PreferredOne Quality Management Program Description

Program Mission
The mission of the Quality Management (QM) Program is to identify and act on opportunities that improve the quality, safety, value of care, and service provided to all PreferredOne members; working both independently and collaboratively with contracted practitioners and community efforts. As part of the organization’s mission, PreferredOne advocates for improvements in the delivery, quality, and coverage of health care services, and pursues health care programs to meet community needs.

Program Scope
The QM Program encompasses all aspects of care and service delivery provided to PreferredOne members. Components of PreferredOne’s QM program include:
- Clinical components across the continuum of care (including pharmacy and mental health)
- Patient safety
- Organization components of service delivery including case management, prior authorizations/medical necessity decision making, provider accessibility/availability
- Business processes that impact our members and/or providers such as claims processing, customer service, credentialing/recredentialing, care transitions, etc.
- Member satisfaction

Additionally, the PreferredOne QM Program scope includes the oversight of vendors to whom services have been delegated.

Utilization Management and Credentialing functions are incorporated into the organization’s QM Program but addressed under separate documents. See Integrated Healthcare Services (IHS) Program Description and Credentialing/Recredentialing policies for additional information. NCQA standards for utilization management and credentialing/recredentialing are the basis for all policy/procedure development and implementation.

Goals and Objectives

Goals
- Ensure an objective and systematic approach to monitoring, evaluating, improving and communicating the quality, safety and value of care and services provided to PreferredOne members and other customers
- Maintain compliance with accreditation and regulatory requirements
- Protect confidential personal health information
- Provide an adequate and accessible network of qualified practitioners and providers
- Exceed member experience expectations
- Monitor the quality of care provided for our members and address their concerns

Objectives
- Adopt and distribute clinical practice guidelines
- Communicate information regarding the quality and cost of care to members and practitioners
- Support continuity and coordination of care
- Ensure access and availability of practitioners
- Evaluate and improve member satisfaction
- Identify clinical and service quality improvements for:
  1. High volume or high-risk activities
2. Problems that may be anticipated or that have occurred in the past
3. Problems that can be corrected or may benefit from preventive action
4. Potential adverse health outcomes
5. Complaints
6. A variety of clinical settings where services are provided (e.g., medical/surgical, behavioral health, chiropractic and pharmacy)
   - Investigate all PreferredOne member complaints and potential quality of care events
   - Obtain and communicate quality and safety data about our practitioner/provider network
   - Oversee delegated entities
   - Provide case management and disease management programming

Program Structure

- **Governance/accountability**
  The ultimate responsibility for the QM and IHS programs resides with the PreferredOne Insurance Company (PIC), the PreferredOne Community Health Plan (PCHP) and the PreferredOne Administrative Services (PAS) Boards of Directors. Authority and responsibility are delegated to the QM Committee and its subcommittees to direct and oversee customer-driven QM and IHS programs for PreferredOne. The PreferredOne QM Committee annually reviews the QM and IHS Program Descriptions, Work Plans, and Program Evaluations and recommends changes to the Boards of Directors, as appropriate. The Boards of Directors also review the activities of the QM and IHS programs by reviewing and formally accepting the QM Committee meeting minutes.

- **Committee Structure and Physician Participation**
  The QM Committee structure includes two subcommittees: the Integrated Health QM Subcommittee and the Pharmacy and Therapeutics QM Subcommittee. Both Subcommittees report to the QM Committee. The overarching role of these Subcommittees is to recommend an ongoing QM Program in each of these unique specialty areas, make specific recommendations as required by individual cases or situations, and facilitate quality improvement efforts when opportunities are identified. The QM Committee’s role is to promote, direct, and oversee the QM program that identifies and acts on opportunities that improve the quality, safety and value of care and service provided to PreferredOne members, working both independently and collaboratively with contracted practitioners and community efforts.

  The Integrated Health QM Subcommittee’s role is to monitor and improve all aspects of health care utilization and services, including behavioral health, provided by PreferredOne Network contracted practitioners and providers. Two licensed board-certified Psychiatrists serve as committee members on the Integrated Health QM Subcommittee, including PreferredOne’s Associate Medical Director for Behavioral Health.

