Quality Improvement Program Description

2019

Avera Health Plans

Table of Contents

EXECUTIVE SUMMARY

About Us

The Health Plan is dedicated to helping the people and communities it serves by providing cost-effective, innovative health plans. Today, we serve over 80,000 members. The Health Plan provides coverage for a variety of customers including individuals, families, and employers. As part of the dedication to provide care and services to those in need, the Health Plan has participated in healthcare.gov since it began in 2013, after the passage of the Affordable Care Act (ACA). Through the ACA and healthcare.gov, individuals and families can take advantage of unique benefits such as:

- Enrollment opportunities for everyone
- Guaranteed coverage
- Reduced costs (lower monthly premiums and out-of-pocket expenses)

It is the purpose of the Population Health Services program to support the Health Plan with achieving its mission to make a positive impact in the lives and health of persons and communities. The Population Health Services program is administered by the population health services department and supports the Health Plan in reaching and maintaining its goals.

Our Mission

Avera is a health ministry rooted in the Gospel. Our mission is to make a positive impact in the lives and health of persons and communities by providing quality services guided by Christian values.

Care for the Poor and Marginalized

The ministry calls us to care for the poor, frail and at-risk people of society. We stand with the poor, trying to see the world the way they do and adjusting our actions accordingly. We turn no one away and are especially attentive to those whose resources are limited.

Care for the Whole Person

The Gospel challenges us to keep the whole person in view at all times. We are called to minister to people's physical, emotional, spiritual, and social needs. Avera offers pastoral care, palliative care, hospice, behavioral health, and other services that address many dimensions of a person's life.

Our Values

Compassion, Hospitality, Stewardship

Our Keys to Excellence

Ministry, People, Service, Quality, Financial Stewardship

Our Standards for Service Excellence

Communication, Attitude, Responsiveness, Engagement

GOALS AND OBJECTIVES

It is the purpose of the Quality Improvement (QI) program to support the Health Plan with achieving its mission to make a positive impact in the lives and health of persons and communities by providing quality services guided by Christian values. The QI program is administered by the population health services department and supports the Health Plan in reaching and maintaining its goals.

The Health Plan strives to provide members with high quality health care. The QI program is designed to objectively and systematically monitor and evaluate the quality, appropriateness, and effectiveness of care. The Health Plan strives to attain high levels of satisfaction and quality to support members, providers, agents, and other stakeholders in the communities that we serve.

The QI program's primary focus originates from an analysis of the demographics and condition incidence of the population, as well as an analysis of quality monitoring activities. The program is also designated to meet and/or exceed standards set by regulatory and accreditation requirements. The annual Quality Improvement Work Plan provides a timetable for the organized activities scheduled for the coming year, and the QI program results provide the basis for the annual program evaluation. Program effectiveness is demonstrated by improvements in both the process and outcome measures established at the beginning of each program year.

The QI program applies to all commercial group and individual populations as well as its own employees. The QI program description specifies the processes for evaluating and monitoring quality of care and services to the Health Plan members and outlines:

- Goals and Objectives
- Scope of the program
- Organizational structure and staff responsibility
- Program components
- Delegation of quality tasks, if applicable
- Annual program evaluation and work plan development
- Confidentiality

PROGRAM SCOPE

The scope of the QI program encompasses the Health Plan's customers including members and employers, as well as key partners including physicians, institutional and ancillary providers. The QI program's focus is to provide members with high quality, medically appropriate and cost-effective health care. This is accomplished by continual monitoring of quality improvement activities that encompass an analysis of the demographics and condition incidences of the member population. The program is also designated to meet and/or exceed standards set by regulatory and accreditation requirements.

The QI program is comprehensive and activities are focused on access, clinical quality, satisfaction, service, and compliance. Activities are designed to:

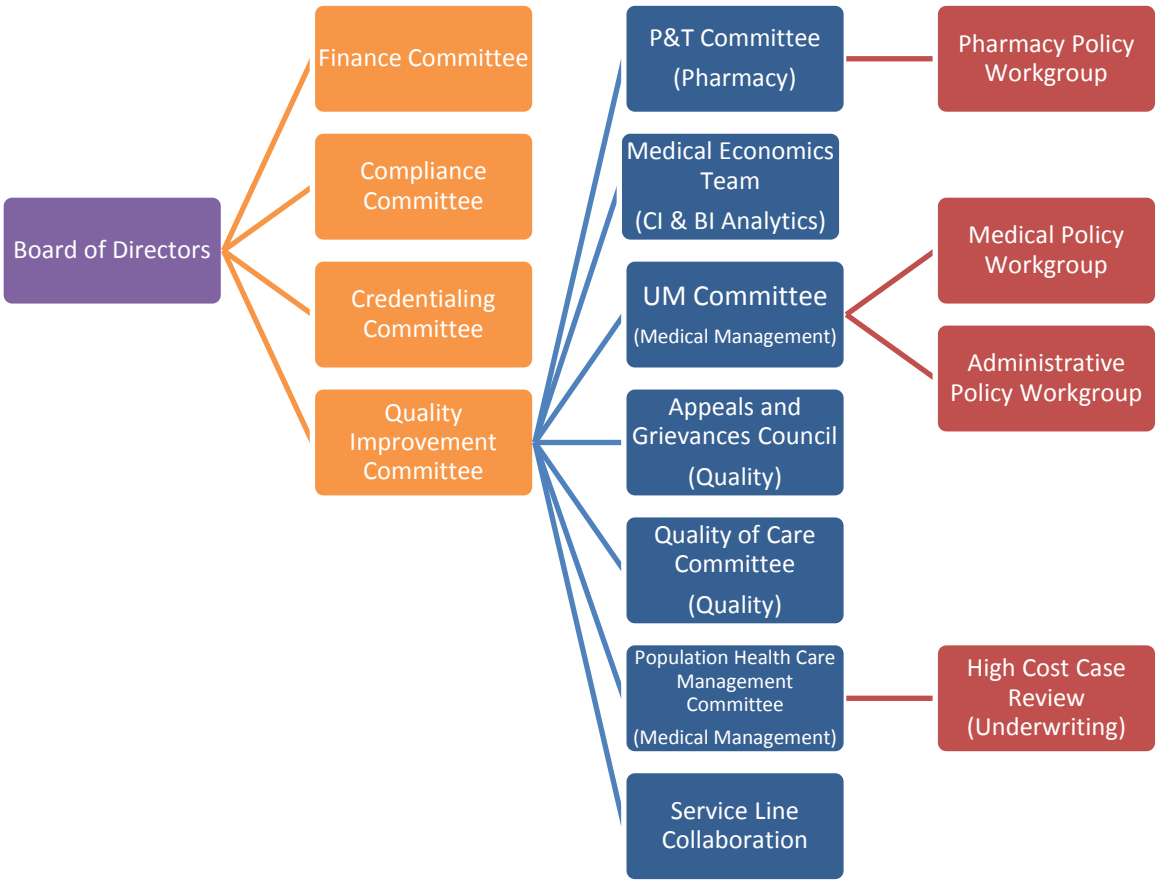
- Address all health care settings
- Evaluate the quality and appropriateness of care and services provided to members
- Pursue opportunities for improvement
- Identify and address concerns/issues

The following sections detail quality improvement components encompassed in this program, as well as the governing structure that monitors the implementation and progress towards program goals.

COMMITTEE STRUCTURE AND OVERVIEWS

The Health Plan Board of Directors, program committees, operational departments, and staff all work together to promote quality and effectiveness of care... The Health Plan committees provide oversight to the implementation of all quality improvement strategies and associated activities.

To promote quality throughout the health system, specific relationships between the health system, program committees, operational departments, and key professional staff are described below. Committees are designed and designated to provide oversight of quality improvement activities (access, quality of service, clinical quality, satisfaction, continuity and coordination of care, compliance and member experience).



