Minnesota Senior Health Options
2014 Model of Care Training
Welcome to the MSHO 2014 Model of Care Training

• Minnesota Senior Health Options (MSHO) is a Fully Integrated Dual Eligible Special Needs Plan in which Medicaid and Medicare benefits and services are integrated into one benefit package.

  HealthPartners contracts with the Minnesota Department of Human Services (DHS) and Centers for Medicare and Medicaid Services (CMS) for the MSHO program.

• The MSHO Model of Care describes the management, procedures, and operational systems that HealthPartners has in place to provide access to services, coordination of care and the structure needed to best provide services and care for the MSHO population.
• Model of Care training is required for employed and contracted personnel who work with MSHO patients/product to ensure staff have knowledge of the MSHO population and the Model of Care.

• CMS requires that Model of Care Training be completed annually.
Meet Rosie

Today we would like to introduce you to Rosie.

She is a new HealthPartners MSHO member.

Rosie is going to tell us about her experience as a MSHO member.
“Hi. My name is Rosie. My daughter helped me sign up with HealthPartners as an MSHO member. A few months ago I met my Care Coordinator.”

Who can be an MSHO member?

- Anyone 65 years of age or older
- Who is eligible for Medical Assistance (Medicaid)
- Who has both Medicare Part A and B
- They must also reside in the HealthPartners 12 county metro service area
“My Care Coordinator called me up that very first month and asked to meet with me. I was a little nervous about meeting someone new and having them come into my home; so I asked my daughter to be there as well. I really didn’t need to worry. My Care Coordinator is very nice. She has helped me so much.”
“When my Care Coordinator came to my house, she did a Health Risk Assessment. I answered a lot of questions about my health and we talked about how I am getting along at home. I really want to stay in my home; but I need some help.”

All Health Risk assessments are completed within 30 days of enrollment and within 12 months of the previous assessment as well as any time the member has a change in condition.

The Health Risk Assessment includes physical/medical, psychosocial, cognitive, and functional areas of need.
“After we completed my Health Risk Assessment, my Care Coordinator included me in the development of my Individualized Care Plan. I was able to choose which services I wanted from the ones I was qualified for and also which providers I preferred.”

Members who meet Nursing Facility Level of Care criteria may be eligible for Home and Community Based services such as Meals on Wheels, Chore Service, Customized Living Services, Adult Day Care, Home Making, and Life Line.
“I qualified to receive meals on wheels and tomorrow someone is coming to mow my lawn. He will even clean the snow off of my driveway this winter. It is called chore service.

My daughter also helps me with many things.”

**Tidbit**

Based on the results of the assessment, provider input and the member’s desires; the member and Care Coordinator develop a care plan that incorporates goals to be achieved during the coming year.

The Primary Care Provider recommends needed health care services and facilitates communication and information exchange among the treating providers.
HealthPartners MSHO has a select, high quality provider network that includes: HealthPartners Medical Group, Park Nicollet, Fairview Clinics, Osceola Medical Centers, Community Clinics.

The provider network is composed of primary, specialty and dental care providers as well as a full-range of geriatric, hospital, acute and post acute rehabilitation, long-term care services, home and community-based services and other specialty services.

Providers are credentialed according to NCQA guidelines and re-credentialed to verify appropriate licensure, insurance and other criteria.

Network specialists can be directly accessed: most often coordinated by the Primary Care Provider and/or the Care Coordinator.
“My Care Coordinator also explained that I am part of my Interdisciplinary Care Team. This is a group of caregivers and providers who help me stay as healthy as I can be, so I can live in my home.”

Interdisciplinary Care Team is composed of:
- Member and/or appropriate family/caregiver
- MSHO Care Coordinator
- Primary Care Provider
- Other providers appropriate to specific health needs (Specialists, Palliative Care Team, Pharmacist, Dentist, etc.)
- Others as needed
“My Care Coordinator calls me to see how things are going and how my services are working out. I also have goals on my care plan that she asks me about.

A few of my goals for this year are to always use my walker so I don’t fall; to always take my medicine; to get a flu shot; and to see my dentist.”

The Care Coordinator works in partnership with the member and Interdisciplinary Care Team members to develop, coordinate, and monitor the Individualized Care Plan on an ongoing basis. The Care Coordinator communicates the member’s progress toward health goals to the Interdisciplinary Care Team.

HealthPartners uses a variety of tools to ensure good communication between all ICT members regarding a member’s health status. Such as use of electronic medical records when available; secure email, fax and other confidential correspondence that meet HIPAA requirements.
All MSHO members receive care management services through their Care Coordinator.

HealthPartners identifies complex and high-risk MSHO members through the use of proprietary predictive monthly algorithm reports based on patterns of care and treatment; high-risk registries; physician input and requests; and Health Risk Assessments.

These services include but are not limited to enhanced care coordination, Palliative Care Case Management and other Disease Management Programs.

“My Care Coordinator even talked to me about my diabetes. She told me about the Diabetes Disease Management Program. I am able to have a Disease Management case manager call me to teach me more about how to manage my diabetes.”
Behind the Scenes

There are many aspects of the Model of Care that occur behind the scenes:

The supporting structure of the Model of Care is composed of employed and contracted staff who perform administrative, clinical and oversight functions. Such as:

- Enrollment processing and eligibility verification
- Adjudication of claims
- Member and provider customer service
- Management of contracts with a variety of providers
- Regulatory compliance
- Professional staff credentialing
- Development and evaluation of standards of care
- Data collection and analysis of program goals
- Assessment of emotional, behavioral and cognitive problems
CMS defines several goals for the Model of Care

Examples of CMS defined goals:

- Improve access to essential services such as medical, mental health, and social services
- Improve access to affordable care
- Improve coordination of care through an identified point of contact
- Improve seamless transitions of care across healthcare settings, providers, and health services
- Improve access to preventive health services
HealthPartners has identified measureable goals around each of the MSHO CMS defined goals.

These goals are utilized to evaluate our ability to provide services to MSHO members.

Examples of HealthPartners MSHO goals:
- Improve member health outcomes through efforts to reduce re-hospitalizations within 30 days of previous discharge.
- Improve access to preventive care by increasing colorectal cancer and mammogram screenings.
• HealthPartners Quality Program is based on the Triple Aim to simultaneously improve:

  • The Health of the MSHO population;
  • The Experience of the MSHO members; and,
  • The Affordability of health care.
“Thank you for talking with me today about MSHO.”

Please close the slide presentation and click on the “Take Survey” link at the bottom of the email to complete the post-training quiz.
The Model of Care defines the management, procedures and operational systems that provide access, coordination and structure needed to provide services and care to the MSHO population.

1. Description of the Minnesota Senior Health Options (MSHO) Population

HealthPartners Model of Care Program is designed to serve members of the HealthPartners Minnesota Senior Health Options (MSHO) Program. MSHO is a Medicare Advantage Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) that provides specialized care to seniors age 65 and older who are eligible for both Medical Assistance and Medicare parts A and B. The population served by this program is primarily frail and elderly.

HealthPartners total MSHO enrollment for January 2012 was 2,951. Of the total membership, 1,159 (39%) members are living in the community and have been assessed as Nursing Home Certifiable. An additional 1,113 (37%) Non-Nursing Home Certifiable members also live in the community. The remaining 679 (23%) members reside in an institutional setting. The average age of our MSHO population is 77.

The cultural make up of our MSHO population is rich with diversity. 55% of enrollment identifies their race as White, 27% as Asian or Pacific Islander, 13% as Black or African American, 4% as Hispanic or Latino and 1% Native American or Alaskan Native. 77% of members speak English, 9% speak Vietnamese, 8% speak Hmong, 5% speak Cambodian and 3 % speak Spanish.

2. Measurable Goals

The 2012 MSHO Model of Care Measurable Goals are being finalized and will be added to this document upon approval.

