2016
Managed Health Services
Quality Improvement
Program Description
2016 QI Program Description

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I. Mission/Purpose

The mission of Managed Health Services (MHS) is to provide health coverage and personalized services through member, community and provider partnerships to promote better health outcomes at a lower cost. The Corporate philosophy values the principles of:
- Strong member and consumer focus
- Superior medical outcomes driven by evidence-based medicine
- Doing what’s right – without exception
- Restless, innovative style
- Empowered, diversified teams
- Value-added functional excellence
- Valued diversity
- Community involvement

The function of the MHS Quality Improvement (QI) Program is to ensure optimal health outcomes for the Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP), Ambetter (HIM) and Hoosier Care Connect (aged, blind and disabled) member populations. We seek to monitor, and improve as needed, care and services to ensure fulfillment of that purpose and the MHS mission. MHS recognizes that included in the definition of quality healthcare is the concept that care is provided in the most appropriate setting, furnished according to professionally-accepted standards and in a coordinated and continuous (rather than episodic) manner.

Our vision is to improve health outcomes by providing safe, high-quality care/services in a culturally and linguistically-sensitive manner that satisfies member expectations for the care/service experience. MHS achieves this through a holistic approach, including integration of medical and behavioral health services via a provider network of Primary Medical Providers (PMPs), Specialty Care Providers, Facilities and Federally Qualified Health Centers (FQHC).

II. Goals

The MHS Board of Directors (BOD) sets the course for MHS organization-wide quality improvement. The QI Program is designed to advance MHS towards the goals sanctioned by the Board.

MHS believes that clinical care delivered to an underserved population requires unique commitments and personalized approaches to achieve the best outcomes. Major components which contribute to goal achievement are ensuring access and availability of care, identifying members with complex conditions and referring them to the appropriate case/disease management program, assuring that safe clinical practices are in place, and tracking/trending/analyzing member complaints and appeals. MHS measures its progress towards its goals using metrics validated and tracked over time.

The primary goals of the MHS QI program are to develop and maintain a system which:
- Is committed to providing MHS members with a healthcare delivery system that meets and exceeds generally-accepted definitions of quality
- Monitors and improves as needed:
  - Clinical Care Quality
  - Continuity & Coordination of Care
  - Services to Members with Special Needs
  - Quality of Service
  - Safety of Clinical Care
  - Satisfaction with the Care/Service Experience
- Actively involves providers in the improvement of the quality of patient care
- Seeks member input and incorporates it into quality improvement program activities
- Provides a definition of performance standards via Healthcare Effectiveness Data and Information Set (HEDIS®) and the Quality Rating System (QRS), standardized measures designed to allow reliable comparison of health plan performance among Medicaid and Ambetter HIM members, respectively.
- Monitors member satisfaction via the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Qualified Health Plan (QHP) standardized surveys that measure patient satisfaction with the
experience of care among Medicaid and Ambetter HIM members, respectively. Provides healthcare services in a manner consistent with:

- Generally-accepted principles of professional practice and adherent to evidence-based guidelines
- Cultural and linguistic needs/preferences of MHS members

Achieves compliance with NCQA and State/Federal regulatory standards
- Analyzes the existence of significant healthcare disparities in clinical areas
- Obtains “Best in Class” standing in the State of Indiana

III. Objectives

A. General

Toward the satisfaction of the above-listed goals, the following objectives have been identified:

- Identify clinical priorities for members within each line of business
- Ensure that effective resources and programs are in place to address clinical priorities, via the following mechanisms:
  - Adoption and distribution of preventive health and clinical guidelines
  - Provider education
  - Member education
  - Care gap/appointment outreach calls
  - Case Management
    - Complex Medical and OB
  - Disease Management
  - ER diversion/medical home promotion
  - Primary-Specialty care coordination
  - Medical-Behavioral Health (BH) care coordination
  - Health promotion incentive programs
  - Grievance and appeals mechanisms
- Monitor trends related to service utilization and respond to identified issues
- Ensure provider network adequacy/geographic distribution via systematic monitoring
- Ensure appropriate appointment and after-hours access via annual monitoring of the PMP network
- Ensure the availability of culturally and linguistically appropriate services through systematic monitoring and improvement activities
- Ensure that the voice of the customer helps inform QI Program direction, through Member and Provider participation in QI committees
- Implement focused monitoring activities to ensure that needs of Members with Special Needs and the Medically Frail are met
- Comply with State and NCQA standards
- Participate in the Office of Medicaid Policy and Planning (OMPP) Quality Strategy Committee and relevant subcommittees
- Participate in External Quality Review Organization (EQRO) initiatives developed by the OMPP
- Evaluate the QI program annually and modify it as necessary to achieve program effectiveness

B. Specific

- Achieve ≥90th percentile HEDIS/QRS priority measure scores; achieve ≥75th percentile remaining measures
- Achieve ≥75th percentile rates on CAHPS/QHP survey measures; reach for ≥90th percentile benchmark rates
- Achieve 100% compliance with State Access and Availability standards
- Achieve 100% compliance with Culturally & Linguistically-Appropriate Services standards
- Record <1.37 Complaints/1000 member months
- Record a 0% Hospital-Acquired Condition rate
- Record an all-cause 30-day Readmission rate ≤ the national average rate (currently 16%)
- Record an ER Utilization rate ≤10th percentile
- Achieve ≥90% Medical Director Inter-rater Reliability for compliance with Milliman Care Guidelines
- Record a Medical Necessity Overturn rate of <40%
- Achieve “Commendable” NCQA accreditation status
IV. Scope

The QI Program applies to all product lines, and is comprehensive, systematic and continuous. It addresses all:

- Key care and service functions
- Care types (medical, specialty, behavioral health)
- Venues (practitioner offices, inpatient/outpatient facilities, health plan)

Monitoring and improvement projects are designed to support the full scope of the QI Program. They focus on topics relevant to the MHS population, especially those that are high-volume, high-risk or problem-prone.

