

**Response to DOC Review Committee Comments**

**Unity Health Care, Inc.**

**Solicitation #: DCFL-2006-R-6001**

**Submitted: June 1, 2006**

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## Narrative Response to Review Committee's Comments

### A. Strategic Issues Affecting the Delivery of Health Care Services

#### 1a. Staffing Plan

Unity's proposed staffing model includes a slight increase in staffing, compared to the current staffing plan. The increase in staffing is necessary due to the Community Oriented model of care included in the Request for Proposal (RFP). However, it is important to note that our staffing plan count presented in the Technical Proposal (253.55) was based on persons staffed during weekdays and weekends, rather than on FTEs, as was indicated (due to weekend staffing not being equivalent to a full FTE). Because this may have caused some confusion, we have included a revised staffing plan in the Appendix, which calculates actual FTEs based on time worked (i.e. adjusted for weekend hours). This staffing plan also includes some reductions itemized below. Furthermore, please note that our FTE count includes amounts necessary for leave coverage. When comparing our overall numbers to those presented by COCHS for the current model, we assume that COCHS did not adjust the FTEs for leave coverage.

Given these changes, Unity's total FTEs including leave coverage, equals 211.12 FTEs. With 18.93 FTEs of leave coverage subtracted from that total, Unity is proposing a base staffing plan including 192.19 actual staff positions. Compared to the Review Committee's citation of the current staffing plan of 182.35 FTE positions, our staffing plan represents only a minimal increase in positions of approximately 5%.

While the Review Committee recommended comparisons of staffing plans to the current model and the Hampden County Model, Unity does not agree that these are appropriate or provide meaningful information. The Hampden County Jail model is not an appropriate comparison because the community health center services at the Hampden County Jail are provided under a different model of care. Furthermore, factors of differing facility size, inmate volume, and inmate population characteristics make the comparison too complex to make accurate adjustments.

While the COCHS report provided basic information on the current health care services staffing model at the DOC facilities, no details about shifts, departments, assignments, or weekend staffing were provided. Therefore, it was not possible to make a meaningful comparison to determine where our staffing patterns differ. Additionally, Unity expects the new and/or enhanced services required in the RFP to account for increased staffing, as described below.

Based on increased expectations and requirements, Unity has added staff members to provide services accordingly. Some staffing increases may also be due to Unity's commitment to provide quality health care services at the same level as in the community. In some cases, such as universal GC/Chlamydia screening, pharmacy services, discharge planning services, Community Correctional Center (CCC) services, the CTF infirmary, and the provision of emergency services in CTF (resulting in 24

hours/day practitioner and additional nursing staff), Unity has proposed a staffing plan for an efficient model and a model that does not compromise quality. Specific explanations for certain components of the staffing plan are provided below. These areas address the most likely differences in the staffing plans based on the minimal information gleaned from the COCHS report and from the known differences in service requirements.

### ADMINISTRATIVE STAFFING

*Deputy Medical Director (0.5 FTE):* Oversees continuity providers and continuity services between the DOC facilities and Unity's community health centers. Oversees quality improvement projects and activities and integrates them into Unity's overall clinical quality improvement program (Section C.3). (Please refer to the attached Job Description.)

*Associate Medical Director (1.0 FTE):* Provide oversight and coordination for advanced level practitioners (MDs, NPs, and PAs) working in the CDF, CTF, and CCCs. This position is equivalent to the on-site Medical Director responsible for the services under this contract; however, due to Unity's multiple locations and overall organization Chief Medical Officer, Dr. Janelle Goetcheus, this position is titled an Associate Medical Director. (Please refer to the attached Job Description.)

*Administrative Assistants (2.0 FTE):* After further consideration, Unity has amended the staffing plan to include only 2 FTE administrative assistants, one to support the Deputy and Associate Medical Directors and one to support the Health Care Administrator and Director of Nursing. Any additional administrative support will be provided through G&A costs.

*Director of Special Needs (1.0 FTE):* Provide oversight and coordination of services and discharge planning for those inmates with special needs, including but not limited to: disabilities, hospice care needs, mental illness, and chronic illness. The responsibilities of this position also include supervision of the discharge planners.

### SUPPORT STAFFING

#### Pharmacy

Unity proposed staffing plan for the pharmacy and pharmacy services represents increased staffing compared to the current model. Based on the history of correctional health care, pharmacy services and medication distribution are often areas of complaint from inmates as well as lack of efficiency and accurate tracking and control. Therefore, Unity proposes a staffing plan to support an improved pharmacy services model with the expectation of improved care and control. The enhancements proposed under our plan include a full-time administrative supervisor and use of blister packs for medication distribution. Unity's original proposed staffing plan included staffing for weekend pharmacy hours. After further consideration and discussions with the current DOC Pharmacy Director, Unity does not expect the need for weekend pharmacy hours.

Prescription medications needed for new intakes will be dispensed through the night carts. This will eliminate a number of positions and reduce costs.

#### *Full-time Supervisor*

It is Unity's understanding that the current contractor is using the pharmacy supervisor as a pharmacist, rather than solely administrative. For smooth, efficient, and controlled operation of the pharmacy and pharmacy services, Unity believes it is essential to have a full-time supervisor (1.0 FTE Pharmacy Supervisor) who is used only sparingly for clinical duties.

#### *Blister Packs for Medication Distribution*

Using blister packs for medication distribution may cost more in the staffing necessary for preparation; however, this model has substantial benefits in terms of efficient distribution and substantially improved tracking and inventory control. The weekday night shift pharmacist will be responsible for dispensing the medications for blister pack preparation. The weekday night shift pharmacy technicians will prepare the blister packs for distribution. These staff members must be staffed during the night shift due to space limitations in the pharmacy (so it cannot be done during the day or evening).

#### Community Correctional Centers (CCCs)

Due to clarifications made during the meeting among Unity, DOC, and OCP on May 25, 2006, Unity has reconsidered the proposed staffing for the CCCs. During the meeting, Unity received information that the RFP did not require on-site comprehensive health care services. Residents of the CCCs are expected to seek health care at the community health centers, when possible. Given this new information, Unity proposes a reduction in staffing to a 1.0 FTE nurse practitioner and a 1.0 FTE medical assistant to cover the on-site needs and coordination of care for the residents of the CCCs. It will be necessary to have staff on-site one or two days each week (per CCC) for residents who are unable to leave the site for care and to distribute medications that come from the CDF pharmacy.

#### CTF STAFFING

##### Infirmiry/Disabled Units

The RFP requirements include the operation of an infirmiry unit with enhanced capabilities and staffing (i.e. 24-hour advanced level practitioner staffing and 24-hour nursing staff within sight and sound of infirmiry unit inmates). Thus, Unity proposed a staffing model to support these services of an enhanced infirmiry unit. The COCHS report states that 48% of the Emergency Department visits for the first 3 quarters of 2005 were of a very low acuity. Unity believes that some inappropriate hospitalizations could be avoided by enhanced care in the infirmiry. The expectation is that this will reduce hospital costs.

The nursing staff for the infirmiry is based upon nurse-to-patient ratios of 1:6 during the day and evening shifts, and 1:7 during the night shifts. During the night shift, the nursing staff will also be responsible for providing emergency services and intakes in CTF during

the evening. Please refer to Unity's original Staffing Plan Narrative in the Pricing Proposal for a description of the duties of each position.

Dr. Janelle Goetcheus, Unity's Chief Medical Officer, has over thirty years of experience operating and staffing a 24 hours/day, seven days/week infirmatory unit caring for patients with similar levels of disease complexity and illnesses as those expected to be cared for within the CTF infirmatory. Unity maintains that these positions are essential to the quality functioning of an infirmatory unit with enhanced capabilities.

#### Continuity/Sick Call

Unity believes that the staffing proposed for continuity care and sick call is appropriate based on the difficulty of movement among the different lofts in CTF and the necessity to respond to sick call requests within 24 hours. With four lofts in CTF, each physician/medical assistant pair will conduct sick call and primary health care services for a half day, equaling a total of 2.0 FTE physicians and 2.0 FTE medical assistants. One RN will be assigned to each loft for a full shift to conduct sick call, triaging, and clinical support for the continuity physicians. These RNs will also be responsible for providing health education, including diabetic education, and developing medical discharge plans for the inmates in their assigned loft.

#### CDF STAFFING

##### Medical Assistants/Phlebotomists

Unity is currently working with a potential laboratory services subcontractor to negotiate the staffing of three subcontractor phlebotomists during day shifts to assist with intake lab processing and drawing labs in the CDF 3<sup>rd</sup> floor medical unit. This would reduce our proposed staffing plan by three medical assistant positions and, thus, decrease costs. However, please note that we will still need two MAs (one day shift, one evening shift) solely for the purposes of processing urine specimens for the required universal GC/Chlamydia screening.

##### Mental Health Staffing

Please refer to the response to comment #7 of this document.

##### Discharge Planners

For budgeting and staffing plan purposes, these positions were included under mental health staffing. However, their duties will cover areas outside of mental health. Please see the response to comment #5b in this document for a specific description of their activities.

The breakdown of discharge planning staff by facility is as follows: 3 FTEs staffed at CTF and 6 FTEs staffed at CDF. In the CTF, the one FTE discharge planner will cover inmates in the infirmatory and disabled units and each of the two full-time discharge planners will cover inmates in two loft units. In the CDF, one discharge planner will be assigned specifically to the mental health inpatient unit, while the remaining five will be assigned to inmates in particular housing units. Based on average daily census

information for 2005 provided by DOC (CTF: 1177, CDF: 2300), at any given time, each discharge planner will be responsible for the discharge planning needs of approximately 400 inmates, including an initial meeting/needs assessment for every inmate.

Additionally, the discharge planners will be responsible for assessing needs and referring inmates to internal programs, such as job training, education, and/or substance abuse services for their cadre of inmates, on an ongoing basis. For chronically and mentally ill inmates within the housing units to which the discharge planner is assigned, the discharge planner will obtain the medical discharge plan from the medical record or from the nurse. Based on a percentage of 45% (30% mentally ill and 15% additional chronically ill), at any given time, each discharge planner will be responsible for following a cohort of about 180 inmates from intake to discharge to post-release follow-up. Then, the discharge planner will be responsible for carrying out that plan prior to the inmate's release, arranging for the discharge needs, linkages, and connections to services under the plan. Follow-up to determine whether and attempt to ensure that the inmate was successfully linked to the necessary services, particularly health care services, will also fall under the responsibility of the discharge planner. Given the focus of this community-oriented model on discharge planning and post-release linkages, case loads of 180 mentally and chronically ill inmates (and 400 total inmates) at any given time is maximizing the use of discharge planners to carry out the discharge plan and appropriate follow-up. As a result, this will contribute to substantial savings in nursing time and staff, since they will only be responsible for writing the medical part of the discharge plan.

#### **1b) Medical Assistant Duties**

Unity supports the primary health care and community health care model of utilizing medical assistants (MAs) in a physician's office and/or clinical setting. The MAs practice within their scope of practice by assisting the primary care/specialty provider in taking vital signs, performing tasks such as EKGs, venipuncture, administration of immunizations, and administering/planting/reading PPDs all under the direct supervision of a licensed practitioner. The use of MAs allows the RNs to focus on appropriate assessment of the patient as well as providing patient education, medication adherence counseling, care management, and appropriate follow-up of patients. The scope of practice of the MA is clearly defined and they are considered an integral member of the health care team; however, they are not a substitute to the licensed nurse. (See Medical Assistant Job Description in the Appendix.)

#### **1c) Principal Leadership Team**

For purposes of naming the Principal Leadership Team responsible for providing Comprehensive Health Care Services under this contract, Unity listed, in our original Technical Proposal, a team of current staff members who have been and will be integral in the planning and transition period until the contract begins. These leaders included some overall Unity management staff, who were considered to be filling key positions on an interim basis. While these staff members will remain involved at some level with the activities under this contract, Unity understands that an on-site Leadership Team with a

specific focus and responsibility to this contract will be necessary to implement this program. While Unity expects to have these positions filled by the beginning of the contract, we have provided qualified staff who could fill these positions until a suitable candidate is hired to replace them. Although Unity may use different titles based on our Human Resources Department determination, the on-site Leadership Team will consist of the following positions:

- Health Care Administrator, already identified as Kerri Gerald, RN
- Director of Nursing, filled on an interim basis by Zerita Hadden-Hudson, RN
- Mental Health Director, already identified as Dr. Robert Keisling, MD, Unity's current Associate Medical Director of Behavioral Health Services (This position is not included in our proposed staffing plan, so it will remain an oversight position, or the responsibilities may be transferred to an on-site psychiatrist if deemed appropriate or necessary.)
- Deputy Medical Director, already identified as Diana Lapp, MD, Unity's current Associate Medical Director for Clinical Support (Dr. Lapp will contribute 0.5 FTE toward activities under this contract, particularly related to the important component of continuity between services in the jail facilities and the community health centers.)
- Associate Medical Director, filled on an interim basis by Janelle Goetcheus, MD (This position will function as the Medical Director for services under this contract and will be filled by the beginning of the contract.)

## **2) Specialty Services**

As part of the planning process, Unity and Health Right will consider and weigh the cost-effectiveness and logistical possibilities of providing additional specialty care types on-site at DOC facilities. We received information at 6pm on May 30, 2006 including data on specialty care utilization on- and off-site. However, given the due date of 2pm on June 1, 2006, we were unable to complete an in-depth analysis for this response. However, we will continue to consider and analyze this issue and will work closely with the Transition Team to address specialty care. Unity and Health Right will increase specialty care capacity on-site, as it is necessary to meet the health care needs of the inmates and maximize cost-effectiveness.

## **3) Pharmacy and Therapeutics Committee**

Unity will establish a Pharmacy and Therapeutics Committee to oversee operations, services, and formularies throughout Unity, including those specific to this DOC contract. The draft policy proposed to establish this committee is included below. While it refers to a Unity-wide pharmacy system, we do recognize that certain aspects will apply specifically and only to this contract (i.e. a formulary specific to the DOC pharmacy). Once amended, finalized, and approved, this policy will become part of Unity's Policies and Procedures Manual.

### Policy

The Pharmacy and Therapeutics Committee exists as part of the Unity Health Care medical staff. This committee is selected under the guidance of the medical staff, and it is also a policy and procedure recommending body to the medical staff and administration on all matters related to the use of medications.

### Purposes

#### *Advisory*

The committee recommends the adoption or assists in the formulation of broad professional policies regarding evaluation, selection, procurement, distribution, use, safe practices and other matters pertinent to drugs throughout Unity. This committee reviews and makes determinations regarding the effect of medications on the patient(s).

#### *Educational*

The committee recommends or assists in the formulation of programs designed to meet the needs of the professional staff (physicians, nurses and pharmacists) for complete knowledge on matters related to drugs and drug practice.

### Composition/Structure

The committee shall consist of at least four (4) physicians, one who shall serve as the chairperson, one (1) pharmacist, the Nurse Executive/Chief of Clinical Operations or his/her representative, Medical Staff Coordinator, the Chief Executive Officer or his/her representative, representative from Nutritional Services and Finance and Management Information System (MIS)

- The recording of the meeting's minutes shall be responsibility of the Director of Pharmacy or his/her designee and shall be maintained in the permanent records of the agency.
- The committee shall meet at regular intervals, no less frequently than quarterly or four (4) times per year, as designated by the chairperson.
- The chairperson will be appointed by the Chief Medical Officer.
- Recommendations of the Pharmacy and Therapeutics Committee shall be presented to the Medical Executive Committee for adoption or recommendation.

### Functions and Scope

- To serve in an advisory capacity to the medical staff, in all matters pertaining to the use of medications.
- To serve in an advisory capacity to the medical staff and the Pharmacy, in the selection or choice of drugs which meet the need in relation to the diseases treated in this institution. Selection of drugs for facility use is based on criteria which

encompass the effectiveness of the drugs, the risks associated with the drugs (i.e., medication errors, abuse potential, sentinel events) and the costs or financial impact.

- To prevent unnecessary and costly duplication of identical chemical entities or combinations of drugs in the formulary.
- The committee shall be responsible for the development of a basic drug list or FORMULARY of accepted medications to be used throughout Unity which will be continually reevaluated and revised to ensure the distribution of the most effective, newest, safest and most economical therapeutic agents available.
- To recommend policies regarding the safe use of drugs at Unity including a study of such matters as investigational drugs, hazardous drugs and others.
- To make recommendations for the solutions of problems involved in the appropriate preparing, labeling, distribution and administration of medications for inpatients and outpatients.
- To review all reported adverse reactions (both significant and minor) to drugs administered to the patients.
- To evaluate the drug therapy component of the patient's medical records.
- To present recommendations of the committee to the medical staff for decisions regarding medical procedures and problems. The medical staff has final authority in these matters. The Governing Body has final authority regarding the administrative responsibilities in carrying out the recommendations of the medical staff.
- To monitor implementation of the written policies and procedures and make recommendations for improvement. The Pharmacist in consultation with other appropriate health professionals and administration shall be responsible for the development and implementation of procedures. Policies and procedures shall be reviewed and/or revised at least annually.
- To annually evaluate the entire service provided and make recommendations to the executive committee of the medical staff, administration and the Governing Body.
- To make recommendations concerning drugs to be stocked in the Unity patient care units or services.
- To plan suitable educational programs for the professional staff or pertinent matters related to drugs and their use.

- To study problems related to the administration of medications.
- To approve and review standing orders for drugs used for specified patients and physicians.
- To review and approve limiting durations of drug therapy.
- To review and approve the medications kept in the night medications locker.
- To review and approve all emergency medications stocked at Unity

#### **4a) Hospital Services**

Health Right is currently negotiating with Greater Southeast Community Hospital for the use of their locked ward for inmate hospitalizations. We plan to utilize the locked ward, when possible based on the inmates' hospitalization needs. Negotiations with Howard University Hospital are also underway for services that may not be offered or available by Greater Southeast. While Unity plans to utilize other hospitals as medically necessary for a particular inmate, we will keep this (and, therefore, the associated costs) to a minimum without compromising care. For example, Unity is aware that Greater Southeast does not have MRI services available. Therefore, Health Right is exploring arrangements with other local hospitals to meet the need for these services.

Regarding concerns about specialty care and oversight, Health Right is addressing this issue by negotiating with Howard University Hospital to have a group of their specialist physicians who will provide on-site care at the DOC facilities be privileged at Greater Southeast to enhance continuity of specialty care and hospital care and follow-up.

#### **4b) Health Right, Inc.**

In 2004, Health Right, Inc. (HRI) contracted with TierMed, a certified HEDIS vendor, to assist in the calculation and provision of HEDIS measures. As part of this process, historical claims information was sent to this vendor for analysis from our 2003 database. HRI used these findings as their baseline source for future comparative analysis. The 2003 data was based on administrative data only. The 2004 and 2005 data that is presented in this report is based on both administrative and hybrid data. Health Right has contracted with TierMed, for a second year to assist in the calculation and provision of the 2006 HEDIS year. Health Right has the ability to monitor the accuracy and completeness of the data received from TierMed by monitoring the FTP transmission logs that exist, which shows the details of the data, as well as, what data has been sent to the health plan. Additionally, as the rates are available for review, reasonableness checks are performed by HRI staff and the NCQA certified HEDIS consultant.

In addition, to contracting the services of TierMed, HRI has also contracted the services of an outside Medical Record Review (MRR) vendor, Manage Access for the past two years. Manage Access, a certified HEDIS medical record vendor, employs nurses in the

Metropolitan area to abstract data from medical records in accordance with HEDIS technical specifications. Health Right monitors the progress, accuracy and completeness of the data presented by Manage Access through periodic review of the submitted worksheets and coordination during the medical record review process.

Health Right's Management Information Systems (MIS) falls into two broad categories: a (1) transaction based system and a (2) decision support system. The transaction based system that HRI utilizes is the PLEXIS Claims Manager (PCM) which was implemented in January 2005. Its primary role is to provide operational support to the various business functions of Health Right, including claims adjudication, provider network management, and membership maintenance. PCM is an integrated healthcare information system with complete benefit administration, manual and electronic medical and dental claims processing, and standardized reporting features. PLEXIS serves as the primary repository of data, which can include service level detail, financial, and historical claims information.

Subsequently, Health Right's decision support system plays an integral role in the integration of data and information to execute HRI's QMP and Quality Improvement Activities. HRI primarily employs a Microsoft SQL Server-based data warehouse for decision support and information analysis. Additionally, HRI has developed proprietary databases to assist HRI's management and departments in the continuous delivery of improved services to members, and to bring QMP goals to fruition.