3. Staff Structure and Care Management Roles

Staff that performs administrative functions
• **Membership Accounting Department**: Process enrollments, verify eligibility, CMS reporting, reconcile capitation payments

• **Claims Department**: Adjudicate claims, provider customer service, medical and code review, third party recovery, authorization administration, data collection

• **Member Rights and Benefits Department**: Review and respond to grievances, review and respond to provider complaints, analyze and assess trends

• **CareLine Department**: Provide medical advice to members 24 hours a day, 365 days a year

• **RideCare Department**: Arrange transportation to covered services

• **Member Services Department**: Member and provider customer service, member outreach calls, assist members in navigating health care system, provide member informational materials upon request and monitors call trends and volume

• **Marketing Department**: Communicate plan information, develop and distribute member materials

• **Government Programs Department**: Product and contract management, strategic planning, regulatory and compliance programs management, audit and monitoring management, internal business area support, external regulatory purchaser, liaison between the Minnesota Department of Human Services, Centers for Medicare and Medicaid services and internal operations groups, local county and community involvement

• **Market Research and Care Innovation & Measurement**: Survey beneficiaries and providers, analyze and present results, project implementation, training

• **Government Relations**: Build relationships with members of state and federal trade associations as well as elected officials; educate officials and advocates in order to advance good public policy that directly or indirectly improves the health of our members, patients and the community.

• **Finance Department**: Lead, facilitate and consult on the management and utilization of financial resources around processing activities such as general accounting, accounts payable, business office, billing and payroll
Staff that performs clinical functions

- **Disease and Case Management Department**: Inpatient and complex case management, disease management, care coordination.

- **Geriatrics Services Department**: Provides primary medical care to members in long-term settings, transitional care centers and assisted living facilities.

- **Behavioral Health Department**: Assessment of emotional, behavioral and cognitive problems, behavioral health case management; assist members and providers regarding the locations, qualification, specialties and services of providers in the direct access behavioral health network; analyze data for oversight of provider network; behavioral health case management.

Staff that performs administrative and clinical oversight functions

- **Dental Department**: Provider customer service, authorization administration, data collection and analysis, process and examine claims

- **Pharmacy Department**: Manages and reviews pharmacotherapy, pharmacy customer service, prior authorization, medication therapy management, drug trending analysis

- **Quality Utilization and Improvement Department**: Admissions point of contact for hospital, same day surgery, and nursing home services; responsible for Utilization Review & management including prior authorization and notification; quality measurement and improvement monitoring and evaluation of clinical services; overseeing and assisting staff on the review process and ensuring that processes are compliant with regulatory statutes and accreditation standards; develop evidence based criteria by reviewing available scientific evidence, current standards of medical practice, and existing coverage positions as defined by state and federal laws, rules and regulations.

- **Operational Integrity Department**: Validate data within the HealthPartners Data Warehouse (HPDW), develop validation methodologies, consult on validation process for other areas, facilitate development of common definitions within the HPDW, facilitate communication of development projects between the Administrative Systems and HPDW as well as project management/acceptance testing of regulatory encounter data reporting.
Health Informatics Department: Improve and facilitate decisions and actions with data; provide analytical, project management, reporting consulting, and information support; design, implement, and report meaningful and actionable metrics; create methodologies that focus on cost of care, quality, efficiency, trend, risk analysis, and predictive modeling.

Corporate Integrity Department: Provide channels for reporting of potential compliance issues; investigate and conduct thorough review to confirm compliance with company policies, and government regulations and laws; facilitate corrective action; compliance training for staff; develop standards of conduct and organizational policies and procedures; advise and assist in development of audit tools and procedures; review privacy complaints.

Internal Audit Department: Review the reliability, integrity and utility of information used by management for risk-assessment, decision-making, and performance-monitoring; assess compliance with approved policies, plans, procedures, laws and regulations; ensure that appropriate procedures are in place to safeguard the organizations assets; carry out analyses to develop recommendations for the effective and efficient use of resources; report findings to appropriate management staff.

Law Department: Provide comprehensive legal advice and direction to the management and governance of HealthPartners and its affiliated entities; manage the risk management functions of the organization.

Executive Leadership Team: Analysis of program quality and performance; identify strategic program direction; provide advice and oversight of implementation and overall program integrity.

HealthPartners & Group Health Plan, Inc. Boards of Directors: The HealthPartners, Inc. and Group Health Plan, Inc. Boards of Directors (the “Board”) represent the members’ interest in ensuring the accomplishment of the organization’s mission to improve the health of our members, patients and the community. The business of the organization is managed under the Board’s direction. The Board delegates to the Chief Executive Officer, and through him or her, to other senior management the authority and responsibility for managing the everyday affairs of the organization.

4. **Interdisciplinary Care Team (ICT)**

Composition of the ICT and how membership is determined.
The Interdisciplinary Care Team (ICT) is made up of the specialists that are appropriate to each member’s health care needs and are specialists that the member chooses to work with. The Primary Care Clinic has input and leadership, together with the member, regarding specialists and other health care professionals that may be needed on the ICT at various points during the care of the member. In conjunction with the member, the MSHO Care Coordinator provides input and leadership, regarding other health care professionals who may be part of the ICT at various points during the care of the member.

The MSHO ICT may include any or all of the following:

- Member/appropriate family or caregiver. Family, caregivers, or any other persons are involved per the member’s choice, and with member’s authorization for providers to speak with such persons.
- MSHO Care Coordinator
- Primary Care Provider
- Appropriate board certified Specialist(s) based on the individual member’s Care Plan
- Dental Provider
- Pharmacist
- Palliative Care Team
- Inpatient Care Manager
- Geriatric Nurse Practitioners
- Disease Manager
- Home Health Care Nurses and/or therapists (physical, occupational, speech)
- Customized Living Services Nurses and/or Social Workers
- Adult Day Service Providers
- Skilled Nursing Facility Nurses and/or Social Workers
- Dietician
- Primary Care Clinic Social Worker/Nurse
- Behavioral Health Case Manager
- Behavioral Health Provider
- Community ARHMS workers (behavioral health in the community setting)
- Medical Director
- Nurse Educators
- Pastoral Specialists
- Health plan utilization review staff (to review prospectively, concurrently and retroactive reviews of care)
Facilitate member participation when feasible.

MSHO member demographics, as well as race, ethnicity, and language are tracked and stored in HealthPartners database. When contacting MSHO members, the availability of this data allows for the use of interpreters for outreach calls, clinic appointments, home visits, and any other interaction with the member.

MSHO Care Coordinators reach out to MSHO members to initiate contact and work with the members to monitor their progress toward reaching goals through the year. Outreach is typically by telephone but may be via letter in some cases. Similarly, clinics reach out to members to remind them of appointments or the need to schedule an appointment, lab work or procedure.

MSHO Care Coordinators complete initial and annual health risk assessments for MSHO members in person, usually in the member’s home. For non-English speaking members, interpreters or Care Coordinators fluent in the member’s primary language are present for the home visit to ensure members are able to fully participate in the assessment and planning process. MSHO Care Coordinators may ask for input from other members of the ICT prior to meeting with the member to complete an assessment, and if the member is in agreement, appropriate ICT members may be asked to participate in the member assessment process. Based on the results of the assessment, as well as the member’s desires and preferences, the Care Coordinator and member together develop an individualized care plan for the member. As part of the care planning process, members are encouraged to identify health goals that are important to them and that they want to achieve during the coming year. Upon completion of the member’s care plan, the member is asked to sign a copy of the care plan indicating agreement with the plan. The member is given a copy of the completed plan.

