DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION
SAN DIEGO SECTION

REPORT ON THE MEDICAL AUDIT OF SENIOR CARE ACTION NETWORK HEALTH PLAN

Contract Number: 07-65712

Audit Period: March 1, 2023 – February 29, 2024

Dates of Audit: June 3, 2024 – June 7, 2024

Report Issued: September 20, 2024

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I. INTRODUCTION

Senior Care Action Network Health Plan (Plan) commenced operations in Long Beach, California in 1977 as a non-profit Multipurpose Senior Services Program. The Plan received a full-service Knox Keene license in 1984. The Plan contracted with California Department of Health Care Services (DHCS) to provide health care services as a Dual Eligible Special Needs Plan in 1985.

The Plan has the only Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) Contract in California and provides this product line to seniors in Riverside, San Bernardino, Los Angeles, and San Diego Counties. The Plan administers the FIDE-SNP Contract to dually eligible seniors and integrates care by providing a full range of Medicare and Medi-Cal services under a single managed care organization.

As of May 2024, the Plan served 12,710 members in Los Angeles, 3,397 members in Riverside, 2,597 members in San Bernardino, and 1,407 members in San Diego through the FIDE-SNP line of business.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of March 1, 2023, through February 29, 2024. The audit was conducted from June 3, 2024, through June 7, 2024. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on September 3, 2024. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. The Plan submitted a response after the Exit Conference. The results of the evaluation of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit report issued on September 27, 2023, for the audit period March 1, 2022, through February 28, 2023, identified deficiencies, which were addressed in the Corrective Action Plan (CAP) dated January 29, 2024. This year's audit included review of documents to determine implementation and effectiveness of the Plan's CAP.

The summary of findings by category follows:

Category 1 – Utilization Management

The Plan is responsible for ensuring that the UM program includes qualified staff that is responsible for the UM program. The Plan did not ensure that the UM Director met qualification requirements, including Registered Nurse (RN) licensure in California.

The Plan must provide the member with written acknowledgment within five calendar days of receipt of the appeal. The Plan did not provide members with appeal acknowledgment letters within five calendar days.

The Plan shall provide linguistic services at no cost to members, such as fully translated member information. This includes grievance and appeal acknowledgment and resolution letters. The Plan did not provide fully translated appeal notices in the member's required language.

The Plan must provide a notice of resolution for each request for an appeal within 30 calendar days from the date the Plan receives the appeal request. The resolution must include the Plan's reasons used in reaching a decision. The Plan did not include reasons for its decisions in appeal resolution notices.

Category 2 – Case Management and Coordination of Care

There were no findings noted for this category during the audit period.

Category 3 – Access and Availability of Care

The Plan is required to ensure that all network providers are enrolled in the Medi-Cal program. The Plan did not ensure contracted Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) providers were enrolled in the Medi-Cal program.

Category 4 – Member's Rights

There were no findings noted for this category during the audit period.

Category 5 – Quality Management

The Plan is required to implement an effective quality improvement system and to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on the Plan's behalf. The Plan did not fully investigate and take effective action to address needed improvements in the quality of care delivered by its providers.

Category 6 – Administrative and Organizational Capacity

There were no findings noted for this category during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted this audit to ascertain that the medical services provided to Plan members complied with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan representatives.

The following verification studies were conducted:

Category 1 – Utilization Management

Appeal Procedures: 15 appeals of medical prior authorizations were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Initial Health Appointment (IHA): 13 medical records were reviewed for timeliness and completeness of IHA requirements.

Category 3 – Access and Availability of Care

NEMT and NMT: 12 records (2 NEMT and 10 NMT) were reviewed to confirm compliance with transportation requirements for timeliness and appropriate adjudication.

Category 4 – Member's Rights

Grievance Procedures: 25 standard grievances (15 quality of care and 10 quality of service), 4 exempt grievances, and 5 call inquiries were reviewed for timely resolution, response to the complainant, submission to the appropriate level for review, and translation in the member's preferred language (if applicable).

