HERITAGE PROVIDER NETWORK

&

AFFILIATED MEDICAL GROUPS

POPULATION HEALTH PROGRAM
2019

Approval Signature:

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Dr. David Leece, Committee Chair

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Date: _____

Contents

Population Health Program

Heritage Provider Network's approach to Population Health Management is through Care Management process which 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 focuses on the Triple Aim Health Care Delivery Model.

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

Population Health Management involves the aggregation of member data across multiple data points, and the subsequent analysis of that data into a single, actionable member record. The analysis of population health data provides clinical decision support related to quality, outcomes, cost, utilization, and other information critical to the health and well-being of the defined populations in the community. Additionally, population health management considers the distribution of such outcomes within a population.

Programs & Services

Care Coordination

HPN care coordination and management services will be available to all enrollees. These services will reflect a member-centered, quality and value based approach. These care coordination services will:
1. Follow the beneficiary's direction about the level of involvement of his or her care caregivers and medical
   Providers.
2. Span medical and Long Term Support Services (LTSS) care systems, with a focus on transitions between service locations
3. Consider behavioral health needs and coordinate with county services
4. Develop individualized care plans guided by evidenced based interventions with enrollees
5. Provide care coordination by nurses, social workers, primary care providers and other medical services and professionals as needed
6. Provide the initial and ongoing training to staff to ensure there is compliance to the goals of the program.

The goals of the Care Coordination are to:
1. Assess our member population to ensure that our care management processes address our membership needs.
2. Provide the education and resources so members are able to self-maintain their condition or diseases processes.
3. Provide culturally appropriate care throughout the healthcare continuum.
4. Provide the member's with Member Rights information as to the services available to them on behalf of HPN, our staff and our contractual relationships with the Health Plans and the member's right to not participate or dis-enroll from the program and/or services provided.
5. Provide care coordination that helps members: navigate the healthcare system in a safe and effective manner; is cost effective, and meets the need of the members.

6. Coordinate care to ensure the member has access to all services available to them, i.e. In Home Support Services (IHSS), Community Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP) and any community based services.
7. Develop a care plan that is member centric and identifies the goals that are based on the member's preferences, needs and level of involvement.
8. Identify the barriers to members being non-compliant with their treatment plan and initiate interventions or resources to overcome those barriers.
9. Develop interventions to the goals that members can achieve.
10. Identify members at risk of care transitions.
11. Reduce unplanned ER and hospital admissions by providing the necessary education, resources and support to the member.
12. Identify measures of program effectiveness and annually assess the metrics to determine if the program has met them.
13. Define the staffing needs of the program and ensure staffing is meeting the requirements.

Disease Management

Heritage Provider Network's Disease Management Program focus on a population based process that offers coordinated healthcare interventions for defined populations to reduce healthcare costs and improve the quality of life of members with chronic conditions. These programs provide an assessment, care coordination, and member education to improve and maintain the health of those members.

Goals of the Disease Management Program are to:

1. Ensure members are using their medications properly
2. Ensure members understand and monitor symptoms more effectively
3. Improve member self-management
4. Improve member education on disease
5. Reduce health care costs
6. Improve coordination of care
7. Improve access to care
8. Improve quality of life

Services

Due to the size and diversity of our population, there are multiple potential avenues for care coordination and Management of eligible members. Our medical groups offer the following services and more depending on the needs of their population:

1. High Intensity and Complex Care Management (telephone or in person) to include:
   a. Member Care
   b. Transitional Care
   c. Ambulatory Care
   d. Home Based Care
   e. Tele-monitoring/Biometric Monitoring
2. Disease Specific Care Management (Monthly)
   a. Anticoagulant Clinics
   b. Diabetic Clinics
   c. Cardiology Clinics
3. Self-Management
   a. Online and Print Tools

4. Palliative Care Management
5. Hospice Care Management
6. Services and resources that support beneficiaries who are frail, disabled or near the end of life

