Overview

The Quality Improvement Program is designed to promote the highest quality medical care and service to members of Network Medical Management and its affiliate IPAs. It is based on the ability to perform on-going evaluation and modification so as to stay effective in the dynamic health care environment. Program goals are achieved through the proactive identification and resolution of issues that directly or indirectly affect member care. The Quality Improvement Plan examines methods, processes and outcomes with emphasis on improvement initiatives.

The objectives of the program are guided by the goal of maintaining an integrated system that assures quality of care and service to all patients. This is accomplished by proactively identifying methods to continuously improve the quality of health care delivered. The program also recognizes the importance of member satisfaction and incorporates this aspect of quality improvement into the overall program goals.

The primary goals of the program are to improve member quality of life, control the cost of care and manage exposure to risk. These goals will be achieved by working with the health plans providers and community resources.

The following objectives will direct the on-going development of the policies and procedures for the QI Program:

1. To increase the process of communication, feedback, education and continuous quality improvement.

2. To improve the quality of care and safety of clinical care provided to members by proactively identifying methods to continuously improve the quality of health care and service.

3. To evaluate the effectiveness of actions implemented to correct identified deficiencies.
Quality Improvement Plan

I. Purpose

The Quality Improvement Program is an ongoing, comprehensive and integrated program designed to objectively and systematically monitor and evaluate the quality, appropriateness and outcome of patient care and service, the processes by which they are delivered and to pursue opportunities for improvement and problem resolution.

II. Philosophy

Quality Improvement is activity designed to initiate, monitor and evaluate standards of healthcare practice, which address the needs of the members. Through this activity, known or suspected problems and opportunities to improve patient care may be identified, studied and corrected. The Quality Improvement Program strives to ensure that the highest quality of care and service is provided to all members.

III. Scope

The scope of the Quality Improvement Program is comprehensive, multi-disciplinary and includes all activities that have a direct or indirect influence on the quality and outcome of clinical care and service delivered to all members and the service provided to employers and provider panel members. This shall apply to all departments, services and activities provided by Network Medical Management and shall include but not be limited to Member Services, Preventive services, Complaint & Grievance and Credentialing.

IV. Goals and Objectives

A. To continuously improve the quality of care and service delivered to both IPA’s and customers through performance monitoring activities throughout the organization, including but not limited to utilization management, credentialing, monitoring and resolution of member complaints and appeals, assessment of member and provider satisfaction, medical record and facility reviews.

B. To develop, implement and coordinate all activities that are designed to improve the processes by which care and service are delivered and to assure responsibilities are assigned to appropriate individuals.

C. To ensure a system of quality management communication that is timely, reports through appropriate channels, to appropriate individuals.

D. To facilitate documentation, reporting and follow-up of quality management activities in order to prevent duplication and facilitate excellence in clinical care, service and outcome and to comply with appropriate state, federal, other regulatory agencies, and contracted health plans.

E. Evaluation review activities will include but are not limited to the areas of:

1. Practitioner accessibility and availability
2. Practitioner satisfaction
3. Practice guidelines
4. Over/under utilization of services
5. Adverse outcome/utilization review monitors/sentinel events
6. Medical record keeping and documentation practices
7. Practitioner site audits
8. Member satisfaction, processing member complaints as indicated per health plan by contacting the Member Service Representative
9. Timeliness of processing claims
10. High risk and high volume services
11. Professional & ancillary services
12. Credentialing
13. Preventive services
14. Continuity and coordination of care across practice and provider sites
15. Continuity and coordination of general medical care with Behavioral Health care
16. Monitor and improve Behavioral Health care
17. Risk management trends
18. Management of patient with chronic conditions
19. Contracted provider network cooperation with the QI program
20. Improve patient safety of clinical care by improving COC to avoid miscommunication, track/trend adverse events to identify system issues which contribute to poor safety, during site visits improve safe practices and f/u on m=complaints related to pt safety

F. The QM program upon request by a member/provider can obtain a condensed version or summary of the Quality Improvement Program, which identifies the purpose of the program by written request via quality management department.

V. Organizational Structure, Authority and Responsibility

A. Board of Directors

The Board of Directors for each IPA has the overall responsibility for establishing, maintaining and supporting the QI Program. The ongoing responsibility for the development and implementation of the Program is delegated by each Board of directors to the QI Committee. Each Board of Directors further delegates responsibility for the Quality Improvement Program to the Medical Director of the IPA.

