Avera Health Plans

2013-2014 Quality Improvement Program Description
History

Avera Health Plans, Inc. is a for-profit company established to provide health care financing and care delivery services. Avera Health Plans, Inc. operates as a health maintenance organization under a Certificate of Authority issued by the South Dakota Division of Insurance on June 4, 1999. Operations began in October of 1999.


In July 2011, Avera Health Plans obtained full Health Utilization Management accreditation with URAC.

Current operations include health insurance services to members in our service area that includes all of South Dakota, northeastern Nebraska and northwestern Iowa. Avera Health Plans also acts as a third-party administrator.

Purpose and Design

The Avera Health Plans Quality Improvement Program strives to provide members with high quality, medically appropriate and cost-effective health care. It is designed to objectively and systematically monitor and evaluate the quality, appropriateness and effectiveness of care.

The program’s primary focus originates from an analysis of the demographics and disease incidence of the population, as well as an analysis of quality management monitoring activities. The program is also designed 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 Quality Improvement 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.

Goals and Objectives

- To define clinical quality and build organizational capabilities to support the achievement thereof
- To systematically monitor and evaluate key indicators and measures to detect trends and identify opportunities to improve quality of care and service to members
- To identify, prioritize and develop interventions that target opportunities for improvement, identifying variance from performance goals and benchmarks, developing and testing improvement and evaluation plans, and regularly re-evaluating quality improvement efforts
To develop data-driven disease and complex case management strategies to improve practitioner and member compliance with clinical and/or behavioral health guidelines and standards

To ensure a system of continuous quality improvement communication that is timely and reports through appropriate channels to appropriate individuals

To monitor ongoing compliance with applicable accreditation and regulatory standards

To enhance relationships with physicians by engaging in collaborative process improvements and supporting them to improve clinical quality and to better manage the care of targeted members

To serve and improve clinical outcomes for members with complex health needs through our Complex Case Management Program, monitoring and improving access to care and monitoring and improving continuity and coordination of care across multiple settings
Program Authority and Accountability

Committee Structure

Avera Health Plans Board of Directors

- Pharmacy and Therapeutics Committee
- Quality Improvement and Utilization Management Committee
- Credentialing Committee
- Finance Committee
- Behavioral Health Service Line
- Medical Policy Work Group
- Operations Work Group
Committee Overviews

Avera Health Plans Board of Directors
Meeting Frequency: Quarterly
Membership:
• President of Avera Health Plans (Chairperson)
• Vice President
• Secretary
• Four Employer/Community Board Members
• One Avera Health Board Member

Roles and Functions of the Committee:
• Reviews the Quality Improvement Program Description annually
• Receives quarterly written reports delineating opportunities to improve care and services identified, actions taken and improvements identified from monitoring and evaluation activities
• Receives the Quality Improvement Work Plan and Quality Improvement Program Evaluation annually

Credentialing Committee
Reports to: Avera Health Plans Board of Directors
Reporting Process: Quarterly written presentation of sanctions and mandatory reporting
Meeting Frequency: Quarterly
Membership:
• Chief Medical Officer, Avera Health Plans (Chairperson)
• Credentialing Coordinator, Avera Health
• Four Participating Network Providers

Roles and Functions of the Committee:
The Credentialing Committee is a multidisciplinary committee of the Avera Health Plans Board of Directors charged with credentialing and recredentialing 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 immunity and confidentiality laws. The Credentialing Committee will:
• Keep all minutes, reports and documents confidential
• Take action on issues as required and follow-up and evaluate actions
• Report important issues to the Avera Health Plans Board of Directors on a scheduled basis
• Obtain final approval from the Avera Health Plans Board of Directors on credentialing participating network providers
• Based upon established criteria, review qualifications and make recommendations regarding the qualifications of an individual provider or facility requesting network participation
Based upon established criteria, review qualifications and provider performance indicators of quality, utilization and risk and make recommendations regarding continued participation in the network

Develop credentialing and recredentialing policies and procedures

Provide regular reports to the Quality Improvement and Utilization Management Committee

