



**HEALTH NET  
QUALITY IMPROVEMENT  
PROGRAM DESCRIPTION  
2004**

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# Section 1

# Introduction and Background

# Introduction and Background

Health Net Health Plan of Oregon, Inc. is a subsidiary of Health Net, Inc., a publicly traded company with health care operations throughout the United States. Health Net Health Plan of Oregon, Inc. is located in Clackamas, Oregon and provides health care coverage to individuals in Oregon and Southwest Washington.

The company traces its roots in the Pacific Northwest to 1938, when a group of Clackamas county physicians joined with local millworkers and employers to seek innovative ways to provide quality health care at affordable costs. Their vision became PACC Health Plans, a local carrier that emerged as a leader in developing community-focused managed care plans. In 1997, PACC was bought by QualMed Oregon. In April 2000, the plan changed its name to Health Net, signaling a new era of innovation and service.

Health Net Life, Inc., is also a subsidiary of Health Net, Inc. Health Net Health Plan of Oregon, Inc. provides administrative services for its affiliate Health Net Life, Inc. for Health Net Life, Inc. insurance products issued in Oregon and Washington.

For purposes of this Quality Improvement Program Description, Health Net Health Plan of Oregon, Inc. and Health Net Life, Inc. will be referred to as Health Net. This document will apply to Health Net members who have health care coverage products and services administered by Health Net Health Plan of Oregon, Inc.

## Health Plan Products and Membership

Health Net currently administers the following products:

- Large and Small Group PPO, HMO, POS , and Indemnity
- Individual and Family PPO
- Medicare Supplement
- Medicare +Choice PPO

## Provider Network

Health Net contracts with more than 6,000 health care providers including over 40 hospitals, and other ancillary services including home health care, durable medical equipment, radiology/imaging, skilled nursing homes, rehabilitation, laboratory services, and hospices. Health Net also contracts with organizations to provide mental health/chemical dependency, vision, pharmacy, and alternative care services.

## Information Systems and Analysis

Health Net's Information Systems consist of a number of integrated databases which support the Quality Improvement Program. The major sources of data utilized for quality improvement activities are obtained from the following systems:

- Claims
- Customer Service
- Membership Accounting
- Provider
- Encounter
- Credentialing
- Medical Management
- Grievance and Appeals

# Section 2

# Mission

## Mission

Health Net is responsible for providing accessible, cost-effective, high quality care and services to its members throughout the continuum of care in accordance with the mission statement:

*The Health Net mission is to help people be healthy, secure and comfortable.*

Health Net provides service to members to assist them as they move through the health care system to reduce barriers to care and support them in reaching their highest level of health. Health Net credentials and contracts with individual practitioners, organizational providers, and institutions to deliver health care and service to members. Health Net maintains responsibility for delegated and non-delegated activities.

## Purpose and Goals

Health Net's Quality Improvement Program (QI Program) provides structure and processes that enable Health Net to carry out its mission and commitment to ongoing improvements to the quality of care and services, availability and access to care, and health status of members. It is an evolving program that is responsive to the changing needs of Health Net's members and standards established by the medical community and regulatory agencies. The QI Program is integrated throughout Health Net's functional areas with each department accountable for reviewing procedures, systems, quality, cost and outcomes related to their areas of responsibility to ensure that they meet regulatory requirements, achieve business objectives, and add value to members and providers.

The purpose and goals of the Quality Improvement Program are:

- Develop and maintain an integrated Quality Improvement Program that provides structure for promoting and achieving excellence in all areas through continuous quality improvement.
- Monitor the quality of care and services provided by participating providers, medical groups, organizational providers, managed behavioral health organizations, and delegated entities to Health Net members.
- Use an ongoing, systematic approach to monitor, evaluate, and improve the quality, appropriateness, availability, and accessibility of medical care and services provided to Health Net members.

- Identify opportunities for improvement of the health status of members through the development and implementation of health promotion, preventive education, and disease management programs.

