



MEDICAL MUTUAL®

INFORMATION

Quality Program Description and Work Plan  
**Executive Summary 2019**

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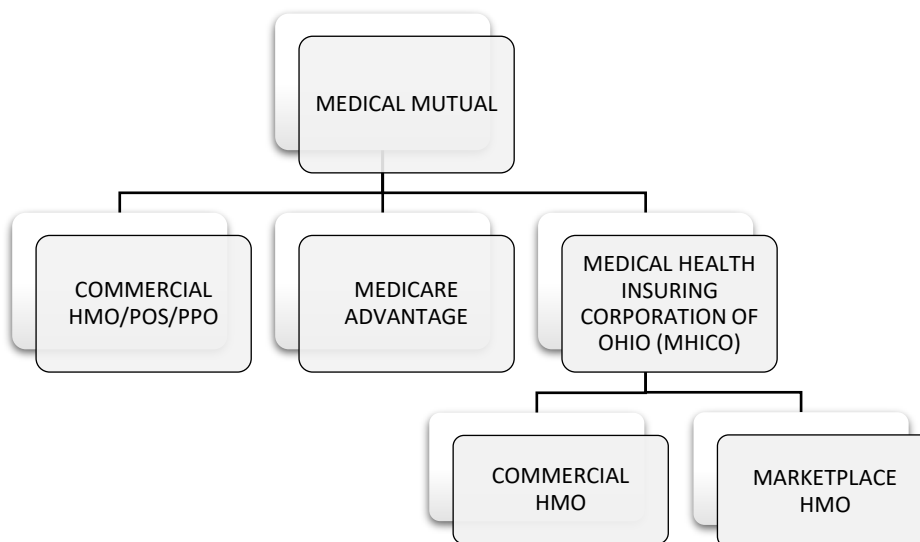
## Introduction

Medical Mutual of Ohio (Medical Mutual) is committed to improving the lives of Ohioans by offering high quality healthcare coverage. Medical Mutual strives to attain high levels of satisfaction and quality to support our customers.

The framework of Medical Mutual's Quality Improvement (QI) program is the Triple Aim: improving our population's health, enhancing our members' experience with care and services, and reducing costs. The Triple Aim directs the company's work toward improvement of safe clinical care and healthcare outcomes, coordination of care across the continuum, access to services, availability of network providers, member experience, provider performance and utilization management.

MMO's QI Program applies to all Commercial and Marketplace members; fully-insured and administrative services only (ASO)--within our two legal entities, Medical Mutual of Ohio and Medical Health Insuring Corporation of Ohio (MHICO). Our Commercial and Marketplace products are accredited by the National Committee for Quality Assurance (NCQA) and hold the Status of Accredited through December 20, 2019.

Figure 1: Medical Mutual products



## I. Program Scope & Structure

The scope of the Clinical Quality Improvement (CQI) Program includes oversight of all aspects of clinical care and services provided to its' members. The program focuses on best practices guidelines, managed care accrediting organizations and regulatory entities such as and Center for Medicare and Medicaid (CMS) and National Committee for Quality Assurance (NCQA).

MMO's quality structure and activities are led by the Chief Executive Officer. With support from the Chief Health Officer (CHO), Chief Experience Officer (CXO), Chief Marketing and Communications Officer, and Chief Medical Officer (CMO).

The CHO is responsible for the strategic direction and governance of the company's overall QI program. The following area's report to the CHO:

**Risk Adjustment** - Conducts activities to comply with government programs. Identifies members who are high risk and communicates member needs to Medical Mutual physicians and/or nurses.

**Pharmacy Management**- Responsible for quality initiatives to improve medication adherence, encouraging members to follow-up with their practitioner for proper treatment. Collaborates on safety issues, cost, and barriers to drug access. Manages the relationship with the Pharmacy Benefit Manager.

**Provider Engagement**- Responsible for all provider/practitioner relationships and is actively transitioning contracts to value-based payment contracts. Monitors provider networks to assure they meet geographic and access standards, include practitioners who meet members' cultural needs, and maintains and improves the accuracy of the provider directory.