The Board of Directors provides oversight of the QI Committee and its activities and participates indirectly with Quality Management issues. The Board reviews, approves and makes recommendations on the annual QI Program and Workplan at least annually and at the time of any revision. At that time, any action that is requested or deemed necessary shall be acted upon by the appropriate Board.

Each Board receives regular quarterly written reports from the QI Committee, delineating opportunities to improve care/service, actions taken and improvements resulting from monitoring and evaluation activities.

Each Board discusses reports, requests additional information when required and directs action to be taken, independent of the QI Committee, on opportunities to improve care and service or to resolve problems when indicated.

B. Administration

The Chief Medical Officer and Chief Operating Officer have organizational responsibility for the QI Program, insures program implementation, function and results and provides for adequate resources and staffing.

C. Medical Directors

The Medical Directors are responsible for insuring that the QI Program is properly developed, implemented and coordinated and are substantially involved in the function of the program, including membership on the QI Committee. The Medical Directors shall share the responsibility for the overall QI process and decision making. The Medical Directors will interact with the Chief Medical Officer and Chief Operating Officer to facilitate the overall flow of the process and transition of information to physician staff and will report directly to their respective Boards for all decisions made. All urgent issues that may arise will be referred directly to the Medical Directors and follow the line of succession and shall be reported back to the QI Committee, if applicable. The peer review process shall be the designated responsibility of the Peer Review Committee. It may delegate specific responsibilities of the Peer Review process as deemed appropriate. In addition the practitioner must hold an unrestricted license to practice in the State of California.

D. Quality Management Chairperson

The chairperson shall be responsible for the overall decision making process of the QI Committee including serving a designated behavioral health care practitioner advisor regarding the QI Program. The responsibility is exercised as needed regarding BH decision making. The chair shall have sufficient time and authority to devote to the QI program as well as the involvement of a designated
behavior care health care practitioner. It is the responsibility of the chairperson to report to their respective Board of Directors and act as liaison for the flow of information from the QI Committee.

E. Quality Management Manager

The Quality Management Manager designated and acts with the authority of the Medical Directors, is responsible for the development and integration of quality management activities, for assisting the Medical Directors, Chief Medical Officer, Chief Operating Officer and management staff in implementing the QI Program.

The Quality Management Manager oversees the QM/Delegation Oversight Coordinators, Health Education Coordinators, and Grievance & Appeals Coordinator, Culture and Linguistics. The Quality Management Manager in the implementation the Quality Improvement In addition the Quality Management Supervisor ensures adequate resources in order to meet the short and long-term goals of the Quality Management Program. The resources include staff, data collection, analysis resources, space and equipment. Other departments may be included in the resource provision.

The Quality Management Manager will facilitate the conduction of Health Plan mandated audits/surveys, along with any other audits/surveys as deemed necessary. The results of these audits/surveys will be reviewed by the QM Committee and reported to the Health plans and other designated parties as appropriate.

The Quality Management Manager is responsible for managing and evaluating the Health Education Program, oversees Quality Management /Health Coordinators in implementing required mandates and all related activities.

The Quality Management Manager is designated and acts with the authority of the Medical Director, implementing of Culture and Linguistic requirements, to deal with non-compliant issues, the responsibility to delegate ‘appropriate tasks to responsible departments for the implementation of Culturally and Linguistically Appropriate Services.

F. Coordinators (QM/Delegation Oversight/ Grievance/Health Education/Culture and Linguistics)

The Coordinators monitor and analyze internal data trends and patterns, such as utilization review, monitor complaints & grievances, perform site and medical record reviews, conduct access studies, coordinate health education services implement required mandates for C & L, prepare required reports, accomplish and complete job duties assigned as needed.

G. Quality Management Committee

The QM Committee is an interdisciplinary Committee of the Board of Directors with membership appointed by each Medical Director. It includes administrative staff and practitioners involved in areas having the greatest impact on patient services.

1. Structure/Membership
   Membership shall be for a one year period with membership automatically renewed at each January QM Committee.