Category 5 – Quality Management

Quality Improvement System: Six potential quality issue (PQI) files were reviewed for timely evaluation and effective action taken to address improvements.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: Ten fraud and abuse cases were reviewed for processing and reporting requirements.

Encounter Data: Five encounter data records were reviewed for complete, accurate, reasonable, and timely encounter data submissions.

A description of the findings for each category is contained in the following report.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.1 UTILIZATION MANAGEMENT PROGRAM

1.1.1 Qualified Staff of Utilization Management Program

The Plan is responsible for ensuring that the UM program includes qualified staff that is responsible for the UM program. *(Contract, Amendment 16, Exhibit A, Attachment 5 (1)(A))*

No person shall engage in the practice of nursing without holding a license that is in an active status. *(California Business and Professions Code, section 2732)*

Every employer of an RN, every employer of an RN required to hold any board-issued certification, and every person acting as an agent for such a nurse in obtaining employment, shall ascertain that the nurse is currently authorized to practice as an RN or as an RN pursuant to a board-issued certification within the provisions of this chapter. *(California Business and Professions Code, section 2732.05(a))*

The Plan's policy, HR-0002, *Health Care Professional Current and Unrestricted License* (publication date January 2, 2024), states that the Plan will perform an initial and annual review of the professional licenses of employees who perform clinical decisions for the Plan. Employees must provide the Human Resources (HR) Department with a copy of their license. HR reviews a monthly report to perform a check on all employees for current license status and reviews relevant state licensure boards, including the California Board of Registered Nurses and the Medical Board of California.

The Plan's *Utilization Management Program Description 2023-2024* (approved December 12, 2023), states that the Director of UM is a California-licensed RN who reports to the Corporate Vice President of Value Based Programs.

Finding: The Plan did not ensure that the UM Director met qualification requirements, including RN licensure in California.

A review of the Plan's job description for the UM Director indicated RN licensure as a requirement. The Plan's policy, *HR-0002* also requires health care professional employees to be licensed by the respective state professional board. Furthermore, the Plan's *Utilization Management Program Description 2023-2024* specified that the UM Director is a California-licensed RN. However, the audit found the UM Director was not a licensed RN in California.

The Plan did not implement policy *HR-0002*, which stated that health care professional employees of the Plan are required to be licensed by the respective state professional board. In a written response, the Plan clarified that the UM Director holds an active Indiana RN license as well as an active compact RN license. A compact RN license is a nationally recognized, multi-state agreement that allows nurses to practice in their home state as well as other states where the compact has been implemented. However, according to the National Council of State Boards of Nursing, California is a non-compact state. In an interview, the UM Director disclosed that a microbiology coursework is still in progress in order to comply with California RN licensure requirements.

If the staff responsible for the Plan's UM program is not qualified for failure to obtain a professional license with the State of California, there is a risk of inappropriate decision making in UM processes and the staff's monitoring and oversight that could ultimately impact the quality of care that members receive.

Recommendation: Revise and implement policies and procedures to ensure the Plan's staff responsible for the UM program are fully qualified, including California licensure as applicable.

1.3 PRIOR AUTHORIZATION APPEAL PROCEDURES

1.3.1 Qualified Staff of Utilization Management Program

The Plan must ensure timely acknowledgment for each request for an appeal and provide a notice of resolution to the member as quickly as the member's health condition requires within 30 calendar days from the date the Plan receives the request for an appeal. *(Contract, Amendment 16, Exhibit A, Attachment 14 (1)(B))*

The Plan must provide the member with written acknowledgment within five calendar days of receipt of the appeal. The acknowledgment letter must advise the member that the appeal has been received and the date of receipt, and it must provide the name, telephone number, and address of the representative who may be contacted about the appeal. *(All Plan Letter (APL) 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

The Plan's policy, GA-0034, *Member Appeal Process for Medi-Cal Only Benefits (Standard/Expedited)* (publication date March 20, 2023), states that the assigned Grievance and Appeal Department (GAD) Coordinator and Clinical Review Nurse collaborate to create and mail the acknowledgment letter to the member or the member's authorized representative within five calendar days from receipt of the request.

