Hennepin Health

Minneapolis Grain Exchange Building
400 South Fourth Street, Suite 201
Minneapolis, Minnesota 55415

2017 Quality Management Program Description

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1 Introduction

1.1 Introduction

Hennepin Health, formerly known as Metropolitan Health Plan (MHP) was established as a not-for-profit, state certified Health Maintenance Organization serving Medicaid, General Assistance Medical Care and MinnesotaCare recipients. It was established to create a vehicle to retain the traditional patient base of Hennepin County Medical Center (HCMC). Voluntary Medicaid enrollment began in 1984 with 800 members. In 1985, Hennepin Health was selected with other health plans to participate in the Medicaid Demonstration Project in Hennepin County. In 1990, Minnesota General Assistance recipients were required to enroll in prepaid managed care programs. Four years later, Hennepin Health expanded to include residents in Anoka, Carver and Scott counties. In 1996, Hennepin Health began offering MinnesotaCare, a program of the state of Minnesota. Hennepin Health became an original participant in in Minnesota Senior Health Options (MSHO) in 1997.

Starting in 2004, Hennepin Health expanded its core network to include residents in Polk, Mower Anoka, Carver, Chisago, Dakota, Hennepin, Mower, Polk, Ramsey, Scott, Sherburne, Washington and Wright Counties. Hennepin Health stopped offering Minnesota Health Care Programs in these counties in 2012.

In 2011, then known as MHP, partnered with Hennepin County's Health and Human Services Department, NorthPoint Health and Wellness Clinic and Hennepin County Medical Center to offer Hennepin Health, a Medicaid expansion program for single adults without dependent children (ages 18 - 64). This project addresses the medical, behavioral and social needs of its members, using an integrated approach to health care. At that time, MHP/Hennepin Health offered covered to Hennepin County resident eligible for MSHO, Minnesota Senior Care Plus and a Special Needs BasicCare (SNBC) program to individual with disabilities.

Hennepin Health ended its contracts with Centers of Medicare and Medicaid Services (CMS) as of December 31, 2014; no longer providing services for dual-eligible (Medicare/Medicaid) enrollees. Effective January 1, 2016, Hennepin Health (then MHP) was awarded a PMAP/MnCare contract by Department of Human Services (DHS); expanding its Hennepin Health's program to include families and children.

Currently, Hennepin Health contracts with the Minnesota Department of Human Services to provide health care coverage to Hennepin County residents who are enrolled in a Minnesota Health Care Program. Through its' contracts with the Minnesota Department of Human Services, Hennepin Health currently provides members in Hennepin County with Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare) and Special Needs Basic Care (SNBC). Hennepin Health is fully at risk for guaranteeing payment for covered services within Hennepin County and must meet all federal and state regulations that apply to health maintenance organizations.

1.2 Mission Statement

Hennepin Health's mission is to continuously protect and improve the health care provided to our members through a high-quality, integrated and cost-effective health delivery system. Building on strengths and identifying opportunities for improvement ensures that Hennepin Health members are receiving high quality care in a cost-effective manner, which will improve the overall health of the communities we serve. In pursuit of this mission, we also seek to become a leader in eliminating health care disparities. (NCQA QI 1)

1.3 Philosophy

Hennepin Health's Quality Management (QM) program strives to provide for each member high-quality, culturally competent, comprehensive health services according to contemporary professional standards.

Hennepin Health encourages our providers to discuss all treatment options with their patients free of retribution concerns, with the goal of building patient-physician concordant relationships. Quality consideration means full participation in; medical treatment, preventive health maintenance services, education, the provision of treatment in the least restrictive environment possible, the appropriate and efficient application of available resources, the delivery of medically necessary care, and avoidance of medically unnecessary treatment or expenses.

1.4 Scope

QM prohibits discrimination in all its' operations and activities on the basis of; race, color, national origin, age, disability, sex, marital status, familial status, parental status, religion, sexual orientation, genetic information, political beliefs, reprisal, and so forth. The QM department reports regularly to the Hennepin Health Quality Management Committee (QMC) and is responsible for investigating problem areas identified through monitoring activities, studies or complaints. QM develops improvement strategies to address problems and follows improvement initiatives through to resolution and sustained improvement. Quality improvement activities are outlined in an Annual Work Plan. (NCQA QI) Hennepin Health annually provides information about its' Quality program, which is available to its members and providers. (NCQA QI 2B)

The QMC reviews the quality of care and utilization of services by Hennepin Health members. Activities reviewed include; performance improvement projects, surveys, monitoring of mortalities, adverse outcomes, complaints, facility site audits, medical record audits, peer reviews and credentialing.

The Director of Medical Administration/Hennepin Health's Utilization Management (UM) department reports regularly to the QMC and is responsible for the daily operation of the UM area. Hennepin Health's UM efforts strive to provide for each member high-quality, culturally competent, comprehensive health services according to community standards of care, contemporary professional standards and accepted evidence based practice guidelines.

2 Goals and Objectives

The goals of the Hennepin Health Quality Program are to:

2.1: Make continuous and sustained improvement in performance improvement indicators as measured by standardized industry measurement methods.

Objective A: Healthcare Effectiveness Data and Information Set (HEDIS) Data are collected annually. HEDIS performance indicators will be tracked over time and will show incremental improvement toward the individual Hennepin Health target for each measure.

Objective B: Non-HEDIS. Additional quality improvement projects will have clearly defined performance targets. This includes the Consumer Assessment of Health Plan Satisfaction (CAHPS) Survey and Health Outcomes Survey (HOS), if available.

2.2: Hennepin Health will improve the health of its members.

Objective A: Members in targeted groups will seek and obtain annual health examinations and preventive services. (NCQA QI)

Objective B: Members with targeted health conditions (e.g. diabetes) will seek and obtain health examinations and preventive services on a regular basis. (NCQA QI)

2.3: Hennepin Health providers will deliver health care that meets community standards of quality, accessibility, and appropriateness of setting.

Objective A: Provider clinics will meet Hennepin Health clinic facility standards, as evidenced by audits for initial credentialing and periodic audits called for by any corrective action plans. Medical records will be included in these audits. (NCQA CR)

Objective B: Network nursing homes will be in compliance with Hennepin Health's standards, as evidenced by annual review of reports from the state Office of Health Facility Complaints. (NCQA CR)

Objective C: Hennepin Health primary care, specialty care, dental and mental health providers will meet community norms as well as Hennepin Health's standards for accessibility, as evidenced by regular access surveys.

Objective D: Patient safety at network facilities will be addressed by review of all member mortalities and adverse outcomes, with appropriate follow-up action. (NCQA QI)

Objective E: Member complaints and grievances will be reviewed and addressed in accordance with Hennepin Health policies and applicable state and federal regulations.

Objective F: Hennepin Health providers will be credentialed initially and on an ongoing basis in accordance with Hennepin Health policies and applicable state and federal regulations. (NCQA CR)

2.4: Hennepin Health member satisfaction is achieved and maintained.