HealthPartners training for MSHO Care Coordinators results in a patient centered, values-based approach to working with members that helps members identify what is important to them at their current stage of life. MSHO Care Coordinators are trained in Intrinsic Coaching and Motivational Interviewing; they have the knowledge and skills needed to engage members and/or their authorized representatives and help them to identify what is most important to them. Care Coordinators also work with members to help them share responsibility for improving their own health and safety, and improving quality of life perception, independence, and pain management. Care Coordinators are also trained to provide shared decision making support for members challenged with making difficult decisions. When a member identifies a decisional conflict, the Care Coordinator is able to provide personalized decision-making support.
In summary, the MSHO Care Coordinator’s work with members includes facilitating member participation in assessment and care planning via face-to-face meetings, phone calls, providing an interpreter as needed, involving the member’s primary care physician and other members of the ICT and providing patient support including direct contact with members and/or family members during transitions of care.

**ICT operations and communications.**

Meetings can be requested by any member of the ICT team, including the member or family/caregiver and MSHO Care Coordinator. The frequency of meetings is at least annually and more frequent as determined by the member’s severity and complexity of medical and/or psychosocial concerns and the member’s desired frequency for meetings. Meetings may take place in the member’s home, primary or specialty care clinic settings, at nursing facilities, Customized Living Facilities, or Adult Day Service Facilities. Care Coordinators are responsible for documentation and retention of records for care coordination meetings as well as distribution and dissemination of appropriate information to appropriate stakeholders. All Physicians, Regions Hospital staff, and all MSHO Care Coordinators have access to the same electronic medical record (EMR) for MSHO members and are able to communicate with ICT staff within the member’s EMR through use of the secure messaging feature of HealthPartners EMR. The EMR is the primary mode of communication among HealthPartners providers.

The ICT has the responsibility, together with input from the member and family/caregiver, to assess needs, develop, implement, monitor and update a care plan that is based on member choices and preferences as well as ICT recommendations. Each MSHO member is assigned to a Care Coordinator that coordinates the ICT. Care Coordinators work with members and providers as part of the interdisciplinary care team to assess, plan and deliver care. The member’s primary care provider has the principle role of recommending and arranging services required for and agreed upon by the member and facilitating communication and information exchange (using the appropriate communication medium) among the different providers treating the member. Providers may request information from members and other treating providers as necessary to provide care. Transition of care policies exist to address continuity of care for the member when a contract for one of the member’s providers is discontinued or a member terminates coverage. The role of the team is:

- Analyze and incorporate the results of the initial and annual health risk assessment into the care plan according to the member’s desires and preferences, and conduct annual care coordination meetings.
- For community and some institutionalized members, the Care Coordinators conduct case rounds on a regular basis or as required based on health status.
For most institutional members, the HealthPartners Geriatric Team conducts case rounds on a regular basis or as required based on health status.

The Care Coordinator collaborates with the ICT as needed to develop and annually update an individualized care plan for each MSHO member.

With every clinic visit, the member receives a printed copy of the visit summary as well as a care plan noting any changes to medications or other treatments.

Manage the medical, cognitive, psychosocial, and functional needs of MSHO members according to the needs and preferences of each member.

Communication to coordinate the care plans and meetings in the forum or format most appropriate to the member and providers. This may include the EMR, face to face meetings and written correspondence as necessary.

HealthPartners MSHO Care Coordination staff hold two types of complex case rounds. The typical process is where the MSHO Care Coordinator meets first with their supervisors at least monthly to review complex cases. Either the MSHO Care Coordinator or his/her supervisor may identify a member appropriate for complex round discussions. When a member is identified from the first case rounds discussion as being in need of further collaboration, the member’s case will be brought to the second complex case rounds which include all MSHO supervisors, several MSHO Care Coordinators, and the Associate Medical Director for the MSHO Care Coordination program. Complex case rounds that include the Medical Director are held every two weeks. The Care Coordinator is responsible to bring current, accurate information to the rounds, including results of discussions with the member’s physician, home-care nurse if appropriate, and other ICT team members. The Care Coordinator’s supervisor is responsible to ensure the complex case rounds are scheduled, that rooms are reserved and that the Medical Director is given the name and identification number to review the member chart in the EMR. Following complex case rounds, the Medical Director will talk with the member’s physician, if applicable, to share recommendations from the complex case rounds. The MSHO Care Coordinator will notify all other members of the ICT as appropriate with any information regarding changes to the member’s plan of care.

5. Provider Network with Specialized Expertise and Use of Clinical Practice Guidelines

Specialized expertise in HealthPartners provider network.

HealthPartners provides access to preventive and primary care, dental care, acute and post-acute rehabilitation and long-term care services. These services are provided and coordinated through a fully integrated health care delivery system. This system is primarily composed of HealthPartners Clinics which provide a full-range of geriatric
programs, dental clinics as well as hospital services provided at Regions Hospital and other facilities.

**HealthPartners Clinics**

HealthPartners Medical Group Clinics make up one of the largest medical groups in Minnesota serving approximately 425,000 members primarily in the Twin Cities, St. Cloud, and western Wisconsin markets. HealthPartners Clinics provide access to a full range of primary care, specialty and dental services at 70 HealthPartners clinics. In addition to primary and dental care, there are more than 35 medical and surgical specialties represented by the group. The medical group is staffed by a little over 700 physicians, including approximately 350 family practice and internal medicine physicians who provide services to both adult and geriatric members. The dental group is staffed by 60 dentists and offers specialties in oral surgery, orthodontics, periodontics and prosthodontics. HealthPartners has 23 geriatricians in the HealthPartners Clinics. The geriatric programs within HealthPartners Clinics include nursing home care, post-acute care services, home-based medical care, hospice care and behavioral health services.

Geriatric care teams, comprised of a geriatrician and nurse practitioner, provide ongoing services at over one hundred different nursing home facilities. In addition, there are intensive geriatric care teams that provide services at seven distinct post-acute transitional care sites. Home-based primary medical care is also provided at several assisted living sites by these geriatrician/nurse practitioner teams. Hospice and palliative care services are delivered through a number of HealthPartners Clinic-owned Medicare certified hospice locations. Geriatric psychiatry services are provided within the system for both institutionalized members and outpatient care. There is also a dedicated outpatient geriatric clinic at Regions Hospital and a dementia assessment clinic within the HealthPartners integrated system.

HealthPartners Clinics deliver hospital care primarily through Regions Hospital which is a 427-bed tertiary care facility and a teaching and research hospital located in St. Paul. The hospital provides specialized expertise in a number of acute care areas including: trauma, burns, emergency, surgery, heart, digestive and cancer care. Regions is a Level 1 Adult and Level 1 Pediatric Trauma Center as well as a regional center for behavioral health care. Hospital care is coordinated with outpatient providers through a network of hospitals which actively see members at Regions Hospital as well as both North Memorial and Mercy Hospitals in the Twin Cities.

HealthPartners Dental Group has 20 locations that provide a significant amount of access to this membership. HealthPartners made a major investment in establishing the HealthPartners Dental Group Midway clinic to specifically improve dental access and
serve the dental care needs of this membership. By keeping appointment schedules flexible and providing clinic hours conducive to appointment access, the Midway Dental Clinic is uniquely positioned to care for members.

Contracted Clinics and Providers
In addition, throughout the geographic service area, HealthPartners has a network of providers and facilities with specialized clinical expertise pertinent to the MSHO population. These providers have training and experience in managing medically complex and/or chronic conditions and provide diagnostic and treatment services to meet the specialized needs of the targeted population.

Home and Community-Based Services Providers
HealthPartners has a network of Home and Community-Based Service (HCBS) providers, also known as Elderly Waiver Providers. Many of these providers offer non-traditional services that enable members to stay in their home such as homemaker, chore services, meals on wheels, and adult companion services. HealthPartners has direct contracts with many Home and Community-Based Service providers as well as contracts with counties for their HCBS provider network.

