical areas include selected areas such as:

- Care of Chronic Condition (diabetes and asthma).

Behavioral health areas are directly managed for SCI and indirectly through continuity and coordination of care activities with the State Entity for Salud!.

The behavioral health improvement project areas include topics such as:

- Behavioral Health Follow Up (SCI only)
- Medication Compliance (SCI only)
- Continuity and Care Coordination (both SCI and Salud!)

The health plan's quality assessment and performance program addresses all Salud! managed care regulations and SCI managed care regulations defined by MAD. The areas include Broad Standards, Standards for Quality Management and Improvement, Standards for Utilization Management, Standards for Credentialing and Recredentialing, Patient Bill of Rights, Standards for Preventive Health Services, Standards for Medical Records, Standards for Access, and Delegation. Additional requirements for the collection and reporting of data may be obtained through such mechanisms as HEDIS® and CAHPS or other clinical and satisfaction measurement systems.

Quality oversight for Individuals with Special Health Care Needs (ISHCN) is addressed within the scope of the Medicaid quality program. Clinical practice guidelines are developed with practice parameters and other criteria that consider the needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population. The guidelines used are based on professionally accepted standards of practice and national guidelines. Specific Medicaid Performance Measures are initiated for the ISHCN membership. Examples of ongoing Performance Measurements are *Childhood Immunizations, Use of Appropriate Medication in Children with Asthma, Comprehensive Diabetes Care Adults, Prenatal and Post Partum Care*. As part of the quality program for ISHCN, the *Company* conducts an annual assessment of ISHCN satisfaction with quality, availability and accessibility and care as well as an understanding of the educational materials provided to the ISHCN.

## **MEDICARE**

This QMPD is designed to meet the quality requirements of Centers for Medicare and Medicaid Services (CMS) as specified in CMS's Medicare Managed Care Manual, Chapter 5, Quality Assessment. An ongoing quality assessment and performance improvement program is developed and evaluated annually. This program, as outlined in this document, includes conducting performance measuring and reporting, undertaking quality assessment and improvement projects, maintaining written policies and procedures that reflect current standards of medical practice, detecting under-utilization and over-utilization, making information on quality and outcome measures available to CMS, achieving minimum performance levels established by CMS,

performing member quality of health and satisfaction surveys such as the Health Outcomes Survey (HOS) and the Consumer Assessment of Health Plans Study (CAHPS), and maintaining a health information system.

The Health Plan's Medicare program addresses all elements required in the CMS Medicare Managed Care Manual, Chapter 5, Quality Assessment. The *Company* coordinates the clinical quality improvement activities related to the CMS required Chronic Care Improvement Program (CCIP) through its disease management program. The Health Plan participates with CMS in routine site audits to measure the Health Plan's compliance to these standards. Additional CMS requirements for the collection and reporting of data are met through HEDIS®, HOS, and CAHPS® participation.

## **MEMBER SATISFACTION**

Member satisfaction is assessed through evaluation of member surveys and member concern and appeal information. Member satisfaction surveys and routine monitoring indicators are designed to measure local health plan performance and to assess member satisfaction with the plan services. Member survey data are used for continuous quality improvement in several key areas: to establish benchmarks and monitor local health plan performance, to assess overall levels of satisfaction as an indication of whether the plan is meeting customer expectations, and to assess service performance in comparison to competitors. Members and providers are informed of survey results and may be consulted for input.

Member concern and appeal information is trended to identify potential opportunities for improvement. The results of this trending and analysis may be correlated with member survey data or other indicators in the assessment and development of action plans. Results are summarized and reviewed by the health plan to identify areas of improvement and prioritize interventions. Action plans to address opportunities for improvement is developed as necessary.

## **MONITORING OF QUALITY INDICATORS**

The quantitative monitoring of health care indicators is designed to reveal trends and performance opportunities in specific areas and to facilitate improvement health plan wide. To achieve this, the health plan monitors a variety of indicators to affect improvements in care and service. The indicators chosen by the *Company* are derived from many sources as appropriate for the health plan's population and service needs. These quality indicators are measurable, based on reasonable research, typically in current use by other like organizations and based on accepted quality methodologies. Quality indicator monitoring is reported routinely through the health plan Monthly Operations Report. Medicaid protocol sets standards for validation of data collection and interpretation for performance measures and performance improvement projects selected by the *Company*. Wherever possible, nationally recognized quality indicators such as HEDIS® and CAHPS® are recommended because of the complexity of validation for "home grown" performance measures.