Finding: The Plan did not provide members with appeal acknowledgment letters within five calendar days.

The Plan's desktop procedure, *Medi-Cal Medical Appeal Process*, outlines the process and steps for the management of member or member-authorized requests for an appeal. However, the procedure did not include a description of the Plan's monitoring process for timeliness of appeal acknowledgment letters.

During the audit period, the Plan received 63 prior authorization appeals. In a verification study, 15 appeals were reviewed to determine if the Plan has an appeals process and adhered to the required timeframes for appeal acknowledgment letters. The audit found that five appeals did not have timely acknowledgment letters. The Plan sent appeal acknowledgment letters to members between 9 to 13 days.

The Plan lacked a monitoring process to detect non-compliance with timely appeal acknowledgment letters to members. Similar to the prior year audit, DHCS found that the Plan did not send grievance acknowledgment letters to members within five calendar days. In an interview, the Plan stated that in order to address the prior year audit finding, the Plan added a grievance acknowledgment monitoring process to the

grievance desktop procedure and explained that appeal acknowledgments are monitored in a similar manner. While the Plan has since corrected the prior year audit finding related to grievance acknowledgment letters through the CAP process, the appeal acknowledgments are independent of the grievance acknowledgments. The Plan has not addressed the lack of timely appeal acknowledgments.

If the Plan does not provide timely acknowledgment of member appeals, members are not informed of their rights during the appeals process. This can cause members to make uninformed decisions about their health care as well as cause delay in the receipt of services that may potentially be found to be medically necessary.

Recommendation: Revise and implement policies and procedures to ensure members receive appeal acknowledgment letters within five calendar days.

1.3.2 Translation of Member Appeal Notice Letters

The Plan shall provide linguistic services at no cost to members, such as fully translated member information. This includes but are not limited to the member services guide, enrollee information, welcome packets, marketing information, and form letters including Notice of Action (NOA) letters, and grievance and appeal acknowledgment and resolution letters. *(Contract, Amendment 16, Exhibit A, Attachment 9 (14)(B)(2))*

The Plan's grievance system shall address the linguistic and cultural needs of its members as well as the needs of members with disabilities. The system shall ensure all members have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and Plan responses to grievances, as well as access to interpreters, telephone relay systems, and other devices that aid disabled individuals to communicate. *(California Code of Regulations (CCR), Title 28, section 1300.68 (b)(3))*

The Plan must fully translate NOAs and Notice of Appeal Resolutions (NARs), including the clinical rationale for the Plan's decision that must be included in the NOA or NAR. If the Plan is not currently in compliance with immediate, full translation of the entire NOA or NAR, the Plan is expected to come into compliance with full translation within six months of the issuance date of this APL. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

The Plan's policy, GA-0034, *Member Appeal Process for Medi-Cal Only Benefits (Standard/Expedited)* (publication date March 20, 2023), states that the Plan addresses the linguistic and cultural needs of its member population as well as the needs of

members with disabilities. The Plan ensures all members have access to and can fully participate in the grievance and appeal system by assisting those with limited English proficiency or with a visual or other communicative impairment. Such assistance includes, but is not limited to, translations of appeal procedures, forms, and Plan responses to appeals, as well as access to interpreters, telephone relay systems, and other devices that aid disabled individuals to communicate.

Finding: The Plan did not provide fully translated appeal notices in the member's required language.

During the audit period, the Plan received 63 prior authorization appeals. In a verification study, 15 appeals were reviewed to determine if the Plan has an appeals process and adhered to linguistic service requirements. The audit found that four appeal resolution notices and one extension notice were not fully translated to the member's required language. All five required a Spanish-translated notice. However, in four of the five appeals without fully translated notices, the Plan's bilingual coordinator only made a call to the member informing them of the decision verbally in the member's required language.