  A group of physician peer reviewers provide specialty expertise for review of quality issues, individual cases as requested, and expert review of clinical criteria used for the IHS medical necessity decision-making process.

* Refer to attachments:
  Quality Management Committee and Subcommittees Role and Function documents
  PreferredOne Community Health Plan, PreferredOne Insurance Company, and PreferredOne Administrative Services Quality Committee Structures
  Medical Policy: MP/C003 Criteria Management and Application
Resources Allocated to the QM Program

PreferredOne commits substantial resources to evaluate and improve the quality of care its members receive. PIC is a wholly owned subsidiary of PreferredOne Administrative Services, Inc. ("PAS"), a for-profit, taxable corporation that is incorporated in Minnesota. PAS employs all employees of the controlled group, and, through a management agreement with PIC and another with PCHP (which is a Minnesota health maintenance organization and affiliate of PAS), provides various services and staffing to PIC and PCHP; including the Quality Management and IHS Programs described herein. Where appropriate herein, PAS, PIC and PCHP are referred to collectively as “PreferredOne.” When various departments and staff positions are referred to throughout this QM Program Description, the reference is to PAS’ employees performing department functions and staffing the position for and on behalf of PIC, PCHP and PAS through the management agreement.

The IHS Department provides the primary staff support to maintain and manage PreferredOne’s QM and IHS Programs. Staff in the IHS and Network Management (NM) Departments support the QM Program including the Chief Medical Officer (CMO), and the following operations staff: the Director of QM, the Sr. Quality Management Specialist, the Director of Pharmacy Benefits, the Vice President of IHS, the Directors of IHS, the Population Health Analyst, 2.5 Chronic Illness Nurses, two Treatment Decision Support Nurses, three Chronic Illness Enrollment Specialists, 6.5 complex case managers (five nurses and 1.5 social workers), the Associate Medical Director of Behavioral Health, the Director of Provider Credentialing, the Director of Provider Analytics, the Manager of Provider Analytics, one Senior Data Analyst, and the Administrative Assistants.

The CMO reports directly to the Chief Operating Officer (COO) and is a member of PreferredOne’s executive management team. The CMO supports relationships with contracted care systems to ensure implementation of PreferredOne’s utilization and quality management strategies. The CMO supports the evaluation and promotion of activities consistent with high quality clinical standards and appropriate cost-effective use of health care resources, and creates and facilitates an environment that is conducive to and supportive of the exchange of ideas and information to encourage the delivery of high quality medical services within the PreferredOne Network. This is accomplished by seeking input from network providers in the development of criteria and policies utilized by the IHS Department for utilization review. Physicians from multiple medical, surgical and behavioral specialties are active participants in PreferredOne’s QM Committee and Subcommittees and provide oversight and input in the IHS and QM Programs in addition to conducting medical necessity and quality of care reviews for PreferredOne.

Specific responsibilities of the CMO include review of individual cases for medical necessity/appropriateness, review/oversight of quality of care complaint investigations, oversight of clinical guidelines, review of credentialing activities, and oversight of mechanisms to monitor, evaluate and improve upon the appropriateness, effectiveness and efficiency of services delivered within the PreferredOne network. This position supervises the Associate Medical Director for Behavioral Health, physician peer reviewers, and the management and staff of the IHS Department.

The Associate Medical Director for Behavioral Health reports to the CMO. The objectives of the Associate Medical Director for Behavioral Health position are the same as those listed for the CMO. Specific responsibilities for PreferredOne include: review of individual cases for medical necessity/appropriateness; review and advise on necessary mechanisms within PreferredOne to monitor, evaluate, and improve the appropriateness, efficiency and effectiveness of services delivered; review and advise on the development and use of guidelines and protocols; review quality of care complaints received by PreferredOne related to the delivery of services and advise on appropriate actions; serve as a voting member of the Integrated Health and the Pharmacy & Therapeutics QM Subcommittees; participate in the development of PreferredOne’s goals and objectives; advise PreferredOne on payer,
provider, and patient communications to make them consistent with high-quality service standards; and represent PreferredOne as requested on matters of clinical practice before such groups as: the organization’s clinical practitioners/providers contracting employers, TPAs, or insurers; prospective contracting groups; the community; and legislative or regulatory agencies.