Specific activities include:

- Annual HEDIS/QRS audits of quality indicators related to preventive health & chronic condition management
- Annual experience surveys:
  - Members: CAHPS/QHP satisfaction survey
  - Providers: The SPH analytics satisfaction survey
- Comprehensive Quality Improvement Activities related to:
  - Access to Member Services by Telephone
  - Accessibility of Primary Care Services
  - ADHD Follow-up Care
  - Alcohol & Other Drug Dependence Treatment
  - Appropriate Use of Antidepressant Medications
  - Availability of Practitioners
  - Culturally & Linguistically Appropriate Services Analysis
  - Diabetes Screening for Members with Severe Mental Illness
  - Effectiveness of Case Management
  - Emergency Room Utilization
  - Exchange of Information Across Care Transitions
  - Exchange of Information Between BH Practitioners & PMPs
  - Member Satisfaction
  - Perinatal Depression Screening & Management
  - Postpartum Care
  - Satisfaction with Case Management
  - Satisfaction with the Utilization Management Process
  - Transition from Hospital to Home

- Monitoring of over and under-utilization of services, particularly Emergency Room visits and narcotic prescriptions
- Monitoring of MHS utilization review activities to ensure that they do not have a negative impact on quality of care and service (through review of denials of authorizations, grievances and appeals)
- Trend analysis of member complaints
- Investigation of quality of care and service issues (identified through review of member complaints or by Medical Management staff)
- Monitoring and promotion of care continuity and coordination
  - Between practitioners & settings; special focus on Members with Special Needs & the Medically Frail
- Monitoring of care safety, including polypharmacy and hospital-acquired condition review and follow-up
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) on-site practitioner surveys and education
- Evaluation of practice sites and medical recordkeeping practices
- Annual review of adopted preventive health and clinical guidelines, and recommendation of additional guidelines corresponding to changes in the make-up of the MHS member population
- Annual retrospective evaluation of the QI program's activities and effectiveness
- Adaptation of the following year's program, informed by the above-noted annual evaluation

V. Governance

The MHS BOD has the ultimate authority and accountability for quality/safety of care and quality of services provided to members. The BOD delegates the responsibility to the Senior Executive Quality Improvement Committee (SEQIC) for the development, implementation and evaluation of the QI program. The BOD approves the annual QI program description and QI work plan. The BOD monitors the program’s effectiveness through review and discussion of the annual program evaluation.

The BOD meets a minimum of two times per calendar year and discusses MHS QI activities as an agenda item. At least one meeting is convened at a point in time where opportunity to consider any mid-course modification of the QI work plan is feasible. The Chief Medical Director (CMD), a primary care physician, serves as the program’s designated physician and provides assistance with agenda, research, and reports to review. The CMD also presents the proposed QI program description, work plan, and evaluation.
The BOD assigns the MHS Chief Executive Officer (CEO) the authority and responsibility to establish, maintain, and support an effective program on a continuous basis. The CEO is an ex officio member of the BOD and the chairperson of the SEQIC.

The CEO assigns the responsibility for the QI/UM program to the CMD and Vice President of Medical Management (VPMM), respectively. The CMD is the Chair of the Clinical and Service Quality Improvement Committee (CASQIC), and has direct oversight of all Quality functions within the health plan. The Senior Director for Quality manages Quality operations.

**VI. Program Structure**

**Organization/Committee Structure**

As noted above, the MHS BOD approves the QI program and maintains the ultimate authority for overseeing its management and direction. The BOD supports the authority and responsibility for development and implementation of effective management of the QI program to the CEO and VPMA, who are responsible for reporting QI activities, findings and actions to the BOD.

Managed Health Services
Quality Improvement Committee Structure
Senior Executive Quality Improvement Committee (SEQIC)

The SEQIC is composed of the CEO and Executive Staff (Chief Operating Officer, Vice President Medical Management, Chief Medical Director, Vice President Finance, Vice President Contracting and Network Development, Vice President Member and Provider Services and Claims, Manager of Human Resources) and is chaired by the CEO and co-chaired by the CMD. The SEQIC approves policy and procedures and ensures the coordination of the QI program. The SEQIC establishes standards and criteria for care and service delivery; it also approves the QI and UM programs, work plans, and annual program evaluations, and monitors progress. The CASQIC, the Credentialing Committee (CC), the UMC, the Pharmacy & Therapeutics Committee and the Delegation Oversight Committee (DOC) report to the SEQIC. Reports include committee minutes and verbal reports from the VPMA and corporate administrators with knowledge of practices and opportunities to improve. Invited guests may also provide reports or input.

Meetings
The SEQIC meets at least quarterly or more frequently as needed. A quorum for action items is no less than three voting members, excluding the committee chairperson, present by teleconference, fax, e-mail, or in person. Vote or consensus determines decisions reached.

Minutes
Contemporaneous minutes are maintained, obtaining signatures on documents as needed, and documenting the decisions made and actions of the committees. Timeframes and responsible parties for actions are included in meeting minutes. Minutes and reports are confidential and available only to the QI and UM committees, BOD, and officers. The minutes are not available as part of “discoverability” or other proceedings associated with litigation.

Clinical and Service Quality Improvement Committee (CASQIC)

The CASQIC is responsible for overseeing clinical and service activities that members encounter within the managed care system.

The CASQIC is composed of practitioners representing a variety of specialties and medical groups reflective of the MHS network, subcontractor representatives, community partners, consumer advocates, members, and Plan associates. The Cenpatico Behavioral Health Medical Director is also a member of the CASQIC (Clinical & Service QI Committee). MHS seeks to maintain a voting majority of non-plan employees on the committee. Plan associates include representatives from Network, Compliance, Operations, Medical Management and Member Services. Committee composition ensures practitioner participation in the QI program through the committee’s planning, design, implementation and review functions.

