Quality Improvement & Health Equity Transformation Program

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PHC CALIFORNIA

BACKGROUND

The Care Management division of AIDS Healthcare Foundation (AHF) has provided people living with HIV quality health care since 1995, when it started the nation's first Medicaid health plan for HIV-positive people living in Los Angeles.

AHF is a 501(c)(3) Not-for-Profit Organization.

AHF has its roots in advocacy and providing the best care for persons living with HIV/AIDS (PLWHA) in a coordinated care environment:

- In high endemic areas
- Part of AHF mission to expand where there is need
- Grow capitated health plans when there are enough people in need who will benefit from managed care

Workforce: 70 direct plan employees; some with responsibilities across all plans within the Managed Care Division.

MISSION AND VALUES

PHC California's Quality Improvement and Health Equity Transformation Program (QIHETP) is designed to support AHF's mission, which is to provide cutting-edge medicine and advocacy regardless of the ability to pay.

AHF is a global nonprofit organization providing cutting-edge medicine and advocacy to over 1,900,000 people in 45 countries. We are currently the largest provider of HIV/AIDS medical care in the world.

AHF funds its mission to rid the world of AIDS through a network of pharmacies, thrift stores, healthcare contracts and other strategic partnerships. Generating new, innovative ways of treatment, prevention and advocacy has been the hallmark of our success.

Since 1987, AHF has cared for millions of people living with HIV and AIDS worldwide. As we create and implement new programs in communities across the U.S. and abroad, we expand delivery of healthcare and influence over policy with the aim of saving more lives.

The QIEHTP supports the organization's core values:

- Patient-Centered
- Value Employees
- Respect for Diversity
- Nimble
- Fight for What's Right

PURPOSE AND SCOPE

The QIHETP consists of the following elements:

A. QIHETP Description, including descriptions of key functional areas: population health, behavioral health, care management, utilization management, and pharmacy programs.
B. Annual QIHETP Evaluation
C. Annual QIHETP Work Plan
D. Quality Improvement and Health Equity Activities
E. QIHETP Committee Structure
F. Policies and Procedures

The QIHETP Program will ensure that all medically necessary covered services are available in culturally and linguistically appropriate manner and are accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups identified in Penal Code 422.56. The annual Population Needs Assessment (PNA) will serve to identify and evaluate member health needs and health disparities and implement targeted interventions.

The scope of the QI process encompasses the following:

1. Quality and safety of clinical care services including, but not limited to:
    - Preventive services for adults
    - Primary care
    - Specialty care, including behavioral health services
    - Emergency services
    - Inpatient services
    - Ancillary services
    - Chronic disease management
    - Care management
    - Population health management
    - Prenatal/perinatal care
    - Family planning services
    - Medication management
    - Coordination and continuity of care

2. Quality of nonclinical services including, but not limited to:
    - Accessibility
    - Availability
    - Member and provider satisfaction
    - Grievance and appeal process
    - Cultural and linguistic services
    - Network adequacy
    - Health equity

3. Patient safety initiatives including, but not limited to:
    - Facility site reviews/medical record review/physical accessibility review surveys
    - Credentialing of practitioners/ organizational providers
    - Peer review
    - Sentinel event monitoring
    - Potential quality issues (PQIs)
    - Provider preventable condition (PPC) monitoring
    - Health education
    - Utilization and risk management

4. A QI focus which represents:
    - All care settings
    - All types of services
    - All demographic groups

AUTHORITY AND RESPONSIBILTY

AHF will promote, support, and have ultimate accountability, authority, and responsibility for a comprehensive and integrated QIHETP. AHF is ultimately accountable for the quality and equity of care and services provided to members, but has delegated supervision, coordination, and operation of the program to the PHC Chief Executive Office (CEO), Quality Improvement Department under the supervision of the Chief of Managed Care (CMC) and its Quality Improvement and Health Equity Committee (QIHEC). The CMC, in collaboration with the Health Equity Officer, is responsible for the day-to-day oversight of the QIHETP Program. The CMC, through the QIHEC, will guide and oversee all activities in place to continuously monitor health plan quality and equity initiatives.

AHF's role is to approve the overall QIHETP Program and QIHETP Work Plan annually and receive regular verbal and written updates to the QIHETP Work Plan for review and comment/ directions. Updates provided to AHF regarding the QIHETP and Work Plan will include reviews of objectives and improvements made. AHF will receive operational information through regular reports from the CMC in conjunction with the operations of its various committees as described below.

To address the scope of PHC California's QIHETP goals and objectives, the structure consists of the QIHEC supported by nine subcommittees that meet at least quarterly:

1. Infection Prevention & Control Committee
2. Member & Provider Committee
3. Pharmacy & Therapeutic Committee
4. Risk Management Committee
5. Utilization Management Committee
6. Credentialing & Peer Review Committee
7. Ryan White Quality Committee
8. Public Policy & Community Advisory Committee
9. Medical Administration Policy & Procedure Committee

QIHETP GOALS AND OBJECTIVES

The overall goal of the QIHETP is to improve the quality, equity, and safety of clinical care and services provided to members through PHC California's network of providers and its programs and services. Specific goals are established to support the purpose of the QIHETP Program. All goals are reviewed annually and revised as needed. Goals are primarily identified through:

- Ongoing activities to monitor care and service delivery
- Issues identified by tracking and trending data over time
- Issues/outcomes identified in the previous year's QIHETP evaluation
- Monitoring of performance measures, e.g., Managed Care Accountability Set (MCAS)
- Accreditation standards, regulatory, and contractual requirements

The QIHETP goals include:

- Develop and maintain QIHETP resources, structure, and processes that support the organization's commitment to equitable and quality health care for our members
- Coordinate, monitor and report QIHETP activities
- Develop effective methods for measuring and reporting the outcomes of care and services provided to members
- Identify opportunities and make improvements based on measurements, validation, and interpretation of data
- Continuously improve the quality, appropriateness, availability, accessibility, coordination, and continuity of both physical and mental/ behavioral health care services to members across the continuum of care
- Provide culturally and linguistically appropriate services
- Measure and enhance member satisfaction with the quality of care and services provided by our network providers
- Maintain compliance with state and federal regulatory requirements
- Ensure effective credentialing and re-credentialing processes for practitioners/providers that comply with state, federal and accreditation requirements
- Ensure network adequacy and member access to primary and specialty care
- Provide oversight of delegated entities to ensure compliance with PHC California standards as well as state and federal regulatory requirements

The program objectives include the following:

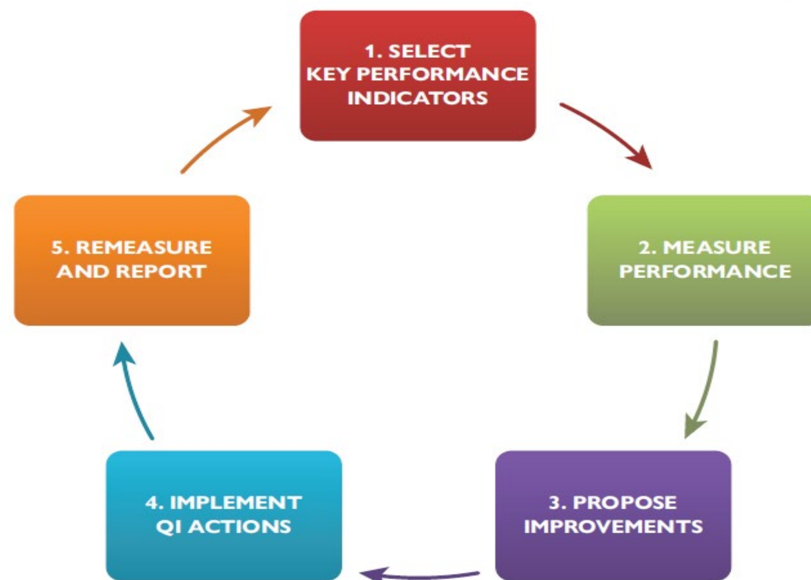
- To integrate the QIHETP with other key operational functions of PHC California
- To conduct an annual evaluation of the QIHETP
- To establish and conduct an annual review of quality, equity, and performance improvement projects (PIPS) related to significant aspects of clinical and non-clinical services
- To identify opportunities for improvement through analysis of utilization patterns and through information collected from quality and performance metrics including DHCS Managed Care Accountability Set (MCAS), the National Committee of Quality Assurance (NCQA) Healthcare

Effectiveness Data and Information Set (HEDIS), the Centers for Medicare and Medicaid (CMS) Core Measures for Medicaid, as well as other measure stewards

- To encourage feedback from members and providers regarding delivery of care and services and to use the feedback to evaluate and improve the manner by which care and services are delivered

QIHETP METHODOLGY

PHC California utilizes the Plan-Do-Study-Act (PDSA) cycle methodology, which is an improvement process tool used by the Institute for Health Care Improvement's (IHI) Model for Improvement and adopted by the state Department of Health Care Services (DHCS) as the standardized process for testing the effectiveness of interventions aimed at improving the quality of care and services. PDSA cycles focus on identifying and measuring improvement opportunities by utilizing small-scale studies to test the effectiveness of interventions that can be modified or expanded to achieve continuous improvement.



The QIHETP Program is based on the latest available research in the area of quality improvement and health equity. At a minimum, it includes a method of monitoring, analysis, evaluation, and improvement in delivering high-quality, equitable care and service. The QIHETP involves tracking and trending of quality indicators to ensure measures are reported, outcomes are analyzed, and goals are achieved. Contractual standards, evidence-based practice guidelines, and other nationally recognized sources (CAHPS, HEDIS, CMS Core Set for Medicaid) may be utilized to identify performance/metric indicators, standards, and benchmarks. Indicators are objective, measurable, and based on current knowledge and clinical experience (as applicable).

The indicators may reflect the following parameters of quality:

- Structure, process, or outcome of care
- Administrative and care systems within healthcare services include:
    - Acute and chronic condition management including care management and population health activities
    - Utilization & risk management
    - Credentialing
    - Member experience/satisfaction
    - Care and provider experience
    - Member grievances and appeals

- Practitioner accessibility and availability
- Plan accessibility
- Member safety
- Preventative care
- Behavioral/mental health
- Health disparities and inequities
- Social determinants of health

MCAS/HEDIS/CMS Core Set for Medicaid measures and CAHPS, among other quality metric results, are integrated in the QIHETP and may be adopted as performance indicators for clinical improvement. The CAHPS survey us utilized as one of the tools for assessing member satisfaction.

Quality initiatives and performance improvement interventions are developed and implemented as indicated by data analysis and/or medical record reviews. Initiatives are reassessed on a quarterly and/or annual basis to evaluate intervention effectiveness and compare performance.

HEALTH EQUITY, INCLUSION, DIVERSITY, AND NON-DISCRIMINATION

Health Equity

PHC California is committed to equality, inclusion, and diversity to maintain high-quality and affordable health care. PHC California's QIHETP will continue to focus on improving health equity in order to develop programs and interventions using the foundational architecture of health equity and quality improvement theory which drive system change and innovation. The 2024 QIHETP includes a focus on community engagement and input, culturally competent care, addressing social determinants of health, health literacy programs, reducing disparities in access, data collection and analysis, policy changes, and collaboration and partnerships. By combining these strategies and actively involving the community in the process, PHC California can work towards fostering health equity and ensuring that healthcare services are accessible and effective for all residents.

Inclusion, Diversity, and Non-Discrimination

PHC California assigns members to primary care providers (PCPs) and follows state and federal civil right laws. The health plan does not unlawfully discriminate, exclude members or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. All contracted providers are expected to render services to members they have accepted assignment for or not refuse services to any member based on criteria above. PHC California follows up on all grievances alleging discrimination and takes appropriate action.

To ensure that members have equitable access to covered services delivered in a manner that meet their needs, PHC California conducts the following activities:

- Review of member complaints and grievances
- Provision of language assistance services to assist providers to provide culturally and linguistically appropriate medical care to Limited English Proficient members
- A Population Needs Assessment as defined by DHCS

- Provision of cultural competency training for both providers and staff
- Surveys of members to determine if culture and language needs are met by providers
- Provision of a seniors and persons with disabilities (SPD) cultural sensitivity training for providers and staff
- Assessment of provider linguistic capabilities
- Assessment of PHC California staff language capabilities
- Review of readability and suitability of member information materials (set by DHCS regulations)

PROGRAM ORGANIZATION, OVERSIGHT, RESOURCES AND EVALUATION

Chief of Managed Care

The Chief Executive Officer (CEO) has appointed the Chief of Managed Care (CMC) as the designated person to support the QIHETP by providing day to day oversight and management of quality improvement activities. The CMC has overall responsibility for the clinical direction of PHC California's QIHETP.

QIHETP Evaluation

A written evaluation of the QIHETP is completed annually. This annual report includes a comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the program, including but not limited to the results of performance measures, health equity outcomes/findings from Performance Improvement Projects (PIPs), consumer and provider satisfaction surveys, and the quality reevaluation of the prior year's QIHETP Work Plan, and the development of the current year's QIHETP Work Plan to ensure ongoing performance improvement.

The evaluation is reviewed and approved by the QIHEC and includes the following:

- A description of completed and ongoing QIHETP activities that address quality and safety of both physical and mental/behavioral health care provided to PHC California members, including trended measures and an analysis of barriers to success
- A description of completed and ongoing QIHETP activities that address service quality and the experience of care for PHC California members, including trended measures and an analysis of barriers to success
- Analysis and evaluation of the overall effectiveness of the QIHETP (QI committee structure, QI program resources, practitioner participation and leadership involvement), including progress toward influencing network-wide clinical practices, population health needs, health disparities, and addressing the cultural and linguistic needs of PHC members
- Recommendation for restructure or changes to the QIHETP for the subsequent year to improve effectiveness

ANNUAL WORK PLAN

The annual QIHETP Work Plan serves as the roadmap for the program and outlines measurable, organizational, and multidisciplinary objectives, activities and interventions focused on improving key performance indicators (KPI). The goal is to identify the PHC California's approach to improving and sustaining performance through prioritization, design, implementation, monitoring, and analysis of performance improvement and health equity initiatives.

