POLICY SUBJECT:

AHN's (AHN) Clinical Management

I. **Scope**

This document describes the requirements of Arkansas Health Network's (AHN) clinical management programs.

II. **Purpose**

The purpose of this Policy and Procedure is to describe the requirements of AHN's clinical management programs.

III. **Policy**

AHN has measures in place to evaluate and modify practice patterns. AHN documents the rationale for guideline selection, adaptation, modification, development, and implementation. AHN has a process to review data to assure that expected outcomes are occurring. AHN implements plans to encourage the establishment of processes to coordinate care that include procedures for managing consumers with chronic clinical conditions that impact the CIN goals. AHN requires and ensures that at-risk eligible consumers are offered and provided adequate education and guidance to support self-management of their at-risk factors/conditions. AHN implements consumer-centered care strategies that are consistent with the goals of the CIN and as required by payer contracts. AHN uses consumer-centered care strategies to implement evidence-based guidelines, clinical protocols, processes, and capabilities to identify the health needs of individuals served within the contracted population, and they provide (or arrange for) interventions directly to members of the population(s) based on individual assessments.

IV. **Definitions**[1]

See AHN Glossary for definitions.

V. **Procedure**

A. Consumer Care Philosophy

1. AHN implements consumer-centered care strategies that are consistent with the goals of the CIN and as required by payer contracts.
2. Participating in Care management and coordination
   a) AHN's clinical team prioritizes self-management of chronic conditions, strong relationships between consumers and their primary care providers, and seeking care in ambulatory settings as much as clinically possible.
   b) These practices encourage integration within the network. The overarching practice for care management and care coordination is to utilize data and analytics to proactively

[1] Unless specific sources are identified, definitions are adapted from the URAC Programs Glossary 2018.

develop strategies aimed at addressing the health care needs of consumers across the continuum of care.

c) These practices promote quality improvement and cost control by ensuring that consumers are receiving the right care from the right provider in the most appropriate setting at the right time.

d) These practices promote performance measurement by ensuring consumers are seeking care from CIN providers with whom AHN has data connectivity through the AHN data and analytics platform. This connectivity allows for more robust performance measuring and monitoring of CIN goals.

e) These practices promote internal and external reporting based on the goals of the CIN by utilization of the AHN data and analytics platform, which aggregates claims and clinical data, to produce and distribute internal and external reporting utilized to monitor achievement of CIN goals.

3. Managing coordinated care transitions between settings and providers
   a) AHN utilizes an advanced data analytics platform that is capable of ingesting both clinical and claims feeds. The platform serves as a data aggregator and helps ensure that care management strategies are data driven. The data analytics platform includes admission, discharge, transfer (ADT) clinical feeds from hospital based EHRs that assist AHN's clinical team members in coordinating and managing transitions of care.
4. AHN promotes specific approaches to consumer engagement including the following:
   a) Preventative care and wellness strategies for consumers, families, and caregivers.
      (1) Annual Wellness Visits
      (2) Well-Child Visits
      (3) Required Immunizations
      (4) Medication Adherence
      (5) Care Gap Closure (including preventive screenings)
      (6) Biometric Screenings
   b) Consumer education promoting active engagement in managing their health
      (1) Consumer education includes information about AHN care management including proactive consumer outreach strategies, self-referrals, and overall benefits of engaging with a RN Population Health Coach or Social Worker. Consumers are provided with education about how to contact an AHN clinical team member, common health goals and initiatives the AHN clinical team can assist with, and what to expect when engaging with the AHN clinical team.
      (2) Disease specific self-management education focused on chronic conditions such as diabetes, hypertension, COPD/asthma, congestive heart failure and others.

(3) Education is focused on recommended preventive screening and closing gaps in care, annual wellness visits, well-child visits and required immunizations, medication reconciliation and adherence.

c) Initiatives supporting self-management for consumers with chronic conditions
   (1) AHN Clinical Care Committee development of Evidence-Based Medicine Guidelines (EBGs) for chronic conditions. See AHN's website for a list of EBGs.
   (2) Proactive care management outreach to members identified with poorly controlled chronic conditions.
   (3) AHN's clinical team uses evidence-based decision support tools such as disease specific Zone Tools for self-management. Zone tools are self-management tools designed to instruct members with particular chronic conditions about signs and symptoms that can be managed at home as opposed to those requiring medical attention.
   (4) Onsite health fairs and biometric screenings.
   (5) Consumer education around use of Employee Assistance Programs.

5. Participation in available case management programs:
   a) The AHN's clinical team prioritizes self-management of chronic conditions, strong relationships between consumers and their primary care providers, and seeking care in ambulatory settings as much as clinically possible. These practices encourage integration within the network. The overarching practice for care management and care coordination is to utilize data and analytics to proactively develop strategies aimed at addressing the health care needs of consumers across the continuum of care. Consumers are proactively engaged in case management programs designed to meet CIN goals.
6. Consumer education that promotes self-management for consumers with at-risk factors and chronic conditions.
   a) Addressing at risk factors and gaps in care among underserved populations through health literacy information.
   b) Providing health literacy information that is culturally and linguistically appropriate utilizing Elsevier ClinicalKey, a consumer education tool with materials available in a variety of health literacy levels and languages.Self-management
   c) AHN requires at-risk eligible consumers are offered and provided adequate education and guidance to support provider-consumer collaboration for self-management of their at-risk factors/conditions.
      (1) Targeted at risk factors/conditions include but are not limited to: Top 15% highest risk score, transitions of care, chronic conditions, smoking cessation, quality gaps in care.

(2) Clinicians and/or care managers shall collaborate with at-risk consumers regarding self-management goals.
   (a) Examples of self-management goals include: AHN's clinical team prioritizes self-management of chronic conditions, strong relationships between consumers and their providers, and seeking care in ambulatory settings as much as clinically possible. AHN's clinical team members are trained in Motivational Interviewing and utilize these techniques while working with consumers to develop both long term and short term consumer-centered goals.
   (b) Examples of self-management support include:
      (i) Consumer access to their health records.
      (ii) Providing consumer educational information that is culturally and linguistically appropriate. Consumer education is available through Elsevier ClinicalKey. Elsevier ClinicalKey education accounts for different levels of comprehension. Materials are written at a 5th to 8th grade level, with easy to read material available at a 4th grade level. Elsevier ClinicalKey provides consumer education material in different languages and health literacy levels.
      (iii) Providing evidence-based decision support tools such as disease specific Zone Tools for self-management.
   (3) The AHN RN Manager, ACO has oversight of care management staff and requires that staff members provide self-management support to all patients enrolled in care management programs utilizing self-management support tools approved by the AHN Clinical Care Committee.

B. AHN has management practices and policies that define transparent organizational relations between clinically integrated providers. These include the following:
   1. Operational capability that facilitates communication and cooperation among CIN participants:
      a) CIN participating providers serve on AHN's Board of Managers, Chapter Advisory Boards, and Committees to support and provide input as necessary. AHN's governance chart is included in Leadership Structure and Oversight section 5 of AHN's Structure and Operations policy.
      b) Participants can contact AHN's team members via the AHN website or AHN Connect app. The AHN Newsletter serves as a method for the CIN to communicate with CIN participants and is distributed quarterly to CIN participants.
      c) Providers and patients have access to a comprehensive list of CIN participating providers and facilities via the AHN website that can be used to assist in ensuring coordination of care happens within the CIN.

d) AHN facilitates communication and cooperation among CIN participants through clinical team members that provide proactive advanced care management to consumers attributed to AHN's value-based contracts. These clinical team members coordinate care for consumers across the continuum of care working in close coordination with CIN participants.

2. Supporting organization, operational, and technical capabilities to assist with clinical decision-making and performance monitoring:
   a) At the point of care for care coordination:
      (1) Having clinical guidelines available to practitioners at the point of care for reference. AHN's evidence-based medicine guidelines are available on the AHN website and can be accessed at any time.
      (2) AHN's clinical team members provide proactive care management to consumers attributed to AHN value-based contracts and communicate with providers at the point of care about gaps in care, consumer needs, and other relevant clinical information that can be utilized to achieve CIN goals.
      (3) Risk stratification through an advanced data analytics platform identifies disease-focused, high risk, high cost consumers in need of care management and coordination.
   b) For coordinated and managed care transitions:
      (1) AHN utilizes an advanced data analytics platform that is capable of ingesting both clinical and claims data feeds. The platform serves as a data aggregator and helps ensure that care management strategies are data driven. The data analytics platform includes admission, discharge, transfer (ADT) clinical feeds from hospital based EHRs that assist AHN's clinical team members in coordinating and managing transitions of care.
      (2) AHN's RN Transition Coaches and RN Coordinator Facility Relations staff are responsible for coordinating and managing transitions of care utilizing ADT feeds in the data analytics platform and additional data sources such as the Arkansas State Health Alliance for Records Exchange (SHARE), a state-wide health information exchange (HIE) system. RN Transition Coaches and RN Coordinator Facility Relations staff communicate with CIN providers while managing transitions of care to ensure coordinated care and desired outcomes.
   c) Performance monitoring as necessary to meet CIN goals:
      (1) AHN's Clinical Care Committee is responsible for CIN performance monitoring.
      (2) AHN's data analytics platform assists in generating performance reporting for ongoing monitoring.

