QUALITY IMPROVEMENT PROGRAM OVERVIEW

Clear Spring Health

Introduction

The Quality Improvement (QI) program guides the company's activities to improve care and treatment for the members we serve. The program aligns with the company's vision which supports continuous quality of care, access to care in a safe, culturally sensitive manner and within compliance of State and federal contract requirements and guidelines.

Purpose

The Plan develops quality objectives each year as outlined in the annual Quality Improvement Program description, which documents the scope, structure and function of the QI Program. We also evaluate the Plan's success in achieving the annual QI program goals each year and document the results in the Quality Program Evaluations. Based on the evaluation findings, the QI Program is modified to ensure problems are addressed and opportunities are acted upon. The QI Program and QI Program Evaluation is shared with the Plan's executive team and the Board of Directors.

Quality Improvement activities are coordinated with other performance monitoring activities and management functions including, but not limited to, patient safety, Health Effectiveness Data Information Set (HEDIS), Health Outcome Survey, Consumer Assessment of Healthcare Provider and Systems (CAHPS), Utilization Management, Care and Disease Management, Cultural Competency, Network Development, and Credentialing.

Scope

The Quality Program is broad in scope and includes patient safety, member satisfaction, clinical care/services, benefit administration, provider participation and provider satisfaction. The QI program's scope includes all the Plan's products across the following states:

- Medicare HMO – Illinois, Colorado, Georgia
- Medicare PPO – Georgia

Goals and Objectives

The QI program consists of the following goals and objectives:

- Provide effective customer service for members, physicians and other health care providers
- Identify and resolve issues related to member access and availability of services
- Improve the overall quality of life of members through personalized and member centric Case Management initiatives
- Monitor coordination and integration of member care across practitioner and provider sites
- Assist members with complex needs and multiple chronic conditions achieve optimal healthout-comes
- Achieve operational excellence through improved health plan functionality
- Develop provider report cards with individualized information and resources needed to provide high-quality care with low administrative burden
- Provide mechanism whereby members, physicians and other health care providers can express concern to the Plan regarding care and services
- Ensure that participating practitioners/providers who provide care to our members are fully credentialed

- The Plan supports activities such as Risk Management, Compliance, Peer Review, Utilization Management and other required programs
- Institute a Member Safety program and initiatives
- Promote activities that result in better communication across departments, improve services for members, physicians and associates
- Mechanism by which members, physicians and other health care providers can express concerns regarding care and services

Ongoing Quality Improvement Services

The Plan provides programs that focus on health and wellness, such as case management. The case management program aims to assist members on how to identify and manage their current conditions, ensure their care is delivered safely and efficiently, help in the management of chronic disease and complex health conditions, and prevent future diseases by stressing the importance of preventive screening.

Program Activities

Part of the QI Program activities include the ongoing monitoring for quality of care. Emphasis is placed upon identifying high risk services, acute and chronic care, preventive care and other delivery settings. Initiatives of the QI Program may include but not limited to:

- Member safety through the implementation of a Member Safety Program
- Clinical measurement, preventive health initiatives and monitoring
- Provider qualifications and performance
- Pharmacy management
- Special Needs Plans member improvement initiatives through dedicated models of care (MOC)
- Continuity and coordination of care and services
- Chronic Care Improvement Program (CCIP)
- Member and provider satisfaction
- Service and availability
- Over and underutilization of services
- Culturally and linguistic appropriate services
- Population Health Management

Member Safety Program

The Plan is committed to building a safer environment for our members by working in collaboration with network providers. The Plan focuses on four key areas

- Reduction of 30-day readmissions
- Prevention of falls
- Monitoring appropriate medication use
- Adverse member outcomes

The program uses claim data (medical and pharmacy) and case reviews to identify opportunities for improvement in each of the four areas.

Clinical Measurement, Preventive Health Initiatives and Monitoring

To gauge the effectiveness of clinical and preventive health initiatives, the Plan uses the Health Care Effectiveness and Data Information Set (HEDIS) measures, which are developed and maintained by the National Committee for Quality Assurance (NCQA).

The Plan will establish a baseline and set annual goals to meet and/or exceed NCQA benchmarks in each of the following measurable HEDIS domains:

- Prevention and Screening
- Respiratory Conditions
- Cardiovascular Conditions
- Diabetes
- Musculoskeletal Conditions
- Behavioral Health
- Medication Management
- Overuse/Appropriateness of Services
- Access/Availability of Care
- Utilization and Risk Adjustment

Provider Qualifications and Performance

The Plan, through its credentialing and recredentialing committee, ensure that participating providers follow credentialing standards based on NCQA guidelines. Selection and retention of participating providers is an important aspect of the QI Program.

The Plan performs ongoing provider monitoring to ensure quality and safety of care between credentialing cycles, including the monitoring of member complaints and adverse outcomes and quality of care concerns involving participating network providers.