## Program Objectives

- QI Program objectives direct staff, activities, and resources to achieve the established QI Program goals. Written objectives are included in the QI Work Plan and address:
  - Planned activities
  - Persons responsible
  - Time frames for meeting objectives
  - Date tasks completed
  - Outcome/status of interventions
- Objectives are developed and established based on:
  - Recommendations resulting from a review of the previous years QI program
  - Changes in Health Plan policies or procedures, and/or regulatory requirements
  - Changes in member demographics, network, and member and provider satisfaction/data, complaints, grievances and appeals

## Confidentiality

Health Net has policies and procedures for the collection, handling, storage and release of confidential information to protect the privacy and confidentiality rights of members, employees, providers and the company, and to ensure the appropriate and legitimate use of information. Health Net contracts require that practitioners and providers maintain the confidentiality of member information and records. Information or copies of records may be released only to authorized individuals as permitted by state and federal law. All documents created as part of the quality improvement program are maintained in a secure fashion in accordance with federal and state law.

The Health Net, Inc. Privacy Officer is responsible to review, approve and disseminate confidentiality policies and practices regarding the collection, use and disclosure of medical information.

## Conflict of Interest

Health Net associates are required to adhere to the Health Net, Inc. policies and procedures for conflict of interest. The Code of Business Conduct policy defines and outlines the individual's responsibilities for complying.

# Section 3

# Program Structure

# Quality Improvement Program Structure

## Roles and Responsibilities

Health Net has established a Quality Improvement Program Committee structure that allows for thorough discussion and consideration of quality improvement activities from multiple areas. Each department is represented and is responsible to meet the established goals and objectives of the Quality Improvement Program by:

- Selecting quality improvement activities and initiatives;
- Designing the study methodology;
- Collecting study data;
- Analyzing quantitative and qualitative data;
- Designing improvement plans;
- Implementing improvement plans across Health Net;
- Evaluating the effectiveness of the Quality Improvement Plan;
- Convening service and clinical quality improvement activity work groups;
- Reporting outcomes and results to regulatory agencies;

The Board of Directors (Board) has ultimate authority and responsibility for the QI Program. The Board delegates the responsibility of the QI Program to the Quality Improvement Committee. The Board provides oversight to the QI Program through reviewing and approving annual revisions to the QI Program Description and Work Plan and provides direction, as needed, based on a review of program updates and annual QI Program Evaluation.

Health Net's Medical Director, (licensed Oregon and Washington physician) has substantial involvement in the design and implementation of program activities that involve or affect clinical care and patient safety, in addition to overall development and evaluation of the QI Program. The Medical Director chairs the QI Committee and three QI sub-committees and participates in the analysis of utilization management and quality improvement data, and decisions regarding provider participation status.

The Quality Improvement Manager is responsible for the structural components of the QI Program including the development of the annual QI Program Description, Work Plan, and Evaluation, Work Plan updates, reporting and meeting schedule, agenda, and minutes, and development of reports for submission to the Board. The Quality Improvement Manager also participates on the quality improvement committee of Health Net's mental health provider.

The Organizational Effectiveness Department maintains current job descriptions that define the role and responsibilities for each position.

## **Quality Improvement Committee Structure**

The Quality Improvement Committee structure includes the Quality Improvement Committee (QIC) and five sub-committees. Each committee meets at a minimum on a quarterly basis with additional meetings added as needed to meet program goals and objectives within established time frames. QIC and sub-committee minutes are recorded at each meeting. Minutes include the topics and key discussion points, and planned actions/follow-up if needed. Participating practitioners are active members on the following sub-committees: Utilization and Quality of Care Committee (UQCC), Professional Review Committee (PRC), and Pharmacy and Therapeutics Committee (P&T). (See Exhibit 1—Quality Improvement Committee Schematic)

### **Quality Improvement Committee**

The Quality Improvement Committee (QIC) oversees the design, implementation, and evaluation of the QI Program, and ensures QI Program goals and objectives are met within established time frames. The QIC conducts final approval on policy and procedures and QI Program documents including the annual QI Program Description Work Plan and Evaluation. The QIC reviews outcome data and reports from quality improvement activities and subcommittees, institutes needed actions as a result of reported findings, and ensures follow-up as appropriate. Representatives from QI sub-committees provide updates to the QIC on a regular basis. Updates of QI Program activities are presented to the Board of Directors for review and approval. (See Exhibit 2—QIC Reporting Schedule).