The functions of the CASQIC include:
- Review information (including EPSDT, HEDIS/QRS and CAHPS/QHP audit results) for compliance with standards and criteria for delivery of care and services to the member population
- Analyze and evaluate the results of QI activities, including by conducting quantitative and causal analysis of data/trends
- Identify and prioritize needed actions
- Promote and recommend improvement in care and services
- Ensure follow-up as appropriate, and evaluate the effectiveness of improvement activities
- Review and recommend approval of Preventive Health & Clinical Practice guidelines
- Review and recommend approval of policies or policy decisions for effective operation of the QI program and achievement QI program objectives
- Review and recommend approval of Quality Improvement Activity (QIA) reports
- Act as liaison to the medical and behavioral health providers for dissemination of QI information
- Review and discuss operational issues that have resulted in poor service to any of our customers
- Provide clinical and service related quality data as performance feedback to network providers and internal MHS departments
- Oversee analysis and evaluation of the QI program
- Review and recommend for approval the annual QI program description, annual work plan, and evaluation in order to formulate improvements to the system
- Serve as the first step in the appeal process for denied recredentialing providers, practitioners, and facilities
Practitioner members of this committee may also serve as peer reviewers for clinical issues involving sentinel events, adverse outcomes, and member complaints/concerns, as appropriate.

Meetings
The CMD is Chair, with the MHS Medical Directors, participating practitioners, and community representatives serving as voting members. The Cenpatico Behavioral Health Medical Director is appointed ex-officio. The CASQIC meets at least six times per year or more frequently, as needed. A quorum for action items is 50% of the voting members, excluding the committee Chair; members may be present by teleconference and vote via fax, email, or in person. Decision-making is by vote or consensus. Representative staff are non-voting members of the committee, including the Director of Quality Improvement, Manager of QI Analytics and representatives from Provider Relations, Medical Management, Compliance and Member Services.

Utilization Management Committee (UMC)

The UMC’s primary purpose is to provide oversight of the utilization management program and associated activities to ensure the integration of UM activities into all functional areas and departments. The committee is responsible for the analysis of UM data, the identification of trends, and addressing identified issues. Additional responsibilities include monitoring appropriateness of care and over/under-utilization of services, and review/approval of medical necessity criteria and departmental policies/procedures. The CMO chairs this committee, which meets a minimum of six times per year. The UMC voting members consist of at least 5 participating physicians, the pharmacy director, a Cenpatico Behavioral Health medical director and the VPMM. Plan staff are non-voting members and include the UM manager, Case Management manager, Compliance manager, the Behavioral Health manager, Quality Improvement Director and ad hoc members as needed.

Credentialing Committee (CC)

The CC is responsible for the review and assessment of provider applications to participate with the Plan and establishes the qualifications of each participating provider through training, experience, and performance consistent with the standards established by the provider credentialing policies to participate as an MHS provider. The CC also reviews quality of service issues that arise when making recredentialing decisions. A participating physician member chairs this committee, which meets a minimum of six times per year. No fewer than six participating providers consisting of a broadly representative group of participating practitioners sit on this committee, as do the provider network director, compliance director and QI director.

Member Complaint and Appeals Analysis Workgroup (MCAAW)

An internal staff committee, the Member Complaint and Appeals Analysis Workgroup (MCAAW) is responsible for reviewing member complaints, grievances, and appeals. (Review and follow-up of Behavioral Health complaints is delegated to Cenpatico, the MHS behavioral healthcare affiliate organization.) The CASQIC reviews this data for consideration when making recommendations to enhance member and provider satisfaction. This committee is chaired by the QI Director, with participation from key associates and managers of operational areas.

Member (Consumer) Advisory Council (MAC)

The MAC solicits member input into the QI and UM programs. The MAC includes members, parents/foster parents/guardians of children who are members and MHS staff, as appropriate to facilitate the meetings.

HEDIS Executive Committee (HESC)

The HESC Committee is a cross-departmental committee. It directs activities designed to raise CAHPS/QHP and HEDIS/QRS scores for MHS. The global objectives are to meet state P4P objectives and capture withholds, as well as meet Corporate goals, strive for and maintain "Best in State" rating, fulfill OMPP contracting requirements and achieve the benchmark 90th percentile NCQA Quality Compass for CAHPS/QHP and HEDIS/QRS scores. The primary focus is to develop effective processes to achieve desired outcomes, set intermediate goals for results and maintain NQCA accreditation, achieve “Commendable” rating and reach for “Excellent” rating.
Culturally & Linguistically Appropriate Services Committee (CLAS)

The CLAS Committee assesses cultural and linguistic competence across MHS, including the providers, contractors, and staff that serve MHS members, and makes recommendations for action in order to close the disparities gap in health care and bring about positive health outcomes. Central to this purpose is the development of work plans to address gaps and the evaluation of MHS’ success in addressing those gaps. The MHS Member & Network Analysis QIA is reviewed (and findings followed up as needed) at least annually at the CLAS. The Director of Compliance chairs the CLAS; members include leads from each MHS department (including the Director of QI, Manager of QI Analytics and QI Coordinator responsible for the practitioner availability assessment of network adequacy, including ability to meet member CLAS needs/preferences).

Pharmacy and Therapeutics Committee (P&T)

The Pharmacy & Therapeutics Committee is a multidisciplinary team of network physicians & pharmacists whose primary purpose is to provide oversight of the pharmacy benefit and its processes. Its global objective is to improve the delivery of pharmaceutical services and outcomes for MHS members. Key functions include formulary management, ensuring regulatory compliance and monitoring drug utilization and medication safety.

Delegation Oversight Committee (DOC)

As part of delegation oversight and coordination of delegated activities, the DOC requires all delegates and vendors to report to the committee, including the behavioral health vendor (Cenpatico®), transportation vendor (LCP), disease/condition management vendor (Nurtur), and multiple delegated credentialing provider organizations. The DOC may, in the course of its activities, review and approve written delegation agreements, QI evaluations, programs and work plans, and review quarterly reports containing results of delegated activities. The DOC may create integrated working groups of both MHS and vendor staff to conduct collaborative discussions and activities regarding vendor reporting and quality improvement. These working groups report directly to the DOC. The DOC minutes are reported to SEQIC. The Compliance Committee Chair leads the DOC. Members of the DOC include representatives of departments who delegate any function to another entity or have relationships with vendors and other members of the MHS delegation team (which includes quality, utilization, compliance, and credentialing).

Other MHS Committees/Work Groups Associated with the QI Program

MHS utilizes interdepartmental work groups, which may include representatives of affiliate partners (such as Cenpatico), to conduct root cause/barrier analysis and suggest improvement strategies during the QIA development process.