Quality Improvement and Utilization Management Committee
Reports to: Avera Health Plans Board of Directors
Reporting Process: Verbal and/or written presentations regarding recommendations, reports and service activities as required
Meeting Frequency: Quarterly and ad hoc as deemed necessary
Membership:

- Chief Medical Officer, Avera Health Plans (Chairperson)
- Chief Administrative Officer, Avera Health Plans
- Health Services Manager, Avera Health Plans
- Pharmacy Manager, Avera Health Plans
- Quality Improvement and Accreditation Coordinator, Avera Health Plans
- Four physician representatives as appointed by the Chief Medical Officer with at least one physician specializing in behavioral health

Roles and Functions of the Committee:

- Provide guidance to Avera Health Plans on quality and utilization management priorities and projects, including health services program oversight and development
- Review and evaluate the results of clinical and service quality improvement activities
- Review, provide input and approve clinical and service policy decisions
- Institute needed actions based on trends and analysis of data
- Review, develop and endorse nationally recognized preventive and clinical practice guidelines in all quality improvement activities
- Provide regular reports to the Credentialing Committee
- Maintains approved records of all committee meetings in the form of minutes

In addition, the Quality Improvement and Utilization Management Committee evaluates, reviews and/or approves:

- Annual Quality Improvement Program Description, Evaluation and Work Plan
- Annual Utilization Management Program Description, Evaluation and Work Plan
- Wellness Program initiatives
- Disease Management Program initiatives
- Case Management/Care Coordination Program initiatives
- Population health performance review (HEDIS)
- Policies and procedures
- Customer satisfaction issues and initiatives
- Member and provider satisfaction surveys
• Compliance audits
• Privacy and confidentiality processes and practices
• Member service metrics
• Quality improvement initiatives
• Utilization Management initiatives and criteria
• Provider access and availability studies
• Appeal and grievance trends

Pharmacy and Therapeutics Committee
Reports to: Avera Health Plans Board of Directors
Reporting Process: Verbal and/or written presentations regarding recommendations, reports and service activities as requested
Meeting Frequency: Quarterly
Membership:
• Chief Medical Officer, Avera Health Plans (Chairperson)
• Chief Administrative Officer, Avera Health Plans
• Pharmacy Manager, Avera Health Plans
• Two pharmacists, one with clinical experience
• Four physicians with the following specialties represented:
  o Oncology
  o Pediatrics
  o Psychiatry
• Pharmacy Benefit Manager representative

Roles and Functions of the Committee:
• Examine and update the drug formulary to reflect the evolving standards of practice in medicine and drug therapy
• Objectively evaluate drugs on their therapeutic merits, avoiding duplication of therapeutically equivalent drugs
• Establish policies and procedures that guide cost-effective drug therapy
• Implement and evaluate drug utilization review projects and offer strategies for quality practitioner prescribing
• Utilize newsletter and educational programs to distribute drug information and communicate drug policy decisions made by the Pharmacy and Therapeutics Committee
• Participate in quality improvement and safety activities related to clinical issues, drug prescribing, adverse drug reactions and drug interactions
• Perform technology assessment on new indications for existing drug therapies or new drugs to market
• Develop, evaluate and revise prior authorization criteria for drug therapy within Avera Health Plans

Finance Committee
Reports to: Avera Health Plans Board of Directors
Reporting Process: Verbal and/or written recommendations and reports
Meeting Frequency: Quarterly
Members:
- Avera Health Plans Board Member (Chairperson)
- Avera Health Plans Chief Financial Officer
- Avera Health Plans Chief Administrative Officer
- Three other voting members

Roles and Functions of the Committee:
- Monitor financial and statistical performance of Avera Health Plans
- Establish benchmarks for Avera Health Plans and measure financial and statistical performance against such standards
- Review annual audits and auditor’s letters to management of Avera Health Plans and meet with the auditors for such reviews
- Review Avera Health Plans’ operating and capital budgets and make recommendations on the adoption of such budgets to the Avera Health Plans Board of Directors
- Ensure the timely preparation of the annual operating and capital budget for Avera Health Plans and makes recommendations for the adoption of such budget to the Avera Health Plans Board of Directors
- Monitor Avera Health Plans financial performance and comparison to the budget on a periodic basis
- Monitor changes in trends in the health care industry and recommends strategies to ensure the financial integrity of Avera Health Plans operations
- Provide counsel, recommendations and support for Avera Health Plans management as requested

