



# Quality and Performance Improvement Program Description 2020

## **Introduction and Purpose**

Contra Costa Health Plan (CCHP) is a federally qualified, state licensed, county sponsored Health Maintenance Organization serving Contra Costa County since 1973. We currently serve almost 180,000 people. Contra Costa County is a primarily suburban county in the San Francisco Bay Area. As of 2010 there were roughly 1,050,000 residents. CCHP administers commercial products including one for County employees and a Medi-Cal HMO. The majority of the business is centered around our Medicaid (Medi-Cal) product operations. The CCHP provider network consists of Contra Costa Regional Medical Center and Health Centers and contracted community providers and facilities. Kaiser Permanente network is a member option for Medi-Cal members with a recent personal or family history with Kaiser. The Plan's contracts with participating practitioners and facilities specifically indicate that the practitioner/provider will cooperate with our Quality Program. This allows us access to clinical information pertaining to members, in accordance with the state and federal regulations, in order to collect appropriate data for monitoring and evaluation. This document provides information on the work of the health plan's Quality functions. The Quality Program serves to facilitate safe, effective, efficient, and economical delivery of services throughout CCHP and its networks. It provides a structure to monitor the quality of clinical care and of service, to prioritize opportunities for improvement, to recommend improvement activities, and to track such activities to ensure resolution.

## **Program Objectives and Scope**

The Quality Program strives to steadily improve the measures of quality and satisfaction year over year and to make more dramatic improvements to measures prioritized and assigned resources, such as through a Performance Improvement Project (PIP). The program tracks issues of quality of care, quality of service, and satisfaction and identifies and prioritizes opportunities for improvement. Tracking and improvement occurs in all three provider networks; we work collaboratively on improvement with the County health center system and with the Community-based clinics. The program ensures that all regulatory and contractual obligations related to quality and service are met. The program has taken on the leadership role for the organization-wide priority of Health Plan Accreditation by NCQA. We were initially granted three year Accreditation in March 2014. We were reaudited and granted another three year Accreditation in early 2017. We submitted our application again in December 2019, and will host surveyors onsite January 2020. (Update: we secured our Accreditation for another three years.)

## **Program Structure**

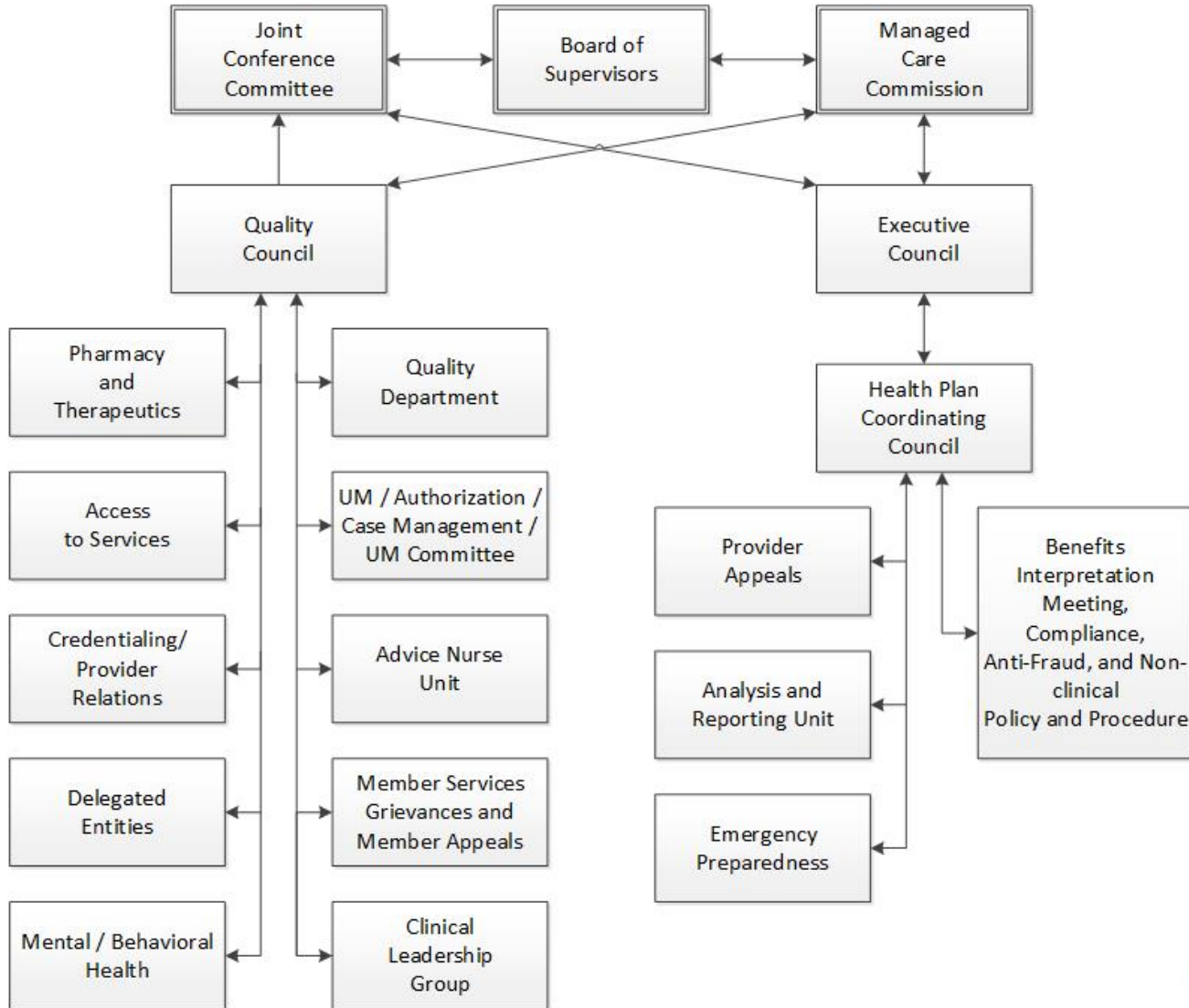
The Quality Improvement Program is provided oversight by the plan's executive management, Quality Council, Clinical Leadership Group, the Managed Care Commission, and the Joint Conference Committee of the Contra Costa County Board of Supervisors. The Joint Conference Committee has been delegated the oversight of the Plan by the County Board of Supervisors.