3. Health care services to improve measures of the health of the persons with selected conditions for quality improvement. Selected conditions and associated health care services include the following:
   a) AHN utilizes an advanced data analytics platform capable of aggregating multiple data sources to ensure a data driven care management process. All quality improvement efforts and care management outreach strategies/initiatives are selected based upon opportunities identified in the data available on this platform. Utilizing this data driven approach, AHN prioritizes care management of persons who meet the following criteria:
   b) Top 15% Highest Risk Score
      (1) Consumers in this risk category receive proactive outreach from AHN's RN Population Health Coaches. RN Population Health Coaches become part of the consumer's care team to provide proactive care management to at-risk populations in order to maintain health and minimize illness. The RN Population Health Coach is based in a central location and works with consumers telephonically to provide self-management support using motivational interviewing techniques. In collaboration with the consumer, caregivers, providers and social workers, the RN Population Health Coach creates a care plan containing both short-term and long-term health goals. The RN Population Health Coach provides high touch outreach to help the consumer achieve these goals and communicates progress and needs to the provider team.
      (2) AHN's Social Workers work closely with RN Population Health Coaches to identify barriers to medical care and provide education and links to community resources to help address those barriers. Working collaboratively with the RN Population Health Coach to provide a holistic approach to care management, the Social Worker can help with needs such as transportation, financial concerns, end of life planning, housing, food availability, access to medications, and behavioral health issues. The Social Worker is based in a central location and works with consumers telephonically to address social needs and communicates progress and needs to the provider team.
   c) Transitions of Care - including inpatient admissions/discharges, emergency department visits, and post-acute (Skilled Nursing Facility, Acute Inpatient Rehabilitation Facility, Long-Term Acute Care Hospital) admissions/discharges
      (1) AHN RN Transition Coaches provide transitional support to consumers who experience a hospitalization. With the goal of reducing readmissions, the RN Transition Coach provides face-to-face bedside coaching (as necessary) and high touch telephone follow-up for 30 days post discharge. Phone calls to recently discharged consumers at 24-48 hours, 10-14 days and 30 days post discharge allow for close monitoring of consumer progress, medication reconciliation, coordination

of necessary follow-up appointments, goal setting, education, and the ability to answer questions and escalate concerns as needed.

(2) AHN RN Coordinator Facility Relations are responsible for coordinating and managing transitions of care in the post-acute setting (Skilled Nursing Facility, Acute Inpatient Rehabilitation Facility, Long-Term Acute Care Hospital). RN Coordinators work in collaboration and continuous partnership with post-acute facilities, providers, clinics, consumers, staff and other healthcare professionals to establish and implement standardized and evidence-based care practices in the post-acute setting. The RN Coordinator Facility Relations works with consumers who discharge to a post-acute setting to ensure a smooth transition of care. They work collaboratively with post-acute facilities on a discharge plan while the consumers are in the facility. Once the consumer discharges, they hand-off care to a RN Population Health Coach in order to closely monitor consumer progress and provide medication reconciliation, coordination of necessary follow-up appointments, education and escalate concerns as needed.

d) Chronic Conditions (Diabetes, Hypertension, etc.)

(1) Utilizing AHN's data and analytics platform, a registry of consumers with identified chronic condition(s) is built and utilized by AHN's RN Population Health Coaches for tracking and monitoring compliance with cost, utilization and quality metrics associated with identified chronic conditions. Data and analytics aid in identifying high priority chronic conditions based upon prevalence, cost and quality information.

e) Smoking Cessation

(1) AHN has Certified Tobacco Treatment Specialists trained to facilitate the American Lung Association's Freedom From Smoking program. AHN offers this voluntary program to attributed consumers interested in tobacco cessation.

f) Quality Gaps in Care

(1) Utilizing AHN's data and analytics platform, quality measure performance is tracked and monitored by AHN's RN Population Health Coaches. RN Population Health Coaches proactively outreach to consumers with identified care gaps. Additionally, care gap lists are shared with CIN practices for clinic monitoring and outreach.

4. Monitoring gaps in care aimed to prevent adverse unintended consequences for medically complex/difficult to treat consumers and to improve consumer compliance with preventative care and chronic disease management. AHN utilizes an advanced data analytics platform that is capable of ingesting both clinical and claims data feeds. The platform serves as a data aggregator and helps ensure that care management strategies are data driven.

a) Monitoring for barriers to access occurs within the AHN data and analytics platform using clinical data and assessments. AHN's Social Workers assist in addressing identified barriers to access and engaging underserved groups such as:
   (1) Poor health literacy
   (2) Underserved groups related to cultural and language barriers

b) The AHN data and analytics platform is utilized to monitor and track utilization, cost, and quality performance across all of AHN's value-based contracts. Dashboards allow for ongoing monitoring and quick identification of opportunities for care management intervention. Registries of consumers identified as needing intervention from the care management team are generated and care protocols enabled in order to address a number of overarching CIN goals including (but not limited to):
   (1) Monitoring for utilization patterns:
      (a) Underutilization: consumers without a visit to a PCP in a specified amount of time, care gap closure opportunities, dropped or missed coding opportunities in particular populations
      (b) Overutilization: frequent ER or hospital utilization, hospital readmission rates, length of stay monitoring in the post-acute setting
   (2) Monitoring for ways to improve consumer compliance with preventative care and chronic disease management: care gap closure opportunities, annual wellness visit compliance and medication adherence.

C. Coordination of care program for chronic conditions or comorbidities
   1. AHN implements plans to encourage the establishment of processes to coordinate care that include procedures for managing consumers with chronic clinical conditions that impact the CIN goals.
   2. Criteria and stratification for at risk consumers is applied to the CIN population.
   3. AHN utilizes an advanced data analytics platform capable of aggregating multiple data sources to ensure a data driven care management process. This risk assessment data is updated as new claims are received within the data analytics platform as defined in AHN's HIT policy. All quality improvement efforts and care management outreach strategies/initiatives are selected based upon opportunities identified in the data available on this platform.
   4. Consumers are identified as those with targeted clinical condition(s) via the following methods:
      a) Health risk assessment data
      b) Claims data ingested in the AHN data an analytics platform
      c) Clinical data feeds ingested in the AHN data and analytics platform such as Admission, Discharge, Transfer (ADT) feeds, ambulatory electronic health record (EHR) feeds, Health Information Exchange (HIE) feeds, etc.

5. Risk stratification occurs within the data analytics platform as new claims data is received utilizing data points such as: HCC risk score, chronic condition prevalence, inpatient and emergency room utilization, total cost of care, and gaps in care.
6. Methods used to identify at-risk consumers are validated in collaboration with AHN's data and analytics platform vendor, the AHN data and analytics team (data analyst, Manager of Data and Analytics), and AHN's clinical team leadership (Market Vice President of Population Health, RN Manager, ACO).
7. Utilizing this data driven approach, consumers who meet the following criteria are targeted for specific care coordination and clinical management activities:
    a) Top 15% Highest Risk Score
    b) Transitions of Care - including inpatient admissions/discharges, emergency department visits, and post-acute (Skilled Nursing Facility, Acute Inpatient Rehabilitation Facility, Long-Term Acute Care Hospital) admissions/discharges
    c) Chronic Conditions (Diabetes, Hypertension, etc.)
    d) Smoking Cessation
    e) Quality Gaps in Care
8. Identify non-established consumers for outreach
    a) AHN utilizes an advanced data analytics platform to identify non-established consumers. AHN's data analytics platform is capable of aggregating multiple data sources to ensure a data driven care management process. This platform allows for the identification and tracking of underutilization in a population. This includes identification and outreach to consumers without a visit to a PCP in a specified amount of time, care gap closure opportunities, dropped or missed coding opportunities in particular populations.
9. Stimulate outreach efforts when indicated to establish clinical relationships to address high-risk conditions and care gaps.
    a) Any consumer who is identified as meeting the criteria outlined in a registry within the AHN data and analytics platform is eligible for outreach. The consumers within a registry are assigned to an AHN clinical team member within the data and analytics platform. Once assigned a clinical team member, that AHN coworker is responsible for outreaching to and engaging the consumer in care management.
    b) AHN tracks all care management outreach within the data and analytics platform. Registries are developed to identify eligible consumers meeting specific criteria. Registries automatically refresh and rerun on a frequency defined by AHN. This can range from daily, quarterly, annually, or ad hoc depending upon the data source and criteria outlined. Once an eligible consumer identified in a registry is assigned to an AHN clinical team member, that coworker is responsible for outreaching to and engaging the consumer in care management. Care protocols define the tasks and frequency of outreach to be completed by AHN's clinical team members. Registry criteria is developed

by AHN's Market Vice President of Population Health and RN Manager, ACO in collaboration with the AHN data and analytics team. Care protocols are developed by the AHN Market Vice President of Population Health and RN Manager, ACO.