## **PATIENT SAFETY (please see Patient Safety Plan (Attachment C))**

To encourage patient safety the health plan strives to provide an environment that fosters safe clinical practice. The Quality Program functions as a key component in the promotion of patient safety. This commitment is demonstrated by some of the following initiatives:

1. Distribution of information to members to improve their knowledge about clinical safety in their own care.
2. Facilitation of informed decision-making.
3. Collaboration with select business/healthcare coalitions, network providers and practitioners to establish mechanisms to ensure safe practices.
4. Directing the focus of existing quality improvement activities on patient safety, including, but not limited to:
  - Continuity and coordination of care initiatives
  - Initial credentialing site visits for practitioners and organizations
  - Ambulatory medical record review
  - Review and distribute nationally recognized preventive health guidelines
  - Complaint and satisfaction data analysis and actions pertaining to patient safety
  - Pharmaceutical practice safeguards to enhance patient safety.

## **PHARMACY and THERAPEUTICS, DRUG USE and MEDICATION THERAPY MONITORING PROGRAMS**

The Pharmacy and Therapeutics Committee is composed of physicians, pharmacists, and other healthcare professionals representing various disciplines within the medical community. The committee is a policy recommending body to the administration of the health plan on matters related to the therapeutic use of medical and behavioral health drugs and pharmaceutical devices. The committee evaluates the clinical use of drugs and devices, develops policies for managing drug use and manages the formulary system. Staff functions include monitoring quality activities related to pharmaceutical management. The reviews conducted include assessing utilization and appropriateness of therapeutic agents, analyzing and aggregating data on drug usage, assessing for evidence of cost shifting activities, reviewing and providing recommendations on formulary status of drugs, participating in drug or disease management initiatives and studies, and developing educational materials and strategies for providers and members. The Pharmacy and Therapeutics committee membership includes behavioral health expertise to aid in the proper development of pharmacy and practice guidelines for primary care practitioners prescribing psychotropic and antidepressant medications.

Pharmacy Exception Center functions include analyzing and aggregating performance data on its service metrics such as activity volume, turn-around time compliance and denial rates. Pharmacy personnel participate in the Medical Director/UM Committee for utilization and coordination and continuity of care purposes and support those activities.

**The Medication Therapy Management Program (MTMP) is organized according to CMS guidelines and managed by a clinical pharmacist.** The Medication Therapy Management Program seeks to ensure Part D covered drugs are appropriately used to optimize therapeutic outcomes through improved medication use.

**An algorithm for determining appropriate program participation is defined.** Eligible members will be auto-enrolled and mailed program materials. Members have the option of opting out and may do so at any time. Eligible members will receive yearly calls from a nurse, pharmacist and/or PharmD candidate to conduct the comprehensive medication review (CMR). The reviewer will offer a face-to-face or telephone based interaction depending upon the member's preference or need.

Once in the program members are provided an interview with the clinical pharmacist to determine the appropriateness of medications, the safety of combinations of medications and any opportunities to switch to less expensive alternatives to current medications. Other issues will be addressed including specific member questions about medications, difficulty paying for medications, trouble remembering to take medication, interest in smoking cessation, information on herbal/OTC medications and interest in receiving more information about medications or specific medical conditions. The pharmacist's suggestions or interventions will be communicated to the member by a written letter which may include educational materials related to a member's disease state or medication. The member's communication will be copied to the appropriate primary care provider. If a clinically significant drug therapy problem is identified that poses great risk to the member, the provider will be called directly for appropriate treatment advice. The Health Plan also has Case Management and Disease Management Programs to assist MTM members when needed.

Quarterly targeted medication reviews will follow up with issues or suggestions identified in the CMR. Additional targeted reviews will be conducted on all MTMP members to review the medication profile for high risk medications. Members will be contacted by mail or by phone when appropriate.

