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Our Mission is to improve your health and well-being.

ProMedica Values

WE ARE ONE PROMEDICA, UNITED BY THESE VALUES.

**Compassion**
We treat our patients and each other with respect, integrity and dignity. Because each of us is a caregiver, our actions, words and tone let others know we truly care about them.

**Innovation**
We continually search to find a better way forward. We seek and embrace changes that enable us to deliver high-quality care and the best possible outcomes.

**Teamwork**
We are an inclusive team of diverse and unique individuals who collaborate to meet the ongoing needs of our patients and communities. We partner with others because we are better together than apart.

**Excellence**
We strive to be the best in all we do; we value lifelong learning, practice continuous improvement and provide exceptional service in living our Mission to improve your health and well-being.
QUALITY IMPROVEMENT PROGRAM OVERVIEW

It is inherent to Paramount’s philosophy that quality improvement is not the responsibility of any single individual or department, but the duty of every employee and contracted provider. Paramount is committed to using a continuous quality improvement cycle in managing all clinical and administrative services. Clinical monitors address all demographic groups, care settings and types of service. Indicators of performance are measured across all pertinent products. Paramount is also dedicated to satisfying customer expectations, and to respecting all people by listening to and supporting them.

PURPOSE

The Quality Improvement Program provides a formal process by which Paramount and its participating providers and practitioners strive to continuously improve the level of care and service rendered to members and customers. It utilizes objective and subjective indicators to measure and evaluate the quality and safety of clinical services provided to members. The program addresses both medical and behavioral health care, and the degree to which they are coordinated. It defines the systematic approach used to identify, prioritize and pursue opportunities to improve services, and to resolve identified problems. The Quality Improvement Program is reviewed, updated and approved by the Medical Advisory Council and forwarded to the Board of Directors at least annually. It is distributed to applicable regulatory bodies and other stakeholders, as requested.

OBJECTIVES

Specific program objectives have been developed to guide quality improvement activities. The objectives of the Quality Improvement Program, as approved by the Board of Directors are as follow.

- To continuously improve the caliber and delivery of clinical and administrative services to Paramount customers through systematic monitoring of critical performance indicators, identifying barriers to improvement, and implementing specific strategies to improve products, processes, and outcomes
- To annually evaluate the efficiency and effectiveness of the Quality Improvement Program, including its structure, processes, outcomes, methodology, and results
- To evaluate at least annually the efficiency and effectiveness of performance from any subcontracted agents or service providers
- To assure that all members are treated with dignity and respect, and are provided with appropriate, understandable education and information to accept responsibility and actively participate in personal health care decisions
- To use evidence-based guidelines as the basis for all clinical decision-making
- To support public health goals, as appropriate for the populations served, by integrating them into clinical quality improvement activities
- To maintain regulatory compliance related to Paramount quality assurance and performance improvement activities
- To cultivate comprehensive patient safety practices among Paramount providers and staff, including coordination of care
- To identify disparities in health care delivery to members, and intervene to reduce them by delivering culturally and linguistically appropriate care and services
DOCUMENTATION
Three annually published documents describe Paramount’s continuous quality improvement cycle.

- Quality Improvement Program Description: A comprehensive explanation of the health plan’s Quality Improvement Program structure and objectives, including accountability and reporting relationships; outlines resources dedicated to improvement activities

- Quality Improvement Work Plan: Documents the improvement process to be implemented in the calendar year through detailed performance goals/targets and timetables, addresses clinical and administrative improvement activities throughout the organization and specifies operational accountability; offers rationale for project selection and task priorities

- Quality Improvement Program Evaluation: Presents formal assessment of the outcomes of the prior year’s quality improvement activities; compares results with baseline rates and benchmarks available at the time those activities were planned (two years prior); identifies barriers to success; includes recommendations for subsequent years

Numerous other evaluations and assessments which inform quality improvement are routinely performed and published as well. They are identified throughout this document, and an itemized schedule is included in the annual QI Work Plan.

RELATIONSHIPS OF BUSINESS ENTITIES, PRODUCTS AND PRODUCT LINES
To remain successful, Paramount’s total book of business includes multiple product lines spread across five business entities. New products are continually in development to meet the demands of the ever-changing marketplace. Except as pre-defined for certain products, Paramount operations and staffing are transparent as to product distinctions. Quality improvement, in particular, crosses all entities, product lines, and products, with very few exceptions.
ORGANIZATIONAL STRUCTURE

ACCOUNTABILITY

As the governing body, the Board of Directors bears overall responsibility for assuring that Paramount members receive high quality care and service. Two subcommittees, effective since 1992, are responsible for developing and recommending to the Board of Directors all policies associated with quality improvement. Paramount's Medical Advisory Council (MAC) is responsible for achievement of high quality delivery of medical and behavioral care, and directs quality improvement initiatives associated with clinical care and medical utilization. The Physician Affairs Council (PAC) is responsible for achieving high levels of quality involving Paramount's practitioners. Aspects of quality improvement overseen by the PAC include credentialing, contracting, network development and reimbursement. Any other quality improvement efforts are overseen directly by the Boards of Directors.

As illustrated below, the Medical Advisory Council and the Physician Affairs Council function as subcommittees of the Board of Directors. Administrative Staff is responsible for monitoring and implementing operational quality improvement activities and reports directly to the President, who is accountable to the Board of Directors.

The Chairman of the Medical Advisory Council and the Chairman of the Physician Affairs Council serve as members of the Board of Directors. The President of Paramount also serves as a member of the Board of Directors.
GOVERNING BODY

As the governing body, it is the responsibility of the Board of Directors to appoint qualified administrative and clinical personnel to direct the operations of the managed care plans. The Board of Directors, with recommendations from appropriate clinical personnel, act on all major contracts and other arrangements affecting the delivery of health care services. The Board of Directors actively supports the Quality Improvement Program as demonstrated by ongoing involvement in the policy making process of the organization.

Responsibilities
The Board of Directors has ultimate responsibility for policy setting and operation of the managed care organization, including but not limited to the following.

1. The Board of Directors annually reviews the specific goals and objectives of the plan, including a description of the services provided. This includes the Quality Improvement Program, Quality Improvement Work Plan, Quality Improvement Program Evaluation, and review of quality improvement progress reports.
2. The Board of Directors is responsible for assuring the appropriate organizational structure of the plan (see the organizational charts on pages 6-9) and also establishing appropriate councils that report to the Board.
3. The Board of Directors establishes and maintains a clearly defined system of financial management that includes an annual, independent audit of financial/operational performance, as well as internal audit procedures.
4. The Board of Directors has adopted a systematic continuous quality improvement program to assure clinical and administrative quality.
5. Long range plans, consistent with the mission, are set by the Board of Directors through a formal three-year planning process.
6. The Board of Directors assures that all plan operations and service deliveries are conducted in accordance with the spirit and intent, as well as all regulatory requirements, regarding non-discrimination including race, color, religion, gender, sexual orientation (preference), national origin, ancestry, marital status, age, Vietnam era veteran status, physical handicap or need for health services.

Meeting Schedule and Minutes
The Board of Directors meets on a bimonthly basis and maintains records necessary to demonstrate the appropriate discharge of duties.

Administration
The Board of Directors is responsible for electing, appointing or employing officers and/or administrators to direct the clinical and administrative activities of the plan. The following sections outline responsibilities of the Medical Advisory Council (page 10), Physician Affairs Council (page 11) and the Associate Medical/Clinical Directors (page 15). Organizational charts on the following pages further illustrate these administrative responsibilities. The Board has designated several physicians and other practitioners currently licensed in the states of Ohio and/or Michigan as Associate Medical/Clinical Directors.
MEDICAL ADVISORY COUNCIL

Council Structure, Role and Function
Accountable to the Board of Directors, the Medical Advisory Council (MAC) consists of up to sixteen (16) voting members, including Paramount physician practitioners representing numerous primary and specialty care categories such as those indicated below.