c) Specific triggers that may warrant repeating risk stratification may include, but are not limited to:
   (1) changes to a population (i.e. significant addition or deletion of consumers),
   (2) newly identified factors contributing significantly to overall risk that were not previously utilized to identify high risk individuals,
   (3) requests from a client,
   (4) key performance indicator (KPI) reporting needs, or others.

d) Selection of the specific criteria utilized to develop a high risk registry within the AHN advanced data analytics platform can be customized for a population. An initial review of factors contributing towards the overall risk of a population is carried out first. Following that review, examples of criteria used to help identify at-risk consumers pertinent to the population served may include a combination of the following:
   (1) Risk factors: HCC risk scores, risk factors identified following completion of a Health Risk Assessment, SDoH risk factors
   (2) Chronic conditions: Diabetes, Hypertension, COPD, CHF, Chronic Kidney Disease, Cancer, or other prevalent chronic conditions
   (3) Comorbidities/poly-morbidities: Consumers with more than one chronic condition
   (4) Medically complex states: Consumers with high claims costs, multiple chronic conditions, uncontrolled chronic conditions, high inpatient and/or ER utilization
   (5) Behavioral health and substance use disorders: Depression, Substance Abuse
   (6) Gaps in care

10. Inclusion and exclusion criteria for identifying targeted conditions pertinent to the population served is as follows:
    a) Inclusion criteria: Any consumer attributed to an AHN value-based contract is eligible for inclusion in registries created in the AHN data and analytics platform.
    b) Exclusion criteria: AHN excludes the following consumers from the registries created in the data and analytics platform for proactive outreach:
       (1) deceased consumers,
       (2) consumers no longer attributed to an eligible AHN value-based contract,
       (3) consumers who opt out/refuse outreach.
11. Outreach efforts used by AHN include:
    a) Medication review
    b) Gaps in care outreach
    c) Assisting with transitions of care
    d) Treatment review with patients recently discharged from the hospital

e) Disease state management for high risk disease states. Examples include Diabetes and Hypertension, among others.

12. These processes are designed and implemented with the active participation of participating providers and reviewed annually by the AHN Clinical Care Committee.
13. Procedures for managing consumers with targeted chronic clinical conditions are aligned with selected clinical protocols and guidelines. Current AHN evidence-based medicine guidelines (EBGs) can be found on AHN's website and outline interventions to be implemented in the management of consumers with these chronic conditions (example: care gap monitoring, referral criteria, etc.)
    a) Care coordination and clinical management activities of these consumers include the following:
        (1) Coordination of care via consumer-centered healthcare home
        (2) Management of safe transitions of care
        (3) Medication reconciliation
        (4) SDoH
        (5) Care gap identification and closure
    b) These practices impact CIN goals by promoting quality improvement and cost control and ensuring that consumers are receiving the right care from the right provider in the most appropriate setting at the right time.

D. Health information for at-risk consumers
1. Health information is available to address the population's specific needs and characteristics including: (see sections C.1-10 for identification of high risk individuals, targeted clinical conditions, and inclusion and exclusion criteria.)
    a) Targeted conditions, including behavioral health
    b) Known prevalence of opioid and other substance use disorders
    c) Known health care disparities
    d) Preventative information using evidence-based care information and guidelines
2. Health information is available to the AHN clinical team through the AHN data and analytics platform. This platform ingests both claims and clinical data and serves as a data aggregator. AHN clinical team members engaging at-risk consumers access health information and document care management interventions utilizing this platform. Additionally, health information is accessible to the AHN clinical team through electronic health records. At-risk consumers have the ability to access their own health information through portals established within their providers' electronic health records.
3. Health education is available through Elsevier ClinicalKey. Elsevier ClinicalKey education accounts for different levels of comprehension. Materials are written at a 5th to 8th grade level, with easy to read material available at a 4th grade level. Elsevier ClinicalKey provides consumer education material in different languages and health literacy levels.

4. This health information is made available to at-risk consumers through AHN's clinical team. AHN clinical team members share and review relevant health information and education with consumers they engage in care management programs.
5. Health information is available using employer or community resources, telehealth technology and/or engaged team members to provide health information to at-risk consumers. Examples of how this is provided is as follows:
    a) Community resources: AHN's Social Workers connect at-risk consumers to local community resources to address SDoH and other risk factors.
    b) Telehealth technology: Telehealth technology capabilities are deployed and maintained by individual participating providers/clinics. Telehealth technology is available throughout the CIN network through a variety of primary care and specialty providers.
    c) Engaged health care team members: Health information is made available to at-risk consumers through AHN's clinical team and through access to their provider's portal within the electronic health record. AHN clinical team members share and review this information and education with consumers they engage in care management programs. AHN's clinical team members who engage with at-risk consumers include Registered Nurses, Social Workers, and Pharmacists, depending upon the needs and risk factors identified.
6. These health information resources are implemented with the active participation of participating providers and reviewed annually by the AHN Clinical Care Committee.
7. When making health information available to at-risk eligible consumers, privacy and confidentiality of PHI is maintained. AHN's Sponsor requires that all employed members of its workforce receive education related to confidentiality of information. This education is required to be completed by all employees during their new hire onboarding period, whenever material changes to related policies are made and education on these changes is offered, and as otherwise assigned. The expectation is that all AHN co-workers comply with all privacy and confidentiality standards outlined by AHN's Sponsor when working with consumers.
8. Evidence-based care
    a) AHN supports a multidisciplinary medical and behavioral evidence-based model of care delivery. The model of care includes considerations for SDoH.
    b) This model of care is a quality improvement tool and helps to ensure that the unique needs of each individual are identified and addressed through the program's care management practices.
9. AHN provides preventative information, services, and access to evidence-based intervention/treatment for chronically ill and poly-morbid beneficiaries for at-risk individuals. AHN's clinical team utilizes the data analytics platform to consider chronically ill and poly-morbid individuals to be at high risk.

a) High risk and rising risk members are identified utilizing the data and analytics platform and proactively engaged in care management. AHN's clinical team implements evidence-based interventions for at-risk members and tracks progress towards goals in care plans embedded in the data analytics platform.
b) At-risk individuals are proactively engaged in care plans to address medical, behavioral, and social risk factors. Multidisciplinary clinical team members work together to provide interventions focused on improving health outcomes.

10. AHN implements action plans to address identified care gaps.
    a) Care gaps may include the following
        (1) Monitoring of at-risk consumers
        (2) Disease management strategies
        (3) Disparities related to SDoH
        (4) Coordination and collaboration between health care providers
        (5) consumer engagement and activation
11. Population assessment
    a) Data is used for population assessment for all population(s) for which AHN holds contracts, irrespective of actual consumer engagement rates.
    b) AHN promotes the analysis of data to drive the model of care for preventative efforts, health care services, benefits, and availability.
        (1) The model of care provides the basic framework through which the program will meet the needs of individuals in the target population(s) and evaluate quality, care management, and care coordination.
    c) Data included in the population assessment is based on available health service area-specific information including:
        (1) Demographics, culture(s) and language(s)
        (2) Socioeconomic status
        (3) Education and literacy
        (4) Mortality rates
        (5) Chronic conditions
        (6) Health behaviors
        (7) Mental health/ substance use disorders
        (8) Infectious diseases
        (9) Violence
        (10) Access to care
12. Use of a broad base of data enables AHN to foster a multidisciplinary approach to consumer care when conducting assessments and formulating and implementing evidence-based care plans in collaboration with the consumer and caregivers. Collaboration includes input from

all disciplines on the consumer's care team, incorporating both medical and behavioral healthcare.

