Metropolitan Health Plan
Cornerstone Solutions Model of Care

Model of Care Overview

Metropolitan Health Plan's Cornerstone Solutions Program is a Medicare Advantage Special Needs Plan for Dual Eligible.(Medicare and Medicaid). Cornerstone Solutions provides integrated Medicare and Medicaid services, along with coordinating social services for adults with disabilities between the ages of 18 – 64, who live in Hennepin County. Overall the mission and vision for the program are:

- **Cornerstone Solutions Mission:** To optimize the health and well-being of people with disabilities in a respectful, efficient and fiscally responsible way.
- **Cornerstone Solutions Vision:** To be the care system of choice for people with disabilities in Hennepin County.

The Cornerstone Solutions model of care builds on the strengths of the current program as well as continuing to refine and improve the quality of services delivered to adults who are dual eligible and certified disabled (special needs individuals). To accomplish the goals outlined in the Cornerstone Solutions model of care each enrolled special needs individual is offered a Care guide who provides personalized care coordination. Care guides serve as an identified point of contact for special needs individuals or authorized representative. Care guides assist enrolled special needs individuals with accessing services, coordinating care and addressing barriers to achieving optimal health and well being. Care guides also pull together the interdisciplinary care team (ICT) for each enrollee consisting of the enrollee or responsible party, primary care physician or health care home, behavioral health and other health care providers, as well as representatives from social services or community resources, as needed.

The care guide works with the enrollee or authorized representative to complete a health risk assessment (HRA). The HRA is completed within thirty (30) days of enrollment and annually thereafter. The care guide and the ICT work together to develop an individualized care plan (ICP) for the enrollee which is based on the enrollee or authorized representatives preferences and the results of the HRA. The ICP is holistic and tailored to meet the enrollee's special health care needs, strengths, benefits and community resources and addresses any barriers.

The purpose of the ICP is to help enrollee maintain optimum health and well-being or improve functioning through services that are provided in the right setting, at the right time and in the right amount. The ICP includes long-term and short-term goals; identification of barriers to meeting the goals; schedule for follow-up; and self-management plans, if applicable. In addition, the ICP includes an evaluation of available benefits and resources and care giver resources, if applicable.

In addition, care guides are responsible for supporting enrollees during all planned and unplanned transitions across health care settings, care providers, and health services and communicate with the ICT including the enrollee or authorized representative; primary care physician or health care home; and the receiving and sending health care settings. To facilitate communication with all relevant parties during transitions in care, Cornerstone Solutions has partnered with the Minnesota Department of Human Services and other Special Needs Plans in Minnesota to develop an Individual Care Transition Log (ICTL). The ICTL is

used to document support provided during transitions in care and communication to the members of the ICT regarding the enrollees special needs during a transition in care. Care guides continually monitor enrollees care by maintaining regular contact with each enrollee or responsible party, relevant providers and members of the ICT. Care guides also monitor physician reports, emergency room and facility admission reports, pharmacy profiles and dental reports, as well as data collected through utilization management to assist in access to needed services and coordinating care.

Finally, in light of the federal and state health care reform initiatives including the Medicare Improvements for Patients and Providers Act of 2008 and the Affordable Care Act, Metropolitan Health Plan's (MHP) Cornerstone Solutions program continues to refine and improve our model of care to align with the Centers of Medicare & Medicaid Services initiatives. MHP is exploring the opportunity to develop an Accountable Care Organization within out Hennepin County family which includes the Hennepin County Medical Center, Hennepin County Human Services and Public Health, as well as a county operated Federally Qualified Health Care Clinic (FQHC) and community physicians and clinics. These are challenging times for health plans, MHP is ready to meet the challenge and provide the highest level of care for the most vulnerable populations.

1. Description of the SNP – Specific Target Population

Many individuals with chronic, disabling conditions require a combination of health care and social services to live independently in the community. Cornerstone Solutions is a dual D-eligible (D-SNP). The target population includes special needs individual's who are:

Medical Assistance (Medicaid) and Medicare Part A & Part B or Medical Assistance (Medicaid) eligible only. Certified Disabled or Blind. This includes individuals who are:

- Disabled due to a physical health disability, mental health disability, developmental disability or traumatic brain injury. Potential enrollees are certified blind or disabled through the Social Security Administration (SSA) or the State Medical Review Team (SMRT) or certified disabled by the county for the purpose of the Developmental Disability waiver.
- Persons 18 – 64 years of age. Persons who turn age 65 after enrollment will have the option of remaining in the program unless they choose to become a participant in the Elderly Waiver (EW) and receive their Home and Community Based Services through the EW waiver.
- Resident of Hennepin County, Minnesota. Special needs individuals may be living in the community, foster care, assisted living, intermediate care facility, or long-term care facility.

Excluded Populations

The following persons are considered excluded populations and are not eligible to enroll:

- Persons committed to a regional treatment center with a diagnosis of sexual psychopathic personality or as sexually dangerous persons.
- Person residing in a Regional Treatment Center. These individuals may be eligible to enroll upon discharge, if they meet the other eligibility criteria.
- Persons who have Medicare coverage through United Mine Workers.
- Persons with a diagnosis of End State Renal Disease (ESRD) prior to enrollment
- Persons diagnosed with ESRD after enrollment may remain enrolled in the program.

Demographics of current population

All of our Cornerstone Solutions Special Needs Plan enrollees are disabled and therefore high risk populations. Overall, they are poor and have complex and chronic illnesses. Our current enrollees are predominantly mentally ill and chemically dependent. Many of our current enrollees have also experienced homelessness and problems with the legal system. Additionally, our current cohort of enrollees:

- The majority of our current enrollees are male 57% and 43% are female
- Almost half of the enrollees 47% are dual eligible (Medicaid and Medicare eligible)- and 52% Medicaid only eligible
- Almost half of the enrollees (49%) are between 50 – 65 years of age.

The exact demographic breakdown of enrollees fluctuates over time.

2. Cornerstone Solutions Model of Care Goals

Cornerstone Solutions model of care has an overarching aspiration to improve access to a full-range of services designed to meet the needs of the specialized populations; improve customer service and enrollee satisfaction with care; and enhancing the quality and accountability of services delivered. A key element to the success of the Cornerstone Solutions model of care is to assign each enrollee a care guide who offers personalized care coordination. The care guide functions as a single identified point of contact for each enrollee and authorized representative. Care guides assist enrollees and authorized representatives by assessing strengths, health risks and needs; developing an individualized care plan (ICP), coordinating the interdisciplinary care team (ICT), ensuring access to and coordination of covered benefits, facilitating access to social services and community resources; and assistance with addressing barriers to optimal health and well-being.

The Cornerstone Solutions specific model of care goals include:

Goal 1: Improve access to essential services such as medical, mental health, and social services.

