HERITAGE PROVIDER NETWORK

&

AFFILIATED MEDICAL GROUPS

POPULATION HEALTH MANAGEMENT PROGRAM

2023

Approval Signature

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Population Health Management Program

The Heritage Provider Network (HPN) and affiliated medical groups (Groups) approach to Population Health Management (PHM) addresses Member needs across the continuum of care with a cohesive, organized Population Health Management Program (Program), including:

1. Program Description
2. Data Integration
3. Population Assessment
4. Targeted Interventions
5. Practitioner Support
6. Measurement and Quality Improvement
7. Members' Rights and Responsibilities

The PHM process provides member-centric care coordination and management for large and diverse member populations. The size and complexity of the network requires multiple programs and approaches to accommodate the needs of a population that has wide variation in age, geography, resources, benefits and culture. The overall goals of the Population Health Program focus on the Triple Aim Health Care Delivery Model.

1. Improve the health of the population
2. Improve the experience for each member
3. Reduce the overall cost of care

Program Structure

A. Governing Body

HPN's Executive Committee shall have ultimate authority and responsibility for the PHM Program. The Executive Committee will establish and maintain an effective and efficient PHM Program and will ensure that each of its Groups receives and complies with all aspects of the Program. The structure and responsibilities of the Executive Committee are outlined in the Executive Committee Charter and made available to its committee members.

B. Quality Improvement Committee

HPN's Quality Improvement Committee reports to the Executive Committee at least semi-annually. Any ad-hoc committees or sub-committees of the QI Committee will report to the Executive Committee via the QI Committee.

The QI Committee will meet at least four times per year to review, evaluate, and provide the Executive Committee with any recommendations for revisions to the Program. For urgent issues that require immediate updating, these will be addressed separately via ad-hoc committee meetings (either virtual or in person), utilizing appropriate practitioners and or Workgroup members. The structure and responsibilities of the QI Committee are outlined in the QI Committee Charter and made available to its committee members.

C. Population Health Management Workgroup

The HPN PHM Workgroup and QI Committee serves as the oversight body for all Program activities and resources. The Workgroup utilizes population assessment and segmentation data to gain a deeper understanding of member populations. Each population has its own needs and assets, as well as its own culture and social structure. The collection, monitoring and analysis of population data allows for the development of targeted interventions for specific member populations, and provides actionable data upon which program planning and strategies may be developed; including the ability to evaluate program efficacy. Identified gaps in services and/or resources serve as the basis for PHM Workgroup and QI committee discussions and assessment of population needs. The discussions are reflected in the PHM Workgroup and QI committee meeting minutes and serve as a resource for further decisions.

HPN's Population Health Management Workgroup reports to the QI Committee at least semi-annually. The PHM Workgroup will meet at least four times per year to review, evaluate, and provide the QI Committee with any recommendations for revisions to the Program. For urgent issues that require immediate updating, these will be addressed separately via ad-hoc Workgroup meetings (either virtual or in person), utilizing appropriate practitioners and or Workgroup members. The structure and responsibilities of the PHM Workgroup are outlined in the PHM Workgroup Charter and made available to its Workgroup members.

Minutes and records are kept of all activities for which the PHM Workgroup is responsible and are considered confidential. Such materials may be made available as required to appropriate staff or representatives from contracted health plans, regulators, or accrediting agencies. Each attendee, including guests, at each PHM Workgroup meeting will agree to confidentiality and conflict of interest statements.

The composition of the PHM Workgroup shall include but is not limited to:

1. HPN's designated senior-level physician
2. Designated senior-level representatives from each Group
3. Designated HPN PHM Program administrator

Additional personnel from HPN and its Groups may participate in the PHM Workgroup as determined to be appropriate but are not considered voting members of the PHM Workgroup. Health plan representatives may participate within areas that apply to member health plans, upon invitation.