E. Population health management program
   1. AHN has an established population health management program. This program is approved by AHN's Board of Managers.
   2. Criteria for individual assessment and plan of care:
      a) Criteria for individual assessment and plan of care for eligible identified at-risk consumers are as follows:
         (1) Section D outlines the interventions carried out by AHN's clinical team when an at-risk consumer is identified via a registry for care management outreach. Eligible at-risk members receive proactive outreach from AHN's clinical team members. Interventions include individual health risk assessment completion as well as the development of a consumer-centered care plan.
      b) These criteria are based on population demographics, risk-types, and risk factors in the target population.
      c) At-risk consumers are identified and stratified via validated methods as noted above (see sections C.1-10 for identification of high risk individuals, targeted clinical conditions, and inclusion and exclusion criteria.) The data analytics platform then automates assignment of high risk consumers identified in a registry to AHN's clinical team for intervention. This process occurs upon initial engagement with a new population. Additionally, registries automatically refresh and rerun on a frequency defined by AHN. This can range from daily, quarterly, annually, or ad hoc depending upon the data source and criteria outlined.
   3. Prevention and wellness communications and educational information is available for all consumers including eligible at-risk and Employer-Based Population Health consumers.
      a) Communications include: Verbal communication over the phone, face-to-face communication, as needed, consumer-facing written materials (letters/mailers), and videos on AHN's website.
      b) Educational information includes: Educational information for consumers is available to AHN's clinical team through Elsevier ClinicalKey. Educational information found through Elsevier ClinicalKey covers an extensive range of health information topics and education. Additionally, evidence-based decision support tools, such as disease specific Zone Tools for self-management, are utilized by AHN's clinical team when working with an at-risk consumer.
      c) Care is culturally and linguistically appropriate. Specific strategies are implemented to assure culturally and linguistically appropriate care is provided. Health education is available through Elsevier ClinicalKey. Elsevier ClinicalKey education accounts for different levels of comprehension. Materials are written at a 5th to 8th grade level, with

easy to read material available at a 4th grade level. Elsevier ClinicalKey provides consumer education material in different languages and health literacy levels.

d) Care is evidence based. AHN uses consumer-centered care strategies to implement evidence-based guidelines, clinical protocols, processes, and capabilities to identify the health needs of consumers served within the contracted population(s). Clinically integrated providers provide (or arrange for) interventions directly to consumers of the population(s) based on individual assessments. Providers use evidence-based assessment and intervention strategies.

e) Education is focused on recommended preventive screening and closing gaps in care, annual wellness visits, well-child visits and required immunizations, medication reconciliation and adherence.

4. Performance reporting occurs utilizing AHN's data and analytics platform. All AHN generated reports are developed using this platform by AHN's data and analytics team. AHN's Manager of Data and Analytics has oversight of the data analysts who can generate performance reporting. Performance reporting is produced quarterly for Employer-Based Population Health clients, and at a minimum of annually for other contracts. Additional performance reporting comes from payor generated reports.
   a) Performance indicators are selected by the CIN with active participation of clinically integrated providers. Measures for performance include: mutually agreed upon, validated quality, cost, and efficiency key performance indicators and measures which are outlined in each individual value-based contract.
   b) The AHN Clinical Care Committee reviews and approves performance measures for various contracts/payers annually.
   c) Types of reporting include the following:
      (1) Employer-Based Population Health quarterly key performance indicators
      (2) Medicare Shared Savings Program quarterly scorecard
      (3) Payor reporting
      (4) Other ad hoc reporting produced utilizing the AHN data and analytics platform.

F. AHN provides communication, health education, and health services to consumers in a way that is culturally and linguistically appropriate. This will help to identify and intervene for the needs of at-risk consumers in the contracted population.
   1. Communication:
      a) Types of communications include:
         (1) Verbal communication over the phone
         (2) Written materials such as consumer facing letters or mailers
         (3) Written materials such as consumer facing text on the AHN website
         (4) Video materials such as consumer facing videos on the AHN website

b) Strategies to ensure that communications are culturally and linguistically appropriate and include the following:
   (1) Language lines/interpreter services
   (2) Translated written communication materials
   (3) Use of plain language when speaking
   (4) Written materials are written at a 5th to 8th grade level, with easy to read material available at a 4th grade reading level.
   (5) Communication with an authorized parent or guardian
   (6) Telecommunication tools to assist the hearing-impaired, or speech-impaired, or Braille or large font for vision-impaired consumers.

2. Health education:
   a) Types of health education include:
      (1) Verbal education over the phone
      (2) Written education such as consumer facing letters or mailers
      (3) Written education such as consumer facing text on AHN's website
      (4) Video education such as consumer facing videos on AHN's website
   b) Strategies to ensure that health education are culturally and linguistically include the following:
      (1) Translated written communication materials
      (2) Written materials are written at a 5th to 8th grade level, with easy to read material available at a 4th grade reading level.
3. Health services:
   a) Types of health services include:
      (1) This includes consumer-centered care based on the population demographics
      (2) Medication review
      (3) Assisting with transitions of care
      (4) Treatment review with consumers recently discharged from the hospital
      (5) Disease state management for high risk disease states (examples: Diabetes, Hypertension, COPD, CHF, among others)
   b) Strategies to ensure that health services are culturally and linguistically include the following: language lines/interpreter services, translated written communication materials, use of plain language when speaking, written materials that are written at a 5th to 8th grade level, with easy to read material available at a 4th grade reading level.
      (1) AHN has considerations for dietary restrictions or religious preferences.
4. The Market Vice President of Population Health and the RN Manager, ACO review materials annually to assure that the programs are culturally and linguistically appropriate.

G. Coordination of care program
   1. AHN requires clinically integrated providers to participate in processes to coordinate care.

a) The terms of the AHN, LLC Clinically Integrated Network Participation Agreement ensures that CIN providers comply with all CIN activities, including care coordination processes. The agreement outlines participant obligations and AHN's participation requirements in sections 2.1 - 2.4. Exhibit A further defines CIN Activities (section 1.5) that CIN providers are expected to participate in upon joining AHN.
b) The care coordination program is centralized by the CIN and implemented in collaboration with practice level resources.
c) The AHN care coordination model is described in section A. 1-5. and B. 5-6.

2. Providers adopt and implement procedures for care coordination and/or case management for eligible consumers identified as requiring the service.
   a) This may include procedures for how the clinically integrated provider and their team identifies a consumer's need and takes steps to address it through other providers.
      (1) Care coordination is performed by a variety of providers or practice staff (e.g., physicians, CIN care management teams, payer case management programs).
      (2) The care coordination program is centralized by the CIN and implemented in collaboration with provider practice level resources and external payer based case management programs.
   b) Care coordination procedures:
      (1) Risk stratification through data analytics identifies disease focused, high-risk, high-cost consumers for care management. See sections C.1-10 for identification of high risk individuals, targeted clinical conditions, and inclusion and exclusion criteria. Patients identified utilizing these methods are engaged in proactive care management with the AHN clinical team.
      (2) Provider patient referrals and patient self-referrals are encouraged. Providers and clinic support staff identify appropriate patient referrals. Referrals are sent to AHN's clinical team for care management support. Examples of referral criteria utilized to identify eligible patients includes, but is not limited to, patients with uncontrolled chronic conditions, multiple chronic conditions, gaps in care, high inpatient and/or ER utilization. Additionally, a patient may self-refer to the AHN clinical team by reaching out directly for care management services.
      (3) Any patient identified for care management services that is not attributed to an AHN value-based program is referred to external payer based case management to address patient needs. Additionally, strong partnerships with payer based case management programs are established to collaborate on care management services between the CIN and payer for medically complex patients. Examples include, but are not limited to, patients with complex diagnoses such as advanced cancer, end stage renal disease, or rare conditions requiring specialized treatment, patients

awaiting and/or recently receiving a transplant, etc.

(4) Providers receive training on the roles of the care management and the appropriate contacts for patient referrals.