Health Plan Board of Directors

- Meeting Frequency: at least quarterly
- Membership:
  - President
  - Vice President
  - Secretary
  - Four Employer/Community Board Members
  - One Avera Health Board Member
- Roles & Responsibilities:
  - Exercises decision making for strategic direction of the Health Plan
  - Ensures adequacy of policy making activities
  - Provides oversight for the operations of the Health Plan
  - Approves the credentialing plan annually
  - Approves the compliance plan annually
  - Approves financial reports including an annual budget
  - Receives and approves reports of the Board committees
  - Receives written progress reports delineating opportunities to improve care and services identified, actions taken and improvements identified from monitoring and evaluation activities
  - Receives the Quality Improvement and Compliance work plans and Quality Improvement and Compliance program evaluations annually
  - Establishes strategy for the operations of the Health Plan

Finance Committee

- Reports to: Health Plan Board of Directors
- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested
- Meeting Frequency: At least quarterly and ad hoc as deemed necessary
- Membership:
  - Health Plan Board Members
  - Health Plan Chief Executive Officer
  - Health Plan Chief Financial Officer
  - Three other voting members
- Roles & Responsibilities:
  - Monitors financial, statistical and risk management performance of the Health Plan
  - Establishes benchmarks for the Health Plan and performance against such benchmarks
  - Reviews annual audits and auditor's letters and meet with the auditors for such reviews
  - Reviews the Health Plan's operating and capital budgets and make recommendations on the adoption of such budgets to the Health Plan Board of Directors
  - Ensures the timely preparation of the annual operating and capital budget for the Health Plan and makes recommendations for the adoption of such budget to the Health Plan Board of Directors
  - Monitors the Health Plan's financial performance compared to budget on a periodic basis
  - Monitors changes in trends in the health care industry and recommend strategies to ensure the financial integrity of the Health Plan's operations
  - Monitors investment decision-making processes
  - Monitors reinsurance decision-making processes
  - Monitors actuarial operations with senior management of the Health Plan

- Provides counsel, recommendations and support for the Health Plan's leadership as requested

Compliance Committee

- Reports to: Health Plan Board of Directors
- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested
- Meeting Frequency: At least quarterly and ad hoc as deemed necessary
- Membership:
  - Health Plan President
  - Health Plan Chief Executive Officer
  - Health Plan Chief Administrative Officer
  - Avera Health Senior Vice President- Office of General Counsel
  - Health Plan Director of Compliance and Privacy
  - Two board members for each respective health plan
- Roles & Responsibilities:
  - Approves the compliance plan annually
  - Reviews and approves the Assessment of Compliance Program Effectiveness annually
  - Oversees operational and regulatory risk management processes for the Health Plan
  - Ensures market conduct standards are met
  - Reviews compliance and audit work plans annually

Compliance Council

- Reports to: Compliance Committee
- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested
- Meeting Frequency: At least quarterly and ad hoc as deemed necessary
- Membership:
  - Health Plan Director of Compliance and Privacy
  - Health Plan Chief Executive Officer
  - Health Plan Director of Population Health Services Operations
  - Health Plan Configuration representative(s)
  - Health Plan Claims representative(s)
  - Health Plan Finance representative(s)
  - Finance Integration Manager
  - Health Plan Provider Services representative(s)
- Roles & Responsibilities:
  - Develops annual compliance work plan
  - Reviews policies and procedures for implementation at the Health Plan
  - Identifies the need for and reviews audit results including action plan and follow up
  - Reviews federal and state mandates in addition to accreditation requirements for impact on operations of the Health Plan
  - Identifies educational needs for the Health Plan as it relates to regulatory requirements and identified compliance concerns

Credentialing Committee

- Reports to: Health Plan Board of Directors
- Reporting Process: Quarterly written presentation of sanctions and mandatory reporting
- Meeting Frequency: At least quarterly and ad hoc as deemed necessary
- Membership:
  - Health Plan Medical Director
  - Avera Health Credentialing Manager
  - Health Plan Director of Provider Services
  - Four participating network providers
- Roles & Responsibilities:
  - The Credentialing Committee is a multidisciplinary committee charged with credentialing and re-credentialing review activities. The activities of this committee are considered part of the peer review process and comprise privileged information. Minutes and associated documentation shall be treated as part of the peer review process, which are protected by state and federal immunity and confidentiality laws. The Credentialing Committee:
    - Keeps all minutes, reports and documents confidential
    - Takes action on issues as required and follow-up and evaluate actions
    - Reports important issues to the Health Plan Board of Directors on a scheduled basis
    - Obtains final approval from the Health Plan Board of Directors on credentialing participating network providers
    - Reviews qualifications and makes recommendations, based on established criteria, regarding the qualifications of an individual provider or facility requesting network participation
    - Reviews qualifications and provider performance indicators of quality, utilization and risk and makes recommendations regarding continued participation in the network
    - Develops credentialing and re-credentialing policies and procedures
    - Provides regular reports to the Quality Improvement Committee

Quality Improvement Committee

- Reports to: Health Plan Board of Directors
- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested
- Meeting Frequency: At least quarterly and ad hoc as deemed necessary
- Membership:
  - Health Plan Medical Director
  - Health Plan Chief Executive Officer
  - Health Plan Chief Administrative Officer
  - Health Plan Associate Medical Director(s)
  - Health Plan Director of Population Health Services Operations
  - Health Plan Director of Quality and Accreditation
  - Health Plan Director of Well-being Services
  - Health Plan Personal Health Services Manager-Clinical Review
  - Health Plan Personal Health Services Manager-Care Management
  - Health Plan Quality and Accreditation Coordinator
  - Health Plan Complaints and Appeals Coordinator
  - Health Plan HEDIS Coordinator
  - Health Plan Director of Provider Services (ad hoc)

- The QI Committee shall consist of a minimum of five (5) voting members, but no more than seven (7) and are appointed by the Medical Director. The QI Committee voting membership shall include a minimum of three licensed providers with at least one provider specializing in behavioral health and another in family practice or internal medicine. The behavioral health provider must be a practicing provider or have a clinical PhD or PsyD.

- Roles & Responsibilities:
  - Supports the Health Plan's mission in achieving a positive impact in the lives and health of its members
  - Works collaboratively to ensure appropriate use of resources and services for the optimal health benefit of members at a reasonable cost to members, facilities and the Health Plan
  - Provides oversight to the development and implementation of quality improvement policies and procedures
  - Assists in the development and approval of a well-structured QI program including its program evaluation, description and work plan
  - Annual review, at a minimum, of all quality improvement policies and procedures
  - Reviews and approves clinical quality indicators used for assessment activities
  - Reviews, updates, and approves clinical practice and preventive health guidelines and standards of care
  - Provides oversight for delegated quality improvement and care management (including wellness) activities
  - Reviews quality peer review activities, determines, and monitors interventions, as needed
  - Ensures the quality improvement programs are compliant with accreditation and regulatory requirements
  - Evaluates and monitors clinical coordination of care activities and recommends opportunities for improvement
  - Reviews and approves activities to improve member safety related to the delivery of health care
  - Reviews and approves quality improvement activities for behavioral health
  - Reviews and approves collaborate quality improvement activities performed with the health system
  - Reviews data and information that addresses member and provider satisfaction with the population health services programs, determines opportunities, and makes recommendations for improvement
  - Provide oversight of subcommittees, relevant ad hoc task forces, or multidisciplinary work groups of network participating practitioners that do not participate in the QI Committee

Pharmacy & Therapeutics Committee

- Reports to: Quality Improvement Committee (which reports to the Board of Directors)
- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested
- Meeting Frequency: At least quarterly (preferably every two months)
- Membership:
  - Health Plan Medical Director
  - Health Plan Associate Medical Director(s)
  - Health Plan Chief Executive Officer
  - Health Plan Chief Administrative Officer
  - Health Plan Director of Population Health Services Operations
  - Health Plan Manager of Pharmacy Benefits

- The P&T Committee shall consist of a minimum of six (6) voting members, but no more than twelve (12) and are appointed by the Medical Director. The P&T Committee voting membership shall include:
  - A minimum of five licensed providers with at least one provider specializing in:
    - Behavioral Health
    - Family Medicine/Internal Medicine
    - Pediatrics
  - Preferable specialties to be considered for voting members include:
    - Dermatology
    - Neurology
    - Oncology
    - Rheumatology
  - A minimum of one and a maximum of two licensed pharmacist(s) with at least one specializing in retail pharmacy.