- Family Medicine
- Internal Medicine
- Pediatrics
- Geriatrics
- Obstetrics/Gynecology
- Colorectal Surgery
- Radiation/Oncology
- Cardiology

Ex officio members, with voting privileges, include the Senior Associate Medical Director, the Associate Clinical Director for Behavioral Health, the Chairperson of the Pharmacy & Therapeutics Work Group, the Chairperson of the Technology Assessment Work Group and the Paramount Vice President/Medical Director who represents the Medical Policy Steering Committee.

Council members are nominated and approved by the Board of Directors to serve a two-year term and may serve multiple terms. The Chairperson is appointed by the Board of Directors and serves as an ex officio member of that body. The Vice President of ProMedica Quality and Process Innovation or designee is a regularly invited guest. The Paramount Director of Quality Improvement and QI Support Coordinator provide staff support.

Purpose
The primary purpose of the Medical Advisory Council is to develop and recommend policies that govern Paramount's Quality Improvement, Condition Management and Utilization/Case Management operations. The MAC considers and evaluates all indicators of clinical and behavioral care effectiveness, patient safety, medical practice performance, and health/health care disparities.

- Develops benefit interpretation guidelines
- Makes coverage recommendations on medical technologies and pharmaceuticals
- Reviews indications for specific medical procedures
- Identifies opportunities for improvement
- Evaluates clinical guidelines (preventive and interventional)
- Assures consistency of UM guidelines and member and provider educational materials with clinical practice guidelines
- Provides oversight for all care management programs, including prescription services
- Evaluates the utilization management program annually
- Oversees compliance with clinical components for regulatory programs and accreditation
- Reviews operational implementation of medical policy

Meeting Schedule and Minutes
The Medical Advisory Council meets 6-8 times per year depending on need, with at least one meeting per quarter. Formal dated and signed minutes documenting the Council's activities, decisions, findings and recommendations are maintained for each meeting. They are available for review at the request of any regulatory or accrediting body.
PHYSICIAN AFFAIRS COUNCIL

Council Structure, Role and Function
The Physician Affairs Council (PAC) is accountable to the Board of Directors. It is composed of nine (9) voting members, including Paramount physician practitioners who represent numerous clinical specialties and types of practice such as the following.

- Primary Care Physician
- Medical Specialist
- Obstetrics/Gynecology Specialist
- Psychiatric Specialist
- Surgical Specialist

Ex officio members, with voting privileges, include the Senior Associate Medical Director, the President, and the Vice President/Medical Director.

Council members are nominated and approved by the Board of Directors and serve a one-year term. Participants may serve multiple terms. The Chairperson is appointed by the Board of Directors, and serves as an ex officio member of that body as well. Support staff to the Council includes the Director of Provider Relations, Manager of Provider Relations, Senior Credentialing Specialist from Paramount, and ProMedica legal counsel.

Purpose
The purpose of the PAC is to develop and recommend policies that govern Paramount's Provider Relations operations, such as credentialing, recredentialing, contracting, network adequacy and reimbursement. To this end, the PAC also considers and evaluates performance indicators.

- Reviews credentials and practitioner applications prior to contract execution
- Makes recommendations regarding the adequacy of the provider panel and network contracting strategy, including the availability of providers and practitioners
- Makes recommendations regarding modifications to provider payment arrangements
- Evaluates issues related to contract non-compliance
- Makes recommendations regarding any modifications to contracting criteria
- Makes recommendations regarding the composition and ability of the provider panel to meet the cultural, ethnic, racial and linguistic needs of the membership
- Oversees ongoing activities to monitor practitioner performance
- Oversees delegated credentialing activities by contracted vendors

Meeting Schedule and Minutes
The Physician Affairs Council meets bi-monthly. Formal, dated and signed minutes documenting the Council's activities, decisions, findings and recommendations are maintained for each meeting. They are available for review at the request of any regulatory or accrediting body.
PHARMACY AND THERAPEUTICS WORKING GROUP

The Pharmacy and Therapeutics (P&T) Working Group is a permanent subcommittee of the Medical Advisory Council (MAC). The P&T Working Group recommends policy action related to pharmaceutical management to the MAC, which in turn is accountable to the Board of Directors. The P&T Working Group participates in formulary decisions, and meets CMS requirements for Medicare Part D plans.

Working Group Structure, Role and Function
The Pharmacy and Therapeutics Working Group includes up to fifteen (15) members representing clinical specialties and expertise such the following. Additional positions may be added as determined to be appropriate.

- Internal Medicine
- Infectious Diseases
- Endocrinology
- Rheumatology
- Psychiatry
- Geriatric Medicine
- Hospital Pharmacy
- Retail Pharmacy
- Advance Practice Nursing
- Physician Assistant
- Geriatric Medicine
- Hospital Pharmacy
- Retail Pharmacy
- Advance Practice Nursing
- Physician Assistant

The Medical Director of ProMedica Physician and Continuum Services is an ex officio member of the P&T Working Group. Paramount Prescription Drug Program Coordinators are voting members. One staff representative from Utilization/Case Management serves as a non-voting member.

The Vice President of Operations, ProMedica Physicians; Vice President of Medical Affairs, ProMedica Toledo Hospital; Vice President/Medical Director, Paramount; and Vice President, ProMedica Quality and Process Innovation are regularly invited guests.

The purpose of the P&T Working Group is to develop policies, procedures and programs that will:

- Minimize the adverse events and side effects of pharmaceuticals
- Maximize the therapeutic outcomes of pharmaceuticals
- Evaluate and promote use of cost effective pharmaceuticals

Specific functions include reviewing and making recommendations in regard to the following.

- Requests for prescription drug benefit changes
- Formulary development, review and maintenance
- Criteria for utilization management tools (prior authorization, step therapy, quantity limits)
- Practice guidelines as they relate to pharmaceuticals
- Responsibilities delegated to pharmacy benefits manager
- Drug utilization review (DUR) activities
- Care management programs, e.g., Asthma, Chronic Heart Failure, Hyperlipidemia, and Adherence programs

Meeting Schedule and Minutes
The P&T Working Group meets bimonthly. Formal, dated and signed minutes of working group business are maintained, and reported to the Medical Advisory Council. They are available on request to any regulatory or accrediting body.
TECHNOLOGY ASSESSMENT WORKING GROUP

The Technology Assessment Working Group (TAWG) is a subcommittee of the Medical Advisory Council. It is responsible for evaluating, and recommending to the MAC for approval, issues relating to new medical technology, behavioral health procedures, devices or new applications of existing technology. The TAWG is also responsible for development and annual review of internal prior authorization criteria for utilization management. The MAC is in turn accountable to the Board of Directors.

**Working Group Structure, Role and Function**

The Technology Assessment Working Group consists of eight (8) voting members including Primary and Specialty Care Practitioners, and Paramount staff from Utilization and Case Management. Additional specialists and sub-specialists are added in consultation, as needed, for input and recommendations relative to the technology being discussed.

Additional positions may be added when appropriate. The Health Services Administrative Assistant serves as staff support to this working group.

The purpose of the Technology Assessment Working Group (TAWG) is to critically review and evaluate new and emerging technology, behavioral health procedures, devices and new applications of existing technology and clinical services. If coverage is recommended, the TAWG develops medical necessity criteria (if needed) and evaluates the criteria on an annual basis, or more frequently as new information becomes available. The TAWG makes recommendations to the MAC for inclusion in the benefit package to keep pace with changes and to ensure that members have equitable access to safe and effective care.

The TAWG will evaluate the new technology utilizing the following resources, as applicable; Centers for Medicare and Medicaid Services policy, HAYES Medical Technology Directory®, the Food and Drug Administration (FDA), current medical/behavioral health scientific literature and practicing subspecialty physician input. Coverage decisions will be based on the following criteria; safety, efficacy, cost and availability of information in published scientific literature regarding controlled trials.