The QIHETP Work Plan is developed largely from recommendations from the annual QIHETP Evaluation. Areas of significant focus include partially resolved and unresolved activities from the previous year, and newly identified focus areas for the coming year. The focus areas include clinical and non-clinical care and service improvement activities that have the greatest potential impact on the quality of care and services, and patient safety. The QIHETP Work Plan also reflects the contractual requirements of PHC California.

At a minimum, the QIHETP Work Plan includes a clear description of the monitoring and improvement activities and objectives, the specific timeframe and responsible parties for conducting the activities, and monitoring of previously identified issues. Activities and outcomes are compared to predetermined goals/ benchmarks and/or target improvement metrics.

Additional improvement activities identified during the year or other changes made to the QIHETP Work Plan are presented to the QIHEC for approval on an ongoing basis. The QIHEC oversees the prioritization and implementation of clinical and non-clinical QIHETP Work Plan initiatives. The QIHETP Work Plan is assessed and updated at a minimum, semi-annually, and is included as part of the Annual QIHETP Evaluation.

PHC views the QIHETP Work Plan as a living document that reflects ongoing progress on QIHETP activities and a tool to focus improvement efforts throughout the year and evaluate progress against the objectives. This continuous quality improvement effort will help PHC California achieve its mission to provide cutting-edge medicine regardless of the ability to pay by providing high quality and equitable medical services.

Quality improvement activities that measure and monitor access to care include the following:

- Access and availability studies
- Initial health assessment monitoring
- GeoAccess studies
- Network adequacy

Quality improvement activities that measure and monitor provider and member satisfaction include the following:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Member grievance reviews
- Provider satisfaction surveys

- Focus groups

Quality improvement activities that evaluate preventive care, behavioral healthcare, care of chronic conditions, as well as coordination, collaboration and patient safety include the following:

- MCAS / HEDIS / CMS Core Set for Medicaid including race / ethnicity stratification of specific measures
- Coordination of care studies
- Facility site reviews
- Potential quality issue investigation

Quality improvement activities that evaluate PHC California's ability to serve culturally and linguistically diverse membership may include but is not limited to the following:

- Annual provider language study
- Annual cultural and linguistic study
- Ongoing monitoring of interpreter service and use
- Ongoing monitoring of grievances
- Focus groups to determine how to meet needs of diverse members
- Population Needs Assessment

Quality improvement activities that evaluate PHC California's quality of care include the following:

- Credentialing and recredentialing activities
- Peer review activities
- Delegation oversight

Communication and Feedback

Ongoing education and communication regarding quality improvement and health equity initiatives is accomplished internally and externally through committees, staff meetings, mailings, website content and announcements. Providers are educated regarding quality improvement and health equity initiatives via on-site quality visits, quality improvement focused trainings and webinars, provider updated memos / e-blasts, Provider Operations Bulletin (POB) articles, and the PHC California website. Reporting of specific MCAS / HEDIS / CMS Core Set for Medicaid measure performance is communicated to providers via an annual report card and monthly progress reports of current and projected rates including care gap reports of members who need specific clinical services. This reporting is also provided to PHC California's Population Health and Behavioral Health Teams for internal development of program initiatives.

PROGRAM RESOURCES DEDICATED TO QUALITY IMPROVEMENT AND HEALTH EQUITY

Multidisciplinary Staff

Resources for the QIHETP come from various department staff in addition to the leadership roles described in the Program Oversight section of this document.

Support for improvement initiatives related to population health, behavioral health, care management, utilization/risk management, and other clinical process improvement and outcome measures are provided by Care Management, Information Technology, and Quality Improvement (QI) department staff.

Quality initiatives related to service, including member satisfaction, and those related to complaints and appeals, are supported by the Member Services Department and Grievance and Appeals staff.

Quality initiatives related to provider network and provider communication is supported by Provider Relations staff.

Credentialing and peer review functions are supported by QI department staff.

The QI Department staff assists the National Quality Director in assessing data for improvement opportunities. They work with other departments to assist in planning and implementing activities that will improve care or service.

Responsibilities of multidisciplinary staff include but are not limited to the following:

- Assist in creating the annual QIHETP Description
- Assist in coordination of MCAS / HEDIS / CMS Core Set for Medicaid data collection, reporting and analysis of results
- Work with other departments to gather information for annual QIHETP Evaluation
- Collaborate in developing activities for the annual QIHETP Work Plan
- Identify areas for improvement and assist in implementing quality improvement and health equity initiatives
- Assist the Health Equity Officer and National QI Director in achieving goals of the QIHETP Program

Program and Tools

PHC California has dedicated resources to the acquisition of programs and tools that promote high quality and equitable services for our members. These include, but are not limited to:

- Online Member Services support: provider directories, health plan benefit summaries, drug formularies and claim forms
- Online Provider Resources: eligibility and benefit look-up, claims submittal, formulary information, forms
- Online Member Education and Engagement Resources

Data Sources

PHC California utilizes tools and resources that provide standards, benchmarks, guidelines, best practices, and measurement and evaluation methodologies to assist in guiding our improvement strategies. These resources include:

- *National initiatives and measurement set* such as Consumer Assessment of Healthcare Providers and Systems (CAHPS), Healthcare Effectiveness Data and Information Set (HEDIS), Centers for Medicare and Medicaid (CMS) Core Set for Medicaid
- *Government issued laws, regulations and guidance* including those from DHCS, DMHC, and CMS
- *Healthcare Quality Improvement Organizations* such as the National Committee for Quality Assurance (NCQA), the Institute for Healthcare Improvement (IHI), and the Agency for Healthcare Research and Quality (AHRQ), Health Services Advisory Group (HSAG)
- *The Guide to Community Preventative Services (The Community Guide)*; a collection of evidence-based findings of the Community Preventative Services Task Force established by the U.S. Department of Health and Human Services (DHHS)

Data, Information and Analytics Support

PHC California's QIHETP monitors and evaluates performance and information from many different sources throughout the organization including, but not limited to:

- Enrollment and demographic data, including race, ethnicity, and language preference data is collected to monitor health care quality and for identifying and reducing health disparities among our patient population
- Claims data (utilization by diagnosis/procedure, provider, treatment/medications, site of care, etc.) to ensure members are receiving appropriate care and to mitigate gaps through sharing of this data with other organization business units
- Population health/care management reports to assess support of members with complex or chronic medical and behavioral health conditions, and to evaluate coordination of care across the continuum
- Grievance and appeal data, including type of grievances, trends, and root cause analysis
- Ongoing tracking and trending of quality of care and serious reportable event (SRE) data to identify patient safety issues and assess provider qualifications
- Member and provider survey data to assess satisfaction with services and operations
- Credentialing process data to measure timeliness of application processing and quality of network providers
- Network adequacy/accessibility measurement data to assess provider availability and accessibility
- MCAS / HEDIS / CMS Core Set for Medicaid data to assess the effectiveness of clinical care and services

HEDIS Certified Software

PHC California's QIHETP utilizes the HEDIS Certified Software vendor, Vital Data Technology (VDT), to calculate all Managed Care Accountability Set (MCAS) and HEDIS quality measure rates to ensure

accurate calculation. The VDT HEDIS engine is used to calculate monthly prospective rates as well as the rates for the annual MCAS/HEDIS audit. The data used to calculate measure rates is produced monthly by PHC California's IT Department Data Analyst. The engine ingests the following data sources to calculate measure rates:

- Enrollment and demographic data, including race, ethnicity, and language preference data
- Claims data
- Encounter data
- Laboratory data
- Immunization registry data
- Health Information Exchange data
- Medical Record data
- DHCS Supplemental data
- Medi-Cal Rx pharmacy data

The calculated measure rates are used to monitor quality metric performance and identify opportunities for quality improvement intervention focus areas.