This goal is measured on completion of the health risk assessment and individualized care plan. The care coordination management team will complete an annual care guide delegation audit. The measure of success is at least a 5% improvement from the previous year up to 80% of enrollees with a health risk assessment and individualized care plan. Once 80% is reached we will sustain that level for three years and then this goal will be retired and a new measure will be established to improve access to essential services.

Goal 2: Improve access to affordable care.

This goal is measured by MHP's pharmacy benefit manager quarterly and reports to the QMC bi-annually. The measure of success is reaching an industry benchmark of 99.6%.of generic drug substitution for non-psychotropic medications utilization. Once 99.6% generic substitution for non-psychotropic medications is reached we will sustain that level for three year and then this goal will be retired and we will establish a new measure of affordable care.

Goal 3: Improve coordination of care through an identified point of contact for each enrollee.

This goal is measured on completion of the health risk assessment and individualized care plan. The care coordination management team will complete an annual care guide delegation audit. The measure of success is at least a 5% improvement from the previous year up to 80% on completion of the health risk assessment and individualized care plan. Once 80% is

reached we will sustain that level for three years and then this goal will be retired and a new measure will be established to improve access to essential services.

Goal 4: Improve seamless transitions of care across healthcare settings, providers and health services by increasing transition of care management and communication with the enrollees, primary care physicians and other participants on the ICT.

This goal is measured by the care coordination management team during the annual care guide audit. The measure of success is at least a 5% improvement from the previous year on the completion of the Individual Care Transitions Log (ICTL). The ICTL is a tool that was developed by a collaborative of Minnesota special needs plans (SNP) to document the transition of care management and communication with the enrollee or authorized representative, enrollee's primary care physician and participants on the ICT. Once 100% of documenting transition management and communication is achieved for planned transitions and 80% of documenting transition management and communication for unplanned transitions is reached we will sustain that level for three years. Then this goal will be retired and a new measure will be established to improve seamless transitions of care across healthcare settings, providers and health services.

In addition, Cornerstone Solutions has a performance improvement project (PIP) /quality improvement project (QIP) on transitions of care. One of the elements in the overall PIP/QIP is to improve the enrollee's knowledge about medications and knowledge of when a condition is worsening and how to respond, as well as management of their own personal health record. This goal will be measured by administration of a care measure transition

(CMT) survey. The measure of success is at least a 5% improvement from the previous year. (see Quality Improvement Program Narrative element 5 on page 4-6)

Goal 5: Improving access to preventive health care services by increasing the percentage of enrollees who have a preventive care visits.

This goal is measured is measured by the quality management staff through claims/encounter data that is collected annually. The measure of success is at least a 5% improvement from the previous year up to 92% of new enrollees receiving preventive care visits within the first six (6) months of enrollment. Once 92% is reached we will sustain that level for three years and then this goal will be retired and a new measure of success will be established for improving access to preventive health care services.(see Quality Management Program Narrative element 5 pages 4-6)

In addition, HEDIS Adult Preventive Care measure is collected annually by the quality management team based on claims/encounter data. The HEDIS benchmark for adults with preventive health care is 92%. (see Quality Management Program Narrative element 7 on page 7)

Goal 6: Assure appropriate utilization of services by reducing potentially avoidable ED visits from the previous year and increasing substitution of generic for non-psychotropic medications.

This goal is measured by quality management staff annually using HEDIS claims/encounter data. The measure of success is a 5% reduction in potentially avoidable ED visits. (see Quality Plan Narrative section 7 on page 7)

In addition, this goal is also measured by MHP's pharmacy benefit manager quarterly and reported to the Quality Management Committee (QMC) bi-annually. The measure of success is reaching the industry benchmark of 99.6% in the use of non-psychotropic medications. Once 99.6% generic substitution is reached for non-psychotropic medications we will sustain that level for three year. This goal will then be retired and we will establish a new measure of success for affordable care .

Goal 7: Improve enrollee's health outcomes. This includes ensuring enrollees are able to:

- Access services in the least restrictive environment appropriate.
- Reduce in-appropriate or unnecessary emergency room, hospitalization and nursing home placement;
- Improve independence and self management;
- Improve mobility and functional status;
- Improve pain management
- Improve quality of life as perceived by enrollee, and
- Improve satisfaction with health status and health care services.

This goal is measured on completion of the health risk assessment and individualized care plan. The care coordination management team will complete an annual care guide delegation audit. The measure of success is at least a 5% improvement from the previous year up to 80% on completion of the health risk assessment and individualized care plan. Once 80% is

reached we will sustain that level for three years. This goal will then retired and a new measure will be established to improve access to essential services.

In addition, Cornerstone Solutions conducts a bi-annual enrollee event. During this event enrollees have an opportunity to complete enrollee feedback survey including providing feedback on quality of life and satisfaction with health status and health care services.

Each of these goals is described in greater detail in Section 11 on pages 44 – 50 Performance and Health Outcome Measurement (Chart 2).

Action Based on the Results

The purpose for the evaluation of the model of care performance and health outcome measures is to follow-up on the results with a series of actions. To do so Metropolitan Health Plan (MHP) Cornerstone Solutions program has a number of avenues through contracts, personnel rules, as well as administrative and clinical policies and procedures.

For network providers, MHP has a specific “cure period” in our contracts to address any deficiencies found in care guide services. A corrective action plan is developed for any deficiencies including findings, development of “cure” and time frames. Generally, the cure period is 30-days, however, a serious deficiency could require immediate cure and a minor issue could be allowed to wait until the next update period (such as routine update to a policy or correction of a typo). Services that are over- or underutilized with a specific clinic or practitioner are addressed on a case-by case basis. Personnel issues are addressed through

training, coaching and progressive discipline, as outlined in the personnel rules and regulations.

Overall, action taken is based on the results of performance and health outcome measurement; identification of opportunities for improvement; professional judgment and significance. Actions may include but are not limited to:

- New or revised policies or procedures
- Corrective Action Plans
- Performance Improvement Projects
- Additional training for personnel, network providers, Care Guides, enrollees or Interdisciplinary Care Team members
- New or revised communication mechanisms or mechanisms for documentation
- Imposing or reducing an authorization or notification requirement
- Over utilizing practitioner will receive a notice from the Medical Director regarding the test, service or pharmaceutical. outbound call campaigns
- Increased supervision of individuals with special needs
- Increased Communication to providers
- Additional Outreach Events
- Monitoring for failure to refill medications
- Monitoring compliance to health risk assessment, individual care plans or treatment plans performance standards
- Communication to or from a Care Guide
- Communication to or from the participants on the ICT

3. Staff Structure and Care Management Roles

Metropolitan Health Plan has the full complement of staff to perform all administrative and clinical functions associated with implementing the model of care including enrollment, member services, provider services, claims processing, contracting, credentialing, information technology, fiscal and encounter data reporting, compliance, and medical administration staff. (See Attached Organizational Chart).

Staff directly involved in the administration of the model of care include: contracted care guide agencies; specialists and consultants, and staff responsible for administrative and clinical oversight. Each of these areas is described in greater detail below.