2. Meetings and participation
   a. The QM Committee shall meet as set forth in the Committee Schedule and at a minimum of quarterly. It may meet more frequently if deemed necessary by the Medical Director as a mechanism for dealing with urgent issues between meetings. A quorum will constitute at least three physicians. All members shall have voting privileges except in the area of medical and peer review issues in which only physicians shall have voting rights.
   b. The QM Committee will recommend policy decisions, establish practice guidelines, select monitoring indicators and studies, institute and analyze results of QM activities, assist in follow-up and problem resolution. Active participation on the Committee includes consistent meeting attendance and
involvement, discussion of agenda items and participation in the QM activities as requested by the Committee.

c. Upon written or verbal notification and with the approval of the QM Chairperson, QM Committee meetings shall be open to contracted Health Plans, who may attend portions of the meeting specific to their enrolled members. Health plan representatives may review QM Committee minutes specific to their enrolled members. A signed statement of confidentiality will be required of all visitors prior to QM Committee attendance and annually for all members.

3) Minutes

a. QM Committee minutes shall be taken in a contemporaneous manner and reflect all Committee decisions and actions, they shall be prepared in a timely manner, be reviewed by the QM Chairperson and submitted to the Committee at the next scheduled meeting. All agendas, minutes, reports, documents and attachments presented to the QM Committee are maintained in a confidential manner and are protected from discovery by California Health & Safety Code 1370.1. Further protection of said documents is granted by Section 1157 of the California State Evidence Code.

b. QM Committee minutes documents and attachments may be reviewed by authorized Health Plan representatives; however, no copies will be provided and thus confidentiality of the information will be preserved. Furthermore, QM Committee minutes will be maintained in a secure area.

c. Peer review issues will be de-identified for provider/member confidentiality.

d. Follow-up on all agenda items will be assured by carrying items on the agenda until resolution.

e. Minutes shall include, but not be limited to:

1. Active discussion of QM issues
2. Establishment or approval of practice & preventive health guidelines
3. Selection of important aspects of care and indicators to monitor
4. Analyzing results of QM activities
5. Credentialing or recredentialing issues
6. Recommendations, actions and follow-up
7. Review of audits and studies
8. Plan, policy and procedure review and decisions
9. Communication to provider
10. Reflect all Committee decisions and actions, produced dated and signed within 1 month

4) Functions/Responsibilities

a. The Quality Management Committee is responsible for developing and maintaining the QM Program and developing an annual QM work plan. The QM program and QM work plan will be reviewed annually, revised as necessary, and approved by the Quality management committee and the governing body.

b. The Committee recommends policy decisions reviews and evaluates the results of QM activities, initiates necessary program improvement and assures follow-up as appropriate.

c. The Committee is responsible for the selection of routine monitoring and evaluation topics and special studies. Those chosen are relevant to the demographic and epidemiological characteristics of the patient population served and resources utilized as evidenced by claims and encounter data.
d. The Committee is vested with the ultimate responsibility for the development and approval of practice and preventive health guidelines that are based on scientific evidence, with quality indicators to monitor provider performance. Methods are implemented to communicate guidelines as well as individual and group performance to providers.

e. The Committee assures that the information and findings of the QM activities are used to detect trends, patterns of performance of potential problems and to develop and implement corrective action plans. The Committee assures that necessary information is communicated to appropriate individuals, departments and providers when problems or opportunities to improve care/service are identified.

f. The Committee provides quarterly and annual reports to the Board of Directors which includes conclusions and recommendation for action and follow-up on identified opportunities to improve care and problem areas.

g. The Committee reports findings of appropriate quality management activities for inclusion in Provider Profiles.

h. The Committee has responsibility for the review, necessary research and response, when a complaint is filed. After analyzing findings pertinent to complaints, the Committee will take action as appropriate. All complaints received from the health plans and other sources will follow the QM complaint policy and protocol to conclusion.

i. The Grievance and Appeals Committee is a subcommittee of the QM Committee and shall meet monthly and report findings to the QM Committee.

j. Issues whether actual, potential or perceived, will be communicated to the QM Committee:
   1. Utilization Management Committee will refer “Potential of Care” issues to the QM Committee for further investigation and action if needed;
   2. Credentialing/Peer Review Committee will refer appropriate issues to the QM Committee for further investigation and action if needed.

k. In the event that a complicated peer review or potential of care issues arise, the medical director will arrange an independent external review. The external reviewers will be board-certified peer physicians or peer consultants. The outcome will be presented to the Quality Management Committee; corrective action plan will be determined and implemented by the designated person. The committee will be kept informed as necessary of progress in the resolution of the issue until a final solution has been achieved. Health plans will be appraised as appropriate to the situation.

l. The QM Committee shall review the scope, objectives, organization and effectiveness of the QM Program at least annually and revise it as necessary, reporting results to the Board.

m. The QM Committee allocates resources to activities that will have the greatest potential impact on the care and service provided.

n. The QM Committee has responsibility for the Health Education program.

o. The QM Committee has responsibility for the Culture and Linguistics program.