The CXO is responsible for all functions related to member engagement, claims and disbursements, membership services, customer care, appeals and grievances. They are fundamental in driving quality from the member perspective. The following area's report to the CXO:

**Member Engagement**- Drives the development and use of personalized and connected cross-channel resources, tools and solutions that help members to be informed healthcare consumers and maximize their health.

**Claims and Disbursements**- Assures members understand how benefits are administered. Responsible for processing claims in an accurate and timely manner according to state and Federal laws.

**Customer Care**- Communicates with customers about benefits and claims payment. First line of contact that impact members' experience with service quality. Participates in the development and execution of care gap closure campaigns.

**Member Appeals and Grievances-** Responsible for investigating and resolving member appeals, grievances and external reviews.

The Chief Marketing and Communications Officer is responsible for the resources to support marketing and multi-channel media for members, providers and employees. The following area's report to the Chief Marketing and Communications Officer:

**Marketing-** Provides expertise on the design and delivery of communications; develops member materials aimed to help with making informed decisions about care, teaching self-care behaviors, and be an active participant in their health and healthcare decisions. Customizes and distributes communications to network providers in support of the quality program.

**Segment Marketing and Advertising-** Using data modeling and customer segmentation to develop customer prospective targeting.

**Community Outreach-** Supporting causes and providing back to the community through volunteerism, philanthropy and charitable partnerships.

The CMO is responsible for the design and execution of the CQI program. They chair the CQPMC and co-chair the CQC. Reporting to the CMO are the following groups with their respective areas of responsibility.

**Physician Staff-** Medical Mutual physicians participate in the Behavioral Health, Credentialing, Clinical Quality & Resource Management, and Pharmacy & Therapeutics committees. Provide consultation on member-related issues. Responsible for utilization management reviews.

**Quality Management Department (QMD) -** Executes evidence-based, data-driven initiatives to advance quality across all populations; develops and implements action plans for quality initiatives; maintains clinical practice guidelines in collaboration with the CMO; performs and over-reads abstracted medical records for the annual Healthcare Effectiveness Data and Information Set (HEDIS®) submission. Attempts to close gaps for members to improved quality and access to health care based on nationally recommended guidelines.

**Clinical Care Management-** Includes Comprehensive Care, Care Authorizations, MA Clinical Services, Care Transitions and Disease Management. Collaborates to promote high quality outcomes across the care continuum.

**Population Health-** Develops health strategy to improve the health outcomes of the population through a spectrum of individual to community-based services as supported by the Triple Aim. These activities can be population, practitioner, healthcare delivery system, employer group or internally focused.

**Clinical Operations-** Includes the newly developed learning and development program that oversees functionality of work systems and CQHS training needs. Department is also responsible for Utilization Management services.

## **II. Reporting Relationship Of The QMD**

The QMD is responsible for maintaining and supporting the advancement of the Quality Program. Within the Department, there are three areas: Clinical Quality Improvement, Clinical Analytics and Accreditation, and Medicare Stars. Collaborative activities between key departments remain bi-directional to achieve the best quality standards.

**CQI-** Registered Nurses (RNs) utilize evidence-based practices, clinical practice guidelines, and data driven initiatives to develop and implement quality plans in collaboration with the CMO. Conducts oversight of the annual Healthcare Effectiveness Data and Information Set (HEDIS®) submission. While providing bi-directional communication with Disease Management, Wellness, Population Health, and Accreditation.

**Healthcare Information Management and Analytics (HIMA)-** Manages the HEDIS®, Medicare Stars, and Quality Rating System (QRS) submissions and provides advanced analysis on the effectiveness of quality initiatives. HIMA conducts assessments of member populations. Results are discussed at Quality committees and are utilized to identify quality improvement opportunities and inform initiatives to address population health management.