The responsibilities of the PHM Workgroup shall include but are not limited to:

1. Overseeing the appropriateness of health care delivery and member and practitioner satisfaction with the Program
2. Reviewing, revising, and approving the Program and its policies, procedures, and description documents annually or more frequently as needed
3. Evaluating Groups' PHM activities to ensure they are being conducted in accordance with HPN's expectations and regulatory, accreditation, and policy standards
4. Reviewing regular reports from Groups
5. Identifying opportunities for quality improvement
6. Utilizing population assessment and segmentation data to gain a deeper understanding of member populations.
7. Review and update of PHM activities to address subpopulation needs

8. Review and update PHM resources to address subpopulation needs
9. Review community resources for integration into program offerings to address member needs

D. Designated Senior-Level Physician

HPN shall designate a senior-level physician (medical director, associate medical director, or equivalent) who holds an unrestricted license to practice medicine in the State of California issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act. These individuals hold responsibility for implementation, supervision, and oversight of the PHM Program as well as being involved in PHM activities, setting and adhering to PHM policies, supervising program operations, reviewing PHM cases, participating on the PHM Workgroup, and evaluating the overall effectiveness of the PHM Program.

E. Group PHM Departments

HPN's Groups will designate clinical (including licensed physicians and nurses) and non-clinical staff to execute PHM activities. The Groups' designated senior-level representatives shall provide primary oversight of the Groups' PHM functions and may work within existing Group functions, such as utilization management and quality improvement. Such departments are responsible for executing functions within the scope of the Program.

The HPN PHM Program and its correlative documents will be resources to Groups to ensure compliance with the applicable regulatory and accreditation standards. HPN will distribute the approved PHM Program and relevant policies, procedures, and correlative documents to its Groups to be implemented as directed by HPN's PHM Workgroup and QI Committee. Groups are responsible for distributing the Program to their staff and contracted providers at least annually to ensure that all are advised of Program requirements and processes.

F. PHM Staff Assigned Activities

Non-clinical staff are responsible for intake and data entry of Program activities, health plan communications, community health outreach efforts, and other valuable non-clinical duties as directed.

PHP 1: Program Description

HPN uses up-to-date evidence-based information to develop the Program, and regularly updates the Program with relevant findings and information. HPN reviews and adopts new findings that are relevant to the Program as they become available.

Annual PHP 1: Program Description elements below are further defined in the document: **2023 PHM Program Initiatives**.

A. PHM Program Description

HPN includes the following elements in the development of the Program:

1. Evidence used to develop the Program
2. Criteria for identifying members who are eligible for the Program
3. Services offered to members
4. Defined program goals

Evidence Used to Develop the Program

HPN uses up-to-date evidence to develop the Program and its case management services, and may be derived from the following sources:

- Clinical practice guidelines from recognized sources
- Clinical pathways developed by specialists
- Scientific evidence from clinical or technical literature or government research
- Evidence from literature reviews for nonclinical components of the program (e.g., dealing with member behavior change)

Eligibility Criteria

HPN specifies Member eligibility criteria for participation in the Program and its services.

B. Systematic Review of Evidence

At least every two years, HPN performs a systematic review of evidence used to develop the program. All new evidence (including clinical or technical literature or government research sources) is reviewed by at least two appropriate professionals. Appropriate professionals (e.g., nurses, pharmacists, social workers, social service providers) are certified or have received specialized training related to the program's subject matter.

C. Program Content Consistent with Evidence

HPN performs the following in the development of the Program:

1. Reviews Program content against evidence used to develop the Program
2. Assesses whether Program materials are consistent with current evidence, and if they are not, takes actions to make them consistent
3. Assesses whether staff training materials are consistent with current evidence, and if they are not, takes action to make them consistent
4. Reviews program content for cultural and linguistic appropriateness

Review of Program Content

HPN reviews its Program content, including all information (e.g., materials, reminders, phone call scripts) and interventions Groups disseminate to members or practitioners to improve health care delivery and management and to promote high quality, cost effective outcomes. Program content may be directed at caregivers if the eligible member is a child or adolescent, or is cognitively impaired.

Materials for members include all information Groups direct at members to support them as they manage their conditions or health risks.

Staff training materials include all information HPN and Groups disseminate to staff to help them provide evidence-based care based on the needs of the population it serves.

Cultural and Linguistic Appropriateness

Linguistic and cultural issues can significantly affect member's ability to synthesize Program content and to understand the services they are receiving. HPN assesses the cultures and languages of its populations to identify potential barriers to effective communication or care and acceptability of specific treatments. The

assessment considers health beliefs and practices, health literacy, preferred languages or other communication needs.