3. Providers must have procedures for maintaining ongoing integrated relationships that support care coordination/case management activities.
   a) AHN's participants include a wide range of primary care and specialty providers, as well as hospitals, post-acute facilities such as Skilled Nursing Facilities, and relationships with payer based case management providers. AHN's providers, as well as AHN's centralized care management resources, maintain integrated relationships among CIN participants in an effort to coordinate care and achieve CIN goals.
   b) AHN designs consumer-centered multidisciplinary teams to help meet the holistic needs of the consumers in the contracted population(s).
   c) Any care management needs that are not managed by the AHN clinical team and/or provider practice level resources are referred to external payer based case management programs. Examples of patients referred to payer based case management programs include those described in Section H. 2.b.3. above.
   d) These practices encourage integration within the network. The overarching practice for care management and care coordination is to utilize data and analytics to proactively develop strategies aimed at addressing the health care needs of consumers across the continuum of care.
   e) These practices promote quality improvement and cost control by ensuring that consumers are receiving the right care from the right provider in the most appropriate setting at the right time.
4. Providers have procedures for coordinating referrals for consumers within the CIN.
   a) AHN promotes coordination and collaboration between participating providers and other health care service providers involved in a consumer's care.
      (1) AHN promotes bidirectional collaboration between participating providers and health care service providers (in and out of network).
         (a) Coordination and collaboration are optimized when clinical information is exchanged within the network and with external referral sources.
         (b) This information is exchanged through EHRs, telephone, letters or other communication methods.
         (c) Clinically integrated providers perform assessments and interventions for referral for necessary services, as needed, with shared accountability and responsibility for the outcomes of the referral by both the provider (or organization) sending and the one receiving the consumer. (Refer to the ntocc.org 7 Essential Elements of Transitions of Care)

(i) Providers refer to specialists as needed based on patient conditions and evidence based guidelines available through national organizations.
(ii) Referrals to specialists are the responsibility of the primary care physician.
(iii) AHN collaborates with network providers to improve access for patient care.

(2) Section O.1.e outlines how CIN providers are trained on referral coordination expectations.
(3) Section Q.3 above outlines how referrals are tracked and reported within the CIN.

5. Providers have procedures for notifying the type of treatments provided to patients among clinically integrated providers and where available from local hospitals, emergency rooms, and urgent care centers to clinically integrated providers.
   a) AHN promotes coordination and collaboration between participating providers and other health care service providers involved in a patient's care, including local hospitals, emergency rooms, and urgent care centers.
      (1) AHN promotes bidirectional collaboration between participating providers and health care service providers (in and out of network).
      (2) Coordination and collaboration are optimized when clinical information is exchanged within the network and with external referral sources.
      (3) This information is exchanged through EHRs, telephone, letters or other communication methods.
      (4) AHN's data and analytics platform serves as a data aggregator, capturing both claims and clinical data in one single platform. In addition to information exchange methods listed above, AHN's data and analytics platform serves as a notification tool for both CIN providers and AHN's clinical team members.
6. Providers have procedures for managing and coordinating the care of patients using appropriate services within the CIN.
   a) AHN designs consumer-centered multidisciplinary teams to help meet the holistic needs of the consumers in the contracted population(s).
   b) These practices encourage integration within the network. The overarching practice for care management and care coordination is to utilize data and analytics to proactively develop strategies aimed at addressing the health care needs of consumers across the continuum of care.
   c) These practices promote quality improvement and cost control by ensuring that consumers are receiving the right care from the right provider in the most appropriate setting at the right time.
   d) AHN promotes bidirectional collaboration between participating providers and health care service providers (in and out of network).

e) Bidirectional communication between CIN providers and consumers participating in care management services with the AHN's clinical team occurs via the EHR, AHN's data and analytics platform, and fax.

H. Coordinating transitions of care

1. The following are consistent with goals of the CIN and contractual requirements.
   a) CIN goals include the following: improve consumer health through education and higher quality of care, improve efficiency, monitor and improve utilization, decrease cost, and enable physicians to succeed in changing healthcare payment and delivery environments. Coordinating transitions of care is a core component of the care management services AHN provides to consumers and aligns with the overarching goals of the CIN.
2. AHN uses the following criteria to identify consumers at-risk for unsafe transitions of care, between all types of service locations and providers (including those admitted to a hospital). At-risk consumer criteria:
   a) AHN's RN Transition Coaches and RN Coordinator Facility Relations, provide transition of care support to any consumer experiencing a transition of care in the acute or post-acute setting. AHN considers any consumer experiencing a hospital discharge or post-acute discharge to be at risk and provides support for 30 days post discharge from either setting.
3. For consumers determined to be at-risk for unsafe transitions of care, CIN provides support to identify, plan, develop and communicate transition plans.
   a) Identifying and planning transitions: AHN's RN Transition Coach is responsible for identifying at-risk transitions of care consumers. The RN Transition Coach is responsible for assisting in the planning of transitions and providing support to consumers during a transition of care from the acute setting to the community. AHN's RN Coordinator Facility Relations provide similar planning and support for consumers experiencing a transition from the post-acute setting to another level of care.
   b) Developing and communicating transition plans: AHN's Transition Coaches and RN Coordinator Facility Relations are responsible for participating in the development and planning of transition plans and communicating those plans to relevant stakeholders. All care management documentation occurs in the AHN data and analytics platform and/or ambulatory EHR (as necessary) to communicate plans to providers and other caregivers. If the ambulatory EHR access is not available, fax is utilized to ensure communication with providers about transitions of care.
      (1) Communication occurs at the time of admission, time of discharge, and throughout the 30 days post-discharge.
4. AHN has an agreed upon process for medication reconciliation at transitions of care. This includes review by a qualified health care professional.

a) Process: AHN's RN Transition Coaches provide transitional support to consumers who experience a transition of care. Their workflow includes phone calls to recently discharged patients at 24-48 hours, 10-14 days and 30 days post discharge. Medication review is completed in the 24-48 hour follow-up call. AHN's network Pharmacist is available for consultation. Issues are escalated to the primary care provider who will perform a Medication Reconciliation at the post discharge visit.

5. AHN ensures that key information is exchanged regardless of source system during transitions of care.
   a) Key information includes the following (when available): Discharge summary, discharge disposition, follow-up appointment information, key information discussed in the 24-48 hour, 10-14 day, and 30 day follow-up call, medication reconciliation completion and/or issues, any barriers to care that could lead to readmission, and any issues requiring escalation to the provider.
   b) Source systems may be electronic or paper-based platforms. If there is variability in how the information is collected and stored, key information will be exchanged at the time of transitions through electronic transfer of documents from one EHR to another, EHR documentation by the AHN RN Transition Coach, and fax.
   c) AHN's RN Transition Coaches document all work in AHN's data and analytics platform. The RN Manager, ACO audits care management work monthly to ensure workflows are being carried out as intended.
6. AHN confirms that transition plans are coordinated with employer or payer-based case management services.
   a) AHN provides care management and transition of care support to all contracted lives. AHN coordinates with payer-based care management teams to clearly define roles for care management and transition of care support. AHN identifies transitions of care using the data and analytics platform and follows all transitions of care consumers for 30 days. Additionally, AHN ensures that the payer provides transition of care reporting to AHN on a routine basis. AHN meets regularly with payer-based care management providers to ensure that each group is following the agreed upon process for providing care management services to a mutual client.

I. Coordination and collaboration
1. AHN promotes coordination and collaboration between participating providers and other health care service providers involved in a consumer's care.
   a) AHN promotes bidirectional collaboration between participating providers and health care service providers (in and out of network).
      (1) Coordination and collaboration are optimized when clinical information is exchanged within the network and with external referral sources.

(2) This information is exchanged through electronic health records (EHRs), telephone, letters or other communication methods.

b) AHN designs consumer-centered multidisciplinary teams to help meet the holistic needs of the consumers in the contracted population(s).

(1) Multidisciplinary teams are well-defined with clarity of roles.

(a) AHN's clinical team prioritizes self-management of chronic conditions, strong relationships between consumers and their primary care providers, and seeking care in ambulatory settings as much as clinically possible.

(b) These practices encourage integration within the network. The overarching practice for care management and care coordination is to utilize data and analytics to proactively develop strategies aimed at addressing the health care needs of consumers across the continuum of care.

(c) These practices promote quality improvement and cost control by ensuring that consumers are receiving the right care from the right provider in the most appropriate setting at the right time.

(d) Active multidisciplinary team roles within AHN include:

(i) RN Population Health Coaches
(ii) Social Workers
(iii) RN Transition Coaches
(iv) RN Coordinator Facility Relations
(v) Pharmacist

(2) Health care teams that are relevant to AHN's population include:

(a) Medical
(b) Behavioral health
(c) Substance use disorders

2. AHN promotes coordination and collaboration between community-based resources and agencies providing services to the consumer.

a) AHN's Social Workers work closely with providers and RN Population Health Coaches to identify barriers to medical care and provide education and links to community resources to help address those barriers. Community-based resources and agencies may include the following:.