Obtaining the assistance of technical vendors such as: (1) TierMed Systems, a NCQA certified data vendor who employs a certified data engine to calculate the appropriate HEDIS quality measures and (2) Manage Access, a NCQA certified HEDIS Medical Record Review vendor who assists in the validation process helps to ensure that HRI meets reporting and information integrity standards. In addition, HRI also utilizes other systems and guidelines for quality assurance monitoring such as: (1) GeoAccess software for network analysis and provider profiling, as well as using (2) InterQual criteria for appropriate utilization management. Used in combination and collaboration, these systems and processes allow for the crucial service tracking and monitoring. They also provide critical evaluation of utilized services, care coordination, EPSDT activities, and overall organization and provider performance. HRI's Information Systems Department will continue to update decision support applications and various proprietary systems to capture, analyze and report data. All HRI staff is involved in ongoing training of systems in order to carry out quality improvement functions. Data resources include claims, encounter, enrollment files, utilization management statistics, medical records, complaint information and HEDIS data. (See full Health Right Report in the Appendix for details on claims processing, data collection, and capacity to carry out the subcontract for specialty and hospital services.)

#### **5a) Health Right, Inc. Quality Improvement/Utilization Management**

Health Right, Inc. continually strives to improve the quality of care and services provided by its health care delivery system. The Quality Management Program (QMP) was developed in

accordance with Health Right's mission and vision, as well as the District's Medical Assistance Administration (MAA) Continuous Quality Improvement Program, which supports continuous quality improvement and utilization management in all phases of our business. This is achieved by adhering to the principles regarding delivery of valuable services to our members and participating providers, in addition, to providing our employees with an environment that supports high standards of performance.

The QMP establishes standards that encompass all quality management activities within our health plan and is an integral component of the Health Right delivery system. The QMP forms the basis by which all quality initiatives are designed and implemented. Additionally, it establishes Health Right's commitment to quality management, quality improvement and enabling all parties to have a clear understanding of Health Right's Quality Management goals and structure within the organization. (See full Health Right Report contained in the Appendix for details on Health Right's process and past successes in utilization management and quality improvement).

#### **5b) Case Management, Care Coordination, and Discharge Planning**

Unity agrees that case management, care coordination and discharge planning are integral components of the Community Oriented Correctional Health Services model. The medical care coordination within the CDF and CTF will be conducted by the primary health care services staff. This consists of advanced level practitioners who work in the CTF or CDF and in one of Unity's community health centers. These practitioners will provide continuity of care for chronically and mentally ill inmates during their incarceration and after they are released back into the community. In addition, RNs will assist with the development of care plans and medical discharge plans for chronically and mentally ill inmates. As stated above, the Deputy Medical Director will be responsible for overseeing the coordination of continuity providers and services.

The case management and discharge planning component will be provided primarily by the 9.0 FTE Discharge Planners, under the direct supervision of the Director of Special Needs. More intensive case management may also be provided by the licensed social workers; however, Unity has proposed a staffing plan that utilizes the licensed social workers predominantly for their clinical skills. For budgeting and staffing plan purposes, the discharge planners were included under mental health staffing, which may have caused some confusion because they will perform duties beyond those related to mental health.

As described in Section C.3.30 of Unity's Technical Proposal, the discharge planners will be responsible for providing discharge planning services for chronically and mentally ill inmates tailored to the individual's needs. Every inmate, when possible based on length of stay and access to the inmate, will receive a discharge planning visit, folder with relevant information, and planning related to linkage to a medical home at a community health center, as well as referrals linkages to other community-based social service agencies.

Specifically for mentally and chronically ill inmates, the discharge planning process will include, but will not be limited to, the following activities:

- Schedule follow-up medical appointments with a community health center convenient for the inmate upon release
- Follow-up to find out whether the client showed up for the designated medical appointment after release (The discharge planners will make a reasonable effort to contact the client if they did not show up for the appointment.)
- Develop a discharge plan (The medical component of the discharge plan will be completed by a licensed nurse or advanced level practitioner.)
- Ensure that inmates receive the proper amounts and types of medications prior to release (This will be conducted by licensed nurses.)
- Assist with housing needs for homeless clients prior to release
- Assist with applications for food stamps, social security income (SSI/SSDI), and other entitlements, as appropriate, so benefits will be restored upon release
- Refer to substance abuse treatment and counseling (This will be done in partnership with APRA and other substance abuse providers.)

These components of discharge planning will help establish the desired outcome of a more stable and supportive environment for inmates upon release.

The Director of Special Needs will be responsible for overseeing the discharge planning program. This person will provide overall coordination of the program, management of the discharge planner staff, and required reporting. Furthermore, the Director of Special Needs, who will have clinical background, will also facilitate collaboration among the nursing staff and discharge planning staff for inclusion of medical discharge plans, as necessary.

One of the goals of Unity's discharge planning program is to connect inmates with other District and community-based organizations upon release. For example, Unity will work with the District Department of Health (DOH), Department of Mental Health (DMH), and Income Maintenance Administration (IMA) to link inmates with services and entitlements. In preliminary discussions, IMA has expressed a plan to staff a representative in R&D, with Unity's nurse/MA intake teams, to screen for Medicaid, Medicare, and DC Healthcare Alliance eligibility. This information will then be communicated to the discharge planners who would make a reasonable effort, based on length of stay and appropriate notification of impending releases, to complete applications for eligible inmates. Having DC Healthcare Alliance coverage upon release will increase access to care. In addition, Unity discharge planners will work with DMH and CSA staff within the jail facilities to determine with which Core Service Agency (CSA) a mentally ill inmate is enrolled. Prior to release, the inmate will be reconnected with that CSA for follow-up care. Referral of mentally ill inmates back to their prior source of care will preserve continuity with providers and medications. (For additional information on coordination with the mental health and substance abuse continuums of care, please see response to comment #7 within this document.)

Unity will partner with DOC case managers through cross-referrals. Unity will accept referrals from DOC case managers for medically- or health-related case management/discharge planning needs. In cases where an inmate has needs beyond Unity's scope of work, particularly GED programs, job training programs, and programs within the jail, Unity may refer the inmate to a DOC case manager for assistance.

### 6) Quality Assurance and Quality Improvement

To provide more detail regarding Unity's current Quality Improvement (QI) program and plan, we have included several attachments which provide specific information. As an Appendix to this document, please find Unity's standard QI plan for an individual health center. While we realize that our services at DOC will require some slight modifications of the plan as well as the indicators, this comprehensive document should provide the level of detail regarding Unity's overall approach to QI. In addition, we have attached the complete Board-approved Unity QI Plan, which should provide an overview of the goals and structure of the program.

Based on the expected use and capabilities of the upgraded Logician, Unity expects to be able to track performance measure much more easily than in our current health centers. While we have not yet developed a comprehensive list of indicators that we will collect at the DOC facilities, we will merge historical performance measures used by DOC, Unity's own performance measures, and measures required by ACA or NCCHC guidelines. Our goals for performance measures reporting and for quality improvement indicators are to cover the areas described below.

#### *Access to Care*

For the inmates served under this contract, access to care encompasses three levels: 1) Access to on-site comprehensive health care services (i.e. sick call, primary care health services), 2) Access to off-site specialty care services, and 3) Access and linkage to health care services upon release. Unity will focus on tracking and improving access measures during the inmate's incarceration as well as upon release. It is our goal to link inmates with a community health center medical home upon release.

#### *Appropriateness of Care*

Unity understands the importance of measuring and tracking the appropriateness of care. It is our goal to provide care at the same level as it is provided in the community. Therefore, we will use many of the same measures. However, we will be able to incorporate more measures into our tracking and reporting for services at DOC due to the expected capabilities of the upgraded Logician system. Minimally, we propose to collect appropriate clinical and/or procedural data, based on Logician capabilities, on the following diseases/conditions:

- Cardiovascular disease/Hypertension
- Diabetes
- Asthma
- HIV

- Communicable diseases (STDs, TB)

In addition to performance measures on diseases and conditions, Unity is particularly interested in providing quality preventive health care and health education services. We believe that prevention is key to improving individual and community health outcomes. Therefore, we plan to include preventive health and health education performance measures to track these important services.

#### *Effectiveness of Care*

In addition to measuring the appropriateness of care, Unity is interested in tracking outcome data related to the effectiveness of care. These data related to achieving the desired results of a particular treatment, medication, or care plan.

#### *Timeliness of Care*

Unity currently tracks timeliness indicators within our health centers. We will continue to track appropriate indicators in the DOC facilities to determine whether we are meeting our contractual goals as well as meeting the needs of the inmates we are serving.

#### *Unity QI Team at DOC*

While Unity has a management level QI committee, we expect to establish committees within the DOC facilities to collect and report the appropriate data, as well as develop and implement QI projects to address areas for improvement. Unity proposes an overall QI team for our services at DOC facilities, but also plans to convene smaller department and/or facility-based teams to address QI from the hands-on level. The overall QI team to oversee the Comprehensive Health Care Services at DOC facilities will consist of the following members: Health Care Administrator, Director of Nursing, Deputy Medical Director, Associate Medical Director, Nurse Managers from CDF and CTF, and the QI/UR Analyst. Other members may be asked to join based on the need and appropriateness. This team will report QI findings and project outcomes to the Unity-wide QI Committee as all of Unity's other health centers currently do.

### **7) Mental Health and Substance Abuse Services**

#### *Mental Health Services*

Unity proposes a comprehensive and multidisciplinary model of mental health care for inmates within the DOC facilities. We see the continuity of mental health care and medication adherence as a priority and an opportunity to reduce recidivism based on increasing the stability of mentally ill patients. Below we have provided more detail about the services we will provide through our mental health care model.

#### *Assessments and Testing*

As part of the intake assessment of inmates, Unity will conduct a brief mental health assessment of each inmate. Inmates with documented indicators for mental illness, suicidal ideations, substance abuse disorders, and/or at-risk behavior will be given a complete Mental Health Assessment. Laboratory and diagnostic (psychological) testing will be completed as needed per physician's order.

### *Medication Administration and Compliance*

All psychotropic medications will be taken under the observation of a licensed nurse. Nurses, psychiatric social workers and psychiatrists will equally share the responsibility of assessing medication effectiveness. Psychiatrists will evaluate patients every other week, and will increase frequency of medication management visits based on nursing and social work reports. Social workers will conduct monitoring visits, follow-up visits and counseling visits and will monitor inmate self reports.

### *Staffing*

Psychiatric social workers will be responsible for conducting comprehensive mental health assessments including diagnostic evaluations, psychotherapy, individual counseling and group counseling services. Also, social workers will be responsible for placing inmates on behavioral observation, evaluating inmates while under observation and making recommendations to the treating psychiatrists. Psychiatrists will focus on medication evaluation, medication management, and ordering and managing patients on suicidal observation. Also, psychiatrists will have the sole responsibility for ordering inpatient treatment within the facility and inpatient care outside of the facility.

It is further proposed that the inpatient units will be staffed with an RN and an LPN to provide closer monitoring and supervision of clinical care of inmates, including medication compliance. Also, the nurses will share the responsibility of providing educational life skills, mental illness, and medication compliance groups.

Unity's proposed staffing plan does not include licensed psychologists. The staffing plan was carefully designed to propose the most cost-effective structure focusing on the most needed services. While both licensed social workers and psychologists can provide diagnostic assessments, the costs for hiring and supervising licensed psychologists far outweigh those costs for licensed social workers. Also, licensed social workers are trained to carefully tailor an assessment with focus on available community resources and lifestyle of the inmate, thus allowing a focus on discharge planning at the onset of care.

### *Suicide Prevention Training*

Suicide prevention education will be provided to DOC staff as specified by DOC regulations. Training will be concentrated in two-hour and four-hour blocks. Officers covering housing units at CDF and CTF will participate in the 2-hour training blocks. Officers on mental health units will be provided with a 4-hour intensive in-service. Training will be co-led by a psychiatrist and a social worker. The training modules will highlight:

- Definition of suicidal behaviors and types;
- Correlation between suicide and substance abuse and mental illness;
- Signs and symptoms of suicidal behavior;
- Role of psychiatrist in management of suicidal behavior;
- Role of social worker or psychotherapy in management of suicidal behavior;
- Behavioral observation plans;
- Safety plans;

- Suicidal observation plans;
- Use of restraints;
- Use of chemical restraints;
- Prevention and early identification of suicidal behavior

Additional modules are designed specifically for officers on the mental health units and will focus on case examples, role plays, and team work with the medical team.

#### *Suicide Counseling*

Inmates who exhibit positive indicators of suicidal behavior at intake and/or during their stay as reported by Correctional Officers and/or other members of the medical team will be assessed by one of the mental health team members. Evaluation will include an assessment of severity of symptoms and its history and influence by current circumstances. Every effort will be made to work with the inmate to contract for safety and participation in on-site general population mental health treatment. The team may recommend behavioral observation and/or the psychiatrist may order suicide observation.

#### *Call Coverage*

Unity's physician on-site during off hours may conduct an initial assessment of psychiatric emergencies and, as medically necessary, will consult with Unity's on-call psychiatrist.

#### *Inpatient Care*

Inmates who can not be stabilized within the housing units and present an imminent risk to self or others and/or have had a poor response to medication therapy may be recommended for inpatient services. Unity's psychiatrists will be solely responsible for conducting assessments and recommendations for inpatient care.

Inpatient care is an interim step until the inmate is stabilized and is successfully treated with medication and psychotherapy. The goal of inpatient care will be to develop and implement a care and discharge plan focused on treatment stabilization so the inmate can return to the general population.

#### *Psychiatric Hospitalization/Off-Site Treatment*

Unity's mental health program will focus on treating inmates on-site, when possible. If off-site treatment or hospitalization is deemed necessary by Unity's psychiatrist, a referral and arrangements will be made for such treatment. A psychiatrist will make the referral for off-site psychiatric treatment and care.

Inmates who are deemed incompetent to stand trial and or inmates who fail to respond to medication management regiment after considerable period of multiple tries maybe considered for involuntary placement, or court order competency evaluation at John Howard Pavilion.

### *Coordination of Mental Health Services within the Continuum of Care*

Unity is currently a certified core services agency (CSA) under the umbrella of the District Department of Mental Health (DMH). As an active participant within the Jail Diversion collaborative, Unity intends to establish a working relationship with four of the largest CSAs to conduct collaborative discharge planning. Unity intends to host one staff member from each agency as a liaison to its services within DOC to conduct discharge planning conferences and referrals prior to release. Also, Unity will have full access to the DMH software program linking inmates with previous histories of mental illness to specific CSAs. Unity is also exploring the possibility of having a computer system that is compatible to DMH Provider Connect. Meetings are underway to evaluate this. This would result in full automation meaning that inmate mental health history would be made available automatically.

### *Substance Abuse Services*

Comprehensive intake assessment will include a brief assessment/quick assessment of risk factors for ongoing drug and alcohol abuse. Inmates with clear indicators of physical signs and symptoms of substance use withdrawal will be assessed by the medical teams and may be stabilized within the housing units or at the infirmary, as medically necessary or appropriate.

Inmates with substantial number of positive indicators for substance abuse will participate in an extended assessment to evaluate the length, severity and type of drug use. Psychiatric social workers will then develop an intervention plan that may include psychiatric care, counseling services, referral to APRA based in-patient treatment programs, and/or residential services, transitional housing services or outpatient care upon release. They will work with the discharge planners to ensure that this plan is included in the overall discharge plan.

Unity participates as part of the APRA provider group and has direct access to specialty providers. Additionally, Unity will be using the Global Assessment of Individual Needs (GAIN) scale. This scale is being implemented by APRA as the universal tool to assess level of need and type of care and will function as the referral tool to all APRA providers.

## **B. Other Issues Requiring Additional Information/Clarification**

### 1) IT Section Inconsistencies

Unity acknowledges the inconsistencies in the original RFP with regard to MMIS and MATS. Although we have received the revised RFP, some confusion remains. It is Unity's understanding that the requirement for Unity's responsibilities to subcontract for IT services through this contract was to be removed. Discussions during the May 25, 2006 meeting included the proposal of alternative options for the IT section (i.e. removal from Unity's contract) so that Unity would not be held responsible for the subcontractor's performance under the contract.

### 2) NCCHC Accreditation

Unity will cooperate with DOC to maintain NCCHC accreditation at CTF and CDF.

### 3) Intake Assessments

In reference to Unity's original Technical Proposal Section C.3.2.1 which responded directly to the RFP requirements, Unity acknowledges that NCCHC standards consider an "immediate" intake assessment to be within 4 hours. Contingent upon appropriate access to inmates, no inappropriate delays due to the HIV counseling and testing requirements (for which Unity is not responsible), and reasonable volumes of inmates arriving at one time, Unity will conduct an intake assessment on inmates within 4 hours of admission.

### 4) Emergency Services at CTF

Based on the revised RFP, Unity will provide emergency services at CTF and will provide primary health care services to inmates in lock-down units.

### 5) Dental Services

In reference to Unity's original Technical Proposal Section C.3.11.2, bullet #2 which included the phrase "when possible," Unity acknowledges that this was in error and would like to strike the phrase "when possible" from our response.

### 6) Suicide Prevention Training

Unity will provide suicide prevention education to DOC staff as specified by DOC regulations. Training will be concentrated in two-hour and four-hour blocks. Officers covering housing units at CDF and CTF will participate in the 2-hour training blocks. Officers on mental health units will be provided with a 4-hour intensive in-service. Training will be co-led by a psychiatrist and a social worker. The training modules will highlight:

- Definition of suicidal behaviors and types;
- Correlation between suicide and substance abuse and mental illness;
- Signs and symptoms of suicidal behavior;
- Role of psychiatrist in management of suicidal behavior;
- Role of social worker or psychotherapy in management of suicidal behavior;
- Behavioral observation plans;
- Safety plans;
- Suicidal observation plans,;
- Use of restraints;
- Use of chemical restraints;
- Prevention and early identification of suicidal behavior

Additional modules are designed specifically for officers on the mental health units and will focus on case examples, role plays, and team work with the medical team.

#### 7) PPD Planting

Unity acknowledges that the revision of the RFP includes new language that Unity will comply with the new standard to perform a new PPD plant at intake if not done within the previous 6 months, rather than the 14 days originally stated in the RFP.

#### 8) Metrics and Metrics Reporting

Since the proposed metrics in the RFP are consistent with accreditation guidelines, Unity will comply with those metrics stated in the RFP. If additional metrics are to be added to the reporting requirements, Unity and DOC shall mutually agree upon those additional elements.

#### 9) Changes Clause

Due to the inclusion of a Changes Clause within the original RFP, no action or response on this item is necessary.

#### 10) Advisory Board

Unity and DOC will work together to establish an internal advisory board and/or develop a health care committee of an existing internal advisory board.

#### 11) Timekeeping System

For consistency and ease of payroll processing, Unity will install and utilize its own biometric timekeeping system. (Please see Appendix for sample reports.)

#### 12) Removal of Unity Staff from DOC Duties

Unity maintains its position that it should not be required to seek approval of the COTR to hire Unity staff, provided that all Unity staff members meet the requirements of Section C.3.25.1 and C.3.25.8 of the contract. Further, Unity does not believe that the COTR should have a "reserve right" of approval of hiring Unity staff. In order to assure an efficient and effective hiring process, Unity should be able to assume that if a potential employee meets the requirements set forth in Section C.3.25.1 and C.3.25.8, that Unity can hire such a person. To this end, the language in Section C.3.25.9 should be amended to remove the COTR's reserve right of approval for all hiring. Removing DOC's right of approval of hiring does not prevent DOC from making decisions regarding who performs the contract on behalf of Unity. If, after Unity hires the employee, the DOC is dissatisfied with the performance of the employee, then DOC still has the absolute right to require the removal of the employee from performing services under the contract and is thereby protected.

With respect to the Committee's concern about the provision of a written explanation/justification of DOC decisions to remove specific staff, Unity maintains that the language in the RFP is appropriate as written. When such action is taken, it is Unity's understanding that the appropriate notice will be given to Unity as soon as possible so that replacement personnel can be recruited in a timely manner. Further, it is Unity's understanding that DOC will expedite the clearance and training process to avoid prolonged vacancies. If the person being removed from a DOC facility is a member of the Principal Leadership Team, Unity requests that such notice be given to the CEO of Unity Health Care, Inc.

## **C. Additional Discussion Points Added by Unity**

### *Liquidated Damages*

Unity will appreciate the opportunity to discuss and negotiate the liquidated damages section of the contract to reach an agreement on a fair and reasonable outcome. We are in the process of developing a proposed revision of the liquidated damages section.

### *Abuse and Molestation Insurance*

After further review, Unity has determined that our current insurance plan covers abuse and molestation. Therefore, no additional action or response is necessary on this item.

### *Request for Information*

While we did receive much of the information that we requested, there are a few items still outstanding. These data would be beneficial to our planning process, as well as important for negotiations of the staffing plan, in particular. The outstanding data requests include:

- 1) Number of infirmity patients, length of stay, and diagnoses
- 2) Number of mental health visits and diagnoses (broken down by mental health units vs. general population services)
- 3) Total number of prescriptions filled per week or month by the DOC pharmacy

In addition, if the review committee insists upon a direct comparison of Unity's proposed staffing plan with that of the current model, we would need detailed current staffing information including shifts, departments, assignments (i.e. for nurses: medication distribution, sick call, intake), and weekend staffing.

