Quality Improvement

Quality Improvement

Molina Healthcare of Wisconsin, Inc. maintains a Quality Improvement (QI) Department to work with Members and practitioners/providers in administering the Molina Quality Improvement Program. Providers can contact the Molina QI Department **toll free at 855-326-5059 or fax (414) 847-1778.**

The address for mail requests is:

Molina Healthcare of Wisconsin, Inc.
Quality Improvement Department
P.O. Box 270208
West Allis, WI 53227

This Provider Manual contains excerpts from the Molina Healthcare of Wisconsin, Inc. Quality Improvement Program (QIP). For a complete copy of Molina Healthcare of Wisconsin, Inc.'s QIP providers can contact their Provider Services Representative or call the telephone number above to receive a written copy.

Molina Healthcare has established a QIP that complies with regulatory and accreditation guidelines. The QIP provides structure and outlines specific activities designed to improve the care, service and health of Members.

Molina Healthcare does not delegate QI activities to medical groups/IPAs. However, Molina Healthcare requires contracted medical groups/IPAs to comply with the following core elements and standards of care:

- Have a QIP in place.
- Comply with and participate in Molina Healthcare's Quality Improvement Program including reporting of access and availability and provision of Medical Records as part of the HEDIS® review process.
- Allow access to Molina Healthcare QI personnel for site and Medical Record review processes.

Medical Records

Molina Healthcare requires that Medical Records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the Medical Record. All entries will be indelibly added to the Member's record. Molina Healthcare conducts a Medical Record review of Primary Care Providers and women's health care providers that includes the following components:

- Medical Record confidentiality and release of Medical Records, including behavioral health care records.
- Medical Record content and documentation standards, including preventive health care.

- Storage maintenance and disposal.
- Process for archiving Medical Records and implementing improvement activities.

Practitioners/providers must demonstrate compliance with Molina Healthcare's Medical Record documentation guidelines. Medical Records are assessed based on the following standards:

Content

- Each patient has his/her own Medical Record.
- Chart pages are bound, clipped or attached to the file (N/A for EMR).
- The Medical Record is organized.
- Patient name or identifier is on every page.
- Personal biographical data is present in the chart (e.g. address, employer, home and work telephone number and marital status).
- All entries are signed - handwritten or initials or unique electronic identifier.
- All entries are dated.
- The Medical Record is legible to someone other than the writer.
- Allergies or adverse reactions are prominently noted or is there a notation NKDA or NKA.
- There is a complete medical history/past history for patients seen more than two (2) times.
- There is a social history for patients seen more than two (2) times (e.g. smoking status, drugs/alcohol, family history etc.).
- Significant illnesses and medical conditions are noted on a problem list.
- A medication list is in the Medical Record and notes the drug name, dosage, strength and the start and stop dates.
- The reason or chief complaint for the visit is documented.
- Each visit has an appropriate history and physical exam including subjective and objective information.
- Each visit notes a diagnosis and plan of care.
- Follow up is noted for each patient visit.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory, imaging, consult notes and other reports are filed in the Medical Record and are initialed by the practitioner to signify review.
- If a consultation is requested, there is a note from the consultant in the chart; and it is initialed to signify review.
- Therapy, home health nursing, surgery and nursing facility reports/notes are in the Medical Record (If applicable).
- A record of Preventive Care is in the Medical Record.
- An immunization record is present in the Medical Record.
- Advanced directives or a discussion about advance directives are noted in the Medical Record or a copy is present in the record.

- Medical Records are protected from unauthorized use.
- Office uses EMR/Electronic Health Record.

Organization

- The Medical Record is legible to someone other than the writer.
- Each patient has an individual record.
- Chart pages are bound, clipped, or attached to the file.
- Chart sections are easily recognized for retrieval of information.

Retrieval

- The Medical Record is available to the practitioner/provider at each encounter.
- A copy of the Member's Medical Record is made available upon the written request of the Member or Authorized Representative and shall be provided in accordance with applicable Federal and State regulations.
- The Medical Record is available to Molina Healthcare for purposes of quality improvement.
- The Medical Record retention process is consistent with State and Federal requirements; and
- There is an established and functional data recovery procedure in the event of data loss.

Confidentiality

- Medical Records are protected from unauthorized access;
- Access to computerized confidential information is restricted; and
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.

Additional information on Medical Records is available from the provider's local Molina Quality Improvement Department **toll free at 855-326-5059.** Providers should also review the Health Insurance Portability and Accountability Act (HIPAA) section for additional information.