MHS also convenes ad hoc issue-focused practitioner advisory groups to gain the practitioner perspective on improvement strategies, pay-for-performance issues and any relevant concerns that may arise.

Communication of clinical QI activities and results to all levels of staff occur through routine employee communication processes that include manager’s meetings, departmental meetings and all staff meetings. In addition, communication of a summary of clinical and service quality improvement and utilization review activities to members and practitioners occurs at least annually via newsletter articles and web postings. Web site notification that the MHS’ QI Program Description has been posted occurs via member and provider newsletters.
Primary Functional Areas & Responsibilities

Quality Improvement Coordination
- Medical record reviews to extract data for HEDIS/QRS audits measuring compliance to evidence-based guidelines for preventive health and chronic condition management
- Member complaint analysis, tracking and follow-up
- First-level investigation of potential quality of care concerns identified through member complaints or Medical Management referral
- Practitioner access and availability audits
- On-site surveys of practitioner office sites and medical recordkeeping practices
- Coordination of QIAs and other systems improvement initiatives
- NCQA readiness activities

EPSDT Coordination
- On-site practitioner surveys of EPSDT care and follows up with individualized practitioner/staff education re: EPSDT standards and compliance strategies
- Member and practitioner-focused improvement strategies for well child and other pediatric care

QI Analytics
- Annual HEDIS/QRS audit coordination
- Practitioner P4P reporting
- Data procurement/analysis to support all QIAs (per page 6 list) and Annual QI Program Evaluation
- Member complaint reporting
- Safety data reporting

Medical Review
- The CMD conducts second level review of identified quality concerns and refers cases to CASQIC for peer review as indicated
- The Medical Directors review authorization requests for medical necessity
- The CMD and Medical Directors provide peer-to-peer consultation with network practitioners
Appeals Management
- The Grievance and Appeals Department processes member/provider appeals and Just Cause/For Cause Health Plan transfer requests.

Staff Resources

Quality Improvement Department and Other MHS Staff Dedicated to the QI Process

Staff resources key to the QI Program include, but are not limited to:
- The CMD leads QI program activities by chairing CASQIC and the HEDIS Executive Steering Committee, and participates in the CC, MCAAW, OMPP Quality Strategy Committee, the State DUR and Therapeutics Committee and the OMPP Medical Directors collaboration group. He additionally serves as the Quality Improvement liaison to the MHS Senior Leadership Team.
- The Sr. Director of Quality Improvement provides strategic guidance to the QI Program, by drafting the annual QI Work Plan and QIAs for input and approval of the CMD and applicable committees/work groups. She additionally serves as the Quality Improvement liaison to the Quality division of the OMPP.
- The Medical Directors conduct medical necessity reviews and actively participate in QI committees, including the Peer Review section of the CASQIC.
- The Quality Improvement Coordinators, EPSDT Coordinator and Program Coordinator accomplish the day-to-day monitoring/evaluation/improvement activities pertaining to OMPP contractual compliance, NCQA standards compliance, HEDIS/QRS and P4P data collection/processing, member complaint follow-up and clinical quality of care case reviews.
- The QI Managers oversee the previously-described functional areas. The quality work groups and committees are responsible for qualitatively analyzing data and recommending improvement strategies.
- The Manager of Grievance and Appeals oversees the appeals functions, reports to MCAAW and CASQIC internally and to OMPP as required.
- The VPMM, Directors of Utilization Management and Case Management, and Manager of Behavioral Health identify and act on opportunities to improve quality and utilization of services in medical management programs.
- The Case Management and Utilization Management teams are responsible for identification and referral of potential quality of care issues.
- Member Services representatives conduct telephonic preventive health outreach and review care gaps at member call-in.
- The Compliance Department oversees MHS-OMPP quality collaboration activities and delegation oversight. The Director chairs the Culturally & Linguistically Appropriate Services Committee and leads related activities.
- The Marketing & Communications Department sponsors health promotion events for members and creates/coordinates health education materials/communications for members and practitioners.
- The Director of Credentialing and staff perform initial credentialing and recredentialing activities, including facility assessments and reassessments.
- The Vice President of Network Contracting and Director of Provider Relations disseminate information to the provider network, facilitate compliance with corrective action plans and orient new practitioners.
- The Vice President of Operations and Director and Manager of Member and Provider Services are responsible for and maintain quality service indicators in their respective areas.
- The Pharmacy Director is responsible for quality and safety of medication management, including development of the Preferred Drug list and monitoring of polypharmacy and Class I & II drug recalls.

Contracted Provider Participation in the QI/UM Process

In addition to providing care and service to MHS members, contracted providers serve on QI committees to offer practitioner input based on clinical and regional practice. The role of the practitioners participating on committees includes, but is not limited to:
- Development and application of credentialing and recredentialing criteria.
- Participation in quality committees and work groups to provide input and expertise in discussions regarding clinical QI activities and intervention strategies.
- Clinical peer review for potential quality of care and service issues and recommendation of actions needed as well as follow-up activities (such as development of corrective action plans).
- Participation in the recommendation, development and revision of preventive health and clinical practice guidelines, utilization protocols and clinical/medical policies.
Recommending potential areas of focus for QI initiatives, based on review of performance and outcome trends.
Input on opportunities for improvement in member safety and recommendation of systems improvements as applicable.
Input into prioritization of clinical care, service and safety issues and recommendation of needed actions and follow-up as necessary.

Quality Partnerships
Healthcare Providers - Practitioners, Facilities, and Contractors
Healthcare practitioners, providers and contractors are informed of MHS member care/service expectations, as well as standards of performance to expect from MHS, via the provider contract, provider manual, and provider newsletters. Through education and committee participation, MHS assures practitioner involvement in the QI Program. Methods include active practitioner participation in Credentialing Committee meetings, CASQIC meetings, provider workshops and the Provider Advisory Group. Provider surveys, peer reviews, office training sessions, the MHS website, provider newsletters and provider bulletins provide information about QI activities.