While the Plan employs Spanish translators, translated letters go through a compliance and internal quality check to obtain approval before being sent to the member. In an interview, however, the Plan did not specify how long the internal quality process takes until a translated letter is approved and sent to the member. The Plan lacks a translation process that accounts for the timeliness of appeal notices.

If the Plan does not provide members with fully translated appeal notices, members may not be given necessary information about their appeal rights to help them make informed decisions about their health care.

Recommendation: Revise and implement policies and procedures to ensure that full translations of appeal notices are provided to members in their required language.

1.3.3 Decision Reasons in Notices of Appeal Resolution

The Plan must ensure timely acknowledgment for each request for an appeal and provide a notice of resolution to the member as quickly as the member's health condition requires within 30 calendar days from the date the Plan receives the request for an appeal. *(Contract, Amendment 16, Exhibit A, Attachment 14 (1)(B))*

For appeals not resolved wholly in favor of the member, the NAR is comprised of two components: (1) the NAR "Uphold" template and (2) the NAR "Your Rights" template. The Plan must send the member both documents to comply with all requirements of the

NAR. For appeals resolved in favor of the member, the NAR only consists of the NAR "Overturned" template.

The written NAR must contain the following: (a) the results of the resolution process and the date it was completed; (b) for decisions to uphold a denial determination that is based in whole or in part on medical necessity: the reasons for its determination and clearly stated criteria, clinical guidelines, or medical policies used in reaching a determination; (c) for decisions to uphold a denial based on a determination that the requested service is not a covered benefit: the provision in the DHCS Contract, or in the evidence of coverage/member handbook, that excludes the service. The response must either identify the document and page where the provision can be found, direct the member to the applicable section of the Contract containing the provision, or provide a copy of the provision and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested; and (d) for appeals resolved in favor of the member: a clear and concise explanation of why the decision was overturned. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Finding: The Plan did not include reasons for its decisions in appeal resolution notices.

The Plan's policy, GA-0034, *Member Appeal Process for Medi-Cal Only Benefits (Standard/Expedited)* (publication date March 20, 2023), states that at a minimum, NARs must include the result and date of the appeal resolution. For decisions not wholly in the member's favor, the Plan at a minimum will include the member's right to request a State Hearing, how to request a State Hearing, the member's right to continue to receive benefits pending a State Hearing, and how to request a continuation of benefits. However, the audit found the policy omitted the requirement to include reasons for its decisions in member appeal resolution notices. Furthermore, in the Plan's desktop procedure, *Medi-Cal Medical Appeal Process*, the sample closure letter for overturned decisions did not include a prompt for reason for the decision.

During the audit period, the Plan received 63 prior authorization appeals. In a verification study, 15 appeals were reviewed to determine if the Plan has an appeals process and adhered to appeal resolution requirements. The audit found that six appeal resolution notices did not include the reasons for its decisions. Specifically, three notices did not include criteria, clinical guideline, or medical policy to uphold its decision, and three notices did not include a clear and concise explanation of why the appeal was overturned.

Based on the member appeal resolution notices reviewed, the Plan was unable to ensure that NARs contained the required elements, such as the reasons to uphold or overturn an appeal. The Plan lacked a policy requiring its member appeal resolution notices to include the reasons for its decisions.

If the Plan does not provide the reasons for its decisions when resolving member appeals, the member may be arbitrarily denied services that could be found medically necessary at higher levels of appeal. This may lead to delay in care and potential harm. Furthermore, this also hampers the ability of the member and provider to lodge effective higher-level appeals if the reason for the adverse decision is not stated. The omission of the reason or criteria that the Plan uses to overturn a decision does not give providers and members the opportunity to understand why the request for services was ultimately approved.

