

**Avera Health Plans 2018
Quality Improvement Program Description**

History

Avera Health Plans, Inc. is a not-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 South Dakota Division of Insurance since June 4, 1999. Operations began in October of 1999.

On July 10, 2001, Avera Health Plans obtained its Certificate of Authority from the Iowa Insurance Division. On November 22, 2004, Avera Health Plans obtained a Certificate of Authority from the Division of Insurance in Nebraska.

In August 2014, Avera Health Plans obtained Interim Health Plan Accreditation with the National Committee for Quality Assurance (NCQA). NCQA First Survey Accreditation status was obtained February 1, 2016, and accreditation status has been maintained since that time.

Current operations include Commercial and Marketplace health insurance services to members in our service area which 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 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 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 for 2018

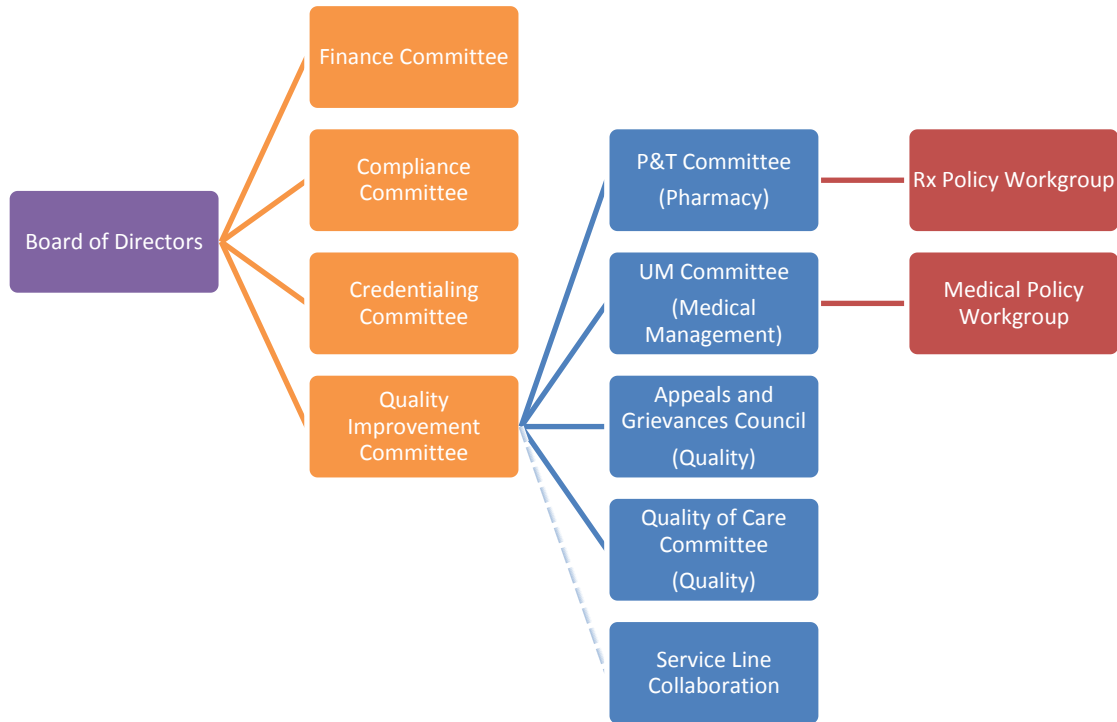
- Maintaining a Quality Improvement structure and process that supports continuous improvement including measurement, analysis, intervention and re-measurement for issues involving patient safety, quality of care and outcomes.
- Defining clinical quality and building organizational capabilities to support the achievement thereof.
- Systematically monitoring and evaluating key indicators and measures to detect trends and identify opportunities to improve quality of care and service to members.
- Identifying, prioritizing and developing 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.
- Developing data-driven disease and complex case management strategies to improve practitioner and member compliance with clinical and/or behavioral

health guidelines and standards.