(1) Financial concerns
(2) Home care services
(3) Transportation services
(4) Organizations providing free or discounted meals and other food options
(5) Insurance assistance
(6) Medication access programs
(7) End of life planning

(8) Employee assistance programs (EAPs)
(9) Legal services
(10) Housing/shelters
(11) Utilities assistance

3. AHN evaluates the effectiveness and impact of coordination and collaboration through performance metrics for various contracts/payers that are measured and reported to the Clinical Care Committee and/or appropriate employer organizations annually. Measures for performance include mutually agreed upon, validated quality, cost, efficiency key performance indicators and measures which are outlined in each individual value-based contract.

J. Consumers have access to referrals with appropriate specialist(s), if applicable.
1. Consumers have access to referrals for both in-network and out-of-network providers.
a) Specialist referrals may include mental health/substance abuse disorder specialists when applicable and not prohibited by payer/purchaser contracts or jurisdictional limitations in laws, regulations, or program exclusions.
b) Access to referrals by appropriate specialist(s) can be confirmed/measured by AHN RN Population Health Coaches with medical record review and provider screenshots for referral monitoring. This data is reported to the Clinical Care Committee and/or appropriate employer organizations annually for review and action as needed.
c) Consumers have access to service accessibility information including clearly specified hours of services operation and locations.
d) Service accessibility, hours of operation and location information is clearly communicated to consumers via clinic signage, websites, social media, and telephone prompts.
e) AHN will monitor the service accessibility information by reviewing provider websites, provider appointment screenshots, provider availability questionnaire calls, and self reported provider information.

K. Appropriate use of clinical practice protocols
1. AHN has measures in place to evaluate and modify practice patterns, allowing each clinically integrated provider to assign and implement interventions for their population's consumers with high priority conditions that are based on clinical or evidence-based best-practice guidelines.
2. Collective and individual practice patterns of clinically integrated providers are evaluated annually.
a) Specific practice patterns evaluated include the following performance measures: see AHN's website for specific EBGs.
(1) Performance standards and evidence-based best practice guidelines are reviewed and compared against specific practice patterns.

(a) Performance standards and guidelines used include: metrics for measuring clinical quality, consumer satisfaction, resource utilization, and cost effectiveness with regard to the delivery of covered health care services, as set forth in the Participant Agreement.

b) Performance measures are reviewed on an annual basis by the Clinical Care Committee.

c) Clinically integrated providers are directly and actively involved in this evaluation through the Clinical Care Committee participating in annual audits.

(1) This is consistent with FTC requirements for provider engagement in CIN planning and decision-making.

3. Clinically integrated providers and contracted payers/purchasers develop and agree upon a plan to adopt performance metrics to improve practice patterns.
   a) Providers develop this plan in conjunction with the Clinical Care Committee, led by the AHN Chief Medical Officer and Market Vice President of Population Health, during the meetings.
   b) Guidelines and evidence-based best practices are used to develop performance/quality metrics. Guidelines used are relevant and align with the quality metrics agreed upon by the providers and contracted payers.
   c) Specific performance metrics targeted are identified on AHN's website.
   d) AHN and contracted payers agree on metrics which are reviewed by the Clinical Care Committee and approved and documented in the meeting minutes.
   e) Once developed, clinically integrated providers implement this plan.
   f) This improvement of practice patterns helps to demonstrate consumer value.
4. The Clinical Care Committee, led by AHN's CMO and Market Vice President of Population Health, monitors CIN provider adoption rates of these performance measures to modify and improve practice patterns.
   a) Clinical quality and health outcome metrics are measured with claims and electronic medical record data compiled in the data analytics platform. Data is reviewed and monitored annually based on Clinical Care Committee approved benchmarks for value based contracts.
   b) Rates of adoption are compared to CIN goals for desired performance dependent on the contract. Clinical Care Committee reviews appropriate data to identify gaps in performance.
   c) AHN utilizes an advanced data analytics platform capable of ingesting both clinical and claims data feeds. This platform serves as a data aggregator and helps to ensure adherence to performance goals which include the previously agreed upon metrics.
5. If performance gaps are identified, or if CIN providers are not meeting CIN defined goals, the Clinical Care Committee may recommend to implement remediation measures when indicated.

a) If the Participant level compliance report demonstrates a need for improvement as identified by the Clinical Care Committee, AHN staff will work with the individual Participant to engage in educational opportunities with the desired result being improved quality of care and performance metrics.

L. Selection of clinical practice protocols

1. AHN documents the rationale for guideline selection, adaptation, modification, development, and implementation.
2. Rationale is documented in the minutes of the Clinical Care Committee for the clinical quality opportunity that the guidelines are designed to address. The Clinical Care Committee will provide clinical and quality oversight for AHN's network-wide selection, adaptation, modification, development and implementation of EBG guidelines stated on AHN's website.
   a) Guidelines are developed:
      (1) due to a large percentage of consumers with these comorbidities in the population
      (2) based on our performance data showing an opportunity for improvement
   b) Quality measures are required for reporting by the majority of government and private payers.
3. The Clinical Care Committee measures guideline adoption by CIN providers and measures the impact on clinical quality and health outcomes for which the guidelines were designed.
   a) Guideline adoption by AHN's providers is measured by the provider quality scorecard data in the data analytics platform.
   b) Examples of clinical quality and health outcomes can be found on the AHN Website for EBGs and quality crosswalk.
   c) Clinical quality and health outcome metrics are measured with claims and electronic medical record data compiled in the data analytics platform. Data is reviewed and monitored annually based on Clinical Care Committee approved benchmarks for value based contracts.
   d) Performance monitoring and reporting helps to show the value to the consumer.
4. Guidelines and evidence-based best practices are used to develop performance/quality metrics. Guidelines used are relevant and align with the quality metrics agreed upon by the providers and value based contracts.
5. Clinical guidelines are available for all participating practitioners within the CIN. Disciplines covered by AHN include the following:
   a) Participating clinical providers
   b) A comprehensive list of selected protocols and guidelines can be found on the AHN Website.
6. Clinical guidelines include information about care coordination and clinical integration. Examples include:

a) Diabetes Mellitus Type II referral guidelines from Primary Care Providers (PCPs) to nutritionist or Diabetes Clinical Educator, endocrinology, and/or podiatry related to risk factors.
b) Hypertension referral guideline from PCPs to cardiology or nephrology.

M. Implementing clinical practice protocols
1. AHN has a mechanism to review data to assure that expected outcomes are occurring through provider utilization and quality scorecard monitoring using the data analytics platform. Examples are achievement of target laboratory values and/or blood pressure.
a) Individual practices will be responsible for operational implementation of the guidelines at their practices, including training of clinic staff and documentation in respective electronic health records.
(1) The mechanism includes oversight by the Clinical Care Committee with review of provider measures annually. This process involves assessing consumer progress towards goals dictated by clinical practice protocols and guidelines.
(2) If expected outcomes are not occurring, the Clinical Care Committee confirms that the clinically integrated provider and staff are initiating an evidence-based intervention.
(a) The Market Vice President of Medical Operations tracks data for non-adherence by the providers and/or consumers and reports this data to the Clinical Care Committee.
2. AHN has a process to track, monitor, report, and document non-adherence.
a) The Market Vice President of Medical Operations tracks data for non-adherence by the providers and/or consumers and reports this data to the Clinic Care Committee. See T.2.d.(4) below for process steps. See N.1 for examples of achievement.
b) AHN has a process to ensure that all clinically integrated providers record meaningful clinical outcomes in areas targeted for performance improvement.
c) Process includes monitoring utilization and quality measures and following the escalation process for non-adherence. The non-adherence data is reviewed by the Market Vice President of Medical Operations and reported to the Clinical Care Committee. The non adherence data is documented in the Clinical Care Committee minutes. Clinical Care Committee submits a report of non adherence to the Board of Managers for their recommendations.

