Samaritan
Health Plan Operations
Building healthier communities together

2016 Quality Management Plan

PREPARED BY:	Quality and Health Outcomes Manager
REFERENCES:	OAR 410-141-3200; 836-053-1170; Chapter 4, 5, 6, 16b Medicare Managed Care Manual; OHA contract
EFFECTIVE DATE:	January 1, 2016
APPROVED BY:	QMC 1/12/16

INTRODUCTION

Samaritan Health Plan Operations is an integrated not for profit healthcare organization made up of InterCommunity Health Plans and Samaritan Health Plans. InterCommunity Health Plans serve Oregon Health Plan members in Linn, Benton and Lincoln Counties under InterCommunity Health Network-Coordinated Care Organization (IHN-CCO). Samaritan Health Plans serve Medicare members under Samaritan Advantage Health Plan (SAHP) in Linn, Benton and Lincoln Counties. Also under Samaritan Health Plan Operations is Sam Choice, (Samaritan Health Service employees), and Commercial Plans.

PURPOSE

The purpose of the Quality Management Plan is to describe how we monitor the care provided to our members to assure that our mission is fulfilled and to describe the components that comprise the quality management program at Samaritan Health Plan Operations.

MISSION STATEMENT – Samaritan Health Plan Operations

- *Samaritan Health Plan Operations coordinates the management of quality integrated health care services for individuals and the communities we serve.*
- *We ensure this coordination through our values of Leadership, Respect, Excellence, Integrity, Stewardship, Compassion, and Service*

GOALS AND OBJECTIVES OF THE QUALITY MANAGEMENT PROGRAM

The Quality Management Program is designed to monitor the quality of healthcare provided to all Samaritan Health Plan Operations' members. The goals and objectives of the program include but are not limited to:

1. Maintain an effective Quality Management Program:
    - Meet or exceed the expectations and standards of Federal, State and contractual entities regarding maintaining a quality management program including an annual evaluation of the program
2. Ensure continual high level member satisfaction and access to appropriate healthcare services:
    - Monitor member complaints/grievances/appeals internally on an ongoing basis to identify areas for improvement.

- Monitor member satisfaction via external agencies such as through Consumer Assessment of Healthcare Providers & Systems Survey (CAHPS), etc. per Federal, State and contractual requirements to identify areas for improvement.
- Implement and monitor appropriate interventions when areas for improvement in member satisfaction or access to appropriate healthcare are identified
- Report results of monitoring member satisfaction and access to appropriate healthcare to the Quality Management Committee and to the appropriate Board of Directors as indicated but at least on a yearly basis.
- Maintain a strong collaborative relationship with the provider network and community entities.

3. Develop programs and interventions to improve health outcomes of members
    - Promote preventive services (including dental) and early detection of disease through the member education program and the case management program
    - Promote self-management of chronic diseases through the member education program and the case management program
    - Monitor health outcomes on an individual basis through the case management program
    - Monitor health outcomes on an overall basis through various methods including Healthcare Effectiveness Data & Information Set (HEDIS) data, internal data, etc.
    - Meet or exceed expectations for all quality projects required by Federal, state or contractual requirements
    - Report results from programs and intervention monitoring to the Quality Management Committee and the appropriate Board of Directors on at least a yearly basis or more frequently as indicated

SCOPE OF THE QUALITY MANAGEMENT PROGRAM

Samaritan Health Plan Operations recognizes that individual performance is integral to achieving our mission and further acknowledges that the most significant advances in quality improvement will result from collaboratively focusing on important processes of service within our organization.

The Quality Management Program has been integrated into all Samaritan Health Plan Operations' departments. When appropriate there is also coordination and/or integration of quality management activities within Samaritan Health Services and/or outside entities (such as collaborative quality improvement projects).

The Quality Management Program addresses the monitoring and reporting requirements set forth in federal and state regulations, and proactively pursues opportunities for improvement in these areas. Additionally, the Quality Management Program facilitates and monitors Samaritan Health Plan Operations' organizational priorities.