Scope of Care
The provider and facility network delivers services that includes, but is not limited to, the following provider types:
- Acute care facility, hospital, medical center
- Laboratory
- Long-term care facility, skilled nursing facility
- Pharmacy
- Radiography facility
- Rehabilitative facility
- Advanced degree social workers
- Board-certified specialists
- Mental health specialists
- Mid-level practitioners (nurse practitioner, physician assistant)
- Registered nurses and other nursing professionals
- Registered pharmacists
- Registered physical, occupational, respiratory and speech therapists
- Other allied health professionals
- Medical specialists pertinent to targeted chronic conditions and identified co-morbid conditions
- Home and community based service providers

Network facilities and providers are actively licensed and competent.
All providers are credentialed in compliance with The National Committee for Quality Assurance (NCQA) guidelines, to ensure they are practicing in fields for which they are appropriately and adequately trained. HealthPartners credentials all providers according to NCQA guidelines. Whenever possible, the Professional Services Network Management department focuses on contracting with board-certified providers.

Providers are re-credentialed on a bi-annual schedule to verify appropriate licensure, insurance and other criteria on a regular basis. HealthPartners investigates quality concerns or issues that arise including exclusion from Medicare.

HealthPartners health care services are supported by a written contractual arrangement. Monitoring of the professional qualifications of practitioners or providers associated with HealthPartners is done through credentialing, contracting and peer review activity. If a concern involving a specific practitioner or provider is identified, appropriate monitoring and/or intervention is initiated. As part of the monitoring process, quality of care issues are monitored and investigated, including cases when a deviation from applicable standards of care is suspected or confirmed. Credentialing is notified of cases involving an adverse outcome and takes appropriate action based on credentialing policies and procedures. When possible in selecting providers, board certified specialists are preferred in the provider network.

Use of clinical practice guidelines
HealthPartners uses reliable and valid measures of quality and resource use to improve the quality and affordability of care provided by network providers. Comparative provider performance results are reported to providers, consumers and purchasers to support improvement and provide consumers with information to help make informed decisions about health care. The annual Clinical Indicators Report features comparative provider performance on clinical measures related to preventive and chronic care, behavioral health, pharmacy, specialty and hospital care.

Collaboration with providers in establishing best practices and defining effective performance measures is essential. All measures are based on evidence-based guidelines established by the Institute for Clinical Systems Improvement (ICSI). The ICSI guidelines provide the basis for the development of improvement initiatives and performance measurement. HealthPartners supports the implementation within its provider network of the ICSI guidelines. The ICSI guidelines facilitate agreement on elements of care that are medically appropriate and result in the best possible outcomes. The use of clinical practice guidelines allows HealthPartners to measure the impact of the guidelines on the outcomes of care and reduce variation in diagnosis and treatment.
Determining services members will receive.

Preventive services are directly available to members. In addition, members can go directly to specialists, with care most often being coordinated by the Primary Care Provider and/or the Care Coordinator. The member, member’s authorized representative, medical practitioner, member’s Care Coordinator and the ICT are all involved in determining which services the member will receive.

HealthPartners has a dedicated Member Services department that serves the MSHO population. Member Services representatives are knowledgeable about the MSHO product, the benefit set and how to access services. Representatives assist MSHO members when they have questions about coverage for services, how to access services, referral questions and any other product related question. For more complex help in navigating the health care system, Nurse Navigators are available to assist members.

The provider network coordinates with the ICT and the member to deliver specialized services.

The provider network, along with the ICT, work to support the member in the following ways:

- Contact members to remind them of upcoming appointments
- Coordinate care from setting to setting in conjunction with the Care Coordinators
- Provide 24-hour access to a nursing hotline
- Assist with developing and updating individualized care plans
- Conduct home visits for clinical assessment or treatment and safety inspections (including fall prevention) and wellness promotion
- Improve coordination of care through the communication and coordination of the ICT. This includes conducting information exchange and/or meetings/teleconferences with the ICT as needed, track, analyze and communicate as appropriate utilization and transitions of care to assure appropriate use of services
- Assist with conducting disease management services
- Provide clinical consultation
- Provide long-term facility care
- Provide telemedicine and telemonitoring services
- Provide pharmacotherapy consultation and management clinics
- Provide in-patient acute care services
- Provide wound management services
- Provide long-term facility care
• Assess, diagnose, and treat in collaboration with the ICT
• Provide home-based palliative or end-of-life care
• Provide home health services
• Provide hospital-based or urgent care facility-based emergency services

HealthPartners model of care is designed to manage the member’s care throughout all stages of their health including the delivery of specialized services and benefits to vulnerable special needs individuals who are frail, disabled or near the end-of-life. Health goals are specific to the member whether to increase function, improve quality of life or improve health status.

Care Coordinators communicate with the primary physician regarding clinical, functional, and psychosocial information. Care Coordinators incorporate the information received from the primary physician and other interdisciplinary care team members into the member care plan. Care Coordinators and the member’s physician and other interdisciplinary care team members collaborate to discuss the member’s progress toward goals and changes to the plan of care.

The care coordination and member services departments are available to link members to services and to facilitate the sharing of information among providers and the ICT.

**HealthPartners assures that providers use evidence-based clinical practice guidelines and nationally recognized protocols.**

HealthPartners adopts the Institute for Clinical Systems Improvement (ICSI) guidelines and supports implementation within its provider network.

Guidelines facilitate agreement on elements of care that are medically appropriate and result in the best possible outcomes. The use of clinical practice guidelines allows HealthPartners to measure the impact of the guidelines on the outcomes of care and reduce inter-practitioner variation in diagnosis and treatment. Medical practice guidelines developed by ICSI utilize continuous improvement principles to standardize health care processes, improve member education, improve health care outcomes and reduce the cost of health care.

In order to assure provider use of clinical practice guidelines and nationally recognized protocols HealthPartners:

• Adopts and supports the development of clinical practice guidelines through the activities of ICSI.
Communicates new and revised guidelines to providers and practitioners, in conjunction with ICSI.

For new medical groups, the ICSI website and phone number is communicated to practitioners at the time of initial contracting. On a quarterly basis, practitioners are notified regarding new and revised guidelines that are available at www.icsi.org and are provided with ICSI’s phone number if they wish to request a hard copy.

Ensures consistency of utilization management criteria, member education materials and disease management programs with ICSI guidelines.

Monitors guideline status within groups through annual reports and site survey processes.

Facilitates implementation through the availability of tools, resources and consultation.

Assesses effectiveness of guideline implementation through various measures, (e.g., HEDIS, Clinical Indicators). The Clinical Indicators Report features comparative provider performance on measures of clinical quality, patient experience and affordability. The Triple Aim approach improves the health of the population, enhances the patient experience of care and helps make care more affordable.

6. Model of Care Training for Personnel and Provider Network

HealthPartners conducts initial and annual Model of Care training including training strategies and content.

Model of Care training is conducted for employed and contracted personnel who are involved in the MSHO Model of Care including all health plan personnel that work with MSHO. Personnel in this training include but are not limited to staff that provide or manage care management and administrative personnel that provide or manage pharmacy, dental, government programs product management, sales, member services, enrollment and claims services.

Training is conducted using the following methods:

- Web based training for providers through the HealthPartners Provider Portal
- A Self-Study program using interactive web-based training & document storage system. This training is followed by an interactive training survey for employed and contracted staff.
- Follow-up is conducted to make sure all appropriate staff is trained using reports to identify those who have not completed the annual training. Any
staff member that does not complete the training within 30 days of the requirement is reported to their respective leadership for follow-up with the employee.

- Face-to-face department training is available as needed.