- Ensuring a system of continuous quality improvement communication that is timely and reports through appropriate channels to appropriate individuals.
- Monitoring ongoing compliance with applicable accreditation and regulatory standards.
- Enhancing 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.
- Serving and improving clinical outcomes for members with complex health needs, disabilities and severe and persistent mental illness through our complex case management program, monitoring and improving access to care and monitoring and improving continuity and coordination of care across multiple settings.
- Validating quality of care trends and communicating trends to Avera Service Lines.
- Provide education to members and network behavioral health care practitioners regarding appointment availability standards.
- Implementation of population health program with data analytics tools.
- Integrate adverse events reporting with Avera Health System initiatives.

Program Authority and Accountability

Committee Structure and Overviews



*Committee reports submitted to the Avera Health Plans Board of Directors – Committee membership includes Avera Health Plans officers who attend the Board of Directors’ meetings in an ex-officio capacity.

Avera Health Plans Board of Directors

- Meeting Frequency: minimum quarterly
- Membership:
 - President of Avera Health Plans
 - Vice President
 - Secretary
 - Four Employer/Community Board Members
 - One Avera Health Board Member
- Roles and Functions of the Board of Directors:
 - Exercises decision making for strategic direction of Avera Health Plans
 - Ensures adequacy of policy making activities
 - Provides oversight for the operations of Avera Health Plans
 - Approves the Quality Improvement Program Description annually
 - 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 Avera Health Plans

Quality Improvement 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 Executive Officer, Avera Health Plans, ad hoc
 - Director of Quality and Accreditation, Avera Health Plans
 - Director of Medical Management, Avera Health Plans
 - Director of Network Services, Avera Health Plans
 - Quality Improvement and Accreditation Coordinator, Avera Health Plans
 - Clinical Pharmacy Specialist, Avera Health Plans
 - HEDIS Quality Coordinator
 - Director of Risk Adjustment, Avera Health Plans
 - Manager of Utilization Management, Avera Health Plans
 - Population Health Manager, Avera Health Plans
 - Designated physician specializing in behavioral health
 - Three participating physician representatives as appointed by the Chief Medical Officer
- Roles and Functions of the Committee:
 - Annually assess the prior year's quality activities through the Quality Improvement Program Evaluation
 - Annually develop, review and approve the Avera Health Plans Quality Improvement Program Description and Work Plan based on findings of the prior year's Quality Improvement Program Evaluation
 - Provide guidance to Avera Health Plans on quality priorities and projects, including quality program oversight and development
 - Review and evaluate the results of clinical and service quality improvement activities
 - Review, provide input, and approve clinical and quality improvement service policy decisions
 - Institute needed actions based on trends and analysis of data
 - Identify, prioritize and develop interventions that target opportunities for improvement, identify variance from performance goals and benchmarks, develop and test improvement and evaluation plans, and regularly re-evaluate quality improvement efforts
 - Monitor ongoing compliance with applicable accreditation and regulatory standards
 - Enhance relationships with physicians by engaging in collaborative process improvements and support them to improve clinical quality and better manage the care of targeted members

- Provide oversight of subcommittees, relevant ad hoc task forces, or multidisciplinary work groups of network participating practitioners that do not participate in the Quality Improvement Committee

In addition, the Quality 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 experience issues and initiatives
- Member and provider experience surveys
- Compliance audits
- Privacy and confidentiality processes and practice

Credentialing Committee

- Reports to: Avera Health Plans Board of Directors*
- Reporting Process: Quarterly written presentation of sanctions and mandatory reporting
- Meeting Frequency: at least quarterly
- Membership:
 - Chief Medical Officer, Avera Health Plans (Chairperson)
 - Credentialing Manager, Avera Health
 - Director of Provider Contracting and Engagement, Avera Health Plans
 - Four Participating Network Practitioners
- 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 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 Avera Health Plans Board of Directors on a scheduled basis
 - Obtains final approval from the Avera Health Plans Board of Directors on credentialing participating network providers
 - Based on established criteria, reviews qualifications and makes recommendations regarding the qualifications of an individual practitioner or facility requesting network participation
 - Based upon established criteria, reviews qualifications and provider performance indicators of quality, utilization and risk and makes recommendations regarding continued participation in the network
 - Develops credentialing and recredentialing policies and procedures