Objective A: Member complaints and grievances will be continuously monitored and trended for patterns.

Objective B: Member satisfaction surveys will be conducted annually.

2.5: Hennepin Health utilization rates will demonstrate neither over- nor under-utilization of services.

Objective A: Hennepin Health will measure and monitor utilization of service for age- and gender-targeted groups (e.g. adolescent well care) with interventions implemented as needed.

Objective B: Hennepin Health will measure and monitor utilization of specific services (e.g. Emergency Department visits) with interventions implemented as needed.

2.6: Hennepin Health will address racial disparities in appropriate quality improvement activities

Objective A: Hennepin Health will evaluate health care disparities through measurement of utilization of targeted services by specific racial and ethnic groups. Hennepin Health will implement interventions as opportunities are identified for specific improvements. (NCQA QI).

3 Scope of Activities

The Quality Program is designed to improve the health care provided to all members, through a high quality, culturally competent, cost-effective health delivery system. The QM scope of activities are in support of that design.

3.1 Annual Work Plan

The Annual Work Plan is developed as an ongoing, integrated document that directs Hennepin Health's quality-improvement efforts. The purpose of Hennepin Health's annual work plan analysis is to provide an objective, critical evaluation of its past, current and planned quality-improvement program initiatives (Evaluation Process NCQA QI). This multidisciplinary process encourages challenges to the status quo and innovation while it demonstrates the strengths and weaknesses of the organization. Whenever possible, Hennepin Health will use data by product-line (MNCare, PMAP & SNBC) as a data group.

The previous year's work plan document is reviewed annually by the Quality Management Committee to measure the effectiveness of the interventions and programs employed in the previous year. (NCQA QI). The initiatives from the previous year's work plan are continued or modified in the current work plan as appropriate, or may be integrated into the current plan on a monitoring status. Components included in the annual evaluation are; access and utilization of emergency services, mental health services and chemical dependency services. Other components included are the effectiveness of case management, discharge planning activities and activities regarding any provider reimbursement arrangements. The evaluation of the previous year's work plan is integrated into an annual evaluation of the overall effectiveness of Hennepin Health's Quality Program, which is revised as needed to reflect the evaluation's findings.

3.2 Delegation Oversight

Hennepin Health delegates certain dental, credentialing, care management, and pharmacy services to contracted entities. Hennepin Health is still accountable for any functions and responsibilities that it delegates to any subcontractor (article 9.3.7 DHS Contract). To ensure compliancy with the standards of Hennepin Health's Quality Program, file copies of each delegates' quality program documents and annual quality improvement work plans are kept. Hennepin Health engages in annual oversight visits of delegates in the following areas:

- Credentialing (NCQA CR 9)
- Complaints and Grievances/Appeals
- Peer Review and Appeals
- Utilization Management policies and procedures
- Member Access
- UM file review
- Quality of Care/ Quality of Service grievances (if delegated)

3.3 Model of Care

Special Needs Basic Care (SNBC), as Special Needs Plans (SNP), have additional specific requirements for a model of care, which exceeds the requirements of Hennepin Health's Plan contract with DHS. Hennepin Health's Quality Program is intended to be a companion to the Model of Care for each of these SNPs and the documents should be read in conjunction with this program.

4 Quality Program Structure

4.1 Quality Management Committee (Authority NCQA QI)

The Hennepin County Board of Commissioners (Board) is the governing body for Hennepin Health. To meet the Minnesota Department of Human Services (DHS) and Centers for Medicare & Medicaid Services (CMS) quality oversight requirements, the Board through board resolution, has delegated responsibility for quality assurance to the Hennepin Health Quality Management Committee (QMC). The QMC has the authority to approve the plan's quality management activities, reports, audits, and findings. It may also recommend studies and corrective actions.

The QMC meets every 60 days throughout the year. Quality management activities are reported to the QMC on a quarterly basis. Following approval by the QMC, the CEO and the Hennepin Health Chief Medical Officer will submit substantive changes to the Quality Management Program to the County Board for approval. (NCQA QI). The Board receives a report on quality assurance activities and outcomes from Hennepin Health four times per year. The Board reviews its' work plan; which is an evaluation of the previous year's work plan and any corrective action plans.

The Hennepin Health Quality Management Committee (QMC) includes representation in the following roles (NCQA QI).

Representation (each member has one vote):

- Hennepin Health, Chief Medical Officer, Co-chair (NCQA QI)
- Hennepin Health, Manager, Quality Management
- Hennepin Health, Sr. Quality Improvement Specialist
- Hennepin Health, Director of Medical Administration
- Physician Representatives (NCQA QI)
- Pharmacy Representative
- Mental Health Provider Representative (NCQA QI)
- Dental Provider Representative
- Hennepin Health, Director of Network Management

4.2 Leadership & Management

The Hennepin Health Chief Medical Officer serves as the Co-chair for the Hennepin Health QMC. The Hennepin Health Chief Medical Officer and Quality Manager set the agenda for the Committee meetings, while assuring the appropriate QM activities are being implemented. The Chief Medical Officer delegates the committee, subcommittee, member assignments, and responsibilities. The Chief Medical Officer also makes recommendation of new Committee members when needed to the Committee. The Chief Medical Officer communicates with providers and others as appropriate regarding implementation of recommendations and/or corrective actions developed by the QM Committee. The Chief Medical Officer also evaluates quality of care complaints, supervises and approves credentialing activities and lastly, verifies the effectiveness of Utilization Management activities. (NCQA QI)

Hennepin Health's Manager of Quality Management reports to the Chief Medical Officer. The Manager of QM is responsible for maintaining documentation of all Committee activities with accurate, complete, written minutes of all meetings to meet regulatory and accrediting requirements. Operational responsibilities for QM activities include; medical record and facility audits, evaluations, and other activities as directed by the QM Committee or Hennepin Health's Chief Medical Officer. The Manager of QM is responsible for providing educational and technical assistance to participating providers in identifying and assessing problems or in recommending and monitoring corrective actions. The Manager

of QM may also participate in requested internal problem resolution or process-improvement work groups.

The Quality Management Resources/Staffing consists of the following:

- Manager of Quality Management (reports to Chief Medical Officer)
- Senior Quality Improvement Specialists (experienced with healthcare outcomes evaluation and analysis).
- Grievances and Appeals Coordinator

4.3 Interdepartmental Support

The Quality Management department receives inter/intradepartmental support from Hennepin County Information Services Technicians and the Data Analytics Team. They provide support in daily operations, database maintenance and HEDIS software support. The QM department collaborates with the Medical Administration department (Hennepin Health's Chief Medical Officer, Associate Medical Director, Director of Medical Administration, Pharmacist, Utilization Management and Care Coordinators) as assigned to support performance improvement projects. Support is also received from Network Management and Outreach Staff.