QUALITY COMMITTEES AND SUBCOMMITTEES

PHC California maintains seven subcommittees reporting up to the QIHEC: Infection Prevention & Control, Ryan White, Pharmacy & Therapeutics, Risk Management, Credentialing & Peer Review, Utilization Management, and Member & Provider. Two additional committees (the Public Policy & Community Advisory Committee and the Medical Administration Policy & Procedure Committee) have a dotted-line reporting relationship to the QIHEC. Committee minutes are recorded at each meeting and reflect key discussion points, recommended policy decisions, analysis and evaluation of QIHETP activities, needed actions, planned activities, responsible person, and follow-up. Minutes record the practitioner and health plan staff attendance and participation. Minutes will be produced within a reasonable timeframe, at a minimum, within one month or by the date of the next meeting. Minutes are reviewed and approved by the originating committee and are signed and dated within the same reasonable timeframe. Committee meeting minutes are submitted to DHCS quarterly, or as requested.

The responsibilities, scope, membership, and objective of the QIHEC, as well as the subcommittees reporting to the QIHEC, are as follow:

The QIHEC is the principal organizational unit that has authority to monitor, evaluate and report on all component elements of PHC California's QIHETP. The QIHEC has a minimum of eight voting members. The committee is chaired by PHC California Chief of Managed Care (CMC) and facilitated by the Health Equity Officer and the National Quality Director. Membership consists of the chairs of the eight subcommittees and at least one practicing physician in the community. The QIHEC meets at least quarterly. Ad hoc committees, however, will meet on an as needed basis. The QIHEC critically examines and makes recommendations on all quality and equity functions of PHC California described in this program and by state and federal regulatory authorities as appropriate.

It is the responsibility of the QIHEC and its subcommittees to assure that QIHETP activities encompass the entire range of services provided and include all demographic groups, care settings, and types of service. The committee reviews recommendations from quality subcommittees and makes recommendations on their implementation. All of PHC California's committees/subcommittees are required to maintain confidentiality and avoid conflicts of interest.

The Health Equity Officer and QIHEC produce an annual QIHETP Report addressing:

A. QIHETP activities, including:
    - Utilization Reports
    - Review of the quality of services rendered
    - MCAS / HEDIS/ CMS Core Set for Medicaid results
    - Quality improvement projects and initiatives (status and/or results)
    - Health equity projects and initiatives (status and/or results)
    - Satisfaction survey results
    - Collaborative initiatives both internally and externally (status and/or results)

B. Success in improving patient care and outcomes, health equity, and provider performance

C. Opportunities for improvement

D. Overall effectiveness of quality monitoring and review activities or specific areas that require remedial action as indicated in the annual report issued by the state's EQRO
E. Effectiveness in performing quality management functions and achieving goals and objectives through quality monitoring programs will be measured and reported
F. Presentation of the QIHETP Work Plan including recommendations for revision identified as a result of the review

QIHEC Objectives:

- Ensure communication processes are in place to adequately track work plan and QIHETP activities and enable horizontal and lateral communication as well as closing the loop when issues are resolved
- Ensure QIHEC members can have a candid discussion about barriers to achieving quality goals and objectives, and to facilitate the removal of such barriers

QIHEC Responsibilities:

- Oversees the annual review, analysis, and evaluation of goals set forth by the QIHETP as well as PHC California's QI policies and procedures
- Makes recommendations for implementation of interventions, or corrective actions based on results of quality improvement and health equity activities
- Facilitates data-driven indicator reviews and development for monitoring key quality management activities, including but not limited to: MCAS / HEDIS, Access / Availability, Performance Improvement Projects, Service / Clinical Quality Measures, UM/CM Metrics, Population Health metrics, Behavioral Health Metrics, credentialing performance, and delegation oversight
- Reviews reports from PHC California committees and departments, including quarterly dashboards, key activities and action plans including subcommittee updates, and reports regarding monitoring of health plan functions and activities

QIHEC Membership:

- Chief of Managed Care (Chair)
- Medical Director Managed Care
- Director of Pharmacy
- National Director of Quality
- National Director of Infectious Disease
- VP, Managed Care Operations
- Deputy General Counsel
- Director of Credentialing
- Behavioral Health Representative
- CA Community Providers
- Other Department personnel as required

QIHEC Reporting Structure:

The QIHEC reports to Executive Oversight Committee (EOC). The chair of the QIHEC ensures that quarterly reports are submitted to the EOC.

Meeting Frequency: The QIHEC meets at a minimum quarterly.

Executive Oversight Committee

Purpose

Provide executive oversight for quality, safety, customer service, compliance program activities, and health care delivery for people living with HIV/AIDS (PLWHA) as designated by the governing body for the AIDS Healthcare Foundation (AHF) and AHF MCO of Florida, Inc., to facilitate the collaboration of system-level operations across AHF with a focus on their impact on revenue streams.

Recommends

- Reviews operations and programs through the Quality Management Committee (QMC) reporting mechanism and makes recommendations concerning their actions and strategies as related the AHF's mission, vision, values, goals and objectives.

Approves

- Policies and procedures that support the orderly conduct of the organization, including AHF's scope of clinical activities
- Quality and performance improvement-related program descriptions and work plans (e.g. QPI, Utilization Management Committee (UMC), Infection Prevention & Control, Member and Provider Committee (MPC), Compliance Committee, Pharmacy and Therapeutics, Credentialing and Peer Review Committee, and Ryan White Quality Committee
- QMC working committee charters, reporting, and activities
- Marketing activities, provisions, and guidelines as defined by the organization and/or regulatory agencies
- Strategies and corrective actions to meet regulatory, accreditation, and clinical requirements.

Reporting Relationship: Executive Committee of the Governing Body

Chair: Chief of Managed Care

Members:

- President/CEO
- Chief of Managed Care
- Senior Vice President
- Chief Financial Officer (CFO)
- Compliance Officer
- Associate Director(s) of Care Coordination
- Health Plan Administrator

- Provider Relations Director(s)
- Southern Bureau Chief
- Western Bureau Chief
- Chief Information Officer
- Vice President, Managed Care Operations, FL
- Director of Pharmacy
- Health Plan Medical Directors
- Director of Risk Adjustment & Plan Revenue
- Chief of Operations, Risk Management
- National Director of Quality
- Sr. Director of Finance & Claims Operations Director of Credentialing
- National Director of Managed Care Operations & Project Development
- Director of Provider Data Management
- Other departments or personnel as required
- Recorder: Administrative support

Meeting Frequency: Quarterly

Quorum: A quorum is considered a minimum of one (1) Senior Manager and two (2) Directors necessary to enact and/or implement decisions. All vote outcomes are determined by a simple majority of a quorum.