- Provides regular reports to the Quality Improvement and Utilization Management Committee
- Member service metrics
- Quality improvement initiatives
- Utilization Management initiatives and criteria
- Provider access and availability studies
- Appeal and grievance trends

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
 - Avera Health Plans Chief Financial Officer
 - Avera Health Plans Chief Executive Officer
 - Three other voting members
- Roles and Functions of the Committee:
 - Monitor financial, statistical and risk management 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 recommend strategies to ensure the financial integrity of Avera Health Plans operations
 - Monitor investment decision-making processes
 - Monitor reinsurance decision-making processes
 - Monitor actuarial operations with senior management of Avera Health Plans
 - Provide counsel, recommendations and support for Avera Health Plans management as requested

Compliance Committee

- Reports to: Avera Health Plans Board of Directors*
- Reporting Process: Verbal and/or written recommendations, reports and service activities as requested
- Meeting Frequency: Semi-annually
- Membership:
 - Avera Health Plans President
 - Avera Health Plans Chief Executive Officer

- Avera Health Executive Vice President - Office of General Counsel
- Avera Health Plans Director of Compliance
- Two additional Avera Health Plans Board members
- Roles and Functions of the Committee:
 - Approve Compliance Plan annually
 - Review and approve Assessment of Compliance Program Effectiveness annually
 - Oversee operational and regulatory risk management processes for Avera Health Plans
 - Ensure market conduct standards are met
 - Review Compliance and Audit Work plans annually

Compliance Council

- Reports to: Compliance Committee
- Reporting Process: Verbal and/or written recommendations, reports and service activities as requested
- Meeting Frequency: Quarterly
- Membership includes representation from the following areas:
 - Compliance (Chairperson)
 - Chief Executive Officer
 - Claims
 - Medical Management
 - Pharmacy
 - Finance
 - Finance Integration Manager
 - Network Services
 - Configurations
- Roles and Functions of the Committee:
 - Identify annual compliance work plan
 - Review policies and procedures that have been approved for implementation at Avera Health Plans
 - Identify need for and review audit results including action plan and follow up
 - Review Federal and state mandates in addition to accreditation requirements for impact on operations of Avera Health Plan
 - Identify education needs for Avera Health Plans as it relates to regulatory requirements

Pharmacy and Therapeutics Committee

- Reports to: Avera Health Insurance Division Quality Improvement Committee (which reports to the Avera Health Insurance Division Board of Directors)
- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested
- Meeting Frequency: At least quarterly
- Membership: The P&T Committee shall consist of a minimum of 6 voting members, but no more than 12 and are appointed by the Chief Medical Officer.

The P&T Committee voting membership shall include:

- A minimum of five licensed providers with at least one provider from each of these specialties:

- Behavior 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.

The following P&T Committee membership are necessary but are not voting members:

- Health Plan Chief Medical Officer
 - Health Plan Chief Executive Officer
 - Health Plan Chief Administrative Officer
 - Health Plan Director of Pharmacy Benefits
 - Representative of the pharmacy benefit manager
- The P&T Committee is responsible for the following functions:
 - Maintain drug formularies that promote safety, effectiveness and affordability using formulary principles.
 - Maintain utilization management criteria like, but not limited to, preauthorization, step therapy, quantity limits, age edits and gender limitations.
 - Review all new legend medications or other chemical entities, new clinical indications, new safety information and new therapeutic classes.
 - Perform annual review of the drug formulary on a therapeutic class basis.
 - Perform annual review of all utilization management programs.
 - Perform annual review of pharmacy management policies and procedures.
 - Participate in the development of and support educational programs that promote appropriate medication use.
 - Other responsibilities that may be included, but not limited to:
 - Perform medication use evaluations.
 - Report adverse drug event monitoring and reporting.
 - Assist in medication error prevention.
 - Participate in the development of clinical care plans and guidelines.
 - Participate in the development and review of quality assurance and/or risk management activities.