Recommendation: Revise and implement policies and procedures to ensure that the reasons for its decisions are included in appeal resolution notices.

COMPLIANCE AUDIT FINDINGS

Category 3 – Access and Availability of Care

3.8 NON-EMERGENCY MEDICAL AND NON-MEDICAL TRANSPORTATION

3.8.1 Enrollment of Transportation Providers

The Plan shall cover NEMT services required by members to access Medi-Cal services, subject to the Plan's Physician Certification Statement form being completed by the member's provider. *(Contract, Amendment 16, Exhibit A, Attachment 10 (K)(2))*

The Plan shall authorize all NMT for members to obtain medically necessary covered services. *(Contract, Amendment 16, Exhibit A, Attachment 10 (K)(3))*

The Plan must ensure that all network providers are enrolled in the Medi-Cal program. *(Code of Federal Regulations (CFR), Title 24, section 438.608(b))*

All Plan network providers must enroll in the Medi-Cal program. The Plan has the option to develop and implement a managed care provider screening and enrollment process that meets the requirements of this APL, or they may direct network providers to enroll through DHCS. *(APL 19-004, Provider Credentialing / Recredentialing and Screening / Enrollment)*

The Plan cannot delegate its obligations related to responsibility for monitoring and oversight of their network providers and subcontractors, grievances and appeals, enrollment of NEMT or NMT providers as Medi-Cal providers, or utilization management functions, including the review of Physician Certification Statement forms, to a transportation broker. The Plan may delegate their obligations related to grievances and appeals, enrollment of NEMT or NMT providers as Medi-Cal providers, or utilization management functions to a subcontractor, so long as the Plan does so in a written subcontract or agreement, and complies with the requirements set forth in APL 17-004, APL 19-004, APL 21-011, and the Contract.

The Plan is responsible for monitoring and overseeing transportation brokers to ensure that transportation brokers are complying with the requirements set forth APL 22-008. The Plan must conduct monitoring activities no less than quarterly. Monitoring activities may include, but are not limited to, verification of the enrollment status of NEMT and NMT providers. *(APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses)*

Finding: The Plan did not ensure contracted NEMT and NMT providers were enrolled in the Medi-Cal program.

A review of the Plan's agreement with SafeRide, Inc. showed that the Plan utilizes an outside broker to provide transportation services for its members. The broker delegates NEMT and NMT services to transportation providers and monitors the Medi-Cal enrollment status. The broker reports to the Plan monthly on various performance measures, including the enrollment status of NEMT and NMT providers.

In a verification study, ten NMT providers were reviewed. The audit found one NMT provider was not included in the transportation broker's monthly enrollment status report. Therefore, the NMT provider was not verified as enrolled in the Medi-Cal program. The Plan did not verify the enrollment of the NMT provider in the Medi-Cal program before paying NMT service claims.

The Plan does not have a monitoring process to ensure that its transportation broker complies with APL requirements. The Plan does not verify the enrollment status of transportation providers in the Medi-Cal program. During an interview, the Plan stated it has delegated the monitoring and oversight of transportation providers to SafeRide, Inc.

If the Plan contracts with transportation providers that are not enrolled in the Medi-Cal program, it cannot ensure that providers meet Medi-Cal requirements.

Recommendation: Develop and implement policies and procedures to ensure NEMT and NMT providers are enrolled in the Medi-Cal program.