- Roles & Responsibilities:
  - Maintains drug formularies that promote safety, effectiveness and affordability using formulary principles
  - Maintains utilization management criteria like, but not limited to, preauthorization, step therapy, quantity limits, age edits and gender limitations
  - Reviews all new legend medications or other chemical entities, new clinical indications, new safety information and new therapeutic classes
  - Performs annual review of the drug formulary on a therapeutic class basis
  - Performs annual review of all pharmacy utilization management programs
  - Performs annual review of pharmacy management policies and procedures
  - Participates in the development of and support educational programs that promote appropriate medication use
  - Other responsibilities that may be included, but not limited to:
    - Performs medication use evaluations
    - Reports adverse drug event monitoring and reporting
    - Assists in medication error prevention
    - Participates in the development of clinical care plans and guidelines
    - Participates in the development and review of quality assurance and/or risk management activities

Pharmacy Policy Workgroup

- Reports to: Pharmacy & Therapeutics Committee (which reports to the Quality Improvement Committee)
- Reporting Process: Verbal and/or written recommendations, reports and service activities as requested
- Meeting Frequency: At least quarterly (preferably every two months)
- Membership:
  - Health Plan Medical Director
  - Health Plan Associate Medical Director(s)
  - Health Plan Director of Population Health Services Operations
  - Health Plan Manager of Pharmacy Benefits
  - Health Plan Provider Relations Representative
  - Health Plan Managed Care Review Representative

- Health Plan Configuration Specialist(s)
- Health Plan Quality and Accreditation Coordinator
- Health Plan Population Health Services Support Specialist

- Roles & Responsibilities:
  - The Pharmacy Policy Workgroup is responsible for the development of policy that is:
    - Clinically and ethically sound
    - Reflects accurate coding standards set forth by CMS
    - Programmable within each respective claims system
    - Compliant with current health plan provider contracting
    - Compliant with all regulatory and NCQA requirements

Medical Economics Committee

- Reports to: Quality Improvement Committee
- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested
- Meeting Frequency: At least monthly and ad hoc as deemed necessary
- Membership:
  - Health Plan Medical Director
  - Health Plan Chief Finance Officer
  - Health Plan Vice President of Sales
  - Health Plan Director of Population Health Services Operation
  - Health Plan Director of Risk Management
  - Health Plan Director of Provider Services
  - Health Plan Director of Quality and Accreditation
  - Health Plan Director of Decision Support
  - Health Plan Manager of Financial & Risk Adjustment Analytics
  - Avera Health Senior Analyst-Payer Analytics
  - Health Plan Senior Clinical Data Analyst
- Roles & Responsibilities:
  - Identifies patterns in our contracted providers that need to be further analyzed from a cost, utilization and quality perspective. These concerns could be on a system, facility or provider level
  - Identifies outliers in the high cost claims reviews related to facilities or providers by utilizing data from a variety of sources
  - Reviews data on a procedural level, a provider level and a line of business level
  - Investigates regional billing practices and gather information from the Provider Services department regarding contracting practices
  - Provides guidance to the Health Plan on utilization management priorities and projects, including utilization management program oversight and development
  - Institutes needed actions based on trends and analysis of data
  - Identifies, prioritizes and develops interventions that target opportunities for improvement, identify variance from performance goals and benchmarks, develop and test improvement and evaluation plans, and regularly re-evaluate utilization management efforts
  - Provides recommendations for reducing out-of-network utilization

Utilization Management Committee

- Reports to: Quality Improvement Committee (which reports to the Board of Directors)

- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested
- Meeting Frequency: At least quarterly
- Membership:
  - Health Plan Medical Director
  - Health Plan Associate Medical Director(s)
  - Health Plan Director of Population Health Services Operations
  - Health Plan Director of Quality and Accreditation
  - Health Plan Personal Health Services Manager-Clinical Review
  - Health Plan Personal Health Services Manager-Care Management
  - Health Plan Quality and Accreditation Coordinator
  - Health Plan Complaints and Appeals Coordinator
  - Health Plan HEDIS Coordinator
  - Health Plan Director of Network Services (ad hoc)
  - The UM Committee shall consist of a minimum of five (5) voting members, but no more than seven (7) and are appointed by the Medical Director. The UM Committee voting membership shall include a minimum of three licensed providers with at least one provider specializing in behavioral health and another in family practice or internal medicine. The behavioral health provider must be a practicing provider or have a clinical PhD or PsyD.
- Roles & Responsibilities:
  - Supports the Health Plan's mission in achieving a positive impact in the lives and health of its members
  - Works collaboratively to ensure appropriate use of resources and services for the optimal health benefit of members at a reasonable cost to members, facilities and the Health Plan
  - Provides oversight to the development and implementation of utilization management policies and procedures, including medical policies, guided by the use of evidence-based research, clinical best practice and outcome measures
  - Assists in the development and approval of a well-structured UM program including its program description
  - Reviews annually, at a minimum, all utilization management policies and procedures, including medical policies
  - Reviews requests and provide recommendations for approval of new technology and new applications of current technology
  - Reviews and maintains a list of products and services deemed experimental, investigational and/or unproven
  - Monitors utilization of products and services; including inpatient/outpatient products and services, emergency room utilization, and out-of-network utilization; for overutilization and/or underutilization. Makes recommendations for action where appropriate
  - Monitors compliance of all providers with pre-admission, notification and referral processes
  - Makes recommendations for action when non-compliance occurs
  - Monitors the triage/referral process for behavioral health services
  - Evaluates sites of service and levels of behavioral healthcare
  - Monitors performance and efficiencies of the Health Plan utilization management departmental activities, including:
    - Turnaround time standards for utilization management decision-making in concurrent, urgent preservice, non-urgent preservice and post-service requests for medical and behavioral health

        - Appropriate and accurate clinical documentation and utilization of policy/procedures in clinical decision-making
        - Staff competency with the use of inter-rater reliability reporting and other performance indicators
        - Appropriate referral patterns to the population health services care management program
    - Monitors performance of utilization management policies based on appeals reporting and other feedback mechanisms
    - Monitors performance of delegated entities performing utilization management activities on behalf of the Health Plan at least semiannually
    - Monitors member/provider experience with the utilization management process
    - Participates in the development and review of quality assurance and/or risk management activities

Medical Policy Workgroup

- Reports to: Utilization Management Committee (which reports to the Quality Improvement Committee)
- Reporting Process: Verbal and/or written recommendations, reports and service activities as requested
- Meeting Frequency: Quarterly, with additional ad hoc meetings, as needed
- Membership:
    - Health Plan Medical Director
    - Health Plan Associate Medical Director(s)
    - Health Plan Director of Population Health Services Operations
    - Health Plan Director of Compliance and Privacy
    - Health Plan Personal Health Services Manager-Clinical Review
    - Health Plan Provider Relations Representative
    - Health Plan Managed Care Review Representative
    - Health Plan Configuration Specialist(s)
    - Health Plan Quality and Accreditation Coordinator
    - Health Plan Population Health Services Support Specialist
- Roles & Responsibilities:
    - Researches current literature for new and revised medical policies
    - Reviews new and updated medical policies
    - Provides physician advice and review of medical technology and policy including recommendations regarding medical policy development and language
    - Implements new and updated medical policies as approved by the Quality Improvement Committee
    - Serves as a liaison with the provider community in the development, dissemination and communication of medical policy

Administrative Policy Workgroup

- Reports to: varies, Utilization Management Committee and Pharmacy & Therapeutics Committee (which reports to the Quality Improvement Committee)
- Reporting Process: Verbal and/or written recommendations, reports and service activities as requested
- Meeting Frequency: Quarterly, with additional ad hoc meetings, as needed
- Membership:

- Health Plan Medical Director
- Health Plan Director of Population Health Services Operations
- Health Plan Director of Compliance and Privacy
- Health Plan Quality and Accreditation Coordinator

- Roles & Responsibilities:
  - Ensures administrative policies are reflective of current Health Plan procedures and compliant with all regulatory and NCQA requirements
  - Reviews policies on an annual basis at a minimum
  - Develops new policy where appropriate

Appeals and Grievances Council

- Reports to: Quality Improvement Committee
- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested
- Meeting Frequency: At least monthly and ad hoc as deemed necessary
- Membership:
  - Health Plan Medical Director
  - Health Plan Chief Executive Officer
  - Health Plan Director of Population Health Services Operations
  - Health Plan Director of Quality and Accreditation
  - Health Plan Director of Provider Services
  - Health Plan Director of Compliance and Privacy
  - Health Plan Personal Health Services Manager-Clinical Review
  - Health Plan Manager of Pharmacy Benefits
  - Health Plan Manager of Customer Service
  - Health Plan Complaints and Appeals Coordinator
  - Health Plan Quality and Accreditation Coordinator
- Roles & Responsibilities:
  - Monitors complaints, appeals, and grievances to ensure that they are completed in a manner and time span consistent with state and federal regulations
  - Reviews reports looking for trends and recommend related actions
  - Establishes member communication standards in regards to the member's benefits, appeals, and grievances rights
  - Maintains a complete database of all appeals and grievances
  - Monitors any appeals and grievances related to delegated vendors

