No. QM-008	Quality Management Monitoring	
Effective Date: 1/1/2021	POLICY AND PROCEDURE	
Committee Approval: 01/19/2021 Previous Versions: see revision history on last page		
DMHC TAG: Quality Management		

Quality Management Monitoring Policy

Canopy Health is not delegated for Quality Management by its upstream health plans. Despite not being delegated, Canopy Health's upstream health plans require a Quality Management Program, including associated policies and procedures and Quality Improvement work plans. The Chief Medical Officer oversees this program in collaboration with Canopy Health's upstream health plans and delegates.

MONITORING OPERATIONS

Canopy Health monitors accessibility, availability, quality, utilization and continuity of care. The Quality Management (QM) Program monitors and documents service elements and utilization services, including accessibility and continuity of care, through appropriate study designs and sound statistical techniques when monitoring, conducting studies and developing reports. Monitoring and analysis include:

- All provider entities such as physicians, hospitals, outpatient surgery centers and other contracted providers and facilities;
- All service types such as preventive, primary, specialty, emergency, inpatient and ancillary care;

The QM Program utilizes a variety of monitoring approaches, which may include:

- National and regional performance benchmarks, including collection and review of HEDIS data
- Canopy Health, through its MSO, uploads all claims data for enrollees to a data warehouse including inpatient, ancillary and professional claims to track and trend quality and performance benchmarks, as well as shared-risk pool performance;
- The Provider Appointment Availability Survey results provided by the upstream health plans which assess for first available appointment times with primary care physicians and specialists;
- Patient satisfaction surveys to monitor quality and access;
- Investigating, tracking and trending enrollee complaints/grievances when provided by the upstream health plans and investigating provider complaints to identify problems in service, access and care;

Canopy Health refers identified issues, if any, to the upstream health plans and QM Committee or other body for input when appropriate. Canopy Health tracks issues referred for quality review such as complaints referred to the CMO to ensure that all issues are investigated, and the investigations are conducted on a timely basis. The QM Program contains the QM standards and procedures, including monitoring activities, and is provided to all healthcare practitioners and network participants.

SPECIFIC MONITORING AND EVALUATION PROCESSES

The Canopy Health QM Program utilizes an integrated process of quality of care monitoring problem identification, and effective action implementation to improve care when deficiencies are identified and planning follow-up where indicated. This process encompasses the following elements:

- Problem Identification and Monitoring – The QM Program may use multiple

avenues to identify opportunities to improve care and service, including, but not limited to, standardized performance measures, provider site visits, satisfaction surveys, investigation, tracking and trending member complaints/grievances, and investigation of provider complaints;

- Prioritization – QM staff, in conjunction with the Quality Management Committee, prioritizes identified opportunities for improvement based on acuity, prevalence, risk, practice standards, and available resources. The Quality Management Committee directs the prioritization, and reports this information to the Board of Directors through the annual QM work plan;

- Indicator Development – Indicators are selected to monitor each important aspect of care and service. An indicator may be utilized to monitor more than one aspect of care or service. Performance goals are established for each indicator or study. This is detailed in the QM work plan;

- Data Sources – Data utilized in QM activities are available from the Information Systems, Claims and UM, and include, but are not limited to, membership, claims, encounters, survey data, referral patterns, and complaint/grievance/appeal data;
- Data Collection, Analysis and Reporting – For each QM activity, the most representative data are selected, information is gathered, results are analyzed and reported. Canopy Health works in coordination with its participant providers and other stakeholders on study design and analysis;

- Development of Improvement Plans – Following the analysis of data collection

results, Canopy Health performs gap analysis to identify opportunities for improvement. Individuals or teams affiliated with the specific process being evaluated are assigned responsibility for development and implementation of improvement plans;

- Evaluation of Improvement Plans – Measures are built into all improvement plans and are tracked through the QM work plan.

- Practitioner Feedback/Performance Assessment – At the completion of a QM activity, results are provided to stakeholders, along with expectations for improvement, and opportunities for assistance from Canopy Health in formulating or continuing improvement activities.

PROCESS FOR INVESTIGATING QUALITY OF CARE REVIEW

- Clinicians with the appropriate knowledge or specialty (e.g. RNs, MDs) are involved in the review process.

- In the event that an 805 Report must be submitted by any contracting IPA and/or Medical Group to the Medical Board of California, such IPA and/or Medical group shall notify Canopy Health's Quality Management and Credentialing/Peer Review Committee and a copy of the 805 report shall be submitted to Canopy Health's Medical Director.