4.4 Intradepartmental Quality Assurance

Professional staff must maintain license and/or certification and engage in annual continuing education as required for their licenses. All staff conducting audits are trained on inter-rater reliability when offered by Minnesota's Center for Medicare & Medicaid Services (CMS) -designated Quality Improvement Organization. Inter-rater or rater-to-standard reliability testing is performed as part of each study.

4.5 Program Documentation & Confidentiality

Hennepin Health requires all employees to complete HIPAA training and sign a Confidentiality Agreement regarding information obtained as part of employment. Orientation is provided to all staff on confidentiality policies and Hennepin Health data security practices. Hennepin Health also cooperates with providers in implementation of their data security practices.

The QM Program documentation and storage follows the Record Retention schedule developed by Hennepin County Records Unit, which is aligned with the State and Federal retention guidelines for maintaining records. Records are retained for ten (10) years before being approved for destruction. Hennepin Health maintains all records in compliance with Minnesota Data Practices, HIPAA, ARRA HITECH and other requirements. All records and documents created as part of a QM activity are confidential and privileged in accordance with HIPAA standards and Minnesota Law and may not be disclosed to any person or entity except as provided by law. A specific, signed release of information is required before any confidential data is released to an outside party unless said release is made pursuant to a state or federal requirement. Included are:

- Care Management
- Quality Management
- Utilization Management
- Peer Review Records

4.6 Information Systems

Hennepin Health's member data supports quality evaluation and improvement activities and is maintained in the following program databases:

- TMG—claims data
- Navitus – pharmacy data
- CCMS—utilization management and case management data

- Hennepin Health developed (internal) databases:
  - Provider Credentialing
  - Complaints and Grievances
  - QM Tracker (mortalities and quality of care investigations)

Data requests from these databases are maintained in a separate, shared database which documents the following; date of request, requested data set, links to specific criteria for inclusion and exclusion in data set, due date and date of delivery.

5 Network Quality

5.1 Credentialing

Hennepin Health's credentialing policy is structured to meet the requirements set forth by the Minnesota Department of Human Services, the Centers for Medicare & Medicaid Services and NCQA Standards and Guidelines for Health Plans – Credentialing. The credentialing policy addresses the following:

- Practitioners and their specialties; credentialed and recredentialed.
- Credentialing verification sources and their criteria for credentialing and recredentialing.
- The delegation, credentialing, recredentialing decision determination process.
- The process for practitioner notification pertaining to information obtained during the credentialing process that varies substantially from the information provided by the practitioner.
- The process ensuring practitioners are notified of the credentialing and recredentialing decision within 60 calendar days.
- The processes used to ensure completion in a nondiscriminatory manner.
- Hennepin Health's Chief Medical Officer's responsibility, participation, and oversight in the credentialing program.
- The process used to ensure confidentiality of information obtained in the credentialing process. (NCQA CR 1A (1, 4, 8, 9, 10 & 11) 1B, CR 2A(3), CR 9 (1))).

NCQA Guidelines

Hennepin Health follows the NCQA guidelines for credentialing and recredentialing. The 12 elements of credentialing are as follows: (NCQA CR 1-9)

1) Credentialing Policies
2) Credentialing Committee
3) Initial Credentialing Verification
4) Application and Attestation
5) Initial Sanction Information
6) Practitioner Office Site Quality
7) Recredentialing Verification
8) Recredentialing Cycle Length
9) Ongoing Monitoring
10) Notification to Authorities and Practitioner Appeal Rights
11) Assessment of Organizational Providers
12) Delegation of Credentialing

See Credentialing Plan/ Policies and Procedures for more information.

5.2 Provider Contracts and Selection Criteria

A "provider" is an individual, facility, clinical group, or other vendor. The following criteria apply to all provider types. Hennepin Health contracts with providers that respects or enhances its existing alliances and relationships among other contracted providers. The provider must have a good reputation for

delivering quality care and be willing to enter into a contractual relationship with Hennepin Health. The provider must cooperate with Hennepin Health's QM and UR programs and meet or exceed all appropriate credentialing or accreditation criteria. The provider's locations must meets Hennepin Health's facility and safety standards and codes, while improving access to care for members. The provider should have an appropriate number and type of affiliated healthcare professionals. Facility and group providers must be able to provide outcomes data for Hennepin Health members, if requested. (NCQA CR 1-9)

Member Based Criteria
The Provider selection criteria uses a Member Based Criteria. Providers are selected based off a Member need. Providers are selected if: services currently are not available in the existing Hennepin Health network, the provider expands geographic access for members, member demand for service exceeds current network capacity or if an expansion or change in covered benefits requires a service or provider not currently in the Hennepin Health's network. New providers may also be selected to address unique ethnic or language needs of members. (NCQA QI 4 & 5).

Hennepin Health Based Criteria
Hennepin Health's criteria for contracting with providers is as follows; the provider must have competitive rates/fees, be willing to accept Hennepin Health's treatment standards/parameters and meet Hennepin County's liability insurance requirements. All providers with a contract valued over $50,000, must have an affirmative action plan. Providers with contracts over $250,000 are encouraged to have a recycling policy. Providers also must have adequate policies and procedures that address cultural competency, while assuring the confidentiality of private health insurance. All providers must adhere to the county's AIDS policy.

Internal Communication
All Participating Provider Agreements contain the following language: "The Provider agrees to cooperate with Hennepin Health and participate in its quality management program, credentialing, dispute resolution process, and utilization management program," Minnesota Statute 62D.123. Internal communication includes; communicating updated information (i.e., notification of provider terminations, new provider updates, medical records audit results, etc) by providing regular status reports at meetings, such as the quarterly QMC meeting and publishing general information on Hennepin Health's Intranet.

5.3 Provider Termination
A termination of a provider's contract may be due to the following reasons; license, insurance, performance compliance and loss of Medicare/Medicaid certification. Under contract, providers agree to terminate the provision of services if their license is suspended, withheld or cancelled. Providers must agree to protect themselves, Hennepin Health and Hennepin County under the indemnity agreement provision; it shall keep and enforce professional liability, commercial general liability, automobile liability, worker's compensation and employer's liability insurance at levels that meet the community standard. Professional liability should not lapse without reinstatement. A loss of Medicare/Medicaid Certification or sanctions by the Office of Inspector General, may also result in termination. Any provider who fails to perform any of the provisions of the agreement, or so fails to administer the work as to endanger the lives or welfare of Hennepin Health members, is in default of their contract.

Providers are notified of contract termination through a written notification. Hennepin Health members are individually notified of the termination if they currently are seeing the terminating provider. Other Hennepin Health members are notified of the network change through changes in the Primary Care Network listing and the Provider Directory. DHS and MDH are notified as required by reporting requirements. All internal Hennepin Health departments are advised.

5.4 Continuity for Members in Case of Provider Termination

When Provider Relations notifies Hennepin Health Member Services or Contracting, that a clinic or provider is terminating its' participation with Hennepin Health, the members affiliated with that provider are identified. Hennepin Health's Member Services will send a letter to the affected members informing them of the change and advising them to select another provider from within their chosen Hennepin Health care system. Members are also advised that assistance is available in locating another provider. If a member does not select a provider/clinic, one may be chosen for them based on previous claims experience. New member cards are then sent to the member with the updated information. Hennepin Health cannot make any exceptions if the provider is terminated for cause.