**Meeting Schedule and Minutes**

The Technology Assessment Working Group meets monthly, or more frequently as the need arises. Formal, dated and signed minutes documenting the Working Group’s activities, decisions, findings and recommendations are maintained, and reported to the Medical Advisory Council. They are available for review by any regulatory or accrediting body upon request.
MEDICAL POLICY STEERING COMMITTEE

Paramount’s Medical Policy Steering Committee is an operational entity charged with the task of implementing medical policy decisions. Due to this essential and critical role, the committee reports to the Medical Advisory Council.

Purposes
• Sustain a venue by which provider reimbursement/coverage guidelines can be discussed and determined
• Develop medical policy reimbursement/coverage guidelines
• Defining reimbursement issues and payment methodology
• Establish financial support as well as software capability for each policy presented

Committee Composition and Individual Roles
• Vice President/Medical Director – Responsible for the direction of medical/healthcare services including provider contracts, medical expense, federal and local coverage standards, Hayes, local contracts, utilization issues, and new technology.
• Associate Medical Director(s) – Responsible for providing supplemental information regarding specific medical procedures or services (e.g., current medical studies).
• Claims Director – Responsible for the evaluation and impact of the policy as it relates to claims processing, and support of the medical policy through existing claims procedures.
• Provider Relations Manager – Responsible for the evaluation and impact of the policy as it relates to the Provider Relations and Provider Inquiry Departments, and support of the medical policy through their existing policies and procedures.
• Utilization/Case Management Director – Responsible for the evaluation and impact of the policy as it relates to the Utilization Department, and the support of the medical policy through existing utilization policies and procedures.
• Benefit Administration Manager – Responsible for the evaluation of the medical policy as it relates to AMISYS configuration, specifically for pricing and benefits.
• Finance/Medical Expense Analyst – Responsible for analysis of the issue by determining the financial impact on the plan.
• Claims Provider Appeals/Health Data Analyst Team Leader – Responsible for issues that may affect the medical policy as it relates to the bundling (software) edit logic; and coordination of agenda items to be presented to the Medical Policy Steering Committee.

Meeting Schedule and Minutes
The Medical Policy Steering Committee meets bimonthly. Formal dated and signed minutes documenting the committee's activities, decisions, findings, and recommendations are maintained for each meeting, and reported to the Medical Advisory Council. They are available for review at the request of any regulatory or accrediting body.
ASSOCIATE MEDICAL/CLINICAL DIRECTORS

A team of Associate Medical/Clinical Directors serves as expert consultants retained by the health plan. The team reports to Paramount's Vice President/Medical Director, and represents the following clinical specialties such as the following. Additional consultants are engaged as needed.

- Family Medicine
- Pediatrics
- Dentistry
- Psychology
- Internal Medicine
- Geriatrics
- Podiatry
- Psychiatry

Role of the Team
Associate Medical/Clinical Directors guide the development and integration of Medical/Behavioral Management, the Disease Management and the Utilization Management and Quality Improvement Programs. As an aggregate body, the Associate Medical/Clinical Directors are involved in all clinically related activities. They provide medical/clinical expertise for utilization and case management questions as they arise in daily operations. The team also assists their peers with interpretation of policies adopted by the Board of Directors.

Individual Responsibilities
On an individual basis, Paramount Associate Medical/Clinical Directors assume responsibility, relevant to their specialty or expertise, for several specific functions.

- Evaluate appropriateness of requests for out-of-plan referrals, inpatient admissions and other pre-certifications (also known as Physician/Dental/Behavioral Health Reviewers)
- Review and critique health education materials developed for physicians and members, and assure consistency of content with approved clinical guidelines
- Review clinical appeals from physicians and members
- Enhance direct communication with providers (e.g., prescription drug profiling, performance feedback, medical expense profiling)
- Participate in selection or development of clinical practice guidelines
- Advise nurse case managers on clinically pertinent aspects of care
- Investigate reported quality of care cases and take/recommend action as appropriate
- Review and critique the Quality Improvement Program Description, Annual Quality Improvement Work Plan, Annual Quality Improvement Program Evaluation, the Utilization/Case Management Program Description, Steps2Health™ Program Evaluations and NCQA Accreditation documentation
- Contribute to implementation of regulatory agencies’ quality programs
- Provide input into development and review of Medical Policy Guidelines for claims payment

Associate Medical/Clinical Directors also influence Quality Improvement activities by actively participating in leadership roles as described with MAC, PAC, P&T, TAWG and the Medical Policy Steering Committee.
PRESIDENT

The President of Paramount reports to the Board of Directors. Through oversight of Administrative Staff, the president directs Paramount in its mission and objectives to promote delivery of high quality health care and service to plan members in all markets.

As described in the company's organizational chart (page 6), three Vice Presidents report to the President.

**Vice President, Health Services / Medical Director** – Responsible for medical and pharmaceutical utilization management, case management, quality improvement, condition management, wellness promotion, provider relations and the clinical functions within all products.

**Vice President, Marketing** – Charged with managing membership growth and retention through market assessment for risk and opportunity, ensuring provision of market-driven managed care services and products, communicating on Paramount's behalf with labor organizations and affiliated employer groups, public relations, member services, and overseeing government-financed products.

**Vice President, Operations & Finance** – Accountable for the plan’s financial performance, increasing the value of Paramount, long-range business planning and development, facilities (infrastructure) management, and regulatory compliance.

ADMINISTRATIVE STAFF

Paramount's Administrative Staff is the leadership team responsible for coordinating interdepartmental and cross-product activities, including operations and service improvement activities. The Administrative Staff consists of Paramount’s president, vice presidents, and directors. The Administrative Staff team meets monthly. Signed and dated meeting minutes documenting activities, findings, decisions and recommendations are maintained for each meeting and are available for review at the request of all regulatory and accrediting bodies.

These key management positions, with their specific accountabilities and reporting relationships, are listed below. (Also see organizational charts on pages 7-9.)

**Quality Improvement Director** - Reports to VP/Medical Director - Provides ongoing and documented assessment of all aspects of quality improvement processes and outcomes; manages clinical improvement interventions and disease management; manages accreditation process to ensure compliance with NCQA standards; responsible for HEDIS® reporting, CAHPS® surveys; publishes newsletters, practice guidelines and educational materials; consistently administers plan policies, procedures and practices within QI/DM department.

* The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).
** The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
Utilization/Case Management Director - Reports to VP/Medical Director - Manages ongoing assessment of all aspects of patient care to ensure coordinated delivery of high quality, safe, and cost-effective medical and behavioral health care to all Paramount members; ensures member satisfaction with case management; administers plan policies, procedures, and practices appropriately throughout the Utilization/Case Management department.

Provider Relations Director - Reports to VP/Medical Director - Manages Paramount's provider network of qualified physicians, practitioners and provider facilities including credentialing and contracting; ensures responsive, accurate information to provider inquiries; responsible for provider satisfaction with Paramount services; consistently administers plan policies, procedures, and practices within the Provider Relations and Provider Inquiry departments.

Federal Programs Director - Reports to VP Marketing - Ensures the Medicare Advantage (Elite) and related products associated with federal programs are compliant with standards and regulations, including mandated reporting; responsible for profit and loss of federal products; responsible for satisfaction of Elite membership; consistently administers plan policies, procedures, and practices within the Federal Programs department.

Marketing Director - Reports to VP Marketing - Implements strategic marketing plans; maintains brokerage relationships; ensures Paramount's compliance with state departments of insurance regulations for sales; oversees operational performance of Paramount Care of Michigan; consistently applies plan policies, procedures, and practices within the Marketing department.

Member Services Director - Reports to VP Marketing - Manages operation of large-volume call center for member inquiries on benefits and coverage; oversees resolution of problems throughout the member appeals process; ensures member satisfaction with non-clinical Paramount services through responsiveness to member inquiries, member education and resolution of member issues; consistently applies plan policies, procedures, and practices within the Member Services department. Also directs ProMedica Call Center (24-hour nurse line, answering service, etc.)