Administrative Functions Related to the Model of Care

Metropolitan Health Pan (MHP) has an Enrollment Department that works closely with the Cornerstone Solutions care coordination management team to perform the monthly enrollment and care guide agency assignment processes. Each month Cornerstone Solutions receives two enrollment reports from the Minnesota Department of Human Services (DHS). DHS also performs third party administrator functions for both Medicaid and Medicare eligibility and enrollment.

Enrollment reports are reviewed by the Cornerstone Solutions care coordination management team. The care coordination management team consists of a program manager, principal planning analyst and lead care guide staff. The care coordination management team collects all available and relevant information and assigns all new enrollees to a care guide agency that is best suited to meet the enrollee's needs. MHP's enrollment information is also uploaded into CareEnhance Clinical Management Software (CCMS) which functions as an integrated electronic record for eligibility verification; care guide assignment; disease management records; claims information; and communication with appropriate staff from across the health plan.

Contracted Care Guide Agencies

Metropolitan Health Plan contracts for care guide services with several private care management agencies that specialize in serving enrollees with mental health disabilities, developmental disabilities and physical health disabilities. Care guides must be social workers, public health or registered nurses, physician assistants, nurse practitioners, or physicians.

Care guides are responsible for assessing enrollee health risks, developing an individualized care plan, coordinating care, educating enrollees on self-management techniques, making referrals for other services as needed.

Additionally, Cornerstone Solutions enrollees with a severe and persistent mental illness (SPMI) are eligible to receive Mental Health Targeted Case Management (MH-TCM) services. Cornerstone Solutions works to integrate care guide and MH-TCM functions whenever possible to avoid duplication and improve service delivery.

Care guides also have regular access to pharmacy profiles, claims, provider reports, laboratory findings, and utilization data to improve quality of care as well as efficiency. Some examples of the data that is available to care guides include daily emergency room and health care facility admission reports, monthly preventive care reports, high dollar claim reports and medication therapy management (MTM) reports.

Specialists and Consultants

In addition, Metropolitan Health Plan's Medical Administration Department has a number of clinical consultants on staff or under contract including physicians with specialties in emergency department and geriatrics, pharmacists, disease management staff, chemical health and mental health professionals, including consulting psychiatrist available to work with care guides. MHP also has the ability to secure second opinions or additional consultation from a wide variety of medical, behavioral health, dental and pharmacological experts, as needed.

These clinical staff and contracted specialists participate on various committees responsible for the overall management of the Cornerstone Solutions program and provide consultation to care guides, as needed.

Administrative and Clinical Oversight

In addition, MHP conducts pre-delegation audits of contracted Care Guide agencies prior to the delivery of services to ensure the agencies have the capacity to meet the performance standards. These audits review the agencies clinical policies and procedures as well as fiduciary information. The audits are conducted on an annual basis by MHP's Quality Department. In addition, clinical audits of the contracted care guide agency enrollees file including health risk assessments, individualized care plans, case notes and other relevant documentation are also conducted annually by the Medical Administration Department.

4. Interdisciplinary Care Team (ICT)

Cornerstone Solutions utilizes interdisciplinary care team (ICT) approach for care planning with all enrollees at least annually. The ICT consists of enrollees or responsible parties, the

enrollee's primary care physician and other service providers and supports included on the enrollees care plan, as needed. The exact composition of each enrollees ICT is based on the needs and preferences of the enrollee or authorized representative and may also include but is not limited to:

- Enrollee or an authorized representative and family or natural supports, whenever feasible
- Enrollee's primary care guide
- Enrollee's primary care physician
- Medical director or other licensed physician or nurse practitioner
- Pharmacy staff
- Medical supervisor or administrator
- Nurse practitioner, registered nurse, physician's assistant, nurse educator, social worker or community resource specialist
- Restorative health specialist (physical, occupational, speech or recreational therapist
- Behavioral/mental health specialist (psychiatrist, psychologist, drug or alcohol therapist)
- Board-certified physician.
- Dietician/nutritionist.
- Disease management specialist
- Pastoral care specialist
- Preventive health/health promotions specialist
- Social service or community resources

Care guides and ICT participants work together to coordinate care and facilitate access to appropriate services and community resources for members. Care guides share the results of the health risk assessment and stratification with the ICT. In addition, care guides notify the ICT anytime there is a planned or unplanned transition in health care settings. Changes to the individualized care plan are documented in the enrollee's record and maybe implemented by one or more members of the ICT.

Annual Interdisciplinary Care Team

Care Guides conduct ICT care planning process for all special needs enrollees at least annually. Care guides endeavor to meet with enrollees or authorized representatives and participants on the ICT for face-to-face. ICT meetings will be held as needed for:

Enrollees who are not making progress in meeting most of their care plan goals, or a care plan goal considered vital to their health and well-being

- Enrollees with high emergency department use, high in-patient hospitalization or high pharmaceutical use.
- Enrollees meeting care plan goals, but considered a complex case due to multiple medical or mental health or social service issues
- Enrollees with a significant change in health status
- Enrollees who transition to another health care setting

However, if face-to-face meetings are not feasible, ICT members may participate in care planning via teleconference, exchange of written information, and other HIPAA compliant electronic interfaces or virtual correspondence communication. The IDT care planning process includes:

- Basic information: age, language, cultural considerations, household makeup
- Results of the health risk assessment and stratification including the members' major health issues; diagnoses and medical history; mental and chemical health; and any concerns or social issues (e.g., abuse or housing problems)
- Pertinent medication information
- Special needs individual's' key providers (e.g., medical home, home care, mental health) and other informal supports
- Special needs individual's health care preferences
- Key goals of care plan
- Specific areas of concern or questions for ICT
- Transitions in care

The results of the health risk assessment, stratification of needs, individualized care plan and recommendations are shared with all members of the ICT. In addition, if the enrollee was not available to participate in the ICT care planning, one or more participants of the ICT (usually the primary care guide) contact the enrollee or their responsible party and discuss the recommendation(s). Care guides document the ICT in CareEnhance Clinical Case Management System (CCMS) or in a delegate's care guide agency case management system, specifically indicating recommendations that are included in the individualized care plan.

Cornerstone Solutions Medical Administration staff will perpetually audited the ICT process to ensure effective and members' needs are being met. This will be done by completing a comprehensive audit of care guide agencies at least annually; regularly reviewing the model of care performance and health outcome measurement; and regular offerings of training and consultation.

Dissemination and Documentation of the Health Risk Assessment (HRA) and Individualized Care Plan (ICP)

The enrollee or their authorized representative and participants on the interdisciplinary care team (ICT) are given a copy of the results of the health risk assessment and stratification, as well as the individualized care plan (ICP) and any updates or revisions. After the enrollee reads the ICP, agrees with it, and signs off on it, copies of the ICP are faxed to relevant providers, including the primary care physician or medical home and other participants on the ICT who need a copy to supply appropriated care. The ICP is maintained in a HIPAA compliant manner in CCMS (the health plan electronic case management system) or the contracted care guide agency records and preserved from destruction. Care guide records are required to be maintained for at least ten (10) years. Care guide agencies also send al1 new

and updated HRA's and ICP's to Cornerstone Solutions for incorporation into CCMS the health plan's electronic case management system.