The Director of QM is responsible for the overall direction, implementation and management of PreferredOne’s QM Program in conjunction with the CMO. Responsibilities include monitoring and assessing the quality and safety of care provided and developing an annual QM work plan and program evaluation. Staff associated with the program support QM activities by managing quality improvement initiatives, analyzing performance measures, reviewing clinical records, overseeing the quality of care complaint investigation process, following up on corrective actions, and preparing and presenting summary reports of performance measures.

The Sr. Quality Management Specialist is responsible for the administrative function of the QM Department. The position serves as a liaison between the QM Department and internal and external customers and is responsible for appropriate communication and training throughout the organization in relation to the QM Department. This position coordinates the quality of care complaint investigation process, organizes and manages member and physician initiatives for the IHS and QM Departments, and plays a key role in coordinating corporate preparations for accreditation and Minnesota Department of Health quality assurance exams. This position reports to the Director of QM.

Additional support for PreferredOne’s QM Program is provided by other PAS organizational departments and staff members which include the CEO, the Executive Assistant to the CEO, COO, the Vice President of Network Management, the Vice President of Business Systems, the Director of Credentialing, the Director of Customer Service, the Director of Marketing, the Manager of Product Development, the Senior Vice President/Chief Information Officer, and the Vice President General Counsel.

- **Collaborative Activities**

In an effort to pool resources, create consistency among provider networks in our community and improve the delivery of health care to our members PreferredOne participates in several collaborative activities.

- **Minnesota Community Measurement (MNCM)** is a collaboration among health plans and provider groups whose mission is to accelerate the improvement of health by publicly reporting health care information. MNCM improves care by:
  - Reporting the results of health care quality performance and improvement efforts in a fair, transparent and reliable way to medical groups, regulators, purchasers and consumers.
  - Providing resources to providers and consumers to improve care.
  - Increasing the efficiencies of health care reporting in order to use our health care dollars wisely.

PreferredOne is one of seven health plan founding members of MNCM. The state medical association, state hospital association, participating medical groups, consumers, businesses, health plans, and state health agencies are all represented on the organization’s board of directors in either a voting or non-voting capacity. Data is supplied by participating health plans on an annual basis for use in developing their annual Health Care Quality Report.

- **Minnesota Council of Health Plans (MCHP)** is a non-profit trade association representing Minnesota’s non-profit health plan organizations. The Council promotes access to high-quality, affordable health care. Health plan members are active in the areas of health care reform, research-
based guideline development, community health and prevention, medical technology assessment and 
health care quality data collection.

PreferredOne executives and staff members serve on various committees through the MCHP 
including the Board of Directors, community health, communications, health policy, quality and 
medical issues.

➢ **Patient Safety**
PreferredOne demonstrates a commitment to patient safety by incorporating safety into existing QM 
activities and taking patient safety into consideration when examining trends and data for possible quality 
 improvement activities. PreferredOne always implements processes with overall patient care outcomes 
and safety as components of quality improvement activities. Elements of patient safety are found in our 
existing quality improvement processes that include, but are not limited to:

- Distributing evidence-based practice guidelines to practitioners
- Identifying and implementing processes for transitions of care for continuity and safety
- Implementing disease management programs that include follow-up systems to ensure that care is 
  received in a reliable and timely manner
- Implementing pharmaceutical management practices and policies that include safeguards to enhance 
  patient safety, including an emerging therapeutic issues program in which members and/or physicians 
  are notified of significant safety issues with products covered under the pharmacy benefit (including 
  prescription drugs and certain medical devices)
- Incorporating adverse event reporting into the credentialing process
- Tracking and trending adverse event reporting to identify systems and/or network issues that may 
  compromise safety
- Analyzing and taking action on member and practitioner complaints and satisfaction data that relate 
  to safety
- Collecting and providing information on provider and practitioner safety and quality, including 
  activities on providers’ actions to improve patient safety and to make performance data publicly 
  available for members and practitioners.