5. Coordination With Other Management Activity

a. QM activities shall be coordinated with other performance monitoring activities, including QM, UM, resolution and monitoring of member complaints in order to expand and improve services and/or identify and correct problems.
b. Encounter and other data collection systems shall be used to monitor and evaluate care and service for specific and appropriate aspects of care.

c. QM activities shall be reported through the QM Committee to assure awareness of monitoring and evaluation and related outcome.

d. Management reports to the QM Committee include, but are not limited to network changes, medical management systems, practice feedback to providers, grievance and appeals data/statistics, patient education, and culture and linguistics.

e. Quality activity reports are made as designated to the QM Committee and may include reports by Credentialing, UM, Member Services, etc.

f. Quarterly and annual QM reports shall be submitted to the health plans according to contractual agreements or California Managed Health Care Quality Coalition requirements.

6. **Scope, Content, measurement, intervention & follow-up of QM Activities**

A. **Scope and Content**

The QM Program represents the Network Medical Management delivery system and meaningful clinical issues that affect its membership. Issues identified, measured, analyzed and acted upon for improvement.

1. The Group ensures the continuity and coordination of care that members receive by:
   a) Identification, collection, assessment and evaluation of meaningful clinical issues.
   b) Monitoring the continuity and coordination of care across practice sites.
   c) Ensuring the continuity and coordination of general medical care and behavioral healthcare.

2. The Group monitors utilization to detect potential under and over utilization. The continuity and coordination of care received by members shall also be monitored.

B. **Measurement**

1) Clinical measurement activities shall be implemented. Quality improvement issues are tracked by data collection, measurement and analysis.

   a) Quantitative measures are adopted or designed to assess performance, identify and prioritize areas for improvement of clinical issues.
      - Measure used for performance assessment are objective and quantifiable
      - Measure are based on current scientific knowledge and clinical experience
      - Measures have an established goal or benchmark.

C. Appropriate methods are utilized to collect data for each assessment:

   1) The affected population is identified.
   2) Appropriate samples are drawn
   3) Valid and reliable data is collected

D) Each assessment measure is analyzed using the collected data:

   1) A quantitative analysis of the assessment data is completed
2) Appropriate staff and practitioners evaluate the analyzed data to identify improvement barriers that are related to clinical practice or operations.

E) The collected data is also analyzed to:
   1) Detect under or over utilization
   2) Evaluate continuity and coordination of care

F) Intervention and follow-up:
   1) Action will be taken to improve clinical quality by addressing opportunities for improving performance. The effectiveness of such interventions is assessed through systematic follow-up:
      a) Decisions are made as to which opportunities will be pursued.
      b) Interventions are implemented to improve practitioner and operational performance.
      c) The effectiveness of such intervention is measured.
   2) Appropriate interventions are implemented when issues are identified
   3) Appropriate interventions are implemented when the Group identifies individual occurrences of poor quality.
   4) Interventions are appropriately implemented to improve the continuity and coordination of care received by patients.

VI. Provider Contracts and Requirements

A. Contracts
   1) Contracts with providers shall include a clause that requires participation in QM activities and adoption of NMM policies and procedures, as well as access to the medical records of members.
   2) Open communication between providers and patients is allowed regarding appropriate treatment alternatives. NMM does not penalize providers for discussing medically necessary or appropriate care for the patient.

B. Availability
   Each IPA shall implement mechanisms to assure the availability of primary care providers and ensures that the network is sufficient in numbers and types of practitioner.
   1) The definition of whom serves as a primary care provider and standards for the number and geographic distribution of primary care practitioners are included.
   2) Data collected and analyzed to measure performance and application of performance with a) above.
   3) Opportunities for improvement are identified and decisions are made as to which opportunities to pursue.
   4) Interventions are implemented to improve NMM’s performance.
   5) Effectiveness of the intervention is measured.