  The Peer Review/Credentialing Committee ensures contracted IPA and/or Medical Groups and comply with industry standard and regulatory compliant peer review

mechanisms, including, but not limited to:

1. A case scoring system that is standardized, defined, and communicated to physicians involved in peer review.

2. Corrective action plans are submitted as required by IPA and/or Medical Group policy and procedures.

3. Canopy Health has the right to request evidence that corrective actions have been implemented by the offending providers.

4. A system is established to judge the severity of issues and the care involved that relies on professionally accepted standards of practice.

5. A Medical Board of California 805 report shall also be filed within 15 days following the imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days.

6. The information to be reported in an 805 report includes the name and license number of the licentiate involved, a description of the facts and circumstances of the medical disciplinary cause or reason, and any other relevant information deemed appropriate by the reporter.

7. The Chief of Staff of a medical or professional staff or other Chief Executive Officer, Medical Director, or Administrator of any peer review body and the

Chief Executive Officer or Administrator of any licensed health care facility or clinic files an 805 report with the relevant agency within 15 days after the effective date of any of the following situation occurring as a result of an action of a peer review body:

- A licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason;
- A licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason; or
- Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.

8. The chief of staff of a medical or professional staff or other chief executive officer, Medical Director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after any of the following occur after notice of either an impending investigation or the denial or rejection of the application for a medical disciplinary cause or reason:
   - Resignation or leave of absence from membership, staff, or employment;
   - Withdrawal or abandonment of a licentiate's application for staff privileges or membership; or
   - Request for renewal of privileges or membership is withdrawn or abandoned.

9. A copy of the 805 report and a notice advising the licentiate of his or her right to submit additional statements or other information are sent by the peer review

body to the licentiate named in the report and a copy of the report is submitted to Canopy Health Peer Review and Credentialing Committee.

10. A supplemental report is made within 30 days following the date the licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as disciplinary action by the reporting peer review body.

11. A Medical Board of California 805.01 form must be filed when a final decision or recommendation has been made by the peer review board. The 805.01 must be filed for the following 4 reasons. These 4 reasons do not have to go to hearing before the 805.01 form is filled out. The proposed action must be given to the practitioner within 15 days after the peer review body makes the recommendation or final decision:

    - Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public;
    - The use of, or prescribing for or administering to himself or herself of any controlled substance, any dangerous drug (as specified), or alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that the licentiate's ability to practice safely is impaired by that use;

    - Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or

furnishing of controlled substances without a good faith effort prior examination of the patient and the medical reason therefore (note that in no event shall a physician or surgeon who is lawfully treating intractable pain be reported for excessive prescribing, and if a report is made, the licensing board must promptly review any such report to ensure these standards are properly applied); and

- Sexual misconduct with any patient during a course of treatment or an examination.

WORKPLAN AND ANNUAL REVIEW

Canopy Health implements a QM Work Plan for corrective actions or QM Programs to address identified quality issues by incorporating input from appropriate professionals into the design of the QM work plan.

The QM Program and QM Work Plan are reviewed, evaluated and revised on an annual basis to assess the effectiveness of its QM Programs. Results of the evaluation are used to formulate corrective actions to the next year's program and are the basis of the next year's QM Program QM Work Plan. The annual evaluation, revised QM Program, and QM Work Plan activities are submitted to the Board of Directors for review, input, and final approval. The QM Work Plan is reviewed semi-annually by the Quality Management Committee, which includes monitoring the effectiveness of the programs and tracks how the QM Work Plan is incrementally performing.

ACCOUNTABILITY AND AUTHORITY

Canopy Health's Board of Directors retains overall responsibility for the QM Program. The Board of Directors meets quarterly and receives reports from the Quality Management Committee which includes minutes from the Utilization Management Committee, Credentialing/Peer Review Committee and the Delegation Oversight Committee. These reports include: performance relative to established clinical, utilization and patient satisfaction benchmarks; credentialing status and issues; compliance with accessibility standards; complaints and grievances; and the status of quality of care initiatives as outlined in the QM plan.

Revision History:

Version Date	Edited By	Reason for Change
11/9/15	M. Stevens	Creation date
7/18/16	M. Durbin	Consolidated sections of Exhibit J-1 and J-3 pertaining to QM management monitoring into a single, standalone policy.
7/1/20	M. Durbin	Added paragraph about QM functions and lack of delegation and required functions. Changed term from "Network" to "Canopy Health". Added reporting obligations to upstream Health Plans and Delegation Oversight Committee. Removed reference to obligations of the upstream health plan oversight of referrals activities not undertaken by Canopy Health.
12/22/20	M. Durbin	Continued clarification of Canopy Health's Quality Management responsibilities.