Quality of Care Committee

- Reports to: Quality Improvement Committee
- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested
- Meeting Frequency: At least quarterly and ad hoc as deemed necessary
- Membership:
  - Health Plan Medical Director
  - Health Plan Medical Director of Quality and Utilization Management
  - Health Plan Director of Quality and Accreditation
  - Health Plan Quality and Accreditation Coordinator
  - Health Plan Quality Review Nurse

    - Manager of Pharmacy Benefits
    - The Quality of Care Committee shall consist of a minimum of five (5) voting members, but no more than seven (7) and are appointed by the Medical Director. The Quality of Care Committee voting membership shall include a minimum of three licensed providers with at least one provider specializing in behavioral health and another in family practice or internal medicine. The behavioral health provider must be a practicing provider or have a clinical PhD or PsyD.
- Roles & Responsibilities:
    - Completes clinical review of members' inpatient or outpatient experiences with contracted providers and facilities. Cases for review will be determined by the Medical Director
    - Monitors and evaluates key indicators and measures to detect trends and identify opportunities to improve quality of care and service to members
    - Discusses results of the clinical review
    - Provides a quality of care rating for each case reviewed
    - Documents discussion details and rating on each clinical case reviewed
    - Provides recommendations on follow-up with the treating provider(s) or facilities involved in the case
    - Provides a summary of clinical cases and case ratings to Quality Improvement Committee
    - Validates quality of care trends and communicate trends to Avera Health Service Lines
    - Completes Quality Improvement Committee recommendations to Quality of Care Committee
    - Communicates trends and variances to Credentialing Department for long-term monitoring opportunities

Population Health Care Management Review Committee

- Reports to: Quality Improvement Committee
- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested
- Meeting Frequency: At least weekly and ad hoc as deemed necessary
- Membership:
    - Health Plan Medical Director
    - Avera Health Vice President of Care Coordination
    - Health Plan Director of Population Health Services Operations
    - Health Plan Personal Health Services Manager-Care Management
    - Health Plan Personal Health Services Manager-Risk Adjustment
    - Health Plan Manager of Pharmacy Benefits
    - Health Plan Director of Quality and Accreditation (ad hoc)
    - Health Plan Director of Well-being (ad hoc)
    - Health Plan Director of Provider Services (ad hoc)
    - Health Plan Manager of Claims (ad hoc)
- Roles & Responsibilities:
    - Assists the care management team to identify additional resources and/or strategies to be utilized to assist members in achieving their healthcare goals and needs
    - Provides suggestions to improve the coordination of care for members that are identified with additional needs that cannot be met through current program capabilities
    - Develops strategies for targeted populations
    - Reviews current programs and services and provide suggestions to enhance such programs/services to meet the needs of the members

High Cost Case Review

- Reports to: Population Health Care Management Review Committee
- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested
- Meeting Frequency: At least monthly and ad hoc as deemed necessary
- Membership:
  - Health Plan Medical Director
  - Avera Health Vice President of Care Coordination
  - Health Plan Director of Population Health Services Operations
  - Health Plan Personal Health Services Manager-Care Management
  - Health Plan Personal Health Services Manager-Risk Adjustment
  - Health Plan Manager of Pharmacy Benefits
  - Health Plan Director of Quality and Accreditation (ad hoc)
  - Health Plan Director of Well-being (ad hoc)
  - Health Plan Director of Provider Services (ad hoc)
  - Health Plan Manager of Claims (ad hoc)
- Roles & Responsibilities:
  - Assists the care management staff to identify additional resources and/or strategies to be utilized to assist members in achieving their health care goals and needs
  - Provides suggestions to improve the coordination of care for members that are identified with additional needs that cannot be met through current program capabilities
  - Develops strategies for targeted populations
  - Reviews current programs and services and provide suggestions to enhance such programs/services to meet the needs of the members

Service Lines

- Collaborate with the Quality Improvement Committee
- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested
- Meeting Frequency: At least quarterly and ad hoc as deemed necessary
- Service Lines include:
  - Behavioral Health
  - Cardiac and Vascular
  - Emergency Medicine
  - Eye Care
  - General Surgery
  - Hospitalist
  - Laboratory
  - Nephrology
  - Obstetrics & Gynecology
  - Oncology
  - Orthopedics
  - Pediatrics
  - Primary Care
  - Radiology
- Roles & Responsibilities: Varies by service line

Avera Clinical Leaders Forum

- Collaborate with the Quality Improvement Committee
- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested
- Meeting Frequency: Twice a year
- Membership:
  - Avera Health Senior Vice President and Chief Medical Officer
  - Avera@Home President and Chief Executive Officer
  - Avera Health Vice President of Care Coordination
  - Avera Health System Quality Staff Leaders
  - Avera Health Clinical Intelligence Team representative(s)
  - Avera Health Business Intelligence Team representative(s)
  - Avera Health IT Leaders
  - Avera Health Clinical Decision Support
  - Avera Health Medical Information Officer
  - Avera Health Vice President of Health Information Management
  - Avera Health Marketing Representative
  - Avera Health Supply Chain Representative
  - Avera Health Pharmacy Representatives
  - Avera Health Director of Service Lines
  - Avera Regional Vice President of Strategy Network and Operations
  - Avera Regional Medical Officers
  - Avera Regional Chief Nursing Officers
  - Avera Regional Quality Directors
  - AMG Vice President of Quality
  - AMG Quality Director
  - Avera eCare Chief Medical Officer
  - Avera eCare Chief Nursing Officer
  - Avera eCare Director of Quality
  - Avera Health Plan Medical Director
  - Avera Health Plan Director of Quality and Accreditation
- Roles & Responsibilities:

  The Avera Clinical Leaders Forum (ACLF) aligns with the National Quality Strategy as authored by Agency of Health Research and Quality (AHRQ) on behalf of the U.S. Department of Health and Human Services in the following categories:
  - Makes care safer by reducing harm caused in the delivery of care
  - Strengthens person and family engagement as partners in their care
  - Promotes effective communication and coordination of care
  - Promotes effective prevention and treatment of chronic disease
  - Works with communities to promote best practices of healthy living
  - Makes care affordable

CLINICAL RESOURCES AND STAFFING

Chief Medical Officer

The Chief Medical Officer is involved in QI activities, including implementation, supervision, oversight and evaluation of the QI program. The Chief Medical Officer who has a current license to practice medicine and functions as follows:

- Responsible for the day-to-day oversight of the Utilization Management program, which includes overseeing utilization management determinations, identifying meaningful reporting, review of data and participation in the preparation of information for presentation to committees
- Provides oversight for UM activities, including review of medical necessity denials
- Reviews and assists in the development of medical policies and clinical practice guidelines
- Reviews and assists with utilization management policies and procedures
- Reviews consistency of applying utilization management decision criteria and implement corrective actions when needed
- Provides oversight for accreditation activities
- Serves as a chairperson for the Utilization Management Committee, Quality Improvement Committee, Pharmacy and Therapeutics Committee, Medical Economics Committee, and Credentialing Committee
- Designates a physician reviewer to provide oversight for medical necessity denials when the Chief Medical Officer is absent or unavailable for reviews
- Has authority to deny based on medical necessity review

The Chief Medical Officer is the designated physician to review denials for medical necessity including:
- Decisions about covered medical benefits defined by the Health Plan, including hospitalization and emergency services listed in member's coverage document(s)
- Decisions about pre-existing conditions when the member has creditable coverage and the organization has a policy to deny pre-existing care or services
- Decisions about dental procedures that are covered under the member's medical benefits

Medical Director of Quality and Utilization Management
- Assists with UM reviews and coordination of appeals, including denial decisions
- Assists with pharmacy department oversight, including medication therapy management reviews
- Assists in development of utilization management policies and procedures, clinical practice guidelines, and procedures and continuous evaluation of quality assurance programs
- Participates as an advisory member of Utilization Management Committee, Quality Improvement Committee, and Pharmacy & Therapeutics Committee
- Serves as a chairperson for the Quality of Care Committee
- Assists the Chief Medical Officer with coordination and collaboration with health system service lines
- Has authority to deny based on medical necessity review