### *Revised RFP*

While we did receive the revised RFP on the morning of June 1, 2006, Unity has not had the opportunity to fully review the changes. We will direct any comments on the revised RFP directly to OCP, as necessary.

### *LSDBE Subcontracting Goal*

Based on e-mail communication from OCP's John Soderberg on March 30, 2006, Unity understands that 35% LSDBE subcontracting referred to in the RFP is a goal, not a mandatory requirement. Based on our current subcontracting plan, we do not expect to meet this goal. However, through our subcontract with Health Right, Inc. and others, Unity will continue to make a reasonable effort toward meeting this goal.

# Revised Staffing Plan





Unit Health Care, Inc.		Workweek		Weekday Staffing FTEs			Weekend Staffing FTEs			Leave Coverage	Total
DC Corrections Health Services		Hours	Day	Evening	Night	Day	Evening	Night	FTEs	FTEs	
Projected Staffing											
CTF:											
Level 82(Infirmar-y-37 beds+addl.) (ICF 82, subacute 96)											
MD		40.00	0.50	-	-	0.50	-	-	0.09	0.79	
NP		40.00	2.00	1.00	1.00	2.00	1.00	1.00	0.75	6.35	
RN		40.00	2.00	2.00	1.00	2.00	2.00	1.00	0.81	7.81	
Charge RN		40.00	1.00	1.00	1.00	1.00	1.00	1.00	0.48	4.68	
LPN		40.00	3.00	3.00	2.00	3.00	3.00	2.00	1.29	12.49	
MA/CNA		40.00	-	-	1.00	-	-	1.00	0.16	1.56	
Lofts vs. Level 68(Continuity/Sick)											
MD/pm		40.00	2.00	-	-				0.27	2.27	
RN		40.00	4.00	-	-				0.46	4.46	
MA		40.00	2.00	-	-				0.23	2.23	
Outpatient Mental Health Services											
Psychiatrist		40.00	1.00						0.13	1.13	
LICSW		40.00	1.00						0.12	1.12	
Discharge Planners		40.00	3.00							3.00	
Medication Distribution											
LPN		40.00	4.00	4.00		4.00	4.00		1.29	12.49	
TOTAL CTF			25.50	11.00	6.00	12.50	11.00	6.00	6.10	60.40	

Unity Health Care, Inc.		Workweek		Weekday Staffing FTEs			Weekend Staffing FTEs			Leave Coverage	Total
DC Corrections Health Services		Hours	Day	Evening	Night	Day	Evening	Night	FTEs	FTEs	
Projected Staffing											
JAIL											
R&D											
RN	40.00	1.00	2.00	-	-	0.30	0.35		0.35	3.35	
MA	40.00	2.00	2.00	-	-	0.46	0.46		0.46	4.46	
Third Floor Medical Unit											
MD	40.00	2.00	3.00	1.00	-	0.81	0.81		0.81	6.81	
NP	40.00	-	2.00	-	-	0.27	0.27		0.27	2.27	
RN	40.00	1.00	1.00	-	-	0.23	0.23		0.23	2.23	
Charge RN	40.00	1.00	1.00	1.00	-	0.35	0.35		0.35	3.35	
Wound Care LPN	40.00	1.00	1.00	-	-	0.12	0.12		0.12	1.12	
MA	40.00	3.00	2.00	-	-	0.58	0.58		0.58	5.58	
Unit Coverage											
NP	40.00	3.00				0.40	0.40		0.40	3.40	
RN	40.00	6.00				0.69	0.69		0.69	6.69	
Pharmacy											
LPN	40.00	3.00		3.00		0.69	0.69		0.69	6.69	
General Pop Psych Services											
Psychiatrist	40.00	2.00				0.27	0.27		0.27	2.27	
LICSW	40.00	2.00				0.23	0.23		0.23	2.23	
Case Managers/Discharge (5dy/wk)											
	40.00	2.00								2.00	
Mental Health											
South 3 (80 Bed)											
Psychiatrist	40.00	0.75				0.14	0.14		0.14	1.19	
LICSW	40.00	1.20				0.19	0.19		0.19	1.87	
RN (Psych)	40.00	1.20	1.20	0.80	0.80	0.52	0.52		0.52	5.00	
LPN (meds)	40.00	0.80	0.80	0.80	0.80	0.39	0.39		0.39	3.75	
Case Managers/Discharge Planners											
	40.00	2.00	1.20	0.80	0.80	0.39	0.39		0.39	4.48	
South 1 (20 Bed)											
Psychiatrist	40.00	0.25				0.05	0.05		0.05	0.40	
LICSW	40.00	0.30				0.05	0.05		0.05	0.47	
RN (Psych)	40.00	0.30	0.30	0.20	0.20	0.13	0.13		0.13	1.25	
LPN (meds)	40.00	0.20	0.20	0.20	0.20	0.10	0.10		0.10	0.94	
Case Managers/Discharge Planners											
	40.00	0.50	0.30	0.20	0.20	0.10	0.10		0.10	1.32	

6/1/2006

Unity Health Care, Inc.  
 DC Corrections Health Services  
 Projected Staffing

	Workweek Hours	Weekday Staffing FTEs			Weekend Staffing FTEs			Leave Coverage FTEs	Total FTEs
		Day	Evening	Night	Day	Evening	Night		
MD	40.00								
RN	40.00				1.00	1.50	1.00	0.19	1.59
Charge RN	40.00				1.00	2.00	-	0.14	1.34
Wound Care LPN	40.00				1.00	1.00	1.00	0.14	1.34
MA	40.00				1.00	1.50	2.00	0.05	0.45
LPN (meds)	40.00				3.00	3.00	3.00	0.16	1.56
								0.28	2.68
<b>TOTAL JAIL</b>		36.50	20.00	4.00	16.50	13.50	4.00	7.95	82.05
<b>TOTAL PROGRAM</b>		110.75	42.00	13.20	30.50	25.00	10.10	18.93	211.12

# Job Descriptions



## Unity Health Care, Inc Job Description

**JOB TITLE:** Medical Assistant

**FLSA:** Non- Exempt

### **INTRODUCTION/POSITION SUMMARY:**

A Medical Assistant provides basic patient care in an ambulatory clinic setting. Working with health care providers and other health center employees, the Medical Assistant is an integral part of the patient care team. The Medical Assistant is directly responsible for, but not limited to, initiating medical history, vital signs, height, weight, preparing patients for examination, reporting special problems or complaints to providers, making appropriate clinic appointments for patients and follow up to determine if appointments were kept.

### **MAJOR DUTIES/ESSENTIAL FUNCTIONS**

- Maintains patient and chart confidentiality.
- Prepares patient and chart for provider visit, reports special problems or complaints to the provider, assists during exam as needed.
- Accurately performs and records basic vital signs, height, weight, chief complaint and initiates medical history for adult and pediatric patients.
- Performs routine lab and patient procedures (i.e. simple dressing changes, urine dipsticks, phlebotomy, finger/heel sticks, injections/immunizations, EKG.)
- Makes appropriate referral appointments/referrals for patients and follows up to determine if appointments were kept as scheduled.
- Participates in medical record maintenance and appropriate completion and disposition of encounter forms.
- Request and uses supplies as needed for patient care.
- Reviews chart after treatment for appropriate signatures, authorizations, relevant data, and follow up and discharge instructions.
- Communicates and assist in effective discharge of the patient.
- Maintains proper cleanliness and organization of office and medical areas including restocking supplies.
- Follows Universal Precautions and Unity Health Care policies and procedures.
- Participates in clinic record keeping including medical and operational logs.
- Demonstrates appropriate customer service with internal and external customers.
- Other duties as assigned.

### **Medical Assistant II**

As above

- Assist in the registration process of patients at the health center.
- Assist in the scheduling/referral of appointments for UHC Patients.
- Assist in obtaining authorizations for referrals.

- Assist in organizing the pharmacy/medical products at the center if applicable.
- 1. Participate in the maintenance of medical records and appropriate completion and disposition of the encounter forms.

### **Medical Assistant III**

As above

- Reviews chart after treatment for appropriate signatures, authorizations, relevant data and follow up and discharge instructions.
- Collaborates with HCM and Nurse Manager on a daily basis for center operations and problem solving and demonstrates the ability to resolve problems.
- Monitors and facilitates a positive patient flow.
- Able to function in various departments of the health center.
- Coordinates and conducts the medical assistant orientation and training.
- Assist in physician scheduling in the AS 400 when requested.
- Serves as the Infection Control Coordinator for team/Center.
- Assist in the QI site audit process.
- Coordinates the medical assistant documentation review process for center.

### **REQUIRED KNOWLEDGE, SKILLS AND ABILITIES**

- Graduate of accredited medical assistant program with diploma.
- Registered Medical Assistant certification preferred.
- High school graduate or GED.
- Current BLS + AED CPR certification
- Minimum of 6 months to 1-year of clinical experience in an acute care/ambulatory setting/ special needs population (i.e., homeless, HIV+, medically indigent).
- Must successfully pass Unity Medical Assistant screening test.
- Effective communication and interpersonal skills with internal and external customers
- Bilingual ability desirable.
- Willingness to articulate Unity's mission through his/her work.

### **SUPERVISORY CONTROLS**

The Staff Nurse and Nurse Manager supervise the Medical Assistant. At sites where there is not a Nurse Manager, the Health Center Manager will supervise the medical assistant. Nurse Manager/designate in conjunction with the Department of Education will assess competencies on an annual and as needed basis

### **GUIDELINES**

The Medical Assistant follows OSHA standards of safety and universal precautions and Unity policies and procedures.

### **PERSONAL CONTACTS**

Medical Assistant works in close collaboration with UHC staff and patients

### **PERFORMANCE REQUIREMENTS FOR II, III**

- Satisfactory attendance records
- No adverse notations/records of disciplinary action on file
- Above average performance appraisal
- Recommendation from Health Center Manager
- One recommendation from Health Care Provider

### **TRAINING REQUIREMENTS FOR II, III**

- Completion of all required annual competency assessment programs (II, III)
- Completion of 8 continuing education sessions conducted by Department of Education (II, III)
- Completion of HIM training course (II, III)
- Completion of Patient registration Course (II, III)
- Completion of a Basic Pharmacology Course (II, III)
- Completion of Infection Control Program (III)
- Completion of Site Review Program (III)
- Completion of Nursing Documentation Learning Packet (III)

### **PHYSICAL DEMANDS**

The Medical Assistant may be required to walk throughout the health center on a daily basis, efficiently moving from job skill to job skill. Assisting patients with mobility difficulties, walking, bending, stooping and lifting up to 30 lbs, sitting and standing are all required.

### **WORK ENVIRONMENT**

Unity Health Care provides primary health care services to indigent people in Washington, DC. As a federally qualified health center there is a commitment to serving traditionally underserved people in the community. Unity seeks to maintain facilities, which are safe, sanitary and patient orientated.

### **OTHER SIGNIFICANT FACTS**

Work hours may include some evenings and/or Saturday work. While every effort is made to assign staff to one health center site regularly, Unity may change the assigned health center/ department and/or site temporarily or permanently, depending upon the need of the patient and organization. Occasionally the Medical Assistant will be required to travel between health center locations on a daily basis. Deployment to other centers and departments may be required upon request of the Staff Nurse/Nurse Manager/Health Center Manager.



Unity Health Care, Inc  
Job Description

**JOB TITLE:** Deputy Medical Director (DMD) Of Unity Clinical Services

**FLSA:** Exempt

**MAJOR DUTIES/ESSENTIAL FUNCTIONS**

- The Deputy Medical Director will coordinate clinical care, connectivity, and continuity between DC Corrections and Unity Health Care's community health centers.
- The Deputy Medical Directors of Unity Health Care work closely together on a number of tasks involving overall Unity Health Care management: Coordinate weekly clinical leadership meetings to include the CMO and DMDs. These meetings should be designed to promote quality of care, operational efficiency, problem-solving, etc...
- Conduct meetings as needed with other senior leadership to coordinate services;
- Attend the monthly senior leadership meetings;
- Attend the monthly board meetings;
- Assist with identification of supply and equipment needs;
- Coordinate provider schedule and coverage of all Unity Health Care clinical sites;
- Collaborate to improve non-medical systems procedures including registration, appointments and patient flow.
- Collaborate to improve or maintain provider/staff/patient satisfaction, quality of care, and productivity
- Participate in committees, meetings and tasks as designated by CMO.
- Provide feedback to the CMO in regards to staffing and hiring;
- Assist and support AMDs of clinical services in their positions;
- conduct annual evaluations of AMDs of clinical support;
- conduct biweekly meetings with the AMDs of clinical support to coordinate services.
- Assist with new provider orientation to Unity Health Care and serve as resource to all providers.
- Contact discipline director for departmental issues and AMDs as they occur; If any identified issues not resolved by the AMD to the DMD's satisfaction, DMD should then notify CMO.
- Assist with conducting monthly AMD meeting.
- Assist with conduct Unity all providers meetings.
- Attend the joint HCM-AMD QI meeting.

### **Qualifications**

- Must have and maintain current RN license with certification by the ANCC, DEA and CDS Licenses.
- Should preferably have 2-3 years experience in ambulatory care setting with some contact with homeless patients.

### **GUIDELINES:**

The position abides by all rules and regulations set forth by applicable licensing and regulatory bodies; and the UHC policies and procedures.

### **PERSONAL CONTACTS**

The position requires contact with staff at all levels throughout the organization. There are also external organization relationships that may be apart of the work of this individual.

### **PHYSICAL DEMANDS**

Some walking, standing, bending and carrying of light items such as books and paper is required.

### **WORK ENVIRONMENT**

The position works involves everyday risk and discomforts, which require normal safety pre-caution typical of such places as offices, meetings, training room and other UHC health Care Sites. The work area is adequately lit, heated and ventilated.

## UNITY HEALTH CARE INC.

Project Title: Improving Access to Medical and Mental Health For Teens and Their Families "Health Street"

Project Director: Jessica Osborn, M.D.

Grantee: Eastern Student Health Center  
Unity Health Care Inc.

Address: 1700 East Capitol St. N.E.  
Washington, D.C. 20003

Phone: (202) 745-4300, (202) 612-3136

Email: [josborn@unityhealthcare.org](mailto:josborn@unityhealthcare.org)

Home Page: <http://www.unityhealthcare.org>

Project Period: 2006 – 2007

Total Amount of Grant Award \$50,000

### **Purpose**

#### ***"WE TREAT YOU WELL"***

**No Person will be refused services at Unity Health Care because of inability to pay.**

Unity Health Care request funds for the expansion of the Health Street Program to two additional Wards in Washington, D.C.. The funds would assist in the need of introduction to comprehensive culturally appropriate linguistically competent medical and behavioral health services either because of cultural background or need for medical insurance that continues to plague the youths in the District. Common barriers to seeking and receiving medical and behavioral health services for this population include cultural factors, a high rate of uninsured and under-insured members, and the reduction of medical and behavioral health services designed specifically to suit the special needs of the adolescent population. Efforts to improve adolescents health and well being in our community must address these barriers if they are to succeed.



## Unity Health Care, Inc Job Description

**JOB TITLE:** Associate Medical Director (AMD) for a Unity site

**FLSA:** Exempt

### **MAJOR DUTIES/ESSENTIAL FUNCTIONS**

- Attend Unity clinic(s).
- The AMD and Health Center Manager work closely together on a number of tasks involving overall clinic management:
- coordinate, at least monthly, the site's Leadership meetings to include the AMD, HCM and NM. These meetings should be designed to promote quality of care, operational efficiency, problem-solving, etc...
- Conduct, at least monthly, the site's All Staff meetings;
- Conduct, at least monthly, the site's Provider meetings to include the Nurse Manager (NM), Chief Medical Officer (CMO) and Chief of Clinical Operations (CCO);
- Assist with identification of supply and equipment needs;
- Coordinate provider schedule to include approval of scheduled absences;
- Define and implement site-specific QI initiatives.
- Collaborate to improve non-medical systems procedures including registration, appointments and patient flow.
- Manage peer review process in accordance with protocol. Specifically, the AMD is responsible for re-evaluating those charts or providers not meeting the minimum standards and providing feedback. Peer review process with discipline directors needed in some cases;
- Collaborate to improve or maintain provider/staff/patient satisfaction, quality of care, and productivity.
  
- Provide feedback to the CMO and complete clinical aspect of annual provider evaluations. AMD should receive feedback from HCM and Nurse Manager re: non clinical aspects, for eg re. timeliness, respectfulness and teamwork with rest of staff.
- Provide feedback to the HCM and NM re: staff evaluations.
- Monitor and evaluate clinical issues related to nursing performance.
- Orient new providers to site and serve as resource to all providers at site.
- Contact discipline director for departmental issues as they occur;
- Conduct weekly meetings with all providers as needed;  
If any identified issues not resolved by the HCM to the AMD's satisfaction, AMD should then notify CMO.
- Verify, sign, and submit leave requests for all providers to the HCM for processing in accordance with the provider leave policy.
- Participate in monthly AMD meetings and the joint HCM-AMD QI meeting.

### **Qualifications**

Must have and maintain current RN license with certification by the ANCC, DEA and CDS Licenses.

Should preferably have 2-3 years experience in ambulatory care setting with some contact with homeless patients.

**GUIDELINES:**

The position abides by all rules and regulations set forth by applicable licensing and regulatory bodies; and the UHC policies and procedures.

**PERSONAL CONTACTS**

The position requires contact with staff at all levels throughout the organization. There are also external organization relationships that may be apart of the work of this individual.

**PHYSICAL DEMANDS**

Some walking, standing, bending and carrying of light items such as books and paper is required.

**WORK ENVIRONMENT**

The position works involves everyday risk and discomforts, which require normal safety re-caution typical of such places as offices, meetings, training room and other UHC health Care Sites. The work area is adequately lit, heated and ventilated.

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Health Right, Inc.  
QI/UR Report

Health *RIGHT*

the *Right*  
Health *Choice*

## **Introduction**

Health Right, Inc. continually strives to improve the quality of care and services provided by its health care delivery system. The Quality Management Program (QMP) was developed in accordance with HRI's mission and vision, as well as the Medical Assistance Administration (MAA) Continuous Quality Improvement Program, which supports continuous quality improvement in all phases of our business. This is achieved by adhering to the principles regarding delivery of valuable services to our members and participating providers, in addition, to providing our employees with an environment that supports high standards of performance.

The QMP establishes standards that encompass all quality management activities within our health plan and is an integral component of the HRI delivery system. The QMP forms the basis by which all quality initiatives are designed and implemented. Additionally, it establishes HRI's commitment to quality management, quality improvement and enabling all parties to have a clear understanding of HRI's Quality Management goals and structure within the organization.

## **I. QUALITY MANAGEMENT PROGRAM**

### **a. Mission**

It is the mission of HRI's QMP to operate an integrated health care delivery system for its members predicated upon a continuous quality improvement model. This mission will be achieved by continually striving to craft an environment of proactive, systems-oriented practice whereby every employee will recognize the importance of their role in the organization and their responsibility toward the quality effort. HRI shall also ensure that the quality health care provided to its members meets and/or exceeds Medicaid and community professional standards and that health care and its delivery are continuously and measurably improved.

### **b. Goals**

The ultimate goal of HRI's QMP is to provide the best comprehensive, cost-effective quality patient care possible to its members. In our quest towards this endeavor, employees will be respected and valued, by operating in a positive environment that encourages their best performance. The specific QM goals are as follow to:

- Promote and build quality into HRI's organizational structure and processes
- Provide effective monitoring and evaluation of care and services to ensure that care and services provided to HRI's members meets and/or exceeds appropriate standards and is positively perceived by the plan's members and health care providers.
- Ensure prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up.
- Promote patient safety through a collaborative partnership between providers, its members and the health plan.
- Maintain compliance with Local and Federal Regulatory requirements and accreditation standards.
- Ensure that culturally and linguistically appropriate health services are available for all HRI members.
- Promote health plan fiscal stability through appropriate cost containment methods.