Infection Prevention and Control Committee

Purpose

The Infection Prevention and Control Committee is chartered to provide direction and support to the infection prevention and control activities of the AIDS Healthcare Foundation Health Center providers and staff for the provision of safe care for people living with HIV/AIDS. The primary goal of the IPCC is to prevent transmission of infectious disease to patients, providers and health care workers at AHF Healthcare Centers and contracted provider offices.

The IPCC recommends:

- Policies, procedures, education and resources to reduce spread of infection
- Actions based on quarterly reports on incidents, performance monitoring and evaluation of infectious disease trends
- Timely responses to emerging infectious disease threats
- Strategies and corrective action to meet regulatory, accreditation and customer requirements.

The following are examples of the activities and resources which may be used:

- Identification of educational needs and resources for providers, staff and patients. [1]

[1] Resources include the Centers for Disease Prevention and Control (CDC), Occupational Safety and Health Administration (OSHA), Morbidity and Mortality Weekly Report (MMWR), Accreditation Association for Ambulatory Health Care (AAAHC), and AHF Policies and Procedures. Additional resources may include the World Health

- Use surveillance to identify and track infection control processes and systems.
- Direct continuous quality improvement projects addressing infection prevention, infection control and patient safety. Evaluate member and provider materials as needed
- Use of an annual workplan for improvement in the quality of prevention and control provided to the HCC environment
- Monitor compliance with regulatory, accreditation and requirements.

Reporting Relationship: Quality Management Committee and Board of Directors

Chair: National Medical Director of Infectious Disease

Members:

- Department of Medicine
- Representation of all levels of leadership, Senior, Regional, HCC
- Nursing
- Quality
- Care Coordination
- Pharmacy

Recorder: Administrative Support

Meeting Frequency: At least four times per calendar year

Quorum: A quorum is considered 50% of committee members plus one with a minimum of two physicians, necessary to enact and/or implement decisions.

Voting Determinations: All voting outcomes are determined by a simple majority of the quorum. All vote outcomes are determined by a simple majority of the quorum, considered two physicians and at least two administrative staff.

Member and Provider Committee

Purpose

Provide direction to AHF/PHP/PHC California activities to support the access to and provision of quality care for people living with HIV/AIDS. Ensure a positive experience of care and satisfaction with programs, services, and practitioners in provider networks and staff model locations. Monitor performance related to specific programs such as the Model of Care. Review demographic, accessibility, and availability data to understand the needs of members and providers, and address areas of improvement. Review the composition and adequacy of provider networks. Review results of annual member and provider surveys (e.g., CAHPS, HOS, DM and Client Services). Identify trends related to complaints and grievances. Evaluate member and provider materials as needed. Evaluate member and provider education through health education materials in line with regulatory requirements. Review and approve Member Services, Provider Relations, and Contracting Policies and Procedures annually.

Organization (WHO), Association for Professionals in Infection Control and Epidemiology, (APIC), Agency for Healthcare Research and Quality (AHRQ) guidelines and others based on program needs.

Monitor compliance with regulatory and accreditation requirements, clinical practice guidelines, and nationally recognized protocols.

Recommends

- Actions for system change to improve experience of care including accessibility, availability, and satisfaction, as well as membership growth and retention
- Actions to improve relationships and communication with providers
- Changes to Member Rights and Responsibilities and Member and Provider materials, including contractual requirements, as appropriate
- Strategies and corrective action to meet regulatory, accreditation and customer requirements

Reporting Relationship: Quality Management Committee and Executive Oversight

Committee of the AHF Board of Directors

Chair: Plan Administrator and/or Provider Relations Designee

Members:

- Chief of Managed Care
- Medical Director(s) Managed Care
- Regional Director(s) of Healthcare Centers
- National Director of Quality
- VP, Managed Care Operations
- National Director of Contracting and Provider Relations
- Compliance Officer or Designee
- Director of Member Services and Call Center Operations
- Associate Director of Data Analytics and EDI
- Associate Director Care Coordination
- Risk Manager, Grievances & Appeals
- Senior Director of Finance and Claims Operations
- Manager(s) of Contracting and Provider Relations
- Director of Care Coordination
- Health Plan Administrator
- Health Education Program Manager
- Director of Pharmacy
- VP, HCC Operations
- Director of Medical Staff Office & Credentialing
- Utilization Review Nurse and Ryan White Program Manager
- QI Project Manager- Contracts/Ryan White
- Associate Director of Contracting and Provider Relations
- Associate Director of Claims Operations
- Associate Director, National Grants, Specialty Network & Operations
- Director of Provider Data Management

- National Director of Managed Care Operations and Program Development
- Behavioral Health Representative, as needed
- Medical Provider Representative
- Other departments or personnel as required

Recorder: Administrative Support

Meeting Frequency: At least four times per year

Attendance: A quorum is considered a minimum of five administrative members necessary to enact and/or implement decisions. All voting outcomes are determined by a simple majority of a quorum

Pharmacy and Therapeutics Committee

Purpose

To provide oversight of formulary management and drug utilization programs. Establish drug use policies based on clinical safety, efficacy and standards of practice for HIV/AIDS. Provide recommendations for Drug Utilization Review (DUR), Medication Therapy Management (MTM), provider/member interventions and pharmacy-related educational campaigns. Provide oversight of pharmacy benefits manager (PBM) activities including formulary compliance with regulatory standards for prior authorizations; therapeutic interchange; step therapies; day limits; quantity limitations; generic substitutions; and new FDA approved drug products.

Recommends

- Policies and procedures for drug utilization review
- Medication Therapy Management targeting criteria
- Policies related to drug and prescription coverage by covered programs
- Provider and member interventions derived from analysis of drug utilization
- Clinical programs and provider educational campaigns

Reporting Relationship: Quality Management Committee (QMC)

Chairs: Chief of Pharmacy, Chief of Medicine, Medical Director, Managed Care or Designee

Vice Chair: Pharmacy Director, Managed Care or Designee

Voting Members:

- Chief of Medicine
- Medical Director, Managed Care
- Pharmacy Director, Managed Care
- Practicing Physicians
- Practicing Pharmacists
- Chief of Managed Care
- Nurse Practitioners
- Registered Nurses

- Specialist (Behavioral Health; Infectious Disease; HIV/AIDS; Pain Management, etc.)

Recorder: Administrative Support

Meeting Frequency: No less than quarterly

Attendance: A quorum is considered a minimum of one physician and one pharmacist. A consensus decision will be made on formulary actions, clinical recommendations and drug use policies. If no consensus is established, the issue will be put to a vote with the decision determined by majority vote of the quorum.

Risk Management Committee

Purpose

The purpose of the Risk Management (RM) Committee is to provide oversight of Health Plan policy and operations to protect the life and welfare of Plan enrollees and the workforce. The Risk Management Program Description and Work Plan are the primary tools to guide the success of the RM Program.