The Quality Management Program monitors four key areas: utilization of services, member satisfaction, clinical services (including behavioral health/mental health, dental services, prevention, chronic care improvement, maternal/ child services, case management, member health education and quality improvement projects, etc.) and

various administrative services. Samaritan Health Plan Operations believes that the integration, monitoring and balance of findings in these areas reflect the achievement of effective and efficient health care that is high quality and cost-effective.

Utilization of Services
This component of the program includes monitoring under and over utilization of services. This is accomplished in coordination with the Samaritan Health Plan Operations Population Health teams and the Samaritan Health Plan Operations Healthcare Assessment Subcommittee.

Member Satisfaction
This component of the program includes monitoring member satisfaction with the plan and with our providers. This is accomplished through various methods including but not limited to the Consumer Assessment of Healthcare Providers & Systems Surveys (CAHPS), member complaints & grievances, member appeals, etc.

Clinical Services
This component of the program includes such clinical aspects as chronic care improvement, case management, member health education, quality improvement projects, preventive health, maternal/child services, behavioral health/mental health services, dental services, etc.) These are accomplished in coordination with the Samaritan Health Plan Operations' Healthcare Assessment Subcommittee and various other subcommittee and departments within Samaritan Health Plan Operations or as collaborative efforts with entities outside Samaritan Health Plan Operations.

Chronic Care Improvement/Case Management

- Samaritan Health Plan Operations maintains a Chronic Care Improvement Program that conforms to all state and federal regulations.
- The Program includes an interdisciplinary clinical team, prevention guidelines, evidence-based clinical practice guidelines, self-management goal setting, case management, continuous analysis of relevant data and cost-effective technology to improve health outcomes of members with specific diseases.
- The goals of the program include: assisting members to understand their chronic diseases/conditions, decreasing healthcare costs, overcoming barriers to compliance with provider treatment plans, implementing education for self-management of their disease or condition and providing resources to the members to manage their chronic diseases/conditions
- Various aspects of this program are provided in coordination with the Samaritan Health Plan Operations' Healthcare Assessment Subcommittee and various other subcommittees and teams within Samaritan Health Plan Operations.

Member Health Education

This component also includes cultural awareness and health literacy. Both preventive and disease specific health education are provided to members through a variety of methods including but not limited to member health newsletters, individual health mailings, targeted health mailings, verbally through case management, referral to group or individual classes, etc.

Quality Improvement Projects/Performance Improvement Projects

- Projects are developed per regulatory requirements but all are designed to improve the health outcomes of our members. Projects may be a collaborative effort with Samaritan Health Services and/or with other health plans or agencies.
- Valid and reliable data methods are utilized to measure improvements and include internal data as well as external data such as the Consumer Assessment of Healthcare Providers & Systems Surveys (CAHPS); Healthcare Effectiveness Data & Information Set measures (HEDIS), Health Outcome Survey (HOS), etc. Data is reviewed and analyzed by the Samaritan Health Plan Operations' Healthcare Assessment Subcommittee and reported to the Quality Management Committee.

Preventive Health

This component includes monitoring preventive care to reduce or eliminate disease, educating members about preventive health including dental health to improve overall health outcomes.

Additional Clinical Services

These include monitoring maternity care, newborn care, mental health/behavioral health care, dental care, etc. These are monitored in coordination with various Samaritan Health Plan Operations' Teams. Data from these services is reviewed and analyzed by the Samaritan Health Plan Operations' Healthcare Assessment Subcommittee and reported to the Quality Management Committee.

Administrative Services

This component of the program includes monitoring of policies & procedures, various operation issues, etc. This is accomplished in coordination with various Samaritan Health Plan Operations' teams.