COMPLIANCE AUDIT FINDINGS

Category 5 – Quality Management

5.1 QUALITY IMPROVEMENT SYSTEM

5.1.1 Management of Potential Quality Issues

The Plan shall implement an effective Quality Improvement System in accordance with the standards in CCR, Title 28, section 1300.70 and CFR, Title 42, section 438.330. The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on the Plan's behalf in any setting. The Plan shall be accountable for the quality of all covered services regardless of the number of contracting and subcontracting layers between the Plan and the provider. *(Contract, Amendment 16, Exhibit A, Attachment 4 (1))*

The intent and regulatory purpose of the quality assurance program is that it must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. *(CCR, Title 28, section 1300.70 (a)(1))*

The comprehensive quality assessment and performance improvement program must include mechanisms to assess the quality and appropriateness of care furnished to Plan members with special health care needs. *(CFR, Title 42, section 438.330 (b)(4))*

The Plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs. *(California Health and Safety Code, section 1370)*

The Plan's policy, QM-0023, *Potential Quality Issues: Adverse Event and Quality of Care Investigation* (publication date July 24, 2023), states that the Plan will investigate identified adverse events and quality of care issues. Upon receipt of an adverse event or quality of care case, the Clinical Review Nurse will perform the investigation and refer the case to and consult with a Medical Director. The Medical Director will review the case and assign a level including educational opportunities and/or a CAP. All cases determined to be moderate to severe level quality of care issues are referred to the Peer Review Committee (PRC) for final determination. The PRC will review the case and render the final level, including educational opportunities and/or a CAP. If the Plan determines that a CAP is required, the Clinical Review Nurse will create, distribute, and monitor for a response on the CAP and submit to the PRC for review and next steps.

The Plan's policy, QM-0014, *Peer Review Committee Process* (publication date May 30, 2023), states that cases are referred to the PRC for clinical review and investigation through the GAD grievance quality of care process. When the PRC agrees to close a case, the Clinical Review Nurse will prepare a closure letter, and if the PRC determines that a CAP is required, the assigned Clinical Review Nurse will create the CAP request and monitor the case for receipt of the CAP response.

The Plan's desktop procedure, *QOC Audit Tool*, states that the Clinical Review Nurse will identify all providers involved in the issue or complaint and separate the quality of care cases that are opened.

Finding: The Plan did not fully investigate and take effective action to address needed improvements in the quality of care delivered by its providers.

According to the Plan's PQI report, the Plan identified 166 PQI cases during the audit period. In a verification study, six PQI cases were selected for review to determine the Plan's process for monitoring, evaluating, and taking effective action to address needed improvements. The audit found that two cases lacked an investigation, evaluation, and/or effective action to address the issues as follows:

A member filed a grievance against her primary care provider (PCP) for a delay in diagnosis of stage four lung cancer. The case was discussed at a PRC meeting where the committee concurred with the initial medical director's review. The case was subsequently assigned the highest severity level, which is a severe quality of care issue identified involving a Plan network provider. However, the PRC did not take any action on the decision at the conclusion of their discussion.

A member complained about delays in obtaining care that she attributed to the actions of multiple providers, which led to a delay in diagnosis and treatment of breast cancer. The Plan determined that there were no quality of care issues substantiated and the case was closed without any actions taken. The leveling of the PQI case was based solely on the care provided by the PCP. The PRC, however, did not address the member's other concerns in her grievance regarding the care that was provided by a radiology facility, a surgical oncology specialist, as well as the Plan's Case Management Department.

The Plan did not follow its policy of requesting a CAP at the time the PRC decided on a severity of the PQI case. In an interview, the Plan stated that the lack of corrective action at the time of case closure was due to a deficiency in PRC oversight.

The Plan also did not follow its desktop procedure of creating separate PQI cases for each provider discussed within a single grievance. In an interview, the Plan explained that it uses an offshore entity for clinical staffing of its PQI investigations, which

contracts with non-California licensed RNs. However, the Plan acknowledged that the RNs work in collaboration with and under the supervision of two of the Plan's California-licensed RNs.

If the Plan does not thoroughly investigate, evaluate, and take appropriate actions to address potential quality of care issues, then providers at issue may continue rendering substandard care to members. This may lead to potential member harm and missed opportunities for addressing underlying system problems.

Recommendation: Implement policies and procedures to investigate and evaluate the PQIs identified and take effective action to address needed improvements in the quality of care delivered by providers.