Medical Policy Workgroup
Reports to: Quality Improvement and Utilization Management Committee
Reporting Process: Verbal and/or written recommendations, reports and service activities as requested
Meeting Frequency: Monthly
Membership:
- Managed Care Review nurse (Chairperson)
- Chief Medical Officer
- Network Services representative
- Account Services representative
- Applications specialist
- Compliance representative, ad hoc
- Pharmacist, ad hoc

Roles and Functions of the Committee:
- Research current literature for new and revised medical policies
- Review new and updated medical policies
• Provides physician advice and review of medical technology and policy including recommendations regarding medical policy development and language
• Implement new and updated medical policies as approved by the Utilization Management and Quality Improvement Committee
• Serves as a liaison with the provider community in the development, dissemination and communication of medical policy

Operations Workgroup
    Reports to: Quality Improvement and Utilization Management Committee
    Reporting Process: Verbal and/or written recommendations, reports and service activities as requested
    Meeting Frequency: Semi-monthly
    Membership:
    • Operations Manager (Chairperson)
    • One representative from each department of Avera Health Plans

Roles and Functions of the Committee:
• Oversee administrative policy review and approval

Behavioral Health Service Line
    Reports to: Quality Improvement/Utilization Management Committee
    Reporting Process: Verbal and/or written recommendations, reports and service activities as requested
    Meeting Frequency: At least quarterly
    Membership:
    • President and CEO of a Regional Hospital (Administrative Lead)
    • Medical Director of Avera McKennan Behavioral Health Center (Physician Lead)
    • Executive Council of Service Lines
    • Avera-employed behavioral health practitioners

Roles and Functions of the Committee:
• Develop, adopt and distribute recognized standards of care for behavioral health care providers, primary care providers and specialists caring for patients with behavioral health comorbidities

Resources for Clinical and Service Quality Improvement
Avera Health Plans is dedicated to the philosophy that all members of the workforce are responsible for quality. Responsibilities specific to each area are outlined below:

Chief Medical Officer:
• Responsible for the day-to-day oversight of the Quality Improvement Program which includes identifying meaningful reporting, review of data and participation in the preparation of information for presentation to committees
• Provides oversight for Utilization Management activities
• Reviews and assists in developing medical policy and clinical practice guidelines
• Provides oversight for accreditation activities
• Serves as a chairperson for the Quality Improvement and Utilization Management Committee, Pharmacy and Therapeutics Committee, Credentialing Committee and Quality of Care Subcommittee
• Attends and presents reports to Avera Health Plans Finance Committee and Board of Directors

Health Services Manager:
• Coordinates the study, design and execution of clinical data collection and analysis
• Identifies trends in important aspects of care and opportunities for improvement
• Oversees and monitors timely responses to clinical member grievances, adverse determinations and appeals
• Interprets clinical and administrative policies for staff developing responses to clinical member grievances, adverse determinations and appeals
• Develops, implements and maintains quality management and medical management programs that are in compliance with all applicable regulatory requirements, accreditation requirements and supports continuous quality improvement for Avera Health Plans’ clinical services
• Assures that the health plan’s utilization management program is in compliance with all applicable regulatory requirements, accreditation requirements and supports the quality, service and financial objectives of the health plan
• Develops, implements and maintains a complex case management program that meets applicable accreditation requirements
• Assures the delivery of disease management and wellness management programming

Pharmacy Manager:
• Oversees the relationship between Avera Health Plans and the plan’s pharmacy benefit administrator
• Provides oversight of the Pharmacy and Therapeutics Committee
• Approves prior authorizations of select medications, conducts utilization review for medications
• Works with prescribers to identify and address prescription utilization trends and issues of clinical performance and effect change in prescribing patterns
• Develops and oversees the Avera Health Plans Medication Therapy Management Program
• Integrates pharmaceutical care into medical management initiatives including leadership and development in the case and/or disease management programs