Our governing body, the Joint Conference Committee, gives authority to the Medical Director and the Chief Executive Officer of the Plan to ensure the Quality program has the needed resources to meet its goals and to evaluate the program's progress toward goals.

The CEO has authority over general administration of the Plan and reports to the JCC on the conduct of operations. The Medical Director provides operational oversight of the daily management of the overall Quality Program, which is executed by the Quality Director and the Quality Department staff who report to him. The Chief Operating Officer and Member Advocate provide the daily management of all service related quality activities. The Provider Relations Director provides the daily management of all credentialing activities. The Director of Pharmacy provides the daily management of all pharmacy related quality and utilization activities. The UM Director provides daily management of the UM and Prior Authorization functions. The Case Management Director provides daily management of Case Management and Care Coordination activities. Various committees (described below) provide oversight to various components of clinical and service quality. These all report through the Quality Council, which in turn reports to the Joint Conference Committee.

# CONTRA COSTA HEALTH PLAN – COMMITTEE REPORTING STRUCTURE

## CONTRA COSTA HEALTH PLAN – COMMUNITY PLAN



Revised 1/23/2020

## **Delegation**

Some Plan functions are delegated to other organizations. For example, Kaiser is broadly responsible for the members we assign to them. We delegate some or all of these elements to Kaiser and CCRMC: Quality, including clinical guidelines and disease management, UM, grievance processing, credentialing, and Health Education. UM delegation to CCRMC was terminated February 1, 2017. Other groups, such as John Muir Physician Network are delegated for Credentialing only. We audit each delegated organization annually using tools based on NCQA standards and report findings to the Quality Council. As of 2015, the State and NCQA no longer require us to perform delegation audits on Kaiser for areas covered by NCQA Accreditation, due to their NCQA Accreditation. We continue oversight through review of data and quarterly meeting with Kaiser leadership. In addition, we review and approve Kaiser's Quality and UM programs and CCRMC's Quality program at appropriate committees. Refer to policy QM14.301 and to the individual delegation agreements for details.

## **Collaboration**

CCHP participates in collaborative improvement efforts with the CCRMC system (County hospital and health centers), with Public Health, and with Community Provider Network providers. We are also collaborating to improve provision of behavioral health services, including embedding such services in physical health clinics. We also participate in the redesign of ambulatory care delivery and improvement of access to care. We also participate in their Lean model improvement events focused on patient safety and care redesign. We are collaborating also with CCRMC on improving PRIME measures (Medi-Cal waiver) and on providing preventive care reminders to our members.