D. Program Information

Groups provide eligible members with written information about:

1. How to use HPN and Group services
2. How members become eligible to participate in the Program
3. Hours of operation and contact information, including telephone number, website, and email addresses, if applicable
4. How to communicate a complaint or provide feedback
5. Whom to contact in an urgent situation
6. How to opt in or opt out of the program

Information Distribution

Groups provide eligible members with information about specific programs for which they qualify. Information is provided when members enroll or are identified as eligible for a program. Groups distribute information using any of the following methods:

- Mail
- Fax
- Email
- Messages to mobile devices
- Real-time conversation
- On its website, if it informs members that the information is available online

If information is posted on a website, Groups notify members that the information is available through another method listed above.

Groups mail information to members who do not have fax, email, telephone, mobile device, or internet access. If Groups use telephone or other verbal conversations, they provide a transcript of the conversation or script used to guide the conversation.

Hours of Operation and Contact Information

Groups provide members with Program information, including hours of operation and any available contact information. Contact information includes telephone numbers, websites and email addresses as available.

Urgent Situations

Groups instruct members to contact another entity (e.g., their physician) or emergency services in an urgent situation.

PHP 2: Data Integration

HPN systematically collects, integrates, and assesses data to inform, measure, and operate its Program. Relevant data is integrated to produce actionable information.

PHP 2: Data integration elements are further defined in the document: **2023 PHM Program Initiatives**.

HPN may integrate the following data, as applicable, to use for population health functions:

1. Medical and behavioral claims or encounter data
2. Eligible member list from client organizations
3. Pharmacy data
4. Laboratory results
5. Health appraisal results
6. Data collected through the utilization management, case management or care management process
7. Data from health management, wellness or health coaching programs
8. Electronic health records (EHR)
9. Information collected from members, practitioners, and client organizations
10. Advanced data sources

Data integration combines data from multiple sources databases. Data may be combined from multiple systems and sources (e.g., claims, pharmacy), across care sites (e.g., inpatient, ambulatory, home), and across domains (e.g., clinical, business, and operational). Data is limited to the minimum necessary to identify eligible members and determine and support their care needs.

HPN and Groups will use the analysis of the interrelated conditions and factors (including both medical and behavioral data) that influence the health of populations over the life course to identify current and evolving systematic variations in their patterns of occurrence, and apply the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations. Data is included from claims, encounters, laboratory results, health appraisal results, EHR, and the health information exchange. Data is also included from health services programs such as case management, utilization management programs, care coordination, disease management, and health education. The collection, monitoring and evaluation of population data allows for the development of targeted interventions for specific member populations, and provides actionable data upon which program planning and service delivery may be developed and allows the stratification of the population into subsets for targeted interventions.

Data Collection

HPN has a process for integrating relevant or necessary data from other programs (utilization management, case management, care management, health management, or wellness or health coaching) to identify eligible members and determine care needs.

Electronic Health Records

HPN integrates EHR data from at least one practice or provider. Data is collected via a direct link from the EHR to the data warehouse.

Advance Data Sources

Advance data sources aggregate data from multiple entities such as all-payer claims systems, regional health information exchanges (HIE), or other community collaborations. When advance data sources are used, HPN accesses data from the source entity.

PHP 3: Population Assessment

HPN assesses its populations' needs, and updates activities and resources, depending on results. To facilitate interventions, HPN uses appropriate data to assess its population. HPN conducts an Annual Population Assessment to determine the characteristics and needs of its member population and relevant subpopulations including the needs of children and adolescents, members with disabilities, and members with serious and persistent mental illness. The Population Health Assessment is intended to contribute to the maintenance and improvement of the health and well-being of the population, including the reduction of any identified disparities.

PHP 3: Population Assessments elements are further defined in the documents: **2022 Population Assessment** (individualized to HPN and Groups).