Specialized Network

HPN offers our Care Management Program members the opportunity to receive quality health care coverage combined with social support services. By effectively coordinating care, providing specialized support services, and respite care for families and caregivers (as applicable), HPN provides eligible members with important advantages and provides a structured care coordination model. These advantages include access to:

1. A primary care provider (PCP)
2. A care manager
3. An Interdisciplinary Care Team (ICT) - team of nurses, specialists, and a support services coordinator, work with the member (and family members or caregivers, if applicable) to develop an individualized plan of care to specifically address the needs of the member.
4. 24-hour access to an on-call health care professional and active involvement of the member in decisions concerning his or her health care
5. Care Coordination with:
    a. Medical Specialists (e.g., Cardiology, Nephrology, Psychiatry, Geriatric Specialists, Pulmonologists, Immunologists, etc.)
    b. Behavioral and Mental Health Specialists (e.g., Drug Counselors, Clinical Psychologists, etc.)
    c. Nursing Professionals (e.g., Registered Nurses, Nurse Practitioners, Nurse Managers, Nurse Educators, etc.)
    d. Allied Health Professionals (Pharmacists, Physical Therapists, Occupational Specialists, Speech Pathologists, Laboratory Specialists, Radiology Specialists, etc.)
    e. MSSP, CBAS, IHSS programs where appropriate.

Population Health Program Steps

1. Introductory letters
2. Telephonic Communication
3. In-person visit
4. Website

The Population Health Program begins with the distribution of program information when the member receives the general awareness welcome letter that introduces some of the components of the program and the concept of Population Health (Care Management). This is followed by a disease-specific mailing within 30 days which includes:

1. Information about care coordination and condition monitoring, including self-management of chronic disease;
2. Description of services included and how to use the services;
3. Explanation of how a member is identified as eligible for our program;
4. How to opt in and out of the PHM Program;
5. Information encouraging goal setting and appropriate lifestyle modification around exercise and smoking (as applicable);
6. Encouragement to work with their practitioner and ICT staff to develop and adhere to a Population Health care plan; and

7. Encouragement to call a physician and/or ICT staff with a focus on behavioral modification, overall assessment of other health conditions as they relate to Population Health and overall health, goal setting, and problem solving.

Population Identification

Population Health Assessment

The health of a population is associated with many factors. Social conditions such as socioeconomic status, educational preparation, employment opportunities, exposure to environmental pollutants, access to employment and job training 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 reflect social factors and the physical conditions in the environment in which people are born, live, learn, play, work and age and impact a wide range of health functioning and quality of life outcomes. Other data elements that will be integrated into the development of the program include:

1. Medical and behavioral claims or encounters
2. Pharmacy claims
3. Health Appraisal Results
4. Electronic health records
5. Health services programs within the HPN Network

Heritage Provider Network and its affiliates conduct an Annual Population Assessment to determine the characteristics and needs of its member population and relevant subpopulations including the needs of children and adolescents, individuals with disabilities, and individuals 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.

Heritage Provider Network Inc. and its affiliates will use the analysis of the interrelated conditions and factors 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. 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.

Population Health Assessment Data Integration

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:
https://www.census.gov/acs/www/methodology/methodology_main/

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

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. The report is generated from the EZ Cap data system of claims encounter data.

Population Health Assessment Activities and Resources

Heritage Provider Network utilizes Population Assessment 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 committee discussion and assessment of population needs. The discussions are reflected in the QIC meeting minutes and serve as a resource for further decisions.