**c. Scope of the QM Program**

The QMP provides a systematic process for the monitoring of important aspects of care through an array of QM activities. These activities include, but are not limited to analyzing and evaluating summary data from the following QM activities and reports, as well as, making recommendations for improvement. These activities include the following:

- Quality Measurement Studies
- Health Education Evaluations
- Clinical and Service Indicator Review
- Quality of Care and Service Data
- HEDIS Performance Measures
- Member and Provider Satisfaction Surveys
- Access Survey
- Complaint and Grievance Review
- Risk Management Reports
- Utilization Management Review
- Pharmacy and Therapeutic Review

- Credentialing and Recredentialing Review
- Patient Safety Management Program
- Disease Management Program
- Case and Care Management
- Fraud, Waste and Abuse
- GeoAccess Analysis Reports
- Other criteria deemed necessary by the CEO

**d. Objectives**

- Develop and evaluate annually the QMP to include measurement, analysis, intervention strategies and re-measurement.
- Identify and monitor clinical and service elements inclusive of national and HEDIS benchmarks and performance standards.
- Measure utilization of services and analysis of utilization data monthly, quarterly and annual basis. Monitor through claims, pharmacy, and encounter data.
- Measure access and availability of care and services on a quarterly and annual basis
- Measure member satisfaction through annual member satisfaction surveys; monthly, quarterly and annual analysis of complaint data and call center data
- Measure provider satisfaction through provider satisfaction surveys and analysis of complaint data

**e. Data Collection and Reporting Procedures**

In 2004, HRI contracted with **TierMed**, a certified HEDIS vendor, to assist in the calculation and provision of HEDIS measures. As part of this process, historical claims information was sent to this vendor for analysis from our 2003 database. HRI used these findings as their baseline source for future comparative analysis. The 2003 data was based on administrative data only. The 2004 and 2005 data that is presented in this report is based on both administrative and hybrid data. Health Right has contracted with TierMed, for a second year to assist in the calculation and provision of the 2006 HEDIS year. Health Right has the ability to monitor the accuracy and completeness of the data received from TierMed by monitoring the FTP transmission

logs that exist, which shows the details of the data, as well as, what data has been sent to the health plan. Additionally, as the rates are available for review, reasonableness checks are performed by HRI staff and the NCQA certified HEDIS consultant.

In addition, to contracting the services of TierMed, HRI has also contracted the services of an outside Medical Record Review (MRR) vendor, Manage Access for the past two years. Manage Access, a certified HEDIS medical record vendor, employs nurses in the Metropolitan area to abstract data from medical records in accordance with HEDIS technical specifications. Health Right monitors the progress, accuracy and completeness of the data presented by Manage Access through periodic review of the submitted worksheets and coordination during the medical record review process.

Health Right's Management Information Systems (MIS) falls into two broad categories: a (1) transaction based system and a (2) decision support system. The transaction based system that HRI utilizes is the PLEXIS Claims Manager (PCM) which was implemented in January 2005. Its primary role is to provide operational support to the various business functions of Health Right, including claims adjudication, provider network management, and membership maintenance. PCM is an integrated healthcare information system with complete benefit administration, manual and electronic medical and dental claims processing, and standardized reporting features. PLEXIS serves as the primary repository of data, which can include service level detail, financial, and historical claims information.

Subsequently, Health Right's decision support system plays an integral role in the integration of data and information to execute HRI's QMP and Quality Improvement Activities. HRI primarily employs a Microsoft SQL Server-based data warehouse for decision support and information analysis. Additionally, HRI has developed proprietary databases to assist HRI's management and departments in the continuous delivery of improved services to members, and to bring QMP goals to fruition.

Obtaining the assistance of technical vendors such as: (1) TierMed Systems, a NCQA certified data vendor who employs a certified data engine to calculate the appropriate HEDIS quality measures and (2) Manage Access, a NCQA certified HEDIS Medical Record Review vendor who assists in the validation process helps to ensure that HRI meets reporting and information integrity standards. In addition, HRI also utilizes other systems and guidelines for quality assurance monitoring such as: (1)

GeoAccess software for network analysis and provider profiling, as well as using (2) InterQual criteria for appropriate utilization management. Used in combination and collaboration, these systems and processes allow for the crucial service tracking and monitoring. They also provide critical evaluation of utilized services, care coordination, EPSDT activities, and overall organization and provider performance. HRI's Information Systems Department will continue to update decision support applications and various proprietary systems to capture, analyze and report data. All HRI staff is involved in ongoing training of systems in order to carry out quality improvement functions. Data resources include claims, encounter, enrollment files, utilization management statistics, medical records, complaint information and HEDIS data.

**f. 2005 Quality Improvement Measures (monthly, quarterly and annual reviews)**

### **MONTHLY CLINICAL INDICATORS**

- Emergency room visits
- Hospitalizations
  - Admissions
  - Days/1000
  - Average Length Of Stay
- Asthma
  - ER Visits (Ages 2-19)
- Prenatal care
  - Total Births
  - Low birth weight
  - LBW <2500gm
  - LBW <1500gm
  - High risk
  - 48-hour visits
  - Postpartum visits
  - Live Births
- Health Check Services (EPSDT)
  - Immunizations (school age and 0-4)
  - Vision 0-20
  - Well Check Visits
- Dental – EPSDT
  - Dental Assessments

- Well Child Calls
  - Calls
  - Letters
- Mental Health
  - Acute
  - RTC – Residential Treatment Center
  - SA – Substance Abuse
  - Average Length of Stay
    - RT – Residential Treatment
  - Call abandonment rates and call answer timeliness
- Utilization Management
  - Medical
  - Mental Health

## MONTHLY SERVICE INDICATORS

- Call Center Statistics
- Patient InfoSystems – Nurse Advise Line (24 hours)
  - Number of Calls
  - Abandonment Rate
  - Average Speed of Answer (seconds)
- Member Services
  - Number of Calls
  - Abandonment Rate
  - Average Speed of Answer (seconds)
- Complaints
  - Total number of complaints
  - Pharmacy Complaints
  - Provider Complaints
  - Transportation
  - Dental
  - Other
- Claims
  - Number of Denials (per line)

- Membership
  - Enrollment
  - Loss of MCO
  - Loss of Medicaid
  - New Members
  - Transfer to another MCO
- Credentialing
  - New
  - Recredentialing
  - Temporary
  - Ancillaries

## QUARTERLY SERVICE INDICATORS

- QPA
  - Dental Visits
  - Vision Visits
- Geo-Access
  - PCP's within 30 minutes
  - Pharmacies within 2 miles
  - Dental Providers within 30 minutes
- Focused Studies
  - Summary Report for Prenatal Care
  - Increasing Timeliness of Prenatal and Post-partum Care
  - Obesity
  - Childhood Immunization Status
  - Comprehensive Diabetes Care
  - Use of Appropriate Medications for People with Asthma
  - Improving Breast Cancer Screening
  - Antidepressant Medication
  - Hypertension
  - Breast Cancer Screening

## ANNUAL CLINICAL INDICATORS

- Lead
  - Number of 1 year olds
  - Number of 1 year old screenings
  - Percentage of 1 year olds screened
  - Number of 2 year olds
  - Number of 2 year old screenings
  - Percentage of 2 year olds screened
- Diabetes
  - Members Identified
  - Eye Exams
  - Percentage of Eye Exams Given

## II. QUALITY ASSESSMENT PROCESS

### a) QM Program Components

HRI is committed to the QM program and strives to both improve and enhance health outcomes and the safety of care provided to its members and takes every opportunity to inject interventions toward the quality of care and service. The structure of the QM program is such that it is able to recognize opportunities to improve and/or enhance the terms of healthcare services and the outcomes of such care for its members. In addition, the QM program addresses and integrates findings from our annual site reviews performed by the Delmarva Foundation, an external independent auditing organization, focused studies, HEDIS measures, and Disease Management Program, along with any recommendations from the Continuous Quality Improvement (CQI) committee that is made up of QM Directors from each MCO in the District of Columbia. The CQI Committee is chaired by DC MAA. The committee meets monthly and focuses on Best Practices across plans and continuous quality improvement initiatives. The CQI meets on a monthly basis.

b) Annual QM Program Evaluation

The Associate Medical Director and Director of Health Services/Quality work closely together in developing the annual program evaluation. The evaluation includes a review of all QM components included in this report, combining clinical care and service activities. These activities along with key clinical and service indicators are tracked on a monthly, quarterly and annual basis, measuring whether goals have been met and significant advancement has been made. The evaluation is presented to the QMC for review, comments and approval and then forwarded to the QAC followed by the BOD. The information from the evaluation is used to modify the following year's QM program description and QM work plan.

c) QM Program Document

The QM program document provides a framework for integrating all departmental functions within HRI. Annually, the QM department evaluates and modifies the program document and submits it to the QMC and QAC for review, discussion and approval then forwards the document to the BOD for final approval.

d) QM Work Plan

The Director of Health Services/Quality is responsible for completing the Annual Work Plan. The QM Work Plan is a detailed, one-year work plan and timetable for the health plan's clinical and service quality improvement activities for the subsequent calendar year. The QM Work Plan is developed as an outgrowth of the evaluation of the previous years QM activities and incorporates the recommendations from that evaluation. The Plan includes objectives, scope, all clinical and service activities, time frame of completion, person(s) responsible, monitoring of previously identified activities, and evaluation of the QM program. This document is updated and approved annually by the QMC, the QAC and the BOD. To initiate and maintain the program and work plan, the Health Services Director/Quality works closely with the Associate Medical Director, Utilization Manager, Member Services Manager, Credentialing Coordinator and Provider Relations representative to accomplish set goals. The Health Services Director/Quality also generates four quarterly reports to the QMC on the status of the work plan. Additionally, an Interim Quality Summary and CQI Work Plan are submitted to DC MAA that covers the periods of January through June. This report is used to assess accomplishments achieved, activities and projects, opportunities for next half of the current calendar year, and best practices during the first two quarters of the current calendar year. The goal of the QM Work Plan is to have a comprehensive plan that will guide HRI toward overall improvements in performance and /or outcomes.

e) Member Satisfaction

The Myers Group, a NCQA-certified vendor performs the Medicaid Adult CAHPS 3.0H survey annually and provides the results to HRI. The Management Team reviews the results of the survey, identifying areas of needed improvements, and performs a barrier analysis to determine root causes of deficiencies, limitations, and priorities. Each department is responsible for implementing interventions to improve member satisfaction in the identified areas needing improvement. Health Right also has a relationship with Patient InfoSYSTEMS, an independent developer of patient-focused health care information products and services that specializes in the measurement, analysis and reporting of self-reported patient data. By using technologies such as interactive voice response and on-demand publishing, they are able to simultaneously gather patient-specific information that HRI can use to improve outcomes, increase customer satisfaction, control costs, and deliver health-related messages that support HRI's overall patient care goals.

f) Provider Satisfaction

Health Right, Inc. conducts an annual provider satisfaction survey with a sample from the provider network with the goal of obtaining feedback from providers to measure the effectiveness of services that HRI provides to this population. By monitoring the feedback that is provided by the sample of providers, it enables HRI to develop and implement strategies that will hopefully improve provider satisfaction, provider retention, and provider growth.

g) Provider Availability

The Director of Information Systems performs an availability analysis on a quarterly basis to determine whether there is a sufficient network of conveniently located providers for HRI members. District of Columbia MAA sets acceptable standards and thresholds for the number and geographic distribution of PCPs, pharmacist, mental health providers, dentist and high volume specialist. A GeoAccess evaluation is performed to assess compliance with geographic availability for an array of providers. This evaluation is compared against HRI's membership quarterly arranged by zip code, mileage, and time via public transportation, to determine areas of need for primary care physicians, specialist, mental health providers, dentist, and pharmacy. The data is then analyzed by provider relations to determine if there are geographic areas that do not meet thresholds and if there are opportunities in network development and contracting. Member complaints regarding location of practitioners are included in the analysis, as available. A compiled report is then presented to the various Quality committees with final review and approval by the BOD.

#### h) Access Survey

On an annual basis the provider relations department conducts an evaluation on the timeliness of access to medical practitioners within the network. HRI has established access and availability standards that comply with HCQIS and DC MAA requirements. These standards include but are not limited to the following:

- 1) **Appointments for Initial EPSDT screen** - shall be offered to new enrollees within 30 days of enrollment date or at an earlier time if an exam is needed to comply with the periodicity schedule.
- 2) **Urgent care** – from PCPs within 24 hours of the request.
- 3) **Appointments for asymptomatic health assessments of adults ages 21 and older** – within 30 days of the request.
- 4) **Initial appointments for pregnant women or persons desiring family planning** – within 10 days of the request.

These appointment standards are disseminated to the providers annually in their Provider Manual and to the members upon enrollment through their Member Handbook. Providers and facilities that are not in compliance are required within in 30 days of request to write a corrective action plan (CAP) documenting how they will meet the required access standards.

#### i) Patient Safety

To improve the quality and safety of clinical care provided to Health Right members, we strive to ensure the following:

- Develop a process to resolve potential quality of care issues identified by UM, QM, case managers, member services, provider services and pharmacy.
- Conduct provider site visits prior to the credentialing and recredentialing process to ensure compliance with regulatory standards

### III. HEDIS PERFORMANCE MEASURES

Annually HRI collects data to prepare a full set of HEDIS® (Health Plan Employer Data and Information Set) performance indicators. HEDIS® is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the health care quality.

HEDIS ® is also the measurement tool used by the nation's health plans to evaluate their performance in terms of clinical quality and customer service. The following is a list of the measures HRI collects annually:

#### **EFFECTIVENESS OF CARE**

- Childhood Immunizations Status – Hybrid
- Adolescent Immunization Status – Hybrid
- Appropriate Testing for Children with Pharyngitis
- Breast Cancer Screening
- Cervical Cancer Screening - Hybrid
- Chlamydia Screening in Women
- Controlling High Blood Pressure – Hybrid
- Beta-Blocker Treatment After a Heart Attack
- Cholesterol Management After Acute Cardiovascular Event
- Comprehensive Diabetes Care
- Use of Appropriate Medications for People with Asthma
- Follow-up After Hospitalization for Mental Illness
- Antidepressant Medication Management

#### **ACCESS/AVAILABILITY TO CARE**

- Adults' Access to Preventive/Ambulatory Health Services
- Children's and Adolescents' Access to Primary Care Practitioners
- Prenatal and Postpartum Care – Hybrid
- Annual Dental Visit

#### **SATISFACTION WITH THE EXPERIENCE OF CARE**

- CAHPS 3.0H Adult Survey

#### **HEALTH PLAN STABILITY**

- Practitioner Turnover

#### **USE OF SERVICES**

- Frequency of Ongoing Prenatal Care - Hybrid
- Well-Child Visits in the First 15-Months of Life - Hybrid
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care Visit

HRI prepares a full set of HEDIS ® measures annually via medical record review, administrative data, claims, pharmacy data, lab data and/or encounter data. We look to our providers to share patient care data to allow us to generate accurate reports. As part of this data collection process, we may request access to medical records and charts to abstract specific HEDIS® information.

#### **IV. GOVERNING BODY**

The Board of Directors (BOD) has the ultimate responsibility for the oversight of Health Right's QMP. The BOD will be held responsible for the following:

- a. For assuring our members optimal quality of all care delivered within all facilities that provide care to HRI members.
- b. To receive reports from the appropriate parties according to the organizational plan on the findings of the Quality Improvement (QM) activities.
- c. To respond definitively, if necessary, to fulfill their responsibility of adherence to the QM program.
- d. To delegate the authority and accountability for the QM program to the Director of Health Services/Quality.
- e. To stipulate that the Director of Health Services and the Associate Medical Director work together in a cooperative manner to create and maintain an effective QM program.

#### **V. QUALITY MANAGEMENT COMMITTEES**

HRI has three system-wide committees to monitor all processes that directly and indirectly impact the health and well being of HRI's members. The committees include the following: Quality Advisory Committee (QAC), Quality Management Committee (QMC) and Credentialing Committee (CC).

##### **A. Quality Advisory Committee (QAC)**

The QAC is a multi-disciplinary committee that includes both clinical and administrative personnel. Membership includes:

1. Chief Executive Officer – Health Right, Inc.
2. Medical Director/Associate Medical Director – Unity Health Care (Chair)

3. Health Service Director (Co-Chair)
4. Director of Quality Improvement
5. Departmental Directors (Information Systems, Marketing, Health Education, Chief of Staff)
6. Board Certified Physicians (Pediatricians, OB/GYN, Family Practitioners)

The Committee meets quarterly or more frequently as indicated. Attendance is monitored to ensure appropriate participation and coordination of departmental and interdepartmental activities. A quorum for the committee will consist of three providers and three staff members.

The QAC assesses and oversees the performance of HRI medical affairs to include credentialing, quality and utilization management. The QAC's responsibilities include:

1. Recommending to the BOD policies relating to providers, utilization management, credentialing and QMP findings.
2. Evaluating the credentials of all applicants and making recommendations to the BOD.
3. Monitoring and evaluating the credentialing process of contracted services.
4. Receiving reports of appeals and grievances concerning medical and mental health/substance abuse care and directing response if unresolved.
5. Reviewing, recommending and communicating standards of practice to contracted physicians.
6. Reviewing reports of pharmacy utilization, discussing and recommending formulary changes.
7. Assessing the care and service provided to members, practice patterns and outcomes of care to identify opportunities for improvement.
8. Determining priority areas and establishing studies by identifying high risk, high volume and/or problem prone areas.
9. Reviewing and analyzing results of studies and reports from the Health Services and Mental Health Department, Utilization Management and Quality Management Departments.
10. Reviewing and overseeing corrective action plans.
11. Reviewing medical content of marketing materials.

12. Evaluating the effectiveness of care through the review of established indicators.
13. Reviewing and authorizing annual changes and updates to HRI's policies and procedures.

## **B. Quality Management Committee (QMC)**

The QMC is a multi-departmental committee that includes both clinical and administrative personnel and is responsible for monitoring program resources and assigning special projects to augment the existing Quality Management Strategic Plan. Each of the department's directors and/or their designee is directly responsible for monitoring all tasks that directly impacts their functional areas. Membership includes:

1. Director of Health Services (Chair)
2. Asst. Medical Director
3. Director of Quality Management
4. Chief of Staff (oversees Credentialing and Provider Relations)
5. Senior Case Manager (oversees Utilization Management and Mental Health)
6. Mental Health Coordinator
7. Manager of Member Services
8. Other Staff Members (as required)

In addition, committee members are responsible for preparing and presenting a written summary and evaluation (monthly, quarterly and annually) of their department's quality improvement efforts/findings to the QAC and the BOD. These findings are compiled together and submitted as a system-wide Performance Improvement Report to the CEO, QAC and the BOD. All recommended actions made by the QAC or BOD are communicated back to HRI's QMC, subcommittees, staff, and members via corporate emails, committee/staff meetings, memos, and/or newsletters.

**SUBCOMMITTEES:** HRI currently has one (1) subcommittee that reports to the QMC. The subcommittee meets on a monthly basis and is comprised of key internal and external personnel. They include:

1. Credentialing Committee (monthly)

## **C. Credentialing Committee (CC)**

The CC is a multi-disciplinary committee that includes both networks providers and staff that are responsible for creating and maintaining a comprehensive approach to

monitoring the credentialing, re-credentialing processes; and overseeing HRI's Credentialing Program. Membership includes:

1. Chief Medical Director/Associate Medical Director – Unity Health Care (Chair)
2. Director of Health Service
3. Board Certified Physicians (Psychiatrist, Family Practitioner, Pediatrician)
4. Credentialing Coordinator

The Committee meets monthly (or more frequently) as indicated and is evaluated annually. Attendance is monitored to ensure appropriate participation and coordination of departmental and interdepartmental activities. A quorum for the committee will consist of three providers and one staff member. The CC's responsibilities include, but are not limited to:

1. Developing, modifying, reviewing and approving credentialing and recredentialing policies and procedures.
2. Recommending to the QMC policies relating providers, credentialing and recredentialing
3. Evaluating the credentials of all applicants and making recommendations to the Quality Management Committee.
4. Monitoring and evaluating the credentialing process of contracted services.
5. Developing, implementing and evaluating corrective action plans based on monitoring activities.

As the Chair, the Chief Medical Officer/Asst. Medical Director (in conjunction with the Director of Health Services) is responsible for providing the CEO and the CC with a schedule of planned activities. The outcomes of these activities are reported to the CEO, QMC, QAC and BOD at least quarterly. Reports include actions taken, number of providers credentialed and re-credentialed, recommendations and improvements made. Quarterly and annual written summary/evaluation of the Credentialing Committee findings/recommendations are presented to the Quality Management Committee and prepared by the CEO and/or her designee for presentation to the BOD.

The scope and content of HRI's Credentialing Committee Plan Activities involves a comprehensive approach to credentialing and re-credentialing. At a minimum, the credentialing process obtains and reviews verifications of the following:

1. A current valid license to practice

2. A valid DEA or CDS certificate, if applicable,
3. Graduated from medical school and completed a residency or post graduate training as applicable,
4. Work history,
5. Professional and liability claims history,
6. Current adequate malpractice insurance according to HRI's policy, and
7. Good standing of clinical privileges at the hospital designated by the practitioner as the primary admitting facility.