The QIC, chaired by the Health Net Medical Director, includes the Director of Health Services, Director of Pharmacy, Director of Product Development, Director of Sales, Quality Improvement Manager, Credentialing Manager, Provider Relations/Contracting Manager, Customer Service Manager, and Claims Quality Assurance Manager.

## Quality Improvement Sub-Committees

### Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) assures provision of safe, appropriate, quality and cost-effective health care services to members. The UMC reviews the clinical practice and preventive guidelines used in decision-making, monitors medical, surgical, and pharmacy utilization indicators to identify trends of under- or over-utilization and medical/care management processes to identify opportunities for process improvement. The UMC is also responsible for oversight of delegated utilization management activities and reports, and monitoring both delegated and non-delegated utilization data for both under and over utilization.

The UMC is responsible for the development/revision and approval of the annual Utilization Management Program Description, Work Plan, and Evaluation. These documents are then submitted to the QIC for final review and approval.

The UMC, chaired by the Health Net Medical Director, includes the Director of Health Services, Director of Pharmacy, Senior Case Manager, Quality Improvement Manager, Care Manager Supervisor, Project Coordinator and two network providers representing two different specialty areas. A representative from UMC provides quarterly updates on activities at QIC meetings.

### Operations Quality Committee / Concept to Completion (C2C)

The Operations Quality Committee / Concept to Completion (C2C) evaluates the quality of services provided to members to improve efficiencies, contain costs, and enhance overall member satisfaction. The committee reviews modifications or additions to state or federal regulatory requirements and facilitates the development of policies and procedures, system changes, and/or member communication materials to be compliant with the requirements.

C2C conducts an analysis of member and provider satisfaction by reviewing formal feedback through complaints, grievance and appeals data, and informal comments from Health Net staff, employer groups, providers, agents and brokers. Based on these evaluations, C2C reviews benefit language/structure, member materials, and processes and allocates resources for appropriate interventions aimed at making benefit and process changes to improve communication and services to Health Net members and other customers.

The C2C, chaired by the Director of Product Development, includes department managers and supervisors. A representative from the C2C provides regular updates on activities and programs at QIC meetings.

### **Professional Review Committee**

The Professional Review Committee (PRC) provides oversight to the credentialing program, ensures network providers are qualified and provide quality and safe clinical care and services to members, and approves program policies and procedures. The PRC is responsible for the evaluation of provider credentials and final decision on acceptance or continued participation in Health Net's network. The PRC also reviews quality of care concerns or provider issues that may pose a risk to members and oversees delegated credentialing/re-credentialing activities.

The PRC, chaired by the Health Net Medical Director, includes the Credentialing Manager, a representative from the Provider Services/Relations Department, and a multi-disciplinary representation of network practitioners. The chair may also appoint, on ad hoc basis, participation on the committee by network providers representing a specific profession. A representative from the PRC provides quarterly updates on activities and programs at QIC meetings.

### **Pharmacy and Therapeutics Committee**

The Pharmacy and Therapeutics Committee (P&T Committee) reviews the quality, effectiveness, and safety of new medications, therapeutic classes on the Formulary, and conversion programs. Retrospective Drug Utilization Review and Drug Use Evaluation is conducted to assess both quantity and quality of medication use.

In addition to Health Net's P&T Committee, the Medical Director and Director of Pharmacy participate in the Health Net, Inc., National P&T Committee. Input and recommendations from the National Committee provide Health Net with information and guidance for drug product selection, appropriate use criteria and consistent policies.

The P&T Committee, chaired by the Health Net Medical Director, includes the Director of Health Services, Director of Pharmacy, and network physicians and pharmacists. A representative from the P&T Committee provides quarterly updates on activities and programs at QIC meetings.

## **Delegation Oversight Committee**

The Delegation Oversight Committee (DOC) monitors Health Net's delegated activities. DOC is responsible for developing oversight policies and procedures, workflows, and assessment tools and establishing reporting requirements. The committee reviews the results of pre-assessments and annual assessments, monitors compliance with established Health Plan performance standards and regulatory requirements, and reviews corrective action plans and reports on delegated activities. Based on this oversight the DOC makes recommendations on whether delegation should be established/continued with an organization and implements corrective action plans to resolve regulatory compliance or performance issues. Final Decisions to establish or terminate an agreement with a Delegate are made by the Executive Management Team.