5. Provider Network and Clinical Practice Guidelines

MHP contracts with an extensive provider network that includes a range of provider specialists. These providers are located throughout MHP's service area. Additionally, enrollees who do not speak English an obtain services from providers that speak their language or, if those providers are not available, then interpreters are made available.

The Provider network includes facilities as well as primary care providers, and physician specialists. Analysis is done annually assure that there are hospital and primary care specialists within 30 miles of each enrollees and specialists within 60 miles. MHP's network also includes all the major physical rehabilitation providers in the service area.
(See Cornerstone Solutions Provider Accessibility Report)

In addition, MHP reviews the adequacy of its provider network and reports annual to CMS on the number of providers by specialty that are in MHP's network and how many of these providers are accepting new patients. (See Cornerstone Solutions Access Report)

Finally, the majority of Cornerstone Solutions current enrollees have a mental health diagnosis. MHP has an extensive network of over two hundred (200) behavioral health

providers including a strong network of providers with an expertise in serving persons with serious mental illnesses.

Network Provider Licensing and Credentialing

MHP credentials professionals in its network to assure that they have appropriate licensure and accreditation and have no outstanding state or federal sanctions. MHP verifies all information with the assistance of a primary source verification organization or through information obtained from delegated entities. Practitioners must be credentialed if they:

- Have independent relationships with organizations,
- Provide services to enrollees outside the inpatient hospital setting or outside free-standing, ambulatory facilities,
- Are hospital based, but also see MHP enrollees as a result of their independent relationship,
- Are dentists who provide care under MHP's medical benefits, or
- Are non-physician practitioners who have an independent relationship and provide care under MHP's medical benefits**.**

Re-credentialing is done every three years to assure that providers in MHP's network continue to be in good standing and qualified to care for MHP enrollees. MHP also assures that hospitals, home health agencies, skilled nursing facilities, free-standing surgical centers and behavioral health providers are assessed. This is done by confirming that the providers are in good standing with state and federal regulatory bodies and have been approved by an accrediting body. MHP performs an onsite assessment of those providers that are not accredited by an appropriate agency. (See Quality Management Plan)

Service Delivery to enrollees

MHP allows enrollees to determine services they wish to receive and to select providers within the network. All Cornerstone Solutions enrollees are assigned a care guide to assist them to obtain not only medical care but also to connect enrollees with social services and housing that is needed to promote maximum health and independence, as needed.

The care guide assists the enrollees to establish a primary medical home; accessing disease management and health care services; and will work with the enrollee or authorized representative and the enrollee's primary care physician to promote medication adherence. The enrollee can also receive assistance accessing social services and community resources such as food shelves, housing resources, clothing shelves, etc., as needed.

In addition, to assure that enrollees are able to contact their health care providers, MHP provides a medical cell phone to enrollees who do not have access to a phone. The medical cell phone has phone numbers for their care guide, primary care physician and service providers are pre-programmed into the phone.

Provider Network Coordination with enrollee and interdisciplinary care team (ICT)

Providers who are directly involved with MHP's Cornerstone enrollees are included on the interdisciplinary care team established to ensure communication and coordination of care. Among the types of providers that might serve on the ICT are a primary care physician; a nurse practitioner, physician's assistant, social worker or community resource specialist; a

registered nurse; a physical, occupational or speech therapist; a behavioral health specialist a dietician; a disease management specialist and a preventive health / health promotions specialist.

Members of the ICT also receive copies of individual care transition log, individualized care plan and supporting documentation when a transition in care occurs. MHP's care guides play a major role in managing the ICT and in assuring that members of the ICT receive all relevant information regarding the member. Information is shared either via face-to-face meetings, teleconferences, written reports or HIPAA compliant electronic exchange of information.

Clinical Practice Guidelines and Nationally Recognized Protocols

MHP establishes practice guidelines annually. The clinical guidelines represent the needs of our population. MHP uses the Institute for Clinical Systems to establish guidelines. These guidelines are reviewed and approved annually by the Quality Management Committee (QMC). The clinical practice guidelines are sent to providers and also included in a provider newsletter. MHP also audits enrollees medical charts and HEDIS results to collect information on the application of the clinical practice guidelines. The results of this analysis are measured and reported to the Utilization Management Committee (UMC) and Quality Management Committee (QMC). (See Annual Evaluation on page 95)

6. Model of Care Training for Personnel and Provider Network

Cornerstone Solutions provides training on the Model of Care to all personnel and network providers. The model of care training includes:

- Goals and objectives for the Cornerstone Solutions program
- Unique needs of the target population
- Staff structure and roles
- Interdisciplinary care team composition and process
- Provider network with specialized expertise
- Use of clinical practice guidelines
- Health risk assessment
- Individualized care plan
- Communication network
- Care management for the most vulnerable populations
- Performance and health outcome measurement.

The model of care training is offered in-a variety of modalities to maximize participation of staff, network providers and participants on the ICT including in-person or via telephone conference, and through sending emails or printed materials. Training materials will also be available on the MHP web site www.MHP4Life.org. In the future, MHP is exploring video conferencing options for training on the model of care.

Attendance at model of care training is mandatory for all internal personnel and contracted care guides, and network providers. A training record will be maintained including but not limited to sign-in sheets, results of testing, emails confirmation, written attestations and/or provider surveys. In the future video conferencing attendance confirmation may also be available. An assessment of comprehension is incorporated into the face-to-face and teleconference training to ensure a good understanding of the information.

Oversight of Model of Care Training

The Cornerstone Solution care coordination management team is responsible for the oversight of the model of care training for both internal staff as well as network providers. MHP will take corrective action on any point where opportunities for improvement or issues are identified.

Additional Training

In addition, plan personnel, care guides and network providers receive training on policies and procedures for operations such as compliance, appeals and grievances, HIPAA/Privacy, principles of managed care, compliance with State and Federal requirements for the program, special needs of the target population, as well as fraud, waste and abuse. MHP's product administration and compliance officer in conjunction with the Cornerstone Solutions care management team are responsible for the oversight of the training on policies and procedures.

7. Health Risk Assessment

Cornerstone Solutions, has developed a standardized comprehensive health risk assessment (HRA) that addresses medical, psychosocial, functional, and cognitive needs; activities of daily living; medical and mental health history. Cornerstone Solutions reviews the effectiveness of the HRA annually including tracking and trending health risk assessment data and makes adjustments to the tool, approach, benefits, policies and procedures, as needed. The HRA is primarily administered by a care guide. Care guides must be social

workers, public health or registered nurses, physician assistants, nurse practitioners, or physicians. (See Health Risk Assessment).