At a minimum, the re-credentialing process obtains and reviews verification of the following:

1. Re-verification of hospital privileges
2. Current licensure
3. Insurance liability
4. A valid DEA or SDS certificate, if applicable

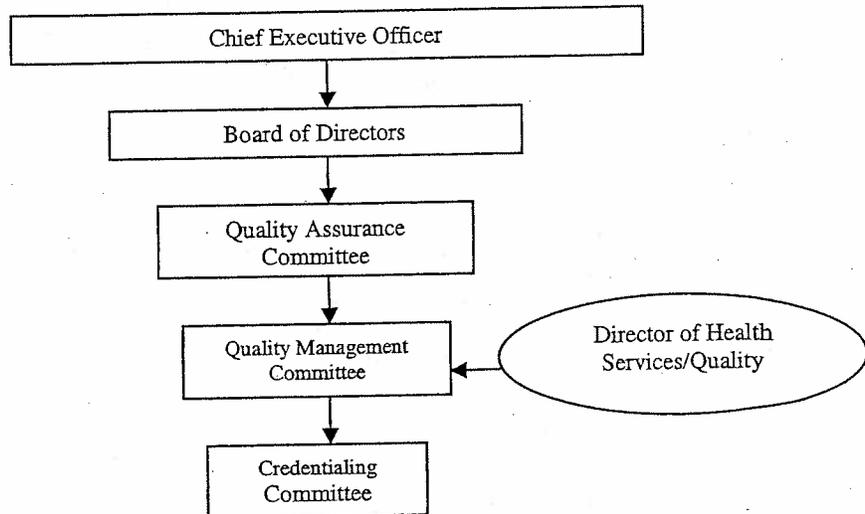
In addition, the re-credentialing reviews include ongoing monitoring and evaluations in performances related to:

1. Member complaints and grievance reviews
2. Results of quality/peer reviews
3. Results of utilization management
4. Member satisfaction surveys
5. Provider satisfaction surveys
6. Peer reviews
7. Encounter claims data
8. Performance appraisals
9. Medical Record Reviews

Complete and accurate minutes are prepared and maintained for each CC meeting. The minutes include the date and duration of the meeting, members and staff present and absent, and the names of guests. The minutes record actions, recommendations, and tracking status of prior unresolved decisions. Individual provider decision reports along with the appropriate verifications are prepared and maintained in each providers file. These reports along with recommended actions are presented to the QMC and BOD at least quarterly.

## **VI. QUALITY MANAGEMENT PROGRAM SUPERVISION**

Below is a chart summarization of the QMP oversight.



**VII. RESOURCES**

Quality is an integral part of Health Right Inc. Each department within HRI has its own departmental quality initiatives, coordinated and overseen by the Quality Management Program. Monthly, quarterly and annual reports are submitted to the QMC, QAC and BOD and evaluated to ensure departmental goals are being meet and documented improvements are being seen by the increase in quality of care our members receive.

**VIII. PROVIDER RESOURCES**

**A. Provider Satisfaction Survey**

HRI conducts a Provider Satisfaction Survey annually. The purpose of the survey is to obtain feedback from providers on the effectiveness of services that are being provided. Monitoring the feedback enables HRI to develop and implement strategies that will improve provider satisfaction, retention, and growth. HRI conducted its annual Provider Satisfaction Survey from September 19, 2005 through October 7, 2005. The comprehensive questionnaire contained thirteen questions, eleven of which respondents were asked to answer Yes, No or N/A. The remaining two questions were used to allow for written feedback and suggestions from the providers.

The below chart annotates the questions presented in the survey for the past four years.

Question
----------

1. Are your calls answered promptly?
2. Are your inquiries answered adequately?
3. Are you treated courteously?
4. Do you feel you and your staff are adequately trained on HRI policies?
5. Do you feel you have adequate access to our Medical Director?
6. Would you be interested in obtaining CEU's if made available?
7. Did HRI provide adequate opportunities for provider orientations?
8. Does HRI have varied/adequate numbers of specialist providers in its network?
9. Has the list of specialists become more accessible and/or improved since last year?
10. Do you have adequate support in making referrals to HRI providers?
11. Has HRI's referral system improved since last year?

**B. Provider Network**

HRI is responsible for maintaining a network of physicians, hospitals, and other health providers through whom it provides the services that are included in covered benefits that comply with the contractual obligations set by DC MAA. This network shall include an adequate number of PCPs and specialists appropriately credentialed as health professionals located in geographically and physically accessible locations to meet the access standards specified in the contract. On a quarterly basis, HRI conducts an accessibility analysis to ensure compliance with these set standards. Located in the Appendices you will find GeoAccess reports identifying the number of PCPs within 30 minutes of HRI members,

pharmacies within 30 minutes of HRI members, and Dental providers within 30 minutes of members.

### **C. Provider Outreach Activities**

Outreach to health care professionals is an important component in assuring patient safety. HRI's provider relations coordinator makes frequent visits to the various providers' offices on a regular basis, establishing good relationships with his/her office staff, providing materials, making presentations and answering questions. On occasions, HRI has taken the office staff goodies as well as restocking their brochures and pamphlets. Additionally, we give framed language posters to all Health Check providers to display in their offices. What have we learned is never forget office staff! The Provider Relations Coordinator Invites himself to any meetings of office managers that take place as an opportunity to remind them of information given and quick updates. We also ensure that office staff are aware of the contact person at HRI and phone number, should they have questions or comments.

## **IX. CREDENTIALING AND RECREDENTIALING**

The appropriate and regular credentialing and recredentialing of network practitioners and providers, as defined by HRI policies and procedures is a key function of both the CC and the QMP. All practitioners participating within HRI's network undergo a review of their qualifications, including education and training, licensure status, board certification, malpractice history, etc. All practitioners undergoing initial credentialing and recredentialing are reviewed and approved by the CC. Credentialing and recredentialing activities, minutes and documents are considered privileged and confidential under state and federal laws.

Currently recredentialing is performed on a biannual basis, but once HRI is NCQA Accredited the goal is to perform this task on a triennial basis, or more frequently, as required by DC MAA. To ensure quality and safety of care between recredentialing cycles, the health plan performance ongoing monitoring of practitioners adverse events, sanctions and complaints. On the first of every month, the Credentialing Coordinator accesses the Office of the Inspector General (OIG) at [www.hhs.gov.com](http://www.hhs.gov.com). The Credentialing Coordinator will pull the previous month's exclusion listing; review that listing for any providers that are credentialed by HRI. If a credentialed HRI provider is on the report, the Credentialing Coordinator will submit this information to the CC for further directives.

Practitioner-specific complaints are reviewed on a monthly basis by the Credentialing Coordinator. Once the log is reviewed for any providers that are with HRI, the Credentialing Coordinator will submit to the Credentialing Committee for further

directives. A copy of the complaint is placed in the providers file. An investigation is completed that includes an evaluation of both the specific complaint and the practitioners' history of issues, if applicable. If a practitioner is identified on both a sanctions report, or there is evidence of poor quality, the practitioner's ability to provide services will be reviewed and assessed by the Credentialing Committee and possible actions will be taken.

The blow charts are a detailed account of HRI's internal and external credentialing/recredentialing activities for 2003, 2004 and 2005.

## **X. MEMBER RIGHTS AND RESPONSIBILITIES**

Member satisfaction is assessed through evaluation of member surveys', member concerns and appeal information. Member satisfaction surveys and routine monitoring indicators are designed to measure HRI's performance and to assess member satisfaction with the plans' services. Members' surveyed data are used for continuous quality improvement in several key areas: to establish benchmarks and monitor local health plan performance, to assess overall levels of satisfaction as an indication of whether HRI is meeting customer expectations, and to assess service performance in comparison to competitors. Members and providers are informed of survey results and may be consulted for input.

The Myers Group, an NCQA-Certified HEDIS® Survey Vendor, was selected by HRI to conduct its 2005 Consumer Assessment of Health Plans (CAHPS® 3.0h) Medicaid Adult Member Satisfaction Survey. Using a mixed (mail and telephone) Survey Administration Methodology (following NCQA protocol), The Myers Group collected 310 responses from the eligible member population from June through July of 2005, yielding a response rate of 24.0%. Information obtained from the member's surveys allows HRI to measure how well the plan is meeting the members' expectations and needs. Based on the data collected, this report summarizes the results, assists in identifying member satisfaction strengths and opportunities, and aids in assessing NCQA accreditation standings.

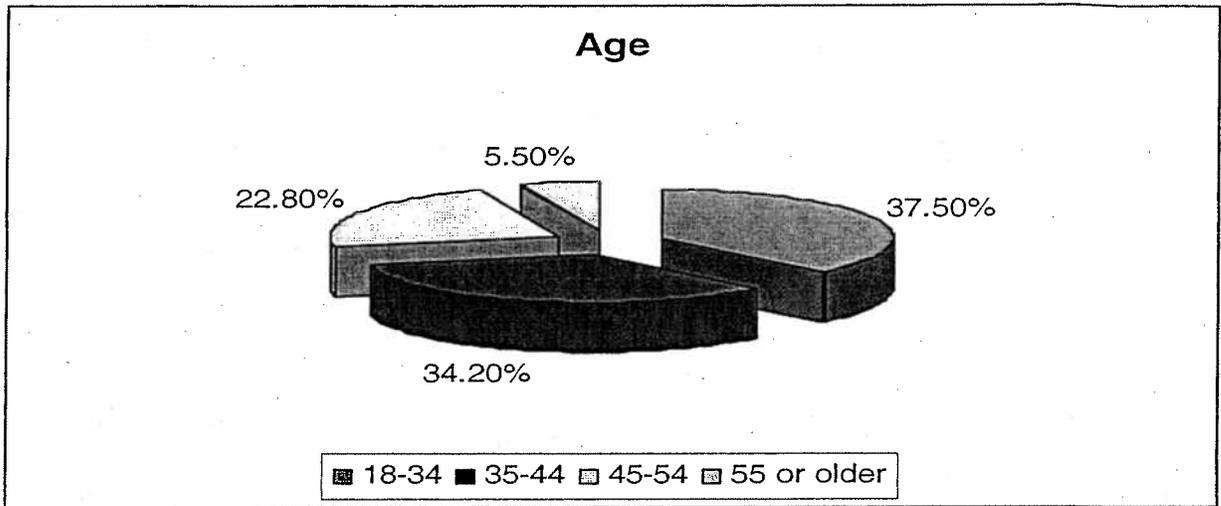
The table below shows the total number of members in the sample that fell into each of the various disposition categories. Depending upon the survey protocol, some of the groupings below may not apply:

<b>Disposition Group</b>	<b>Disposition Category</b>	<b>N</b>
	Deceased	2
	Does not meet criteria	17

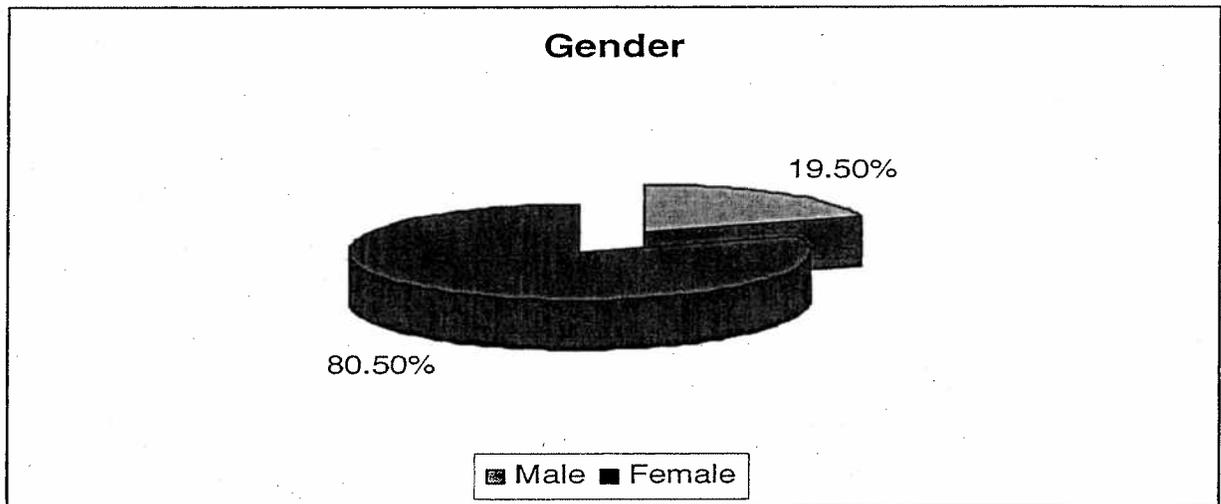
Ineligible	Language barrier	34
	Mentally/physically incapacitated	4
	<b>Total Ineligible</b>	<b>57</b>
Non-response	Bad address/phone	177
	Incomplete	22
	Refusal	35
	Maximum attempts made	749
	<b>Total Non-response</b>	<b>983</b>

Table 1: Depicts Ineligibles and Non-responders with disposition for CAHPS Survey

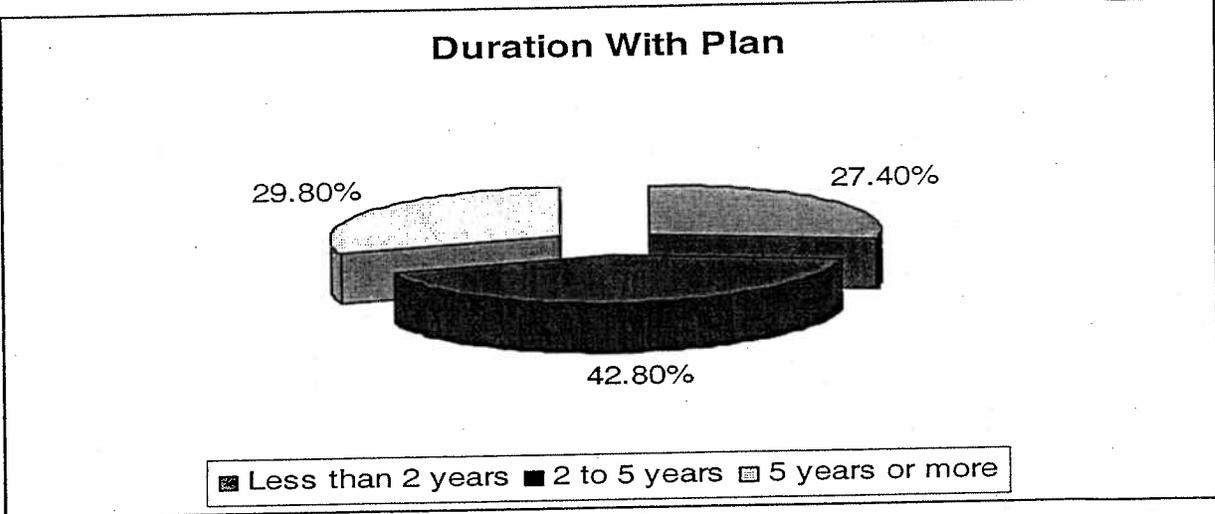
### Survey Demographic Comparisons



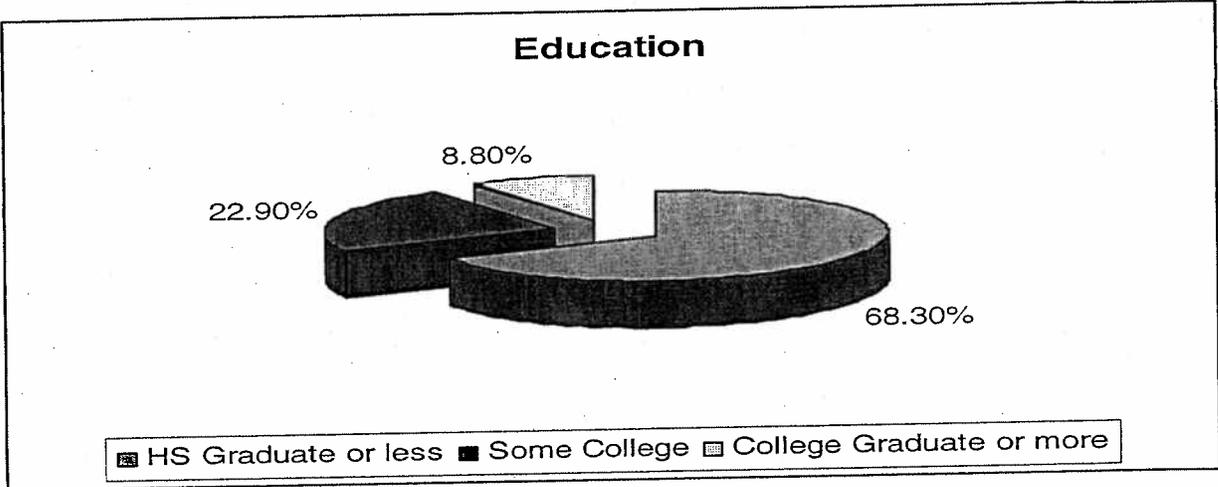
**Table i:** Breakdown by Age of responders to CAHPS Survey



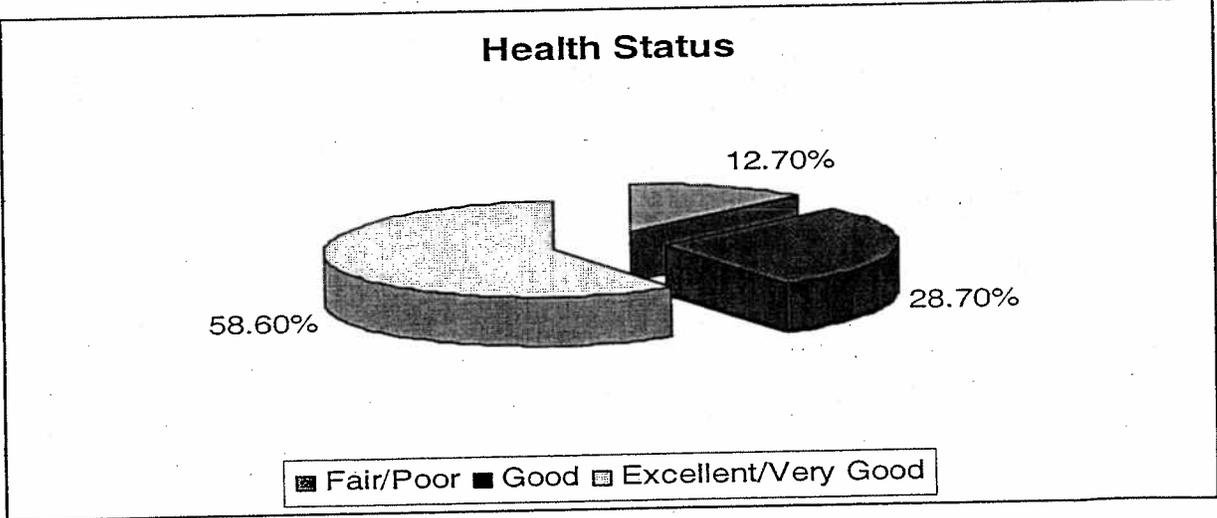
**Table ii:** Breakdown of Gender for responders to CAHPS Survey



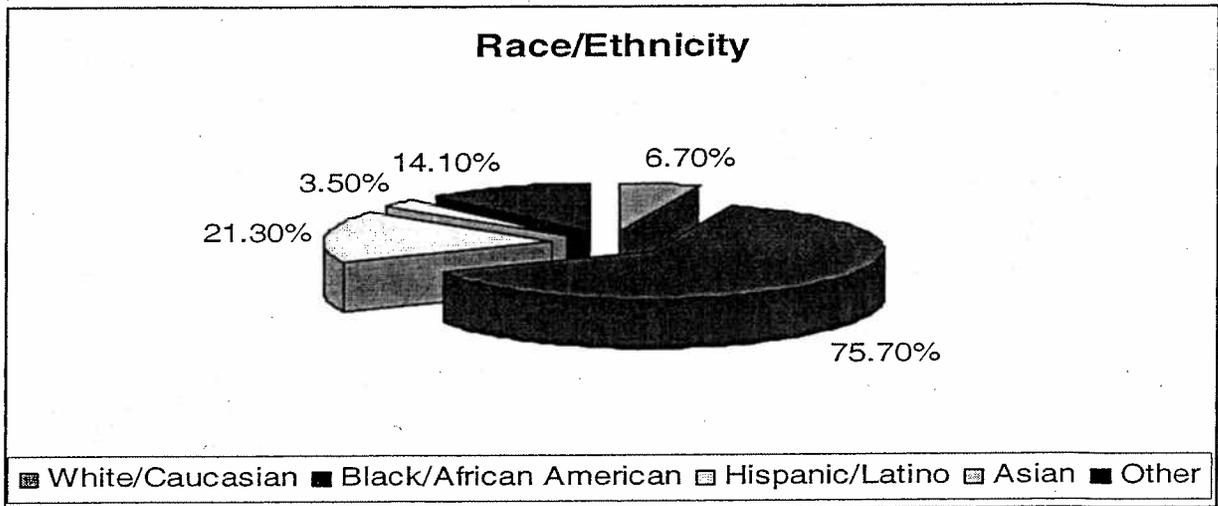
**Table iii:** Breakdown of Duration with Plan for responders to CAHPS Survey