The Medical Director of Quality and Utilization Management reviews denials for medical necessity including:
- Decisions about covered medical defined by the Health Plan, including hospitalization and emergency services listed in member's coverage document(s)
- Decisions about pre-existing conditions when the member has creditable coverage and the organization has a policy to deny pre-existing care or services
- Decisions about dental procedures that are covered under the member's medical benefits

Director of Quality and Accreditation
- Works directly with Chief Medical Officer to maintain quality assurance and full compliance with accreditation programs, including but not limited to, NCQA accreditation and ACA QRS Ratings

- Communicates closely with Service Line Clinical Champions to identify and implement programs and services appropriate to the needs of members and practitioners
- Provides oversight and management for all functions of quality assurance/improvement, accreditation and complaints and appeals
- Supports leadership team in the development, implementation and evaluation of practices and programs to maintain accreditation and continually improve outcomes
- Ensures proper performance of delegation oversight activities and participates as necessary in these activities
- Assists with member complaints regarding quality of care issues
- Performs and promotes interdepartmental integration and collaboration to provide effective and efficient use of resources
- Creates and ensures timely and accurate reporting, including trending, to executive management and appropriate committees
- Coordinates Quality Improvement Committee's activities to ensure communication of new and ongoing quality improvement and data collection activities

Director of Population Health Services Operations

- Works directly with the Chief Medical Officer to provide oversight of population health services operations.
- Provides direction and support to:
    - Personal Health Services Manager-Clinical Review
    - Personal Health Services Manager-Care Management
    - Manager of Pharmacy Benefits
    - Manager of Clinical Risk Adjustment
- Develops, implements, evaluates and provides oversight of the clinical programs for the Health Plan's population health services programs (i.e. clinical review, care management, pharmacy and risk adjustment) to meet the needs of its membership and ensure compliance with all regulatory and NCQA requirements
- Assists with the evaluation of department's performance via competency assessments, performance improvement programs and productivity
- Creates and ensures timely and accurate reporting to executive management and appropriate committees
- Has authority to deny based on medical necessity review

Director of Well-being Services

- Leads well-being operations - overseeing the daily operations of the well-being program and organization
- Researches, assesses and makes recommendations on tools that support the Health Plan's health and wellness program
- Provides advice, guidance, direction, and authorization to carry out major plans and procedures; coordinates the efforts of the organizational leadership and works with them to develop current and long-range objectives, policies, and procedures
- Interprets data from reports to stratify, intervene and evaluate the health of multiple cross sections of an employer's population and the impact of wellness programs on the health of the population
- Participates in overall program evaluation and makes recommendations for employer program quality improvements

Personal Health Services Manager-Care Management

- Works directly with the Director of Population Health Services Operations to facilitate oversight to care management operations
- Provides direction, oversight, and support to care management staff in its daily activities
- Provides day-to-day oversight of the care management programs to meet the needs of its membership
- Performs and promotes interdepartmental integration and collaboration to provide effective and efficient use of resources
- Assists with the evaluation of department performance via competency assessments, performance improvement programs and productivity
- Prepares summary data for use at various committee meetings
- Conducts clinical staff audits reports results to the Quality Improvement Committee

Personal Health Services Manager-Clinical Review

- Works directly with the Director of Population Health Services Operations to facilitate oversight to utilization management operations
- Provides direction, oversight, and support to UM staff in its daily activities
- Provides day-to-day oversight of the UM programs for the Health Plan's clinical review team to meet the needs of its membership
- Performs and promotes interdepartmental integration and collaboration to provide effective and efficient use of resources
- Assists with the evaluation of department performance via competency assessments, performance improvement programs and productivity
- Prepares summary data for use at various committee meetings
- Conducts clinical staff audits and inter-rater reliability (IRR) reviews and reports review results to the Utilization Management Committee

Manager of Pharmacy Benefits

- Works directly with the Director of Population Health Services Operations to facilitate oversight of pharmacy operations
- Provides direction, oversight, and support to pharmacy staff in their daily activities
- Provides day-to-day oversight of the pharmacy programs for the Health Plan's pharmacy team to meet the needs of its membership
- Performs and promotes interdepartmental integration and collaboration to provide effective and efficient use of resources
- Assists with the evaluation of department performance via competency assessments, performance improvement programs and productivity
- Provides ongoing evaluation and recommendations regarding Health Plan policies and procedures to ensure compliance with directives of leadership, regulatory and NCQA requirements
- Prepares summary data for use at various committee meetings
- Assists in development of screening criteria, data analysis, problem identification, data retrieval related to quality improvement activities and prepares related reports
- Conducts clinical staff audits and inter-rater reliability (IRR) reviews and reports review results to the Pharmacy & Therapeutics Committee
- Has authority to deny based on medical necessity review

Personal Health Services Manager-Risk Adjustment

- Works directly with the Director of Population Health Services Operations to facilitate oversight of clinical risk management
- Provides direction, oversight, and support to clinical risk adjustment staff and Member Health Advocates in its daily activities to assist members with their needs, including social determinants of health
- Performs and promotes interdepartmental integration and collaboration to provide effective and efficient use of resources
- Assists with the evaluation of department performance via competency assessments, performance improvement programs and productivity
- Provides ongoing evaluation and recommendations regarding Health Plan policies and procedures to ensure compliance with directives of leadership, regulatory and NCQA requirements
- Prepares summary data for use at various committee meetings
- Assists in development of screening criteria, data analysis, problem identification, data retrieval related to quality improvement activities and prepares related reports
- Conducts staff audits and inter-rater reliability (IRR) reviews and reports review results to the Quality Improvement Committee

Well- being Supervisor

- Supports Director of Well-being by maintaining an understanding of the needs and changing priorities of the organization and focuses on clinical and engaging solutions to address member and client/group needs.
- Supervises the day-to-day operations including oversight of program development, staff supervision, customer service, quality assurance review, workflow development and consistency of work instructions
- Works with internal leadership to operationalize the integration of well-being into Avera's population health strategy
- Provides guidance and support to staff members and facilitates effective problem-solving among team members
- Provides coverage of services (i.e. screenings and health coaching) as appropriate when staffing levels are not meeting client/group needs

Quality and Accreditation Coordinator

- Prepares and provides oversight of accreditation survey process and site visits
- Prepares and maintains standards and documentation to ensure a state of continuous readiness for accreditation
- Maintains documents related to quality improvement processes including, but not limited to, policies and procedures, and quality improvement
- Prepares documentation requirements in support of accreditation standards
- Functions as the accreditation/certification source to ensure programs meet governing body compliance
- Establishes and oversees an interdepartmental accreditation work group to support initial and renewal accreditation/certification goals and objectives
- Develops and maintains reporting mechanisms and project plans that allow for the tracking and trending of accrediting body performance measures, quality initiatives and the monitoring of progress related to the accreditation

- Develops agenda and materials, schedules, supports and records minutes for Quality Improvement Committee
- Assists in executing quality improvement projects

HEDIS Coordinator
- Gathers medical records and supplemental health care data directly from members, providers and vendors and stores information electronically
- Receives care gap reports for selected HEDIS measures
- Develops and executes plan to target members with care gaps for gap closure
- Maintains the HEDIS reporting project schedule, monitoring program progress and HEDIS vendor performance
- Provides technical subject matter expertise while integrating data from multiple entities through the system. Analyzes the integrated data to explain variation, identify opportunities and explain trends for the HEDIS measures

Complaints and Appeals Coordinator
- Maintains database of complaints and appeals
- Provides report of all complaints and appeals for regulatory compliance and for leadership action as a part of ongoing quality improvement process
- Coordinates all external appeal reviews
- Coordinates reporting linguistically diverse membership activities
- Cooperates with Network Services staff to assess provider linguistic availability

Personal Health Services Nurse
- Supports all care management functions through compliance with regulatory and NCQA standards
- Supports and assists with the implementation of the care management, including complex case management and work plan
- Establishes documents, executes, and monitors care management plans of care for each member enrolled in the care management program
- Evaluates and presents data in the measuring of interventions to determine the outcomes of care management involvement including clinical, financial, variance, quality of care, quality of life, and member satisfaction
- Directs and transitions care to participating providers and facilities to ensure cost-effective care is provided to the Health Plan members
- Advocates for member's health by identifying age appropriate health screening(s), wellness, and other needs as identified through assessment
- Collaborates with the Member Health Advocates to identify resources, including community resources, to meet the needs of members to improve the overall health of a member