Managed Care Review Nurse:
• Monitors FDA new-product releases and performs product/technology research
• Interprets available literature for the purpose of medical policy development
• Develops and authors medical policies for health plan use seeking direction from Avera Health Plans’ Chief Medical Officer as needed
• Prepares summary data for use at Avera Health Plans committee meetings
• Reviews claims data to detect coding deficiencies – review pended claims and provide timely responses to assure correct adjudication based on medical necessity, compliance with contract benefits, medical policy, correct coding, referral and pre-authorization guidelines and reimbursement guidelines
• Provides ongoing evaluation and recommendations regarding Avera Health Plans policies and procedures to ensure compliance with directives of Avera Health Plans Executive and Leadership teams, and also as required by federal, state and accreditation agencies
• Assists in development of screening criteria, data analysis, problem identification, data retrieval related to quality improvement activities and prepares related reports

Quality Improvement and Accreditation Coordinator:
• Preparation and oversight of accreditation survey process
• Coordination of HEDIS activities
• Preparation and maintenance of standards achieving a state of continuous readiness for accreditation
• Maintenance of documents related to Quality Improvement process including, but not limited to, policies and procedures, and Quality Improvement trilogy documents
• Preparation of documentation requirements in support of accreditation standards
• Functions as the accreditation/certification source, to ensure programs meet governing body compliance
• Establish and oversee a multi-departmental accreditation work group to support initial and renewal accreditation/certification goals and objectives
• Prepare organization for accreditation survey visits
• Develop and maintain 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
• Develop agenda and materials, schedule, support and record minutes for Quality Improvement and Utilization Management Committee
• Develop and execute quality improvement project activities

Complaints and Appeals Coordinator:
• Maintain database of complaints and appeals
• Provide report of all complaints and appeals for regulatory compliance and for leadership action as a part of Avera Health Plans’ ongoing quality improvement process
• Coordinate all external appeal reviews
• Coordinate reporting linguistically diverse membership activities
• Cooperate with Network Services staff to assess provider linguistic availability
Health and Wellness Champion:
• Serves as a leader for the delivery of preventive health campaigns and wellness programs for employers and members
• Creates, coordinates and delivers communication and collateral materials that support the wellness program
• Works with employers’ wellness teams to educate, establish goals and work plans, and create environments that support positive health behaviors aimed at enhancing health and productivity and controlling costs
• Detects cultural needs based on employer populations and implements educational programs as needs are identified
• 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
• Provides reports to employers on findings
• Researches, assesses and makes recommendations on tools that support Avera Health Plans’ health and wellness program
• Creates and maintains files on community resources that can be used to augment Avera resources in implementing the health and wellness program

Credentialing Coordinator:
• Coordinate all credentialing and recredentialing activities
• Ensure all credentialing functions are completed in an accurate and timely manner and according to federal, state and accreditation standards
• Organize and coordinate peer review activities in coordination with legal counsel to ensure all functions, documentation and processes meet ethical and regulatory standards
• Assist leadership in planning and relationship development by providing concise summaries of credentialing data
• Develop and implement tools, policies and procedures that assess and evaluate provider offices in accordance with accreditation standards

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

Customer Care Manager:
• Create the Service Excellence plan to effectively position the health plan for top quartile performance as measured by CAHPS and other surveys
• Coordinate, execute and communicate results of annual CAHPS surveys
• Evaluate the results of member and provider surveys, communicate findings and develop action plans
• Implement programs, strategies and initiatives based on the findings and recommendations to improve overall satisfaction
• Formulate and administer department procedures/protocols in compliance with federal, state and accreditation requirements
• Establish and maintain management and performance controls for customer services and sales managed though the customer service structure in order to meet and exceed retention and new sales goals

Information Technology:
• Supplies Avera Health Plans with data extracts from various data repositories to support quality improvement, utilization management and network development activities
• Supports the data needs of HEDIS and CAHPS activities
• Provides programming support for quality improvement, utilization management and continuity of care initiatives

Clinical Resources:
• InterQual
• Internally developed medical policy and clinical practice guidelines
• Hayes
• ICSI
• AHRQ
• U.S. Food and Drug Administration
• The American Hospital Formulary Service Drug Information
• Micromedex/DrugDex database
• U.S. Pharmacopeia
• Milliman MedInsight
• Like-specialty review organization