A. Population Assessment

HPN uses data at its disposal (e.g., claims, encounters, lab, pharmacy, utilization management, socioeconomic data, demographics) to identify the needs of its population. HPN conducts the following annually:

1. Assesses the characteristics and needs of the population, including social determinants of health
2. Identifies and assesses the needs of relevant subpopulations
3. Assesses the needs of child and adolescents
4. Assesses the needs of members with disabilities
5. Assesses the needs of members with serious and persistent mental illness (SPMI)

Social Determinants of Health

The health of a population is associated with many factors. Social conditions, such as socioeconomic status, are strong contextual features that influence the health of individuals and communities. Understanding how populations interact with and within structural systems will allow for an understanding of the conditions experienced by groups that influence prevalence and incidence of disease.

Social determinants of health (SDOH) are economic and social conditions that affect a wide range of health, functioning, and quality of life outcomes and risks. HPN defines the determinants assessed. SDOH characteristics may include, as applicable:

- Resources to meet daily needs
- Safe housing
- Local food markets
- Access to education, economic and job opportunities
- Access to health care services
- Quality of education and job training

- Availability of community based resources in support of community living and opportunities for recreational and leisure activities
- Transportation options
- Public safety
- Social support
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
- Exposure to crime, violence and social disorder (e.g., presence of trash and lack of cooperation in a community)
- Socioeconomic conditions
- Residential segregation
- Language/literacy
- Access to mass media and emerging technologies
- Culture

Other Characteristics

HPN assesses other characteristics that define a relevant population, which may also include, but are not limited to:

- Federal or State program eligibility (e.g., Medicare or Medicaid, SSI, dual-eligible)
- Multiple chronic conditions or severe injuries
- At-risk ethnic, language, or racial group

Identifying and Assessing Characteristics and Needs of Sub-Populations

HPN uses the annual population assessment to identify and assess relevant subpopulations, including the subpopulations of children and adolescents, members with disability, and members with SPMI. Additional subpopulations may include those with a specific condition or within a specific demographic, or another characteristic that may present unique needs. Assessments may include, as applicable, physical determinants and other characteristics such as:

- Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change)
- Built environment, such as buildings, sidewalks, bike lanes and roads
- Worksites, schools and recreational settings
- Housing and community design
- Exposure to toxic substances and other physical hazards
- Physical barriers, especially people with disabilities
- Aesthetic elements (e.g., good lighting, trees, benches)
- Eligibility categories included in Medicaid managed care (e.g., TANF, low income, SSI, other disabled)
- Nature and extent of carved out benefits
- Type of Special Needs Plan (SNP) (e.g., dual eligible, institutional, chronic)
- Race/ethnicity and language preference

Needs of Children and Adolescents

HPN annually assesses the needs of children and adolescent members. The State of California Department of Managed Health Care (DMHC) defines children as those "under the age of 19," which is used by HPN in its annual assessment.[1]

Individuals with Disabilities and SPMI

HPN annually assesses members with disabilities and serious and persistent mental illness (SPMI). These members have acute needs for care coordination and intense resource use (e.g., prevalence of chronic diseases).

Frequent Diagnoses

HPN measures the population, and sub-populations, based on the top 25 diagnoses for PCP Office Visits, Behavioral Health Office Visits, Hospital Admitting Diagnosis, Behavioral Health Admitting Diagnosis, ER Admitting Visits, and ER Behavioral Health Admitting Visits.

American Community Survey[2]

Data from the American Community Survey (ACS) is used in identification of racial and ethnic distribution, linguistic preference and disability throughout the counties of service. The American Community Survey is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data that are comparable across all U.S. geographies. The ACS is a federally funded statistical product that the Census Bureau makes available to the public through online access tools, documentation, and support programs for data users. It has an annual sample size of about 3 million addresses across the United States and Puerto Rico and includes both housing units and group quarters (e.g., nursing facilities and prisons). The ACS is conducted in every county throughout the nation, and every municipality in Puerto Rico, where it is called the Puerto Rico Community Survey. For more information related to data validity and sample size please visit the American Community Survey website.