**Medicare Stars-** Designs and implements programs to support Medicare Advantage Star Ratings clinical measures.

## **III. Behavioral Healthcare Aspects Of The Program**

Medical Mutual's VP/Senior Medical Officer-Clinical Operations who is board certified in Psychiatry and Addiction Medicine is responsible for the behavioral healthcare aspects of the quality program. This physician leads a multi-disciplinary Behavioral Health (BH) Committee composed of physicians, psychologists, nurses, analysts and management who are committed to improving the quality and access of care to our members having behavioral healthcare needs. Marketing and electronic communications collaborate on developing outreach materials targeted to this population. Primary areas of responsibility include but are not limited to:

- A. Determining the strategic direction of the behavioral healthcare programs.
- B. Evaluating the quality of care, access to services and availability of providers.
- C. Evaluating and approving clinical practice guidelines for behavioral healthcare which are approved at the committee level.

- D. Evaluating clinical data, survey results and effectiveness of care studies to determine opportunities for improvement.
- E. Reviewing and approving communications to members and providers.

#### **IV. Involvement Of The Designated Physician In The Program**

Medical Mutual's Chief Medical Officer (CMO) is the designated physician responsible for the development and maintenance of the corporate quality structure including committees, advising about corporate-wide quality initiatives, and the provision of clinical services and health management programs for members across all lines of business. The CMO is board certified in Internal Medicine and Geriatrics and reports directly to Medical Mutual's Chairman, President and CEO. The CMO is the co-chair of the Corporate Quality Committee and chair of the Clinical Quality & Resource Management (CQRM) committee.

#### **V. Involvement Of The Designated Behavioral Health Practitioner In The Behavioral Aspects Of The Program**

The Designated Behavioral Healthcare Practitioner is the VP/Senior Medical Officer-Clinical Operations who is responsible for all behavioral healthcare quality initiatives. The Senior Medical Officer is board certified in Psychiatry and Addiction Medicine and chairs the Behavioral Health (BH) Committee and Credentialing Committee. He is a member of the Pharmacy & Therapeutics Committee and the Clinical Quality & Resource Management Committee. The VP/Senior Medical Officer Clinical Operations collaborates on improving services for members with behavioral health needs.

#### **VI. Oversight Of QI Functions Of The Organization By The QI Committee**

The Corporate Quality Committee (CQC) is the body which oversees Medical Mutual's corporate quality program. Reporting to the CQC are committees that monitor, direct and evaluate clinical and service initiatives while promoting the Triple Aim. Work groups and/or ad hoc teams may be assigned as needed.

**Corporate Quality Committee (CQC)** - The CQC oversees compliance with quality-related standards, guidelines and operational processes. The quality improvement process is intended to optimize the health, safety and experience of all members; promote collaboration with providers to drive value; and reduce healthcare costs of the population.

**Clinical Quality & Resource Management (CQRM) Committee** - The CQRM Committee provides strategic direction and oversight to all quality committees focused on the quality and safety of clinical care. The CQRM is responsible for the reporting of delegated oversight of the utilization management vendor.

Reporting to CQRM committee are five supporting committees.

- A. **Behavioral Health (BH) Committee** - The BH Committee provides leadership and guidance on the strategic direction of the behavioral health services, medical policy decisions and quality activities.
- B. **Credentialing Committee** - The Credentialing Committee uses a peer-review process to make final determinations regarding credentialing decisions. This committee is responsible for the reporting of delegated oversight of delegated credentialing entities.
- C. **Population Health (PH) Sub-Committee** – Formerly the Disease Management/Wellness & Health Promotion Committee. This committee is responsible for the reporting of delegated oversight of the disease management and wellness vendors, strategic direction of programs, activities, quality improvement initiatives and vendor oversight that support population health management across the continuum of healthcare.
- D. **Pharmacy & Therapeutics (P&T) Committee** - The mission of the P&T Committee is to provide safe, high quality, pharmaceutical care that is cost-effective by providing ongoing oversight and direction to Medical Mutual's prescription drug program and drug management initiatives. This committee is responsible for the reporting of delegated oversight of the Pharmacy Benefit Manager and the utilization management vendor for drug.
- E. **Member Experience/Service Quality (MESQ) Committee** - The MESQ Committee is a cross-functional committee whose objectives are to oversee and improve upon the quality of service and members' experience with health plan services.