C. Accessibility of Services
   1) Each IPA shall implement mechanisms to assure accessibility of primary care services, urgent care services and member services.
   2) NMM has established standards for:
      a) Timeliness of routine primary care appointments
      b) Timeliness of urgent care appointment
      c) Timeliness of specialty care appointments
d) Timeliness of emergency care  
e) Access to after hours care  
f) Telephone access and responsiveness

3) Data collected and analyzed to measure performance and application of performance with standards.
4) Opportunities for improvement are identified and decisions are made as to which opportunities to pursue.
5) Interventions are implemented to improve Group performance.
6) Effectiveness of intervention is measured.

D. Patient Satisfaction

1) Mechanisms to assure member satisfaction have been implemented
   a) Network Medical Management patient satisfaction is measured by:
      1) Patient satisfaction survey  
      2) Patient complaint/grievance evaluation  
      3) Evaluation of requests to change practitioner  
      4) Evaluation of voluntary disenrollment
   b) Appropriate methods are utilized to collect data for each assessment activity.
      1) The affected population is identified  
      2) Appropriate samples are drawn  
      3) Valid and reliable data is collected.
   c) Data is collected and analyzed for the assessment activities
   d) Opportunities for improvement are identified and decisions are made as to which opportunities to pursue
   e) Interventions are implemented to improve IPA performance
   f) Effectiveness of intervention is measured
   g) Staff and practitioners are informed of the results of member satisfaction activities

A. Systems for Health Management

1) Network Medical Management will actively work to improve the health status of its members with chronic medical conditions
   a) Members with chronic medical conditions are identified and offered appropriate services and programs to assist in the management of their conditions.
   b) Providers are informed and educated about the use of Health Management Programs for their assigned members.
   c) The Disease Management Program includes:
      1) Clearly defined population with a chronic condition  
      2) An analysis of baseline demographic and epidemiological data  
      3) A strategy to ensure that an “at risk population is being reached for the identified information  
      4) Continuum of care assessed by well-informed actions  
      5) A strategy to evaluate the effectiveness of activities  
      6) Practitioner involvement
VII. Quality Improvement Process:

The Network Medical Management quality improvement process includes performance-monitoring activities throughout the organization to evaluate the overall effectiveness of the Quality Management Program. Actions are taken to implement appropriate changes which demonstrate improvement in the quality of clinical care and services rendered to patients and overall IPA operations. The process is implemented on a continuum, with evaluations and improvement activities addressed.

A. Important aspects of care and service are:
   - Provider accessibility and availability
   - Provider satisfaction
   - Practice Guidelines
   - Preventive Health Care and Education
   - Utilization Management
   - Sentinel events
   - Medical record keeping practices
   - Provider performance and site evaluations
   - Trends in patient satisfaction/complaints/grievances
   - Timeliness of Claims processing and appeals
   - High risk/high volume services
   - Continuity and coordination of care across practice sites
   - Risk Management trends
   - Sub-contracted ancillary service performance
   - Provider training, ancillary experience, licensing and professional liability claims experience
   - Patient safety monitored during site reviews/grievance reporting to health plan
   - Behavior Health

Peer Review

The findings of Peer review activities will be used in the selection of important aspects of care for routine monitoring, evaluation and special study.

B. Monitoring and Evaluation

1) Clinical monitoring and evaluation is conducted overtime for all types of services provided by Network Medical Management and subcontracted professional and ancillary services. This may include, but is not limited to care provided in institutional (acute and long term) and outpatient care settings, primary care provider offices, home care, frequently used specialty services, ancillary services (Lab and Radiology), Mental/Behavioral Health and Substance Abuse Services, Drug Utilization and Preventive Services monitoring. High volume, high risk services as well as the care of acute and chronic conditions and customer service issues are also monitored.

2) All professional and subcontracted ancillary providers will be credentialed in accordance with NCQA standards and Network Medical Management policies and procedures.

3) Customer service monitoring deviation is conducted for all internal and external customers, via patient and provider satisfaction surveys, complaint, grievance and appeal trending.

4) Continuity and coordination of access to care and service which patients receive health promotion activities and performance on approved practice guidelines are included in monitoring and evaluation.