The DOC, chaired by the Quality Improvement Manager, includes the Director of Health Services, Ancillary Contracts Manager, Director of Pharmacy, Director of Product Development, Credentialing Supervisor, Customer Service Manager, Claims Quality Assurance Manager, Membership Accounting Manager, Claims Liaison, Claims Supervisors, Finance Manager, and auditors from Health Net Inc.'s Audit and Advisory Services. A representative from the DOC provides quarterly updates on activities and programs at QIC meetings.

# Section 4

# Program Scope

# Quality Improvement Program Scope

The Quality Improvement Program includes the development and implementation of standards for clinical care and service, the measurement of conformance to the standards and implementation of action to improve performance. These efforts cover all lines of business including Commercial, Individual and Medicare products. The scope of these activities is determined in an annual evaluation of the previous years Quality Improvement Program, demographics and health risk characteristics, public health goals and feedback from members and providers. The scope of the program includes:

## Health Plan Performance

Key Indicators, experience-rated benchmarks and industry-driven performance standards are used to report and evaluate key aspects of operations. Department managers and supervisors are responsible for the Key Indicators within their area of responsibility. Reports are updated and reviewed on a regular basis and used as the basis for the development and implementation of initiatives to maintain and improve internal processes to a level that meets established performance standards.

## Member Satisfaction

Complaints, grievances and appeals are tracked and reviewed on a regular basis for identification of trends and to make modifications to communication materials, benefits changes and/or process improvements that will improve care and service to members. Information/feedback from member committees, providers, brokers/agents, and surveys are also used to evaluate member satisfaction.

## Network Adequacy and Access to Care

An ongoing review of Health Net's network is conducted to ensure the network is adequate and access needs are being met for all levels of care. The review includes an analysis of the scope of the network physicians, including primary care and specialists, facilities and ancillary services in relationship to member's needs. Site and medical record reviews are also conducted to ensure access to care and services, and appointment standards are met. Recruitment will take place in areas where unmet needs are identified. Referral policies and procedures are identified and documented to meet the service needs of members who are located in areas where network services are not available.

## Quality and Safety of Care and Services

A thorough review is conducted on any quality and/or safety of care or quality of service concern identified internally by a Health Net associate based on established Quality Indicators, or reported externally by a provider, member, or the member representative. Major adverse events where significant standard of care issues are identified are reviewed by Health Net's Medical Director and PRC. Reports are monitored for quality of care and service concerns to identify any trends by a particular provider. These reports are also utilized in the re-credentialing process.

## Utilization Management

Health Net operates a multi-dimensional Utilization Management Program (Program) to direct and monitor the use of health care services provided to its members. The Program is designed to promote fair, safe and consistent utilization management decision making. The Program is under the clinical supervision of the Medical Director, an Oregon and Washington licensed physician, who has substantial involvement in developing and implementing the program.

The program involves prior authorization, concurrent, and retrospective review evaluation of the utilization of services provided to members. The program requires cooperative participation of HNOR, participating practitioners, delegates, hospitals, and other providers to ensure a timely, effective, and medically sound program. The program is structured to assure that medical decisions are made by qualified health professionals, using written criteria based on sound clinical evidence, without undue influence of Health Net management or concerns for the plan's fiscal performance. The model is patient centric and empowers the member with knowledge that allows them to become more active participants in health care decisions.

The Utilization Management Program Description summarizes the utilization management policy, procedures and process, and the use of utilization management standards.

## Credentialing and Recredentialing

Initial credentialing and recredentialing is conducted on licensed health care practitioners and organizational providers in accordance with industry standards and regulatory requirements. Participation in Health Net's network is determined by the degree to which applicants meet defined eligibility requirements including education/training, licensure, professional liability insurance, claims history, regulatory sanctions, and professional standing. Onsite medical record reviews and site visits are also included in the

credentialing decision process for primary providers, OB/Gyn's, Pediatricians, and Internal Medicine physicians.

## **Disease Management and Health Improvement**

Based on a health risk analysis of the member population, disease management interventions are developed and focus on improving the health status of members with a chronic disease or condition. Interventions include, but are not limited to, individual case management, care coordination, access to educational/community resources, and educational reminders to access recommended screenings applicable to their disease.