We collaborate with the Community Provider Network on increasing member completion of preventive services and on improving diabetes care. We are also encouraging our provider partners to become recognized by NCQA as Patient-Centered Medical Homes by offering our expertise in working with NCQA and financial support toward applying for the Recognition.

The Quality Director and others report to Clinical Leadership Group and Quality Council about these activities.

## **Quality Management Staff and Resources**

The work of the department is overseen by the Quality Management Director and carried out by two Registered Nurses, two Senior Health Education Specialists (one fluent in Spanish), a Quality Improvement Manager, a HEDIS Project Manager, a Quality Analyst, and one Secretary. In 2017, we added the position of Assistant Director of Quality and Population Health. She directs our Population Health Management Program and also directs work on improvement projects. Additional Quality Nurses are available as needed on a per diem basis. The department receives direction from CCHP's Medical Director and consultation and guidance from five Medical Consultants. The Medical Consultants are Board Certified in their areas of expertise: three in Family Medicine, one in Pediatrics, and one in Cardiology. The Medical Director, too, is a Family Medicine practitioner. We also have access to a consultant in Behavioral Health, and he participates in our Quality Council. The Medical Director chairs the Quality Council; the Medical Consultants are voting members. The Medical Director and Medical Consultants make decisions on grievances and appeals and provide consultation and direction on the selection and operation of Quality Improvement projects and other Quality Initiatives.

Most of the objectives in the Work Plan are executed by the departmental staff, but there is also collaboration across CCHP departments and with other areas of the county's Health Services Division. These staff are found in Member Services, where they provide information to members and help solve problems including resolution on non-quality of care grievances, Case Management, which provides Complex Case Management services as well as a Transitions program to support continuity and continuation of medical care, Analysis and Reporting Unit, which provides reports and extracts data needed for more extensive analysis by the department, Utilization Management which tracks utilization metrics and ensures that appropriate services are authorized for members, Information Technology which provides data and maintains and improves the Electronic Health Record, and Provider Relations which maintains the Community Provider Network, ensures appropriate credentialing and recredentialing, performs Facility Site Reviews, and assists with educating providers and involving them in our improvement activities.

To support and ensure that staff can meet program responsibilities and goals, the following resources are made available: sufficient and ergonomic work space, necessary equipment and software, contracted services as required, funds for materials and publications, career development reimbursement, funds for member incentives for healthy practices, Print and Mail services, and temporary staff as necessary.

## **Medical Director and Medical Consultants**

The Plan's Medical Director has ultimate authority over the Quality Program. He provides program oversight through regular meetings with the Quality Director, through direct guidance of Quality Department staff as appropriate, by input and approval of all major reports and documents originating from Quality and Utilization Management, and through chairing the Clinical Leadership Group and the Quality Council. The Medical Director provides guidance to the development of clinical guidelines, improvement projects, and other initiatives. The Medical Director makes determinations in grievances and appeals and has authority over peer review. The Program receives assistance and clinical direction from Medical Consultants who have regularly scheduled hours in the Quality Department and who participate in the Clinical Leadership Group and Quality Council. At least one Consultant is Board certified in Pediatrics, at least one is Board certified in Family Medicine, and one is Board certified in Behavioral Health.

## **Patient Safety**

Patient safety is addressed by multiple Plan departments. Quality Program staff gather available data, stratify HEDIS measures, and monitor grievances and occurrences. Clinical guidelines are carefully reviewed and approved by the Medical Consultants and the Quality Council to ensure they are aligned with best practices. Provider Relations staff perform Facility Site Reviews and chart reviews and share the data with the Quality Program. Pharmaceutical safety is also addressed through abuse reporting, provider multiple prescribing of opiates, identification and sharing with Case Management of members on high numbers of medications, drug safety updates, member education materials on correct drug usage and adverse drug reaction identification. The Quality Department collects, researches, and evaluates Potential Quality Incidents, which are possible quality issues identified by staff or others. When problems are found, a corrective action plan is created and followed up on. In cases of more serious safety risks or when issues remain unresolved within a reasonable amount of time, the Medical Director may decide to remove a provider from our network. Safety issues are also addressed in our member and provider newsletters and other publications.