5) The Quality Management Committee will monitor information complied by the UM Committee to determine trends and potential quality issues, per established guidelines. Any potential or perceived issues will be reported to the QM Committee.
6) Prior to credentialing of all potential PCP’s, OB/GYN’s and High Volume Behavioral Health practitioners, the QM Department will perform/adopt the results of an on site review of the practitioner. The visit will be a documented, structured review of the site and of the medical record keeping practices to ensure conformance with approved standards.

7) The outcome of these visits will be communicated to the Credentialing Committee for inclusion in their decision making process, with any deficiencies reviewed by the QM Committee as per established guidelines.

8) At the time of moving to a secondary office, there will be a visit to the office of all Primary Care Practitioners, Ob/Gyns and high volume Behavioral Health Specialists. The outcome of these visits will be communicated to the Credentialing Committee for inclusion in their decision making process with any deficiencies reviewed by the QM Committee.

9) The consistency and accuracy of the application of review criteria by the UM staff responsible for the decision making process, shall be reviewed as deemed appropriate by the QM Committee.

C. Criteria Development

1) Criteria for use in the monitoring and evaluation process is developed by the QM Committee using current published literature and standards, as well as the opinion of recognized experts in the field of study. Practice guidelines shall be adopted with the assistance of appropriate members of the provider panel and shall be communicated to appropriate practitioners.

2) The practice guidelines shall include the provision of services, which are relevant to the enrolled membership. The guidelines shall be reviewed and updated as appropriate and on an annual basis.

D. Data Collection and Analysis

1) Data is collected utilizing approved criteria. The data is analyzed and evaluated for variance from established criteria and performance goals by appropriate clinicians for clinical issues or multidisciplinary teams for systems issues.

2) Identified variances, opportunities to improve care, service and problems are referred to appropriate sources as indicated. Operations items are referred following internal procedures.

3) Other quality of care and service issues will be referred to the QM Committee for action. Systematic monitoring, tracking and follow-up of identified issues and the effectiveness of actions taken, will be continued until resolution has been achieved.

E. Prioritization

Action taken on identified opportunities to improve care and service, identified problems and sentinel events are prioritized according patient impact, urgency and severity. Preliminary investigation of all issues identified is conducted in order to prioritize and prevent further action on items that are identified as non-problems.

VIII. Quality Management Work Plan

A Quality Management Work Plan is developed and implemented annually by the QM Committee and approved by the Board of Directors. The plan describes:

1) Scope
2) Goals and Objectives
3) Planned projects and activities for the year including continued follow-up on previously identified quality issues.
4) Mechanism for adding new activities to the plan as needed.
5) The plan delineates who is accountable for and the time frame in which planned activities are to be achieved. The plan provides a mechanism for its annual review, evaluation and revision by means of QM reports on effectiveness outcomes, including recommendations for approval to the Board of Directors.

IX. Annual Quality Management Report

a) The Quality Management Committee provides an annual summary and evaluation report on the effectiveness of the Quality Management Plan and activities to the Board of Directors. The report includes progress made on achieving the goals of the work plan including:

- Summary and trends of monitoring and evaluation activities
- Special studies and reports
- Follow-up on previous studies and reports
- Actions taken and effectiveness
- Demonstrated improvement in quality of care and services
- The report makes recommendations on future QM activities, work plan revisions and changes to the overall QM Program
- The report may include graphs, charts and narrative that emphasize key findings and results
- The Board of Directors may approve the recommendations and report or may make independent recommendation for action as indicated.

X. Plan Review and Revision

a) The QM Program is reviewed and evaluated annually and revised as indicated by the QM Committee. The review includes:

- The structure and organization of the plan
- The resources allocated to support the plan
- The efficiency and effectiveness of the QM processes

b) The review and revision may be conducted more frequently as deemed appropriate by the QMC or BOD. The Committee’s recommendation for revisions shall be submitted to the BOD for review and recommendation for change and/or approval.

XI. Confidentiality

a) All members of the QM Committee shall be required to sign a confidentiality agreement annually. All guest of the QM Committee shall sign a confidentiality agreement prior to attendance. The confidentiality agreements shall be maintained in the Quality Management Department.

b) All peer review records and medical staff committee proceedings shall be confidential as provided by California Health & Safety Code 1370.1 and Section 1157 of the California State Evidence Code.

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1Appropriate task refers to, but not limited to, Monthly tracking log of member calls, Provider training’s, Dissemination of provider and member materials, Monthly Grievance and Appeals log for CLAS members.