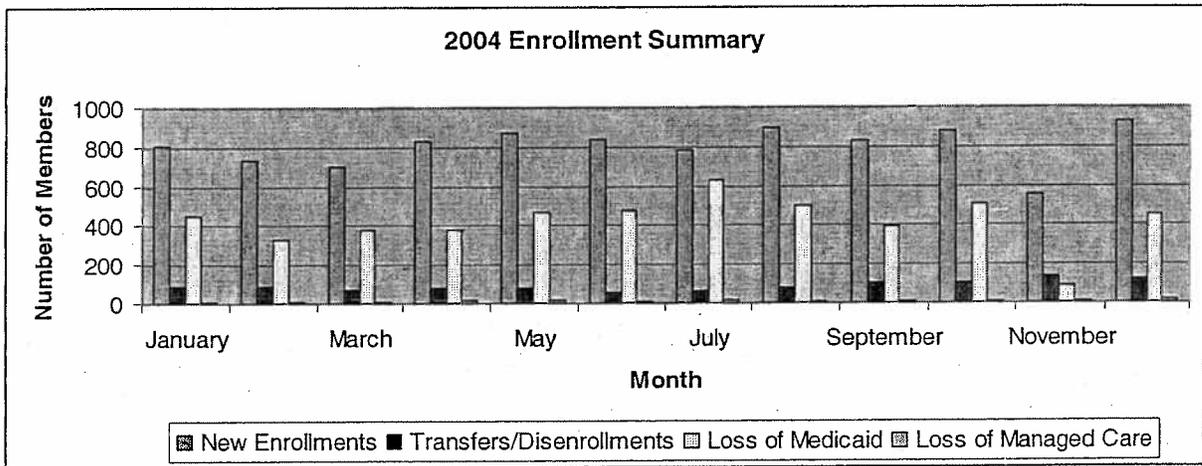
**Table IV:** Breakdown of Education for responders to CAHPS Survey

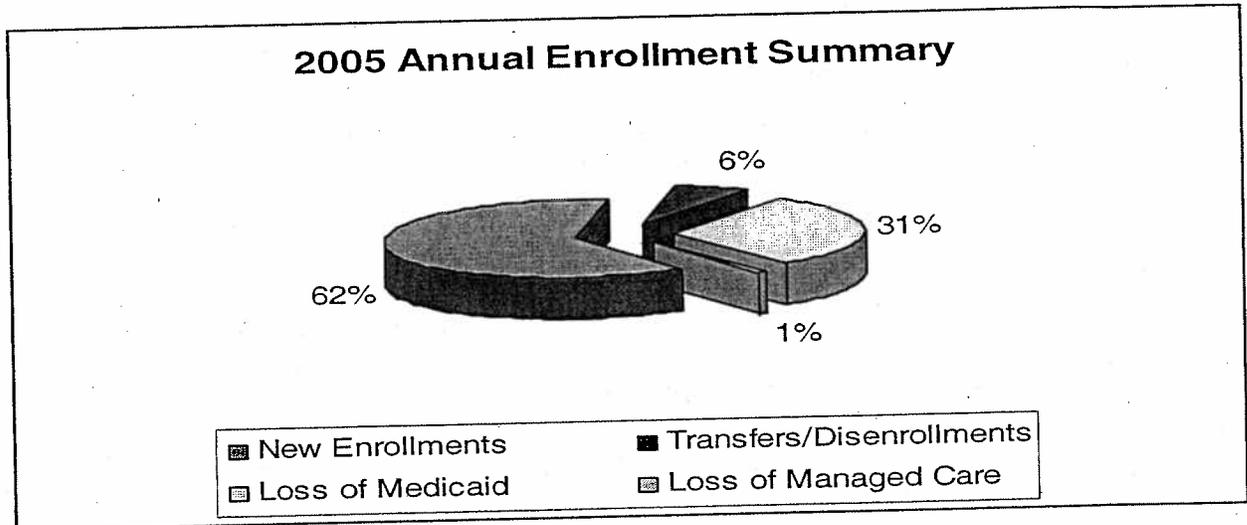
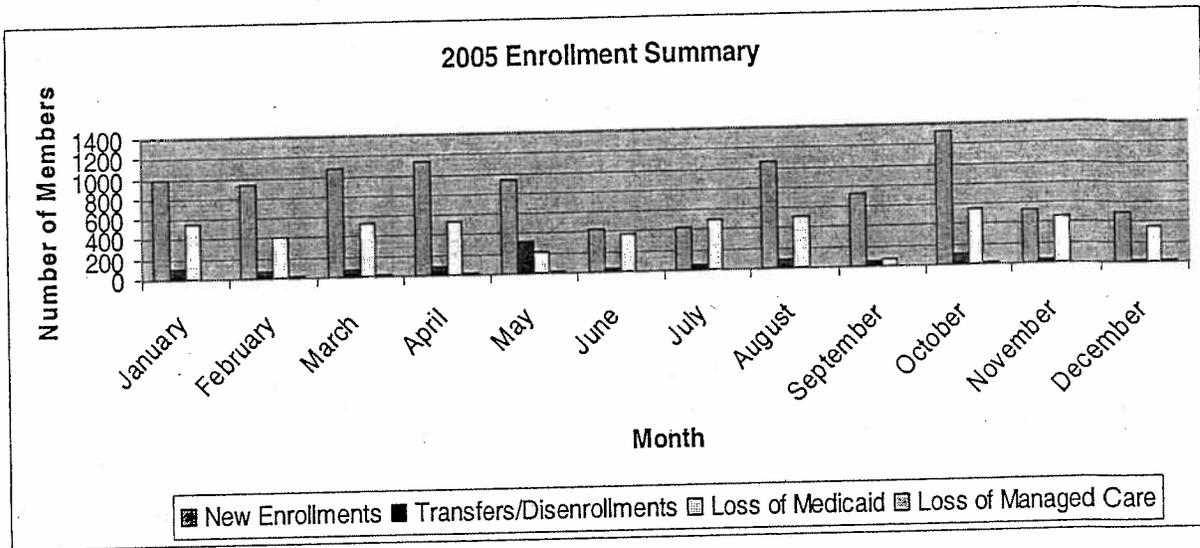


**Table v:** Breakdown of Health Status for responders to CAHPS Survey



**Table VI:** Breakdown of Race/Ethnicity for responders to CAHPS Survey





Outreach staff conducted a random Disenrollment Survey with members who had transferred to a different MCO between 2004 and 2005. Outreach staff attempted to contact 506 members. Of the 506 phone numbers called, 160 attempts resulted in disconnected, non-published, hang ups or wrong numbers. There were 94 no answers, 106 left messages and 9 phones busy. A total of 94 members were successfully contacted and were included in the survey. The question posed was "Why did you transfer to another provider (MCO)."

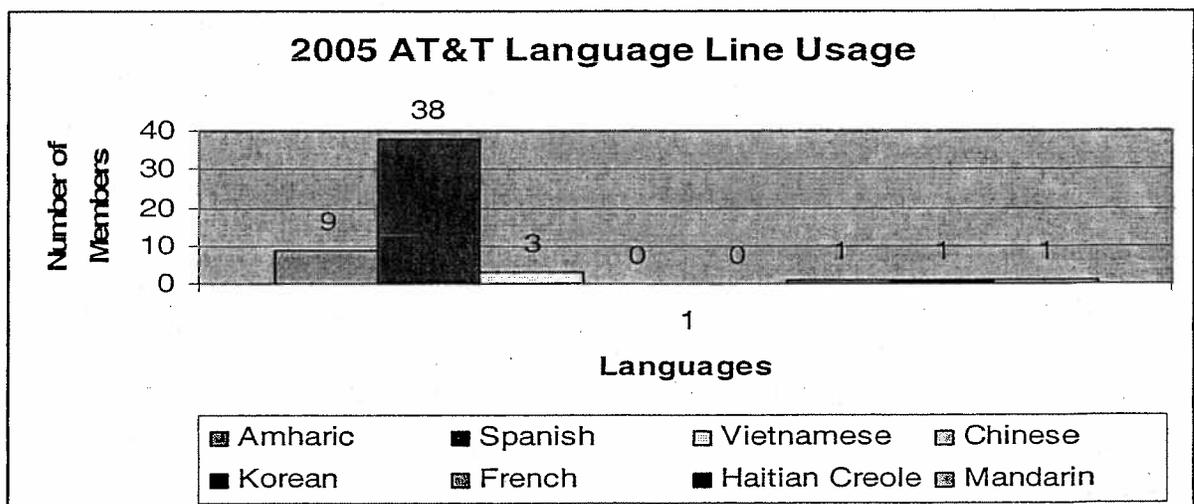
The following recommendations were made as a result of the outcomes from the survey:

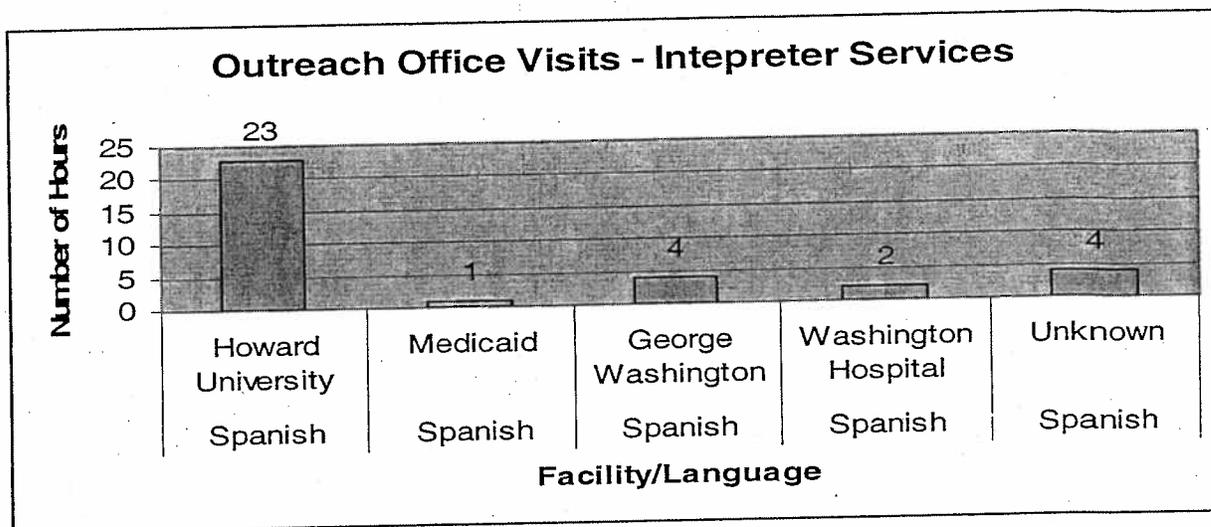
- Sixteen members wanted to continue with HRI once Outreach staff provided education to members on what to do in the following situations:
  - When you receive a bill

- Are not satisfied with services rendered
- What to do to make your voice heard (i.e. becoming a member of HRI Medicaid Advisory Committee, calling customer service.)
- Increase the number of providers in HRI's network
- Ensure the Resource Workers, whom are stationed in the various clinics about member orientation and to also assist members with any concerns
- Continue to conduct random surveys with members who make a decision to leave the plan as a way to monitor trends

## XI. AVAILABILITY AND ACCESSIBILITY

The inability of health care professionals and patients to communicate with each other because of language differences constitutes a barrier to receipt of services. This measure is used as an indication where persons seeking health care or information on how to use health care services may be confronted with a linguistic barrier. The overall purpose of the accessibility and availability analysis is to determine to what extent HRI members have access to health care services. Specifically, to provide a measurement tool allowing HRI to monitor our individual members access to necessary medical and behavioral health treatment. AT&T Language Line report from HRI's Customer Service department was used to monitor access to informational services for members who were non-English speaking and/or hearing impaired. HRI exceeds this standard by having the AT&T Language Line and the TTY line available for 100 percent of our members who are non-English speaking. The below two charts give an overview of the AT&T Language Line usage and Interpreter Services usage.





**XII. MEDICAL RECORDS**

HRI contracted providers are responsible for the maintenance of original copies of medical records. In compliance with current laws and regulations of the District, medical records are confidential. HRI employees may not access these copies of enrollees' medical records unless there is a valid reason approved by the Chief Medical Officer or the Health Services Director. HRI has policies and procedures governing the practices of medical records maintenance, handling and reviewing. The Health Services Director determines which physicians require review and assigns staff to perform the review. All providers are given a copy of the required contents in the medical record in the Provider Manual as well as being oriented to the standards at the time of enrollment. Adherence to the standards is measured on a quarterly basis. The outcome of the Medical Record Contents Audit is reported to HRI's Chief Medical Officer and the QMC. Recommendations and corrective actions plans (CAPs) are approved by HRI's Chief Medical Officer and the QMC. The Chief Medical Officer or her designee will report audit outcomes and discuss the CAP with providers who fail to meet documentation standards. Provider records will be reviewed again in 45 to 90 days to ensure medical record documentation compliance.

Services to Health Right, Inc members provided by non-plan providers may also be included in the medical record review. Such services include but are not limited to Family Planning services and service for the treatment of sexually transmitted diseases. The PCP will be responsible for reviewing and initialing the medical information prior to the PCP office staff filing the medical information in the member's medical record. Any reports or consultations which may have been inadvertently sent to Health Right, Inc

(HRI) will be sent to the office of the enrollees' PCP. If the enrollee contacts non-plan providers directly, the member will be asked to contact the provider to request that a copy of his/her consultation report be forwarded to his/her PCP. HRI will conduct quarterly medical record audits to ensure that medical information for non-plan providers are initialed and filed in the member's medical record. HRI's audit will also focus implementation of medical follow-up when appropriate, and compliance with established medical standards.

Chart analysis shall be completed to assure compliance with established policies. Each contracting provider must maintain an adequate medical record for each enrolled member assigned. Quality Management Department shall review the medical record for completeness. This analysis should include that the records comply with policies and standards established by HRI, as well as, various accrediting bodies, and licensing and certifying agencies. All providers shall have a minimum of five records reviewed prior to recredentialing if possible. At least one month prior to recredentialing the Credentialing Department shall send a list of physicians who appointment needs renewal to the CC and QMC. A random sample of medical records based upon volume but no more than three records or less than one will be requested by the Director of Health Services for review. The Health Service Director or her designee will review the chart for specific points. Charts which have not meet HRI standards will be taken to the Chief Medical Officer for physician review. The Clinical Pertinence Review Form (Medical Records Audit Forms) will be completed by the reviewing physician. Results will be sent to the Credentialing and Quality Management Departments for inclusion in materials to be reviewed by the Credentialing Committee and QMC to establish standard of performance for recredentialing. HRI staff will check for omissions, discrepancies and lack of signatures or reports in the medical records. All entries must be legible. If a record cannot be read by one professional reviewer, it will be given to a second. If neither can read the record, it will be determined illegible, recorded as a quality defect and referred back to the provider for clarification. The outcome of the medical record chart analysis will be reported to the QMC.

### **XIII. UTILIZATION MANAGEMENT REVIEW**

As evidenced by Health Right's top five diagnoses encounter information, the majority of our services are provided to women, infants and children. This is in congruency with the needs of our population base analysis. Data has shown that the

average HRI member is twenty-two years of age. The infant mortality rate for the District has shown a marked decrease. This may be attributed to the aggressive supervision of pregnant women in managed care organizations. As well, as a result of our EPSDT efforts immunization rates and screening rates for infant/child have reached an all-time high for HRI. As expected general health care was also an area of high utilization for HRI members. Another area which entailed a high encounter rate for HRI was Human Immunodeficiency virus (HIV). Data reveals that HIV medications were number one in total utilized prescription cost for our health plan during the CY 2005. The following two graphs address the top five diagnoses, costs and encounters.

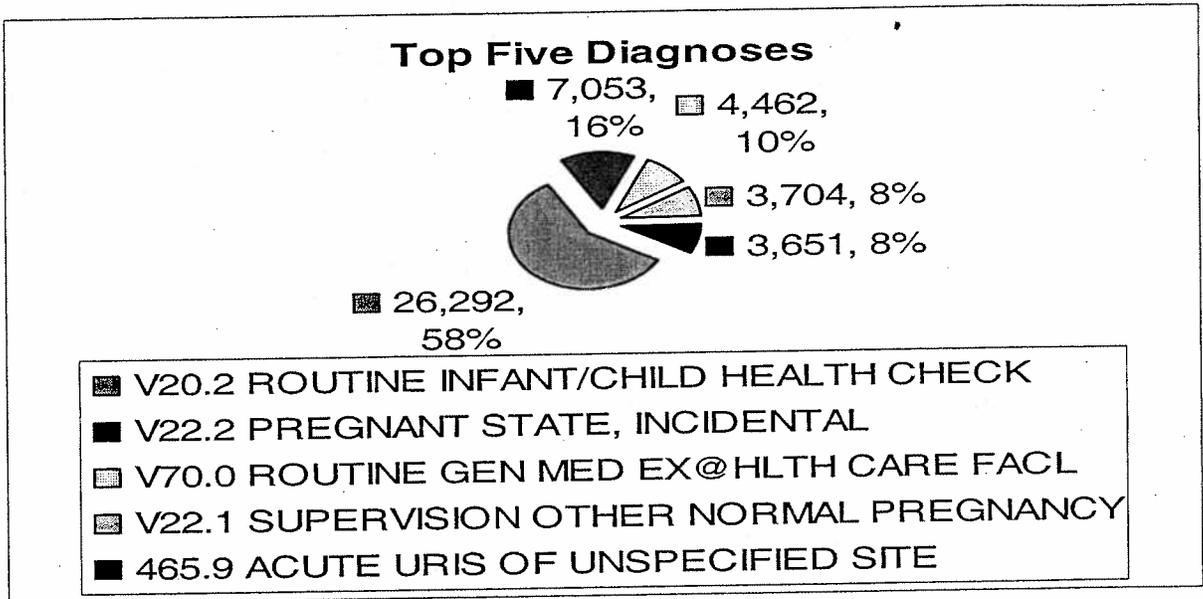


Table 1: Top Five Diagnoses with number of encounters

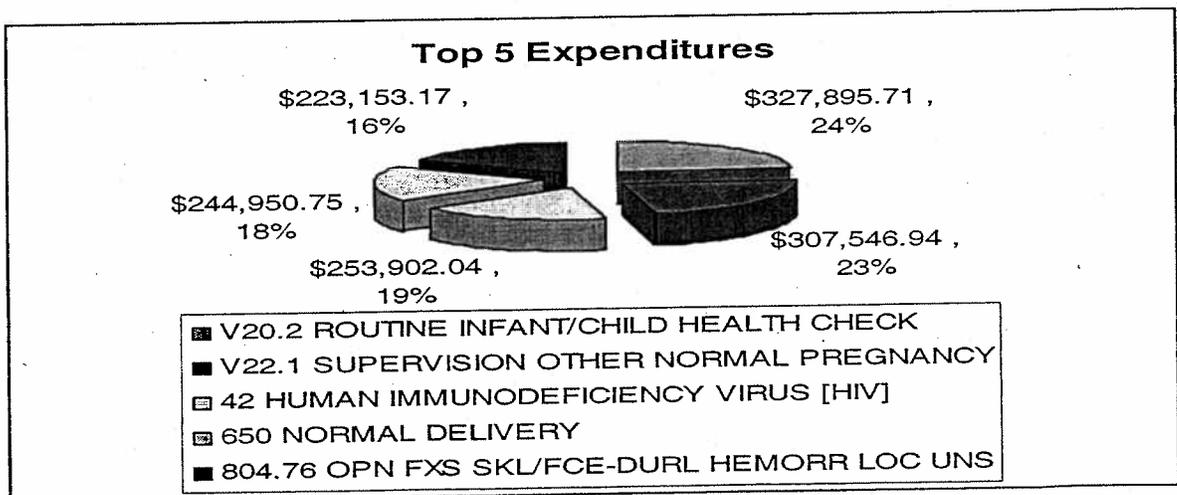


Table 2: Top Five Cost

In order to review/improve standards and promote epidemiological outcomes HRI has:

1. *Established standards and indices of performance*

In establishing standards of performance, HRI has provided a firm foundation for the pursuit of excellence by declaring its intent to pursue accreditation by the National Committee for Quality Assurance (NCQA), which has developed performance standards and measurements called HEDIS (Health Plan Employer Data and Information Set).