Access to Care

Molina Healthcare is committed to timely access to care for all Members in a safe and healthy environment. Practitioners/providers are required to conform to the access to care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on 95% availability for Emergency Care services and 80% or greater for all other services. The PCP or his/her designee must be available twenty-four (24) hours a day, seven (7) days a week to Members.

Appointment Access

All practitioners/providers who oversee the Member's health care are responsible for providing the following appointments to Molina Members in the timeframes noted:

Medical Appointment Type	Time Frame
Routine Asymptomatic Primary Care	Within 30 days
Routine Symptomatic for non- urgent	Within 14 days
Specialty, outpatient referral, consultation	Within 21 days
Urgent Specialty Care Appointments	Within 24 hours
Urgent Conditions	Within 24 hours
High risk Prenatal Care	Within 2 weeks or within 3 weeks if specific provider is requested
Emergency	Immediately

Behavioral Health Appointment Type	Time Frame
Non- urgent behavioral healthcare need	Within 10 days
Non-life threatening emergency	Within 6 hours
Consult and outpatient referral	Within 10 days
Urgent Behavioral Health need	Within 24 hours
Life threatening emergency	Immediately

Dental Appointment Type	Time Frame
Routine Asymptomatic Primary Care	Within 30 days
Routine Symptomatic for non- urgent	Within 14 days
Specialty, outpatient referral, consultation	Within 21 days
Urgent Conditions	Within 24 hours
Emergency	Immediately

Office Wait Times

For scheduled appointments, wait time in offices should not exceed thirty (30) minutes from appointment time until the time seen by the PCP. All PCPs are required to monitor wait times and to adhere to this standard.

Additional information on appointment access standards is available from the provider's local Molina QI Department **toll free at 855-326-5059.**

Appointment Scheduling

Each practitioner must implement an appointment scheduling system. The following are the minimum standards:

1. The practitioner must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments;
2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the practitioner is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the Medical Record. If a second appointment is missed, the practitioner is to notify the **Molina Healthcare Member Services Department toll free at 855-326-5059 or TTY/TDD 414-847-1779**;
3. When the practitioner must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time;
4. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to, wheelchair-using Members and Members requiring language translation;
5. A process for Member notification of Preventive Care appointments must be established. This includes, but is not limited to immunizations and mammograms; and

6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

In applying the standards listed above, Participating Providers have agreed that they will not discriminate against any Member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, and place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Additionally, a Participating Provider or contracted medical group/IPA may not limit his/her practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost care.

Women's Open Access

Molina Healthcare allows Members the option to seek obstetrical and gynecological care from an obstetrician or gynecologist or directly from a participating PCP designated by Molina Healthcare as providing obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure Members have direct access to Participating Providers for obstetrical and gynecological services.

Additional information on access to care is available under the Resources tab on the MolinaHealthcare.com website or from the provider's local Molina QI Department **toll free at 855-326-5059.**

Monitoring Access Standards

Molina Healthcare monitors compliance with the established access standards above. At least annually, Molina Healthcare conducts an access audit of randomly selected Participating Provider offices to determine if appointment access standards are being met. One or all of the following appointment scenarios may be addressed: routine care; acute care; Preventive Care; and after-hours information. Results of the audit are distributed to the practitioners after its completion. A corrective action plan may be required if standards have not been met.

In addition, Molina Healthcare's Member Services Department reviews Member inquiry logs and Grievances related to delays in access to care. These are reported quarterly to committees. Delays in access that may create a potential quality issue are sent to the QI Department for review.

Additional information on access to care is available under the Resources tab at MolinaHealthcare.com or is available from the provider's local Molina QI Department **toll free at 855-326-5059.**

Office Site Visit - Clinical

Site and medical record-keeping practice reviews

Molina Healthcare has a process to ensure that the offices of all practitioners meet its office-site and medical record-keeping practices standards. Molina Healthcare assesses the quality, safety and accessibility of office sites where care is delivered. A standard survey form is completed at the time of each visit. This form includes the Office Site Review Guidelines and

the Medical Record-Keeping Practice Guidelines outlined below and the thresholds for acceptable performance against the criteria. This includes an assessment of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting- and examining-room space
- Availability of appointments
- Adequacy of medical/treatment record-keeping

Adequacy of medical record-keeping practices

During the site visit, Molina Healthcare discusses office documentation practices with the practitioner or practitioner's staff. This discussion includes a review of the forms and methods used to keep the information in a consistent manner and include how the practice ensures confidentiality of records. Molina Healthcare assesses medical/treatment records for orderliness of record and documentation practices. To ensure Member confidentiality, Molina Healthcare reviews a "blinded" medical/treatment record or a "model" record instead of an actual record.