Finance Director - Reports to VP Operations and Finance - Responsible for accounting, financial reporting, and tax functions; facility management; subrogation and accounts receivable; ensures plan policies, procedures, and practices are consistently administered within the Finance department in accordance with current federal and state requirements.
Claims Director - Reports to VP Operations & Finance - Accountable for claims administration; ensures all plan policies, procedures, and practices are consistently administered in accordance with current federal and state requirements within the Claims department.

Actuarial Services Director – At the time of publication, this is a vacant position with a decision pending about restructuring. In the interim, underwriting and actuarial staff report directly to the VP Operations and Finance.

Decision Support Services Director – Reports to VP Operations and Finance – Responsible for medical expense analysis and risk analysis; oversees planning and budgeting; oversees group reporting and TPA services; consistently administers plan policies, procedures, and practices within the Decision Support Services department.

Regulatory Compliance Administrator/ Privacy Officer – Reports to VP Operations and Finance – Responsible for ensuring that plan remains in compliance with applicable federal, state and local rules and regulations for all products; directs HIPAA privacy program; two direct reports.

Information Systems Director/Security Officer - Reports to ProMedica’s Chief Information Officer with business unit responsibility to Paramount’s President - Responsible for performance, integrity, security and user satisfaction with the Managed Care, Financial, Telecommunications and networked systems; ensures that automated systems contribute to Paramount’s mission; oversees functional operations and compliance with current federal, state and local standards, guidelines and regulations governing the facility; maintains provider data base and fee schedules; responsible for claims system configuration; consistently manages the Information Systems department in accordance with plan policies, procedures, and practices.

Human Resource Director - Reports to ProMedica’s Vice President of Human Resources with business unit responsibility to Paramount’s President - Develops and implements human resource policies and practices that are in concert with Paramount's objectives, philosophy and regulatory requirements, including salary/wage program, recruitment, interviewing, hiring, discipline, counseling, personnel records maintenance, staff education/training, morale programs and employee relations; consistently applies plan policies, procedures, and practices within the Human Resource department; has one Paramount direct report.

Operational Management staff members, accountable to the directors listed above, include Managers of Membership; Application Services; Configuration Services; Technical Services; Provider Relations; Utilization Management; Case Management; Medicare Risk Adjustment; and Brokerage & PPO Sales. There are also numerous team leaders, supervisors, and program coordinators as shown on pages 7-9.
QUALITY IMPROVEMENT STAFF

The Vice President/Medical Director is designated as the senior executive responsible for Paramount's quality improvement plan. Reporting to him, the Quality Improvement Director is responsible for analyzing clinical needs of the membership in order to develop relevant clinical initiatives, preventive health services and condition/disease management programs. To meet these responsibilities, the Quality Improvement department is involved in developing and implementing quality improvement policies and procedures, producing and evaluating quality related data, conducting statistical analyses to identify real and potential quality problems, producing specific quality improvement initiatives based on those findings, and reporting on quality improvement.

All Quality Improvement department staff members who are responsible for development and/or implementation of quality improvement initiatives have the appropriate and necessary clinical education, and experience. The following Quality Improvement positions report to the Director. Descriptions include tasks associated with all products, not just Paramount Care, Inc.

• The Senior Quality Improvement Coordinator is responsible for documenting clinical quality improvement activities to assure compliance with regulatory agencies’ quality requirements; assists with implementing activities required for compliance with CMS regulatory requirements; conducts chart reviews for HEDIS® hybrid measures and other studies as necessary.

• The Senior HEDIS® Data Analyst is responsible for producing and submitting Health Outcomes Survey (HOS) and CAHPS® samples, accurate HEDIS® reports in compliance with NCQA and CMS guidelines for the commercial and Medicare (Elite) product lines; and serves as liaison with the HEDIS® software vendor and HEDIS® Auditor.

• The Quality Improvement Project Coordinator III provides support to assure compliance with National Committee for Quality Assurance (NCQA) accreditation; conducts statistical and qualitative analyses; coordinates the patient safety and health care disparities/cultural competency programs; reports on quality of care issues; and manages other projects.

• The Wellness & Publications Coordinator is responsible for published and web-based communication with members, providers, and employer groups; and leads Paramount wellness initiatives.

• The Quality Improvement Support Coordinator provides logistical support to quality improvement activities, and provides administrative support for quality of care function and for QI Department.

• Quality Resource Coordinators (QRCs) are accountable for developing, implementing, and evaluating clinical quality improvement activities as approved by the Medical Advisory Council, and serve as inter/intradepartmental resources for quality improvement. QRCs are generally assigned to projects for which their professional experience is most suitable. QRCs participate in annual HEDIS® chart reviews.
• Medical Records Coordinators are responsible for implementing and tracking all Paramount medical record review activities, including HEDIS® hybrid data collection, and other practitioner chart audits.

• The Quality Improvement Data Analyst assists with various QI activities such as coordinating HEDIS® data chases; loading, validating, manipulating and reporting multi-source data for DM; and creating ad hoc reports and databases.

• The Disease Management Program Coordinator is responsible for coordination of inter/intra-departmental activities related to Steps2Health condition management programs, including program development, registry maintenance, and outcome reporting.

• The Disease Management Specialist collaborates with the Disease Management Program Coordinator on internal DM programs and other clinical initiatives to improve member health.

• Health Educators (I and II) are integral to the Steps2Health team with responsibility for outreach, individual education, and documenting outreach for members enrolled in the Paramount’s condition management programs. Health educators work staggered shifts to accommodate member schedules.

Numerous staff members are responsible for specific aspects of quality management that reside in other various departments, as described previously (pages 17-18).
INTERDEPARTMENTAL COORDINATION OF QUALITY

Interdepartmental coordination is facilitated by each vice president (i.e., each unit's vice president meets regularly with department directors/managers to coordinate activities). Additionally, all department directors meet monthly (Administrative Staff meetings, see page 16) to coordinate activities across divisions. Management retreats (including operational management staff) are held three times each year for the purpose of strategic planning, goal setting, addressing service issues, developing plans for product expansion, corporate training, etc.

In developing and prioritizing quality improvement initiatives, directors and managers rely on information from other departments, as well as the QI Program Evaluation. Following are some of the most commonly referenced information sources and reports.

### Information Sources and Reports

- CAHPS® Surveys
- HOS® Survey
- Member Service Survey Responses
- Appeals/Grievances
- Member Complaints
- Employer Groups
- Member Advisory Council
- Enrollment Meetings
- Regulatory Agency Projects
- Quality of Care Report
- Health Equity and CLAS Assessment

- HEDIS® Data
- Provider Satisfaction Surveys
- Reports from Delegated Entities
- Provider Appeals/Inquiries
- Access and Availability Report
- Case Management Satisfaction
- Prescription Drug Utilization Data
- Medical Advisory Council
- Physician Affairs Council
- Status Reports from Contracted Vendors
- Utilization Management Program Description

Other standing interdepartmental groups which contribute to the high quality exhibited by Paramount include the Product Review Committee (PRC), Strategic Implementation Group (SIG), NCQA Oversight Team, Disaster Recovery/Business Continuity (DR/BC) Team, Service Excellence Council, Medicare Compliance Committee, Internal Error Resolution Process (iERP) Team and Financial Improvement Group and Revenue Optimization (FIGARO) Team. Additionally, ad hoc groups with interdepartmental representation are frequently formed to coordinate individual projects, e.g. new product development or implementation of new information technology.