Member Involvement
Education occurs through social media, member newsletters, the MHS website, educational mailings, new member handbooks, one-on-one counseling, MAC meetings, and focus group participation with cultural or linguistic minority members to determine the best way to meet needs.

Delegated Activity Providers
Where services are delegated, ongoing communication and training in clinical quality improvement principles and functions are available to delegates. Providers of delegated activities are required to maintain and report clinical QI activities to MHS through the DOC. An agreed-upon reporting schedule is in place for each delegate to ensure that the data is reported. All delegated providers are reviewed annually through a review/audit process. Additional details are described in the Delegated Activities section.

Office of Medicaid Policy and Planning (OMPP)
The Quality Improvement Program is designed for compliance with all applicable OMPP standards. MHS staff participate in the OMPP Quality Strategy Committee and subcommittees (Neonatal, Health Services Utilization).

Centene Quality Management Group
The Director of Quality Improvement participates in monthly conference calls with Centene corporate QI staff and other Health Plan QI Directors. MHS also conducts the HEDIS/QRS audit in partnership with Centene and participates in ad hoc reporting and improvement projects.

Data Resources & Analytical Support
MHS utilizes numerous data sources in the development, monitoring, and evaluation of the QI Program. As applicable, these sources include, but are not limited to, the following:
- Claims and encounter data
- Member Enrollment data, including age, gender, language, race and ethnic diversity
- Authorization data
- Inter-rater Reliability Testing of clinical staff regarding the use of Milliman Criteria
- Member complaints and appeals information
- Medical record review data
- Pharmacy data
- Health information exchange data (Indiana Health Info. Exchange; Michiana Health Info. Exchange)
- P4P quarterly scorecards
- Member incentive data
- HEDIS/QRS & CAHPS/QHP data
- Satisfaction with CM surveys
- Effectiveness of CM via SF-12 surveys
- Behavioral health data
- Financial indicators
- Data from delegates and vendors
- Web site utilization data
Language line utilization
GeoAccess data: geographic distribution and practitioner-to-member ratios
Practitioner Satisfaction Survey
Call center ASA and Abandonment Rates

Data resources that are used include regular and ad hoc reports obtained from the corporate health informatics teams, Impact Pro, Impact Intelligence, CRM, TruCare, QSI, Portico, and MHS’ own SQL server. Staff support is primarily provided by the Manager of QI Analytics and QI Data Analyst. Additional support is available as needed through the MHS Reporting & Business Analytics Department and the corporate Centene Data Analysts as needed.

**Delegated QI Activities**

MHS has established a Delegated Oversight Committee (monitored through the Compliance department) that provides an organized and systematic approach to assure oversight of delegated functions, including quality improvement.

A detailed inventory of delegated QI activities is listed in Appendix A.

Oversight responsibilities include:

- Pre-assessment of the delegate’s capacity to perform delegated activities prior to delegation
- Ongoing monitoring and evaluation of performance through quarterly or regular reports or as specified in corrective action plans
- Annual approval of the delegate’s required annual documentation utilizing the program description, work plan, evaluation, and policies and procedures
- At least annual performance evaluation of the delegate’s ability to perform delegated activities according to defined requirements which can occur on-site or by desktop
- Although we may delegate the authority to perform services and/or functions, MHS retains responsibility and accountability for activities, including the right to rescind delegation
- The responsibilities or requirements of each delegate are included in the Delegation Agreement

**Collaborative QI Activities**

MHS and Cenpatico (Behavioral Health), Nurtur Health (Disease Management) and US Script (Pharmacy Services) collaborate on quality improvement activities related to enhancing and ensuring Continuity and Coordination of Care. MHS and each of these entities review/analyze quality data and discuss any improvement needs/plans at joint oversight committee conferences quarterly. The entities additionally provide quarterly reports to the CASQIC, where additional analysis and planning may occur.

MHS additionally participates on state governmental, medical society and Department of Health initiatives. Examples of recent activities include Neonatal Abstinence Syndrome, Prematurity Prevention, Substance Abuse treatment in pregnancy, Reduction of Infant Mortality and provision of HIV treatment in rural areas. The results of these collaborations are communicated back to MHS Quality workgroups and CASQIC for review and analysis.

**VII. Behavioral Healthcare**

In an effort to monitor and improve behavioral healthcare for members, MHS collaborates with the NCQA-accredited MBHO, Cenpatico®. The Cenpatico Medical Director is a board-certified psychiatrist who is the designated practitioner involved in the behavioral health aspects of the MHS QI program. He is involved in several of the Cenpatico quality committees, including the QI Committee (Chair), UMC, Credentialing Committee, and Provider Advisory Committee; and participates in MHS’ CASQIC, BH workgroup, DOC, and specialty advisory groups as applicable. The Cenpatico medical director may designate other plan behavioral health practitioners to review data and suggest recommendations as appropriate regarding: use of psycho-pharmacological medications, management of follow-up for enrollees with coexisting medical and behavioral disorders, and behavioral health access and appointment availability. Cenpatico also maintains its own QI Program, overseen by MHS through delegation oversight. Cenpatico’s QI Director additionally provides progress reports at the MHS CASQIC.
Evaluation and follow-up activities related to BH complaints are delegated to Cenpatico. Some UM and Credentialing functions are also delegated to Cenpatico, which is a subsidiary of Centene Corporation. MHS collaborates with Cenpatico to support the integration of care between medical and behavioral health providers by the following:

- MHS sends monthly a record of behavioral health services and medications prescribed to members by psychiatrists to the member’s PMP, to be included in the member’s medical record.
- The Cenpatico QI Director participates in the MHS-Cenpatico quality workgroup, which develops QIAs related to continuity and coordination of care between BH and Medical practitioners/settings.
- Cenpatico, MHS Medical Management and MHS Medical Affairs staff meet semi-weekly to assess and coordinate care for members with co-existing conditions, through medical and inpatient rounds.
- MHS distributes a depression survey to all enrolled pregnant members, with completed surveys sent to the Cenpatico case management team to review and refer members to behavioral health providers. Post-partum depression surveys are also coordinated with behavioral health case management.
- Nurtur, the MHS disease management partner, also works to coordinate medical and behavioral health co-existing conditions.
- Upon discharge from a psychiatric inpatient facility, the behavioral health case manager faxes a discharge form to the member’s PMP.
- MHS encourages medical and behavioral health providers to utilize a care coordination fax form listing the member’s services and medications.
- Cenpatico also supports integration through its school-based healthcare initiative and community mental health centers.