The QIHEC and the EOC are responsible for the oversight of the Risk Management Committee (RMC) and delegate the day-to-day operations to the Registered Nurse (RN) Clinical Risk Manager or designee. The RMC provides quarterly updates to the QIHEC, EOC, and PPCAC. These Committees oversee the implementation and ongoing assessment of the RM Program.

The RMC's responsibilities include:

- Providing direction to the Health Plan RM program
- Serving as an advisory and oversight committee
- Ensuing program activities are deployed
- Monitoring, reporting, and acting on trends in adverse, potential quality of care issues complaints, appeals, and grievances data
- Monitoring compliance with regulatory, accreditation, and contractual requirements
- Establishing and implementing risk identification, evaluation, treatment, and monitoring subsystems
- Identifying data resources
- Developing lines of communication
- Evaluating problems to determine corrective action
- Implementing corrective actions
- Monitoring the effectiveness of actions implemented
- Developing, reviewing, and advising on matters of policies and procedures
- Reviewing claim activity
- Recommending the advisability of waiving enrollee bills
- Developing educational programs aimed at the reduction of liability claims
- Participating in the investigation of potentially compensable events
- Conducting periodic audits of departments and services for risk exposure

The RM Program is an integral part of the quality management program and it reviews and approves at least annually by the EOC, QIHEC, and PPCAC.

Recommends:

- RM Program including Work Plan directions and Program Description
- RM Program policies and procedures
- Interventions to address trends identified in adverse critical events, ear misses, potential quality of care issues, complaints, appeals, and grievances patterns
- Course of action when there are opportunities for improvement to ensure access to safe care
- Strategies and corrective action to meet regulatory, accreditation, and customer requirements
- Educate all physicians and staff o grievance process

Reporting Relationship: QIHEC, EOC, PPCAC

Chair: Health Plan Medical Director or Designee

Members:

- Health Plan Medical Director(s) or designee
- Legal Counsel
- Chief of Managed Care
- Vice President (VP) of Managed Care
- Registered Nurse Clinical Risk Manager/ Risk Manager
- National Quality Director or designee
- Compliance Officer
- Health Plan Administrator

Recorder: Risk Management Designee

Meeting Frequency: At least four times per year. Special meetings and work groups convened as needed.

Attendance: A quorum is considered a majority with a minimum of one physician (Medical Director) and two administrative members necessary to enact and/or implement decisions. All vote outcomes are determined by a simple majority of a quorum.

Utilization Management Committee

Purpose

Provide direction to PHC California's Utilization Management Program and act as the oversight committee of the medical care utilization, benefit parameter structure, claims payment, appeal management, external review response management, management of the health plan's incurred but not reported (IBNR) claims, medical loss ratio financial oversight and network development. The UM Committee accomplishes this by:

- Reviewing and approving criteria for use in clinical and administrative utilization review decisions, e.g., InterQual, Milliman/Roberts, Medicare Local and National Determinations (LCD, NCD), health plan evidence-based criteria, HIV/AIDS Bureau (HAB) standards, Centers for Disease Control (CDC) standards, etc.
- Reviewing and monitoring the implementation of evidence-based HIV/AIDS and other clinical protocols, clinical practice guidelines and medical necessity criteria employed in the utilization management process
- Ensuring that UM, clinical care, claims and risk adjustment (RA) staff receive education and training on covered benefits, UM criteria, and the appeals process so that members receive consistent and equitable application of care and services
- Assisting in the development of annual benefit determination, policy and procedure review and approval, network development strategies/ tactics, and approval of materials developed by plan/program Administration that communicate the benefits and UM guidance for said benefits to members, providers and staff
- Analyzing under- and over-utilization patterns in order to:
    - Recommend direction or program changes
    - Evaluate program performance and effectiveness against standards and goals and identify opportunities for improvement
    - Evaluate current and proposed utilization management activities for UM, Case Management, Disease Management and Model of Care
    - Review utilization and risk adjustment performance of medical providers, downstream contracted service providers (behavioral health, vision, dental)
    - Review the financial performance of the plan and medical loss ratio (MLR)
    - Monitor compliance with regulatory, accreditation and contractual requirements related to utilization, claims payment, organization determinations, redeterminations, appeals, external review vendor performance and independent review entity (IRE) case management
    - Annual review and approval of the Medication Therapy Management Program (MTMP)
    - Review unit cost of inpatient and outpatient services delivered to ascertain the cost and quality of services delivered and make recommendations for contracting and value-based agreements
- Providing input and approving program descriptions and work plans for UM, Case Management and Population Health Management programs including the Model of Care (MOC).
- Determining and approving evidence-based UM criteria, clinical practice guidelines and protocols
- Reviewing and approving UM, Case Management, MOC and Population Health Management program policies and procedures that relate to processes by which medical necessity and benefits coverage for inpatient and outpatient services are determined
- Determining corrective action interventions and quality improvement activities to address utilization patterns and trends, and monitoring corrective action plans for compliance and sustainability

- Determining, in cooperation with PHC California administration, course of action when there are opportunities for improvement to ensure access to essential services, appropriate utilization of services, coordination of care, seamless transitions of care, and outcomes of care
- Developing strategies and corrective action to meet regulatory, accreditation and customer requirements
- Overseeing delegated vendors that engage in UM functions
- Reviewing denial, appeal and reconsideration reports for trends, appropriateness and opportunities to improve the processes and decisions involved
- Monitoring utilization of services for suspected fraud, waste or abuse and taking appropriate action when suspected incidents are a\identified

Reporting Relationship: QIHEC, EOC

Chair: Medical Director or designee

Members:

- Chief of Managed Care
- Managed Medical Director(s)
- National Director of Quality
- Director of Pharmacy
- Director of Care Management/Care Coordination
- Behavioral Health Clinical Representative
- VP, Managed Care
- Associate Director of Quality
- Senior Director of Finance and Claims Operations
- Director of Risk Adjustment (Ad Hoc)
- Associate Director(s) of Care Management/Care Coordination
- Other departments or personnel as required

Recorder: Administrative Support

Meeting Frequency: Quarterly

Attendance: A quorum is considered a minimum of 50% of Voting Members with presence of Medical Director, licensed in the state for which the decision is being made to enact and/or implement decisions. Only AHF staff will have voting rights. All vote outcomes are determined by a simple majority of a quorum.

Credentialing and Peer Review Committee

Purpose

Direct credentialing and recredentialing activities to ensure quality care for people living with HIV/AIDS. Review all new applicant practitioner credentials prior to full participation using established criteria. Obtain meaningful advice and expertise from participating practitioners for credentialing decisions. Review of credentials for practitioners who do not meet established thresholds. Conduct reviews for

practitioner privileging. Use a peer review process to make recommendations regarding credentialing decisions. Approve or deny participation of all practitioners and institutional and ancillary providers. Review delegated credentialing documentation of provider groups, institutional or ancillary, including pre-delegation audit results. Conduct peer review clinical cases of potential quality of care to determine the need for disciplinary action. Review of Credentialing and Peer Review policies and procedures. Monitor compliance with regulatory, accreditation and contractual requirements.