PRINCIPLES/STRATEGIES OF THE QUALITY MANAGEMENT PROGRAM

The Quality Management Program is designed with the philosophy and methodology of continuous measurable improvement in the quality of service to members and other customers in order to promote effective, efficient, and caring health management. To accomplish this we utilize the following:

- **Systems Thinking**
  We recognize that each hospital, medical group, dental group, county agency, department and individual is part of an integrated system of services for the delivery of member care. This recognition directs our efforts in improving processes and meeting member needs through linking key customers and suppliers together in the process of problem solving or new process design.
- **Teamwork**
  Process improvement, new process design and/or problem solving is accomplished via individual and team based approaches. For example the scope of the Samaritan Health Plan Operations' "Interdisciplinary Clinical Team" includes the healthcare systems of Samaritan Health Services, Quality Care Associates, The Corvallis Clinic, independent providers, dental providers, mental health/behavioral health providers, county providers, the members and the health plan staff. A predefined process that reflects the Plan-Do-Study-Act (PDSA) methodology of continuous improvement will guide our improvement efforts:
  - Define the problem
  - Identify desired outcomes
  - Develop effective process based solutions
  - Provide education and implement the improved process
  - Monitor to evaluate the gains and continuously improve the process
- **Customer awareness**
  We listen to our customers; both internal and external, to measure our quality against their expectations. We commit to objectively measure all aspects of our service system, and evaluate points of variance from expected performance. The challenge is to balance the many and varied customer expectations with the reality of limited resources. The strategic framework established by all Samaritan Health Plan Operations' Boards of Directors will serve as a guide for priority setting and resource assignment.
- **Fact based decision making**
  We utilize valid, reliable data as a source of decision making, rather than instinct, personal preference, or feeling. Data resources within our organization will be shared whenever possible, respecting confidentiality and appropriateness of distribution while complying with HIPAA regulations.
- **Quality Planning**
  This is conducted on at least an annual basis and includes the review of the strategic initiatives developed by the governing body based on state and federal regulations and contractual requirements. From this direction, goals are established, responsibility assigned and resources allocated.
- **Quality Control**
  These monitors are ongoing measurements designed to assess the achievement or exceeding of a predetermined threshold. Quality control measures incorporate mechanisms to assess over- and under-utilization of services. Quality control activities are reviewed and revised as indicated or at least on an annual basis.
- **Quality Improvement**
  These activities are identified through quality control, regulatory and Health plan quality initiative measurements. The focus of Quality Improvement activities is

high risk, high volume services and care of acute and chronic conditions. Improvement activities are accomplished primarily via integrated team activities utilizing problem solving or new program design processes. The quality improvement model adopted by Samaritan Health Plan Operations for measuring the Chronic Care Improvement Program, Quality Improvement Projects and Performance Improvement Projects is based on The Plan-Do-Study-Act (PDSA) quality improvement model. PDSA is an iterative, problem-solving model used for improving a process or carrying out change.

AUTHORITY, OVERSIGHT AND REPORTING OF QUALITY MANAGEMENT PROGRAM ACTIVITIES

The Quality Management Program is overseen by the appropriate Board of Directors who retains authority and accountability for all quality activities. The Samaritan Health Plan Operations' Quality and Health Outcomes Manager is responsible for the daily operations of the Quality Management Program and works closely with the Samaritan Health Plan Operations' Chief Medical Officer , the Samaritan Health Plan Director of Population Health and other Samaritan Health Plan Operations' managers/directors and reports indirectly to the Samaritan Health Plan Operations' Chief Executive Officer and directly to the Samaritan Health Plan Director of Population Health.

The Quality Management Committee monitors the ongoing effectiveness of the Quality Management Program. They provide the appropriate Board of Directors with regular reports, at least on a quarterly basis, which include findings, actions and recommendations regarding the various aspects of the Quality Management Program. The Quality Management Committee meets at least every other month. Members of the committee include practicing providers (physical health, mental health, behavioral health and dental) from the communities we serve. The Samaritan Health Plan Operations' Healthcare Assessment Subcommittee is a subcommittee of the Quality Management Committee. They meet monthly to review, analyze data, review the effectiveness of the various programs and make recommendations to the Quality Management Committee.

See Attachment A - Quality Management ***Committee Charter***
See Attachment B – ***IHI's Triple Aim Initiative***

QUALITY MANAGEMENT PROGRAM EVALUATION

The Quality Management Committee reviews the Quality Management Program on an annual basis for effectiveness and makes revisions to any elements of the plan as indicated. Summaries of the evaluation are provided to the appropriate Board of Directors for review. An annual program evaluation is provided to all regulatory organizations as required.