HRA Timeframe

Care guides meet with the enrollees face-to-face within the first thirty (30) days of enrollment and annually thereafter to complete the HRA. If the enrollee refuses to meet face-to-face the care guide will attempt to gather the health risk assessment information over the telephone. If the enrollee can not be reached by phone the care guide mails a written HRA to the enrollee.

Additional Assessments

Based on the results of the health risk assessment additional assessments maybe indicated including but not limited to:

- **Mental Health Assessment:** Enrollees with severe and persistent mental illness will have an up to date diagnostic assessment. If one has not been complete or updated within the past six months, the care guide will assist the enrollee in securing a diagnostic assessment by a qualified mental health professional. This assessment will include a functional assessment of all daily activities including substance abuse screening.

- **Developmental Disabilities:** Enrollees with developmental disabilities (DD) are referred to complete a DD screening if one has not been completed prior to

enrollment. This screening will include assessment of daily activities. These assessments will be used by enrollees, family members and care guides to develop a care plan. If enrollees need Medicaid home and community based waiver services, which are outside of the plan benefit set, the care guide will coordinate with county staff to ensure appropriate services are provided.

- **Physical Disabilities:** Members with physical disabilities complete a long term care consultation (LTCC), personal care attendant assessment or waivered services assessment that includes assessment of their daily activities. This information is used by members, their family and case manager to develop the care plan. This assessment will identify enrollees who are frail and have multiple chronic health conditions. The care guide will coordinate with county staff to ensure appropriate services are provided including Medicaid waivered, personal care attendant, or private duty nursing services, which are outside of the health plan benefit set.

- **Traumatic Brain Injury:** Enrollees with traumatic brain injury will be referred to complete a LTCC to identify their needs. This assessment will include all activities of daily living. Identified needs will be addressed in the care plan developed with the enrollee. Frequently, there are high needs for supervision while taking into consideration the highest level of independent functioning possible. Care guides will assist with locating housing services and supports if needed to ensure that enrollees are living in the least restrictive environment in the community.

- **Chemical Dependency – Rule 25 Assessment –** Enrollees with chemical dependency issues will be referred for a Chemical Dependency (Rule 25) assessment. The assessment will include an interview with a chemical dependency counselor in which the enrollee's chemical use will be reviewed along with the impact of that use on the individual's daily life and relationships. The chemical dependency assessments may also include a review of relevant medical, legal, mental health and previous treatment records, a physical screening and assessment for detoxification and interviews with other people in that individual's life.

Health Risk Assessment Stratification and Communication of Results

Care guides, in consultation with their clinical supervisors, stratify enrollee's health care needs according to medical and behavioral health risks. In addition, the results of the HRA and stratification are shared with participants of the interdisciplinary care team (ICT). The HRA, enrollee or responsible party preferences and other information is used to develop a comprehensive individualized care plan (ICP). The ICP identifies medical, behavioral health and community services and supports tailored to the enrollee's unique needs. If the member has other chronic illnesses, with the enrollees' permission a referral will be made for the appropriate chronic care management program or disease management program.

Stratification - Quadrant Model

Cornerstone Solutions uses a quadrant model to stratify members' mental health and physical health care needs for services. The quadrant model is used to promote the clinical integration of mental health and physical health services. The quadrant model enables a focus on the

high prevalence of co-occurring disorders (i.e. depression and diabetes) for adults with disabilities. Levels change as members achieve stability or encounter changes in their physical or mental health status.

The quadrant model is built to enhance the integration of mental health and physical health care. This model for a comprehensive, continuous and integrated system of care has differing levels of mental health and physical health care integration, divided into continuums of care for physical and mental health needs. The quadrant model (See Chart 1) provides an overview of who is involved with a enrollee, the tasks they perform, and where they work together. The quadrant model outlines interventions, problems, strengths, goals and objectives including long-term (i.e., monitoring medication compliance for chronic conditions) and short-term (i.e., help locating a food shelf close by) goals.

Chart 1: Quadrant Model

Quadrant II: high mental health, low physical health needs • Care guide, member and Mental Health Targeted Case Manager (MH-TCM) • MH-TCM has primary role • Care plan includes task and interventions beyond the scope of	**Quadrant III:** high mental health, high physical health needs • Care guide, member, Home and Community Medicaid waiver & MH-TCM • Care guide with limited role, MH-TCM primary • Care guide coordinates medical

MH-TCM, including medical coordination • Care guide and MH-TCM share plans to avoid duplication or confusion • Care guide gets more involved when member transitions from MH-TCM	benefits, maintain relationship with client. • Some tasks require teams or collaboration
Quadrant 1: low mental health, low physical health needs • Care guide and member only • Care plan may include variety of tasks and interventions address: • Coordinate medical services, health plan benefits and support network. • Advocate for client to get basic and other needs met in community. • Ongoing relationship and continued reassessment (may also include members who refuse mental health or other interventions)	**Quadrant IV:** low mental health, high physical health needs • Care guide, member and home and community based wavier case manager • Care plan to include tasks and interventions outside the scope of waiver services and case mgmt., including medical coordination. • Care guide and waivered case manager to share plans, communicate to avoid duplication and confusion for client • Care guide gets more involved when client transitions from MH-TCM

8. Individualized Care Plan (ICP)

Once the enrollee's health risk assessment (HRA) is completed and the enrollees needs and preferences are identified, the care guide works with the enrollee, whenever feasible, to establish a individualized care plan (ICP). The ICP is a very comprehensive and includes demographic information; enrollee strengths and needs; addresses the inclusion preventative health care, oral health, chemical health, mental health; maintaining Medicaid eligibility; social service, recreational, cultural, educational and vocational needs; as well as informal and caregiver supports and input, as applicable. All areas of concern identified on the health risk assessment are addressed on the ICP. In addition, the ICP must have measureable goals, interventions, time frames and enrollee or responsible party signatures.

As part of the ICP development and on-going care coordination, care guides educate enrollee's on best practices and evidence-based services, as they related to the enrollee's health status and needs. Care guides also work with enrollee's to identify and address provider preferences and recommendations to meet the special needs of the enrollee. Care guides communicate with the enrollee's ICT including primary care provider or medical home as well as other relevant providers and community supports to develop the ICP, coordinate care and meet the needs of the enrollee.

Frequency of Individual Care Plan (ICP) Review

Care Guides continually monitor enrollee's health status and implementation of the enrollee's individualized care plan (ICP). ICP's are updated at least every 180 days. Often

the ICP is reviewed more frequently, especially when the enrollee experiences a transition in care, sentinel event or significant change in health status. When special needs enrollees experience a transition in care it often signals a chance in health status and the care plan is updated care guides notify the ICT participants if the special needs individual's health status changes or circumstance significantly interferes with members' achievement of key goals, or a transition in care occurs.

Special needs enrollee's or authorized representatives, primary care physician and respective providers, as well as other members of the ICT, receive a copy of the health risk assessment (HRA), individualized care plan (ICP), individual care transition log (ICTL) and supporting documentation.