Recommends

- Policies and procedures for well-defined credentialing and recredentialing process for evaluating and selecting practitioners and institutional and ancillary providers
- Rigorous process to select and evaluate practitioners and institutional and ancillary providers
- Approval of delegated credentialing based on established criteria
- "For cause" denials for continued participation of participating providers and offer appeal rights per the Practitioner Fair Hearing Policy
- Peer review with follow-up disciplinary action, as necessary, with the practitioners
- Strategies and corrective action to meet regulatory, accreditation and customer requirements

Reporting Relationship: QIHEC, Board of Directors

Chair: Medical Director of Managed Care

Vice Chair: Deputy Chief Medical Officer

Members:

- Regional Medical Directors
- Dental Director
- Medical Practitioners (Physicians, Specialists, Dentist, Mid-level Providers)
- Chief Medical Officer
- Pharmacy Designee
- Division Chief, Managed Care
- National Director of Contracting & Provider Relations
- Provider Relations Manager
- Director of Medical Staff Office & Credentialing
- National Director of QI Manager(s)
- Other departments or personnel as required

Recorder: Administrative Support

Meeting Frequency: Monthly

Attendance: A quorum is considered a minimum of three (3) physicians necessary to enact and / or implement decisions. All vote outcomes are determined by a simple majority of a quorum

Ryan White Quality Committee

Purpose

Ensure and advance health care quality and outcomes for people living with HIV/AIDS under the Ryan White Program, which is designed to improve primary health care, retention in care and health outcomes. Develop and direct scope and activities for quality and performance improvement for clinical quality, medical case management, experience of care (e.g., access and retention) and compliance activities related to the national program and local authorities. Provide oversight of QI functions. Approve and ensure successful deployment of the annual work plan. Review and approve annual program descriptions, work plans and summaries of previous year's quality based organizational activities. Serve as an action body and coordinate the actions taken by workgroups and teams in the Healthcare Centers. Approve policies and procedures. Monitor compliance with regulatory and contractual requirements.

Recommends

- Organizational strategy for systematically achieving quality goals and objectives to provide high-quality health care services in accordance with the principles of professional practice and ethical conduct and with concern for improving the health status of the individual and community
- Objectives for serving a culturally and linguistically diverse membership and serving clients with complex health needs.
- Key monitoring indicators that measure performance against operational and service guidelines and contract requirements including clinical practice guidelines, benchmarks and program goals
- Recommend actions when new opportunities are identified to improve clinical care, experience of care, or patient safety
- Approaches for communicating program activities and results to members/patients/clients, providers and AHF workforce
- Strategies and corrective action to meet regulatory and contractual requirements

Reporting Relationship: QIHEC

Chair: Contracts Quality Project Manager

Members:

- Medical Director(s)
- Chief of Managed Care
- Office Administrator(s)
- Nurse Manager(s)
- Director of Nursing
- Director, Clinical Operations
- Pharmacist
- Projector Director (PHD)
- Contract Managers
- Regional Directors

- Health Education Program Manager
- National Director of Quality
- IT
- Director of Ryan White Medical Case Management
- Care Manager(s)
- Providers/Practitioners, as needed
- Regional Medical Directors
- Director of Contracts
- Other departments or personnel as required

Recorder: Contracts Quality Project Manager

Meeting Frequency: Each Region/Bureau will meet quarterly. Western, Southern, and Northeast Regions/Bureaus will rotate monthly, with one Region/Bureau meeting every month

Attendance: A quorum is considered a minimum of one (1) physician and three (3) administrative members necessary to enact and/or implement decisions. All vote outcomes are determined by a simple majority of a quorum

<u>Public Policy and Community Advisory Committee</u>

Purpose

The Public Policy and Community Advisory Committee (PPCAC) provides a mechanism for structured input from enrollees, network providers and related community agencies regarding how the health plan's operations affect the delivery of enrollees' care. The role of this committee is to implement and maintain community linkages. Activities of this committee may include: developing a culturally appropriate service or program design; setting priorities for health education and outreach programs; implementing member satisfaction surveys and developing marketing materials and campaigns; developing a community resource guide; and periodically reviewing the health plan's grievance processes and metrics and other performance metrics related to enrollee satisfaction.

Recommends

- Actions to improve culturally appropriate communications with enrollees
- Setting priorities for health education and enrollee outreach programs
- Changes to health plan operations that improve enrollee experience and satisfaction.

Reporting Relationship: QIHEC, EOC

- Chair: Health Equity Officer
- Members:
- Managed Care Executive Oversight Committee Member
- Health Plan Administrator
- VP Managed Care Operations
- Director of Member Services and Call Center Operations
- National Director of Contracting and Provider Relations

- Quality Improvement & Risk Management
- National Director of Care Coordination
- Medi-Cal Managed Care Plan Contract Manager
- Health Equity Officer and Director of Health Education
- PHC California Enrollees
- PHC California Network Providers
- Community Health and Advocacy Organization Members

Recorder: Administrative Support

Meeting Frequency: At least four times per year.

Attendance: A quorum is considered a minimum of five attendees necessary to enact and/or implement decisions. All voting outcomes are determined by a simple majority of a quorum.

POPULATION HEALTH MANAGEMENT PROGRAM

PHC California's QIHETP is built upon a Population Health Management (PHM) framework. The health plan employs data-driven methodologies to identify clinical and social drivers of health, monitor performance of clinical and service initiatives, identify opportunities for improvement and implement corrective action plans with the goal of improving the health of Medi-Cal enrollees and health equity for all populations

The PHM Program ensures that all members have access to comprehensive set of services based on their needs and preferences across the continuum of care, which ultimately leads to longer, healthier, and happier lives, improved outcomes, and health equity. Specifically, the PHM Program:

- Builds trust with and meaningfully engages members
- Gathers, shares, assesses timely and accurate data to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predicative analytics, identification of gaps in care, and standardized assessment processes. This data is provided by or through collaboration with the QI Department
- Addresses upstream drivers of health through integration with public health and social services
- Supports all members in staying health through development of PHM interventions guided by QI identified focus areas. This is accomplished through the provision of gaps reporting and identification of target populations by QI. Gaps reporting and identification of target populations is completed utilizing PHC California's Healthcare Effectiveness Data and Information Set (HEDIS) certified software engine as well as through QI analysis
- Provides care management services for members at higher risk of poor outcomes
- Provides transitional care services (TCS) for members transferring from one setting or level of care to another
- Reduces health disparities
- Identifies and mitigates social drivers of health (SDOH)

PHC California is currently in the building phase for its PHM Program and will continue to improve the depth and breadth of services available to our members as we learn more about their needs and characteristics through data-driven, quality improvement approach.

DELEGATION OF QUALITY IMPROVEMENT

Delegation is the formal process by which the health plan gives an external entity the authority to perform certain functions on its behalf. These functions may include quality improvement, health equity, population health, utilization management, credentialing/recredentialing, and grievances and appeals. PHC California retains accountability for ensuring the function is being performed according to expectations and standards set forth by the state Department of Healthcare Services (DHCS).