6 Peer Reviews

6.1 Qualifications and Role of Peer Reviewers

A peer reviewer is a physician of the same or similar clinical specialty of the subjective medical review being performed. If a specific set of conditions is reviewed, the physician reviews records where previously defined standards were not met. Nursing representatives are considered a peer, if a review is done strictly regarding the practice of nursing. Behavioral Health, chiropractic, dental, pharmacy, optometric and ancillary providers (e.g., OT, PT Speech, etc.) are involved in peer review within their individual scope of practice. The peer reviewer selected by the Hennepin Health Chief Medical Officer will review the medical records and information related to a specific case or a provider's pattern of care. The reviewer will provide a written summary of findings and analysis to the Hennepin Health Chief Medical Officer.

6.2 Process (NCQA QI 1A(6) & 2A(1-5))

A peer review is a five (5) phase process.

1. Problem – Seeking is the first phase. The content of this phase is determined by the Hennepin Health Chief Medical Officer and may or may not include involvement by the QM Committee. When a medical record audit is a part of the problem-seeking phase, a Hennepin Health QM Specialist will perform it.
2. Problem Identification is the second phase. This involves the Hennepin Health Chief Medical Officer and QM Committee evaluating the information collected during the problem-seeking phase and selecting areas to be further investigated or recommended for corrective action plans.
3. Intervention and Resolution is the third phase. Interventions are based on findings of the above investigations and may be one or more of the following as recommended by the QM Committee; corrective action plans, censure, revocation of participating privileges, withhold of payment and termination of contract.
4. The fourth phase is Problem Re-evaluation. This phase involves the QM Manager re-evaluating the problem under the direction of the Hennepin Health Chief Medical Officer. The results of this phase will be shared with the appropriate providers and QM Committee, as needed, for further action.
5. Communication and Report of Findings is the last phase. Written reports of peer review activity are approved by the Hennepin Health Chief Medical Officer and stored in QM's confidential files in accordance with the requirements of statutes and rules. Reports of significant findings, recommendations and Hennepin Health actions will be sent within thirty (30) days of completion of review to; affected provider(s), State Board of Medical Examiners (as required) and the QM Committee. The QM Department will maintain the confidential peer review findings in the provider's credentialing file. In addition, Hennepin Health will notify appropriate regulatory and law enforcement agencies if fraud or abuse is suspected.

6.3 QM Committee Responsibility

The QM Committee will review all internal peer review activities on a quarterly basis or as needed on a more frequent basis. If corrective action is required, the QM Committee will recommend to the Hennepin Health Chief Medical Officer specific stipulations for corrective action to be sent in writing to the provider, requesting a formal written plan for correcting deficiencies within sixty (60) days. All quality of care reviews are considered peer review and are protected as confidential pursuant to Minnesota statute, 145.64.

7 Effectiveness of Care

7.1 Medical Record Audits

Medical Record Audits are conducted in efforts to monitor for adherence to medical record standards. Medical record standards promote efficient and effective treatment by facilitating communication, coordination, and continuity of care. Hennepin Health's QM staff reviews a random sample of Hennepin Health member medical records at contracted provider sites. Each site is reviewed for compliance with medical record-keeping practices. The provider site is responsible for developing and maintaining a system for the collection, processing, maintenance, storage, retrieval, distribution, and retirement of medical records. Each record should have a unique identifier, with system capability to identify the location of each medical record.

All clinical information relevant to a member should be readily available to the health care practitioner and staff and be produced on demand. Reports; medical histories, physical exam records, progress notes, laboratory reports, x-ray readings and consultations should be incorporated into each member's medical record in a timely manner. All records that contain clinical, social, financial, or other data on a particular member is treated in a strictly confidential manner and is reasonably protected from loss, tampering, alteration, destruction, unauthorized or inadvertent disclosure of information, except as required by law.

Written policy must address the confidentiality of patient medical information and reflect an understanding of HIPAA regulations. Medical record review must include determination of provider compliance with Hennepin Health's chosen practice guidelines. (NCQA QI 2B(2)). In accordance with NCQA documentation guidelines, individual records are audited for compliance according to Hennepin Health's medical record standards. Hennepin Health's standards address the presence of the following:

- Patient identification
- Personal demographic data
- Author identification
- Dated entries
- Legibility
- Problem lists
- Allergies
- Past medical history
- Notation regarding smoking, alcohol, and substances
- Purpose of the visit
- History and physical exam
- Medications
- Diagnosis
- Patient referrals
- Test results and evidence of review
- Plan/treatment/follow-up care
- Preventive screening

- Health education
- Counseling regarding high-risk behaviors
- Mental health status
- Advanced directive status
- Immunization record

Communication and Report of Findings (NCQA QI 2B(2))
Hennepin Health utilizes opportunities such as the annual HEDIS project and medical records abstractions to assess provider compliance with Hennepin Health standards. Any standards not met are addressed in a letter within thirty (30) days of the audit. Hennepin Health will notify the facility by letter and also may request a corrective action plan within sixty days. If a corrective action plan is not received, the Credentialing staff will notify the Chief Medical Officer and Provider Relations for further direction and action. Communication to the QM Committee is provided quarterly. It is within the purview of the Hennepin Health Chief Medical Officer to determine when a deficiency is of the magnitude that a special review by the QM Committee is required.

Responsibility of the QM Committee (NCQA QI 1A(6) & 2A)
The QM Committee reviews all exceptions to provider medical records findings on a quarterly basis. If further corrective action is required, the committee recommendations are given to the QM Manager and Hennepin Health Chief Medical Officer for further follow-up, which may include; corrective action plans, censure, revocation of participating privileges, withhold of payment and termination of contract

7.2 Care Coordination (Model of Care)
The care coordination program is designed to provide a continuum of health care services between the member's home, clinic provider, outpatient services, acute hospital stays, and nursing home. Members selected for care coordination (also called case management) may include but are not limited to:

- Special Needs Basic Care
- Members with HIV or AIDS, and Diabetes (NCQA QI 1A(9))
- Members with disabilities or chronic health problems (NCQA QI 1A(9))
- Members with end stage renal disease (ESRD) (NCQA QI 1A(9))
- Members requiring transplants (NCQA QI 1A(9))
- High-risk obstetrical cases (NCQA QI 1A(9))
- Members with conditions prone to acute exacerbation such as asthma (NCQA QI 1A(9))
- Members with complex care and disease management (behavioral health, asthma, and cardiovascular disease) (NCQA QI 1A(9))

Process:
A Care management is a structured system involving many key components. The process is systematic and cyclical, involving; assessment, care planning, outcome identification, implementation, monitoring, and evaluation. The emphasis is to maintain or improve health, functional ability and prevention of illness and injury for members. An information system with common database elements is used to record fundamental care coordination processes and member information (CCMS, or CareEnhance Clinical Management Software®).