The formal annual evaluation addresses at a minimum the impact and effectiveness of the following:

- Quality Management Program
- Utilization Management Program
- Special Needs Plan Model of Care Evaluation

- Special Needs Plan Care Management
- Validation of Part C Medicare Reporting

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Attachment A

QUALITY MANAGEMENT COMMITTEE CHARTER – 2016

PURPOSE	Regulatory Agencies (i.e. Oregon Health Authority (OHA), CMS, Department of Consumer and Business Services (DCBS), etc.) require that Health Plans have a planned, systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of services provided to members. Many of the elements of this program are detailed in OAR 410-141-3200; 836-053-1170 and chapters 4, 5, 6 and 16B of the Medicare Managed Care Manual, as well as 42CFR422 & 438. Other key aspects are identified through contractual agreements, customer feedback, adverse outcomes, or identified opportunities to improve. Samaritan Health Plan Operations is committed to continuous improvement of service delivery to our members, providers and regulatory agencies.
MISSION	Design, implement, monitor, facilitate action and evaluate effectiveness of key services provided to members, providers, and regulatory agencies through the adoption of the IHI's Triple Aim Initiative. The IHI's Triple Aim Initiative includes three dimensions: improving the patient experience of care, improving the health of populations and reducing the per capita cost of health care. (see attachment B)
FUNCTIONS	1. Required elements of quality monitoring compliance with regulatory agencies are identified. 2. Annual quality monitoring plan is developed based on required elements, identified opportunities to improve, governing body direction, and assessed needs of the participating medical, behavioral health/mental health and dental groups. 3. Responsibility is assigned for conducting, reporting and facilitating elements of the quality monitoring plan on at least an annual basis. 4. Quality monitoring will include appropriate utilization of services (both under and over utilization), member satisfaction, clinical services (including behavioral health/mental health, dental services, prevention, disease management, maternal/ child services) and various administrative types of services. 5. Reports of quality monitoring findings, conclusions and actions will be reported to the appropriate governing body on at least a *quarterly* basis. 6. Any delegated functions will be monitored and reported on at least an annual basis to assure compliance with requirements. 7. The committee will minimize impact on providers and the health plan offices in the data collection process. 8. Review the Quality Management Program on an annual basis for effectiveness and value to the various customers. 9. The Quality Management Committee (QMC) provides oversight to quality monitoring and improvement activities, including quality planning and assigning accountability with assistance from their various subcommittees.
MEETING FREQUENCY	The committee will meet at least 6 times per year or as needed to meet the Quality Management Plan. Minutes will be recorded of each meeting and stored appropriately.

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Attachment A

SCOPE	The Quality Management Committee will monitor key services delivered to members and associated supportive processes: utilization of services, member satisfaction, clinical services (including behavioral health/mental health, dental services, prevention, disease management, maternal/ child services) and various administrative services.
AUTHORITY	The Quality Management Committee's primary focus is to act as the leadership body for quality improvement activities within Samaritan Health Plan Operations. With this focus, the Quality Management Committee acts to identify and facilitate the accomplishment of a planned, systematic, valid and valuable quality management plan for members and providers. The Quality Management Committee is authorized to take action upon issues related to member care and make recommendations related to contracts, compensation and/or provider participation. Voting members include designated provider representatives from various medical groups, dental groups, behavioral/mental health groups, and county agencies. The Samaritan Health Plan Operations' Chief Medical Officer vote is reserved as a tiebreaker. Quorum size for voting is a majority of voting members. Vote by proxy representation is permitted if documented and delivered by a representative from the same medical/dental/behavioral/mental health/ group or county agency.
MEMBERSHIP	1. Samaritan Health Plan Operations Chief Medical Officer – Chairman 2. Samaritan Health Plan Operations Quality & Health Outcomes Manager 3. Designated Samaritan Health Plan Operations Staff 4. Designated provider representatives as noted above
REPORT TO	Samaritan Health Plan Operations' Chief Medical Officer and Samaritan Health Plan Operations' Chief Executive Officer on an ongoing basis; appropriate Board of Directors on at least a quarterly basis.