## **Behavioral Health**

CCHP is responsible for mild to moderate behavioral health services for Medi-Cal and all mental/behavioral health services for commercial members. For Medi-Cal, CCHP partners with the Contra Costa County Behavioral Health Division to triage patients to determine level of severity and to provide appropriate treatment. For members who are seen at FQHCs in the community, members are generally triaged and treated at those facilities. Some County Health Centers are providing embedded behavioral health services. CCHP partnered with those clinics in several pilots to provide behavioral health care to patients receiving primary health care and primary care to patients receiving behavioral health care. Those services are now permanently established. They also now provide non-emergency drop in behavioral health care. Quality activities for behavioral health focus on HEDIS measures, continuity and coordination of care for outpatient behavioral health, and behavioral health practitioner access and availability.

A Psychiatrist is one of our Medical Consultants. This provider advises the Quality and UM departments on behavioral health aspects of those programs. He also sits on the Quality Council to provide insight into behavioral health issues. Another Behavioral Health provider serves on the Pharmacy & Therapeutics Committee.

## **Objectives for Serving Members with Complex Health Needs**

The Plan ensures members receive comprehensive high quality, well-coordinated care and service. The Complex Case Management program is focused on the delivery of cost-effective, appropriate health and social services for members with complex and chronic care needs. Proactive clinical and administrative processes are implemented to identify, coordinate, and evaluate appropriate services, which may be delivered on an ongoing basis. Case Management is performed through a process of telephonic assessment and review, and, as required, complemented with in-home visits. This program is directed at coordinating resources and creating individualized care plans to meet the member's unique medical and psychosocial needs. These services are provided by our Case Management Department. The Case Management Department also has staff to facilitate transfers from hospital to home to ensure that all equipment, medications, and appointments are arranged. The Population Health Management program is expected to provide additional support for members with complex needs.



## **Quality Management Governance**

The work of the QM Unit is reviewed and approved by CCHP executive management. QM Work Plan, Program Description, and Annual Program Evaluation receive approval from the Quality Council and our governing body, the Joint Conference Committee, which is chaired by a Board of Supervisors Member to provide oversight and appropriate review. To ensure appropriate opportunity for such oversight, the documents will be presented for approval in the meeting in the first quarter of each year. The documents will be distributed to the JCC electronically in advance of the meeting for approval in order to avoid the possibility that a quorum is not reached and therefore that the documents would not be approved until later in the year. The annual HEDIS report is also presented to those groups.

## **Quality Council**

The Plan's Quality Council provides oversight to the Program. The members review and evaluate reports from the Quality function and other departments; they identify needed actions, recommend policy decisions, and ensure follow up as needed. The committee ensures that providers are involved in the planning and implementation of quality initiatives, as well as their review.

### Membership

Members are nominated by the Chair and Co-chair and presented to the Council as either a voting or non-voting member. The nominees are accepted as members if a majority of the Council present agrees. Membership or voting rights can be removed by the same process.

### Voting Members

Medical Director, Chair

Quality Director, Co-chair

Director of UM and Auth

Case Management Director

Plan Pharmacy Director

Provider Relations and Credentialing Director

Marketing and member Services Director

Assistant Quality Director

Providers from both care networks (CCRMC, CPN), including the Plan's Medical Consultants. There should be at least two certified in Family Medicine, two in Pediatrics, and one in Behavioral Health. In 2020, the specialties represented are Pediatrics (2), Family medicine (3), OB-GYN (1), and Behavioral Health (1).

Non-voting Members

One or more non-physician representatives of the Contra Costa Regional Medical Center and Health Centers' Quality functions

Member Services Manager

The Council meets monthly, at least nine times per year. A quorum of half of the eligible voting members is required to make official decisions. It has responsibility to review and approve the reporting for the following committees and departments:

- Quality Department activities including: cultural and linguistic membership trends, linguistic needs and accessibility, multi-departmental health education projects and outreach, quality improvement reporting activities such as major regulatory reports, including the annual HEDIS report, and other results of quality measures, studies such as adherence to clinical guidelines, and projects such as Performance Improvement Projects (PIPs). The department also reports on activity and outcomes of the clinical quality grievances and access to care, stratified by network. Reports on grievance rates and appeal rates are presented quarterly. Comprehensive member satisfaction results are presented annually through the thorough evaluation of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and other satisfaction surveys, along with data from complaints and grievances. Annual delegation reports and quarterly data on the care networks, including oversight of Behavioral Health, are presented.
- Utilization Management: Annual program description and evaluation, major criteria or benefit changes. Approval of delegates' UM programs. (The Utilization Management Program and Evaluation documents are separate from the Quality Program documents.) Quarterly reporting on IRR, referral turn around time, under/over utilization, appeals/denials/referrals, UM Committee minutes referencing delegate reports reviewed.

- Case Management: Reports on programs and updates on improvement projects. Updates on service, including number of members served and their experience.
- Pharmacy: Reports on service and costs; improvement projects or studies; formulary updates and other reporting on proceedings of Pharmacy and Therapeutics Committee. The Pharmacy Management program will assure pharmacy administration practices are aligned with DMHC, CMS, and NCQA regulations and standards.
- Advice Nurse Unit reports on quality of service: call answer data and satisfaction measures, trends in call topics, and improvement projects.
- Member Services presents tracking data on grievances and appeals and service quality data on the Member Call Center.

Additional QC Responsibilities:

Requests for chartering of QI and PI projects or teams

Discussion/approval of Clinical Guidelines

Oversight of delegated entities, including review and approval of delegate QI programs and review of reports.

The Quality Council also receives informational reports from the Medical Director.

**Subcommittees Reporting to Quality Council**

Pharmacy and Therapeutics reports to QC semi-annually. P&T Advisory committee meets at least quarterly to review pharmaceutical management. P&T keeps the Quality Council and provider networks abreast of drug utilization activities, fraud, waste and abuse, and all other issues of pharmacy management. P&T also reviews formulary changes, drug safety updates, recalls, pharmacy restriction and preference guidelines and generic substitution, therapeutic interchange and step therapy and other pharmaceutical management policies.

Credentialing Committee presents semi-annually to the QC summary data on the operation of the credentialing function, such as number of providers credentialed, recredentialed, or dropped. It submits the detailed information and recommendations directly to the Board of Supervisors. See committee charter for detailed information.

UM Committee minutes come to QC as part of the quarterly UM/Auth report. This committee oversees all Utilization Management, Utilization Review, and Referral/Authorization policies and practices for the plan. Membership includes UM Director, Medical Director and consultants, including one from the Community Provider network, UM staff as assigned, Case Management Director, Quality Director, Claims Supervisor, and the Medical Director. The committee meets at least every two months.

CCHP/BH Meeting: Access Line Manager reports three times a year. The Quality Director reviews additional reports from them at CCHP/BH coordination meetings.

### **Clinical Leadership Group**

The CLG consists of the Medical Director, the Medical Consultants, a provider representative from the Community Provider Network, the Director of Utilization Management, Case Management Director, and the Quality Director and Assistant Director. Others are invited as required. The group serves to advise the Quality Director, solve problems in care delivery, and provide recommendations to the Quality Council. The group provides input on matters related to clinical practices, such as policies, clinical guidelines, improvement projects, and other clinical quality programs. For minor matters, such as approval of policies or guidelines with minimal updates, CLG can approve on Quality Council's behalf, as long as such activities are reported to QC to ensure there are no objections. The group meets monthly, at least nine times a year.

### **Functions and Strategies**

The overall functions of the Quality Program are:

Performance Measurement: Basing our prioritization of activity on high quality data helps ensure that the program is as effective and efficient as possible. Calculation of HEDIS (Health Effectiveness Data and Information Set) measures is essential to meeting contractual requirements with federal, state, and county entities and allows us to benchmark against other plans to identify opportunities to improve. Similarly, collection and analysis of stakeholder satisfaction allows us to prioritize opportunities for improvement. In addition, we provide oversight to delegated entities and contracted staff by reviewing their reports or otherwise measuring performance.

Quality Improvement: Based on priorities determined by data analysis and other methods, we apply a variety of established improvement methodologies and tools to improve the well-being and satisfaction of those we serve and to improve the internal working of the health plan. Two of our projects are PIPs (Performance Improvement Projects) required by the State. In 2019, these are Diabetes, including the Spanish speaking Latino population disparity, and Well Visits in the First 15 Months.. Other improvement projects are our own initiatives or collaborations with other organizations or County entities. We are working to establish a sustainable asthma home visiting program with the support of Green and Healthy Homes.

Accreditation: The QM Program takes the lead on interpreting standards, identifying gaps, consulting with other functions on closing their gaps, ensuring submission of appropriate and timely documentation, and providing general oversight and maintenance of the NCQA accreditation status.

Cultural and Linguistic Services: Health Services Leadership emphasizes the importance of appropriately serving our culturally and linguistically diverse membership. Our program is frequently recognized as being at the forefront of these services. We ensure that CCHP members are aware of and have access to linguistic services necessary for them to communicate when receiving health care services. We are assisting the County with implementing the concepts we created in the area of REaL (Race, Ethnicity and Language) data collection thus ensuring they meet their own evolving regulatory requirements and provide improved service to those served. These services are essential to our work on reducing health disparities and to ensuring that all of the population served receives appropriate, effective care and a more satisfying experience. We also provide training to CCHP staff and contracted providers on cultural awareness and sensitivity. In 2020, C&L staff will continue to assist in the Health Services-wide implementation of SO/GI (sexual orientation/gender identity) data.

The goals of our CLS program are:

- To prevent discrimination and to provide culturally sensitive and appropriate care to all CCHP members including beneficiaries with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. To provide oversight of cultural and linguistic services provided by contracted providers at CCRMC, Kaiser, and CPN
- To educate members, providers and employees about the importance of language services, cultural humility, health disparities, and their impact on health outcomes
- To assist providers in the delivery of culturally competent health care services
- To promote cultural competency/humility within CCHP in order to offer respectful and sensitive services to members
- To work with county health services department and community agencies to address the reduction of health disparities
- To be accountable and responsive to the needs of both our providers and our members for cultural and linguistic services and resources

Health Education: This program provides current educational materials for persons served by CCHP and reviews and promotes evidence-based materials and curricula for providers and staff members. We are making these available through electronic means where possible, while continuing to provide paper versions where necessary. Our program ensures that we meet all contractual, regulatory, and accreditation requirements in this area.

Population Health Management: In mid-2018, we began new interventions in support of Population Health. We began studying and planning for this program in late 2017. The program was built on our Disease Management programs and health education and preventive outreach efforts and is expanding the use of targeted interventions. Complex Case Management will also be an important aspect.

Service Excellence: The Quality Management Department strives to exemplify the County's Service Excellence philosophy in all of our internal and external interactions. Our department no longer processes grievances, but we do report on Quality of Care grievances semi-annually.

Additional service issues tracked (some described in other sections) include call answer data from the Member Service and Advice Nurse call centers, CAHPS and other survey results, access to care, and availability of services.

Patient Safety Staff regularly review data from grievances and appeals, PQIs and PPCs, access and availability data, HEDIS measures, survey results, Utilization and Case Management data, studies on adherence to clinical guidelines, and data from Facility Site Reviews to identify areas of risk to members' safety. Several programs are in place to improve safety, including the Disease Management Program, the Complex Case Management Program, the Performance Improvement Projects (PIPs), the High Acuity Program, and the Care Transitions program.

General Program Management: To provide the county and plan members with the kind of Quality Management Program they have a right to expect, we must support a culture of continuous improvement. Staff receive training and development. Program is evaluated to ensure it has the necessary resources to fulfill its responsibilities. The specific goals and the necessary actions to achieve the strategies behind these functions are detailed in the Work Plan. That document is created annually and updated throughout the year to reflect changes in direction and to track completion of tasks.

Additional quality management work is conducted by other departments. See the annual Case Management and UM reports for details.

Refer to the QI Work Plan for more details about activities planned, tracked, and assessed throughout the year. See also the Annual Evaluation of the prior year for trended measures, evaluation of effectiveness of the program, and descriptions of activities and barriers.

### **Top Goals for 2020**

Leadership met to set goals for the year. They are:

- Increase provision of well visits and preventive care
- Establish a sustainable asthma home visiting program
- Improve diabetes care and increase A1c control
- Educate members about appropriate use of the Emergency Room and Urgent Care facilities
- Improve completion rate of adolescent immunizations

**2020 Quality Program Description  
Signature Approval Page**

**Approved by CCHP Quality Council:**

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**Quality Council Committee Chair** **Date**

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**Quality Council Committee Co-chair** **Date**

**Approved by the Joint Conference Committee:**

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**County Supervisor Committee Member** **Date**

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**County Supervisor Committee Member** **Date**