MHS and Cenpatico collaborate on the selection of behavioral practice guidelines designed to meet the needs of the population served by MHS.

MHS monitors the outcomes of efforts to improve behavioral health for its members. It does so by review of appropriate HEDIS/QRS measures such as Follow-Up After Hospitalization for Serious Mental Illness, Alcohol and Other Substance Abuse screening and treatment, adherence with behavioral health medications for depression and schizophrenia and screening for diabetes for persons taking medications associated with weight gain.

VIII. Patient Safety

Many of the aforementioned activities promote the safety of clinical care and services provided to members. In addition, specific examples of initiatives that demonstrate MHS’ commitment to improving safe clinical practice include, but are not limited to, the following:

Safety Metrics

MHS has identified the following safety metrics for formal ongoing monitoring and corrective action planning:

- Hospital-Acquired Conditions - list defined by CMS (CASQIC)
- Polypharmacy (P&T Committee)
- Class I & II drug recalls (P&T Committee)

Medication Safety

The MHS Pharmacy and Therapeutics (P&T) committee takes safety concerns into account when approving medications for inclusion in the Preferred Drug List (PDL). Additional medication safety activities include:

- P&T Committee review of FDA safety issues and recalls; when a high level of concern for safety is identified, US Script supplies MHS with a list of members that may be affected, to inform follow-up activities
- On-line alerts to dispensing pharmacies that identify potential drug-drug interactions
- Medication Therapy Management, which involves:
  - RPh-to-member in-person Comprehensive Medication Review
  - Safety alerts and resolution monitoring
- Polypharmacy notices to practitioners
- Drug Utilization Review, including opiate usage monitoring (in pregnancy, multiple prescribers, etc.)
Call outreach re: lab monitoring needed for members on persistent medications
Medication adherence letters to members (re: continuation of asthma controller meds, antidepressants, etc.)
Under-utilization letters to practitioners (re: need for ACE-I/ARBs for members with diabetes, controller meds. for members with asthma who frequently refill rescue inhalers, etc.)
Plans are additionally underway to initiate psychotropic medication utilization review (PMUR) in children <18 for targeted review & peer-to-peer education/consultation between the prescribing practitioner and the BH Medical Director as needed, with the goal of redirecting therapy to be consistent with evidence-based guidelines

MHS classifies Quality issues from Level 0 (none) to Level 4 (resulting in serious permanent injury or death) and tracks and trends the types of issues, e.g. medication error, and also by individual practitioners and providers.

On-Site Office Evaluation and Medical Record Review

MHS conducts on-site practitioner office inspections and medical record reviews when quality or safety concerns have been identified through the member complaint process. The review process promotes safe clinical practice by evaluating the physical space, medical records (to determine compliance with medical record documentation standards and medical recordkeeping systems), in addition to assessment of continuity and coordination of care. The QI Coordinator assists the provider in the development of interventions to resolve identified issues and monitors the interventions to determine resolution. Results are summarized and reported to CASQIC and included in the annual QI program evaluation.

Credentialing/Recredentialing

Practitioners are initially credentialed prior to admission to the network and re-credentialed every three years. As part of this process, Provider Relations staff conducts site visits to PMP offices to assess safety and accessibility of care and services. When standards are not met, a corrective action plan is requested prior to completion of the credentialing process.

The recredentialing process occurs every three years. The process includes, but is not limited to, a review of quality of care/safety information and member complaints.

Organizational Provider Assessment and Reassessment

The organizational provider assessment process is in place to maintain the quality and safety of the facility/ancillary network in the MHS service area. Only providers meeting the MHS participation criteria are accepted for contracting. Prior to contracting, each potential network provider undergoes a site evaluation to determine if the provider meets criteria established by MHS. Network organizational providers must also have appropriate license, accreditation, and Medicare certification in order to participate.

Reassessment occurs, at minimum, every three years and includes the following facility and ancillary providers: hospitals, home health agencies, skilled nursing facilities, and freestanding surgical centers. MHS confirms that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body at least every three years. In the case of non-accredited providers, MHS reviews the Indiana State Department of Health (ISDH) survey in order to verify that the provider meets the MHS standards.

Quality of Care Review Process

The quality of care review process promotes member safety by evaluating (including via the formal peer review process as appropriate) clinical safety issues identified through member complaint review or by Medical Management. Additionally, all Hospital-Acquired Conditions identified via monthly claims report runs undergo quality of care review. The process involves medical record review, practitioner/provider/member interview if deemed necessary, first-level review by a QI Coordinator, forwarding of any findings indicative of substandard care to the Chief Medical Director, and CASQIC peer review of cases forwarded by the CMD. Corrective action plans are developed as appropriate and subsequent systems improvements monitored. Findings of substandard care are tracked and trended and also provided to the Credentialing Director for consideration during the
recredentialing process.

The QI department educates in-house staff on quality issue identification and the appropriate use of CRM and TruCare software for classifying and routing issues.

Examples of safety issues uncovered and successfully addressed through review of hospitalized patient include the prevention of pressure ulcers and appropriate recognition of meningitis, non-recognition of abnormal pre-operative test results, partially compensated shock, monitoring for nephrotoxicity and appropriate management of acute respiratory failure. CAPS have been focused at the practitioner, provider and members receiving home health services.

**Preventive Health and Clinical Practice Guidelines**

Preventive Health and Clinical Practice Guidelines relevant to the MHS member population are updated annually or as needed when new information becomes available. The intention is to promote safer clinical practice by providing evidence-based reference information to practitioners and members.

**Provider Accessibility/Availability Monitoring**

As previously mentioned, ongoing evaluations are performed to ensure adequate practitioner availability (PMP, Specialist, BH) and access (PMP and BH). Availability monitoring includes an analysis of CLAS elements. Access standards are communicated via the provider manual and provider/member websites. Compliance with standards is also assessed during the initial office site visit and annually thereafter at all PMP offices. Non-compliant issues are addressed through corrective action plans that are reported to the CASQIC.