INTEGRATION OF QUALITY IMPROVEMENT WITH CORPORATE GOALS

Communication is critical to assure that each employee is aware of how his or her contributions meld into Paramount's overall goals for member service and continuous quality improvement. Monthly all-staff meetings are held to share information and keep all employees focused on these goals. Appropriate horizontal communication is encouraged to improve interdepartmental problem solving and to assist in prompt problem resolution for improved customer service and satisfaction.
SCOPE OF ACTIVITIES

IMPROVEMENT OF CLINICAL QUALITY

Clinical Practice Guidelines for Medical, Behavioral, and Preventive Care
Paramount recognizes that use of evidence-based clinical guidelines improves health outcomes. Following are commonly accepted medical, behavioral and preventive care guidelines, adopted by the Medical Advisory Council to guide Paramount providers in the delivery of care. Many of the standards and protocols contained within these guidelines are integral to the plan's process of monitoring the caliber of care delivered by participating practitioners. Although the value in using these guidelines is high, Paramount providers are not obligated to apply them in all circumstances.

• Adult and Senior Preventive Care Guidelines based on “Guide to Clinical Preventive Services”, US Preventive Services Task Force (USPSTF) 2009; “Guidelines for Colorectal Cancer Screening”, American College of Gastroenterology 2008; and AHRQ Recommendation on Urinary Incontinence Screening and Education for Seniors, 2010

• Pediatric Preventive Care Guidelines based on American Academy of Pediatrics (AAP) Guidelines, 2010; with additional Recommendations from AAFP and ACOG


• “Standards of Medical Care for Patients with Diabetes Mellitus”, American Diabetes Association (ADA), 2012 (Updated by ADA annually)  Note: Includes pre-diabetes

• “Recommended Childhood Immunization Schedule”, Centers for Disease Control and Prevention (CDC), 2012 (Updated by CDC at least annually)


• Prenatal and Postpartum Care Guidelines based on “Guidelines for Perinatal Care”, 6th Ed, American College of Obstetricians & Gynecology (ACOG) and AAP, Revised 2009

• Depression Guideline based on the “Recommendation on Depression Screening in Adults, Adolescents and Children”, USPSTF, 2009

• Clinical Guideline for Outpatient Management of Chronic Heart Failure based on “2009 Focused Update of American College of Cardiology/American Heart Association (ACCF/AHA) Guideline on Diagnosis and Management of CHF in Adults”, 2011

• Cholesterol Management Guideline based on the “National Cholesterol Education Program (NCEP)” Expert Adult Treatment Panel III, 2004 (Readopted 2011; update due in 2012)


• Chronic Obstructive Pulmonary Disease Guideline based on “Global Initiative for Chronic Obstructive Lung Disease (GOLD)”, NHLBI/WHO, 2009; including “Pocket Guide to COPD Diagnosis, Management and Prevention”, 2008

• Tobacco Cessation Guideline based on “Smoking Cessation Clinical Practice Guideline”, USPSTF, 2009; including “Five A’s for Intervention” and “Five R’s for Cessation”, US Public Health Service (PHS), 2008
Care Management
Paramount continues to expand its Care Management (CM) program to meet new regulatory requirements and the NCQA Complex Case Management standard. The plan implemented a risk profiling mechanism that incorporates all medical, behavioral and pharmacy claims to identify members potentially eligible for care management services.

Complex case management is the coordination of care and services provided to members who have experienced a critical event or diagnosis requiring the extensive use of resources. These members need help navigating the system to facilitate appropriate delivery of care and services, including community resources. Members that are followed in complex case management are stratified as high-risk case management. Routine case management focuses on chronic disease conditions that require monitoring and education to help members manage their conditions. This may include members in an acute care setting with continuity of care post hospital discharge issues and members with inappropriate emergency room and hospital utilization. Members followed in routine case management will typically be stratified as low- or medium-risk.

Recognized as a high-risk population, it is imperative that Paramount Elite Members have appropriate access to care and management of their health care needs. An electronic geriatric assessment tool is used to guide telephone and mail contact with these Medicare members. It allows for direct recommendation to (enlistment in) condition or case management depending on the member’s identified conditions or problems. Members found at high risk for poor health outcomes are placed into case management to facilitate coordination of care with the primary care physician.

Program objectives include wellness promotion, member health and self-care education, help with access to services, care coordination and information about community services. The Care Management program encompasses disease management and case management strategies. Detailed information about Paramount Case Management is presented in the annual Utilization and Case Management Program Description, usually published in June. Oversight resides with the MAC.

Steps2Health™ (Condition Management)
Paramount administers numerous condition management programs as described on pages 32-35. The purpose of condition management is to provide timely, appropriate intervention to every Paramount member accurately identified with one or more of the targeted diseases or conditions. The programs are designed to function as an adjunct to care provided in medical offices and to support the medical home concept. Common program objectives include consistent long-term self-management, reducing emergency services and inpatient admissions, lowering unnecessary health care costs, and prevention and/or delay of disease complications. Telephonic outreach is an integral component. Paramount’s condition management programs incorporate an opt-out process. Program oversight is the responsibility of the Medical Advisory Council (MAC, page 10).

Behavioral Health Care
As with all aspects of health care, Paramount utilizes the same quality improvement process described throughout this document to ensure that behavioral health is targeted as intensely as is physical health. Paramount does not delegate management of behavioral care to any other entity, preferring instead to promote, monitor and coordinate comprehensive clinical care.
All members have direct access to behavioral health providers; however, referral by PCPs is encouraged as a means to coordinate care, especially where medication is concerned. Paramount does not operate a centralized triage service. New legislation in 2009 initiated benefits parity for medical and behavioral care in some products.

**Quality of Care**

Quality of Care (QOC) is defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. On a continual basis, clinically-related complaints and concerns are evaluated according to a defined procedure as a means to maintain the high level of quality in care received by Paramount members.

Besides member complaints and those voiced by practitioners or providers, all employees are responsible for reporting perceived QOC concerns. They are referred to designated staff within the Quality Improvement department and reviewed by an Associate Medical Director. Reported issues (both perceived and realized) are investigated for actual or potential problems, tracked, monitored, and when appropriate, corrective action is initiated. A comprehensive Quality of Care Report is prepared for the MAC annually to inform their evaluation. It summarizes the investigations and outcomes of the prior year’s QOC cases and analyzes administrative data to identify possible quality of care patterns.

**Patient Safety**

Paramount promotes a comprehensive strategy to assure patient safety by partnering with members, physicians, practitioners, hospitals, ancillary providers and pharmacies. Education and risk-awareness are central to this on-going program, along with assessment of providers’ patient safety initiatives. Medication safety is evaluated in the QOC Report described above, and acted upon accordingly. Drug recalls, market withdrawals, and so forth are monitored on a continual basis and addressed as part of the delegated services delivered by Paramount’s contracted pharmacy benefits manager (PBM). In addition, Paramount pharmacists and the P&T Working Group review concurrent and retroactive drug utilization reports from the PBM (page 12).

Paramount participates on the ProMedica Patient Safety Steering Council as a means for monitoring and influencing patient safety across the full continuum of care delivered by ProMedica providers. Continuity and coordination of care are recognized as integral elements of patient safety, by omission and commission.

**Health Literacy/Limited English Proficiency**

Although the prevalence of Limited English Proficient (LEP) communicators among Paramount members is estimated to be about 2% at this time, other sources indicate that 3-7% of persons in the service area prefer to speak a language other than English, primarily Spanish, and a large portion of the region’s bilingual adults report speaking English “less than well”. Paramount associates who work directly with members and potential members are educated on using Language Line™ telephone interpreting services, whether in the office or in the field. Selected Paramount materials have been professionally translated into Spanish, and many alternate language health education resources are available as website links, and in print from case managers and health educators.
Practitioners are routinely advised about available interpreter services, and reminded of their obligation to provide interpretation for LEP and ASL-using patients free of charge. ProMedica providers, including the ProMedica Physicians Group, participate in a system-wide language access program managed by the ProMedica Office on Diversity.