Clinical Review Nurse
- Supports all UM program functions through compliance with regulatory and NCQA standards
- Supports and assists with implementation of the UM work plan
- Performs accurate data entry of preauthorizations in the UM software application
- Collects data and performs medical necessity review of requests for elective and urgent medical and behavioral health services as defined in the member's coverage document(s)
- Conducts concurrent review for inpatient medical and behavioral health admissions

- Approves care and services based upon established medical policy and/or clinical criteria
- Collaborates with care management to facilitate the transfer of members admitted to out-of-network facilities to in-network facilities
- Facilitates process for referrals of potential medical necessity denials to the Medical Director
- Notifies providers and members of service approvals, non-certification and appeal rights
- Participates in discharge planning process with hospital or inpatient facility staff and the Health Plan's care management staff, ensuring adequate and appropriate disposition and post-discharge plans
- Monitors UM daily tasks/needs to provide timely review of preauthorizations and improve the overall member/provider experience
- Participates and complies with appeals processes through collaboration with the Complaints and Appeals Coordinator
- Meets established goals for consistency in medical decision-making

Clinical Pharmacy Specialist

- Monitors United States Food and Drug Administration new product releases and performs product/technology research
- Interprets available clinical literature for the purpose of pharmacy policy development
- Develops and authors pharmacy policies for Health Plan use seeking direction from the Medical Director(s) as needed
- Prepares summary data for use at various committee meetings
- Reviews claims data to detect coding deficiencies – new pended claims and provide timely responses to assure correct adjudication based on medical necessity, compliance with contract benefits, medical policy, correct coding, referral and preauthorization guidelines and reimbursement guidelines
- Provides ongoing evaluation and recommendations regarding Health Plan policies and procedures to ensure compliance with directives of leadership, regulatory and NCQA requirements
- Assists in development of screening criteria, data analysis, problem identification, data retrieval related to quality improvement activities and prepares related reports
- Has authority to deny based on medical necessity review

Clinical Pharmacist

- Reviews member medication profiles for drug-drug interactions, drug-disease interactions and side effects or other medication-related problems not otherwise specified
- Prepares member-specific medication summaries and personal care plans
- Communicates with members and providers to seek resolution to medication-related problems
- Provides education to members regarding medications, including appropriate use and compliance
- Conducts utilization review, including issuing approvals and denials, for selected pharmaceuticals, through compliance with regulatory and NCQA standards
- Integrates pharmaceutical care into medical management initiatives in the case and/or disease management programs
- Has authority to deny based on medical necessity review

Member Health Advocate

- Serves as a concierge on behalf of the Health Plan, community resources, facilities, and providers to assist members with healthcare needs

- Identifies appropriate resources, provides all necessary information to the member, and makes contacts with other agencies on behalf of the member if necessary, as well as follow-ups with the member to determine if his or her needs were met
- Provides member support for population health initiatives for various campaigns, including but not limited to, risk adjustment and HEDIS initiatives
- Assists with member transitions to participating providers for those members who are new to the Health Plan
- Serves members who may be low-income, disadvantaged, hard-to-reach and in need of assistance

Well-being Specialist
- Assists with the development and execution of tailored well-being plans for an assigned group of clients and their associated members, in partnership with the well-being leadership team to fully engage members and drive a high level of participation in assigned populations/client groups
- Detects cultural needs based on employer populations and implements educational programs as needs are identified
- Creates, coordinates and delivers communication and collateral materials that support the wellness program
- Coordinates and delivers program services
- Performs on-site health screening components such as: blood pressure, body composition, and lipid with glucose
- Performs on-site education for members in one-on-one or group setting

Director of Provider Services
- Delivers a broad, stable and high-performing network to members
- Directs, develops and executes negotiation strategies that directly impact financial and quality performance of the network consistent with senior leadership objectives
- Provides accountability for all network development, contracting and management activities with hospitals, physicians and other health care providers meeting the credentialing standards of the Health Plan
- Ensures provider and practitioner agreements comply with the Health Plan's policies, business standards, regulatory guidelines, and accreditation standards
- Establishes and directs a provider communication strategy that supports provider compliance with the Health Plan's policies, coding, e-commerce, billing, and reimbursement instruction
- Performs and monitors activities related to provider performance/service issues and provider disputes

Director of Customer Experience
- Assumes responsibility for planning, motivating and providing direction and leadership to matrixed and functional resources both within and outside the direct customer services team
- Provides accountability for all member experiences while remaining compliant with all accreditation and regulatory standards
- Directs the collection of customer feedback, analysis, and design of specific practices around customer experience
- Directs and manages customer experience tracking to ensure metrics are in line with strategy
- Collaborates, cooperates, and shares accountability with product directors to support and accomplish strategic goals of the Health Plan

Director of Compliance and Privacy

- Provides direction on compliance with legislative and regulatory requirements
- Ensures submission of regulatory filings and annual reports
- Oversees and monitors implementation of an effective compliance program
- Coordinates the development of a risk management program
- Develops and oversees the implementation of administrative policies and procedures

Credentialing Manager

- Coordinates all credentialing and re-credentialing activities
- Ensures all credentialing functions are completed in an accurate and timely manner and according to federal, state and accreditation standards
- Organizes and coordinates peer review activities in coordination with legal counsel to ensure all functions, documentation and processes meet ethical and regulatory standards
- Assists leadership in planning and relationship development by providing concise summaries of credentialing data
- Develops and implements tools, policies and procedures that assess and evaluate provider offices in accordance with accreditation standards

Department of Information Technology

- Supplies the Health Plan with data extracts from various data repositories to support quality improvement, care management, and network development activities
- Supports the data needs of CAHPS, HEDIS, and risk adjustment activities
- Provides programming support for quality improvement, care management, and continuity of care initiatives

Resource Allocation

Staffing resources for QI activities are evaluated annually by the Chief Medical Officer and Director of Quality and Accreditation for the purpose of ensuring adequate support for fulfillment of all QI functions in a timely fashion and according to all regulatory and NCQA requirements.

BEHAVIORAL HEALTH ASPECTS OF THE QUALITY IMPROVEMENT PROGRAM

The Health Plan has a designated behavioral health provider who serves on the Utilization Management Committee, Pharmacy and Therapeutics Committee, and Quality Improvement Committee. This designated behavioral health provider serves as the senior provider actively involved in implementing the Behavioral Health aspects of the QI program and:

- Provides oversight to the delegated behavioral health providers that are members of the Utilization Management Committee, Pharmacy and Therapeutics Committee and Quality Improvement Committee
- Assists in establishing behavioral health QI administrative/clinical policies and procedures
- Participates in annual review for use of standard, published utilization management criteria
- Assists in decision-making for coverage of behavioral health care services and pharmaceuticals
- Advises on behavioral health topics and new technologies applied to behavioral health care
- Performs analysis of behavioral health quality of care and makes recommendations for improvement

QUALITY IMPROVEMENT PROCESS AND COMPONENTS

The QI program defines its quality improvement structures and processes and assigns responsibility to appropriate individual.

Population Health Services

Population health services is a population-driven, patient-centered care management, including complex case and chronic condition management, provided to a defined population in order to improve the overall health of that population and empower members to take responsibility for managing their own health and health outcomes. The program aims to also reduce health inequalities or disparities within the population due to social determinants of health. In addition, the program encompasses coordination between all members of the care team and the member, the monitoring and measuring of clinical metrics, and establishment and adherence to basic clinical practice guidelines.