Health Net offers a number of health improvement programs and web-based educational resources that encourage members to adopt a healthy and active lifestyle and participate in regular self-care. Quality initiatives are also conducted which remind members to receive preventive health screenings and exams.

## **Delegation Oversight**

Health Net may delegate to an organization the authority and responsibility to carry out an activity that is otherwise performed by Health Net including claims, customer service, credentialing, utilization management, pharmacy benefit administration, and membership accounting. Quality improvement functions are not delegated and Health Net reviews the Delegates' internal quality improvement programs and documents to ensure that state and federal regulatory requirements are met. A pre-delegation review is conducted by Health Net prior to delegating functions to an organization. Entities who do not meet Health Net's criteria must complete a satisfactory corrective action plan before services will be delegated.

Health Net retains accountability for delegated activities and conducts assessments and reviews reports and policies and procedures to assure established standards and regulatory requirements are met. Health Net also retains the grievance and appeals functions as a way to monitor the quality of care and services provided to Health Net members. A corrective action plan must be successfully completed by those Delegates who do not meet established quality standards. Delegation oversight documents are maintained in hard copy and/or electronically, when possible.

## **Section 5**

# **Program Evaluation and Work Plan**

# Program Evaluation and Work Plan

## Quality Improvement Program Evaluation

An annual Quality Improvement Evaluation (Evaluation) is completed to determine the overall effectiveness of the QI Program in meeting established goals and objectives based on outcome information in clinical performance, program participation, network adequacy and access, quality of care and service, and member and provider satisfaction. The QI Program is also evaluated against regulatory requirements to ensure compliance.

Actions taken in response to the annual Evaluation of the QI Program include revising the Program Description and goals and objectives, re-allocating resources to meet objectives, and developing the annual Work Plan for the following year. Consideration is also given to changes in Health Plan policies/procedures, regulatory requirements, member demographics, and network and service area. The Evaluation is reviewed and approved by the QIC and the Board.

## Quality Improvement Program Work Plan

An annual Quality Improvement Work Plan (Work Plan) defines the QI Program's goals and objectives, and planned activities and projects to be accomplished for the year. The Work Plan identifies the staff and/or committee responsible for completing the activities and establishes the time frame for when the activities or projects are to be completed. The Work Plan also provides a structure for measuring progress towards achieving program objectives through regularly scheduled updates and a review of the document at quarterly QIC meetings. The Work Plan is developed annually and is approved by the QIC and Board.

Information about Health Net's Quality Improvement Program, including program description, activities and projects and progress toward goals is available, upon request, to members, prospective members, and providers. Health Net notifies members of the availability of information about the quality improvement program through the member handbook. Providers are notified of the availability of information about the quality improvement program through the Provider Operations Manual.

**ACKNOWLEDGEMENT AND APPROVED BY:**

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Andrew Glass, M.D. Date  
Medical Director, Chair of Quality Improvement Committee  
Health Net Health Plan of Oregon, Inc.