Pharmacy Policy Workgroup

- Reports to: Avera Health Insurance Division Pharmacy & Therapeutics Committee
- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested
- Meeting Frequency: Quarterly, with additional ad hoc meetings, as needed
- Membership:
 - Chief Medical Officer
 - Associate Medical Director(s)

- Director of Pharmacy Benefits
- Compliance Representatives
- Provider Relations Representatives
- Managed Care Review Representatives
- Configurations Specialists
- Clinical Pharmacy Staff
- Roles and Functions of the Committee:
 - Development of pharmacy policy and procedures that are:
 - Clinically and ethically sound based on current evidence-based literature
 - Reflects accurate coding standards set forth by CMS
 - Programmable within each respective claims system
 - Compliant with current health plan provider contracting
 - Review updated pharmacy policies

Utilization Management Committee

- Reports to: Avera Health Insurance Division Quality Improvement Committee (which reports to the Avera Health Insurance Division Board of Directors)
- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested
- Meeting Frequency: At least quarterly
- Membership
 - Chief Medical Officer, Avera Health Plans (Chairperson)
 - Chief Executive Officer, Avera Health Plans
 - Director of Medical Management, Avera Health Plans
 - Director of Quality and Accreditation, Avera Health Plans
 - Clinical Pharmacist, Avera Health Plans
 - Director of Provider Contracting, Avera Health Plans
 - Manager of Clinical Resources, Avera Health Plans
 - Quality Improvement and Accreditation Coordinator, Avera Health Plans
 - Complaints and Appeals Coordinator, Avera Health Plans
 - HEDIS Coordinator, Avera Health Plans
 - Physician members representing the Avera network with at least one behavioral health specialist and one primary care practitioner
- Monitor and improve effectiveness and outcomes for inpatient care and complex care management
- Maintain collaboration with delegated entities to support optimal utilization outcomes
- Review commercially and internally produced utilization management decision-making criteria annually and provide training to staff
- Ensure accuracy and consistency in utilization management decision-making across all utilization management reviewer roles by using inter-rater reliability
- Implement staff competency program to provide measurable performance indicators on an employee level
- Ensure appropriate and accurate clinical documentation by using clinical documentation audits for staff members

- Encourage appropriate utilization and discourage underutilization by educating providers, members and staff about incentives for utilization management decisions
- Meet or exceed turnaround time standards for utilization management decision-making in concurrent, urgent preservice, non-urgent preservice and postservice authorization requests for medical, behavioral health and pharmacy reviews
- Monitor member and provider experience with the utilization management process
- Meet or exceed targeted inpatient utilization goals
- Reduce out-of-network utilization
- Implement online authorizations for providers

Medical Policy Workgroup

- Reports to: Utilization Management Committee, then 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:
 - Medical Director (Co-chair)
 - Utilization Review Manager (Co-chair)
 - Chief Medical Officer
 - Director of Pharmacy
 - Director of Medical Management
 - Provider Relations Representatives
 - Managed Care Review
 - Customer Service Representatives
 - Accreditation Coordinator
 - Director of Quality and Accreditation
 - Health Services Support Specialist
 - Sales Representative
 - Configurations Specialists
 - Compliance Representative
- Roles and Functions of the Committee:
 - Research current literature for new and revised medical policies
 - Review new and updated medical policies
 - Provide 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 Quality Improvement Committee
 - Serve as a liaison with the provider community in the development, dissemination and communication of medical policy