#### **PROVIDER ACCESSIBILITY AND AVAILABILITY MONITORING**

Provider Accessibility and Availability monitoring is conducted on an ongoing basis to ensure that established standards for reasonable geographical location, number of practitioners, hours of operation, appointment availability, provision for emergency care and after hours services are measured. Monitoring activities may include provider surveys, on-site visits, evaluation of member satisfaction surveys, evaluation of concern, complaint, and grievance reports, geo-access surveys, evaluation of provider to member ratios, and monitoring of closed primary care physician panels. Specific deficiencies are addressed with a corrective action plan, and a follow up activity is conducted to reassess compliance. Data are presented to the Health Plan Quality Council for evaluation and recommendations.

#### **PROVIDER SATISFACTION**

Provider Satisfaction Surveys are designed to assess what services are important to health plan providers and determine provider satisfaction with the health plan. A survey is conducted annually to a sampling of PCP, OB-GYN providers and specialists. Results are summarized and reviewed by the health plan departments who serve providers, to identify and prioritize areas for improvement and to develop action plans.

#### **QUALITY OF CARE AND PEER REVIEW**

Peer review is the mechanism utilized to conduct review of suspected inappropriate care or inappropriate professional behavior by a practitioner(s) or provider while providing care to a health plan participant. If the findings of the independent investigation indicate that a practitioner or provider who is subject to investigation has provided substandard or inappropriate patient care, or has exhibited inappropriate professional conduct, the health plan will exercise its discretion and take appropriate action against such practitioner. The process and the scope of actions that may be taken are identified in the health plan policies defining the quality of care process. The actions that may be taken if a quality issue is identified may include, but are not limited to: development of a corrective action plan with time frame for improvement, education, counseling, monitoring and trending of data, sanctions on the practitioner's practice, notification to appropriate state and federal bodies, and limitation or termination from participation in the health plan. All peer review information is considered privileged and confidential under applicable state and federal laws.

#### **QUALITY MEASUREMENT STUDIES**

Quality Measurement Studies are designed and documented to objectively and systematically monitor and evaluate the quality and appropriateness of care and service provided to members. Topics for routine monitoring and for special studies are chosen based on relevant demographic and epidemiological characteristics of the plan membership. Preventive health studies can measure against the preventive health guidelines or relevant HEDIS® performance results. Scientifically based criteria are utilized for specific conditions based on nationally recognized health organizations. The health plan uses a population-based assessment whenever appropriate, supplemented by focused medical record review or patient surveys.

Data are collected, reviewed, and analyzed for trends and opportunities for improvement. These data are then presented to the designated quality committee for review and recommendations. The Health Plan Quality Council also reviews the results of special studies and associated interventions as part of their QMP oversight role.

## **RISK MANAGEMENT**

The health plan is committed to providing quality services, enhancing the safety of members, patients, and staff, and preserving its financial integrity to continue its mission. Risk management identifies, evaluates and resolves actual and potential liability exposures under the direction of the health plan's legal counsel. The designated health plan legal counsel is responsible for evaluating and coordinating risk management activities.

## **UTILIZATION MANAGEMENT and CARE MANAGEMENT REVIEW**

Utilization Management and Care Management written program descriptions and evaluations are reviewed and approved by the Health Plan Quality Council. Nationally recognized guidelines are reviewed, discussed and, if appropriate, approved by the Medical Director Committee. The Medical Director Committee utilizes input from practicing physicians when approving applicable clinical practice guidelines and criteria. Criteria used by the health plan for decisions related to medical necessity or care management are reviewed and approved by the committee annually.

The Technology Assessment Committee reviews requests for new technologies. Any clinical issues identified in the course of utilization and case management activities that are relevant to the health plan population are assessed and evaluated. Utilization Management activities encompass evaluation of continuity and coordination of care, as well as, over and under utilization.

The UM and CM Program Descriptions are the source document for details of the objectives, structure, program scope, and activities of the Health Services Department.