The Health Plan at least annually assesses the needs of its population to determine if there are actionable subpopulations that need targeted intervention. The assessment will include the following:

- Assessment of the characteristics and needs, including social determinants of health, of the membership
- Identification and assessment of the needs of relevant member subpopulations
- Assessment of child and adolescent members
- Assessment of members with disabilities
- Assessment of the needs of members with serious and persistent mental illness

The Health Plan population health strategy is developed from the utilization management description, quality improvement description, and population assessment. It is then incorporated into daily activities of the care management program. The population health strategy outlines processes for implementing population health activities and includes the following:

- Goals and targeted populations as identified in the population assessment with focus on:
  - Keeping members healthy
  - Managing members with emerging risk
  - Member safety or outcomes across all settings
  - Managing multiple chronic conditions
- Programs and services offered to members
- Activities (direct and indirect) defined to assist member to improve their overall health
- Coordination of programs and services for members within the Health Plan and the health system
- Member education about available population health programs and services to assist them with their overall health

The care management program is a voluntary member-centric program supported by clinical and non-clinical staff. The care management program is aligned with NCQA, Case Management Society of America (CMSA), and health system recommendations and standards for best practice. Referrals to the care management program come from multiple sources: utilization management, pharmacy, Member Health Advocates, well-being, facilities, providers, members, customer services, risk stratification, high cost claims, and other health system sources. The care management program identifies and addresses members' needs and provides member-centered care plans that are mutually agreed upon that allows for stewardship of resources for the members through the health system. Care management focuses on assisting members in achieving and maintaining wellness. Collaboration with the provider and member

increases adherence to a care plan and promotes successful outcomes. The Health Plan's Personal Health Nurses collaborate with the care coordination teams throughout the health system to promote health, safety, wellness, and quality of life. The care management program promotes the following:

- Stewardship of resources to achieve clinical and financial outcomes
- Appropriate access to care in a timely and cost-effective manner
- Health care choice, and promotion of self-care where it is needed
- Member self-directed care and self-advocacy to make informed health care decisions

Please refer to the utilization management description and population health strategy for additional information about the Health Plan's population health services programs. Effectiveness of the care management is measured by select HEDIS (discussed further in health promotion and preventive care) and Health Plan specified measures.

Behavioral Health Services

The Health Plan works collaboratively with Avera Behavioral Health to ensure continuity and coordination of care of members' behavioral health needs. Personal Health Nurses work with Avera Behavioral Health to best serve members for routine, urgent, and emergent behavioral health issues to ensure the appropriate level of care. As previously described, a designated behavioral health provider serves on the Utilization Management Committee, Pharmacy and Therapeutics Committee, and Quality Improvement Committee. He or she further serves as an advisor toward the development of behavioral health aspects of the various programs available at the Health Plan.

The Health Plan works collaboratively with Avera Behavioral Health to assess member experience with behavioral health services through a member survey and quality improvement activities. The Health Plan Quality Improvement Committee reviews, approves, and adopts clinical practice guidelines developed by the Avera Behavioral Health Service Line. The QI program at the Health Plan assesses continuity and coordination of care with behavioral health through the provider satisfaction survey and assessment of HEDIS behavioral health indicators and other metrics annually.

Continuity and Coordination of Care

The Health Plan is committed to improving quality of care provided to its members. Care coordination is designed to coordinate the diverse aspects of member care and is a critical element to improving member health and experience with the Health Plan. Coordination involves communication among all providers and caregivers assisting the member. Member Health Advocates offer support for effective and efficient use of health care and community resources from transitional care concerns to coordinating care and negotiating access with non-participating providers.

The Health Plan monitors continuity and coordination by assessing the facilitation of continuity and coordination of health care across transitions and settings of care to ensure members are receiving care and services that are needed. In addition, the Health Plan collaborates with behavioral health providers to monitor and improve coordination between medical care and behavioral health care.

The Health Plan annually collects data about opportunities for collaboration between medical and behavioral health care for the following:

- Exchange of information
- Appropriate diagnosis, treatment, and referral of behavioral conditions commonly seen in primary care

- Appropriate use of psychotropic medications
- Management of treatment access and follow-up for members with co-existing medical and behavioral health conditions
- Prevention programs for behavioral health
- Members with severe and persistent mental illness

The Health Plan will act as necessary to improve the continuity and coordination of care across the health system and collaborate with the appropriate providers and service lines to monitor and improve coordination of care.

Member Safety
The Health Plan focuses on the monitoring of clinical performance, quality of care, provider credentialing, and coordination of care to ensure a safe health care delivery system. The annual QI evaluation addresses the quality and safety of clinical care. The evaluation includes trending of measures to assess performance in the quality and safety of clinical care and the overall effectiveness of strategies and initiatives as outlined in the QI program description and work plan including progress towards network-wide safe clinical practices.

The Health Plan collaborates with the health system to identify and report safety concerns to develop innovative strategies and initiatives to improve member safety and clinical outcomes. Member safety standards are developed and communicated in key areas that have been documented as potential safety concerns, such as reduction of medical errors and improving patient outcomes.

Quality of Care and Peer Review
The Health Plan is committed to monitoring and evaluating key indicators and measures to detect trends and identify opportunities to improve quality and safety of clinical care and service to its members. The Health Plan has an established means of assessing and reporting quality of care concerns to ensure identification, review, and timely resolution of quality issues. Concerns regarding quality of care may be identified by any staff member with the Health Plan, health system, or external sources. Each year various measures are chosen based on historical concerns, Avera Health initiatives, or known issues within the industry.

Peer review is the mechanism utilized to conduct review of suspected inappropriate care or inappropriate professional behavior by a provider provided to a Health Plan member. The process and scope of actions that may be taken if concerns are identified are outlined within the quality of care policies and procedures. The reader is referred to the quality of care annual report that is presented to the Quality of Care Committee.

Health Promotion and Preventive Care
Health promotion and preventive care programs are incorporated to ensure that members are kept informed about evidence-based, nationally recognized preventive health care guidelines and encourage members to seek services related to these guidelines. The Health Plan adopts and disseminates clinical practice guidelines for preventive, medical, and behavioral health services. These clinical guidelines are reviewed and approved annually by the Quality Improvement Committee; these guidelines are the foundation for performance reports that are provided to providers and health system committees.

The Health Plan targets members with gaps in preventive health indicators through a multi-directional approach. Educational mailers, targeted telephonic education, and reducing geographic and time barriers to preventive care are strategies utilized by the Health Plan. To reduce geographic and time barriers, the Health Plan collaborates with the health system for alternative resources. As an example, the Health Plan coordinates with Avera Mobile Mammography for breast cancer screenings at alternative sites for member convenience.

The Health Plan offers members a health risk assessment tool, in easy-to-understand language, to identify and manage health risks yet maintain the member's privacy. The health risk assessment will include questions addressing:

- Demographics
- Health history, including acute and chronic conditions
- Self-perceived health status
- Identification of behavioral change strategies
- Special hearing and/or vision needs
- Language preferences

The member has access to the health risk assessment results which includes overall summary of the member's risk or wellness profile, a summary of individual risk factors, information on how to reduce risk by changing specific behaviors, reference materials to understand his or her results, and comparison to previous results (if available). In addition the health risk assessment tool, the Health Plan offers self-management tools that provide the member with information on health promotion, preventive care, and wellness in the following, but not limited to, areas of focus:

- Healthy weight and physical activity
- Healthy eating
- Activities to reduce stress
- Identification of depressive symptoms
- Smoking and/or tobacco use cessation
- Avoidance of at-risk drinking

HEDIS is one of the health care's most widely used performance improvement tools. The Health Plan utilizes HEDIS to measure performance which evaluates six domains of care and service:

- Effectiveness of care
- Access/availability of care
- Experience of care
- Utilization and risk adjusted utilization
- Health plan descriptive information
- Measures collected using electronic clinical data systems

The Health Plan complies with all HEDIS reporting requirements established by NCQA, the Office of Financial and Insurance Regulations, Centers for Medicare and Medicaid Services, state departments/divisions of insurance, and other regulatory bodies not specifically mentioned. Activities focused on improving the rates for select HEDIS measures are integrated in the population health strategy and other health system initiatives. The impact of these implemented strategies and initiatives are measured incrementally throughout the year and annually to assess the impact. HEDIS activities and results are audited by an NCQA-certified auditor and submitted for public reporting annually.

Utilization Management Program Review
The Health Plan's UM program is intended to provide a framework for ensuring that the best, most appropriate medical and behavioral health care is delivered across the continuum in a manner consistent with a member's condition(s). The Health Plan's organizational structure ensures high performance by defining authority and accountability and defining program goals.

The Health Plan works to achieve these goals by delivering comprehensive services through a professional staff of physicians, behavioral health specialists, pharmacists and registered nurses adept in population health services and quality improvement. Quality is promoted through the use of evidence-based research, clinical best practice, and outcome measurements. The Health Plan's population health model provides a suite of personal health services designed to improve the health of its members while improving clinical outcomes and containing costs, including a focus on the delivery of appropriate and timely health care services. Data is continuously collected and evaluated in order to identify utilization trends and patterns, assess quality of care and access to services for Health Plan members, to monitor member satisfaction and to ensure compliance with all state and federal regulations.