CDC SDOH Measures[3]

Social determinants of health are determined using synthesized data from a variety of National and State data sources. Data sources include but are not limited to; The Behavioral Risk Factor Surveillance System (BRFSS), The Safe Drinking Water Information System (SDWIS), The Food Environment Atlas, The US Census Bureau Small Area Income and Poverty Estimates (SAIPE), and the Health Resource and Services Administration (Area Resource File). These measures were standardized and combined using scientifically informed weights calculated by the National Center for Health Statistics of the Centers for Disease Control and Prevention (CDC). For more information regarding definition of terms, the validity and quality of data please visit http://www.cdc.gov/nchs/surveys.htm.

B. Activities and Resources

HPN annually uses the population assessment to:

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[1] State of California Business, Transportation and Housing Agency: Department of Managed Health Care, (May 12, 2011). *Letter No. 4-K: Implementation of AB 2244*. https://www.dmhc.ca.gov/Portals/0/LawsAndRegulations/Directors LettersAndOpinions/dl4k.pdf?ver=2020-04-22-163928-880

[2] United States Census Bureau, (December 20, 2021). Methodology. https://www.census.gov/programs-surveys/popest/technical-documentation/methodology.html

[3] Centers for Disease Control and Prevention, (March 5, 2018). National Center for Health Statistics: Surveys and Data Collection Systems. http://www.cdc.gov/nchs/surveys.htm

1. Review and update its activities to address members' needs
2. Review and update its resources to address members' needs
3. Integrate community resources into program offerings to address members' needs

Activities and Resources

HPN uses assessment results to review and update its Program (which may include services and activities) and resources (e.g., staffing ratios, clinical qualifications, job training, external resources needs and contacts, cultural competency) to meet members' needs. Program activities may be directed at caregivers if the eligible member is a child or adolescent or is cognitively impaired.

Community Resources

Groups connect members with community resources or promote community programs to members. Groups actively and appropriately respond to members' needs through the integration of community resources. Community resources correlate with needs discovered during the population assessment. Actively responding to member's needs includes posting on Group websites as well as active response to referral services and helping members access community resources.

Groups integrate community resources and promote community programs based on identified member needs discovered during the population assessment. Resources and programs may include shelters, food security programs, health clubs and fitness classes, community planning events, community health workers, social workers, and more. At a minimum, identified members are connected via:

1. Posting a list of resources on the website
2. Actively referring members to identified service needs
3. Helping members access identified resource needs

PHP 4: Population Segmentation

HPN segments its population for targeted interventions. HPN uses appropriate data or information to segment or stratify members into actionable categories for intervention.

PHP 4: Population Segmentation elements are further defined in the document: **2023 PHM Program Initiatives**.

HPN annually segments or stratifies its entire population into subsets for targeted interventions. Based on the description of the program and types of data integrated, HPN evaluates members and classifies them into a group or strata for interventions. Interventions and severity classifications may be prescribed based on the needs of the identified subpopulation.

Population segmentation divides the population into meaningful subsets using information collected through population assessment and other data sources.

Risk stratification uses the potential risk or risk status of members to assign them to tiers or subsets. Members in specific subsets may be eligible for specific services.

Segmentation and risk stratification result in the categorization of members with care needs at all levels and intensities. Segmentation and risk stratification are means of targeting resources and interventions to members who can most benefit from them.

Methodology

HPN describes its method for segmenting or stratifying its population, including the subsets to which members are assigned (e.g., high-risk pregnancy, multiple inpatient admissions). HPN may use various risk stratification methods or approaches to determine actionable subsets.

Segmentation and stratification methods use population assessment and data integration findings (e.g., clinical and behavioral data, population and social needs) to determine subsets and programs/services for which members are eligible. Methods may also include utilization/resource use.

Reports

HPN provides reports specifying the number of members in each category and the programs or services for which they are eligible. Reports may be a "point-in-time" snapshot during an appropriate look-back period.

Reports reflect the number of members eligible for each program, activity, or program subset. They display data in raw numbers as a percentage of the total population.