Delivery System Supports

Practitioner or Provider Support

HPN and its affiliates, integrate member information from multiple data systems that allow providers, care managers, disease management and utilization management teams to access relevant clinical information. Heritage Provider Network utilizes a centralized Care Coordination and Management system that provides real time analytics and practice support that allows practitioners to bridge processes between clinical and non-clinical systems across the continuum. Heritage Provider Network Care Coordination and Management Systems allows providers to:

1. Integrate Electronic Medical Records documentation of care management, care planning, and input from the interdisciplinary care team, transitions, assessments and authorizations constructing a longitudinal record of care which includes care that the member may have received from other providers and organizations;
2. Extraction and prospective chart abstractions of **Electronic Medical Record** (EMR) data. Chart abstractions capture biometrics, lab results and screening tests with longer "look-back" periods.
3. Enable providers to evaluate comprehensive medical records and avoid ordering duplicate or unnecessary tests or procedures;
4. Improve member safety by avoiding contraindicated prescription medications by accessing data available via medication reconciliation records;
5. Identify members with gaps in care across domains and allow for targeted member interventions;
6. Evaluate the Individualized Care Plan (ICP);
7. Generate member newsletters, educational outreach, provider updates via mail, phone, fax or online; and
8. Access to community resources.

Shared Decision Making Aids

Clinical Practice Guidelines - Heritage Provider Network and its affiliates review the top twenty-five diagnoses for hospitalization (rates and average length of stay [ALOS]) and member encounters to identify Clinical Practice Guidelines relevant to our membership. These 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, Heritage Provider Network reviews and adopts evidence-based Clinical Practice and Preventive Health Guidelines promulgated from peer reviewed sources for diseases and health conditions identified as most salient to our membership for the provision of preventive, acute or chronic medical and behavioral health services.

 "UpToDate," is an online evidence-based, physician-authored clinical decision support resource. HPN recommends "UpToDate" as an additional resource to supplement adopted Clinical Practice Guidelines or for guidelines not covered.

Care Management System Applications within the care management system have the ability to refer/recommend health education services (e.g. classes, support groups) and/or materials relevant to a member's needs. Care Managers have the ability to:
1. Automate appointment reminders
2. Automate Preventative Screening Notifications
3. Automate Health Education Scheduling, Monitoring and Tracking
4. Automate Chronic Care Monitoring Appointments

Wellness and Prevention
Health Appraisal Components
A holistic assessment is performed to include all aspects of the member (spiritual, physical, social, economic and psychological). In some instances a Health Risk Assessment (HRA) is provided by the designated Health Plan. Health Plan Health Appraisals will include questions regarding, or to assist in identifying, the following information:
1. Member demographics (e.g., age, gender, ethnicity, etc.);
2. Personal health history, including chronic illness(es) and current treatment(s); height and weight
3. Self-perceived health status, based on body mass index (BMI), smoking status, physical activity frequency, stress levels, , healthy eating habits, at-risk drinking, productivity or absenteeism, etc.);
4. Personal health characteristics and behaviors and safety behaviors;
5. Behavioral change strategies and Depressive symptoms and
6. Special needs in the areas of hearing and vision impairment and language preference.
7. Preventive Screenings to include: Breast Cancer, Colorectal Cancer, Cervical Cancer
8. Influenza vaccinations

Health Appraisal Scope and Disclosure
Heritage Provider Network (HPN) shall comply with all State and Federal requirements to maintain confidentiality of members protected health information (PHI); and inform members of how their specific information will be used through a notice of privacy practices. A privacy notice includes a complete description of the uses and/or disclosures of member protected health information (PHI). HPN will notify members of any updates to the notice of privacy practices and shall not distribute information from the Health Appraisal outside of the organization.

Members may consent, or decline to have the information they provide shared or to request restrictions on the use and disclosure of protected health information (PHI) and shall also reserve the right to decline to complete the voluntary Health Appraisal, or discontinue a Health Appraisal process previously initiated.

The goal of the assessment is to identify and describe the medical and health conditions impacting the member, including condition specific issues and health care needs. Information obtained from the Health Appraisal is used internally by Care Management teams and may be shared with the members' Primary Care Physician if gaps in care need to be addressed. Only those individuals identified as providing care or part of the care management process will have access to the member's Protected Health Information (PHI).