Model of Care Training for Providers

- All providers who are contracted or employed by HealthPartners are provided with training.
- Providers in HealthPartners network are linked to HealthPartners electronically via the HealthPartners provider portal. This website is updated continually, includes a training manual, and also has links to additional information for providers.
- Information regarding the Model of Care is available via the provider portal, which is an online site used regularly by provider offices for administration of HealthPartners programs. Within the provider portal, the Model of Care and training document are part of the provider manual. Providers are notified annually of the requirement to complete the Model of Care Training. This notification is sent in the Provider Newsletter sent to all contracted provider offices. A copy of the mailing labels is retained by the Provider Contracting department as evidence. In addition, the Model of Care is discussed in annual contract meetings with large group practices.

The Model of Care training reviews all major components of the Model of Care including:

- Overview of HealthPartners Model of Care Training
- Minnesota Senior Health Options Overview
- Model of Care Definition
- Measurable Goals
- Staff Structure and Roles
- Interdisciplinary Care Team
- Provider Network of Specialized Expertise
- Model of Care Training
- Health Risk Assessment
- Individualized Care Plans
- Communication Network
- Care Management
- Performance & Health Outcome Measurement
HealthPartners assures and documents completion of training by the employed and contracted personnel.

The training for employed and contracted personnel is performed through an electronic training and document storage system that allows tracking of the completed training. The system stores the training data and provides reports that are used for training reminders and tracking training completion.

Personnel responsible for oversight of the model of care training.

HealthPartners Government Programs department works with the Monitoring and Compliance department to monitor the progress of training and verify that all staff completes the training.

Actions HealthPartners takes when the required model of care training has not been completed.

An electronic training and document storage system is used to create reports to identify personnel who have not completed the annual training. During the training time period, reminders go out to staff that have not completed the training. Personnel that do not complete the training are reported to their respective leadership for follow-up training completion.

7. Health Risk Assessment

Health Risk Assessment (HRA) tool used to identify special needs.

HealthPartners uses a comprehensive Health Risk Assessment (HRA) tool required by the State of Minnesota. The assessment addresses medical, social, environmental and mental health factors, including the physical, psychosocial and functional needs of the member. It includes assessment of the following:

- Activities of daily living
- Instrumental activities of daily living
- Falls risk including environmental hazards
- Independent living skills including money management, and use of transportation
- Cognitive orientation which includes administration of the Katzman test for cognition
• Depression
• Social isolation and support
• Prescription and OTC medications
• Chronic and acute conditions through member interview as well as the Care Coordinator’s review of claims, the member’s electronic medical record, and other utilization records
• Environmental hazards
• Engagement with primary care
• Dental health
• Exploitation and abuse
• Living arrangement and housing status
• Caregiver support if appropriate
• Preventive health immunizations and screenings
• History of inpatient, emergency department, and nursing home admissions
• Impact of incontinence on activities of daily living and access to the community
• Nutritional status
• Access to culturally appropriate services
• Emergency plans and contacts
• End of life planning including advance directives
• Self preservation skills

The initial HRA and reassessments are conducted for each member.

Initial HRA
An initial HRA is completed within 30 calendar days of enrollment and is usually done face-to-face in the member’s home.

MSHO introductory letters, including the name and telephone number of the MSHO Care Coordinator, are mailed to all new MSHO members within the first ten days of enrollment. The Care Coordinator contacts the member by telephone to introduce herself/himself, to ensure the member has her/his name and telephone number, to explain the role of MSHO Care Coordination services, and to schedule an initial HRA. The Care Coordinator brings an interpreter for assessment visits with members when the Care Coordinator does not speak the member’s primary language. This personal interaction gives the Care Coordinator firsthand knowledge about functional abilities and the ability to manage in their home environment.
The Care Coordinator is expected to pursue every avenue available to reach the member and complete an initial face-to-face assessment. HealthPartners has developed a document titled “Patient Locator Tips” that outlines multiple ways to try to find a member’s correct phone number and/or address. If the Care Coordinator is unable to reach the member after multiple attempts on different days and times of day, the Care Coordinator will send the member an “unable to contact” letter along with a paper copy of the HRA tool. The letter asks the member to complete and return the tool to the Care Coordinator, and to provide the Care Coordinator with a best time of day to reach the member or provide the Care Coordinator another number where the member can be reached. If the member mails in the completed HRA, the Care Coordinator will review their responses and contact the member to discuss the findings. The Care Coordinator will develop a care plan based on the results of the paper HRA form. If the Care Coordinator has been unable to contact the member, and the member has not returned a completed HRA form, the Care Coordinator will continue to attempt to contact the member quarterly for as long as the member is enrolled in MSHO unless the member has asked to have no Care Coordinator involvement.

The results of the initial assessment are used as part of care planning. The member and/or member’s authorized representative and the Care Coordinator discuss and agree on goals for the member’s care plan. The Care Coordinator implements the care plan by referring to service providers, disease management programs, primary or specialty care, or other resources as defined during the care planning process. The care plan includes:

- Long- and short-term goals, with timeframes for re-evaluation
- Resources to be used
- Barriers to meeting goals or complying with the care coordination plan
- Relocation assistance planning for nursing facility residents returning to a community setting
- Consideration of the member’s cultural heritage and written/oral communication needs
- Coordinating the medical needs of the patient with his/her social service needs including coordination with county social services staff and other community resources such as Area Agencies on Aging
- Development and communication of member’s self-management plan including any identified risks to health and safety including risks due to the member’s refusal of recommended services
- Schedules for follow-up and communication with the member
- Collaboration with the member’s health care team, including the Veteran’s Administration when applicable
- Planning for continuity of care
The Care Coordinator sends a printed copy of the care plan to the member and to the primary physician.

**Follow-up and Reassessments**

Follow-up HRAs are performed annually for each member, within twelve months of the member’s previous assessment and when the member’s condition changes such as after a hospitalization, upon a new diagnosis or decline in functional ability.

The Care Coordinator communicates with the member and provider(s) per an agreed-upon follow-up schedule, follows a defined process for members experiencing a care transition, and does periodic assessments of the member’s progress toward achieving health goals, overcoming barriers to care, and meeting treatment goals.

Care Coordinators call members within two days of discharge from a hospital or nursing home setting. They assess the member’s health status telephonically by review of hospital records, and from input from other Interdisciplinary Care Team members such as HealthPartners Inpatient Case Managers and discharge planners who were onsite where the member was hospitalized. If such an assessment indicates a significant change in the member’s health or functional status, the Care Coordinator will complete a face-to-face assessment with the member for a more comprehensive assessment using all elements of the HRA tool. The Care Coordinator documents their assessment findings in the member’s electronic chart.

The Care Coordinators also assess and adjust the goals and the care plan as needed. This includes:

- Reviewing progress towards existing goals
- Developing new goals, including rehabilitation services following an acute event
- Creating new health actions aimed at meeting goals and removing barriers
- Re-evaluating acuity and functional status
- Assessing medications—at least annually; more frequently when warranted by the member’s health situation (e.g., after a hospitalization)
- Assisting members in their choice of providers/hospitals, using publicly reported quality data (such as Leapfrog Group for hospital choice)

When the member’s care plan is updated, the Care Coordinator sends printed copies of the plan to the member and to the primary physician. The member is provided two copies of their care plan; the first copy is for the member to keep, the second copy is for the member to sign and return to the Care Coordinator.
Personnel who review, analyze and stratify health care needs.

The MSHO Care Coordinator, either a registered nurse or licensed social worker, is the primary person responsible for review, analysis and stratification of the member’s health care needs. The Care Coordinator uses information from the HRA, medical records, member and family/caregiver input, utilization reports to the extent records are available and predictive modeling risk scores in the development of a comprehensive care plan. The HRA results are stratified to identify the risks for each member. Care Coordinator assessment may result in a re-stratification of the member. Members with difficulty living in the community may be assessed as needing a nursing facility level of care and Elderly Waiver services to prevent or delay nursing home placement. The Care Coordinator assessment may identify the need for member to move from a nursing facility level of care to a nursing home placement. A member may also be moved from a nursing home resident status to a community setting if the member’s condition has improved.