**Program Scope and Content**
The scope of the Quality Improvement Program includes an overall assessment of the efficacy of quality improvement activities, including review of specific processes and outcomes at all levels of care. Avera Health Plans is part of a larger, integrated health care delivery system that is dedicated to quality improvement.
Cross-functional integration within Avera Health Plans occurs during interdepartmental meetings and work groups, both formal and informal, to analyze performance. Quality indicators for clinical, service and operational metrics are objective, measurable, based on existing knowledge and clinical experience, and reviewed on an ongoing basis to assure that potential program changes are promptly identified. After data is collected and analyzed, action plans are developed to delineate the person or department responsible for the completion of each task as well as the timeframe for completion.

Activities include review and subsequent reporting of the following:

- Review processes and outcomes for disease management, case management, utilization management, customer care, provider relations and credentialing
- Evaluate the quality, utilization and continuity of care for medical and behavioral health care and service across the continuum settings for all members to include inpatient and outpatient services provided by physicians, ancillary practitioners and providers
- Track and trend member and provider satisfaction though the evaluation of complaints, grievances, appeals and survey data and take action where appropriate
- Evaluate the quality of service and customer service operations such as availability and access and call answer time
- Assess the scope and content of the quality improvement program on an ongoing basis to ensure compliance with all regulatory and accreditation standards
- Evaluation of continuity and coordination of care, as well as, under and over-utilization of services and pharmaceuticals
- Review of indicators measuring outcome of care to members

Quality Improvement Program Activities
Quality improvement activities include a variety of mechanisms and procedures to measure, evaluate and improve the total scope of services provided to health plan members and providers. The following activities and processes are used to support improvement in areas that reflect important aspects of quality of care and service:

- Clinical Activities
  - Behavioral Health Services
    Avera Health Plans works collaboratively with Avera Behavioral Health Center to ensure continuity and coordination of care. Case managers work with Avera Behavioral Health Center to best serve members for routine, urgent and emergent behavioral health issues to ensure the appropriate level of care. A behavioral health practitioner serves on the Pharmacy and Therapeutics Committee and the Utilization Management and Quality Improvement Committee and further serves as an advisor toward the development of behavioral health aspects of the Utilization Management, Disease Management and Complex Case Management programs.

    Avera Health Plans also works collaboratively with the Avera Behavioral Health Center to offer innovative treatment to members. The My Recovery Chemical Dependency Treatment Program is a benefit exclusively
available to Avera Health Plans’ members. The program was created using a successful evidence-based model that focuses on a short-term inpatient stay complimented with an outpatient rehabilitation program under the direction of highly specialized physicians and counselors. *My Recovery* Chemical Dependency Treatment Program includes a 3- to 7-day inpatient stays for members who need detoxification. This is followed with an 8-week program of outpatient counseling. The outpatient program includes three sessions per week over an eight-week timeframe and is currently designed for members who live within a 90-mile radius of Sioux Falls. Outpatient therapy is scheduled to accommodate the member’s work schedule. With this structure, members can continue a normal working schedule and achieve the anonymity not afforded with traditional 28- to 30-day residential treatment.

- **Complex Case Management**
  The Complex Case Management Program is designed to identify and intervene in complex cases though assessment, coordination, planning, monitoring, implementation and evaluation. The goal of the Complex Case Management Program is to promote quality, cost-effective outcomes. Clinical criteria for referral include:
  - High-risk obstetrics
  - Neonatal ICU admissions
  - Complex medical conditions and chronic disease
  - Extensive burns
  - Severe or major limb amputations
  - All solid organ and bone marrow transplants
  - Repeated inpatient admissions
  - High cost cases

- **Continuity and Coordination of Care**
  Care coordination is designed to coordinate the diverse aspects of patient care. Nurses 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. Avera Health Plans also monitors care across settings to ensure continuity and coordination for members receiving care and services from primary care, specialists and hospitals. In addition, the plan collaborates with behavioral health practitioners to monitor and improve coordination between medical care and behavioral health care.