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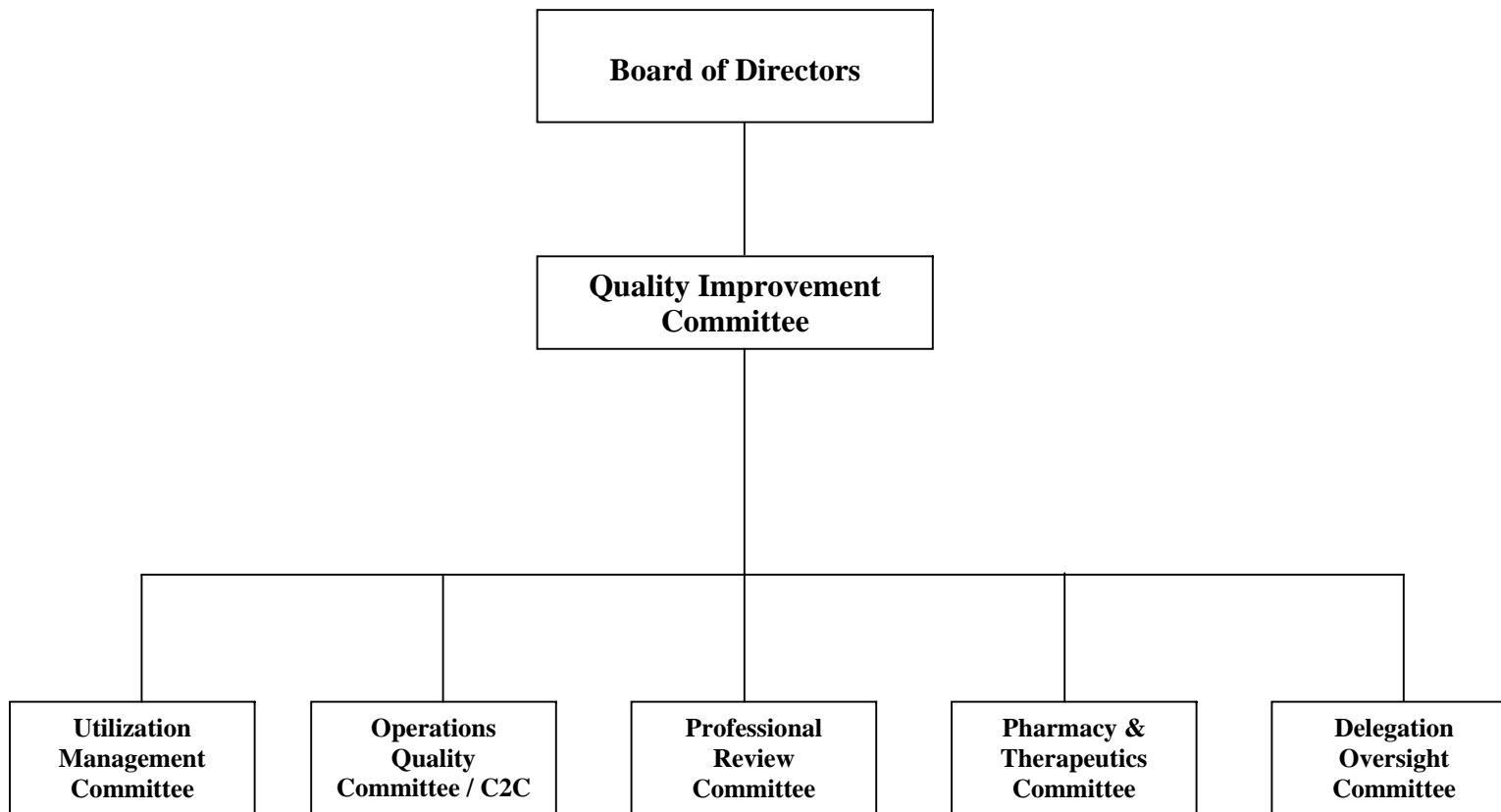
Stephen Lynch Date  
President  
Health Net Health Plan of Oregon, Inc.

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Chris Wing Date  
Chair of Board of Directors  
Health Net Health Plan of Oregon, Inc.

**Exhibit 1**

**Quality Improvement Committee Schematic**



**Exhibit 2**

<b>Quality Improvement Committee Reporting Schedule</b>													
		Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>QI MEETING (Quarterly / Adhoc as needed)</b>			X		X			X			X	X	
<b>BOD MEETING</b>					X	X			X			X	
<b>C2C</b>	Quarterly		X		X			X			X		
<b>P&amp;T Committee</b>	Quarterly		X		X			X			X		
<b>UMC</b>	Quarterly		X		X			X			X		
<b>PRC</b>	Quarterly		X		X			X			X		
<b>DOC</b>	Quarterly		X		X			X			X		
<b>Update QI Work Plan</b>	Quarterly		X		X			X			X		
<b>Review/Approve QI Program Updates</b>	Quarterly		X		X			X			X		
<b>Review/Approve Annual UMC Program Evaluation and Description</b>	Annually											X	
<b>Review/Approve Annual QIC Program Description</b>	Annually				BOD							X	
<b>Review/Approve Annual QIC Program Work Plan</b>	Annually				BOD							X	
<b>Review/Approve Annual QIC Program Evaluation</b>	Annually				BOD							X	