Appeals and Grievances Council

- Reports to: Avera Health Insurance Division Quality Improvement Committee (which reports to the Avera Health Insurance Division Board of Directors)
- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested

- Meeting Frequency: Monthly
- Membership
 - Chief Medical Officer, Avera Health Plans (Chairperson)
 - Chief Executive Officer, Avera Health Plans
 - Director of Quality and Accreditation
 - Complaints and Appeals Coordinator
 - Director of Pharmacy
 - Quality and Accreditation Coordinator
 - Director of Medical Management
 - Manager of Customer Service
 - Director of Network Services
 - Director of Compliance
- Roles and Functions of the Council:
 - Monitor complaints, appeals, and grievances to ensure that they are completed in a manner and time span consistent with State and Federal regulations
 - Review reports looking for trends and recommend related actions
 - Establish Member communication standards in regards to the Member's benefits and complaints, appeals, and grievances rights.
 - Maintain a complete database of all appeal and grievance documentation
 - Monitor any appeals and grievances related to delegated vendors

Quality of Care Committee

- Reports to: Avera Health Insurance Division Quality Improvement Committee (which reports to the Avera Health Insurance Division Board of Directors)
- Reporting Process: Written and/or verbal presentations regarding recommendations, reports and service activities as requested
- Meeting Frequency: Quarterly, with additional ad hoc meetings, as needed
- Membership:
 - Chief Medical Officer, Avera Health Plans (Chairperson)
 - Director of Quality and Accreditation
 - Medical Director of Quality
 - Quality and Accreditation Coordinator
 - Quality Review Nurse
 - A minimum of four licensed providers with at least one providers
- Roles and Functions of the Council:
 - Complete clinical review of members' inpatient or outpatient experiences with contracted providers and facilities. Cases for review will be determined by the CMO of Avera Health Plans.
 - Systematically monitor and evaluate key indicators and measures to detect trends and identify opportunities to improve quality of care and service to members
 - Discuss results of the clinical review
 - Consensus by providers on Quality of Care rating
 - Document discussion details and rating on each clinical case reviewed
 - Provide recommendations on follow-up with the treating practitioner(s) or facilities involved in the case

- Summary of clinical cases and case ratings presented to Quality Improvement Committee
- Validate quality of care trends and communicate trends to Avera Service Lines
- Complete Quality Improvement Committee recommendations to Quality of Care Committee
- Communicate trends and variances to Credentialing Department for long-term monitoring opportunities

Behavioral Health Service Line

- Collaborates with Quality Improvement 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 providers, primary care providers and specialists caring for patients with behavioral health comorbidities

Primary Care Service Line

- Collaborates with Quality Improvement 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
 - Executive Council of Service Lines
 - Avera-employed primary care practitioners
- Roles and Functions of the Committee
 - Develop, adopt and distribute recognized standards of care for primary care providers

Ob/Gyn Service Line

- Collaborates with Quality Improvement 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
 - Executive Council of Service Lines
 - Avera-employed ob/gyn practitioners
- Roles and Functions of the Committee

- Develop, adopt and distribute recognized standards of care for ob/gyn providers and primary care providers

Avera Clinical Leaders Forum

- Collaborates with Quality Improvement Committee
- Reporting Process: Verbal and/or written recommendations, reports and service activities as requested
- Meeting Frequency: At least quarterly
- Membership:
 - Senior Vice President and Chief Medical Officer of Avera Health
 - President and Chief Executive Officer of Avera@Home
 - Director of Coordinated Care and Clinical Quality
 - Avera Health System Quality Staff Members
 - Avera Clinical Intelligence Team
 - Avera Business Intelligence Team
 - Avera Health Medical Information Officer
 - Avera Health Chief Nursing Information Officer
 - Avera Health Plans Chief Medical Officer
 - Avera Health Plans Director of Quality and Accreditation