Health Appraisal Results

Once the Health Appraisal has been completed, Members shall receive an overall clinical summary of their individual risk or wellness profile to assist the member in understanding their personal health appraisal results. The results are provided to members in a language that is easy to understand and in the threshold language that accommodates each individual member's needs. Health appraisal results shall include an overall summary, including a clinical summary of risk or wellness; information on how to reduce risk by changing certain behaviors; reference information to help members understand their personal results, and a comparison of previous health results, if applicable.

Health Appraisal Format and Frequency

The Member's Health Plan shall provide the Health Appraisal in various formats in order to ensure member accessibility. The following formats will be available: The Health Plan website, US Mail, and telephonically utilizing easy to understand language in the members preferred language. The frequency of the Health Appraisal is at least annually per member. The Health appraisal review and update process shall be reviewed every two years and in accordance with Health Plan policy.

Member Education & Self-Management Tools

HPN offers self-management support which allows members to learn more about their conditions and take an active role in their health care. Self-management support goes beyond simply supplying members with information and includes interdisciplinary team collaboration and provides members with customized education and access to community resources appropriate for different cultures and health literacy levels. Usability testing shall include a review of language to ensure information is presented clearly and utilizes words with common meanings and shall also be assessed for vision and hearing limitations. Self-management tools, techniques, resources and goal setting derived from available evidence, shall provide Members with information and support on a minimum of one (1), or more, of the following wellness and health promotion areas:

1. Healthy weight (BMI) maintenance;
2. Smoking and tobacco use cessation;
3. Encouraging physical activity;
4. Healthy eating;
5. Managing stress;
6. Avoiding at-risk drinking; and
7. Identifying depressive symptoms.

Member educational material will be available in print, and on-line:

1. Integrated into clinical management system

2. Consistent with best practice recommendations
3. Designed to meet State and/or Federal cultural competency requirements
4. Available in different learning modalities
5. Available in different languages
6. Reviewed on an annual basis for appropriateness and accuracy
7. Designed to encourage member self-management and monitoring and assistance available to self-direct care
8. Information on available treatment options, supports, and/or alternative course of care
   a. The material provided will be on his or her conditions and care options

Complex Case Management
Complex Case Management (CCM)

Complex Case Management is the coordination of care and services to a member who has experienced a critical event or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services. The goal of Complex Case Management is to help members regain optimum health, or improve functional capability, educate members regarding their chronic condition in the least restrictive setting and in a cost-effective manner. All eligible Members have the right to participate or decline participation. Complex Case Management involves a comprehensive assessment of a Member's condition, determination of available benefits and resources, and development and implementation of a Care Plan with performance goals, monitoring, and follow-up.

Access to Case Management

HPN provides multiple avenues for clinicians, members and caregivers to refer members for case management services including but not limited to:

1. Internal Department Referrals; Claims, Utilization Management, Pharmacy, etc;
2. Other Care Coordination programs when a member is found to meet criteria for inclusion;
3. Vendor Reports including: Advice Nurse Reports, Dashboards, etc;
4. Primary Care Providers and Specialists;
5. Hospital Discharge Planners;
6. Ancillary Providers;
7. Behavioral Health Specialists;
8. Community Partners i.e. Case Managers, County Public Health Departments, etc.;
9. Regional Centers;
10. California Children's Services (CCS);
11. Members or their caregiver/representative are provided information on the CCM program through; Member newsletters, their providers, and or through direct outreach by Heritage's Care Coordination Team, and members may request CCM assistance at any time; and
12. Web-based materials with information about the Care Coordination & Case Management Program.

Care Management Systems

Operating within HIPAA regulations, HPN and its affiliates, integrate member information from multiple systems that allow disease management, care management, utilization management and health information-line staff to access relevant clinical information. Current enterprise systems include but are not limited to:

1. NextGen® Electronic Medical Record
2. MZI (E Z-CAP®, EZ-CARE®, EZ-NET®)
3. Heritage Connect
4. Internally developed care coordination and management systems (QHMO.)