In addition to the results of HRAs, predictive modeling software helps to identify members at risk for hospitalization. Complex and high-risk MSHO members are proactively identified by methods such as predictive modeling or review of multiple inpatient admission reports. Care Coordinators receive multiple inpatient reports monthly for review and analysis, and they are notified of members identified as high risk by predictive modeling. High risk scores as a result of predictive modeling are saved in the member’s record in the electronic charting system for easy reporting of members by risk score. Complex and high-risk MSHO members receive a more intense level of Care Coordination activities and are often included in complex case rounds that include the Medical Director, home health care providers, palliative or hospice care service providers and the MSHO Care Coordinator. Case rounds may result in identification of interventions to assist the member to achieve health goals, potential adjustments to medications and treatments. Other members of the Interdisciplinary Care Team are consulted for the review, analysis and stratification of health care needs as needed.

The MSHO Care Coordinator continues to assess the member’s risk throughout the year during conversations with the member, through calls to the member following an acute event, and through review of the member’s inpatient and emergency department utilization reports.
Communication mechanism HealthPartners institutes to notify the Interdisciplinary Care Team (ICT), provider network, members, etc. about the HRA and stratification results.

Care Coordinators work with providers as part of the ICT to assess, plan and deliver care. Results of the HRA are shared with the ICT. The member’s primary care provider has the principle role of recommending and arranging services required for the member and facilitating communication and information exchange among the different providers treating the member. The primary means of communication among members of the ICT is through the member’s chart in HealthPartners electronic medical record (EMR). Physicians, home care providers, hospital staff, specialists, hospice and palliative care staff and MSHO Care Coordinators all have access to the member record in the EMR. Providers can send ICT members secure messages from within the member’s electronic record to share information and inform providers that certain notes, assessment or test results are available. Providers may request information from other treating providers as necessary to provide care. HRA results are incorporated into the individual care plan and shared with the Interdisciplinary Care Team, the member and pertinent providers.

The delivery and review of services and benefits are coordinated through communication systems connecting all members of the ICT. Some of these systems include the following:

- Member Services Department for member inquiries regarding benefits, network or any issues or problems, including facilitation of any formal member complaint, appeals and grievances.
- Appeals and grievances are monitored and tracked using a coordinated system as well as monitored for adherence to requirements and timelines for resolution.
- Call-line for provider inquiries
- Care Coordination Meetings
- Follow-up on members that are inpatient in hospitals, nursing homes and rehabilitative facilities
- Electronic medical records when available

8. Individualized Care Plan

Personnel that develop the individualized plan of care and member involvement.

Care Coordinators develop the individualized care plan along with the member and any family or caregivers the member chooses to have involved with this process. MSHO Care Coordinators are either RNs or Social Workers. For a subset of institutionalized
members, care coordination is handled by Geriatric Nurse Practitioners who complete both health risk assessments and care plans for MSHO members residing in nursing facilities.

The Care Coordinator has the responsibility to assess the member’s needs, develop, implement and monitor a care plan for the member. The Care Coordinator works in partnership with the member and/or authorized family members, responsible parties or guardians. The Care Coordinator collaborates with the member in developing, coordinating and, in some instances, providing supports and services identified in the care plan and obtaining consent to the medical treatment or service. Care Coordination is provided at a level of involvement based on the needs and choices made by the member and/or authorized family members or guardian, and as appropriate to implement and monitor the plan of care.

The essential elements incorporated in the care plan.

The following are the essential elements that HealthPartners incorporates in the care plan.
- Results of the Health Risk Assessment (initial and annual)
- Medical history
- Family involvement
- Interdisciplinary team involvement
- Documentation of member involvement in care plan development with consideration given to member preferences, such as:
  - Documentation of member choice of services needed
  - Documentation of member choice of providers
  - Documentation of member choice to receive services in the community or in a skilled nursing facility when appropriate
- Follow-up and monitoring of member goals updated upon change of condition (at least annually with the reassessment of the health risk assessment) and shared with Interdisciplinary Care Team
- Includes goals and objectives, services, benefits and measurable outcomes
- Documentation of all assessed needs being addressed in care plan in the care management system
- Specific services and benefits to be provided, including home and community based services provided to prevent or delay nursing home placement.
- Regularly scheduled and as needed communication with the member and appropriate care giver and providers
- Status of member’s preventive care
- Cultural needs such as interpreter or culturally appropriate providers
• Includes risks the member is accepting by refusing services recommended by the Care Coordinator
• Maintenance of health care information systems for appropriate documentation and facilitation as needed to the documented individualized care plan within the HealthPartners care management system
• End of life planning.
  o HealthPartners promotes appropriate end of life planning. Staff is trained regarding who is eligible, how to refer and how to coordinate care with on-going treatment. Care Coordinators also educate members and family members regarding advance directives.
  o HealthPartners is working to enhance in-home care coordination for the frail and seriously ill MSHO members who have chronic and/or serious life-limiting illnesses. MSHO Care Coordinators may partner with palliative care case managers who specialize and are gifted in end of life planning and care.

**Personnel who review the care plan and frequency of review and revisions.**

All providers involved in the care of the member, the member, necessary and appropriate caregivers and family are regularly updated by the Care Coordinator for the member’s individualized care plan. Results of the initial and annual health risk assessments are used in the development of the individualized care plan and it evolves with the member’s medical needs and health status. Compliance with HIPAA standards with regard to patient information and privacy laws is maintained in all communications.

A health risk assessment is performed annually and when the member’s condition changes. The Care Coordinators implement the care plan by referring to service providers, disease management programs, or other resources as defined during the care planning process.

The Care Coordinator communicates with the member and provider(s) per an agreed-upon follow-up schedule, follows a defined process for members experiencing a care transition, and does periodic assessments of the member’s progress toward achieving health goals, overcoming barriers to care, and meeting treatment goals. The Care Coordinator reviews the care plan with the member at a minimum of every six months. The Care Coordinator also communicates the care plan to the primary physician who also reviews the plan. The Care Coordinator co-manages a member’s care with interdisciplinary care team members; this includes but is not limited to Social Workers, behavioral health case managers, health educators, inpatient and complex care case
managers, disease management staff, MTM staff, the primary care physician and other health care providers.

The care plan is documented and documentation is maintained.

Documentation of MSHO care coordination efforts and a completed care plan is maintained in HealthPartners medical management database system. The documentation includes results of patient assessments, the MSHO care plan, services authorized to prevent or delay long-term care placement and/or hospitalization, notations about patient care transitions, notations about co-management with other partners in care and measurements of progress toward meeting member’s safety and health care goals. Care plans are also communicated to the member’s primary and specialty physicians as applicable; communication is via the electronic medical record system.

HealthPartners medical management system is a secure, encrypted database that is backed up daily. Records are never expunged. Copies of paper care plans that are signed and returned by the member are kept in a locked file room.

The care plan and revisions are communicated to the member, ICT, HealthPartners, and pertinent network providers.

The Care Coordinator communicates with the member and provider(s) per an agreed-upon follow-up schedule, follows a defined process for members experiencing a care transition, and does periodic assessments of the member’s progress toward achieving health goals, overcoming barriers to care, and meeting treatment goals. The Care Coordinator co-manages a member’s care with interdisciplinary care team members including but not limited to Social Workers, behavioral health case managers, health educators, inpatient and complex care case managers, disease management staff, MTM staff, the primary care physician and other health care providers.

The Care Coordinators assess and adjust the goals and the care plan as needed. This includes:

- Reviewing progress towards existing goals
- Developing new goals, including rehabilitation services following an acute event
- Creating new health actions aimed at meeting goals and removing barriers
- Re-evaluating acuity and functional status
• Assessing medications—at least annually; more frequently when warranted by the member’s health situation (e.g., after a hospitalization)
• Assisting members in their choice of providers/hospitals, using publicly reported quality data (such as Leapfrog Group for hospital choice)

The Care Coordinators communicate with the primary physician regarding clinical, functional, and psychosocial information. The Care Coordinators incorporate the information received from the primary physician and other interdisciplinary care team members into the member care plan. The Care Coordinators and the member’s physician and other interdisciplinary care team members collaborate to discuss the member’s progress toward goals and changes to the plan of care.