Original Approved: **QMC** 12/12/12
Revised/approved: **QMC** 5/14/13; 3/11/14; 3/10/15; 1/12/16

Optimize the health system taking into account three dimensions: the experience of the individual; the health of a defined population; per capita cost for the population

The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the "Triple Aim":

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

Concept Design

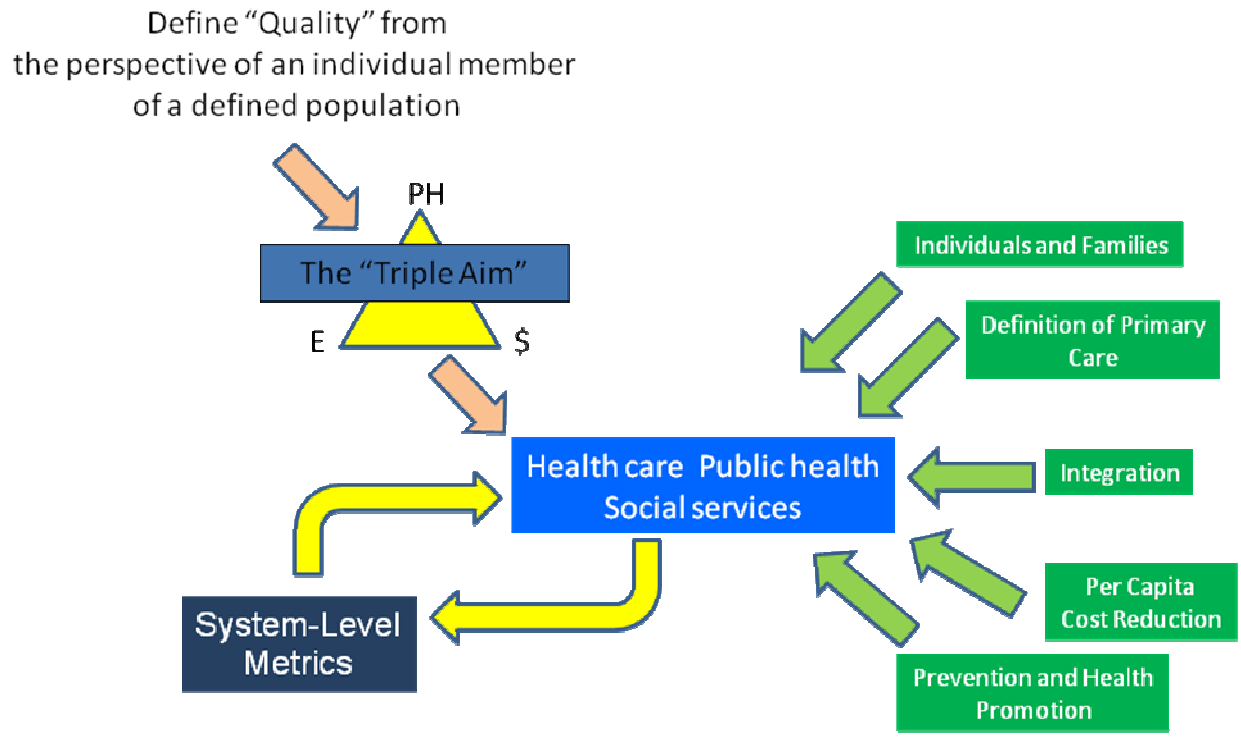
IHI's innovation team developed a concept design and described an initial set of components of a system that would fulfill the IHI Triple Aim. The five components are listed below, and a more detailed list can be found in the Concept Design document (attached).