Office Site Review Guidelines and Compliance Standards

Practitioner office sites must demonstrate an overall 80% compliance with the Office Site Review Guidelines listed below. If a serious deficiency is noted during the review but the office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Reviewer to ensure correction of the deficiency.

Facility

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted and parking area and walkways demonstrate appropriate maintenance.
- Handicapped parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is handicapped accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two (2) office exam rooms per physician.

Access

Standards for appointment scheduling include:

- Next available date for Preventive Care appointment is < = thirty (30) calendar days.
- Next available date for routine primary care appointment is < = fourteen (14) calendar days.
- Next available date for a mental health provider to receive an initial assessment if < = ten (10) days and the wait time for this type of appointment is encouraged to be no longer than five (5) calendar days.
- Next available time for urgent appointment is within twenty-four (24) hours.

- Standard wait time to be seen for a scheduled appointment is less than forty-five (45) minutes.

Safety

- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one (1) CPR certified employee is available.
- Yearly OSHA training (Fire, Safety, Bloodborne Pathogens, etc.) is documented for offices with ten (10) or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence hazardous waste management.

Administration & Confidentiality

- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical Records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double locked. Medication and sample access is restricted.
- There is a system in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Wisconsin Specific Requirements

- The statewide consumer call center telephone number, including hours of operation and a copy of the summary of Wisconsin's Patient's Bill of Rights and Responsibilities are posted in the provider's waiting room/reception area.
- The waiting room/reception area has a consumer assistance notice prominently displayed.
- Providers without professional liability coverage must prominently post a sign clearly visible to all patients or provide a written statement which includes the following: "Under Wisconsin law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Wisconsin law."

Medical Record-Keeping Practice Guidelines and Compliance Standards

Practitioner medical record-keeping practices must demonstrate an overall 80% compliance with the Medical Record-Keeping Practice Guidelines listed below. If a serious deficiency is noted during the review but the office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Reviewer to ensure correction of the deficiency.

1. Molina Healthcare of Wisconsin, Inc. conducts a review of Member's Medical Records from all Primary Care Providers that have a fifty (50) member or more assignment against the medical record-keeping standards and requirements that are provided to them as well as other providers as determined necessary.
2. Practice sites include both individual offices and large group facilities.
3. Practice sites are scheduled for review, at a minimum, one (1) time during each two (2) year period.
4. Molina Healthcare of Wisconsin, Inc. reviews a reasonable number of Member's Medical Records at each site to determine compliance. A minimum of five (5) records per site is mandatory, although additional reviews are performed for large group practices or when additional data is necessary in specific instances.
5. Results of Medical Record reviews are assessed against Molina Healthcare of Wisconsin, Inc.'s performance goals, defined in the Medical Record documentation guidelines to identify specific practitioner deficiencies as well as opportunities for improvement throughout the network.
6. Overall Medical Record results are presented to the Quality Improvement Committee for determination of follow-up actions.
7. A review score of 80% or above is considered a passing score with no corrective action.
8. Results of individual provider audits that do not meet quality standards for care or documentation are reported to the Professional Review Committee.
9. A review score of 79% or below requires a Corrective Action Plan (CAP) to be requested in writing from the practitioner's office.
    - The CAP is due within fifteen (15) days of notification
    - If the CAP is not received within fifteen (15) days, a second and final request is sent to the practitioner allowing an additional fifteen (15) days
    - If a CAP is not received within the total thirty (30) day timeframe, the assigned Provider Service Representative is notified that the practitioner is out of compliance
10. Focused follow-up may include individual and organizational corrective action and general interventions designed to improve record-keeping practices.
11. Practitioners who fail to receive a passing score are re-audited following implementation of corrective actions within ninety (90) days of CAP implementation.
12. Molina Healthcare of Wisconsin, Inc.'s performance goals are reviewed and approved annually by the Quality Improvement Committee.

Advance Directives (Patient Self-Determination Act)

Advance directives

Practitioners/providers must inform adult Molina Healthcare Members of their right to make health care decisions and execute advance directives. It is important that Members are informed about advance directives. During routine Medical Record review, Molina Healthcare auditors will look for documented evidence of discussion between the practitioner/provider and the Member. Molina Healthcare will notify the provider via fax of an individual Member's advance directive identified through care management, care coordination or case management. Providers are instructed to document the presence of an advance directive in a prominent location of the Medical Record. Auditors will also look for copies of the advance directive form. Advance directive forms are State-specific to meet State regulations.