The MSHO Care Coordinator develops a care plan together with the member and other members of the ICT as appropriate. The MSHO Care Coordinator completes the care plan and sends the member a letter and two copies of the care plan. One copy is for the member to keep, one is for the member to sign and return to the Care Coordinator. Any time a change is made to the member’s plan of care, the MSHO Care Coordinator sends the Care Coordinator a copy of their revised care plan so the Care Coordinator and member both have the most recent care plan.

Clinic providers give members a printed visit summary and care plan upon completion of all clinic appointments with MSHO members. The MSHO Care Coordinator views the provider’s clinic care plan in HealthPartners electronic medical record system.

9. **Communication Network**

**HealthPartners communication network structure.**

Some of the tools used in care management to help ensure good communication about the member’s health status:

• Daily admission reports from hospitals
• Admissions reports from SNFs
• Common medical management database/system which provides a means of access to shared electronic health information and documentation of results of care conferences
• Electronic medical records (EMR)
• Interdisciplinary Care Team conferences
• Telephonic care conferences
• Face-to-face meetings between members of the Interdisciplinary Care Team and the member and/or designee for planning or providing of care
• An integrated system. HealthPartners as an integrated health care system composed of care delivery, medical and dental clinics and hospitals allows access to medical information across the system.
• Inpatient case management specialists focused on care management while the member is hospitalized and to assist with transiting member home
• Behavioral health case management specialists focused on care management
• Written care plan that is made available to all members of the Interdisciplinary Care Team and documents personnel responsible for communication
• Geriatric specialists for consultation or care
• Secure e-mails, secure fax machines, and confidential written correspondence to meet HIPPA requirements
• Health education materials and interpreter services
• Electronic meetings for training and communication in coordinating care
• The State’s online Medicaid eligibility verification system (MN-ITS), and established forms and communication protocols to assist in communication between HealthPartners and county financial workers
• Reminder calls to members for upcoming appointments as needed
• Grievance and appeals reports
• Newsletters to members
• Department meetings, complex case rounds resulting in communication with the member’s physician and Interdisciplinary Care Team and teleconference options if needed.

Other communication tools used by the health plan:
• Web based Provider Portal with information for providers
• Newsletters to members (HPCare Today)
• Provider newsletters that communicate health plan and member information

Communication network that connects the plan, providers, members, public and regulatory agencies.

Through HealthPartners integrated health care system, the Interdisciplinary Care Team is able to communicate between care coordinators, the member’s medical and dental providers and hospital staff. The communication network provides consistent and clear information to staff at the health plan, to providers in the MSHO network, to members, to the community and to our Regulatory agencies. Each necessary communication is evaluated using communication protocols to determine who needs the information or needs to take action, the appropriate communication tool, the appropriate documentation and any necessary follow up actions.

When required, the appropriate regulatory agencies are consulted. This may include regulatory guidance or notification of communication that is necessary per contract requirements.
In addition, all required reporting is submitted to regulatory agencies. For example, SNP Structure and Process Measures, HEDIS, encounter reporting, etc.

**HealthPartners preserves aspects of communication as evidence of care.**

HealthPartners has written procedures describing how communication among stakeholders is documented and maintained as part of the administrative and clinical care records. Documentation includes:

- Meeting minutes and agenda
- Recordings of meetings if necessary
- Transcripts of meetings if necessary
- Web-based database of communications
- Written correspondence as necessary
- HIPPA standards for secure emails, fax machine and other written materials

**Personnel with oversight responsibility for monitoring and evaluating communication effectiveness.**

HealthPartners works across departments to assure regulatory compliance, monitoring, and consistent and effective communication. Regular meetings are held with personnel having responsibility for oversight in these areas to share feedback and enhance future communications.

**Disease and Case Management:** The Disease and Case Management department management staff is responsible for the information that is communicated by the MSHO Care Coordinators to members, family members and the health plan regarding Care Coordination functions.

**Government Programs Department:** The Government Programs department management staff are responsible for the monitoring and oversight of the information that is communicated about the MSHO product to regulatory agencies including the MN Department of Human Services and CMS. In addition, Government Programs sends all member materials and communications to the Regulatory agencies for review and approval.

**Marketing Department:** The Marketing Department management staff is responsible for the information that is communicated about the MSHO product in member materials and marketing pieces. The Marketing Department works closely with internal partners to evaluate whether materials are meeting the needs of members. Member satisfaction measurement tools (such as CAHPS, HEDIS and NCQA) are used to judge if communication improvements are needed.
HealthPartners uses a member-friendly communication checklist and a 7th grade reading level standard to assist with health literacy.

Examples:

- Based on an analysis of market materials, HealthPartners added additional translated information to documents. As part of an annual process, Marketing evaluates the languages spoken by current MSHO members and potential MSHO members in the plan service area to determine if there is a need to add or adjust the translated languages currently offered.
- Marketing evaluates and improves, when necessary, communications sent to MSHO members throughout the year. Improvements include making the communications as member-friendly as possible. This is an on-going process and is done both proactively and as materials are updated throughout the year.
- HealthPartners conducts an annual audit of the materials that are mailed to prospective MSHO members. This audit ensures that prospective members are receiving the correct enrollment materials.

**Government Relations Department:** The Government Relations department works at the local, state and national level to advance public policy that directly or indirectly improves the health of our members, patients and the community. The Director of Legislative Affairs in Government Relations provides regulatory information and updates that may impact the MSHO product to the Manager of State Public Programs. The Manager of State Public Programs reviews regulatory guidance and provides feedback to Government Relations.

**Member Services Department:** The Member Services staff has input on member communications and also receives feedback from members about communications sent out from the health plan and regulatory agencies. This feedback is shared to correct existing communications and to enhance future communications.

Members Services also utilizes a phone monitoring program to improve effectiveness. When opportunities for improvement are identified, coaching and improvement action plans are implemented.

**Sales Department:** The Medicare and Individual Sales department staff has input on prospective member communication and work closely with the Government Programs and Marketing Departments to ensure clarity and regulatory compliance in communications. They are responsible for educating and informing potential members about the enrollment process and elements of the HealthPartners Medicare plans to ensure the applicant has the necessary information to make an informed decision prior to enrolling. Sales team calls to members are recorded and randomly monitored by the Supervisor and/or the Manager for accuracy and effectiveness. Sales team inbound call scripts are submitted to CMS for review prior to use. Written materials are also submitted to CMS for review prior to use. Feedback on communications is shared to continuously improve future communications.
10. Care Management for the most Vulnerable Subpopulations

HealthPartners identifies the most vulnerable members.

The most vulnerable MSHO members will receive a more intense level of Care Coordination and additional services. They may have complex health or behavior needs and also be at high risk for hospitalization or emergency department admission.

Complex and high-risk MSHO members are proactively identified by methods such as:

- Predictive algorithm monthly report (based on patterns of care and treatment, non-disease specific) using monthly data files including medical claims, pharmacy claims, hospital admission and discharge data, and authorizations from the UM process
- Other high-risk registries (e.g., high utilizers of emergency room or multiple inpatient admissions)
- Hospital census reports
- Care coordinator and Interdisciplinary Team observations
- Member, family or authorized representative requests
- Physician input and requests
- Initial and annual Health Risk Assessment
- Member Services also identifies our most vulnerable beneficiaries and reports this to the Care Coordinator for specialized follow-up.

Additional services and benefits HealthPartners delivers to the most vulnerable members.