* Refer to attachments:
  *Medical Policy: MP/T002 Transition of Care - Continuity of Care*
  *QM Policy: QM/F001 Facets & Episodes Quality of Care Triggers – Review and Analysis*
  *QM Policy: QM/Q001 Quality of Care Complaint Investigation*

➢ **Complex Case Management**
Complex Case Management helps members regain optimal health or improved functional capacity in the 
right setting and in a cost-effective manner. Members with multiple or complex health conditions are 
identified by claims or by other internal processes for case management. Registered Nurses and Social 
Workers complete a comprehensive assessment with members and, based on that information, develop an 
individualized case management plan with performance goals, monitoring and follow up using best 
practice guidelines and evidence based care. Barriers to care are identified and then strategies are 
implemented to minimize or eliminate their impact. Staff provide members with a variety of community 
resources to help with transportation, financial, psychosocial and other needs. The goal of the program is 
to improve members’ quality of life and clinical outcomes, minimize complications and avoid unplanned 
admissions, readmissions, and emergency room visits.
Treatment Decision Support
Treatment Decision Support targets two specific conditions (low back pain and pregnancy) identified by claims data triggers. The program encourages members to self-manage and actively engage with their providers by educating them about their medical conditions, possible treatment options, and the clinical and cost ramifications of various options with the goal of helping them make informed decisions that align with their individual preferences and values. Specialized nurses trained in Shared Decision Making and Motivational Interviewing techniques provide education and resources. The nurses use comprehensive assessment tools, best practice guidelines, and decision support tools.

Chronic Illness Management
The Chronic Illness Management program is available to members who are diagnosed with any of the following chronic conditions:

- Diabetes
- Coronary Heart Disease
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Asthma (adult and juvenile)
- Ulcerative colitis
- Crohn’s Disease
- Rheumatoid Arthritis
- Multiple Sclerosis
- Rare Conditions (Sickle Cell, Cystic Fibrosis, Lupus, Parkinson’s, Myasthenia Gravis, Hemophilia, Scleroderma, Dermatomyositis, Myositis, Polymyositis, CIDP, ALS, and Gaucher Disease)

The goals of the Chronic Illness Management program are to promote self-management of chronic conditions, improve adherence to treatment plans with an emphasis on medication therapy, reduce or delay disease progression and complications, reduce hospitalizations and emergency room visits and improve quality of life.

Continuity and Coordination of Care
PreferredOne develops a work plan to specifically address issues related to continuity and coordination of care within our network among our members. Data from various sources will be used to determine areas in which there is an opportunity for improvement and programs to address these opportunities will be developed as necessary.

Proposed areas in which we are investigating opportunities for improvement include

- Appropriate Diabetic Screenings
- Medical inpatient follow-up
- Hepatitis C medication adherence
- Opioid prescribing and utilization
- Reduction of emergency room utilization
- Exchange of Information
- Appropriate diagnosis, treatment and referral of behavioral health seen in a primary setting
- Special needs for members with severe and persistent mental illness
- Appropriate use of psychotropic medications
- Management of treatment access and follow-up for members with coexisting medical and behavioral disorders
- Secondary preventive behavioral healthcare program implementation
- **Serving a Culturally and Linguistically Diverse Membership**
  PreferredOne incorporates into its annual work plan efforts to better serve our culturally and linguistically diverse membership; provides information and tools to staff and network practitioners to support culturally appropriate care and facilitate effective communication; and provides these services through LanguageLine Solutions™, annually communicating their service availability to members.

- **Delegated QM Activities**
  PreferredOne delegates certain quality management activities to Magellan Healthcare, which is a chiropractic services provider, and to ClearScript, which is a pharmacy benefit manager. Although PreferredOne delegates some quality management activities to Magellan Healthcare and ClearScript, PreferredOne retains responsibility for the performance of all the delegated activities. PreferredOne has a written and mutually agreed upon delegation agreement, performance reporting requirements and a written process for consequences for failure to perform. On an annual basis, PreferredOne conducts an audit of Magellan Healthcare and ClearScript’s quality management and utilization management activities.

- **Confidentiality**
  PreferredOne respects and vigorously safeguards the confidentiality of our members’ health information. We are committed to protecting our members’ information in a responsible and professional manner. PreferredOne communicates our Notice of Privacy practices to members on an annual basis. Federal and State law provide privacy and confidentiality protection for certain records and information which relate to quality. These protections are designed to help ensure that practitioners and staff implement confidential and effective programs for assessing the quality and efficiency of patient care services.