- **Patient Safety**
  Avera Health Plans focuses on the monitoring of clinical performance indicators, quality of care indicators, provider credentialing and coordination of care to ensure a safe health care delivery system. Avera Health Plans has a Medication Therapy Management program to address safe and appropriate medication use and detect potential drug safety
issues. The Avera Health Plans Medication Therapy Management Program utilizes a collaborative approach between members, providers and the health plan.

Avera Health Plans distributes newsletters to members to improve their knowledge about clinical safety in their own care.

- **Health Promotion and Preventive Care**
  The purpose of Health Promotion and Preventive Care is to assure that members are kept informed about evidence based, nationally recognized preventive health care guidelines and that they seek services related to these guidelines. Avera Health Plans regularly reviews these guidelines with input from practicing practitioners. The guidelines are made available to practitioners and members for educational and quality enhancement purposes.

- **Disease Management**
  The objective of the Avera Disease Management program is actively work to improve the health status of its members with chronic activities. Health Coaching activities are used to monitor the care received by the member population with certain chronic conditions. Program development seeks to improve members’ health status and reduce serious health problems. Avera Health Plans collects relevant data about the health status of its members and develops actions to assist members and their practitioners in managing targeted chronic conditions.

- **Quality of Care and Peer Review**
  Peer review is the mechanism utilized to conduct review of suspected inappropriate care or inappropriate professional behavior by a practitioner or provider while providing care to a health plan member. The process and scope of actions that may be taken if a quality issue is identified are outlined within the Quality of Care Process Policies of the health plan. Quality indicators include:
  - Readmission within 30 days of inpatient stay
  - Mortality
  - Surgical or clinical procedural error, complication or infection
  - Unexpected trauma during treatment
  - Unexpected return to surgery
  - Access/availability to care
  - Delay in diagnosis, treatment or service
  - NICU admission
  - Other quality of care/quality of service issue.

- **Utilization and Care Management Review**
  The Utilization Management Program description, evaluation and work plan is maintained by the Health Services department with oversight from the Quality
Improvement and Utilization Management Committee. Utilization management activities encompass any clinical issues identified in the course of utilization and case management, evaluation of continuity and coordination of care, as well as, over and under utilization.

- Service and Operational Activities
  - Customer Service
    The Avera Health Plans Customer Service Department consists of customer service representatives, one customer service coordinator and one customer service manager. The department is available Monday through Friday, 8 a.m. to 5 p.m. CT. Calls received after business hours are answered by an off-site answering service and returned on the next business day.

    Language services are available through the Language Line. Customer service representatives utilize a conference line to communicate with members requesting non-English communications. The Language Line is able to translate 181 languages as of February 2013.

  - Linguistic and Cultural Diversity
    Avera Health Plans’ objective is to provide culturally and linguistically appropriate care and services to our members:

    - We complete an annual analysis to assess our population’s demographic profile for linguistic needs using U.S. Census data. The analysis is also compared to available provider linguistics. Any gaps between provider and population linguistics are analyzed and action is taken as necessary.

    - We work closely with employer groups through our Health and Wellness Champion. Any cultural needs or preferences regarding health education are added to the wellness goals for the employer’s group. Interpreters are utilized during on-site wellness activities on an as-needed basis.

    - We provide cultural diversity education to our employees to promote greater knowledge of the diverse cultures we serve.

  - Credentialing and Recredentialing
    Credentialing of network providers, as defined by health plan policies, is a key function of the Quality Improvement Program. All practitioners 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 recredentialing are reviewed and approved by the Credentialing Committee.
Ambulatory medical record reviews are conducted on PCP, OB-GYN and high-volume behavioral health specialists to assess safety, physical accessibility, adequacy of appointment availability and compliance with medical records standards. Avera Health Plans and providers will develop a follow-up action plan to address any guidelines not met.

- **Member Grievance Process**
  Avera Health Plans has a member grievance process for the review of member complaints and appeals. A member complaint is an oral or written expression of dissatisfaction. An appeal is a request to change a previous decision made by the organization. If a member is not satisfied with a decision that affects their coverage or the outcome of a complaint, they may file an appeal. The grievance process facilitates identification of quality issues regarding care delivery and Avera Health Plans.