PHP 5: Targeted Interventions

Groups provide appropriate targeted interventions based on the member's level of need. Groups demonstrate that interventions:

1. Are delivered to members based on the intervention plan
2. Include person-centered goals

Exceptions to Targeted Individual Interventions

Groups are required to develop and document individualized target intervention plans for all Program eligible members, except when the following criteria is met:

- Eligible members whom it cannot locate or contact after three or more attempts across a 2-week period through at least two of the following mechanisms:
    - Telephone
    - Regular mail
    - Email
    - Fax
    - Mobile application engagement via application download or engagement in application platform
- Eligible members who opt out of participation in the Program

Providing Targeted Individual Interventions

Groups use assessment and stratification or segmentation to develop an intervention plan and provides targeted interventions to members against the plan. Groups consider changes in the member's needs and may periodically adjust the intervention plan as needs change. Groups document the number and type of planned and delivered interventions in the member's file.

Types of interventions may include:

- Educational mailings

- Telephone calls to check progress or offer coaching
- E-mail reminders of tests due
- Written or electronic tools to record progress and transmission of biometric results

Person-Centered Goals

Groups document at least one person-centered goal per Program enrolled eligible member. The intervention includes goals for the Program set by or with the member, and considers their preferences, needs and personal goals. A member's goals are the foundation of person-centered care planning and address a desired outcome.

The member is involved in setting goals to the extent they prefer or are capable. Goals are not dictated by program staff and are directly connected to the member's needs or preferences. If the member determines or sets a goal that does not directly align with the program offering, how and why the goal was determined is recorded by the Group.

PHP 6: Practitioner Support

Groups provide support to practitioners and informs them of care opportunities that require attention. Groups perform the following:

1. Inform the practitioner on record about care opportunities that need to be addressed in a timely manner
2. Collaborate with the practitioner by soliciting input or advice, when necessary

Communicating Information

Groups communicate with the practitioner if a care opportunity is discovered outside the scope of the Program. Groups communicate relevant information, such as gaps in care, with the practitioner. The information may be discovered through member assessments or during the program interventions or services. Groups must specify the reason for the notification (e.g., test out of range), and shows the dates when the information was received by the Group and sent to the practitioner. Notifications must comply with HIPAA and other federal and state laws and access, use and share the minimum amount of PHI necessary to perform the services that the Group is obligated to perform.

Seeking Practitioner Input

Groups seek input or advice from the practitioner on record for care situations that require practitioner input, such as therapeutic interventions. Groups must document evidence (e.g., case notes, communications between the Group and practitioner) that it collaborates with practitioners in these care situations. Care situations that may require practitioner input include identified needs for:

- Assistance in managing a member who is suffering severe or worsening symptoms
- Assistance with care planning for members with multiple co-morbidities
- Assistance with therapeutic interventions (e.g., treatment to assist tobacco cessation, potential changes to prescribed medications, order for needed screening or diagnostic tests)
- Assistance with any situation requiring clinical decision making by a practitioner as determined by scope of practice

Clinical Practice Guidelines

HPN Clinical Practice Guidelines are used to guide efforts towards the improvement of the quality of care of our members and potentially reduce hospitalization rates and healthcare costs. Every two years, HPN reviews and adopts evidence-based Clinical Practice and Preventive Health Guidelines promulgated from peer reviewed sources for diseases and health conditions identified as most relevant to our membership for the provision of preventive, acute or chronic medical and behavioral health services.

PHP 7: Measurement and Quality Improvement

At least annually, Groups measure member experience. At least annually, HPN measures Program effectiveness, cost and participation rates. HPN measures, analyzes and works to improve experience, Program effectiveness, and member participation.

PHP 7: Measurement and quality improvement elements are further defined in the document: **2023 PHM Program Initiatives**.

A. Measuring Clinical Quality

Using at least two measures, HPN annually evaluates the effectiveness of its Program. For each measure, HPN:

1. Identifies a relevant process or outcome
2. Uses a valid method that provides quantitative results
3. Sets a performance goal
4. Clearly identifies measure specifications
5. Uses a population-based measure

Relevant Process or Outcome

HPN selects a combination of process or outcome measures that have significant bearing on the Program's population or on a defined subset of the population.

Valid Methods and Quantitative Results

HPN defines and considers the following criteria in evaluating measure validity:

- Numerator and denominator
- Sampling methodology
- Sample size calculation
- Measurement periods and seasonality

Performance Goal

HPN establishes an explicit, quantifiable performance goal for each measure. The goal may be based on external benchmarks, as appropriate.