Goals of Care Coordination

- Quality care and member satisfaction through a consistent approach to case management and outcomes-based care evaluation.
- Continuity of care between providers and sites of services with a single care coordinator planning, coordinating and evaluating care.

- Integration of services.
- Elimination of redundant service and activities.
- Enable member's access to health care services.
- Cost efficiencies.
- Reduction in predictable and preventable adverse outcomes.
- Transitions of care.

QM Collaboration and PIPs
The QM provides support to the care coordination program. QM collaborates with other health plans to develop and disseminate tools and guides for care coordinators to use to improve outcomes for members of the SNBC program. QM also engages in Performance Improvement Projects (PIPs) that focus on aspects of Care Coordination. It is the goal of Hennepin Health to work collaboratively with the other Minnesota Managed Care Organizations and Minnesota's Quality Improvement Organization (Stratis Health), to design projects for the SNBC populations that will meet the requirements of the CMS Quality Improvement Activities ("QIPs"). All PIPs/QIPs follow the federal protocol for conducting a quality improvement project. PIPs are submitted to the Minnesota Department of Human Services (DHS) for validation before they are implemented. The complete care coordination process can be found in Hennepin Health's Coordination Manual.

Member Identification of PIP Eligibility
Members in a PIP and/or focus studies are identified at several points in their enrollment with Hennepin Health. Welcome calls at enrollment include questions about chronic diseases or high risk conditions and "Alerts" are immediately sent to the disease management staff to initiate contact with the members. During the initial Health Risk Assessment (or equivalent), conditions related to a PIP and/or focus studies are identified and a member is passively enrolled into the project unless active enrollment is required. In most cases, passive enrollment is sufficient to allow educational mailings and claims tracking to occur. If there is an incentive or item (i.e. car seat), then members need to actively enroll in the program. During any claims encounter, triggers are programmed to watch for specific conditions (i.e. Pregnancy, Diabetes, Asthma) and various actions take place as a result of a claim including "stratification" and possibly a contact with the county eligibility unit. Pharmacy utilization is monitored for drugs that indicate the presence of a condition and adherence with treatment. Asthma inhalers, blood pressure medications, etc., are identified and letters are sent to prescribers if the members are missing refills. This is part of the Medication Therapy Management Program. Member materials explain how a member can join a disease management programs. SNBC Care Guides offer programs to members during home visits or via telephone calls.

Responsibilities of the QM Committee (NCQA QI 1A (6) & 2A)
The QM Committee reviews the annual summary report of Care Coordination activities and Performance Improvement Projects (PIP) reports. They also make recommendations and oversee corrective action plans when issues are identified.

7.3 Practice Guidelines
Hennepin Health adopts behavioral health, chronic disease and preventive care clinical practice guidelines. On an annual basis, the QMC reviews existing guidelines in consultation with Hennepin Health's Chief Medical Officer, QM and UM department staff. Guidelines are selected based on clinical evidence, professional recommendations and consensus, and the identified needs of Hennepin Health's enrollees. The selection and review process includes:

- Review of government positions on health care via authorized sources (MDH, DHS, HealthyPeople.gov).

- Analysis of Hennepin Health's over/under utilization rates.
- Review of current literature pertaining to guidelines and measurement (ICSI, NCQA HEDIS, MNCM, USPSTF and medical journals).
- Input from Hennepin Health's QMC including board-certified practitioners and appropriate specialties
- Consensus obtained from QMC regarding Hennepin Health's decision to adopt the guideline.

Hennepin Health encourages the use of all current and standard guidelines, but also recognizes the key role of a provider having the ability to practice within the scope of their professional knowledge. It is Hennepin Health's intention to continue collaborating with its provider advisors on the annual adoption of clinical practice guidelines. Hennepin Health's ultimate goal is to help members improve their health outcomes and assist providers in delivering the highest quality care.

7.4 Patient Safety (NCQA QI 1A(3))

Purpose & Process:
In order to promote a supportive environment that will help Hennepin Health providers continuously improve the safety of their practices, QM performs ongoing reviews of adverse outcomes. QM monitors for patient safety issues by reviewing adverse outcomes. This process may be applied to any adverse outcome including, but not limited to the following:

- Medical/surgical mishaps
- Facility incidents
- Treatment complications
- Premature discharge.

Documentation
Quality of Care/Service investigation data are documented in an integrated internal Hennepin Health database ("QM Tracker"). Member confidentiality is ensured by limiting access to this database to QM staff, Hennepin Health's Chief Medical Officer, and only those IT personnel who support the database and its server.

QM Committee Responsibilities (NCQA QI 1A(6) & 2A)
The QM Committee reviews, on a quarterly basis, quality of care/service outcomes. The QMC may determine there is a concern in areas such as a pattern of frequent readmissions (adjusted for risk) at the individual provider or group level. The QMC will then make recommendations on how the concern should be further studied and any follow-up action.

7.5 Performance Improvement Project

Purpose:
Performance Improvement Projects (PIPs) are developed according to a systematic approach outlined by the Centers for Medicare & Medicaid Services (CMS) and designed by the state Department of Human Services (DHS). Hennepin Health conducts ongoing quality improvement projects designed to achieve, through a cycle of measurement, intervention, and re-measurement, significant improvements in health outcomes and member satisfaction. These projects are designed to assess and improve processes, and thereby outcomes of care. Each year, one new project is initiated for Hennepin Health – PMAP and Hennepin Health – SNBC member groups.

Process:
A PIP is conducted in a four-part cycle; Project Proposal, Intervention Initiation, Measurement One and Measurement Two.

1. Project Proposal: By September 1st of each year, Hennepin Health proposes a performance improvement project with a topic selected from a list developed by DHS or through collaborative discussion around membership needs. The project plan incorporates the following steps required by DHS and CMS:

    - Select the study topic
    - Define the study question
    - Select the study indicator(s)
    - Use a representative and generalizable study population
    - Use sound sampling techniques (if sampling is used)
    - Reliable data collection
    - Implement intervention and improvement activities
    - Analyze data and interpret study results
    - Plan for "real" improvement
    - Achieve sustained improvement over two measurement cycles

2. Intervention Initiation: The intervention is implemented by the first quarter of the second year. By December 1st, an interim project summary is completed and kept on file.

3. Measurement One: Data analysis of the previous period's intervention is performed, and an interim project summary, noting any project modifications, is completed and kept on file.

4. Measurement Two: Data analysis of the previous period's intervention is performed, and an interim project summary, noting any project modifications, is completed and kept on file. All interim reports are posted to MN-ITS, per DHS regulatory guidelines.

If Hennepin Health is unable to demonstrate improvement in the area of study, the modified project may be extended for additional measurement cycles, which would create a 5th cycle, called Project Extension.