  Avera Health Plans' Complaint and appeals handling includes documentation of the substance of the complaint and actions taken, investigation, notification to members of the resolution and the right appeal.

- **Performance Measurement**
  - **Population Health Management/HEDIS**
    HEDIS is the Healthcare Effectiveness Data and Information Set, which is a comprehensive measurement tool used by the health plan to help with evaluating the performance and effectiveness of its quality program. HEDIS contains multiple measures representing a variety of health care related areas, including effectiveness of care measures, access to care, use of health care services, members’ satisfaction, health plan stability and health plan descriptive information. Annually, this data is collected, analyzed and evaluated. Based on the findings, Avera Health Plans determines its strategy for quality improvement activities.

  - **Member Satisfaction**
    Member satisfaction is assessed through evaluation of CAHPS surveys and member complaint and appeal information. Member satisfaction surveys and routine monitoring indicators are designed to measure local health plan performance and to assess member satisfaction with the plan services. Member complaints and appeal information is trended and correlated with CAHPS survey results to identify potential opportunities for improvement. The results of this trending, analysis and comparison are used in development of action plans. Results are summarized and reviewed by the health plan to identify areas of improvement and prioritize interventions.

  - **Provider Satisfaction**
Provider satisfaction surveys are designed to assess which services are important to health plan providers and determine provider satisfaction with the health plan. A survey is conducted annually with a sampling of primary care and specialty physicians. Results are summarized and reviewed by health plan departments that serve providers to identify and prioritize areas for improvement.

- Monitoring of Quality Indicators/Quality Measurement Studies
  The quantitative monitoring of health care indicators is designed to reveal trends and performance opportunities in specific areas to facilitate improvement health plan wide. To achieve this, the health plan monitors a variety of indicators to affect improvements in care and service. The indicators chosen are derived from many sources as appropriate for the health plans’ population and service needs. These quality indicators are measurable, based on reasonable research, and use current, and accepted quality methodologies.

**Quality Improvement Program Annual Work Plan**
The purpose of the annual work plan is to focus on quality improvement goals and objectives and planned projects and activities for the forthcoming year. The document is intended to be dynamic in nature. The annual work plan includes anticipated time frames of project completion or due dates, and is utilized as an action plan to document the status and changes in activities throughout the year. The annual work plan is reviewed and approved by the Quality Improvement and Utilization Management Committee. The Board of Directors reviews this work plan. Updates to the plan are presented to the Quality Improvement and Utilization Management Committee on an as-needed basis.

**Quality Improvement Program Confidentiality**
The health plan adopts and maintains confidentiality and HIPAA privacy and security policies and procedures. No voluntary disclosure of peer review or quality assurance information is made except to persons authorized to receive such information in the conduct of Avera Health Plans quality management activities. Information is strictly confidential, is not to be released and is not considered discoverable. Avera Health legal counsel must authorize any release.

No voluntary disclosure of identifiable member information is made without obtaining prior consent from the member, except as required by law. Member information is strictly confidential and utilized only on an as-needed basis to meet the administrative and legal obligations of the health plan.

Data utilized by the quality committees are maintained in a confidential manner through the mechanism of codes 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. Each committee participant must understand and agree to comply with the confidentiality policies and sign a confidentiality statement.

**Quality Improvement Program Annual Evaluation**

An annual evaluation of the Quality Improvement Program is conducted to assess the overall effectiveness of the health plans’ quality improvement processes. The evaluation reviews all aspects of the program with emphasis on determining whether the program has demonstrated improvements in the quality of care and services that are provided by the health plan. The annual evaluation includes:

- An assessment of how the year’s goals and objectives were met
- A review of staffing and technological resources
- A summary of quality improvement activities
- The impact the quality improvement process had on improving health care to members
- Potential and actual barriers to achieving goals
- Recommendations for quality improvement program revisions and modifications resulting from the evaluation

The annual evaluation is reviewed and approved by the Quality Improvement and Utilization Management Committee. The results of the annual quality program evaluation are used to develop and prioritize the annual quality work plan for the upcoming year.