## **DELEGATION AND VENDOR OVERSIGHT**

The Delegation and Vendor Oversight Committee (DVOC) is a subcommittee of the Health Plan Quality Council (HPQC). This committee maintains oversight for quality improvement, utilization management, member connections, credentialing, member services and appeal and grievance activities delegated to groups, agencies, or organizations outside of the *Company*. It also serves to oversee and assure that vendor performance rather delegated or not meets expectation and contractual agreements.

The contractual agreement between the delegated group, agency, or organization and the *Company* specifies the responsibilities of both parties; the activities that are to be delegated; the frequency of reporting; the process by which the performance will be evaluated; and the remedies, including revocation of obligations, available to the health plan if obligations are not fulfilled.

Prior to delegation, the DVOC assesses, based on reports and recommendations from relevant health plan departments, the capability of groups, agencies or organizations to fulfill the responsibilities and requirements of the health plan, Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), and any other pertinent accreditation or regulation organizations for the specific area. The DVOC makes recommendations regarding delegation to the HPQC. HPQC shall provide oversight of the DVOC to assure that the delegation policy and procedure is followed and that appropriate and timely delegation oversight activities occur.

### **Oversight**

The DVOC designates individuals, working groups or subcommittees to assist in the oversight process. Delegates are monitored according to a reporting schedule whereby regular reports are received and reviewed, audits are conducted as required, annual documents are reviewed as required, and comprehensive evaluations of performance are conducted at least semiannually.

The DVOC seeks recommendations from the Credentialing Committee regarding the delegation of credentialing activities. For each group or organization to which Credentialing functions are delegated, the Credentials Committee reviews and approves practitioners credentialed and recertified by delegates as part of its regular activities. The health plan retains the right, based on quality issues, to approve new practitioners, providers and sites and to terminate or suspend individual practitioners or providers.

For each group or organization to which activities are delegated, the DVOC reviews relevant documents. A representative of the Health Plan will conduct the annual evaluation of the delegate's performance. This can occur as a site visit or through another acceptable means as long as the required review can be completed.

If the delegate has been awarded accreditation or certification by NCQA, for the areas delegated, the requirement for the annual evaluation is waived. The delegate must provide the DVOC with evidence of the accreditation or certification and a copy of any recommendations made by NCQA for improvement or corrective action plan.

If, during the course of oversight activities, opportunities for improvement are identified, the DVOC works with the delegate to develop a corrective action plan. The DVOC then monitors the delegate's compliance to that corrective action plan. Corrective action plans are individualized to unique delegate or problem areas. Delegates may be required to submit a report outlining accomplishments against the plan, issues identified and corrective actions taken.

Report activities and the findings of the review process are reported by a representative of the DVOC to the Health Plan Quality Council at least twice a year or more often as required. A list of delegated entities and the activities delegated to each is maintained by the Quality Management Department. DVOC meeting proceedings are documented in written signed minutes filed with the QM department.

**QUALITY MANAGEMENT PROGRAM ANNUAL EVALUATION**

An annual evaluation of the Quality Management Program is conducted to assess the overall effectiveness of the health plan's quality improvement processes. The evaluation reviews and documents all aspects of the Program with emphasis on determining whether the Program has demonstrated improvements in the quality of care and services that are provided by the health plan. The annual evaluation includes:

- an assessment of how the year's goals and objectives were met;
- a review of human and technological resources;
- a summary of quality improvement activities;
- the impact the quality improvement process had on improving health care and service to members;
- potential and actual barriers to achieving goals; and
- recommendations for quality improvement program revisions and modifications resulting from the evaluation.

The annual evaluation is reviewed and approved by the HPQC and the Executive Board of Directors for Lovelace Health Plan and the Board of Directors for Lovelace Insurance Company. The results of the annual quality program evaluation are used to develop and prioritize the annual quality work plan for the upcoming year.

**QUALITY MANAGEMENT PROGRAM ANNUAL WORK PLAN**

The purpose of the Annual Work Plan is to focus on Quality Management Program goals and objectives and planned projects and activities for the forthcoming year. The document is intended to be dynamic in nature. The Annual Work Plan includes anticipated time frames of project completion or due dates, and is utilized as an action plan to document the status and changes in activities throughout the year. The Quality Management Evaluation reflects the progress and outcomes of the Annual Work Plan and is reviewed and approved by the Health Plan Quality Council. Updates to the plan are presented to the HPQC on an as needed basis.