N. AHN has a training program for clinically integrated providers.
1. An ongoing training program for clinically integrated providers implemented by AHN includes the following topics:
a) Goals and principles of AHN
(1) Improve consumer health through education and higher quality care
(2) Improve efficiency

(3) Monitor and improve utilization
(4) Decrease cost, and
(5) Enable physicians to succeed in changing healthcare payment and delivery environments

b) Compliance training includes regulatory compliance with applicable state and federal laws, including HIPAA and HITECH, and a document link to the CommonSpirit Health Our Values in Action Policy and Reference guide
(1) Training includes provider requirements for state licensure, board certification (if applicable), DEA certification, clinical privileges at a CIN facility or credentialed by a CIN payer, participant in Medicare/Medicaid and/or other private payers, and professional liability insurance.
(2) Compliance policies and annual updates will be available by email to the providers.
(3) Provider training consists of the provider training slide deck with attestation, participation agreement and compliance policies.

c) Clinical management, efficiency, and quality improvement standards of the CIN.
(1) Provider education covers AHN's clinical management, efficiency with finance/utilization metrics in data analytics platform, and quality metric targets for AHN providers through payer programs.
(2) AHN policies and procedures pertaining to their work.

d) Documentation and communication expectations regarding completion of provider training on the AHN Connect app and/or AHN website. Providers are encouraged to provide a contact email and may communicate with AHN through email, AHN Connect app, or the AHN website.

e) Referrals to in-network versus out-of-network providers and services, including training with:
(1) Network fidelity reports and data tracking with data shared with providers and/or administration.
(2) Network fidelity meetings with employed physician group administration to review reports and develop and implement action items.
(3) Provider talking points related to network fidelity shared with providers to help their discussions with consumers.
(4) Participating providers and facilities are listed at https://arkansashealthnetwork.com/ and the AHN Connect app for mobile devices.

f) Information systems implemented by the CIN for the purpose of collaboration and improved consumer care. Training includes documentation expectations related to system use.
(1) AHN's staff will provide training to the providers on the value and use of AHN's data analytics platform.

g) Expectations of providers, including the following:
   (1) Evidence-based medicine practices: Provider approved evidence-based guidelines are disseminated and reviewed with providers during provider onboarding. The guidelines are updated in line with national source information through communication via AHN's newsletter, AHN's website and/or the AHN Connect app.
   (2) Efficiency standards: see section B.4.(1) in this document related to underutilization and overutilization monitoring
   (3) Care coordination procedures:
      (a) The AHN's clinical team prioritizes self-management of chronic conditions, strong relationships between patients and their primary care providers, and seeking care in ambulatory settings as much as clinically possible.
      (b) Risk stratification through data analytics identifies disease focused, high-risk, high-cost clients for care management.
      (c) Provider patient referrals and patient self-referrals are encouraged.
      (d) Providers receive training on the roles of the clinical team and the appropriate contacts for patient referrals.

h) Quality improvement and performance measurement processes and reporting required by the CIN: Providers are expected to comply with evidence-based medicine in accordance with value based programs through processes that cover diagnoses with significant potential for AHN to achieve quality improvements taking into account the circumstances of individual beneficiaries.
   (1) The Clinical Care Committee reviews and approves the quality measures for various contracts.
   (2) Quality measures/targets will be reviewed and disseminated to providers annually.
   (3) Quality measures/targets will be posted on AHN's website and AHN's Connect app.
   (4) The data analytics platform generates provider quality measure scorecards.
   (5) Manual audits of selected quality measures are completed for providers whose EMRs are not captured in the data analytics platform.

i) Consumer experience and engagement strategies:
   (1) AHN's training strategy for consumer experience/engagement is the expectation that providers (and not AHN) take full responsibility for the consumer experience process to include performing surveys, collecting data, analyzing data, and improving processes to enhance the consumer experience.
   (2) Training includes a provider attestation that this process is in place and that AHN may request data related to consumer experience and process improvement as part of the AHN Quality Program.

2. Ongoing training to maintain competency in assigned roles and responsibilities

a) On-going training is provided when there are changes to policies, laws and regulations, shifts in business functions or strategy or changes in accreditation standards. Notification of changes in laws, regulations, standards, business functions and strategy, quality measures/targets are communicated to the provider through the AHN Newsletter, electronic communications, the AHN Connect app and/or AHN website. These training sessions will occur every four years .

b) Clinically integrated providers have access to the most current policies and procedures applicable to their duties on an ongoing basis. This information is updated and kept on the AHN Connect app in the provider training presentation. Ongoing training of employed physicians is delegated to their administrative team through facility learning platforms.

3. Documentation of training
   a) Documentation of training will include, but not be limited to the topics outlined in section O.1.a-i of this policy. Training log will be maintained through facility employed provider logs and AHN's Connect app tracking logs. Communication to the providers regarding training will include that the staff receiving information must be:
      (1) responsible for knowing content,
      (2) able to ask questions related to content, and
      (3) accountable for implementing changes as appropriate to their roles.

O. AHN directs clinically integrated providers to have consumer safety policies and processes in place to respond to situations that pose an immediate threat to the health and safety of its patients. Policies and processes include the following:
   1. Standards for safe transitions of care between settings and providers. Minimum standards include:
      a) Coordinated discharge planning.
      b) Procedures that include appropriate consideration for health literacy, shared decision-making, physical accessibility, and roles of family/caregivers.
      c) Training will refer providers to the National Transitions of Care Coalition (NTOCC) 7-Essential Elements at https://www.ntocc.org/knowledge-and-resource-center.
      d) AHN will follow state and federal reporting and transitions of care requirements.
   2. The ability to direct consumers to urgent and emergent services during and after business hours of operations.
      a) AHN providers will attest that there is a process in place to provide access to care for patients with urgent issues that occur outside normal office hours that need to be addressed immediately.

b) After hours, at a minimum, the clinically integrated providers' Interactive Voice Response (IVR) or voicemail indicates that if the consumer is having an emergency, they shall dial 9-1-1.
c) Sample Process for Dealing with Consumers for Possible Harm to Oneself, Harm to Others and Clinical Distress:
(1) Staff who might have contact on the phone with a distressed consumer, which is defined as one who threatens harm to oneself or others or is in clinical distress (i.e., an allergic reaction or a heart attack) will be trained on how to handle these calls.
(a) The staff member will not place the distressed caller on hold and will speak calmly to the distressed consumer.
(b) The staff member in receipt of the distressed consumer call will signal to a colleague to dial 9-1-1 immediately.
(c) The staff member remains on the line until 9-1-1 emergency services arrive.

3. Identification and appropriate reporting of abuse, actual or potential violence, or gross negligence as required by law.
a) Suspected cases of physical, mental,and/or financial abuse or assault are reported to appropriate agencies for children, elderly and domestic abuse.
b) Failure to maintain consumer safety mechanisms by clinically integrated providers may be considered a violation of conditions of participation in the network and may be grounds for de-selection of providers.

P. Oversight of service access and availability
1. AHN ensures that its multidisciplinary services are accessible and available in accordance with contract requirements.
2. AHN requires after-hours and off-hours services by providers, practitioners, and pharmacies.
a) After hours and off hour services are stated in contract employer benefit guides or summary plan documents.
b) After hours and off-hour services can be confirmed/measured by data monitoring through provider availability questionnaire calls and provider appointment schedule screenshots. This data is reported to the Clinical Care Committee and/or appropriate employer organizations annually for review and action as needed.
3. AHN tracks and reports on the outcome of referrals
a) Internally tracks and reports the outcome of referrals as part of its quality management program.
b) If required by regulation or contract, results are reported as required.
c) Outcome of referrals will be confirmed/measured by data monitoring through medical record review by the RN Population Health Coaches, self-reported provider information, and provider screenshots. This data is reported to the Clinical Care Committee and/or appropriate employer organizations annually for review and action as needed.

d) AHN collaborates with consumers, providers and employers to identify barriers to care.

4. AHN includes a variety of providers in its service care model, including non-physician providers such as nurse practitioners, physician assistants, rehabilitation professionals, and behavioral health/substance use disorder practitioners.
   a) This will ensure that AHN has the benefit of the advice of behavioral health professionals.
   b) AHN collaborates with behavioral health network providers to identify access and availability needs. AHN requires the use of telehealth or related technology-enabled strategies to improve access to care.
   c) Telehealth technology capabilities are deployed and maintained by individual participating providers/clinics. Telehealth technology is available throughout the CIN network through a variety of primary care and specialty providers.
5. For any of the topics monitored and reviewed listed above, if care gaps or disparities are identified, AHN will implement a timely corrective action plan and/or performance improvement activities.

Q. AHN provides participating providers and their staff training on selected approaches to consumer engagement.
1. Topics covered include, but are not limited to: High risk/rising risk identification strategies, care protocol enrollment, motivational interviewing techniques.
2. Staff are trained by the RN Manager, ACO with oversight from the Market Vice President of Population Health during new coworker orientation. Review of selected approaches to consumer engagement and ongoing education occurs annually.
3. Participating providers are trained as part of the ongoing provider training process documented in section O.1.a-i of this policy.
4. Training is documented in the AHN department training log.