**Health Needs Screening**

Health Needs Screening of new members facilitates timely identification and referral of conditions/circumstances that might benefit from Medical Management services.

**Hospital Readmission Reduction**

CASQIC monitors same and all-cause readmission rates/trends via the Transition from Hospital to Home QIA. To promote safe, successful transitions home and avoid readmission, the MHS UM Social Worker coordinates discharge plans with hospital staff to ensure adequate home support. Additionally, all MHS members recently discharged from the hospital receive Case Management outreach follow-up.

**Right Choices Program (RCP)**

The RCP provides clinical guidance for members who are overutilizing narcotics and emergency room services. The program goal is to enhance continuity and coordination of care by facilitating the establishment and utilization of a medical home for participating members.
IX. Serving a Diverse Membership

MHS deems it of critical importance to ensure accessible care that meets the cultural, racial, ethnic and linguistic needs of the member population, through assessment of member/practitioner characteristics and network adjustment as indicated. To that end, MHS conducts a comprehensive assessment of its membership and practitioner network at least annually for review and discussion at CASQIC of improvement needs and action plans.

Indiana’s population is increasing in ethnic diversity, particularly in the Hispanic, Asian and East African populations. Indiana, like other states has historical patterns of health care disparities. It also suffers from health literacy issues. It has a large rural population and underserved urban areas.

In order to reduce disparities the QI program regularly reviews reports concerning network adequacy, complaints about access and availability of care, and care that should be delivered in a culturally competent manner. Complaint and CAHPS/QHP data is reviewed at the regional level to determine areas that may need joint intervention by Network and QI teams. MHS has also focused on reducing disparities in infant mortality found in certain regions or among various groups of members.

As previously noted, MHS also has an active Culturally and Linguistically Appropriate Services (CLAS) Committee that evaluates care and services for compliance with the U.S. Dept. of Health and Human Services Office of Minority Health CLAS standards. It reviews any member complaints related to CLAS issues and assesses cultural and linguistic competence across MHS (including providers, contractors, and staff that serve MHS members), and makes recommendations for action in order to resolve any identified health care disparities, such as differences in treatment among different racial groups. EPSDT chart audit sites are preferentially selected for providers who underperform on well-child care. Observations are made of office staff behavior and counseling may be provided as needed.

MHS conducts member focus groups to better understand the member perspective on cultural issues.

MHS routinely provides CLAS-related education to all new practitioners and at least annually to the general practitioner network, to ensure awareness of and sensitivity to the cultural needs of their diverse member panels. All MHS employees also receive CLAS training. Additional activities aimed at meeting CLAS needs include nursing advice and interpretation services available in multiple languages, provision of member materials in languages most relevant to the MHS membership, Member Advisory Council membership diversity and discussion of CLAS-related needs, and Family Education Network one-on-one outreach activities facilitated through the MHS-Indiana Minority Health Coalition partnership.

X. Serving Members with Complex Health Needs

The MHS approach to serving members with complex health needs is stratified, to ensure that all levels of complexity are addressed:

- Families of low-risk children with special health needs receive relevant educational materials on a quarterly basis
- Low-acuity members with complex health needs receive Care Coordination assistance (by an LPN, Social Worker or Health Coach) with:
  - Health monitoring
  - Coordination of social services
  - Appointment scheduling
  - Transportation
- Hospitalized members receive discharge-planning assistance
- Aged, blind and disabled members with polypharmacy receive the following services from the Medication Therapy Management Program involving:
  - Member education
  - Development of a Medication Action Plan
  - Safety alerts
  - Care gap alerts
Complex Case Management services are offered to members with physical or developmental disabilities, multiple chronic conditions or severe injuries. Conditions and diseases managed might include, but are not limited to, spinal injuries, transplants, cancer, serious trauma, AIDS, multiple chronic illnesses, and serious and persistent mental illness. Case Management goals include:

- To practice cultural competency, with awareness and respect for diversity,
- To facilitate informed choice, consent and decision-making,
- To use a comprehensive, holistic approach that promotes evidence based discussions,
- To promote self-determination through advocacy,
- To coordinate efforts to move the member towards self-care management,
- To promote optimal member safety,
- To assist with navigating the health care system to promote effective care delivery especially during transitions between providers or communications between Primary Care Practitioners and Specialists,
- To use member centered, strengths-based, collaborative partnership approaches that assist members with multiple or complex conditions,
- To assist the member and provider in facilitating care to optimize health outcomes or improve the member’s functional capability in the most appropriate setting and in a cost effective manner,
- To perform a comprehensive assessment of the member’s condition and care needs,
- To develop and implement a member-centered plan of care, which includes identified or potential needs, prioritized goals, a monitoring schedule and follow-up to evaluate the member status.

Medical Management activities include identification of candidates by mining data from multiple sources, comprehensive assessment (including but not limited to medical and behavioral health status/functional status/psychosocial needs/CLAS preferences/resources), care planning, stratification and care coordination. Further details are available for review in the MHS Medical Case Management policy/procedure.

The MHS Children with Special Needs Program additionally provides case management services to members with chronic conditions such as neurological disorders, developmental disorders, HIV/AIDS, blood diseases and musculo-skeletal disorders. The Children with Special Needs program approach also includes appropriate client identification, stratification, interventions and documentation.

Quality measures related to Complex Case Management effectiveness and member satisfaction with those services are evaluated/improved through ongoing departmental activities and the Quality Improvement Activity process, and summarized in the annual QI Program Evaluation.

**XI. Methods to Identify and Improve Aspects of Care and Service**

**Identification of Issues**

Important aspects of clinical quality improvement are identified by reviewing QI related complaints, grievances and appeals, monitoring the organization’s key performance measures, conducting satisfaction surveys and other techniques, as appropriate.