The NCQA has established more than 50 rigorous standards in the following areas: quality management and improvement, utilization management, credentialing and recredentialing, member rights and responsibilities, preventive health services, and medical records. When evaluating objective measures, HEDIS looks at effectiveness of care, such as immunization rates and the percentage of low birth weight babies. They review access and availability, for example, what percentage of children receives primary care? They examine the use of services, such as the frequency of selected procedures. Lastly, they analyze the cost of care by evaluating rate trends.

2. *Developed a pliable network in order to enhance access and availability.*

Health care delivery systems can determine the number of primary care physicians and specialists they need, the best location for facilities, the most convenient office hours, and the optimal approach to scheduling based on the science of access and availability.

Therefore, HRI utilizes Geo-Access mapping software that matches member population by zip code with a list of health care providers, showing how convenient a particular provider/facility would be to a specific member.

### *3. Instituted practice guidelines*

Health Right has adopted and instituted practice guidelines that have been developed by nationally respected professional societies and non-profit organizations, as well as health-related divisions of the federal government. These practice guidelines, or algorithms, provide a framework of appropriate treatments and services for patients who fall into certain categories by clinical condition or diagnosis. Guidelines are reviewed by network experts and participant providers to allow for some local or regional modification and then disseminated throughout provider networks. Implementing clinical guidelines has been supported by using clinical leadership endorsement, tying clinical guidelines to utilization management, and building disease management programming.

### *4. Pushed for outcomes measurement*

HRI has sought to measure outcomes to better understand the value of dollars spent. To accomplish this goal, data warehousing has been initiated, and applied to health care information. This provides the plan with the ability to assess and provide report cards on its performance compared to peers and offered remarkable opportunities in quality improvement.

## **XIV. CONTINUITY OF CARE**

To enhance continuous and appropriate care for members, and to strengthen industry-wide continuity among medical and between medical and behavioral healthcare, HRI monitors continuity and coordination of care among primary, specialty, and behavioral health care practitioners. HRI's Care Coordination Unit Goals include:

- Improvement in clinical outcomes
- Improvement in functional outcomes
- Improvement in quality of life
- Reduction of healthcare utilization and costs
- Increase in patient/member satisfaction
- Increase in provider satisfaction
- Improved compliance with current NCQA, and HEDIS requirements

### **HRI's Care Coordination Unit Services and Interventions:**

- Routine Care Management Follow-up

- Targeted Intensive Case Management
- Behavioral Health Management
- Coordination with Medical Disease Management

**New HRI Care Coordination Initiatives include:**

*Early maternity management:* Recognizing better outcomes based on earlier maternity management, managed HRI has worked to initiate maternity care within the first trimester of pregnancy. As a consequence, more and more pregnant women are seeking care in the first trimester of their pregnancy. Comprehensive maternity management programs were originally implemented to reduce premature and low birth weight amongst infants, as well as to reduce the cost for care. Maternity management programs identify, in a systematic fashion, pregnancies that are deemed to be high.

*Mental Health Inpatient Post-Hospitalization Follow up after discharge:* Behavioral health coordinators are responsible for ensuring that appropriate discharge planning has occurred with our facilities. This involves Psychiatric discharge follow-up services on all members discharged from inpatient psychiatric facilities. Care Coordination staff contact providers and/or members to verify that a follow-up appointment has been made and kept. Care Coordination Unit staff identify any obstacles to members keeping follow-up appointments and make every effort to facilitate those appointments. A note is then made in the member's electronic chart to document whether the appointment was kept, when it was kept, or why it was not kept.

*Coordination with Medical Disease Management:* HRI currently offers prevention and follow-up education to specific targeted populations within our health plan members. HRI's epidemiological research and population health analysis resulted in the conclusion that for reasons of diagnostic frequency, cost, and risk, certain targeted diseases and disorders would be good candidates for a disease management approach. These are chronic, recurring disorders in which a focus on prevention is likely to benefit both the patient's quality of life and the health plan's cost of care. These chronic disorders targeted by HRI include:

- Diabetes

- Hypertension
- Asthma
- Epilepsy

Patients are identified with these diagnoses through screenings or through hospitalizations. Those patients who enroll are called regularly by staff, which monitor progress, encourage compliance and provide written and verbal information and education. HRI believes that the right information, consistently and clearly provided, can help patients improve their management of their diseases and improve their lifestyles in order to prevent relapse and readmission.

In addition to these diagnosis-specific programs, HRI has developed a trigger list aimed at identifying and targeting individual high risk, high cost cases and applying intensive and extended management techniques in order to reduce recidivism and improve outcomes. Readmission to higher levels of care is one of the screening criteria for the program. Cases are referred by Utilization coordinators and providers and are carefully screened by the program's staff. The goals of the HRI's Case Management/Care Coordination program are to help develop and engage the patient's support system, to supplement it with community-based "wrap around services" and to ensure that the appropriate services are in place. The staff is responsible for monitoring coordination of care and patient compliance. The staff conducts a health status check, verify that the patient is at the proper level of care, coordinate care among multiple providers and the patient's support network, remove any roadblocks or obstacles to treatment, verify patient compliance with treatment, including medications, and verify that the patient is continuing in follow-up care.

## **XV. QUALITY MANAGEMENT PROGRAM DOCUMENTATION**

Health Right Incorporated's (HRI) information system capabilities can be broadly categorized into three functional aspects: (1) claims processing, (2) reporting/data analysis, and (3) monitoring. All three components when taken in sum total constitute an integrated business information and data system, which allow staff to comply with District Medicaid contract standards and fulfill specified duties as it relates to the operation of a health plan. This system is electronically based in a networked PC environment, and utilizes various software packages to supplement and/or support the functional aspects. In general, the

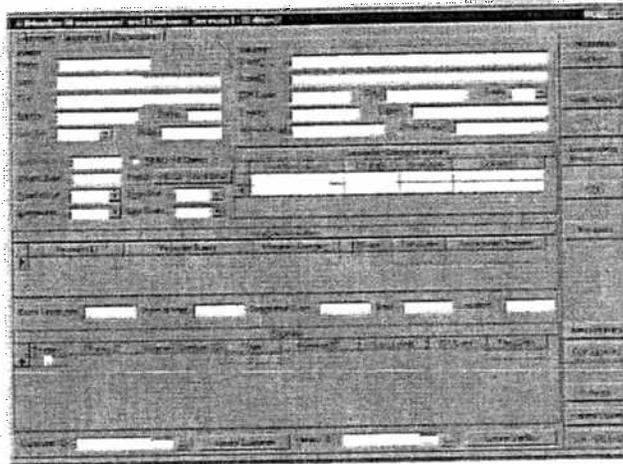
various components that make up HRI's integrated data system allow for the transformation of 'raw' data into useable information for the purposes of both analysis and decision-making. Overall, HRI's MIS meets the functional and operational criteria set forth in section C.12 of its contract with the District's Medicaid 1932(a) waiver program.

The following is a more detailed description of the system's components:

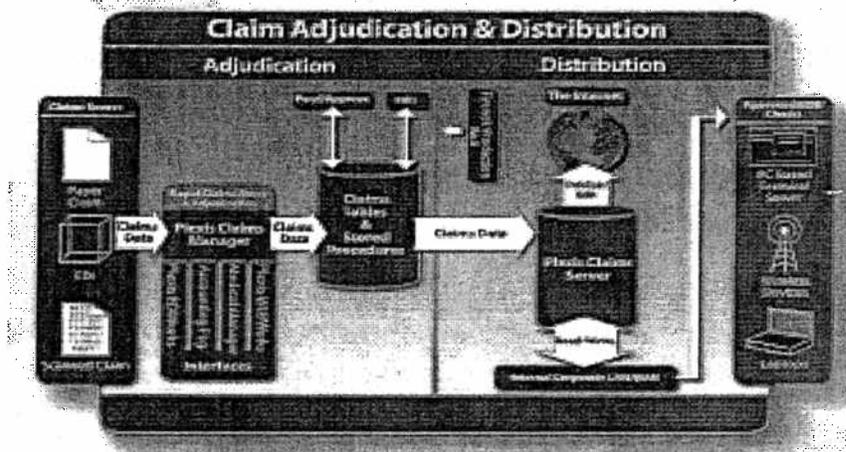
## I. CLAIMS PROCESSING

### A. PROFESSIONAL AND INSTITUTIONAL CLAIMS

Claims processing accounts for all electronic based transactions that are mostly related to payment of claims. Health Right has undergone a successful transition of its claims management system, moving from CSC's PowerStepp platform to a more reliable Microsoft SQL Server based system developed within the latest .NET and XML framework. Plexis Claims Manager (PCM) was developed by PLEXIS Healthcare Systems and is an integrated healthcare information system providing complete benefit administration, medical and dental claim processing, and reporting features programmed specifically to meet the needs of HRI business processes. Claim processing and auto adjudication is accomplished by entering claim-processing data on a single screen (see below sample screen shot).



Pertinent payment information such as provider details and recipient eligibility have been thoroughly integrated and easily accessed by claims processing staff. Claims flow seamlessly from batch entry to final preparation for payment. PCM delivers an acceptable auto-adjudication rate. The following is the basic claims information flow standard to Plexis PCM:



PCM integrates benefit administration, claim processing and reporting functions. Also, it allows for premium billing and referral authorizations. Accumulators and custom reports in Plexis using a rules-based engine makes it efficient to change processes and respond to trends and Medicaid program adjustments. PCM provides powerful automated reporting tools that allow appropriate HRI staff to query any information in the database, extract data with any ODBC-compliant software, and create standard or custom reports on any data in the claim processing or benefit administration process. Reporting features include forecasting, trend and cost benefit analyses. Finally, as the primary conduit of operational data (provider, member, and claims transaction history), Plexis PCM is the cornerstone for HRI information systems and a majority of information is managed through this process.

## **B. DENTAL, VISION AND PHARMACY CLAIMS**

Health Right's dental and vision claims are processed through a contracted vendor, QPA. HRI networked dental and vision providers are paid from that system, but closely monitored by HRI. That claims information is provided to HRI electronically and only uploaded to various reporting systems on a monthly basis. Similarly, a contracted pharmacy benefit manager, PharmaCare, processes the pharmacy claims and service information.

## **C. REPORTING AND VALUE ADDED FUNCTIONS**

Additionally, PLEXIS PCM has integrated components that allow for basic analysis all based on claims processing through the development of 'canned' reports and use of

basic analysis components integrated into the software. These value added functions allow the various HRI business units to tailor analysis specific to their program areas and has become critically integrated in the day-to-day operations of each business area. This includes, but is not solely limited to, member benefits administration, provider network update and analysis, outcome measurement, care management (referrals and authorizations) and utilization review, and financial accounting.

## *II. REPORTING AND DATA ANALYSIS*

Aside from the aforementioned PLEXIS PCM system, HRI employs several PC based reporting tools to aid in research and analysis. Under the guidance and auspices of the Director of Information Services, a range of data-related software and propriety databases are used for both routine and ad-hoc reporting. The following is a listing of the most pertinent data tools:

### **A. HRI DATA WAREHOUSE**

HRI has developed a comprehensive data warehouse using the Microsoft SQL server platform. Just as most data warehouses, HRI's SQL server warehouse is composed of two inter-related components: (1) the files holding the physical database (as seen through tables) and the database management system (DBMS) software that applications use to access data. The DBMS is responsible for enforcing the database structure, including:

- ✓ Maintaining the relationships between data in the database.
- ✓ Ensuring that data is stored correctly and that the rules defining data relationships are not violated.
- ✓ Recovering all data to a point of known consistency in case of system failures.

To work with data in a database, HRI technical staff uses a set of commands and statements (language) defined by the DBMS software. There are several different languages that can be used with relational databases; the most common is SQL. HRI has a development team

consisting of a DBA and the Director of Information Services. The tables or raw data for the data warehouse is primarily derived from the PLEXIS claims processing system. Report and information analysis can be performed in a multitude of ways, static or canned reports (e.g., claim inquiries and membership counts) using various report packages such as Crystal reports and Access to develop specific report requirements.

## **B. GEOCODER AND GEONETWORKS**

This software developed by Ingenix Corporation. The GeoNetworks software is the industry standard for analyzing service accessibility in the managed care arena. GeoNetworks combines a Windows GUI interface with sophisticated analytical capabilities. With it, HRI produces presentation-quality maps, graphs and tabular reports to determine network adequacy and accessibility (see attached reports). GeoCoder is an associated program, which converts raw data into geocoded data for use with GeoNetworks. Specifically, HRI employs this application to analyze provider network metrics such as access to care, availability of care, and network composition.

## **C. HRI EPSDT TRACKING**

Developed internally this Access database utilizes tables generated by HRI's data warehouse to analyze EPDST-related information. Member eligibility and service information is integrated from PLEXIS PCM, and enhanced from other data sources such as the DC DOH, Immunization Registry, Lead Registry, and other administrative sources. This is essentially a data mart specific to well child and EPSDT-related metrics. It also serves as the repository for data used to support the operations of the EPSDT program, such as the production of mailers and notices.

## **D. OTHER DATABASES**

HRI has developed other program specific databases to meet the needs of various plan requirements. This includes tracking of newborns and pre-natal care, provider related information such as profile reports, service utilization (e.g., emergency room visits), as well other various and sundry requirements. Data sources for each depend on report type and context of use for the

information. This includes the ability for HRI to provide advanced analysis for such program areas as member/client satisfaction and member customer service, service management and care coordination, and other clinical data assessments.

### **III. MONITORING**

One of the more operational aspects of HRI's information system is the use of various databases as part of a process. This can include file format transformation, data entry, and data reconciliation. In this aspect, the database programs are used to ensure data integrity and/or quality. The following are some of the more pertinent databases that achieve this:

#### **A. HRI ENCOUNTER REPORTING**

This database was developed primarily as an extract tool for encounter data. Health Right, Inc. (HRI) has developed a process in accordance to MAA guidelines to capture encounter data from the claims system. Health Right has created specific processes to produce the required 837 Institutional and Professional HIPAA compliant format for submission via ACS Electronic Data Interchange (EDI). HRI has also complied with MAA guidelines in its submission of dental data using pre-defined workbooks. Primarily, the encounter data is to be used to assess and improve quality, as well as monitor program integrity and determine capitation payment rates through focused actuarial studies, which will be conducted by Mercer. This database also allows for manual adjustments of denied encounter data.

#### **B. HRI-PLEXIS SQL REPORTING**

Developed internally to meet the various process monitoring requirements. This database includes static reports for monthly, quarterly, and annual measures submitted to MAA. Also included in this database are file extract tools in order generate files that are sent to the enrollment broker. This includes newborn, provider list, and PCP selection data interface.

### **III. DATA QUALITY AND INTEGRITY**

HRI's commitment to data quality and systems integrity has led to various levels of checks and audits to ensure the systems meets various program requirements including compliance

to NCQA HEDIS standards, EQRO systems review standards, and various industry regulatory requirements such as meeting HIPAA transaction and security standards. HRI has developed a complete business process centered on the use of information systems.

### **A. AUDITS**

Throughout the year, HRI routinely participates in several mandated audits, which assist HRI's Office of Information Services to account for any possible gaps and systems performance issues. These include:

- *Annual External Quality Review.* A Medicaid specific review, which has some information systems components.
- *Annual National Committee of Quality Assurance HEDIS Audit.* As part of the NCQA certification process, HRI undergoes a comprehensive systems audit targeted specifically at the systems involved in the processing of data for the HEDIS metrics.
- *Annual Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Audit.* This review focuses on the data systems involved in the EPSDT program including
- *Other Internal Audits.* Subsequently, there are various internal initiatives such as HIPAA Security and Privacy on-site reviews and other data specific audits and information reconciliation efforts in place that address data integrity.

### **B. POLICIES, PROCEDURES, AND PROTOCOLS**

HRI has supported the technical efforts by developing complimentary policies and procedures to help on-going business continuity. This includes relevant policies, which address system access and use, and protocols, which ensure data security. The MIS meets the security standards set forth in HIPAA, and

### **C. DATA RESTORATION**

HRI has developed a comprehensive data restoration process by leveraging the latest on-line back up solution through Evault. HRI is employing EVault's InfoStage product, which is a disk-to-disk backup and recovery software for protecting business-critical data. EVault InfoStage cost-effectively backs up data from all locations over the network to a

remote or centralized storage server (or virtual vault). Automated, disk-to-disk backup eliminates labor-intensive manual tasks, as well as the frequent error-prone results associated with traditional tape-based solutions.

Additionally, HRI uses EVault's Backup Agent add-on, which provides an added level of protection against disaster or accidental corruption. With the Backup Agent, backup data stored on the vault can be easily migrated to disk, tape, or a second off-site storage vault using EVault's exceptional delta block technology. The following is a basic process flow for the daily back up

Finally, HRI has a comprehensive Disaster Recovery Plan, which sets the stage for the business continuity process by creating guidelines for restoring critical data and information systems.

## **XVI. BEHAVIORAL HEALTH**

Health Right Inc (HRI) coordinates and monitors the behavioral health services provided to its members. This effort requires a collaborative effort across multiple departments within the organization such as Member Services, Provider Relations, and Utilization Management.

*Member Services:* Members are instructed in their member handbook that HRI will be responsible for providing transportation to mental health and behavioral health appointments through various methods (e.g. newsletter, member services recording, member mailings, member orientation, etc.) Members are also informed about the availability of the Mental Health and Substance Abuse Provider Directory. All HRI member services representatives and outreach staff are trained to assist members with obtaining behavioral health appointments, as well as offer transportation to all members seeking services.

*Provider Relations:* Upon joining HRI network, along with the HRI provider manual, all providers are given a copy of the Mental Health and Substance Abuse provider directory. Providers are informed that a referral authorization to mental health providers is not required, but a notification form should be submitted to HRI for tracking purposes only.

Overall, Health Right Inc (HRI) Behavioral Health Management program is designed to assist behavioral health providers and primary care physicians in the delivery of quality behavioral health services to all HRI members. Health Right's policies and procedures are designed to facilitate communication between the provider, members and their family. Our Behavioral Health program works closely with the Quality Management Committee to ensure that the care and services provided are medically necessary and appropriate for the members in accordance with state of the art regulatory and accrediting entity standards.

Additionally, HRI offers an array of behavioral health services to meet our member's needs. The following is a comprehensive list of services that are covered under the HRI benefit plan:

- Diagnostic Evaluation/Assessment
  - a comprehensive face-to-face interview inclusive of history, mental status examination, treatment planning and interventions
- Psychiatric Inpatient Hospitalization
  - 24 hour supervised hospital setting with a full range therapeutic services
- Partial Hospitalization
  - Stabilization in structured environment outside hospital minimum of 3-4 hours /day, 5 days /wk. (usually time limited). For children & adolescents-education component required
- Day Treatment
  - Structured setting usually for those individuals requiring longer term placement in order to maintain optimal levels of functioning and/or activities of daily living
- Residential Treatment Services
  - 24-hour supervision w/full range therapeutic services for those (for 30-60 days) requiring supervision and structure but not at the intensity of an acute inpatient level of care.
- Outpatient Clinic Services
  - Medication Management
  - Interactive Individual Therapy (Play)
  - Insight Individual Psychotherapy
  - Group (>2 persons) Psychotherapy
  - Family Psychotherapy

- Intensive Outpatient- 2hr/day, 6hr/wk
- Psychological Testing/Laboratory
  - A series of tests to validate or support clinical diagnoses, formulation and treatment

Lastly, the following graph displays a summary of behavioral health services utilized in 2005.