Data Integrity
All data collected for a QM study are those items minimally necessary for analysis of the subject. All data are handled, stored, and destroyed according to HIPAA regulations and Hennepin Health's Data Privacy and Records Retention policies. Upon completion of a study, the data is presented to and approved by the Hennepin Health Chief Medical Officer prior to presentation to the QM Committee. The QM Committee reviews the study's methodology and validity. (NCQA QI 1A(4&6) & 2A)

Responsibilities of the QM Committee (NCQA QI 1A(6) & 2A)
The responsibility of the QM Committee in regards to PIPs is to make topic recommendations for future projects; review the annual summary report of projects and recommend/oversee corrective action plans when issues are identified.

7.6 Special Services Programs (NCQA QI 1A(8&9))

Purpose:
Special Services Programs or projects are developed to help provide adequate services to Hennepin Health's members. These projects are designed throughout the years by the Quality Management Department, Outreach and Medical Administration. These projects are designed to assess and improve processes, and thereby outcomes of care.

Listed below are several special services programs:

- Health. Care. Respect. Campaign

- Pregnancy/ Post-partum care incentives
- Well child and teen check-ups
- Medication Therapy Management
- YMCA, Transportation, and Cellular Services

Medication Therapy Management (MTM)
The 2005 Minnesota Legislature directed the Minnesota Department of Human Services (DHS) to pay qualified pharmacists for Medication Therapy Management Services (MTMS) for Medical Assistance (MA), or MinnesotaCare recipients, effective for dates of service on or after April 1, 2006. The MTMS program was developed with input from an advisory committee representing pharmacy groups and other interested parties.

The criteria for the given program include the below mentioned items. Per Centers for Medicare and Medicaid Services (CMS) guidelines; members targeted for the MTMS are those who:

- Have three or more of the targeted chronic diseases
- Are taking at least eight covered Part D drugs
- Are likely to incur annual costs for covered Part D drugs in excess of $3,000.

Medication Therapy Management services include the following service definitions:

- Performing or obtaining necessary assessments of the patient's health status.
- Formulating a medication treatment plan.
- Monitoring and evaluating the patient's response to therapy, including safety and effectiveness.
- Performing a comprehensive medication review to identify, resolve, and prevent medication related problems, including adverse drug events.
- Documenting the care delivered and communicating essential information to the patient's other primary care providers.
- Providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications.
- Providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens.
- Coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

In regard to the eligibility criteria to provide MTM services, pharmacists must enroll individually with MHCP and be a Minnesota licensed pharmacist. Additional guidelines include the following:

- Have graduated from a college of pharmacy after May 1996 or passed a DHS approved Accreditation Council of Pharmacy Education (ACPE) program that has both didactic and clinical elements.
- Practice in a pharmacy or an ambulatory care setting, such as a clinic or hospital, as part of a multidisciplinary team.
- Have a structured patient care process allowing for assessment, development of a care plan and evaluation.
- Use an electronic MTMS documentation system that is specifically designed to optimize the therapeutic outcomes of the patient's medications; and
- Meet Privacy/Space requirements.

Eligible Recipients
PMAP and MinnesotaCare (fee-for-service and managed care) Recipients are eligible for MTMS if they are:

- An outpatient (not inpatient or in an institutional setting);
- Not eligible for Medicare Part D; and
- Taking four or more prescriptions to treat or prevent two or more chronic conditions.

Recipients not meeting these criteria may still be identified by DHS as recipients who would benefit from MTM services and referred to a qualified pharmacist.

Special Needs Populations (SNPs) (NCQA QI 1A (8&9)
To meet the requirements set forth by the Minnesota Department of Human Services, Hennepin Health follows the SNP policies for serving all SNPs.

Care management requirements state that all SNPs (SNBC) are required to implement an evidence-based model of care having explicit components. These components include:

- Measurable goals specific to the target special needs individuals.
- An adequate staff structure having care management roles.
- An interdisciplinary care team for each beneficiary.
- A provider network having specialized expertise pertinent to the target special needs individuals.
- Training on the model of care for plan personnel and contractors.
- Comprehensive health risk assessment for each beneficiary.
- An individualized plan of care having goals and measurable outcomes for each beneficiary.
- A communication network that facilitates coordination of care.
- Evaluation of the effectiveness of the model of care.

Hennepin Health designed its' model of care to accommodate the needs of the most vulnerable members of its target population; the frail, the disabled, those near the end-of-life, those having multiple or medically complex chronic conditions, and those who develop end-stage renal disease after enrollment.

The Interdisciplinary Care Team meeting is the confidential member specific communication venue for discussing a focused care conference that often addresses a single member needs/problem. For SNBC members, the need may be the chronic homelessness that accompanies chronic mental illness.

The focus of Hennepin Health's SNP quality improvement program is to measure indices of quality, beneficiary health outcomes and to evaluate the effectiveness of its model of care in meeting the needs of its targeted special needs individuals. Hennepin Health collects, analyzes, reports and acts on data through a systematic and continuous quality improvement program. Indicators used are selected from many quality domains such as; functional status, care transitioning, disease management, behavioral health, medication management, personal and environmental safety, beneficiary involvement and satisfaction, and family and caregiver support.

Hennepin Health reports the following data:

- HEDIS measures (if enrollment threshold is met)
- Consumer Satisfaction Surveys (CAHPS®) survey (if enrollment threshold is met)
- MTM measures for each SNP Member.

8 Utilization of Services

8.1 Purpose

The purpose is to promote the highest quality of health care for members, while reducing the use of inappropriate or medically unnecessary health care. This is done by identifying over- and underutilization of services (medical and behavioral), applying physician developed/established criteria and standards, along with community norms to screen medical and behavioral health care services. Efforts are also made to increase awareness among health care consumers and providers; comparing the cost and benefit of requested health services to alternative, traditionally proven methods of treatment. Through the promotion of guideline-based health care and the utilization of disease management and complex case management, Hennepin Health is able to optimize outcomes.

8.2 Goals and Objectives

1. To certify that health care is medically necessary, appropriate and of acceptable quality by providing a utilization review (UR) system that includes; inpatient and outpatient review, alternative care assessment, planning and implementation of case management services wherever indicated, data collection and reporting.

2. To identify high-quality, cost-effective alternative treatment and delivery modalities and facilitate their use when appropriate to the member's medical condition, if reasonably available within the community.

3. To promote timely interaction with Hennepin Health's members and providers in order to effect positive changes in current medical practice and purchase patterns; toward the delivery and utilization of more efficient, high-quality medical and behavioral care and services. (NCQA QI 2B)

8.3 Utilization Management Criteria

Hennepin Health has a firm commitment to the use of decision-making criteria that is objective and evidence based. Hennepin Health selects criteria from nationally recognized sources that are applicable to Hennepin Health's membership and the local care delivery systems. Hennepin Health's criteria include but are not limited to the following:

- Institute for Clinical Systems Improvement (ICSI)
- Minnesota Community Measurement (MNCM)
- InterQual
- HEDIS
- State of Minnesota benefit guidelines
- CMS Medicare benefit guidelines
- United States Preventive Services Task Force (USPSTF)

Detailed information about the adoption, application, dissemination and verification of guidelines is found in Hennepin Health's Utilization Management Program.