Links are created between all systems to allow coordination of care and support to ensure that the care is appropriate and delivered at the proper time. Facilitating timely access to member records is fundamental to the success of health promotion and Population Health Programs. Integrated information allows HPN to offer interventions that match the severity of the condition.

The care management computer data systems will automatically document staff member's ID, date and time of action on the case or when interaction with the member occurred. In all systems, the ICT staff has access to the member's health information electronically to facilitate care and documentation for the provision of seamless care.

To assure timely care management follow-up, the computer data system is required to provide automatic prompts for frequency of ICT staff communication and referrals. The acuity score derived from the Health Risk Assessment and progress towards the goals in the care plan determines the frequency of follow-up. The ICT staff uses the acuity score to set the automated prompts for follow-up in the care management system.

The Care Management Process

The Care Management Process is designed to maximize health outcomes and resource utilization for populations and the individuals within them using evidence-based clinical guidelines and algorithms to conduct assessments and management of members. The process focuses on coordinating care for the entire population, followed by an individualization of that care. Care Management is a collaborative process of data analysis, selection, assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive needs of the member and their family while promoting quality and value. While the process is generally linear, steps can be repeated as necessary particularly if additional information, assessment, or analysis is required.

The Care Management process shall include, but is not limited to:
1. Identification of all Members in need of Care Management and Coordination;
2. Standardized mechanisms to systematically identify high-risk Members;
3. Access to care management and coordination by ensuring multiple avenues for referrals;
4. Management of Members using a documented and evidence-based Case Management system;
5. Documented care management process;
6. Process to inform eligible Members of Covered Services provided and ability to elect, or decline, the Covered Services;
7. Initial assessment process;
8. Coordination of carve-out services;
9. Coordination of Out-of-Network services;
10. Coordination of long term services and supports (LTSS);
11. Process for providing ongoing care management and coordination;
12. Ensuring a care management process that assesses and evaluates the needs of each Member in collaboration with the PCP in order to develop an Individual Care Plan (ICP);
13. Incorporating the Health Risk Assessment data and all available information and in the development of the Member's care plan;
14. Mechanism for identification and referral of quality of care issues to the Quality Improvement (QI) Department;
15. Process for measuring the effectiveness of care management;

16. Communication of the self-management plans to the member or caregiver either verbally or in writing to help members manage a condition that are based on instructions or materials provided to them or their caregivers.
17. Informing and educating Practitioners in writing and verbally about the program.

The Initial Assessment

The Initial Assessment is an integral step in the Care Management Process. All members eligible for care management will receive a completed assessment no later than 30 calendar days from the date the member is identified as eligible or their enrollment date or sooner if the member's condition requires. Information for the assessment may be derived from encounters occurring up to 30 calendar days prior to the member's enrollment if the information is relevant to the current episode of care, for example physician, specialist, concurrent review or relevant notes from another program. The assessment may be a team effort, with components completed by members of the care team in collaboration with the member, member's family or caregiver. If the member is unable to communicate because of infirmity, assessment may be completed by professionals on the care team, with assistance from the member's family or caregiver. Assessment results for each factor must be clearly documented in the assessment or notes, even if a factor does not apply to the member. Data for the assessment may be gathered verbally or in writing. If complex case management stops when a member is admitted to a facility and the stay is longer than 30 calendar days, a new assessment will be performed after discharge if the member is still eligible for complex case management.
A member may be excluded from the assessment requirement, only if the member is enrolled in the case management program but cannot be located or contacted after the medical group has made 3 or more documented attempts across a 2 week period within the first 30 calendar days after identified as eligible. The medical group will document all attempts to contact the member, either by phone; letter e-mail or fax.