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
- Attends and presents reports to Avera Health Plans Finance Committee and Board of Directors
- Serves on the Executive Committee which oversees the Avera Service Lines

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 Medical Management

- Works directly with the Chief Medical Officer to provide oversight of medical management operations
- Provides direction and support of the Manager of Clinical Resources
- Develop, implement, evaluate and provide oversight of the clinical programs for Avera Health Plans' Medical Management to meet the needs of its membership
- Assist with the evaluation of department performance via competency assessments, performance improvement programs and productivity
- Create and ensure timely and accurate reporting to executive management and appropriate committees
- Oversees the relationship between Avera Health Plans and the plan's pharmacy benefit administrator
- Provides oversight of the Pharmacy and Therapeutics Committee
- 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
- Oversees Medication Therapy Management Pharmacist who conducts utilization review for medications, including providing denial decisions

Population Health Manager

- Assists with the development, revision and implementation of member and/or marketing programs to meet specific needs of a member population
- Develop and administer policies and procedures to establish methodologies to identify which members would qualify and to improve health care delivery to meet the member's needs and preferences
- Work directly with the Directory of Medical Management to facilitate oversight of care coordination operations
- Perform and promote interdepartmental integration and collaboration to provide effective and efficient use of resources
- Assist with the evaluation of department performance via competency assessments, performance improvement programs and productivity

Designated Behavioral Health Practitioner

Avera Health Plans has a designated behavioral health physician who serves on the Quality Improvement Committee and Pharmacy and Therapeutics Committee. This designated behavioral health physician serves as the senior physician actively involved in implementing the Behavioral Health aspects of the Utilization Management program and:

- Serves as the Behavioral Health leader for the Quality Improvement Committee and Pharmacy and Therapeutics Committee
- Assists in establishing Behavioral Health Utilization Management policies and procedures and quality improvement initiatives such as member experience survey, behavioral health clinical practice guideline development and mental health / psychosocial requirements in the Complex Case Management and Disease Management programs
- Participates in annual review for use of standard, published utilization management criteria
- Assist 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 utilization and makes recommendations for service improvement

Clinical Pharmacy Specialist

- Monitors United States Food and Drug Administration 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 the 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 – 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 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
- 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 Committee
- Assist in executing quality improvement projects

HEDIS Quality 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

- 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 Manager

- 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 through the customer service structure in order to meet and exceed retention and new sales goals

Director of Compliance and Privacy

- Provide direction on compliance with legislative and regulatory requirements
- Ensure submission of regulatory filings and annual reports
- Oversee and monitor implementation of an effective compliance program
- Coordinates the development of a risk management program
- Develops and oversees the implementation of administrative policies and procedures

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 Technology Assessment
- UpToDate
- Institute for Clinical Systems Improvement (ICSI)
- Agency for Healthcare Research and Quality (AHRQ)
- United States Food and Drug Administration
- The American Hospital Formulary Service Drug Information
- Micromedex/DrugDex Database
- United States Pharmacopeia
- Milliman MedInsight
- Like-specialty review organization
- Conifer Data Warehouse

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 of care settings for all members to include inpatient and outpatient services provided by physicians, ancillary practitioners and providers
- Track and trend member and provider satisfaction through 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
- Oversight of delegates performance against Avera Health Plans expectations, regulatory compliance and accreditation standards

Quality Improvement Functional Areas and 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. As described in the section Resources for Clinical and Service Quality Improvement, a designated behavioral health practitioner serves on the Pharmacy and Therapeutics Committee and the Quality Improvement and Utilization Management 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 works collaboratively with the Avera Behavioral Health Center to assess member experience with behavioral health services through a member survey. Avera Health Plans Quality Improvement and Utilization Management Committee reviewed, approved and adopted clinical practice guidelines developed by the Avera Behavioral Health Service Line. Avera Health Plans 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

- Population Health Management

Population Health Management is a population-driven, patient-centered care coordination service provided to a defined population in order to improve the overall health of that entire population and empower members to take responsibility for managing their own health and health outcomes. The Population Health Program aims to also reduce health inequalities or disparities within the population due to social determinants of health. The Population Health Management program coordinates between all members of the care team and the member, monitors and measures clinical metrics and establishes and adheres to basic clinical practice guidelines.