At present, nearly 15% of the region’s adults (25 years and older) have less than a high school level education. Since this influences the ability to read and comprehend information related to one’s health and well-being, Paramount has addressed health literacy as a tool for improving members’ health outcomes, patient self-management and safety. Readability of written communications to members, careful selection of patient education materials, monitoring website usability, and educating providers about the role of health literacy are examples of these interventions.

**Health Care Disparities and Culturally Competent Care**

Paramount conducts a comprehensive, organizational self-assessment of cultural competency to assure progress in identifying and meeting the diverse needs of members, providers, staff and the community. It illustrates the racial, ethnic, age, gender, educational and socioeconomic characteristics of the regions’ population; and compares those factors to Paramount membership. The assessment also utilizes public health analyses available for many of the counties in the service area. In addition to identifying health disparities and prioritizing opportunities to achieve health equity, competence in the delivery of culturally and linguistically appropriate health care is targeted for intervention, often in collaboration with ProMedica’s Office on Diversity.

**Promotion of Member Wellness**

Education and self-management are essential factors in achieving and maintaining one’s well-being, but it is also important to recognize their status quo in order to set goals. Health assessment tools (electronic and printed) are available to all Paramount members, with some employer groups offering incentives for completion. Beyond self-assessment, Paramount provides a wide array of interactive resources for members such as weight management, smoking cessation, blood pressure control, back and neck care, and fitness. Paramount’s vendor is NCQA-certified for health appraisal and self management tools (Exp 10/20/2012), and URAC-accredited as a health content provider (Exp 6/1/2013).

Paramount is also a key participant in the ProMedica Wellness Council which coordinates and delivers outreach services and health education for the community and as an employer. For example, ProMedica volunteers staff the first aid station for all Toledo Mud Hens home baseball games.

**Healthcare Effectiveness Data & Information Set**

HEDIS® is a core set of performance measures originally developed in response to employers' need to compare health plans and now serving as the industry standard. Through detailed specifications for deriving performance measures, HEDIS® provides commonly accepted methods for evaluating and trending health plan performance. Although many measures are captured as a hybrid of claims data and medical record reviews, most are collected as administrative-only data from claims and enrollment records. Results of the annual measurement are utilized for a myriad of internal and external performance indicators as described throughout the QI Work Plan and Program Evaluation.
To generate and manage HEDIS® data, Paramount utilizes NCQA-certified software with abstraction directly into the laptop-loaded application. Reports are submitted to NCQA annually for each of Paramount's accredited HMO product lines. The reporting process and results undergo a rigorous external audit by an NCQA-approved auditor each year.

**Medicare Health Outcomes Survey**
Annually, the Medicare Health Outcomes Survey (HOS) is conducted as an adjunct to HEDIS/CAHPS® reporting. HOS captures a Medicare managed care plan's ability to maintain or improve the health of its members over time. The survey queries members’ physical and mental health status, with appropriate risk-adjustment, at the beginning and end of a two-year period. Findings from the HOS contribute to the selection and prioritization of health care interventions for Paramount’s Medicare membership.

**QUALITY IMPROVEMENT AMONG PRACTITIONERS & PROVIDERS**
Physicians, non-physician practitioners, hospitals, ancillary facilities, and all other types of health care providers contracting with Paramount are expected to maintain optimal levels of quality in their practice or service. The Physician Affairs Council (PAC, see page 11), sets performance expectations for participating (i.e., contracted) physicians, defines network composition and panel size, and exercises peer review for contract compliance and practice performance. Coordination of services among providers in different health care settings is also monitored.

**Primary Care Incentive Programs and Performance Profiles**
Since primary care practitioners are the cornerstone of Paramount's health care delivery system, it is essential to systematically assess and recognize their ability to manage patient care effectively and appropriately. A formal program was in place from 1991 to 2007 to provide practitioner-specific feedback to primary care physicians (PCPs) on performance for commercial members. The goal of the program was to achieve high quality care while controlling costs and reducing inappropriate utilization. An Elite Incentive Program was initiated in May 2005 to evaluate care and service rendered to the Paramount Elite (Medicare) population using measures of inpatient admission and emergency department utilization. It has been replaced by a pay-for-performance program that was successfully piloted in 2009 with selected, high-volume Elite primary care physicians. This program has been expanded to include over 420 PCPs across all product lines. The focus of this incentive program is clinical quality, focusing initially on diabetes care and outcomes.

Since 2005, Paramount has supplied Profiling Reports to PCPs with 100 or more commercial HMO members. These informational reports are produced semiannually for approximately 350 physicians, providing data on a number of indicators including economic measures, inpatient admissions, emergency visits, office visits, generic prescribing, and imaging visits.

**Patient Satisfaction with Practitioners**
As a complement to access and complaint analyses, Paramount surveys patient (i.e., member) satisfaction with practitioners. From year to year, the focal practitioners vary, depending on complaints, current issues, and more. Survey questions often include topics more specific to patient encounters than with CAHPS®, with data attributed to and shared with particular practitioners.
Effective 2010, Paramount collaborates with sister organization ProMedica Physicians to evaluate their physician satisfaction survey findings, obtained for the NCQA Physician Practice Connections®-Patient-Centered Medical Home™ recognition program (Exp 3/29/2014). Opportunities for improvement are identified at practitioner, group, and aggregate levels.

**Public Reporting of Performance**
Paramount encourages members and practitioners to avail themselves of publicly reported information on provider performance. Although these sources are not suitable for credentialing, many do offer valuable consumer information. Examples include CMS “Hospital Compare”, The Joint Commission, URAC, and both the Ohio and Michigan state medical boards. Selected data from these national sources are occasionally used to compare Paramount providers with industry benchmarks and with one another. In addition, Paramount identifies physicians who achieve special recognition in the physician directory.

**Practitioner Contracting and Credentialing**
All physicians and non-physician practitioners participate in a 3-year credentialing cycle and are subject to ongoing review for sanctions and complaints. Key quality-related elements of the recredentialing review include access to patients, member satisfaction with the practitioner, and performance on a variety of administrative and clinical measures.

Physician Affairs Council recommendations for recredentialing are based not only on the physician meeting established criteria, but also on peer review of utilization and quality management reports. Consideration is given to these other important quality-related issues.
- Member complaints and rate of disenrollment from the practice
- Quality of care issues (number, severity, and responsiveness to correction)
- Review of referral compliance and corrective action issues

**Facility Contracting and Assessment**
A three (3) year assessment cycle, utilized to confirm good standing with state and federal regulatory bodies and current accreditation status, provides assurance that facility providers meet high levels of quality in the care, patient safety and services they render to Paramount members. Provider facilities include, but are not limited to, hospitals, nursing homes, home health agencies, laboratories, and freestanding surgery centers. They are often referred to as organizational providers, and many of them are “sister organizations” within ProMedica.

**IMPROVING QUALITY IN ADMINISTRATIVE FUNCTIONS**

**Access and Availability of Clinical Services**
Accessibility and availability are evaluated annually for Primary Care Physicians and practitioners in high volume specialties including, but not limited to, obstetrics/gynecology and behavioral health. The combined Practitioner Availability and Access to Medical and Behavioral Health Care Report is presented annually for evaluation by both the MAC and the PAC.
Access is defined as the extent to which a member can obtain available services at the time they are needed. This refers both to telephone access and the ability to obtain appointments. Access standards have been developed and adopted in accordance with NCQA Standards and include access to general medical care as well as behavioral health care. Paramount publishes the access standards in newsletters, on the website, and in member handbooks to ensure that members and providers are aware of these expectations. Compliance is assessed from patient satisfaction survey results, complaints and grievances, HEDIS® access measures, CAHPS® data, and other vehicles, such as an occasional secret shopper survey for specialist appointments.