Each Molina Healthcare practitioner/provider must honor advance directives to the fullest extent permitted under law. Members may select a new PCP if the assigned provider has an objection to the beneficiary's desired decision. Molina Healthcare will facilitate finding a new PCP or Specialist as needed**.**

PCPs must discuss advance directives with Members and provide appropriate medical advice if Members desires guidance or assistance. Molina Healthcare's Participating Providers are expected to communicate any objections they may have to a Member's advance directive prior to service whenever possible. In no event may any practitioner/provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an advance directive. CMS law gives Members the right to file a Complaint with Molina Healthcare or the State survey and certification agency if the Member is dissatisfied with Molina Healthcare's handling of advance directives and/or if a practitioner/provider fails to comply with advance directive instructions.

When there is no advance directive

If there is no advance directive in place for a Member, the Member's family and practitioner will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

EPSDT Services to Members Under Twenty-One (21) Years

Molina Healthcare maintains systematic and robust monitoring mechanisms to ensure all required EPSDT Services to Members under twenty-one (21) years of age are timely according to required guidelines. All Members under twenty-one (21) years of age should receive screening examinations including appropriate childhood immunizations at intervals as specified by the EPSDT Program as set forth in §§1902(a)(43)and 1905(a)(4)(B) of the Social Security Act and 89 Ill. Adm. Code 140.485. Molina Healthcare's Quality Improvement Department is available to perform provider training to ensure that best practice guidelines are followed in relation to well child services and care for acute and chronic health care needs.

Well Child/Adolescent Visits

Visits consist of age appropriate components including, but not limited to:

- Comprehensive health history.
- Nutritional assessment.
- Height and weight and growth charting.
- Comprehensive unclothed physical examination.
- Immunizations.
- Laboratory procedures, including lead toxicity testing.
- Periodic objective developmental screening using a recognized, standardized developmental screening tool, as approved by DCH.
- Objective vision and hearing screening.
- Risk assessment.
- Anticipatory guidance.
- Periodic objective screening for social emotional development using a recognized, standardized tool, as approved by DCH.
- Perinatal depression for mothers of infants in the most appropriate clinical setting, (e.g., at the pediatric, behavioral health or OB/GYN visit).

Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the Member's Covered Services. Members will be referred to an appropriate source of care for any required services that are not Covered Services. Molina Healthcare shall have no obligation to pay for services that are not Covered Services.

Quality Improvement Activities and Programs

Molina Healthcare maintains an active Quality Improvement Program (QIP). The QIP provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Clinical Practice Guidelines

Molina Healthcare adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-practitioner/provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriate established authority. Clinical Practice Guidelines are reviewed annually and are updated as new recommendations are published.

Molina Clinical Practice Guidelines include the following:

Asthma	Cholesterol
Chronic Obstructive Pulmonary Disease (COPD)	Coronary Heart Disease
Depression	Diabetes
Hypertension	Substance Abuse Treatment
ADHD	

The adopted Clinical Practice Guidelines are distributed to the appropriate practitioners, providers, Provider Groups, staff model facilities, delegates and Members by the Quality Improvement, Provider Services, Health Education and Member Services Departments. The guidelines are disseminated through provider newsletters, Just the Fax electronic bulletins and other media and are available on the Molina Healthcare website. Individual practitioners or Members may request copies from their local Molina QI Department **toll free at 855-326-5059.**

Preventive Health Guidelines

Molina Healthcare provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF) and in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include, but are not limited to:

- Mammography screening;
- Prostate cancer screening;
- Cholesterol screening;
- Influenza, pneumococcal and hepatitis vaccines;
- Childhood and adolescent immunizations;
- Cervical cancer screening;
- Chlamydia screening;
- Prenatal visits.

All guidelines are updated with each release by USPSTF and are approved by the Quality Improvement Committee. On an annual basis, Preventive Health Guidelines are distributed to practitioners/providers via www.molinahealthcare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Healthcare provider newsletter.

Cultural and Linguistic Services

Molina Healthcare serves a diverse population of Members with specific cultural needs and preferences. Practitioners/providers are responsible to ensure that interpreter services are made available at no cost for Members with sensory impairment and/or who are Limited English Proficient (LEP).

The following cultural and linguistic services are offered by Molina Healthcare to assist both Members and practitioners/providers.

24-Hour Access to Interpreter

Practitioners/providers may request interpreters for Members whose primary language is a language other than English by calling **Molina Healthcare's Member Services Department toll free at 855-326-5059.** If Member Services Representatives are unable to provide the interpretation services internally, the Member and practitioner/provider are immediately connected to Language Line telephonic interpreter service.