Pharmacy Management

The Plan follows the Medication Therapy Management (MTM) program to ensure that it promotes clinically appropriate, safe, and cost-effective drug therapies. This program requires evaluation for safety and efficacy when developing formularies, procedures to ensure appropriate drug class review and inclusion and a regular review of drug policies.

Our internal Pharmacy Data Analyst and Pharmacist analyze member pharmacy data to identify those members with polypharmacy, potential drug reactions, inappropriate use of medication usage, the presence of controlled substance, and voluntary drug recalls.

The Case management department addresses the needs of members through the following:

- Assist members with the coordination of care and services
- Improve member health outcomes
- Empower members via education of chronic conditions to attain the established goals
- Establish a plan of care and treatment that is consistent with the values, beliefs and wishes of the member
- Evaluate care according to the member's needs and changes in the member's health status
- Provides follow-up post discharge assessment

Continuity and Coordination of Care and Services

Case Management (CM) initiatives, analyses of data, the Plan can identify areas where opportunities exist to improve continuity and coordination of care between settings of care and transitions of care from one provider to another.

Case Management post-discharge initiatives focus on the individual member's needs for assistance postacute inpatient stay to outpatient settings, need for intervention by clinical personnel (nurses), care coordination, social services, and pharmacists. The Case Management program emphasizes the importance of post discharge calls in improving continuity and coordination of care for the members.

The Plan collects and analyzes data from various delivery sites and through each disease process. The data is used to determine where opportunities exist to improve the coordination of care and transitions of care from one provider to another.

Examples include:

- Coordinating home health care services
- Increasing the understanding of discharge plans and instructions
- Reconciliation of current vs. post discharge medications
- Enhancing the communication between primary care physician and specialist
- Expediting the communication of a negative member outcome to primary care physicians.

Chronic Care Improvement Program (CCIP)

CMS also requires the implementation of CCIPs as part of the mandated Quality Improvement (QI) program under the federal regulations.

The focus area is to promote effective management of chronic disease, improve care and member health outcomes. The program will be conducted over a three-year period. Effective management of chronic disease is expected to slow disease progression, prevent complications and development of comorbidities, reduce preventable emergency room (ER) visits and inpatient stays, improve quality of life, and save cost.

The Plan has selected Hypertension as the chronic condition. The interventions implemented will be through Case Management initiatives and provider participation.

The expected outcomes are:

- Improvement in the control of blood pressure controls (HEDIS-CBP measure)

The Plan is expected to attest each year that the CCIP is in progress for each contract. The study will contain data analysis of the outcomes and interventions, as well as barriers to meeting goals, plans to reduce barriers, best practices, and lessons learned.

Member Satisfaction

The monitoring, evaluating, and improvement of member satisfaction is a vital component of the QI program. This is accomplished using surveys, as well as through the aggregation, trending, and analysis of member complaint data.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is administered annually. The goal is to evaluate the experience members have with the Plan and the participating providers. The Plan contracts with a qualified, agency approved, NCQA certified vendor to conduct the annual enrollee satisfaction survey.

Survey results will be compiled and analyzed to identify areas for improvement. Results are reported to the Quality Improvement Committee and are made available to participating providers, upon request.

Service and Availability

The Plan assesses member satisfaction with services through internal call center metrics, member complaints, member grievances, identified quality of care concerns related to access/availability, claims and satisfaction survey reviews. The Plan continuously monitors these service indicators and determines appropriate action to address concerns and needed improvements.

Over and Underutilization of Services

The Plan monitors over and underutilization of services through Utilization Management and Case Management. The Plan reviews and monitors provider performance through utilization management reports for prospective, concurrent, retrospective reviews, authorizations/certifications, denials, ER services, and inpatient data.

The Plan uses MCG clinical guideline criteria and standards, National Coverage determinations and Local Medicare Review policies to determine medical appropriateness and medical necessity as applicable to UM functions.

Culturally and Linguistic Appropriate Services

A goal of the Plan is to ensure that members have access to culturally and linguistically appropriate services, ensuring that all services delivered to members are tailored to member needs.

The Plan, through a Cultural Competency program, evaluates the availability of language services within the network and develops interventions when improvement opportunities are identified. The program evaluates the cultural competence of the Plan's staff and participating providers.

Population Health Management

The Plan uses a variety of systems that deliver actionable data to providers for use in improving their patients' health and wellness.

Conclusion

The Plan is committed to creating solutions that engage members in their health and health care, leading to high-quality outcomes to achieve lifelong well-being.

Quality Improvement reporting of activities by all areas within the company continues to focus on evaluation of effectiveness of interventions, learning from past responses, and sharing of best practices. This includes a move from operational metrics to outcome metrics where possible.

The Plan will:

- Evaluate progress towards goals, evaluate barriers, evaluate effectiveness of interventions, and implement changes as needed with a focus on outcomes
- Evaluate compliance to regulations through internal monitoring of processes
- Evaluate future expansion resource requirements, define responsibilities for all requirements, and continually assess for possible efficiencies
- Evaluate QI program structure for any needed changes to address new business or new regulations
- Work towards achieving accreditation from a nationally recognized accrediting body.