Measure Specifications

HPN describes the data source, the eligible population, coding, or other means of identifying the clinical process or outcome. HPN ensures the provision of measure specifications that have enough detail to guide valid measurement.

Population-Based Measurement

HPN reviews measures' technical specifications to verify that at least one measure for each Program pertains to the entire relevant population for which it has responsibility, not just members who have actively participated in the Program. To meet the definition of a population-based measure, members must be included in the measure population, even if the Program calls only for monitoring data and not for providing interventions. In circumstances, where HPN is contracted to enroll members from a general population not identified as having a particular condition, the denominator is the number of members who voluntarily enroll.

When producing measure results, HPN may:

- Use a sample, particularly for member surveys, if it shows that the sample is drawn from the entire population
- Produce a measure by stratification level, such as HbA1c rates for three acuity levels of diabetes

B. Analyzing Experience Data

At least annually, Groups evaluate members' experience by analyzing feedback on:

1. The overall Program
2. The Program staff
3. Usefulness of the information disseminated
4. Ability of the member to adhere to recommendations
5. Whether the Program helped members achieve health goals
6. Complaints from members, when data is available

Methodology

Groups use a standardized, validated tool to measure member experience. Member feedback may be obtained from one or more sources, including:

- Inquiries
- Routine contacts, as part of working with members
- Surveys
- Participation rates

Groups conduct a quantitative data analysis to identify patterns in feedback and conducts a causal analysis if it did not meet stated goals.

Individual Experience Measures

Groups may use focus groups or satisfaction surveys to obtain and analyze members' feedback. Feedback is specific to the Program being evaluated.

Analyzing Complaints

Groups analyze complaints to identify opportunities to improve experience with its Program.

C. Analyzing Patient-Reported Outcomes

At least annually, Groups evaluate patient-reported outcomes by analyzing:

1. A measure of patient-reported health outcomes

2. A second measure of patient-reported health outcomes

Methodology

Groups to use a standardized, validated tool to measure patient-reported outcomes. Member feedback may be obtained from one or more sources, including:

- Inquiries
- Routine contacts, as part of working with members
- Surveys

Patient-Reported Health Outcomes

Groups monitor members' feedback on their perception of their health outcomes. This may include their perceptions on their current health status or function, or improved status or function. These measures may include:

- The member's perceived ability to manage health
- The member's perceived improvement in health
- The member's perceived improvement in function
- Whether the member missed work because of the condition

D. Comprehensive Analysis

At least annually, HPN conducts a comprehensive analysis of the impact of the Program that includes the following:

1. Quantitative results measured in Measurement and Quality Improvement
2. Comparison of results with a benchmark or goal
3. Interpretation of results

Quantitative Results

HPN describes why measures included in the evaluation are relevant, and presents findings. Measures may focus on one segment of the population or on populations across the organization.

Comparison of Results

HPN performs a first-level quantitative data analysis that compares results with an established, explicit and quantifiable goal or benchmark. Analysis includes past performance, if a previous measurement was performed.

Interpretation of Results

HPN ensures quality measurements are analyzed and assessed together to provide a comprehensive analysis. Interpretation of results gives the organization insight into its Program and helps HPN understand the Program's effectiveness. Interpretation of the measurement includes detailed findings to ensure a comprehensive understanding of the Program.

E. Improvement and Action

At least annually, HPN uses results from the analysis to:

1. Identify opportunities for improvement
2. Act on one opportunity for improvement

Opportunities for Improvement

HPN uses the results of its analysis conducted to identify opportunities for improvement, which may be different each time data are measured and analyzed.

Act on Opportunity for Improvement

HPN develops a plan to act on at least one identified opportunity for improvement.

F. Participation Rates

At least annually, HPN measures participation rates. The participation rate is defined as the number of members who received at least one interactive contact with response (e.g., the Group contacted the member and the member responded), divided by the number of members identified by the as eligible for the Program, as identified in the Program Description and reported in Segmentation.

- Numerator: The number of members who received at least one interactive contact with response
- Denominator: The total of all eligible members for a specific program

Note: Enrollment rate is not the same as active participation rate.

An interactive contact is defined as a two-way interaction in which the member receives self-management support, health education, or assistance coordinating care through one of the following methods:

- Phone
- In-person contact (i.e., member or group)
- Online contact, such as secure email or interactive web-based modules.