8.4 Behavioral Health Utilization Management (NCQA QI 1A(2), UM 1)

All behavioral (encompassing mental health and chemical dependency) health care services are managed according to the same goals and objectives as other medical services. The same criteria and guidelines for the management of medical services is used for behavioral health care. The following standards apply specifically to Hennepin Health's Utilization Management activities for behavioral health care: (NCQA QI 1A(2&5))

1. Hennepin Health employs a consulting psychiatrist to review behavioral health care for medical necessity denials and appeals.
2. A Registered Nurse performs all behavioral health care reviews, employing InterQual criteria.
3. Hennepin Health has a contracted network of behavioral health providers that is subject to the same credentialing, recredentialing, site visit, and audit policies as other medical providers.
4. Hennepin Health addresses potential barriers to member access to behavioral services by allowing covered care services provided by any Minnesota licensed provider.

8.5 Staff Qualifications (NCQA UM4)

A Registered Nurse, pharmacist and/or physician may each perform some aspect of utilization review (UR). Licensed Practical Nurses and administrative support staff, under the direction of a Medical Administration manager, may perform supporting duties. A Reviewer must demonstrate a full understanding of applicable clinical criteria for areas of UR responsibilities. The reviewer must have knowledge of diagnoses, conditions and familiarity with acceptable treatment plan standards of care. An ability to accurately compare clinical findings with UR criteria and accurately discern when the involvement of a physician reviewer is required is necessary skill.

1. All Hennepin Health employees conducting reviews of medical services and other clinical areas of specialty must be currently licensed and/or certified by the State of Minnesota.

2. All Hennepin Health employees involved in UR activities will be provided with a formalized orientation program, will be qualified for their duties and will have ongoing training and supervision of their UR activities.

3. A physician makes all decisions regarding denial of coverage and in situations where there are no applicable criteria or standards.

4. A mental health board certified psychiatrist will advise UR activities.

5. A senior physician is actively involved in implementing the UM program. (NCQA QI 1A(4))

6. UM program is annually reviewed and evaluated as necessary.

8.6 Data Information (NCQA UM 6)

Hennepin Health will only request the information minimally necessary to certify an admission or procedure in order to justify a length of stay. Any requests for medical record copies should be limited to copies of the pertinent portion of the medical record. Pertinent information is that which is needed to assist in the review, when a difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay. Hennepin Health may request copies of medical records retrospectively for auditing the services provided; quality of care oversight, ensuring compliance with the provider's contract with Hennepin Health and ensuring compliance with Hennepin Health's UR activities. Reimbursements are made to providers for the reasonable costs incurred to obtain the duplication of records requested, unless otherwise provided under the terms of the provider contract. Exceptions to reimbursement include records associated with an appeal and investigation or audit of data discrepancies.

8.7 Communication and Reporting of Utilization Findings (UM Committee)

Written reports and utilization analyses are submitted to Hennepin Health's Chief Medical Officer and other Directors. Hennepin Health analyzes UM data at least quarterly during the UMC meeting and provides a quarterly utilization summary to the QM Committee. (NCQA QI 1A(6) & 2A). The UM Committee reviews data and makes recommendations as appropriate regarding; utilization trends, rates exceeding community norms and appropriate application of guidelines. (NCQA UM 1)

9 Appeals and Grievances

9.1 Appeals and Grievances

The Appeals and Grievances (A/G) Department tracks and trends complaints to examine for reoccurring issues to identify a root cause. Hennepin Health also captures other issues that might arise from a complaint for possible correction. Root Causes and other issues are brought to the appropriate department for their review and possible process change to illuminate further complaints. All submissions are checked against actual complaint logs to verify that the submission is complete. Data submitted to DHS must be in the required format to be accepted. Hennepin Health will help the (member) complainant to file an appeal or grievance and can write the complaint for the (member) complainant if needed. The completed written complaint is sent to the (member) complainant to review and sign.

9.2 Oral Appeals and Grievances

Oral appeals and grievances received by telephone or in person are directed to the Hennepin Health Appeals/Grievances (A/G) Coordinator. These request can be standard or expedited. Some appeals are resolved by the A/G Coordination only and require no additional interventions. Any Quality of Care complaints that are received by the A/G Coordinator are sent immediately to the Manager of Quality Management. The A/G Coordinator is responsible for sending out a Quality Letter to the Complainant. (NCQA QI 2B(1)). Hennepin Health staff may receive/take grievance information from providers, members and others; staff can resolve grievances, but must always forward the grievance to the A/G Coordinator. Oral grievances that are not resolved by staff must be immediately forwarded to the A/G Coordinator for resolution. The A/G Coordinator will resolve and respond to the complainant. All oral grievances are resolved within ten (10) calendar days and are provided with the right to file at the Minnesota Department of Health.

9.3 Written Standard Appeals and Grievances

Written Standard Appeals and Grievance may be received by mail or courier. The written A/G will be date stamped upon receipt by Hennepin Health's reception area. Once date stamped, all written appeals and grievances are routed to the A/G Coordinator. The A/G Coordinator reviews the complaint and makes a determination if the complaint is an appeal, grievance, and/or quality of care. All Quality of Care complaints are immediately forwarded to the Manger of Quality Management. The A/G Coordinator is responsible for sending the Quality of Care letter to the member. All appeals and grievances are reviewed with the appropriate Hennepin Health internal departments, as well as any external associates, who Hennepin Health does business with to resolve each Appeal or Grievance, as it pertains to each complaint. Appeals and grievances are resolved as expeditiously possible, within 30 calendar days. Fourteen (14) calendar days may be taken if the complainant request an extension or if Hennepin Health needs additional information and an extension is in the member's best interest. If Hennepin Health deems an extension necessary, notification must be provided to the member regarding the reason for the decision to extend the timeframe. A determination must be issued no later than the date the extension expires. All appeals and written grievances receive a copy of the DHS approved rights notice. All members are also provided with these rights.

9.4 Expedited Appeals

Expedited appeals may be received orally or in writing. Hennepin Health must resolve as expeditiously as the member's health condition requires, but not exceeding seventy-two (72) hours after the receipt of the appeal. Hennepin Health will notify the member and attending health care professional by telephone of our decision and send a letter within twenty-four (24) hours. If Hennepin Health denies the request for expedited decision, the member is notified within twenty-four (24) hours and a written notice is sent within two days. Hennepin Health must transfer the denied request to the standard appeal process, preserving the first filing date as the receipt date. The Standard appeal process policy is then followed.