Individualized care plan revisions can also stem from transitions of care, sentinel event or significant change in health status. The SNP's in Minnesota have collaboratively developed an individual care transition log (ICTL) which tracks changes in enrollee health status, transition care management and communication with relevant parties including the enrollee or authorized representative, enrollee's primary care physician and/or a discharge planner at a hospital. These transitions of care signal to the care guide to notify such entities as providers or the ICT that the enrollee has experienced a change and there may need to be a change in the enrollee's individualized care plan.

Occasionally, an enrollee is unable to participate in the development of their own ICP, such as when an enrollee has significant cognitive deficits, or refuses to participate in the

development of an ICP. In these instances, the care guide seeks the input from authorized representatives, providers, care givers or family members, as appropriate, to develop the ICP.

Crisis Plans

In addition, as part of the care planning process enrollee's will be educated on crisis services available and how to access these services. Care guides will educate enrollees on the options and benefits of completing a crisis plan. This crisis plan will be accessible twenty four hours a day, seven days (24/7) a week through mobile adult mental health crisis team, HealthConnections (nurseline) and/or ICT. Care Guides encourage special enrollees to sign releases of information to accompany the ICP and crisis plan. These releases of information should include permission to share all medical information with the treating health care professional, as requested by the enrollee or authorized representative. We will also recommend the enrollee sign releases for crisis workers to engage the enrollee's natural supports (family, friends, etc.) to assist in stabilizing the crisis.

Individualized Care Plan (ICP)- Dissemination, Communication and Documentation

The enrollee or their authorized representative and participants on the interdisciplinary care team (ICT) are given a copy of the ICP and any updates or revisions. After the enrollee reads the plan, agrees with it, and signs off on it, copies of the care plan are sent to providers and other participants on the ICT who would need a copy to supply appropriated care. The ICP is maintained in a HIPPA compliant manner in CCMS, the health plan electronic case management system, or the agencies records and preserved from destruction. Care guide

records are required to be maintained for at least ten (10) years. Care guide agencies also send al1 new and updated ICP's to Cornerstone Solutions for incorporation into CCMS the health plan's electronic case management system.

Audit

In addition, the care coordination management team conducts a comprehensive annual audit of care guide agencies to ensure that the health risk assessment, individual care plan, transition management and care coordination are being conducted according to established standards.

9. Communication Network

Cornerstone Solutions maintains several mechanisms to improve communication with enrollees, providers, and participants on ICT, regulatory agencies, public, plan personnel, and other stakeholders. Communication systems including:

- Member Services call-line for special needs individual's inquiries
- Provider Services call-line for provider inquires
- ICT care coordination process including face-to-face meetings, conference calls, mailing information, and HIPAA compliant electronic interface or virtual correspondence.
- Case consultation meetings, as needed.
- Complaint and grievance documentation and system and quality management process for resolution
- Committees (standing and ad hoc) including the Utilization Management Committee, Quality Management Committee, Pharmacy and Therapeutics Committee, Technology Assessment Committee, and ad hoc focused meetings, as needed on targeted areas.
- Electronic and telephonic network for meetings, trainings, and sharing information
- Electronic records
- Newsletters and bulletins

- Face-to-face meetings and conference calls with members, providers and other key stakeholders

In the future, we are exploring the option of webinars or teleconferencing capacities.

Oversight of the Communication Network

The Cornerstone Solutions care coordination management team, quality management, medical administration, marketing, member services, provider relations, compliance, product administration and care guide staff are responsible for ensuring communication systems are in place and that model of care performance standards are met. Specifically,

Member services department oversees an enrollee and provider call center available for enrollee or provider inquires, as well as arranging transportation, finding providers and answering questions regarding benefits.

- Care guides are responsible for scheduling and overseeing ICT meetings and maintaining regular communication with enrollees and ICT members.
- Care coordination management team oversees at least monthly face-t-face case consultation meetings with care guides and monthly program administration meetings and training sessions, as well as regular emails and other communication.
- MHP's Medical Administration oversees the UMC, QMC, P & T, TAC, and ad hoc focus group meetings, as needed.
- MHP's Marketing Department is responsible oversight of the internet and intranet site and ensuring that information relevant to staff, providers, and ICT are available on www.MHP4Life.org.
- Medical Administration oversees the utilization of CCMS – CareEnhanced Clinical Management Software. The CCMS system allows the user to see an integrated view of the member's enrollment, claims' history, eligibility, diagnostic history, communications, clinical data and other elements including a disease management module.
- Provider Relations oversees the distribution of quarterly newsletters to network providers to communicate information about the model of care and other relevant information.

All of these entities report to the MHP Executive Committee who is ultimately responsible for ensuring that effective communication mechanisms are in place for communicating with regulatory entities, staff, providers, enrollees, participants on ICT's and other stakeholders.

10. Care Management for vulnerable subpopulations

Cornerstone Solutions special needs plan (SNP) model of care is committed to identifying and meeting the needs of all special needs enrollees including those who are frail/disabled, have multiple chronic illnesses, or who are near the end of life.

Comprehensive care coordination is provided to each enrollee including assuring that palliative care services; support in completing an advance directives; service appropriate to the enrollee's ability and condition. A full continuum of support services is available to allow the enrollee to remain in the environment of their choice and meet the needs of vulnerable special needs individual's by ensuring that:

- Each enrollee has a health risk assessment completed within 30 days of enrollment and annually thereafter to determine the appropriate level of services and support needed.
- Following the health risk assessment, additional assessments may conducted depending on the members needs. (see detailed list under health risk assessment).
- Each enrollee will have a care plan designed to meet their unique needs. These care plans will include medical services including palative care, behavioral health, as well as social and community supports.
- Each enrollee will have the option of incorporating a crisis plan and advance directives into the care planning process.

In addition, Cornerstone Solutions SNP enrollees have access MHP's medication management therapy programs (MTMP) and disease management programs. Participation in these programs is voluntary and encouraged by the care guide. Disease management programs are available for enrollees with diabetes, COPD, heart disease and asthma. These programs will be modified to the needs of the population served. Program materials are tailored to allow greater understanding by the enrollee and the enrollee's family or support system. Enrollee's also have access to a fitness program to meet their needs.

Training on working with frail, disabled, chronic illnesses and end-of-life

Training will also be provided regarding working with enrollee's who are frail, disabled, or have multiple chronic illnesses and end of life principles. Each enrollee will be encouraged to develop an advance directive or medical power of attorney. The Cornerstone Solutions care guide will also coordinate with hospice programs as desired for enrollee's near the end of life.

Add-on Services and Benefits

In addition, many adults with disabilities and chronic conditions have a high need for transportation, DME and home modifications. While many of these items are covered under Medicaid, Cornerstone Solutions is able to access these services for members in an integrated manner due to our contract with the Minnesota Department of Human Services (DHS) for Medicaid covered benefits. Cornerstone Solutions also assesses the need for substitute

services or additional equipment if needed to support the enrollee in his/her community. Substitute services may be covered based on individual need, quality of life, cost-effectiveness and to support the goals identified by the enrollee and the ICT.