The Population Health Management Program Strategy outlines processes for implementing Population Health management activities, and includes the following:

1. Goals and populations targeted for each of the four areas of focus:
2. Programs and services offered to members
3. Activities that are not direct member interventions
4. How member programs are coordinated
5. How members are informed about available PHM programs

The objective of the Population Health Management program is to help members maintain optimal health or improved functional capacity, in the right setting and in a cost effective manner. It involves keeping members healthy, managing members with emerging risk, assessing patient safety or outcomes across settings and managing multiple chronic illnesses.

- Serving Members with Complex Health Needs

To serve members with complex health issues such as physical or developmental disabilities or severe and persistent mental illness, Avera Health Plans provides coordination of care activities such as:

- Health system navigation for members who have had, or are preparing to undergo, solid organ transplant
- Referrals for members with severe and persistent mental illness to Avera Behavioral Health Assessment Referral Center
- Utilization review activities for members with cancer diagnoses to ensure appropriate chemotherapy and/or radiation treatments are prescribed and health system navigation services

For more information about Avera Health Plans' complex case management, see the Avera Health Plans Population Health Management Plan strategy. Avera Health Plans is implementing population health management using Avera-employed staff members. The project is being managed by a multi-disciplinary team, including clinicians and administrative staff, to ensure the highest quality and most effective program is implemented.

- Continuity and Coordination of Care

Care coordination is designed to coordinate the diverse aspects of patient care. Nurses and 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. 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 by identifying drug-to-drug interactions, drug-disease interactions and side effects or other medication-related problems and communicating issues to prescribers for intervention and correction. The Medication Therapy Management pharmacist also provides education to members regarding medications, including appropriate use and compliance.

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. Avera Health Plans targets members with gaps in selected preventive health indicators (e.g., breast cancer screening, colorectal cancer screening)

through a multi-directional approach. Educational mailers, targeted telephonic education and reducing geographic and time barriers to screening are the top three strategies utilized by Avera Health Plans. To reduce geographic and time barriers to breast cancer screening, Avera Health Plans collaborates with Avera Mobile Mammography, employer groups and members to plan breast cancer screening events which bring the screenings to the members. For these screening events, employers typically do not require members to take time off from work to participate in the screening. The mobile unit is available at the worksite and after screening, members are able to return to work. Geographic and time barriers to colorectal cancer screening are reduced by distributing fecal immunochemical testing supplies to members at the worksite. After the member completes the test, it is mailed to the lab for processing in a postage-paid package. After the results are compiled, the member is contacted. If the screening ends in a positive result, the member is contacted to schedule a screening colonoscopy with an Avera Medical Group practitioner.

- 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:
 1. 30 Day Readmissions
 2. Perioperative Pulmonary Embolism or Deep Venous Thrombosis
 3. Postoperative Sepsis
 4. Abdominopelvic Accidental Puncture or Laceration
 5. Total Hip/Knee Complication
 6. Special Requests
 - a) Access/Availability to Care
 - b) Delay in Diagnosis, Treatment, or Service
 - c) Quality of Care Complains from Members
- Utilization and Care Management Review
The Utilization Management Program Description, Evaluation and Work Plan is maintained by the Medical Management department with oversight from the Quality Improvement and 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 representative, one customer service coordinator, one customer care/quality coordinator and one customer care 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 Cyracom Language Service. Customer service representatives utilize a conference line to communicate with members requesting non-English communications. Cyracom Language Services is able to translate over 200 languages.

Customer service indicators, including service metrics, are reported to a multi-disciplinary team quarterly for review and identification of opportunities for improvement.

- Linguistic and Cultural Diversity

Avera Health Plans' objective is to provide culturally and linguistically appropriate care and services to our members.

Avera Health Plans completes an annual analysis to assess the population's demographic profile for linguistic needs using United States Census data. The analysis is also compared to provider linguistics and Cyracom Language Services utilization. To ensure network adequacy to meet the needs of underserved populations, any gaps between provider and population linguistics are analyzed and action is taken as necessary.

To improve cultural competency in materials and communications, Avera Health Plans works closely with its customer service department, medical management department, employer groups and the health and wellness champion. Any cultural needs or preferences regarding member materials are addressed. Health education cultural diversity is added to the wellness goals for the employer's group. Interpreters are utilized in customer service and during on-site wellness activities on an as-needed basis.

Avera Health Plans provides cultural diversity education to employees to promote greater knowledge of the diverse cultures in the membership.

- Credentialing and Recredentialing

Credentialing of network practitioners and 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 practitioners and providers undergoing initial credentialing and recredentialing are reviewed and approved by the Credentialing Committee.

Avera Health Plans informs new practitioners and providers of office site quality standards and thresholds. When a threshold is met, an office site quality review is scheduled with the office site location. If deficiencies are identified and/or a score of lower than 85% compliance occurs, Avera Health Plans outlines the quality improvements necessary to comply with performance standards. The office site must implement an action plan to comply with the performance standards within six months of the initial visit. If another complaint threshold is met during the review of the initial complaint, Avera will perform another office quality review within 60 calendar days of the reasonable complaint threshold being met, and will institute actions to improve office site quality, and will continue to evaluate the office's actions at least every six

months until a deficient office meets standards. Results of the office site quality review are included in the initial credentialing review and subsequent recredentialing reviews as appropriate.

- 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' complaints and appeals handling includes documentation of the substance of the complaint (or appeal) and actions taken, investigation, notification to members of the resolution and the right to appeal.

Quarterly reporting of complaints and appeals is brought to Quality Improvement Committee for evaluation and recommendations for improvement as needed.

- Performance Measurement

- 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, access to care, use of health care services, member experience, 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 Experience

Member experience is assessed through evaluation of CAHPS surveys, QHP Enrollee surveys and member complaint and appeal information. Member experience surveys and routine monitoring indicators are designed to measure local health plan performance and to assess member experience with plan services. Member complaints and appeals 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 Experience

Provider experience surveys are designed to assess which services are important to health plan providers and determine provider experience with the health plan. A survey is conducted annually with primary care practitioners, specialty care practitioners, and behavioral health practitioners. 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 plan's population and service needs. These quality indicators are measurable, based on reasonable research, and use current and accepted quality methodologies.

Delegation Process

Avera Health Plans monitors delegates performing quality improvement activities such as complex case management and disease management. Avera Health Plans has a rigorous delegate oversight process. Predelegation audit is conducted to ensure delegate has the capacity to conduct delegated activities according to health plan expectations, state and federal regulations and accreditation requirements as applicable. After Avera Health Plans has evaluated and approved the delegate, a delegation agreement is signed by both parties. The agreement includes responsibilities of both parties. Semiannual reports are presented to the Quality Improvement Committee for review and recommendation for improvement, if applicable. Annually, Avera Health Plans reviews and approves, or provides correction to, the delegate's Quality Improvement Program. If the delegate is not performing activities to the expectations outlined in the delegation agreement, the delegate is placed under a corrective action plan. If deficiencies are not addressed, Avera Health Plans may revoke the delegation agreement.

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 Quality Improvement Annual Work Plan addresses activities and objectives for improving quality and safety of clinical care, quality of service and member experience. Time frames are assigned for each activity's completion and staff members are assigned to each activity. The document includes monitoring of previously identified issues and annual evaluation of the Quality Improvement Program. 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 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.