**QUALITY MANAGEMENT PROGRAM CONFIDENTIALITY**

The health plan adopts and maintains confidentiality and HIPAA privacy and security policies and procedures. No voluntary disclosure of peer review or quality assurance information is made except to persons authorized to receive such information in the conduct of Health Plan Quality Council activities. Information is strictly confidential, is not to be released and is not considered discoverable. Lovelace legal counsel must authorize any release.

No voluntary disclosure of identifiable member information is made without obtaining prior consent from the member, except as required by law. Member information is strictly confidential and utilized only on a need to know basis to meet the administrative and legal obligations of the health plan.

Data utilized by the quality committees are maintained in a confidential manner through the mechanism of codes and summary information. Only those persons who require information to perform corrective action are given access to identifiers. Committee records are available only to authorized personnel in accordance with local, state, federal, and other regulatory agencies. Each committee participant must understand and agree to comply with the confidentiality policies and sign a Committee Member Confidentiality Statement.

**APPROVED BY:**

Health Plan Quality Council

Lovelace Health Plan  
Executive Board

Lovelace Insurance Company  
Board of Directors

Chairperson:

Chairperson:

Chairperson:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

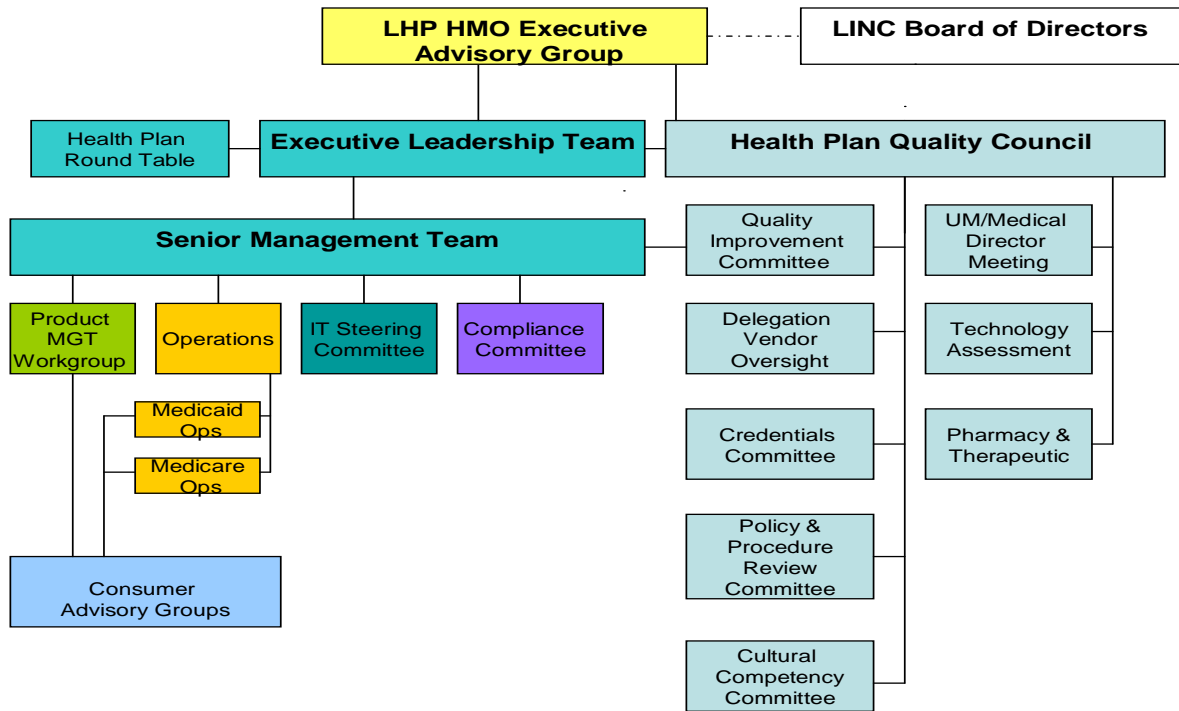
Date: \_\_\_\_\_

Date of HPQC Approval:

\_\_\_\_\_

Attachment A

Lovelace Health Plan and Lovelace Insurance Company  
Committee Structure



----- = two-way communication

## Attachment B

### Quality Committees

Committee	Role and Function	Meeting Frequency
Appeals and Grievances	DOI and HCFA regulations, and NCQA standards, define the procedures for processing member appeals. The process is sub-divided into Non-Utilization and Utilization issues. The group hears the reasons for the grievance or appeal and makes a determination upholding or overturning the initial decision.	Hearings Weekly
Credential Committee	The Credential Committee provides oversight of all credentialing activities including but not limited to the review of physician credentials, physician performance and delegated credentialing activities to ensure that all contracted professional practitioners and organizational providers are qualified and competent to practice and provide care to Lovelace members. The Credentials Committee also reviews and approves all credentialing-related standards and policies. Other activities include monitoring the implementation of corrective action plans, reviewing cases with confirmed quality problems having significant adverse effects on the members and recommending termination, suspension, or limitation of clinical privileges of practitioners and providers to the Lovelace Network Operations Department.	Monthly
Cultural Competency Committee	The Cultural Linguistic Competency Steering Committee determines the cultural competency needs of the Health Plan's members using community demographics, surveys, review of CMS plan specific non-English speaking language data as provided in the HPMS system, other forums or key informants and identifies key issues and approaches to assure cultural competence while managing and coordinating care. The committee identifies key issues and approaches to assure cultural competence in member communications and member materials and identifies community resources to support culturally competent member care and service delivery. The committee assures cultural sensitivity competency, education and training for the Health Plan staffs, providers and subcontractors interacting with members and promotes cultural competency planning at the department level to address improvements related to the provision of culturally competent care or service.	Quarterly
Delegation and Vendor Oversight Committee	Provides oversight of all delegated activities, i.e. UM, Credentialing, and Appeal and Grievances. Activities include ensuring delegation agreements are included with appropriate contracts; performing annual audits and making improvement findings as needed; ensuring follow-up of findings; reviewing and analyzing quarterly quality improvement metric reports from delegated entities; conducting a substantive comprehensive evaluation of delegate's performance semi-annually; and recommending the delegation of or termination of delegation activities.	Quarterly

Committee	Role and Function	Meeting Frequency
Health Plan Quality Council	The Health Plan Quality Council is responsible for providing oversight of the <i>Company's</i> Quality Management Program. Through this oversight it strives to assure quality and comprehensive health care services are provided to members through an ongoing, systematic evaluating and monitoring process that facilitates continuous quality improvement. The process includes review, analysis and evaluation of quality metrics, improvement studies, and survey results; making recommendations when areas in need of improvement are evident; and through the implementation of policy. The council ensures plan compliance to regulatory and accreditation requirements.	Quarterly
Quality Improvement Committee	Provides oversight for all lines of business quality improvement efforts conducted by departments and committees and ensures coordination of quality improvement activities throughout the organization. Activities include reviewing and monitoring reports and studies; implementing policy, and evaluating QI activities, including implementation and follow-up of improvement plans.	Quarterly
Health Plan Medical Directors Committee	<p>The MD Committee receives reporting from other utilization-related committees, as noted. The committee reviews and approves the UMPD, establishing direction for the plan's medical management activities. It also evaluates the effectiveness of the UM program; reviews, approves and distributes medical criteria for review; and monitors provider performance through over/under utilization data, HEDIS performance data related to utilization and member and provider satisfaction with medical necessity decisions. The Medical Director reports the committee's activities to the HPQC on a quarterly basis.</p> <p><u>Committees and Departments reporting to the MD/UM Committee are:</u></p> <ul style="list-style-type: none"> <li>• Pharmacy Operations and Utilization</li> <li>• Technology Assessment Committee</li> <li>• Medical Necessity Appeals Committee</li> <li>• P&amp;T Committee and Drug Use Review Committee</li> </ul>	Monthly
Pharmacy & Therapeutics (P&T) Committee	Provides direction for the pharmaceutical services provided throughout the health plan. Responsible for the development, implementation, and monitoring of drug management programs. The programs include developing and maintaining the drug formulary; formulating policies regarding the evaluation, selection, distribution, use and safety procedures related to medication therapy; and reviewing and evaluating pharmacy care and service issues.	Quarterly or more often if needed
Technology Assessment Committee	The Technology Assessment Committee assesses the appropriateness of new technology and pharmaceuticals for the delivery of high quality care. Its activities include establishing criteria for technology and pharmaceutical reviews that will result in demonstrable improvement in health outcomes, health risk, and health benefits; making recommendations for benefit changes and coverage issues based on new technologies and pharmaceuticals; and developing guidelines and protocols based upon ECRI recommendations for use by contracted clinicians.	Semi-annual or as frequently as needed