- Focus on individuals and families
- Redesign of primary care services and structures
- Population health management
- Cost control platform
- System integration and execution

INSTITUTE FOR HEALTHCARE IMPROVEMENT

Triple Aim – Concept Design

Optimize the health system taking into account three dimensions:
the experience of the individual; the health of a defined population; per capita cost for the population



Dimension	***Measure***
Population Health	1. Health/Functional Status: single-question (e.g., from CDC HRQOL-4) or multi-domain (e.g. SF-12, EuroQol). 2. Risk Status: Composite health risk appraisal (HRA) score. 3. Disease Burden: summary of the prevalence of major chronic conditions; summary of predictive model scores. 4. Mortality: life expectancy; years of potential life lost;standardized mortality rates. *Note: Healthy Life Expectancy (HLE) combines life expectancy and health status into a single measure, reflecting remaining years of life in good health. See http://reves.site.ined.fr/en/DFLE/definition/.*
Patient Experience	1. Standard questions from patient surveys, for example: - Global questions from US CAHPS or How's Your Health surveys - Experience Questions from NHS World Class Commissioning or CareQuality Commission - Likelihood to recommend 2. Set of measures based on key dimensions (e.g., US IOM Quality Chasm aims: Safe, Effective, Timely, Efficient, Equitable and Patient-centered).
Per Capita Cost	1. Total cost per member of the population, per month. 2. Hospital and ED Utilization Rate.

INSTITUTE FOR HEALTHCARE IMPROVEMENT

Triple Aim – Concept Design

1. Individuals and Families

The Chasm Report of the Institute of Medicine in the United States contains the following two passages.

> *"Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over the decisions that affect them. The health care system should be able to accommodate differences in patients' preferences and encourage shared decision making."*
>
> *"The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice or when choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction."*

A. For medically and socially complex patients, establish partnerships among individuals, families and caregivers, including identifying a family member or friend who will be supported and developed to coordinate services among multiple providers of care.
B. Jointly plan and customize care at the level of the individual.
C. Actively learn from the patient and family to inform work for the population.
D. Enable individuals and families to better manage their own health.

2. Redesign of "Primary Care" Services and Structures

Basic health care services are provided by a variety of professions: doctors, nurses, mental health clinicians, nutritionists, pharmacists, and others.

A. Have a team for basic services that can deliver at least 70% of the necessary medical and health-related social services to the population.
B. Deliberately build an access platform for maximum flexibility to provide customized health care for the needs of patients, families, and providers.
C. Cooperate and coordinate with other specialties, hospitals, and community services related to health.

3. Prevention and Health Promotion

A. Work with the community to advocate and provide incentives for smoking prevention, healthy eating, exercise, and reduction of substance abuse.
B. Develop multi-sector partnerships, utilize key stakeholder resources (worksites, schools, etc.) and align policies to provide community-based support for all who wish to make health-related behavior change.
C. Integrate healthcare and publicly available community-level data utilizing GIS mapping to understand local context to determine where and for whom health-related strategic community-level prevention, health promotion and disease-management support interventions would be most useful.

4. Cost Control Platform

Many countries are concerned with the rate of increase in health care spending. In the United States the task of mitigating this increase is termed "impacting the trend." In United Kingdom and other countries with government sponsored health care systems it is framed as "receiving value for money."

A. Achieve < 3% inflation yearly for per capita cost by developing cooperative relationships with physician groups and other health care organizations committed to reducing the waste of health care resources.
B. Achieve lowest decile performance in the Dartmouth Atlas measures by breaking or countering incentives for supply-driven care.
C. Reward health care providers, hospitals, and health care systems for their contribution to producing better health for the population and not just producing more health care.
D. Orient care over time - the "patient journey" - targeted to the best feasible outcomes.

Triple Aim – Concept Design

5. System Integration

If the experience of the individual is the primary driver of the Triple Aim system, the health of the population and the per capita cost become constraints. Individuals cannot get all the services that they might want or perhaps even need.

A. Match capacity and demand for health care and social services across suppliers.
B. Insure that strategic planning and execution with all suppliers including hospitals and physician practices are informed by the needs of the population.
C. Develop a system for ongoing learning and improvement.
D. Institute a sustainable governance and financial structure for the Triple Aim system
E. Efficiently customize services based on appropriate segmentation of the population.
F. Use predictive models and health risk assessments that take into account situational factors, medical history, and prior resource utilization to deploy resources to high-risk individuals.
G. Set and execute strategic initiatives related to reducing inequitable variation in outcomes or undesirable variation in clinical practice.