Complex case management is provided for members identified as in need of enhanced care coordination. Care coordination may include the provision of additional services or care coordination for members identified as frail, disabled, with end-stage-renal disease that developed after enrollment, near the end of life (such as hospice and palliative care services) and those having multiple and complex medical conditions.

Care Coordinators assist members with services that help members maintain independent living and program enrollment. This includes but is not limited to helping members with their eligibility paperwork, paying bills, connecting with housing and social services and other essential services that help members.

Elderly waiver services are provided as needed for members living in the community who are assessed as being nursing home certifiable to allow at-risk seniors to remain in their homes as long as possible. Elderly waiver services include:

- Homemaker services
- Respite care services (In Home and Out of Home)
- Adult day services (ADS)
- Adult companion services
- Specialized medical supplies and equipment
• Extended State Plan home health care services, including home health aide
  and skilled nursing services
• Extended State Plan private duty nursing
• Extended State Plan personal care assistance services
• Family and care giver training and education services
• Home delivered meals
• Residential care services
• Customized living services
• 24-hour customized living
• Adult foster care services
• Environmental accessibility adaptations
• Chore services
• Consumer directed community supports
• Transportation
• Transitional supports services
• Adult day service bath

In addition, HealthPartners is able to offer supplemental benefits that go above and
beyond the robust Medicaid and Medicare benefits and services. These supplemental
benefits for calendar year 2012 include extra vision benefits, dental benefits and DME
benefits.

Palliative care case management services are available for frail and seriously ill MSHO
members who have chronic and/or serious life-limiting illnesses. MSHO Care
Coordinators partner with palliative care case managers who specialize and are gifted in
end of life planning and care. These specialized Care Coordinators meet individually
with members to provide:

  • Eight visits per year over a two year period by a Registered Nurse, MSW
    and chaplain (primary follow up occurs with phone contacts)
  • Pain and symptom management
  • 24 hour nurse available for phone consultation
  • Goals of Care and Advance Care Planning including discussions
    surrounding the Advance Directive and DNR/DNI
  • Education on disease process, emotional support and counseling services
  • Medical Director oversight and regular team meetings with Palliative Care
    Team members to review and update the plan of care

11. **Performance and Health Outcome Measurement**

HealthPartners collects, analyzes and reports Model of Care data.

HealthPartners Health Informatics department collects, analyzes and reports data for the
Model of Care evaluation from HealthPartners systems. A report is prepared for the Bi-
annual Review Meeting in collaboration with department leadership. The data is
reviewed to determine if goals are met and if future actions are needed. Goals may be
adjusted during this mid-year review. A Comprehensive Annual Analysis report is also prepared for review by the Government Programs Quality and Utilization Improvement Committee. Action items from these meetings are identified, documented and accountable owners are assigned for follow-up.

Scheduled reviews to evaluate the status of CMS Star Rating performance data are also scheduled at the Medicare QUI Workgroup and QUI Committee. Data is reviewed on a quarterly, bi-annual or annual basis. This includes a review of HEDIS, CAHPS, HOS, PDE data, IRE, CMS audits, CMS phone monitoring, complaint tracking module and call center monitoring data.

A multidisciplinary work group reviews and updates the established CMS Star rating work plan that includes initiatives for improvements. The work plan is brought to the Medicare QUI Workgroup for review and approval. Updates on new and current initiatives are also given at both of these meetings.

**Personnel collect, analyze, report, and act on data to evaluate the Model of Care.**

The Medicare Quality Improvement Workgroup and Government Programs Quality Improvement Committee are responsible to collect, analyze, report and act on data to evaluate the Model of Care. The required reporting is assigned to each committee and reports are assigned to respective staff. Reporting is done on a regular reporting schedule. The committee reviews the information and determines follow-up actions to manage the Model of Care. HealthPartners Quality Improvement Program for MSHO is based on the Triple Aim to simultaneously improve:

- Health of the MSHO population
- Experience of the MSHO members
- Affordability of health care

HealthPartners has a written Quality Improvement Plan, including policies, procedures and a systematic methodology to conduct an overall quality improvement program with components targeted to our MSHO members. Health information systems and analysts are used in the collection, analysis and integration of valid and reliable data used in the Quality Improvement program. The data that is collected, used and reported is overseen by a department called Operational Integrity to verify reliability, validity, completeness and accuracy of data within the organization. On an annual basis, HealthPartners quality and utilization management activities are evaluated and approved by the Quality Committee of the Board and the Board of Directors. Specific components for review include:

- Quality Improvement Program Description
- Quality Annual Work Plan
- Annual Evaluation
# Responsibility to collect, analyze, report and act

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<td>Quality Utilization Improvement Consultant</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-Medicare QUI Workgroup -Government Programs QUI Committee -Multi health plan collaborative group</td>
</tr>
<tr>
<td>CMS Stars Quality Report</td>
<td>Government Programs MSHO Manager</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-Medicare QUI Workgroup -Government Programs QUI Committee -Operations workgroup -Stars management team</td>
</tr>
</tbody>
</table>

**HealthPartners uses the analyzed results of the performance measures to improve the Model of Care.**

The quality reporting committees have the responsibility to analyze results of performance measures to improve the Model of Care. If the results are not consistent with the established goals, the information is sent to the Medicare Quality and Utilization Workgroup and others as needed to analyze and to recommend a plan for improvement.

Modifications to the Model of Care are made as needed based on the results of committee review and analysis, as well as observations, trends, and patterns identified in response to current and new state and federal regulatory mandates and/or member feedback. These changes, if
required, may include changes in policies and procedures, staffing patterns or personnel, changes in provider or facility network, initiatives and goals and/or changes in system of operation.

The evaluation of the Model of Care is documented and preserved.

Minutes from the Government Programs Medicare Workgroup and the Government Programs QUI Committee contain documentation of the evaluation and any changes made to the Model of Care initiatives and goals. Minutes are reviewed and approved by all committee members and saved electronically. Additionally, the Model of Care document is updated accordingly and the new version is given a revision date. All associated reports to evaluate the Model of Care are stored electronically in the yearly evaluation files.

Oversight responsibility for monitoring and evaluating the Model of Care effectiveness.

Members of the quality committees have oversight responsibility for monitoring and evaluating the Model of Care effectiveness.

The Government Programs QUI Committee is chaired by the HealthPartners Medical Director of Medical Management & Government Programs. Committee members include other Medical Directors, management from Disease and Case Management, Behavior Health Strategy and Operations, Health Plan Quality Utilization Improvement, Government Programs, Pharmacy Services, Medical Policy, Health Informatics, Quality Measurement and Improvement. Other areas are invited as needed.

The Medicare QUI Workgroup is chaired by the Associate Medical Director and the Quality Measurement Improvement Consultant. Committee members include staff from Quality Measurement Improvement, Government Programs, HealthPartners Medical Group Quality consultant, Behavioral Health Manager, Disease and Case Management and Pharmacy. Other key contacts and ad hoc membership include staff from Health Informatics, Medical Policy, Legal, Marketing, Provider Contracting and Geriatric Services.

HealthPartners communicates improvements in the Model of Care to stakeholders.

HealthPartners communicates improvements made to the Model of Care in the following manner:

- Changes are communicated to members of the Government Programs QUI Workgroup and Medicare QUI Committees and documented in the meeting minutes.
- The Model of Care document is updated and training will occur with the Care Coordinators and Interdisciplinary Care Team as needed. Appropriate implementation changes will occur including any changes needed to policies and procedures.
- Training regarding the changes will also be made to all other impacted areas. Appropriate implementation changes will occur including any changes needed to policies and procedures.
• Changes relevant to providers will be communicated along with any implementation action that needs to occur. Provider policies will be updated as needed.
• Changes to the Model of Care will be incorporated into the Model of Care training and materials.
• Additionally, information will be shared with CMS and the Minnesota Department of Human Services as requested.