## Attachment C

# LOVELACE HEALTH PLAN PATIENT SAFETY PLAN

### ACCOUNTABILITY:

The patient safety initiative process is a coordinated and collaborative effort that is approved by senior leadership and monitored by the Quality Management (QM) Department. The QM department ensures a systematic collaborative process throughout the health plan. The annual documents, QMPD, QM Work Plan and the QM Evaluation specifically address member safety activities. The Health Plan Quality Committee (HPQC), under the guidance of the Medical Director is responsible for the annual review of the process.

### SCOPE

The scope of patient safety initiatives includes an ongoing assessment of activities related to error mitigation and reduction and improvement in overall safety for our members.

Commitment to patient safety for members may be monitored through the following existing quality initiatives:

- Collaboration with network practitioners to establish mechanisms for safe clinical practices
- Articles related to member safety published in the provider or member newsletters.
- Member and practitioner notification of pharmacy updates on recalled medications
- The Quality of Care process reviews member inpatient and outpatient occurrences for potential safety quality of care issues. These are identified through:
  - Member Services
  - Member Appeals
  - Member Complaints
  - Health Services
  - Disease Management
- Continuity and coordination of care identified through medical rounds, case management and drug use review
- Continuity and coordination of care between Behavioral Health and primary care providers
- Initial credentialing site visits for practitioners and organizations
- Ambulatory medical record review
- Pharmaceutical practice safeguards to enhance patient safety
- Medication Therapy Management programs and drug monitoring for the elderly
- Disease management clinical guidelines and preventive health guidelines communicated to members and practitioners
- Provider accessibility and availability monitoring to ensure emergency care and after hours services are available for members
- New technology assessment
- Wellness and preventive health reminder programs

### DATA COLLECTION

Data are monitored to assess opportunities for improvement in patient safety and actions taken to address opportunities. Analysis and summaries of the findings from patient safety monitoring and review are prepared by departments involved in the activity and reported to HPQC per the committee's reporting requirements.

Data used to assess patient safety includes but not limited to:

- Member complaints related to practitioner office site safety or quality
- Track and trend adverse events related to safe and appropriate care to members
- Track and trend potential safety issues identified through ambulatory medical record review
- Monitoring drugs to be avoided in the elderly
- Member complaints

Activities to improve patient safety are a continuous process of collecting and analyzing data, reporting outcomes and initiating improvement activities.

The following are Quality Committees committed to ensuring patient safety:

- Credentials committee monitors the implementation of corrective action plans, reviewing cases with confirmed quality and problems having significant adverse effects on members and recommending termination, suspension or limitation of clinical privileges of practitioners and providers.
- Quality Improvement Committee provides oversight for quality improvement activities including quality initiatives and follow-up improvement plan. They also oversight activities for disease management, preventive care and health promotion activities with coordination and assessment of clinical activities to improve safe clinical practice. Provides oversight for drug use evaluation of prescription drug use among members to ensure use is appropriate, safe, and meeting current medication therapy standards. Additionally this committee is responsible for reviewing behavioral health clinical care and service reports, studies and performance measures and identifying opportunities for improvement
- Delegation Oversight Committee is responsible for providing oversight of those functions the *Company* delegates and those provided by a vendor for members.