Finally, Cornerstone Solutions enrollees are eligible to participate in a number of outreach services including a fitness program; cell phone program for enrollees, without access to a phone, this enables the enrollee to communicate with their care guide and other providers; and special services are available to enrollees who are pregnant.

Case Consultation

Cornerstone Solutions periodically has case consultations including care guides, medical director, disease management staff, program administrators, pharmacist and other medical and mental health professionals, as needed. Care guides are encouraged to bring complex cases and special needs individual's who are in a vulnerable subpopulation to a case consultation. Case consultations may also be held for special needs enrollees with multiple transitions in care including emergency room, hospitalization, nursing home admissions, or high service utilizes. Case consultations may function as an ICT when all of the required ICT components are met.

Results of the ICT and case consultation will be disseminated to all members of the ICT including the enrollee or responsible party, primary care physician and maintained in the enrollee's records.

11. Performance and Health Outcome Measurement

Cornerstone Solutions has established performance metrics to monitor the effectiveness of the model of care, with consideration of the local standards and nationally recognized benchmarks of care, as well as trending of practitioner utilization and service utilization trends for both over and underutilization.

Cornerstone Solutions has the identified a number of mechanisms to collect, analyze, and act on the evaluation of the model of care. Medical Administration staff are primarily responsible for collecting, analyzing and acting on the evaluating the effectiveness of the model of care. Medical Administration consists of Medical Director, Associate Medical Director, Pharmacist, Disease Management, Program Administrators, Quality Manager, Quality Specialists, Medical Services Coordinators, and Analysts.

The Performance and Health Outcome (Chart 2 below) contains the specific performance and health outcome measurements for each goal including how the data is collected, analyzed, frequency, and data source; personnel responsible for data collection, analysis and reporting; and communication mechanisms through various committees and other structural mechanisms.

Committee Structure and Communication

Cornerstone Solutions has a number of mechanisms for collecting, analyzing, reporting and acting on health outcomes to evaluate the model of care. The process includes the Health

Information System data generation, reporting data at regular intervals to the Care Guide and through a formalized committee structure, finalizing the recommendations and taking corrective action or implementation of recommendations for improvement.

Health Information Systems

MHP generates data for performance and health outcome measurement using five (5) major reporting systems: 1) CCMS – CareEnhanced Clinical Management Software; 2) IDX – General Electric's data warehouse and claims processing systems; 3) TierMed Systems – MHP's NCQA accredited HEDIS software vendor, 4) pharmacy benefit manager systems, and 5) dental benefit manger systems. The data systems are audited by an external NCQA accredited vendor (MetaStar) to validate HEDIS data each year and MHP's data has been a validated as accurate for the past 10 years. Data utilized for quality improvement activities are submitted in the Annual Program Evaluation and QIP/PIP documents.

CCMS system allows the user to see an integrated view of the member's enrollment, claims' history, eligibility, diagnostic history, communications, clinical data and other elements including a disease management module.

IDX system includes claims adjudication, contract information and a customer service module. TierMed Systems HEDIS software allows MHP quality staff to combine the elements of the disease management. MHP can and routinely adds "study" elements to the HEDIS measures to complement the data collection. For example, Minnesota Community Measurement, a collaborative measurement and reporting effort uses a direct reporting from clinics along with HEDIS rates and adds some Minnesota-specific study elements such as,

for diabetes, if the person smokes and takes a daily aspirin. These study items are added to the HEDIS collection by the health plans and reported in addition to HEDIS.
Pharmacy benefit manager system provides claims, medication adherence, as well as an analysis of single source and generic, top medication utilized, and cost per member.
Dental benefit manager system reports on dental service utilization.

All of the Health Information Systems used to collect outcome data are required to be HIPAA compliant. As a governmental agency, MHP is held to the higher level of privacy found in Minnesota Statutes Chapter 13 ("Data Practices Act") which are in many cases more strict than HIPAA privacy requirements. All MHP employees and contracted care guides are required to sign an annual confidentiality statement and annual HIPAA and compliance test. MHP has multiple, detailed policies on aspects of HIPAA. A representative sample of the policies and training has been provided. All MHP employees are subject to the counties progressive discipline process for any infractions of a county policy. However, privacy violations are particularly egregious, and violations are viewed with greater weight. MHP reports all violations annually to the Department of Health and Human Services are required by the federal law and all HIPAA policies are reviewed and updated annually.

Committee Structure for Communication of the Findings and Development of Recommendations

The results are communicated through a number of standing and ad hoc committees that review the results, complete an analysis of these measures and develop recommendations for corrective action or opportunities for improvement. The committees include the Utilization

Management Committee (UMC), Pharmacy and Therapeutics Committee (P&T), Quality Management Committee (QMC) and Hennepin County Board of Commissioners, who serve as the governing board for the health plan, and other ad hoc focus committees as needed.

- **Utilization Management Committee (UMC)** – The UMC consists of representatives from Medical Administration including the Medical Director, Provider Relations, Product, Fiscal, and Quality personnel. The UMC meets at least quarterly and reviews the results of performance and health outcome measurement, as well as trends and over utilization or under utilization. Based on the findings and analysis, the UMC develops recommendations that are forwarded to the Quality Management Committee.

- **Pharmacy and Therapeutics Committee (P&T)** –The P&T Committee is comprised of physicians and pharmacists from the community along with representatives from Caremark (Pharmacy Benefit Manager) who meet to review trends in data and provide academic detailing on different medications on a quarterly basis. MHP's formulary is available on the website www.MHP4Life.org.

- **Technology Assessment Committee (TAC)** – The TAC is comprised of medical director, mental health professionals, pharmacist, and other medical administration staff, as needed. The group reviews new technologies, new applications for existing technologies, pharmaceuticals and trends in the popular press.

- **Quality Assessment Committee** – The QMC receives findings from the UMC, P & T and TAC. The QMC includes representatives from Quality, Medical Administration, several Medical Professionals from the community, Hennepin County Board of Commissioners. Any of these committees or governing bodies can recommend opportunities for improvement or areas to be addressed. MHP takes corrective action on all points raised by the UMC, QMC or governing board.

Action Based on the Results

The purpose for the evaluation of performance and health outcome measurement is to follow-up on the results with a series of actions. MHP has a specific "cure period" in our contracts to address any deficiencies found in Care Guide services. Generally, the cure period is 30-days, however, a serious deficiency could require immediate cure and a minor issue could be allowed to wait until the next update period (such as routine update to a policy or correction of a typo). Services that are over- or underutilized with a specific clinic or practitioner are addressed on a case-by case basis. Personnel issues are addressed through training, coaching and progressive discipline, as needed.