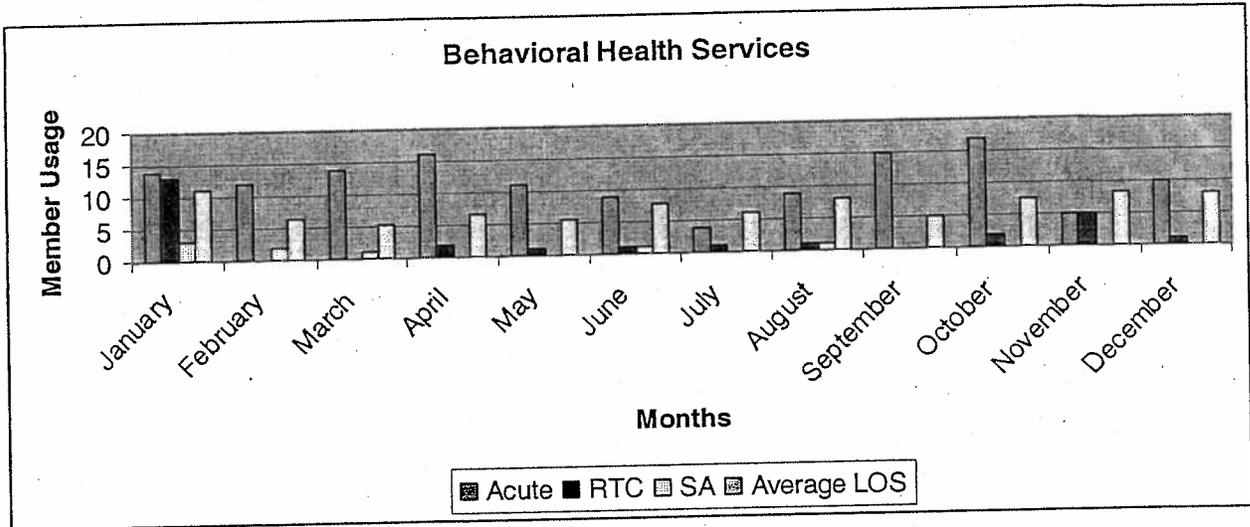


Table 1: Behavioral Health Utilization by Month and Service Received

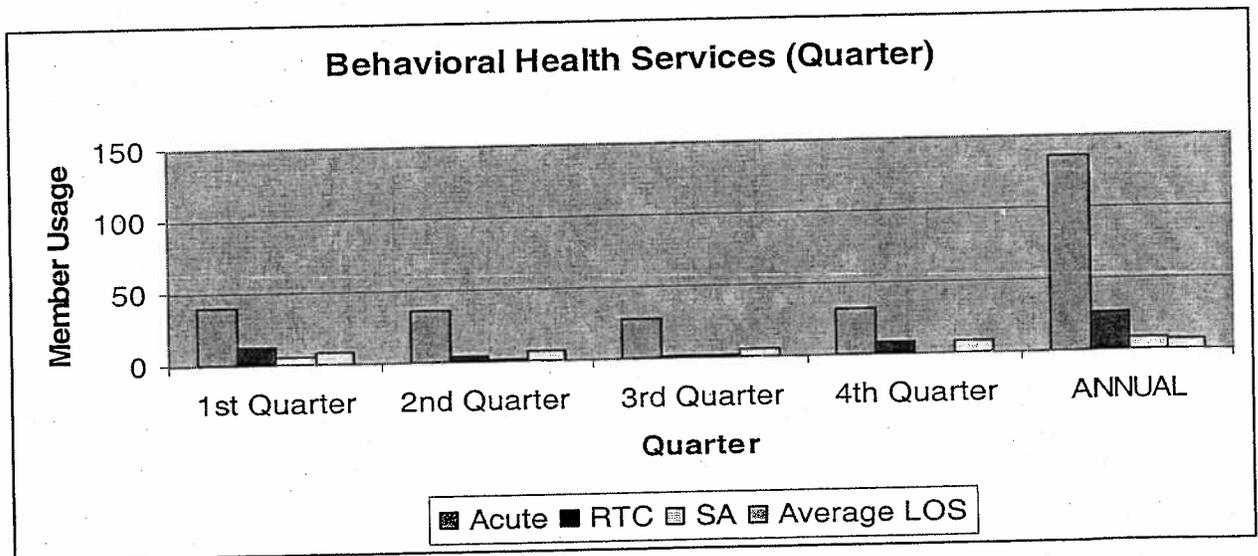


Table 2: Behavioral Health Utilization by Quarter and for the Year

To assess the quality of care HRI provides to its members receiving Behavioral Health Services, a member satisfaction survey was conducted during 2005. The survey was compiled and conducted from November 03, 2005 to November 14, 2005. The

purpose of the survey was to obtain feedback from HRI members regarding services received and to measure the effectiveness of the services being provided to HRI members. Monitoring the feedback from members will enable HRI to develop and implement strategies that will improve member satisfaction, member retention and membership growth.

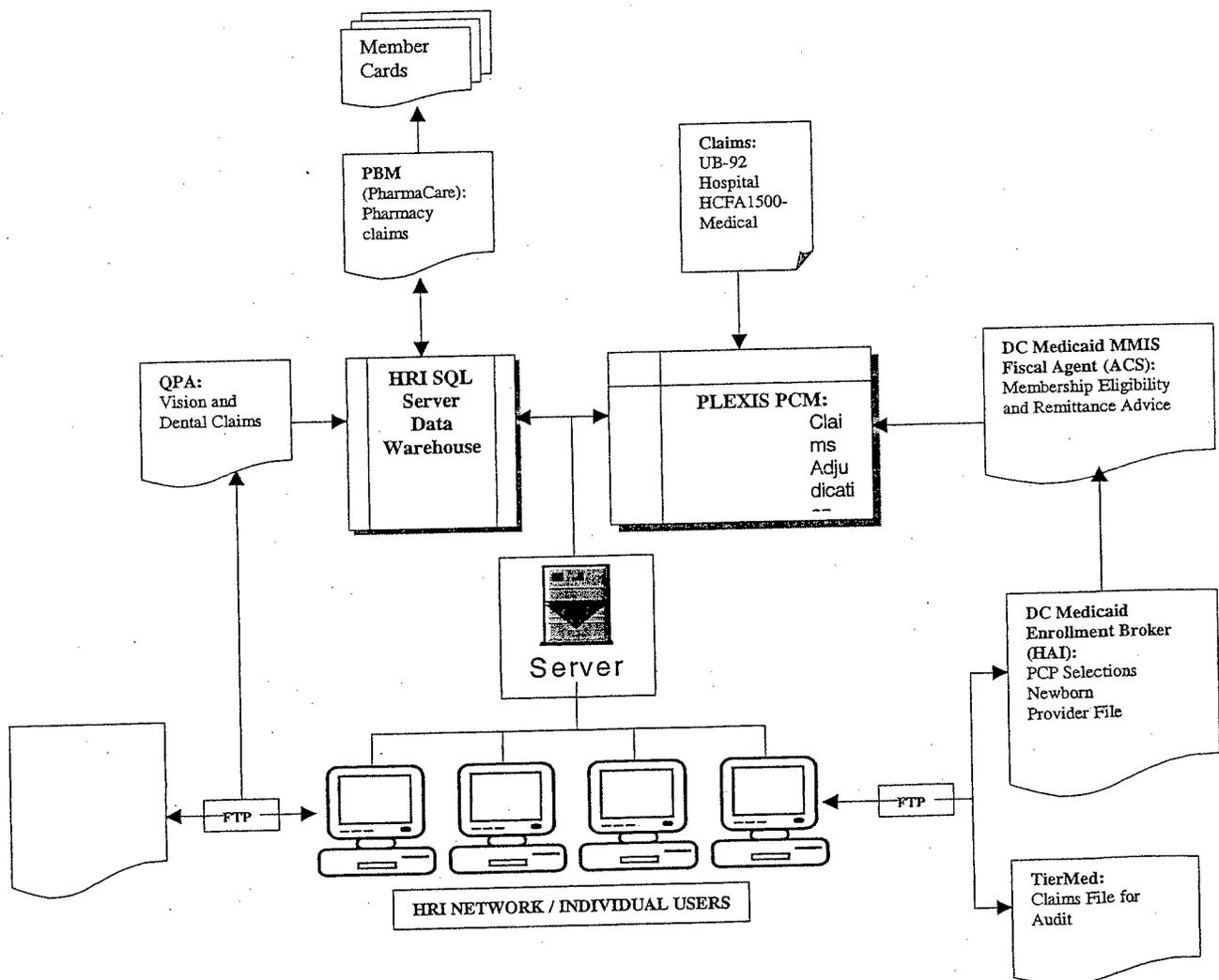
The Mental Health survey questionnaire contained six questions, five of which encompassed quality of services and care being delivered, customer service, access to care and services and waiting times. Respondents were asked to use Very Dissatisfied, Dissatisfied, Satisfied, Very Satisfied and Does Not Apply. The remaining question related to recommendation of provider and suggestions for improvement. The survey was offered in English and Spanish. In order to obtain as many responses as possible, HRI staff conducted a telephonic interview using the Mental Health Member Satisfaction Survey.

Pharmacy and encounter data were generated to identify those members who had received psychotropic medications and/or mental health services from the period January, 2005 through October, 2005. A total of 523 members were identified as having utilized mental health services based on the DSMIV Codes (290-316 covers Axis I psychiatric diagnosis). From this a valid sample size of 191 members was obtained from the sample size calculator ([www.surveysystem.com](http://www.surveysystem.com)). Sample size is based on the 523 HRI enrollees with a confidence level of 95% and a confidence interval of 5. To ensure the integrity of the sample size, an additional 90 members added as a buffer. HRI staff conducted telephonic interviews during the month of November 2005. A total of 191 surveys were to be completed with 41 successful completion, 70 with invalid phone numbers, 76 no answers and 4 refusals. Overall, HRI members receiving Behavioral Health Services reported being very satisfied with the services provided and made a few suggestions that could enhance overall service delivery.

# OVERVIEW

Health Right Incorporated's (HRI) information system capabilities can be broadly categorized into three functional aspects: (1) claims processing, (2) reporting/data analysis, and (3) monitoring. All three components when taken in sum total constitute an integrated business information and data system, which allow staff to comply to District Medicaid contract standards and fulfill specified duties as it relates to the operation of a health plan. This system is electronically based in a networked PC environment, and utilizes various software packages to supplement and/or support the functional aspects. In general, the various components that make up HRI's integrated data system allow for the transformation of 'raw' data into useable information for the purposes of both analysis and decision-making. Overall, HRI's MIS meets the functional and operational criteria set forth in section C.12 of its contract with the District's Medicaid 1932(a) waiver program.

**FIGURE 1: HRI DATA INTEGRATION FLOWCHART**



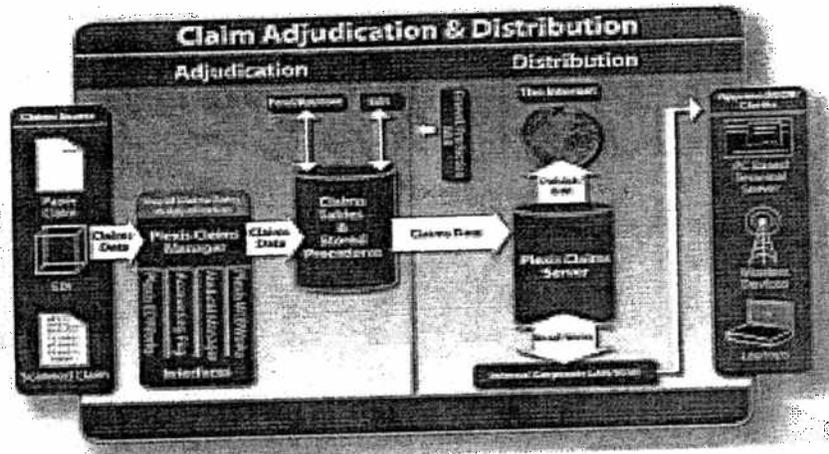
The following is a more detailed description of the system's components:

## I. CLAIMS PROCESSING

### A. PROFESSIONAL AND INSTITUTIONAL CLAIMS

Claims processing accounts for all electronic based transactions that are mostly related to payment of claims. Health Right has undergone a successful transition of its claims management system, moving from CSC's PowerStepp platform to a more reliable Microsoft SQL Server based system developed within the latest .NET and XML framework. Plexis Claims Manager (PCM) was developed by PLEXIS Healthcare Systems and is an integrated healthcare information system providing complete benefit administration, medical and dental claim processing, and reporting features programmed specifically to meet the needs of HRI business processes. Claim processing and auto adjudication is accomplished by entering claim-processing data on a single screen (see below sample screen shot).

Pertinent payment information such as provider details and recipient eligibility have been thoroughly integrated and easily accessed by claims processing staff. Claims flow seamlessly from batch entry to final preparation for payment. PCM delivers an acceptable auto-adjudication rate. The following is the basic claims information flow standard to Plexis PCM:



PCM integrates benefit administration, claim processing and reporting functions. Also, it allows for premium billing and referral authorizations. Accumulators and custom reports in Plexis using a rules-based engine makes it efficient to change processes and respond to trends and Medicaid program adjustments. PCM provides powerful automated reporting tools that allow appropriate HRI staff to query any information in the database, extract data with any ODBC-compliant software, and create standard or custom reports on any data in the claim processing or benefit administration process. Reporting features include forecasting, trend and cost benefit analyses. Finally, as the primary conduit of operational data (provider, member, and claims transaction history), Plexis PCM is the cornerstone for HRI information systems and a majority of information is managed through this process.

## B. DENTAL, VISION AND PHARMACY CLAIMS

Health Right's dental and vision claims are processed through a contracted vendor, QPA. HRI networked dental and vision providers are paid from that system, but closely monitored by HRI. That claims information is provided to HRI electronically and only uploaded to various reporting systems on a monthly basis. Similarly, a contracted pharmacy benefit manager, PharmaCare, processes the pharmacy claims and service information.

## C. REPORTING AND VALUE ADDED FUNCTIONS

Additionally, PLEXIS PCM has integrated components that allow for basic analysis all based on claims processing through the development of 'canned' reports and use of basic analysis components integrated into the software. These value added functions allow the various HRI business units to tailor analysis specific to their program areas and has become critically integrated in the day-to-day operations of each business area. This includes, but is not solely limited to, member benefits administration, provider network update and analysis, outcome measurement, care management (referrals and authorizations) and utilization review, and financial accounting.

## II. REPORTING AND DATA ANALYSIS

Aside from the aforementioned PLEXIS PCM system, HRI employs several PC based reporting tools to aid in research and analysis. Under the guidance and auspices of the Director of Information Services, a range of data-related software and propriety databases are used for both routine and ad-hoc reporting. The following is a listing of the most pertinent data tools:

### **A. HRI DATA WAREHOUSE**

HRI has developed a comprehensive data warehouse using the Microsoft SQL server platform. Just as most data warehouses, HRI's SQL server warehouse is composed of two inter-related components: (1) the files holding the physical database (as seen through tables) and the database management system (DBMS) software that applications use to access data. The DBMS is responsible for enforcing the database structure, including:

- ✓ Maintaining the relationships between data in the database.
- ✓ Ensuring that data is stored correctly, and that the rules defining data relationships are not violated.
- ✓ Recovering all data to a point of known consistency in case of system failures.

To work with data in a database, HRI technical staff uses a set of commands and statements (language) defined by the DBMS software. There are several different languages that can be used with relational databases; the most common is SQL. HRI has a development team consisting of a DBA and the Director of Information Services. The tables or raw data for the data warehouse is primarily derived from the PLEXIS claims processing system. Report and information analysis can be preformed in a multitude of ways, static or canned reports (e.g., claim inquiries and membership counts) using various report packages such as Crystal reports and Access to develop specific report requirements.

### **B. GEOCODER AND GEONETWORKS**

This software developed by Ingenix Corporation. The GeoNetworks software is the industry standard for analyzing service accessibility in the managed care arena. GeoNetworks combines a Windows GUI interface with sophisticated analytical capabilities. With it, HRI produces presentation-quality maps, graphs and tabular reports to determine network adequacy and accessibility (see attached reports). GeoCoder is an associated program, which converts raw data into geocoded data for use with GeoNetworks. Specifically, HRI employs this application to analyze provider network metrics such as access to care, availability of care, and network composition.

### **C. HRI EPSDT TRACKING**

Developed internally this Access database utilizes tables generated by HRI's data warehouse to analyze EPDST-related information. Member eligibility and service information is integrated from PLEXIS PCM, and enhanced from other data sources such as the DC DOH, Immunization Registry, Lead Registry, and other administrative sources. This is essentially a data mart specific to well child and EPSDT-related metrics. It also

serves as the repository for data used to support the operations of the EPSDT program, such as the production of mailers and notices.

#### **D. OTHER DATABASES**

HRI has developed other program specific databases to meet the needs of various plan requirements. This includes tracking of newborns and pre-natal care, provider related information such as profile reports, service utilization (e.g., emergency room visits), as well as other various and sundry requirements. Data sources for each depend on report type and context of use for the information. This includes the ability for HRI to provide advanced analysis for such program areas as member/client satisfaction and member customer service, service management and care coordination, and other clinical data assessments.

### **III. MONITORING**

One of the more operational aspects of HRI's information system is the use of various databases as part of a process. This can include file format transformation, data entry, and data reconciliation. In this aspect, the database programs are used to ensure data integrity and/or quality. The following are some of the more pertinent databases that achieve this:

#### **A. HRI ENCOUNTER REPORTING**

This database was developed primarily as an extract tool for encounter data. Health Right, Inc. (HRI) has developed a process in accordance to MAA guidelines to capture encounter data from the claims system. Health Right has created specific processes to produce the required 837 Institutional and Professional HIPAA compliant format for submission via ACS Electronic Data Interchange (EDI). HRI has also complied with MAA guidelines in its submission of dental data using pre-defined workbooks. Primarily, the encounter data is to be used to assess and improve quality, as well as monitor program integrity and determine capitation payment rates through focused actuarial studies, which will be conducted by Mercer. This database also allows for manual adjustments of denied encounter data.

#### **B. HRI-PLEXIS SQL REPORTING**

Developed internally to meet the various process monitoring requirements. This database includes static reports for monthly, quarterly, and annual measures submitted to MAA. Also included in this database are file extract tools in order generate files that are sent to the enrollment broker. This includes newborn, provider list, and PCP selection data interface.

### **III. DATA QUALITY AND INTEGRITY**

HRI's commitment to data quality and systems integrity has led to various levels of checks and audits to ensure the systems meets various program requirements including compliance to NCQA HEDIS standards, EQRO systems review standards, and various industry regulatory requirements such as meeting HIPAA transaction and security standards. HRI has developed a complete business process centered on the use of information systems.

## A. AUDITS

Throughout the year, HRI routinely participates in several mandated audits, which assist HRI's Office of Information Services to account for any possible gaps and systems performance issues. These include:

*Annual External Quality Review.* A Medicaid specific review, which has some information systems components.

*Annual National Committee of Quality Assurance HEDIS Audit.* As part of the NCQA certification process, HRI undergoes a comprehensive systems audit targeted specifically at the systems involved in the processing of data for the HEDIS metrics.

*Annual Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Audit.* This review focuses on the data systems involved in the EPSDT program including

*Other Internal Audits.* Subsequently, there are various internal initiatives such as HIPAA Security and Privacy on-site reviews and other data specific audits and information reconciliation efforts in place that address data integrity.

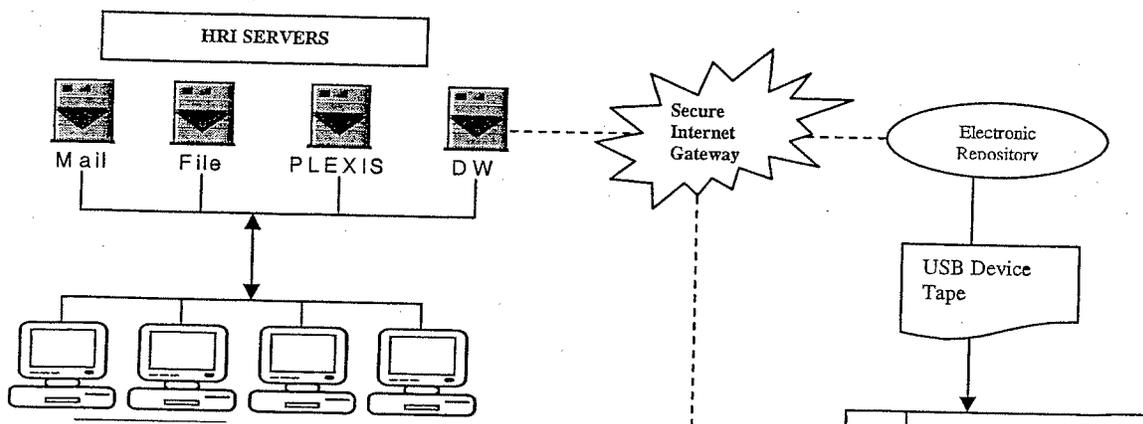
## B. POLICIES, PROCEDURES, AND PROTOCOLS

HRI has supported the technical efforts by developing complimentary policies and procedures to help on-going business continuity. This includes relevant policies, which address system access and use, and protocols, which ensure data security. The MIS meets the security standards set forth in HIPAA, and

## C. DATA RESTORATION

HRI has developed a comprehensive data restoration process by leveraging the latest on-line back up solution through Evault. HRI is employing EVault's InfoStage product, which is a disk-to-disk backup and recovery software for protecting business-critical data. EVault InfoStage cost-effectively backs up data from all locations over the network to a remote or centralized storage server (or virtual vault). Automated, disk-to-disk backup eliminates labor-intensive manual tasks, as well as the frequent error-prone results associated with traditional tape-based solutions.

Additionally, HRI uses EVault's Backup Agent add-on, which provides an added level of protection against disaster or accidental corruption. With the Backup Agent, backup data stored on the vault can be easily migrated to disk, tape, or a second off-site storage vault using EVault's exceptional delta block technology. The following is a basic process flow for the daily back up



Finally, HRI has a comprehensive Disaster Recovery Plan, which sets the stage for the business continuity process by creating guidelines for restoring critical data and information systems.