PHC California will evaluate the delegated entity's capacity to perform the delegated activities prior to delegation. PHC California will only delegate activities to entities who have demonstrated the ability to perform those duties, and who have the mechanisms in place to document the activities and produce associated reports, prior to delegation of that activity. PHC California retains the right to delegate these functions.

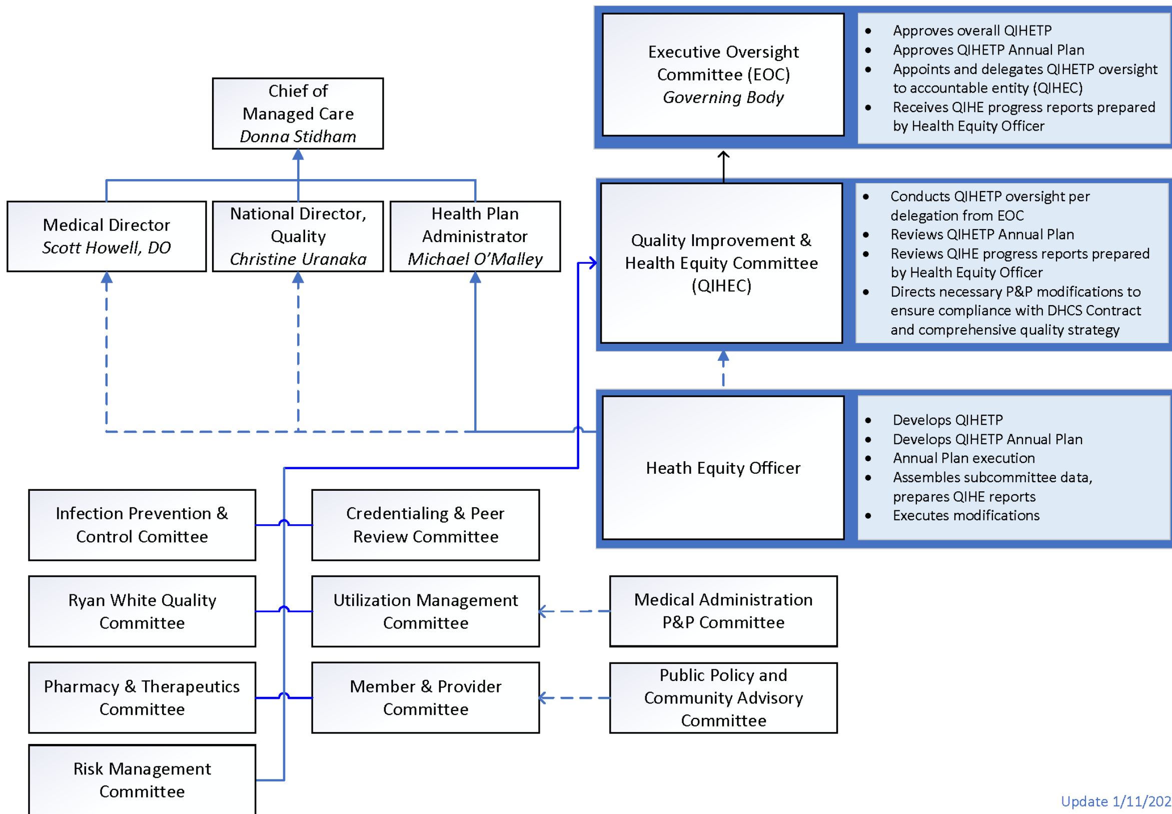
Any delegated functions are fully described in mutually agreed upon signed and written formal delegation agreement between PHC California and each delegated entity and includes an effective date. All agreements clearly define PHC California's and the delegates specific duties, responsibilities, activities, reporting requirements and identifies how PHC California will monitor and evaluate the delegate's performance. The agreement also includes PHC California's right to resume the responsibility for conducting the delegated function should the delegated entity fail to meet PHC California standards.

PHC California conducts ongoing oversight, evaluation and monitoring of the delegate. At a minimum, an annual audit is conducted using an audit tool that is based upon current NCQA and DHCS standards and modified on an as-needed basis. In the event any deficiencies are identified though the oversight process, corrective action plans are implemented based upon areas of non-compliance. If the delegate is unable to correct or does not comply with the corrective action plan within the required timeframe, PHC California will take action that may include imposing sanctions, de-delegation of the delegated function or termination of the contract or agreement. Focused audits may be performed to verify deficiencies have been corrected or if a quality issue is identified. Audit results and outcomes of corrective action plans are reported to the QIHEC.

Delegated entities are required to submit at least quarterly reports to PHC California according to the reporting schedule specified in the delegation agreement. Joint operation meetings (JOM) are held on quarterly basis as a means of discussing performance measures and findings as needed. JOM includes representation of the delegate and PHC California departments as applicable.

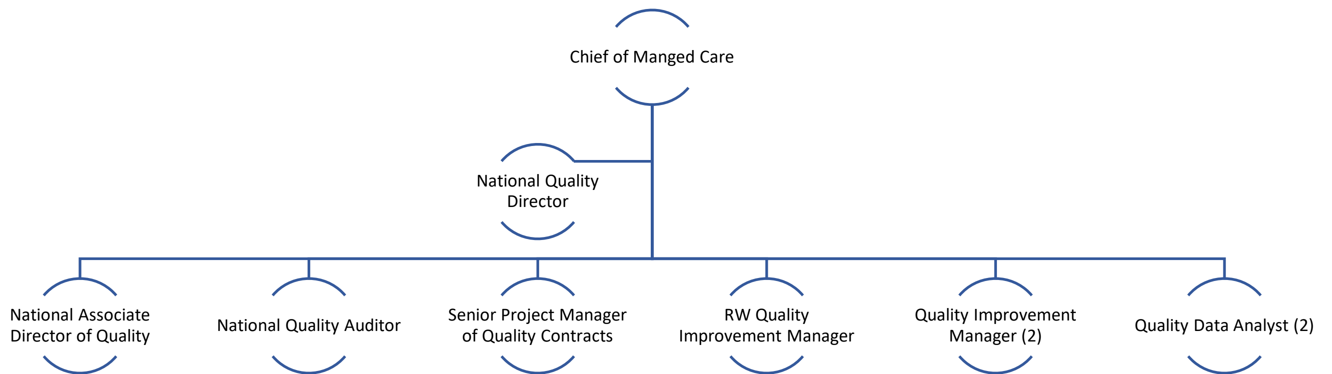
QUALITY COMMITTEE ORGANIZATIONAL CHART

The following organizational chart shows PHC California quality committees and their reporting relationships.



QUALITY IMPROVEMENT DEPARTMENT ORGANIZATIONAL CHART

The following organizational chart shows the PHC California Quality Improvement (QI) Department reporting relationships.



QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE MEETINGS FOR CALENDAR YEAR 2024

Dates	
Monday	February 26th
Monday	May 27th
Monday	August 26th
Monday	November 18th
Location: Sunset Headquarters via teleconference (with audio)	

AVAILABILITY OF THE QIHETP DOCUMENTS TO PRACTITIONERS AND MEMBERS

QIHETP documents available on PHC California's website www.phc-ca.org. Printed copies are available upon request.