The action taken is based on the results of performance and health outcome measurement; identification of opportunities for improvement; professional judgment and significance. Actions may include but are not limited to:

- New or revised policies or procedures
- Additional training for personnel, network providers, Care Guides, enrollees or Interdisciplinary Care Team members
- New or revised communication mechanisms or mechanisms for documentation
- Imposing or reducing an authorization or notification requirement, etc.

- Over utilizing practitioner will receive a notice from the Medical Director regarding the test, service or pharmaceutical. outbound call campaigns
- Increased supervision of individuals with special needs
- Increased Communication to providers
- Additional Outreach Events
- Monitoring for failure to refill medications
- Monitoring compliance to health risk assessment, individual care plans or treatment plans performance standards
- Communication to or from a Care Guide
- Communication to or from the participants on the ICT

Personnel with Oversight Responsibility

The Quality Management Department conducts an annual evaluation of these processes. The results of this evaluation are included in a written Quality Program, Quality Program Work Plan, and Annual Program Evaluation. The quality management program work plan and annual program evaluation are approved annually by the QMC and the Hennepin County Board of Commissioners. The Hennepin County Board of Commissioners is a publically elected body that also functions as the MHP governing board. In addition, the quality management committee program evaluation is also disseminated to the Minnesota Department of Human Services (DHS), Minnesota Department of Health (MDH) and posted on the health plan's web site www.MHP4Life.org.

Specific Performance and Health Outcome Measurement

Chart 2: Specific Performance and Health Outcome Measures

Goal 1: Improve access to essential services such as medical, mental health, and social services. This goal is measured on completion of the health risk assessment and individualized care plan.			
Goal Attainment	Frequency and Data Source	Staff Responsible to collect, analyze and	Results Communicated to

		report	
At least a 5% improvement from the previous year up to 80% of completed comprehensive health risk assessment	Annual Case Management Audit of Health Risk Assessment Tool	Care Coordination Management Team	Center for Medicaid and Medicare Services (CMS), UMC, QMC and County Board of Commissioners
At least a 5% improvement from the previous year up to 80% of completed individualized care plans.	Annual Case Management Audit of Health Risk Assessment Tool	Care Coordination Management Team	UMC and QMC

Goal 2: Improve access to affordable care. This goal is measured by MHP's pharmacy benefit manager reports.

Goal Attainment	Frequency and Data Source	Staff Responsible to collect, analyze and report	Results Communicated to
Achieve industry benchmark of 99.6%. in generic drug substitution for non-psychotropic medications utilization	Bi-annual report from pharmacy benefit manager (PBM) to the Quality Management Committee	Medical Administration Pharmacist	UMC and QMC

Goal 3: Improve coordination of care through an identified point of contact for each enrollee. This goal is measured on completion of the health risk assessment and individualized care plan.			
At least a 5% improvement from the previous year up to 80% of completed comprehensive health risk assessment	Annual Case Management Audit of Health Risk Assessment Tool	Care Coordination Management Team	Center for Medicaid and Medicare Services (CMS), UMC, QMC and County Board of Commissioners
At least a 5% improvement from the previous year up to 80% of completed individualized care plans.	Annual Case Management Audit of Health Risk Assessment Tool	Care Coordination Management Team	UMC and QMC

Goal 4: Improve seamless transitions of care across healthcare settings, providers and health services by increasing transition of care management and communication with the enrollees, primary care physicians and other participants on the ICT. This goal is measured by completion of the Individual Care Transition Log (ICTL). The ICTLS is a tool that was developed by a collaborative of Minnesota special needs plans (snp) to document the transition of care management and communication with the enrollee, enrollee's primary care physician and participants on the ICT.			
Goal Attainment	Frequency and Data Source	Staff Responsible to collect, analyze and report	Results Communicated to
At least 5% improvement annually from the previous year on the completion of the Individual Care	Annual Case Management Audit of Individualized Care Transition Log (ICTL)	Care Coordination Management Team	UMC, QMC, and NCQA Structure and Process (SNP # 4)

Transitions Log (ICTL) until 80% completion rate is achieved.			
At least 5% improvement annually from the previous year on care measure transition survey (CMT). This is a formal performance improvement project/quality improvement project (PIP/QIP)	Annual Care Measure Transition Survey	Quality Management Staff	CMS, UMC, QMC, Minnesota Department of Human Services, and Minnesota Department of Health.
Goal 5: Improving access to preventive health care services by increasing the percentage of enrollees who have a preventive care visits. This goal is measured is measured claims/encounter data and HEDIS data collection.			
Goal Attainment	Frequency and Data Source	Staff Responsible to collect, analyze and report	Results Communicated to
The measure of success is at least a 5% improvement from the previous year up to 92% of new enrollees receiving preventive care visits within the first six (6) months of enrollment.	Annual claims data	Quality Management Staff	CMS, UMC, QMC, Minnesota Department of Human Services, and Minnesota Department of Health.

This is a formal performance improvement project/quality improvement project (PIP/QIP)			
The measure of success on HEDIS is the benchmark of 92% of enrollees receiving an annual preventive care visit at least annually.	Annual HEDIS data including claims/encounter and chart reviews.	Quality Management Staff	CMS, UMC, QMC, Minnesota Department of Human Services, and Minnesota Department of Health.
Goal 6: Assure appropriate utilization of services by reducing potentially avoidable ED visits from the previous year and increasing generic substitutions of non-psychotropic medications.			
Goal Attainment	Frequency and Data Source	Staff Responsible to collect, analyze and report	Results Communicated to
The measure of success is a 5% reduction in potentially avoidable ED visits.	Annual HEDIS data source including claims/encounter data and medical records	Quality Management Staff	UMC, QMC, and Minnesota Department of Human Services and Minnesota Department of Health
Achieve industry benchmark of 99.6%. in generic drug substitution for non-psychotropic	Bi-annual report from pharmacy benefit manager (PBM) to the Quality Managemen	Medical Administration Pharmacist	UMC and QMC

medications utilization	t Committee		

Goal 7: Improve enrollee's health outcomes. This includes ensuring enrollees are able to:

- Access services in the least restrictive environment appropriate.
- Reduce in-appropriate or unnecessary emergency room, hospitalization and nursing home placement;
- Improve independence and self management;
- Improve mobility and functional status;
- Improve pain management
- Improve quality of life as perceived by enrollee, and
- Improve satisfaction with health status and health care services.

This goal is measured on completion of the health risk assessment and individualized care plan.

Goal Attainment	Frequency and Data Source	Staff Responsible to collect, analyze and report	Results Communicated to
At least a 5% improvement from the previous year up to 80% of completed comprehensive health risk assessment	Annual Case Management Audit of Health Risk Assessment Tool	Care Coordination Management Team	Center for Medicaid and Medicare Services (CMS), UMC, QMC and County Board of Commissioners
At least a 5% improvement from the previous year up to 80% of completed individualized	Annual Case Management Audit of Health Risk Assessment Tool	Care Coordination Management Team	UMC and QMC

care plans.