R. The AHN Market Vice President of Population Health measures and reports consumer engagement and satisfaction indicators at least annually.
1. Measures for consumer engagement include: Successful consumer enrollment in a care protocol within the data analytics platform. This metric is tracked in the data analytics platform by the RN Manager, ACO and Market Vice President of Population Health monthly and reported to the AHN Clinical Care Committee and Employer-Based Population Health client(s) annually.
2. Measures for satisfaction include: AHN's training strategy for consumer experience/engagement is the expectation that providers (and not AHN) take full responsibility for the consumer experience process to include performing surveys, collecting data, analyzing data, and improving processes to enhance the consumer experience. Training includes a provider attestation that this process is in place and that AHN may request data

related to consumer experience and process improvement as part of the AHN Quality Program.

3. Results are reported to the AHN Clinical Care Committee and Employer-Based Population Health client(s) annually.

S. Consumer care integration

1. AHN uses consumer-centered care strategies to implement evidence-based guidelines, clinical protocols, processes, and capabilities to identify the health needs of individuals served within the contracted population(s). Clinically integrated providers provide (or arrange for) interventions directly to members of the population(s) based on individual assessments. Providers use evidence-based assessment and intervention strategies.
2. Clinically integrated providers perform assessments and interventions for primary care and specialty physical health needs.
   a) Providers determine need for assessments for their patients based on evidence based guidelines available from national organizations, such as but not limited to:
      (1) American Heart Association (AHA)
      (2) American Diabetes Association (ADA)
      (3) US Preventive Services Task Force (USPSTF)
      (4) American Academy of Family Physicians (AAFP) and other specialty associations
   b) Data is reviewed annually regarding access to care and availability of providers in a geographic area to determine the need for additional providers to the network. Access data reviewed may include a maximum distance or time enrollees will have to travel to see a provider. These standards are intended to ensure that enrollees can access care with a network provider within a reasonable distance from their residence. Targets include:
      (1) Primary Care: 60 miles
      (2) Specialists: 100 miles
      (3) Availability data reviewed may include waiting times for appointments based on urgency. Targets include:
         (a) Same day: on the day of call
         (b) Urgent: within 48 hours
         (c) Routine: within 4 weeks
         (d) Annual Physical Exam: within 60 Days
   c) Clinically integrated providers shall meet AHN's performance measures set by the CIN regarding access and availability of services:
      (1) AHN will audit providers annually, utilizing methods including but not limited to provider availability questionnaire calls, provider appointment system screenshots and self reported provider information.

(2) Timely appointments can be confirmed/measured by data monitoring through Provider availability questionnaires and provider appointment screenshots for appointment availability. This data is reported to the Clinical Care Committee and/or appropriate employer organizations annually for review and action as needed.

d) AHN's clinically integrated providers actual performance is measured and compared with established goals.
   (1) The Clinical Care Committee measures and reviews actual performance of participating providers annually.
   (2) Transparent internal reporting occurs on quality, cost, and outcomes metrics as required to meet AHN goals.
      (a) AHN leadership is responsible for ensuring that internal reporting occurs annually within the appropriate committees/boards.
      (b) Reporting results can help give feedback to participating providers on their performance for the purposes of distribution of incentives and/or remediation or other action related to their contract with AHN.
   (3) If clinically integrated providers are not meeting goals, the CIN works with providers to implement improvement plans where necessary.
      (a) Changes may be made when established goals are not being met, for example, alterations in provider agreements, or addition or de-selection of providers. If the Participant level performance report demonstrates a need for improvement as identified by the Clinical Care Committee, AHN staff will work with the individual Participant to engage in educational opportunities with the desired result being improved quality of care and performance metrics.
      (b) The Clinical Care Committee will be apprised of said educational efforts and will monitor the participant level performance reports for those identified participant providers to ensure performance measures improve and/or is maintained in accordance with AHN's requirements.
      (c) In the event of lack of quality performance measures improvement to meet the standards, in spite of the guidance and support from AHN, and per recommendation of the Clinical Care Committee, the AHN board will review and make final determination for possible termination of the provider's participation agreement.

e) Patient-centered care strategies are culturally and linguistically appropriate. Interpretation services or the electronic health record provides patient education material in different languages. To obtain an interpreter for American Sign Language (ASL) or other languages, contact telephone numbers are available to call for these services. Patients can refer to their local hospital for interpretation services. Cultural

competence is maintained through educational opportunities available through national organizations and partner facilities.

f) Implementing evidence-based practice can help demonstrate improvement of care to the benefit of consumers through improved patient outcomes in laboratory values, medication management and utilization of services.

3. Clinically integrated providers perform assessments and interventions for mental health and substance use disorder status.
   a) Providers determine need for assessments for the patients based on evidence based guidelines available from national organizations, such as:
      (1) National Institute of Mental Health (NIMH)
      (2) National Alliance on Mental Illness (NAMI)
      (3) Substance Abuse and Mental Health Services Administration (SAMHSA)
      (4) American Psychiatric Association
   b) Clinically integrated providers perform assessments and interventions for social service and support needs.
      (1) Examples of these assessments include social determinants of health (SDoH) patient questionnaires with referral to local agencies to fulfill needs for transportation, food insecurity (local pantries), medication assistance (NeedyMeds), housing and utilities, and behavioral health needs.
      (2) Resources used may include Aunt Bertha, United Way and other social service agencies.
   c) Clinically integrated providers perform assessments and interventions for referral for necessary services, as needed, with shared accountability and responsibility for the outcomes of the referral by both the provider (or organization) sending and the one receiving the patient. (Refer to the ntocc.org 7 Essential Elements of Transitions of Care)
      (1) Providers refer to specialists as needed based on patient conditions and evidence based guidelines available through national organizations.
      (2) Referrals to specialists are the responsibility of the primary care physician.
      (3) AHN collaborates with network providers to improve access for patient care.
      (4) The AHN Clinical Team, including the RN Population Health Coaches, use selective audits of provider screenshots as well as medical record review for referral monitoring. Providers may self-report referral information also.

T. AHN establishes an understanding of baseline health status and needs.
   1. AHN's Market Vice President of Population Health, RN Manager, ACO, and data analyst(s) work together to determine needed preventative services by reviewing population data as described above. This review informs specific workflows for AHN's clinical team that address health needs of the population.
      a) At-risk individuals may require specific types of services, depending on their type of risk.

2. Consumer health status and needs are assessed for all population(s) for which AHN holds contracts, irrespective of actual consumer engagement rates.
   a) AHN utilizes an advanced data analytics platform capable of aggregating multiple data sources to ensure a data driven care management process. All quality improvement efforts and care management outreach strategies/initiatives are selected based upon opportunities identified in the data available on this platform.
3. AHN's Market Vice President of Population Health, RN Manager, ACO, and data analyst(s) work together to identify the expected prevalence of at-risk, chronically ill, and poly-morbid conditions throughout the eligible population(s).
   a) Criteria for identifying at-risk consumers can be found in sections C.1-10 .
   b) The prevalence for various risk factors may influence the type and availability of various services that may be needed within the population.
   c) AHN utilizes an advanced data analytics platform capable of aggregating multiple data sources to ensure a data driven care management process. The platform allows for the creation of registries of consumers meeting specific criteria. Registries are created to identify at-risk, chronically ill consumers. Additionally, detailed analytics provide information related to chronic condition prevalence within a population.
4. When services are needed for consumers, they are provided by CIN providers and/or the CIN's multidisciplinary clinical team depending upon the need.
   a) Services needed may include the following:
      (1) Preventative measures
      (2) Primary care and specialty medical care
      (3) Behavioral health and substance use disorder treatment
      (4) Pharmacy services
      (5) Social services support
      (6) Rehabilitation services
      (7) Medical supplies
      (8) Ongoing consumer monitoring
      (9) Care coordination
      (10) Multidisciplinary care between multiple specialties or care settings
   b) Network providers include those needed to provide needed services, including behavioral health professionals. If In-network providers are not available, referrals are made outside the network to available qualified behavioral health professionals appropriate for the level of care needed.
5. AHN's clinical team members consider the impact of known SDoH to better understand baseline health status and needs.

a) AHN's clinical team members, including Registered Nurses and Social Workers, conduct SDoH screenings on at-risk consumers enrolled in care management. SDoH risk factors are included in care plans and addressed by AHN Social Workers.

U. AHN's annual re-evaluation of population health needs

1. The AHN data and analytics team with oversight from the Market Director of Operations and in collaboration with the AHN Market Vice President of Population Health, work together to re-assesses population(s) needs annually or when the population is known to change through market trends or contract negotiations.

POLICY SUBJECT:

AHN's (AHN) Clinical Management

ATTESTATION OF LEADERSHIP REVIEW:

By signing this document, I do hereby attest that I have read and agree with the contents of this policy.

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Bob Sarkar, President & CEO

DocuSigned by:
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Camille Wilson, Market VP, Population Health

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