## **VII. Annual Work Plan**

The QI Work Plan is developed annually and applies to all lines of business. Initiatives are selected based upon input, a review of quality measures not attaining 50<sup>th</sup> percentile rating, impact to member experience and satisfaction, and identified workflow needing improved efficiency or effectiveness. Medical Mutual follows the Plan-Do-Study-Act (PDSA) model for quality improvement, operating under the Triple Aim. Separate project plans are the responsibility of a project lead and are developed and updated periodically throughout the year as progress is achieved and/or barriers are identified.

### **2019 Goals and Objectives Summary**

The following are the goals planned for 2019 by the QMD. Medical Mutual's Quality Improvement Work Plan is a dynamic document that lists the planned activities, objectives, goals, time frame and responsible departments.



- A. Improving the quality and service provided to beneficiaries.
- B. Maintaining compliance with rules and regulations including; accreditation standards, local, state and federal.
- C. Improving patient access and availability.
- D. Continuing a systematic approach to quality improvement with established framework and tools.
- E. Enhancing a high value network of providers and practitioners promoting safe, quality of care delivered to our beneficiaries.
- F. Ensuring that clinical initiatives address the needs of special populations related to population diversity and complex health needs.

### **2019 Clinical Quality Improvement Work Plan**

All goals within the work plan will be made actionable with hopes to improve upon the previous years rates while comparing results to the Chicago Regional Quality Compass as the benchmark. The following measures have been accepted for the work plan.

- 1. Adult Body Mass Index Assessment
- 2. Breast Cancer Screening
- 3. Controlling Blood Pressure
- 4. Comprehensive Diabetes Care
- 5. Cervical Cancer Screening
- 6. Colorectal Cancer Screening
- 7. Flu Vaccination for Adults
- 8. Prenatal and Postpartum Care
- 9. Childhood Immunization Status
- 10. Plan All Cause Readmission

### **2019 Improving Safety of Clinical Care**

The following measures are the 2019 goals directed towards patient safety. These goals are; Quality Case Event Tracking, Serious Reportable Adverse Events Hospital Acquired, Skilled Nursing Facility Adverse Events, and Pharmacy Monitoring of Non-Adherence.

### **2019 Quality of Service**

The following measures are the 2019 goals for improving service. The goals are; High Volume Member Appeal and Satisfaction with the Health Plan.

### **2019 Improving Member Experience**

The following measures are the 2019 goals for improving member experience with the health plan. These goals are; Satisfaction with the Health Plan, Accuracy of Provider Directory, Availability of BH Providers and Facilities, Member Experience, Continuity

and Coordination of Care across the delivery system, and BH Quality Improvement Strategy for Marketplace.

## **VIII. Evaluation Of The QI Program**

The responsibility of the QI Program Evaluation lies within the CQI department with input from each responsible area and support from HIMA. The following five components are used for the annual evaluation of Medical Mutual's Quality Improvement Program.

- A. Each HEDIS, Stars and CAHPS clinical quality measures are evaluated against the prior year's performance, Quality Compass percentiles (national and regional) and Medicare Stars Ratings cut-points (as available)
- B. Performance compared to established goals as stated within the Action Plan
- C. Barriers to improvement and root cause analysis
- D. Structure of the quality program and ability to meet areas of responsibilities
- E. Adequacy of appropriate resources dedicated and available to the quality program

## **IX. Objectives For Serving A Culturally And Linguistically Diverse Membership**

Health Information Management and Analytics (HIMA) analyze Medical Mutual's membership.

Medical Mutual's 2019 objectives for serving a diverse membership are to:

- 1. Meet identified cultural and linguistic needs in materials and communications
- 2. Assure network practitioners are available to meet the needs of our members
- 3. Identify healthcare disparities related to culture, language or race as detected during quality case reviews or analysis of member complaints
- 4. Identify and reduce healthcare disparities if detected through reporting of geographic variances of healthcare outcomes or care gaps
- 5. Reinforce identification of issues through staff training

*Note: Information generated as a result of the Company's CQI Program is strictly confidential and is to be accessed only by those with authority and as required by certain governmental agencies. CQI activities are conducted in a manner that protects the confidentiality of the member and provider.*