Criteria for selecting important aspects of clinical and service QI topics include:

- Is the clinical quality concern reflective of the MHS population?
- Is there an opportunity to improve outcomes?
- Does this issue involve high-volume, high-risk, high-cost, or problem-prone areas of concern?
- Is this issue included in the health services delivery areas of concern as identified in the scope of work?
- Are there objective or reasonable subjective criteria for assessing improvement in service for the selected topic?

Any committee or subcommittee, work group, or department can identify, recommend, and pursue opportunities for assessing improvement with the endorsement from defined levels of oversight.

**Framework for Process Improvement**

MHS has chosen to utilize Deming’s Plan – Do – Study – Act (PDSA) cycle as a framework for process improvement. Deming’s model serves as a guide to team members as they follow the methodology of process improvement, and is summarized below:
Once the priority opportunity for improvement has been identified, a multidisciplinary team of process owners convenes to perform barrier analysis and recommend actions. The action plan includes what interventions should be implemented to achieve the desired outcome. The next step is to do the intervention or make the change on a small scale or pilot basis. After implementation of the intervention, the team should study the results of the intervention to determine its effectiveness. If the desired result is achieved, the next step is to act to implement the intervention on a wider scale. (If the desired outcome is not achieved, the planning phase should begin again.)

**Documentation of Service and Clinical QI Activities**

Selected care, service and safety QI activities are recorded in the format standardized by NCQA as a QIA (Quality Improvement Activity). Included in documentation are the study methodology, quantitative and qualitative analysis of findings, identification of barriers to improvement and both planned and implemented improvement strategies. Additionally, at least two QI projects (QIPs) designated for State reporting are documented in the required OMPP format (which is similar to the QIA form, in an EQRO-recommended Excel document).

**XII. Annual Program Evaluation**

At least annually, MHS reviews QI program activities and process/outcomes data to assess effectiveness of the QI program. This evaluation includes a review of completed activities, trending of clinical care/safety and service indicators and member/practitioner satisfaction ratings. The evaluation is reported to the quality improvement committees and the BOD. The evaluation informs the development of the following year’s QI program strategy, resources needed to accomplish goals, and work plan.

The evaluation addresses:
- Trend analysis of quality measure data
- Progress toward meeting established goals
- Completed and ongoing improvement activities
- Analysis of successes/best practices
- Opportunities for improvement
- Overall effectiveness of the QI program, including progress toward influencing network-wide safe clinical practices

**XIII. Work Plan Development**

Based on the annual year-end program evaluation, the QI Program Description is revised and a new Strategic QI Work Plan is developed. The purpose of the work plan is to identify goals and plans for their achievement in the coming year. Work plan components include, at a minimum:
- Yearly Planned activities & objectives for improving:
  - Quality of clinical care
  - Safety of clinical care
  - Quality of service
  - Member experience
- Timeframe for each activity’s completion
- Staff members responsible for each activity
- Monitoring of previously-identified issues
- Evaluation of the QI Program

The BOD determines final approval of the submitted Annual QI/UM Program Evaluation, Strategic QI Work Plan and QI Program Description.

OMPP QI Work Plan components of the Strategic QI Work Plan (for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect), detailing State-required and priority initiatives, are also submitted annually to the Office of Medicaid Policy and Planning.

The workplan is a dynamic document that can be amended and expanded to meet the needs of state requirements and the needs of our membership.
## Appendix A
- QI Delegation Inventory -

<table>
<thead>
<tr>
<th>Quality Management and Improvement Functions</th>
<th>Cenpatico BH</th>
<th>Nurtur Health</th>
<th>US Script</th>
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<tbody>
<tr>
<td><strong>QI Program Structure</strong></td>
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<tr>
<td><strong>Clinical Programs</strong></td>
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<tr>
<td>A &amp; B. Submit Quality Management Program Description, Quality Management Work Plan, Quality Management Program Evaluation, &amp; all applicable Quality Management policies &amp; procedures annually.</td>
<td>N/A</td>
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<td><strong>Behavioral Health Programs</strong></td>
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<tr>
<td>A &amp; B. Submit Quality Management Program Description, Quality Management Work Plan, Quality Management Program Evaluation, &amp; all applicable Quality Management policies &amp; procedures annually.</td>
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<tr>
<td><strong>Program Operations</strong></td>
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<tr>
<td>A-B. Maintains functional QI Committee</td>
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<td><strong>Health Services Contracting</strong></td>
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<td>Use Appropriate Provider Contracts</td>
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<tr>
<td>A. Practitioner Contracts (including allowable use of performance data)</td>
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<td>B. Affirmative Statement</td>
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<td>C. Provider Contracts (including allowable use of performance data)</td>
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<td><strong>Availability of Practitioners</strong></td>
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<td>Provides &amp; Monitors Appropriate Availability of Practitioners, as applicable</td>
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<td>A. Cultural Needs &amp; Preferences</td>
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<td>C. Practitioners Providing Specialty Care</td>
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<td>D. Practitioners Providing BH Care</td>
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<td><strong>Accessibility of Services</strong></td>
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<td>Provides &amp; Monitors Appropriate Accessibility of Practitioners, as applicable</td>
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<td>A. Assessment Against Access Standards (medical)</td>
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<td>B. BH Access Standards</td>
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<td>C. BH Telephone Access Standards</td>
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<td><strong>Member Experience</strong></td>
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<td>A &amp; B. Measures &amp; Promotes Member Satisfaction– physical health</td>
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<td>C &amp; D Measures &amp; Promotes Member Satisfaction– behavioral health</td>
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<td>B. Program Description</td>
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<td>C. Identifying Members for Case Management</td>
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<td>D. Access to Case Management</td>
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<td>E. Case Management Systems</td>
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<td>F. Case Management Process</td>
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<td>I. Experience with Case Management</td>
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<td>J. Measuring Effectiveness</td>
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<td>K. Action &amp; Remeasurement</td>
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<td>Quality Management and Improvement Functions</td>
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<td>C. Frequency of Member Identification</td>
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<td>D. Providing Members with Information</td>
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<td>E. Interventions Based on Stratification</td>
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<td>F. Eligible Member Participation</td>
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<td>G. Informing &amp; Educating Practitioners</td>
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<td>H. Integrating Member Information</td>
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