9.5 Appeals and Grievances Procedures Explanations and Notifications

The appeals and grievances procedures are summarized in marketing materials. A detailed description of the procedures are found in the Certificates of Coverage, Denial/termination/Reduction (DTR) Letters, and plan information packets. Non-English speaking members have special telephone numbers that provide them with access to interpreters. Member Services also provides members with additional explanation as needed. All public program documents are approved for content and literacy levels by the Minnesota Department of Health and Human Services before issuance by Hennepin Health.

9.6 Documentation, Communications and Reporting

Documentation is done in the Hennepin Health Appeals and Grievances database. Member appeal and grievance files are maintained by Hennepin Health for a period of 10 years. A quarterly report summary of all appeals and grievances is provided to the QM Committee for their review and comments. (NCQA QI 1A(6) & 2A). All Hennepin Heath providers are required to submit reports of complaints filed at the provider/clinic level per their contract with Hennepin Health. (NCQA CR 3A(5) & 3B(4) & 6A).

Authorized Representative

An Authorized Representative is a person who has assumed the responsibilities outlined in and pursuant to Minnesota Rules, Part 9505.0085, Subpart 2. A health care professional may appeal utilization review decisions at Hennepin Health without the written signed consent of the member in accordance with Minnesota Statutes, §62M.06. Oral appeals and grievances may be communicated to Hennepin Health by someone other than the member, if oral or written approval is received from the member. All appeals and grievances received in writing must be submitted by the member. If the member wants someone to represent them, a "Release of Information" must be signed by the member. (Exception is 7.a.) Documentation provided by the member must be secured and filed for purposes of an appeal or grievance (i.e. Power of Attorney).

10 Satisfaction with Care and Services (Surveys)

10.1 Surveys

Member Satisfaction Surveys

Member Satisfaction Survey measure the degree of member satisfaction regarding; physician care, hospital care, other medical services, level of benefit coverage, costs, access to care (appointment availability, location, courtesy and concern of providers), health education preferences, health plan customer service and communications (A DHS survey may be substituted for this process).

Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)

All surveys, depending on the sample size and the applicability to Hennepin Health's enrollment in the case of pooled results, will result in analysis and action times by Hennepin Health. The Annual Quality Work Plan reflects those topics prioritized by the organization as having broad applicability and being actionable on a long and short term basis. (NCQA QI 1A(7)). When possible, Hennepin Health utilizes HEDIS data as a measurement tool to track and trend the associated clinical changes related to member care over time.

Provider Satisfaction Survey

Network Management will use a validated survey instrument to measure provider degree of satisfaction regarding; system of referral, health plan communications, timeliness of reimbursement/prior authorization requests and response time.

Provider Access and Availability Surveys
Hennepin Health surveys a selected set of network primary care providers and specialists to inquire about appointment availability. The most recently generated quarterly report created for the Primary Care Network List is used to generate a sample. A sample of 25% or higher of the total number of primary care, specialists, outpatient mental health/chemical health and dental providers in each county are surveyed. Behavioral Health Providers and dental providers are surveyed semi-annually. The analysis will include a meeting to review/approve results, as well as plan a necessary course of action and corrective action plan. Follow-up with the affected providers will occur no later than 60 days after the information has been completed. If network providers demonstrate wait times in excess of the average of the community norms (as determined by the survey), Hennepin Health Network management will work with the provider in order to improve member access and ensure contract compliance. Corrective action review and analysis will occur by the first month of the following quarter.

Provider Access Protocol (complete access and availability policies in contracting department) (NCQA QI 2B(2))
Hennepin Health reviews geographic and appointment availability for provider services on a quarterly basis. Geographic access is analyzed by mapping member and provider locations to ensure that adequate geographic coverage is available. To ensure timely access to urgent and routine appointments, Hennepin Health places telephone calls to Hennepin Health providers to ensure that appointments are available within Hennepin Health's required timeframes.

Disenrollment Survey
A validated survey mechanism instrument may be sent to all Hennepin Health members to measure former member reason for disenrollment. A DHS disenrollment survey may be substituted for this process.

Communication and Report of Findings
A written summary of all survey outcomes and reports is submitted annually to the Hennepin Health Executive Director, Hennepin Health QM Committee and is communicated to stakeholders (members and providers) (NCQA QI 2B)

- Electronic newsletters, websites and mailings are used to notify providers of key results and messages.
- Newsletters, websites, social networking sites, and member events (face-to-face group meetings) are used to communicate changes/improvements.
- Hennepin Health also uses community TV/Radio sessions to talk about topics (e.g., KMOJ radio program, Somali TV program) (NCQA QI 1A(8))

QM Committee Responsibilities (NCQA QI 1A(6) & 2A)
The QM Committee will review all satisfaction survey and annual reports and recommend corrective action, as appropriate.

11 Health Education

11.1 Scope of Program (NCQA QI 1A(9) & 2B(1))
The QM program reviews health education services provided to members on an annual basis through the evaluation of the previous year's work plan. The information provided to Hennepin Health members covers a wide range of topics including (this is not an all-inclusive list):

- Diabetes (risk)
- Breast and cervical cancer

- Cardiovascular Disease
- Communications
- Diabetes
- Health Screening and Immunization
- Resources for Help
- Blood Pressure
- Influenza
- Rubella
- Smoking

During the audit of network providers by QM staff, an assessment is made regarding:

- The availability of general patient education materials.
- Specific materials targeting medical testing or procedures.
- Bilingual materials.
- If the provider or clinic serves a significant number of non-English speakers.
- Evidence of patient education and anticipatory guidance is reviewed in medical records.
- Also, evidence that members are informed of the name, title and basic credentials (i.e., MD, RN, DC) of the provider, typically through a name tag is also assessed.

12 Annual Quality Improvement Work Plan (NCQA QI 1A(7))

12.1 Purpose (NCQA QI 1B(1) & Content

The purpose of the Annual Quality Improvement Work Plan is to provide a detailed description of the proposed quality evaluation activities that will be conducted in the following year. The content of the work plan is prescribed by law and includes the following; clinical, organizational and consumer components. Organization components includes all aspects of the health plan that affect; accessibility, availability, comprehensiveness and continuity of health care delivery. Consumer components includes the member's perceptions, regarding all aspects of the quality of the health plan's service.

The Evaluation Steps

Problem identification

- Actual or potential problems
- May include monitoring of process, structure and outcomes.
- May include consumer components
- Must incorporate valid patient care and clinical criteria

Problem selection

- Assessment of prevalence and impact on members
- Ability to impact professional practices
- Corrective action
- Measurable objectives (NCQA QI 1B(2))
- Expected changes
- Time frames for actions
- Responsible parties

Evaluation of corrective action (NCQA QI 1B(3))

- Requires monitoring by Hennepin Health until the correction is sustained.
- Efforts must be documented

- Activities must be communicated to the governing body (see: Evaluation of Work Plan Section I C. 2).

Other studies (Allowed to replace focus studies)

- DHS mandated studies
- Multiple health plan collaborations
- Community based studies

Approved by QMC February 9, 2017

Approved by Hennepin County Board of Commissioners March 14, 2017