Availability is the extent to which the plan has secured the services of practitioners and providers of the appropriate types and number distributed geographically to meet the needs and preferences of the membership. Paramount monitors availability through several methods. Targets have been set for the percent of primary care physicians with open practices and the continued recruitment of providers in all regions. Data on practitioner-used languages other than English are routinely captured, and published as a searchable field in the directories. Subsequent to Paramount’s 2010 health equity assessment, rigorous analysis began to identify any gaps in meeting members’ linguistic needs. If at any time an urgent case-specific access or availability issue is identified, it is referred to the Utilization/Case Management Department for immediate resolution. Other member-specific or practitioner/provider-specific issues are handled by the quality of care process described earlier.

**Utilization of Health Care Services**
A valuable tool for managing health care quality is a reliable system by which to balance the volume of the services and resources delivered. Overutilization is wasteful and can even be harmful, such as excess exposure to radiation due to repeated diagnostic procedures. Underutilization can be an indication of poor use of resources, carelessness or other signals of less than acceptable health care quality. Effective January 1, 2011, the referral requirement for in-plan specialists was eliminated at the request of practitioners, to reduce administrative burden of providers and the health plan. Subsequent findings support the decision, with no significant increase or decrease in specialty care utilization. Annually, Paramount publishes a Utilization Management (UM) Program Description, as approved by the MAC. UM work plans and evaluation are incorporated into the QI documents.

**Member Advisory Council**
Another source of member input is the Member Advisory Council. This group is comprised of Paramount members who volunteer to serve on the council. Members from all product lines are eligible, and invited to participate. The purpose of the Council is to obtain member feedback on various issues, such as product changes, benefit modifications, website usability and proposed marketing campaigns. The Member Services Director facilitates these quarterly meetings and minutes are maintained.

**Member Privacy and Confidentiality of Personal Information**
Paramount respects its members’ right to privacy and is committed to protecting personal health information. Policies and procedures have been established to prevent unauthorized access to, and use or disclosure of member information in accordance with HIPAA. Paramount maintains physical, electronic and procedural safeguards to protect members’ health information. Internally, only authorized personnel who provide services to member accounts have access to protected health
information (PHI). Employees are trained to properly handle PHI and are required to sign an attestation agreeing to abide by Paramount confidentiality policies on an annual basis.

Providers and third parties who perform contracted or delegated services are required to abide by terms set forth in their contract with Paramount, a separate Business Associate Agreement and/or Confidentiality Agreement. Transmission of PHI must be secured using accepted health information industry procedures such as encryption and passwords, for signature-required delivery of packages. Paramount reserves the right to share member information as allowed by law, i.e. Paramount can use and disclose PHI for treatment, payment and health care operations activities. A member’s written authorization is required prior to use or disclosure of PHI for any other purpose. Rights and responsibilities for PHI are shared with stakeholders annually.

Complaints, Grievances, and Appeals
All members have the right to appeal an adverse decision associated with her or his care. Paramount maintains detailed policies and procedures specific to the complaint, grievance and appeal processes, ensuring they are compliant with regulations and legislation. The Appeals team fully investigates all administrative appeals before presenting them to the Directors of Member Services and Utilization/Case Management, and the Regulatory Compliance Administrator for a determination. All clinical appeals are evaluated by an Associate Medical Director.

The complaint, grievance and appeals process is an important component of the Paramount Quality Improvement Program. Through appropriate categorization of appeals, complaints and grievances, the plan can differentiate between isolated problems and issues that are more systemic in nature. Quarterly and annual reporting is provided as part of this analysis. These reports, with recommendations for mitigation and/or improvement, are reviewed by the Administrative Staff.

Consumer Assessment of Healthcare Providers & Systems
CAHPS® Surveys are utilized by Paramount, in conjunction with HEDIS®, to evaluate member satisfaction with their overall health care experience. An NCQA prescribed protocol defines sampling and administration of the survey, identifies approved vendors, requires an external audit of the process and outcomes, and specifies data submission to NCQA and the National CAHPS® Benchmarking Database (NCBD). CAHPS® is conducted for all NCQA-accredited product lines.

A summary of member satisfaction findings is reviewed by Administrative Staff, the Medical Advisory Council and the Board of Directors, to enable the following tasks.

- Identify and investigate sources of member dissatisfaction
- Identify and implement follow-up action steps on the findings
- Inform providers and members of the survey results
- Evaluate the effects of the interventional activities

Member Satisfaction with Paramount Services
In late 2009, formal quarterly surveys of the Member Service Call Center were initiated in collaboration with other health plans. Baseline results placed Paramount best and/or significantly higher than the mean on nearly all indicators. Additionally, to replace the post card survey system, Personal Call Center Representatives (PCCRs) are now evaluated via a commercial on-line survey
tool. Results are shared regularly with staff. Post-enrollment surveys are conducted by the Marketing department staff to assure sufficient and appropriate information is shared with new members. In addition, member complaints from new members are distinguished in order to identify possible opportunities to increase member understanding of their rights, benefits and Paramount procedures.

**Physician/Office Manager Satisfaction with Paramount**
Through an independent research company, Paramount routinely conducts Physician and Office Manager Satisfaction Surveys. This survey team selects offices with a large enough volume of Paramount patients to assure a valid sample. In alternating years, office managers are interviewed by telephone; physicians with a written survey. Responses to surveys are analyzed for opportunities to improve, with review by the MAC and the Board of Directors.

The surveys address topics such as the following.
- General Satisfaction with Paramount
- Satisfaction with Provider Inquiry, UCM, DM, and Provider Relations
- Satisfaction of the Prescription Drug Program
- Adequacy of hospital and physician network
- Consistency of administration of utilization policies and procedures
- Promptness and accuracy of claims payment

**Service Organization Audit**
Paramount engages in the preparation of a Service Organization Control Type I (SOC I) Report. Findings have been positive, and have also identified opportunities for improvement. Successful examination of an organization, as set forth in the AICPA’s Statement on Standards for Attestation Engagements No. 16 (SSAE 16), *Reporting on Controls at a Service Organization*, demonstrates that adequate internal controls and safeguards are in place to process transactions and other data effectively. The SOC I audit is valuable to Paramount’s relationship with customers and other service organizations.

**Operational Efficiency Strategies**
In response to ProMedica’s system-wide calls to increase productivity and effectiveness, Paramount’s Strategic Implementation Group (SIG) accepted the challenge. Its charter was expanded to include identification of potential projects, researching feasibility, and initiating change throughout Paramount. Recent examples have included developing a process to assure appropriate systems security for employee and other secured member records, conducting peer-lead workshops on commonly used software applications, and launching “Get REaL”, a process to capture and use members’ race, ethnicity and preferred language for communicating about their health.

**Business Continuity and Disaster Recovery**
Paramount maintains a detailed plan for recovering and maintaining business operations in the event of an unplanned crisis. Contingency service providers are under contract, department level training is conducted and alternate sites are monitored. In addition to physical and weather-related crises, plans have been expanded to address health situations that could simultaneously limit available staff and increase the volume of covered services to members, e.g., a flu epidemic. Plans are maintained electronically on an externally accessible shared website, and in hardcopy off-site.
SUPPORT OF COMMUNITY HEALTH STATUS AND PUBLIC HEALTH GOALS

As part of ProMedica, and reflected in the mission statement, Paramount collaborates with community and government agencies to improve the health of both its members and the community at large. This approach is demonstrated by Paramount's delivery or support of numerous community programs.

- Active participation in and support of community health coalitions and projects, e.g., Lucas County Colorectal Cancer Coalition, North West Ohio Asthma Coalition, Lucas County Tobacco Cessation Coalition, Breast Health Coalition, Preconception Health Coalition
- Active participation on governing boards of community service agencies
- Support for community events targeted toward the senior population
- Provision of health-related education programs in public schools
- Promotion of statewide immunization registry

EXTERNAL QUALITY IMPROVEMENT PROGRAMS

One of the goals of Paramount's Quality Improvement Program is to coordinate its activities with the requirements of state and federal regulatory bodies, such as the state departments of insurance and health (ODI & ODH) and the Centers for Medicare and Medicaid Services (CMS). Mandated reporting to these agencies has increased since ACA was enacted, consuming a substantial portion of resources throughout Paramount. The MAC and Administrative Staff attempt to fully integrate the requirements of these bodies in an efficient manner while maintaining compliance with numerous unique standards and regulations.
Steps2Health℠  
CONDITION MANAGEMENT PROGRAM SUMMARY

The condition management staff is a team of health care professionals dedicated to improving the health and quality of life for our members with chronic disease(s). A holistic health approach is used to promote wellness that encompasses the entire person, not just the chronic condition(s).