- **QM Activity/Study Design**
  PreferredOne’s Quality Management activities document:
  - The rationale for why the activity is important to PreferredOne members or practitioners
  - Why there is an opportunity for improvement
  - Intervention selected to improve performance
  - Date intervention started and ongoing project timelines
  - Measurable goals for performance improvement
  - Baseline benchmark
  - Projected time frame for improvement
  - Estimated time frame for achieving improvement and at what intervals periodic measurement will be performed
  - Analysis and revisions to activity, as indicated

New program activities and focused studies in 2018 will be selected based on data analysis of current data resources. Focus will be placed on areas in which there is opportunity for improvement and across the continuum of care.

- **Data Sources and Monitoring Methods**
  - Member satisfaction survey (CAHPS®)
  - HEDIS® collection and reporting, and such other quality assessment and improvement activities as are directed by the Minnesota Commissioner of Health
  - Medical record review
  - Member complaints
  - Quality of care event reporting
  - Utilization data including medical and pharmacy claims
• Case reviewer inter-rater reliability
• MNCM Total Cost of Care and Quality Measurement Data Sets

The QM program utilizes claims information, medical record information, predictive modeling software, and data supplied by PreferredOne’s delegates to perform program functions.

➢ Peer Review Activities
As part of the quality evaluation process, quality or utilization concerns identified from any data source may undergo peer review to provide a qualified, unbiased opinion of the care and management provided. PreferredOne may utilize one of several accredited Independent Review Organizations for this activity. The selection is based on the provider specialty or procedure involved and the reviewer’s individual area of expertise.

➢ Communicating QM Program Activities
Information regarding PreferredOne’s QM activities including the QM Program description and yearly evaluation on the effectiveness of quality improvement activities are made available on PreferredOne’s website and in the practitioner newsletter. Written notification of the information’s availability on the web is mailed to all contracted practitioners and providers in the quarterly newsletter and is made available to members in the annual member mailing during the second quarter of each year. Visitors to the PreferredOne website can find quality management program information, consumer information (i.e., claims repricing, condition cost estimator), medical criteria, medical policy, and details on collaborative activities.

Program Work Plan
The annual work plan is a separate document that is dynamic and updated frequently to reflect the activities and progress of QM activities throughout the year. It is also used to accurately document overlap of activities from year to year. The scope of the work plan is defined in this program description and is updated and reviewed by the QM Committee annually, and approved by the Board of Directors.

*Refer to document: 2018 Quality Management Work Plan

Program Evaluation and Notification
The QM Committee annually evaluates the QM Program and work plan and recommends changes to the PIC, PCHP, and PAS Boards of Directors as necessary when there is clear evidence that QM activities are not improving care and there are opportunities deemed appropriate to take action on. The written evaluation and recommendations are annually reviewed and formally approved by the PIC, PCHP, and PAS Boards of Directors. In brief, the evaluation includes:

• A description of completed and ongoing QM activities that address quality and safety of clinical care and quality of service
• Analysis of the results of the previous year’s QM initiatives including barrier analysis
• Evaluation of the overall effectiveness of the QM Program including progress toward influencing network-wide safe clinical practices
• Evaluation of delegated entities’ QM programs
• Trending of measures to assess performance in the quality and safety of clinical care and quality of service

Attachments

- Quality Management Committee and Subcommittees Role and Function documents
  - Quality Management Committee Role and Function
  - Subcommittee Role and Function: Integrated Health Quality Management Subcommittee
  - Subcommittee Role and Function: Pharmacy and Therapeutics Quality Management Subcommittee
- PreferredOne Community Health Plan, PreferredOne Insurance Company, and PreferredOne Administrative Services Quality Committee Structure
- Medical Policy: MP/C003 Criteria Management and Application
- Medical Policy: MP/T002 Transition of Care - Continuity of Care
- QM Policy: QM/F001 Quality of Care Triggers – Review and Analysis
- QM Policy: QM/Q001 Quality of Care Complaint Investigation

Additional documentation to support 2017QMI Program Description includes:

- 2018 Quality Management Work Plan

Document History:

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