The Utilization Management program integrates non-behavioral health, behavioral health and pharmacy services under a clinical structure that utilizes primary care, sub-specialists and behavioral health specialists and practitioners to support day-to-day activities. The UM evaluation, program description, and work plan are maintained by the population health services department with oversight from the Utilization Management Committee.

Member Experience
The Health Plan is committed to members' experience; thus, the Health Plan has developed a Director of Customer Experience position. This position will be committed to the overall experience of a member throughout the Health Plan and the health system. It is expected that there will be the development of a committee to provide oversight for current and prospective members regarding member communications, satisfaction, protected health information, appeals and grievances to improve quality and consistency of services for members across all departments, functions, and touch points.

Currently, member experience is assessed through evaluation of CAHPS surveys, QHP Enrollee surveys, and member appeal and grievance information. Member experience surveys and routine monitoring indicators are designed to measure Health Plan performance and to assess member experience with its services. Member appeal and grievance information is trended and correlated with CAHPS survey results to identify potential opportunities for improvement. The results of this trending, analysis, and comparison are summarized, reviewed, and utilized to develop strategies and initiatives to improve the quality of the member experience.

The Director of Customer Experience will coordinate development of ongoing programs to educate staff on member "pain points" identified through the trending and analysis described above. Member experience initiatives will likely evolve throughout 2019 as the Health Plan focuses more on this initiative.

The Health Plan participates in the CAHPS survey annually which addresses topics that are important to members and focuses on aspects of quality that members are best qualified to assess, such as the communication skills of providers and ease of access to health care services. CAHPS surveys consist of a core set of questions administered to all members in a standardized manner and are suitable for

comparison across heterogeneous populations. The Health Plan contracts a third-party vendor to administer the CAHPS survey on its behalf.

Linguistic and Cultural Diversity

An objective of the Health Plan is to provide culturally and linguistically appropriate care and services to its members. The Health Plan completes an annual population assessment to identify potential disparities based on race, ethnicity, language, disability, and poverty status. The population assessment data is collected through a variety of resources including, but not limited to, Health Plan data, United States Census data, Robert Wood Johnson Foundation reports, and America's Health Rankings.

The analysis is also compared to provider linguistics and language services utilization. To ensure network adequacy to meet the needs of disparate populations, any gaps between provider and Health Plan population linguistics are analyzed and action is taken as necessary. The Health Plan works interdepartmentally to ensure that all member materials and communications are culturally and linguistically appropriate according to member needs and regulatory requirements. Language translation services are utilized in customer service and during onsite wellness activities on an as-needed basis.

Credentialing and Re-credentialing

The credentialing and re-credentialing process is designed to establish and ensure quality providers are participating in the Health Plan's network. Credentialing of network providers, as defined by Health Plan policies, is a key function of the QI program. All providers participating with the Health Plan undergo a review of their qualifications, including education and training, licensure status, board certification, hospital privileges, and malpractice history. All providers undergoing initial credentialing and re-credentialing are reviewed and approved by the Credentialing Committee.

The Health Plan informs new providers of office site quality standards and thresholds including physical accessibility, physical appearance, adequacy of waiting/examining room space, availability of appointments, and adequacy of medical record keeping. An office site quality review is scheduled with the office site location upon initial credentialing request and subsequent re-credentialing according to policy. Results of the office site quality review are included in the initial credentialing review and subsequent re-credentialing reviews as appropriate. The Health Plan conducts ongoing monitoring of grievances and serious adverse events through the quality of care program.

Appeals and Grievances

The Health Plan has a member appeals and grievance process which allows a member to file appeals and grievances in an oral or written expression of dissatisfaction. An appeal is a request to change a previous decision made by the Health Plan. If a member is not satisfied with a decision that affects their coverage or the outcome of a grievance, the member may file an appeal. The grievance process facilitates identification of quality issues regarding care delivery and/or the Health Plan. All member complaints regarding medical, contractual, or administrative concerns are received, categorized, reviewed, and analyzed.

The Health Plan utilizes appeals and grievances data to improve service and overall member satisfaction. Reporting of appeals and grievances is presented to the Quality Improvement Committee for evaluation and recommendations for improvement as needed. Additionally, the Health Plan maintains a consistent

process in compliance with federal and state regulations for the handling of appeals and grievances, including the external review process.

Provider Experience
Provider experience surveys are designed to assess which services are important to participating providers and determine the provider's level of satisfaction with the Health Plan's delivery of care and services. A survey is conducted annually with primary care providers, specialty care providers, and behavioral health provider. Results are summarized and reviewed by the Health Plan to assess level of satisfaction and prioritize opportunities for improvement.

Delegation Oversight
The Health Plan may elect to delegate select functions to a qualified entity that conforms to federal/state rules and regulations as well as accreditation standards. The Health Plan is committed to ensuring full compliance with NCQA standards for all delegated entities; the Health Plan reviews delegated entity's program descriptions and evaluations to ensure quality practices.

Pre-delegation review is completed to ensure compliance with federal/state rules and regulations, accreditation standards, and delegated functions are clearly defined. The pre-delegation review includes an evaluation of the potential delegated entity's compliance with the Health Plan's standards and accreditation standards through initial audit of respective documentation.

Upon approval of the pre-delegation audit, a contract is developed that details the following:

- The responsibilities of the Health Plan and the delegated entity
- A defined list of delegated utilization management functions and associated requirements
- A description of how the delegated entity will be monitored and evaluated including remedies for non-compliance including revocation of delegation
- HIPAA requirements
- HITECH requirements
- Structural requirements including UM program description, UM program evaluation, medical criteria, credentials of staff performing delegated functions, reliability of authorization determinations, documentation of authorization determinations and data system capabilities
- Data reporting requirements

Delegated entities report per contract specifications and at least semi-annually and any issues identified are remediated as they occur. Delegated entity performance is reported to the Compliance Committee and other relevant committees.

RECOMMENDATIONS FOR THE 2019 QUALITY IMPROVEMENT PROGRAM

Recommendations from the Health Plan's 2018 Quality Improvement Program Evaluation are integrated into the Quality Improvement Program Description as targeted program goals for 2019:

Quality/Improvement

- Develop a strategy to address gaps in care identified by the care management tool to improve overall member health as measured by HEDIS.
- Implement LiveNOW well-being program and service deliverables for commercial groups to enhance population health management strategy.
- Outreach to commercial individual members to engage in the My365 well-being portal.

- Explore new ways to develop deeper analytics about our members by integrating information from the Health Plan care management tool with electronic medical record information, health information exchange information, and publicly available datasets.
- Create a solid reporting analytic for routine monitoring and trending of our quality of care measures in a consistent fashion.
- Improve policies and processes that impact the NCQA accreditation and monitor accordingly.

Member/Provider Satisfaction
- Collaborate with the customer experience department to provide cost transparency resources to members.
- Assist the customer experience department to review potential member navigation issues and make changes as appropriate.
- Develop a strategy to address the decline in the provider specialist member-provider satisfaction scores.

Financial Stewardship
- Support the initiatives set forth in the QI Program Description and Population Health Management Program Description and Strategy documents.
- Utilize the health waste calculator to identify areas of potential waste and assist in the development of strategies to address such waste.
- Develop reporting to assist in provider performance including financial and clinical information such as costs, diagnoses, network referral patterns, risk adjustment/coding or documentation issues, and gaps in care information.

The quality improvement work plan will be developed from the above targeted program goals. Please refer to the quality improvement work plan to reflect ongoing process on quality improvement activities which addresses:

- Annual QI activities and objectives
  - Quality of clinical care
  - Safety of clinical care
  - Quality of service
  - Members' experience
- Timelines for each activity
- Staff responsible for each activity
- Monitoring of previously identified strategies, initiatives, or issues
- Evaluation of the QI program

CONFIDENTIALITY

No voluntary disclosure of utilization or peer review information is made except to persons/entities authorized to receive such information in the course of conducting quality and resource management activities.

Information utilized by various Health Plan committees is maintained in a confidential manner through the mechanism of codes, blinding and summary information. Only those persons who require information to perform corrective action are given access to identifiers. Committee records are available only to authorized personnel in accordance with local, state, federal and other regulatory agencies.