Paramount’s Chronic Condition Management Programs are:

- Asthma
- Chronic Kidney Disease (CKD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Heart Failure (CHF)
- High risk and Co-morbid Depression
- Diabetes Mellitus
- Migraine
- Post Acute Cardiac Event

Overall goals of condition management:

- Help members manage their condition(s) with personalized, caring, and expert support with a focus on education and strategies for:
- Development of a written individual condition-specific action plan
- Knowing and understanding personal blood pressure readings, laboratory results and goals
- Ways to reach individual goals and follow individual treatment plans
- Identification of triggers or things that cause symptoms and how to avoid them
- Decreasing the number of missed work and/or school days
- Smoking cessation
- Proper diet and exercise
- Increase the use of appropriate medications
- Improve medication and treatment plan adherence
- Increase the number of members receiving flu and pneumonia vaccinations
- Reduce use of the emergency room
- Decrease hospitalizations
- Lower unnecessary health care costs
- Prevent or delay disease problems and complications

Program content and design for each program are based on Paramount’s clinical practice guidelines or national evidence based clinical guidelines, and input from Associate Medical/Clinical Directors, appropriate specialists, and the Medical Advisory Council. Members are identified and stratified monthly through proprietary claims-based algorithms in Disease Monitor℠, a disease management software application. Members may also be identified through UM/care/case management services, health risk appraisal results, employer health fairs, physicians, or self-referral. Complete identification and stratification coding schematics are included in the program description detail for each program. Identified members are automatically enrolled in the appropriate program unless they choose not to participate, or “opt-out”, which can be done by telephone, mail or e-mail.
Each program is fully integrated and includes health coaching, case management, and pharmacy services. All educational materials are reviewed and edited to ensure consistency with clinical, utilization management, and pharmacy guidelines. Language, readability, and patient safety concerns are also evaluated.

Program components include:

- Welcome packets
- Educational mailings
- Web-based education and interactive web-based tools
- Public forums
- Individualized health coaching calls/assessments/personalized education
- Case management services
- Pharmacy services, including internal and external medication therapy management (MTM)
- Biometric monitoring for qualifying CHF and COPD members
- Patient care navigator services

**Program-Specific Details:**

Automatic triggers which signal a member’s need for health coaching and/or case management services for each clinical condition have been determined based on clinical guideline recommendations, member risk, and predictive modeling. Individual program descriptions present complete detail, including program modifications since implementation. A summary of criteria for each program follows.

**Asthma**

- Stratification levels: Low-risk and At-risk (Medication non-compliance, and/or emergency or inpatient admissions with primary asthma diagnoses)
- Promotes:
  a) Individualized written asthma action plans
  b) Use of appropriate asthma controller medication
  c) Asthma education classes
- Program effectiveness evaluation:
  a) HEDIS® Use of Appropriate Asthma Medications
  b) Acute asthma exacerbation rates
  c) Member and physician satisfaction

**Chronic Kidney Disease (CKD)**

- Renal categories: CKD Stage 3, CKD Stage 4, CKD Stage 5, or ESRD
- Promotes:
  a) Nephrology and dietary service visits, as appropriate
  b) Blood pressure, cholesterol, and A1c control
- Program effectiveness evaluation:
  a) Use of Angiotensin Converting Enzyme Inhibitor (ACE-I) or (Angiotensin Receptor Blocker (ARB) in members with CKD stages 3-4 and hypertension
  b) Member and physician satisfaction
**Chronic Obstructive Pulmonary Disease (COPD)**
- Stratification levels: Defined according to number of COPD/COPD-related exacerbations or lung cancer
  a) Low-risk=0 exacerbations
  b) Moderate risk=1 exacerbation
  c) Intermediate risk=2 exacerbations
  d) High risk=3 or more exacerbations and/or diagnosis of lung cancer
- Promotes:
  a) Pulmonary rehabilitation
  b) Individual written COPD action plans
  c) Smoking cessation
- Program Effectiveness Evaluation:
  a) Acute COPD/COPD-related exacerbation rates
  b) Member and physician satisfaction

**Chronic Heart Failure (CHF)**
- Stratification levels: All members are considered high risk and are automatically scheduled to receive telephonic outreach from case management or health educator staff
- Promotes:
  a) Control of blood pressure, cholesterol, diabetes and weight
  b) Smoking cessation and a low salt diet, as appropriate
  c) Coordination of care by the health care team
- Includes: Symptom and biometric monitoring
- Program Effectiveness Evaluation:
  a) Percentage of CHF members that receive telehealth monitoring, an annual cardiology visit, and/or have a documented ejection fraction
  b) All cause emergency room visits
  c) All cause inpatient admissions
  d) Member and physician satisfaction

**High Risk and Co-morbid Depression**
Stratification groups: High risk (suicide attempts, acute depression exacerbations), Co-morbid depression (chronic condition management disease with associated depression)
- Promotes:
  a) Antidepressant medication adherence
  b) Prompt and ongoing follow-up doctor visits after initiation of antidepressant medication
  c) Discussion with physician of depression treatment plan and potential need for change, as appropriate
  d) Management of co-existing chronic medical conditions
  e) Behavioral health provider visits, as appropriate
- Program Effectiveness Evaluation:
  a) Quick Inventory of Depressive Symptoms (QIDS) evaluation
  b) Member satisfaction
**Diabetes Mellitus**

- Stratification levels: Maintenance, Non-compliant (missing one or more guideline recommended diabetes services), or High-risk (elevated A1c or LDL levels, wounds/ulcers, acute diabetes exacerbations)

- Promotes:
  - a) Recommended annual diabetes testing
  - b) Blood pressure, A1c, blood sugar, and cholesterol control
  - c) Diabetes education classes
  - d) Endocrinology visits, as appropriate

- Program Effectiveness Evaluation:
  - a) HEDIS® Comprehensive Diabetes Care measures
  - b) Percentage of adult diabetes members on lipid lowering agents
  - c) Acute diabetes exacerbation rates
  - d) Member and physician satisfaction

**Migraine**

- Stratification levels: Maintenance (without exacerbations), Moderate risk (1 or 2 acute migraine exacerbations, members w/o prophylactic migraine medication, co-morbid depression), High-risk (3 or more acute migraine exacerbations, continuous narcotic use)

- Promotes:
  - a) Use of individual migraine diary
  - b) Education, especially related to rebound headaches
  - c) Preventive migraine medication
  - d) Visits to a neurologist or headache specialist, as appropriate

- Program Effectiveness Evaluation:
  - a) Acute migraine exacerbation rates
  - b) Member and physician satisfaction

**Post Acute Cardiac Event (Defined as MI, CABG, PTCA, Coronary vessel thrombolysis)**

Initially, all identified members are considered high-risk. After assessment, members are stratified into one of three levels.

- Stratification levels: Maintenance, Non-compliance (missing LDL screening or missing beta blocker therapy after MI), High-risk (elevated LDL or cardiac-related emergency visit or inpatient admission post event)

- Promotes:
  - a) Blood pressure and cholesterol control
  - b) Cardiac rehabilitation services
  - c) Recommended annual screenings

- Program Effectiveness Evaluation:
  - a) HEDIS® Beta-Blocker and Cholesterol Management measures
  - b) Acute cardiac related exacerbation rates
  - c) Member and physician satisfaction
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2012 QI Program Description
Paramount Care, Inc.