Assessments will include the following elements:
1. Initial assessment of member health status, including issues specific to identified health conditions and the presence or absence of co-morbidities and their status; (e.g., high-risk pregnancy and heart disease, for Members with diabetes), Member's self-reported health status, and information on the event or diagnosis that led to the Member's eligibility for Case Management.
2. Documentation of clinical history, including disease onset, comorbidities, and key events, such as: acute phases, member stays, treatment history, and current and past medications, including schedules and dosages;
3. Activities of daily living such as: eating, bathing, and mobility, and instrumental activities of daily living (IADLs), such as light housekeeping, shopping and laundry;
4. Behavioral health status, including cognitive functioning, and the ability to communicate, understand instructions, and process information about their illness as well as the presence of any mental health conditions, or substance use disorders;
5. Psycho-social issues that may affect members' ability to adhere to the care plan such as: beliefs and concerns about the condition, or treatment, perceived barriers to meeting treatment requirements, or access to transportation and financial barriers to obtaining treatment;
6. Social determinants of health which are the economic and social conditions that affect a wide range of health, quality of life outcomes, and risks that may affect a member's ability to meet case management goals.
7. Life-planning activities as to whether members completed a will, living will or advance directives, health care powers of attorney and medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST forms)
8. Cultural and linguistic needs, preferences or limitations
9. Visual and hearing needs, preferences or limitations

10. Caregiver resources and involvement in and decision making about the care plan and address adequacy of the resources;
11. Available benefits
12. Available community resources and the availability of those resources.

Ongoing Care Management

Care Management is an ongoing process that is designed to meet the individual needs and goals of the member and adapts to changes in the member's condition, needs and preferences. Based in the member's initial assessment and their stated goals and concerns, an individualized care plan is developed for each member. The care plan includes prioritized goals that take into account the preferences and desired level of involvement for the member and caregiver. The care plan includes identification of any barriers to meeting these goals and plans to resolve them, if possible. The care plan also includes resources to be utilized for the appropriate level of care, continuity of care, transition of care and transfers between settings. Communication schedules and plans for follow up are documented in each plan and takes into account any counseling, follow-up after referral to other programs or health resources, member education, self- management support and when follow-up is not appropriate. Care plans are re-evaluated, modified or changed in order to continue to be relevant to the member's goals and needs; this includes assessing progress towards overcoming barriers to care ,meeting treatment goals and adjusting the care plan and its goals as needed.

Experience with Case Management

The Medical Groups will evaluate satisfaction with the Population Health Program annually and as needed through:
1. Obtaining feedback from members via satisfaction surveys which include information about the overall program, the program staff, the usefulness of the information provided, and the member's ability to adhere to recommendations.
2. Analyzing member complaints and inquiries.

We will make every effort to address member and provider concerns. If we are unable to resolve complaints internally, we will refer the Member to the Health Plan's Customer Service and provide them with the toll-free telephone number.   Member complaints will be leveled, tracked and trended.

Member and provider complaints and outcomes will be tracked and reported to the HPN Quality Committee on a quarterly basis. An analysis of member complaints will be completed on an annual basis. Member adverse events will be reported to the network risk manager and the member's health plan within 24 hours of identification.

Population Health Management Impact

Measuring Effectiveness

Annually, HPN will select a minimum of three measures that identify a relevant process or outcome in which to evaluate the effectiveness of the Population Health Program. The three measures (relevant clinical, cost/utilization and experience measures) with goals and clearly identified specifications for the network will be developed. Measure selection will not be exclusive by product or product line. Data collected will not be health plan specific. Process measures will be based on the best scientific evidence, professional standards or expert opinion. The Medical Groups will use valid methods to provide quantitative results, collect data set benchmarks and analyze results and identify areas of improvement.

Based on the results of the measurement and analysis of Population Health Program (PHP) effectiveness and satisfaction, each medical group will identify, implement and re-measure to determine the impact, at least:

1. One intervention to improve clinical performance
2. One intervention to improve member experience