G. Transparency in Reporting Outcomes

HPN is transparent about the methods it uses to calculate the impact of its Program. HPN shares measurement details with Groups, which facilitates understanding of results and comparison among organizations, including:

- The definition of the population included in the denominator
- How members are placed in the numerator
- The time period and how it affects inclusions and exclusions in the numerator and denominator

PHP 8: Individuals’ Rights and Responsibilities

Groups communicate their commitment to the rights of their members and its expectations of members’ responsibilities. The intent is that members understand what they are entitled to and what is expected of them while enrolled in the Program.

A. Individuals’ Rights Information

Groups distribute written information to members that addresses their rights to:

1. Have information about the Group (including programs and services provided), its staff and its staff’s qualifications and any contractual relationships.
2. Decline participation in or dis-enroll from programs and services offered by the Group
3. Know which staff are responsible for managing their services and from whom to request a change
4. Be supported by the Group to make health care decisions interactively with their practitioners

5. Be informed of all treatment options included or mentioned in clinical guidelines, even if a treatment is not covered, and to discuss options with treating practitioners
6. Have personal identifiable data and medical information kept confidential; know what entities have access to their information; know procedures used by the Group to ensure security, privacy, and confidentiality
7. Be treated courteously and respectfully by the Group's staff
8. Communicate complaints to the Group and receive instructions on how to use the complaint process, including the organization's standards of timeliness for responding to and resolving issues of quality and complaints
9. Receive understandable information

By clarifying members' rights, Groups help create a structure of cooperation among all involved parties. The rights information is not required to be contained in the same document or worded the same way, and may be in the form of a statement, a letter, or other written materials. Rights information must be distributed to all eligible members.

Distribution of Individuals' Rights Information

Groups distribute information to eligible members by mail, fax or email, or on its website, if it informs eligible members that the information is available online. Groups mail the information to members who do not have a fax, email, or internet access.

B. Individuals' Expectations

Groups distribute members' expectations information and distributes written information to members that address the expectation that they will:

1. Participate in the program offered by the Group
2. Provide the Group with information necessary to carry out its services
3. Notify the Group and the treating practitioner if a member dis-enrolls from the Program

When expectations are made clear, it creates a structure for cooperation among all involved parties. A member's inability or refusal to meet the Group's expectations as stated above does not disqualify the member from participation.

The expectations information is not required to be contained in the same document or worded the same way, and may be in the form of a statement, a letter, or other materials.

Distribution of Individuals' Expectations Information

Groups distribute information to eligible members by mail, fax or email, or on its website, if it informs eligible members that the information is available online. Groups mail the information to members who do not have a fax, email, or internet access.

C. Handling Individuals' Complaints

HPN and Groups are not delegated to process or resolve complaints. Groups shall direct members, or the member's representative, to their respective Health Plan and provide the member with instructions on how to file a complaint with the plan. Groups may assist members, or the member's legal representative, in the

submission of the complaint to their respective full-service Health Plan. Groups make every effort to assist the Health Plan with the following, when requested:

1. Documentation of the substance of complaints and actions taken
2. Investigation of the substance of complaints, including any aspect of clinical care involved
3. A process for triaging complaints that are not about the Group, its staff, or the services that it provides to appropriate parties and to client organizations, if applicable
4. Notification and update members on the progress of the investigation
5. Notification to members of the disposition of complaints
6. Standards for timeliness, including standards for clinically urgent situations

D. Resolving Complaints

HPN and Groups are not delegated for complaints or member communication for complaints. Member communication regarding the disposition of each complaint received is maintained by the full-service Health Plan.

At the conclusion of each complaint received, the Group may follow-up with the member to ensure their needs were adequately met and to coordinate their care. Upon receipt of complaint resolution from the Health Plans, Groups document:

1. The resolution of the member's complaints
2. Turnaround times for resolution of the member's complaints, if available from the Health Plan

HPN and its Groups act on member complaints in accordance with its policies and procedures.

PHP 9: Delegation of Population Health Program

HPN does not delegate Program elements or activities. All Program activities are overseen and performed within the organization.