If a patient insists on using a family member as an interpreter after being notified of his/her right to have a qualified interpreter at no cost, providers should document this in the Member's Medical Record. Molina Healthcare is available to assist providers in notifying Members of their right to an interpreter. All counseling and treatment done via an interpreter should be noted in the Medical Record by stating that such counseling and treatment was done via interpreter services. Practitioners/providers should document who provided the interpretation service. That information could be the name of internal staff or someone from a commercial vendor such as Language Line. Information should include the interpreter's name, operator code number and vendor.

Face-to-Face Interpreter Services

Practitioners/providers may request face-to-face interpreter services for scheduled medical visits, if required, due to the complexity of information exchange or when requested by the Member. To request face-to-face interpreter services, please contact the Quality Improvement Department. Additional information on cultural and linguistic services is available at www.molinahealthcare.com, from the provider's local Provider Services Representatives, and from the Molina Healthcare Member Services Department.

Measurement of Clinical and Service Quality

Molina Healthcare monitors and evaluates the quality of care and services provided to Members through the following mechanisms:

- Healthcare Effectiveness Data and Information Set (HEDIS®);
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®);
- Provider Satisfaction Survey; and
- Effectiveness of Quality Improvement Initiatives.

Participating Providers must allow Molina Healthcare to use its performance data collected in accordance with the provider's or facility's contract. The use of performance data may include, but is not limited to, the following:

1. Development of quality improvement activities;
2. Public reporting to consumers;
3. Preferred status designation in the network; and/or
4. Reduced Member cost sharing.

Molina Healthcare's most recent results can be obtained from the provider's local Molina QI Department **toll free at 855-326-5059 or fax (414) 847-1778.**

HEDIS®

Molina utilizes the National Committee for Quality Assurance (NCQA©) HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is a set of standardized performance measures developed by NCQA which allows valid comparison across health plans. Through HEDIS®, NCQA holds Molina Healthcare accountable for the timeliness and quality of health care services (acute, preventive, mental health, etc.) delivered to Members and the provider's patients.

HEDIS® rates can be calculated in two (2) ways: administrative data or hybrid data.

Administrative data consists of Claim or Encounter Data submitted to the Molina Healthcare and are **wholly dependent upon the quality of the provider's diagnosis and procedure coding.** Measures typically calculated using administrative data include: cancer and chlamydia screening, treatment of pharyngitis and depression, access to PCP services and utilization of services.

Hybrid data consists of both administrative data and a sample of Medical Record data. Hybrid data requires review of a random sample of the provider's Medical Records to abstract data for services rendered both that were not reported to Molina Healthcare through Claims/Encounter Data. **Accurate and timely Claim/Encounter Data reduces the necessity of Medical Record review.** Measures typically requiring Medical Record review include: blood pressures, diabetes care, immunizations, and prenatal care.

HEDIS® is an annual activity conducted in the spring. The data comes from on-site Medical Record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects, including immunizations, women's health screening, pre-natal visits, diabetes care, and cardiovascular disease.

HEDIS® results are used in a variety of ways. They are the measurement standard for many of Molina Healthcare's clinical quality improvement activities and health improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

Selected HEDIS® results are provided to regulatory and accreditation agencies as part of Molina Healthcare's contracts with these agencies. The data are also used to compare to established Molina Healthcare performance benchmarks.

With increased availability of electronic Medical Records, Molina Healthcare hopes to reduce the number of charts it reviews each year for HEDIS® and rely upon queries or downloads from the provider's system. As a reminder, HEDIS® does not require a consent or authorization from the patient since protected health information (PHI) used for purposes of payment or health care operations, including quality measurement, is permitted by HIPAA Privacy Rules (45 CFR 164.506).

CAHPS®

CAHPS® is the tool used by Molina Healthcare to summarize Member satisfaction with the health care and service he/she receives. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Health Promotion and Education, Coordination of Care and Customer Service. The CAHPS® survey is administered annually in the spring to randomly selected Members by a NCQA-certified vendor.

CAHPS® results are used in much the same way as HEDIS® results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Molina Healthcare's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® both focus on Member experience with health care practitioners/providers and health plans, Molina Healthcare conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina Healthcare, as this is one of the primary methods it uses to identify improvement areas pertaining to the Molina Healthcare provider network. The survey results have helped establish improvement activities relating to Molina Healthcare's specialty network, inter-provider communications, and pharmacy Authorizations. This survey is fielded to a random sample of practitioners/providers each year. Providers who are selected to participate are asked to please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

Molina Healthcare monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. Molina Healthcare's performance is compared to that of available national benchmarks indicating "best practices". The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods.