CHAIRPERSON’S WELCOME & OPENING ADDRESS

Melanie Richey, Vice President of Quality
CENTAURI HEALTH SOLUTIONS, INC.
Melanie Richey
VP of Quality, Centauri Health Solutions

As VP of Quality, Melanie Richey has more than 20 years of healthcare experience with deep expertise in quality management strategies, regulatory compliance, operations and product development.

Ms. Richey’s experience includes a broad healthcare background across payers, providers and employer groups, commercial, Medicare and Indigent programs as well as care delivery re-design.

Prior to joining Centauri Health Solutions, Ms. Richey served as the senior director, Quality Solutions for Verisk Health, leading all aspects of quality management and improvement products for commercial, Medicaid, Medicare and QHP clients.

Prior to joining Verisk Health, Ms. Richey was responsible for launching and expanding a network model quality management program for Kaiser Permanente Colorado. During her tenure at Kaiser Permanente, Ms. Richey oversaw a broad range of network operations for the organization including risk adjustment, disease management, accreditation and regulatory compliance, wellness and P4P programs.

Ms. Richey holds a Master’s degree in Business Administration from the University of Phoenix and a Bachelor’s in Nursing from Wright State University.
OPTIMIZING SCORES THROUGH EFFECTIVE VENDOR SELECTION AND COLLABORATION STRATEGIES

Robert T. Gofourth, Vice President, Operational Strategy and Performance
BLUE CROSS BLUE SHIELD OF NORTH CAROLINA

Dr. Kevin Kearns, Chief Medical Officer
ADVANCE HEALTH
ROBERT GOFOURTH, VICE PRESIDENT OPERATIONAL STRATEGY AND PERFORMANCE

Robert has more than 20 years of operations and risk management experience across a variety of industries including insurance, mortgage banking, government enterprise, and outsourcing. In 2014, Robert accepted the position of Vice President of Operational Strategy and Performance at BlueCross BlueShield of North Carolina, Robert is responsible for the overall Quality, Compliance, Analytics, Process and Informatics programs.

Robert has been a certified Six Sigma Master Black Belt since 1999. After earning his M.B.A., he applied a combination of process improvement and operational knowledge to drive quality, reduce cost and improve efficiency to the benefit of several companies. Prior to joining BCBSNC, he was with Citizens Property Insurance Corporation, a government entity acting as the insurer of last resort for the State of Florida. Robert first held the position of Vice President of Operations, improving performance levels which could compete with private enterprise. His final position at Citizens was Vice President of Enterprise Risk Management. As the corporate officer in charge of risk, he utilized his knowledge of process improvement and operations to develop and deploy the company’s risk program which ultimately helped the company in achieving its mission and strategic goals.

The ultimate vision Robert has for operations as a whole is to utilize predictive and prescriptive informatics in conjunction with performance data coupled with Key Risk Indicators. By applying this model, operations can move to the next level through a predictive approach and deliver unsurpassed value to the Enterprise.
Kevin J. Kearns, MD
Chief Medical Officer
Advance Health

Bio: Kevin Kearns, M.D. is a Board Certified Internist with a diverse background in medical management, clinical practice, managed care and academic medicine. Prior to joining Advance Health, Dr. Kearns served as Corporate Vice President and Senior Medical Director at Universal American, where he developed and implemented medical management strategies to enhance the Healthy Collaboration Model for the Medicare Advantage membership. Previously, Dr. Kearns held senior positions at UPMC Health Plan and Coventry Health Care of Delaware. Dr. Kearns received his undergraduate degree in Biology from St. Joseph University and completed medical school at the Pennsylvania State University College of Medicine. Dr. Kearns completed his internship in Internal Medicine at the University of Maryland and his residency at Thomas Jefferson University Hospital.
Find An Approach that Provides Results

INSIGHTS + TECHNOLOGY + EXECUTION = RESULTS
Impact Quality Measures

Advance Health effects 42 out of 47 STARS measures and 21 HEDIS measures; both are more than any other vendor

- For 2016 STARS Ratings; for client’s that improved ratings, the average improvement was .625 STARS (compared to .11 STARS for all plans)

<table>
<thead>
<tr>
<th>SAMPLE</th>
<th>Measure</th>
<th>Measure Type</th>
<th>Source</th>
<th>Weight</th>
<th>Metric</th>
<th>Prospective Opportunity</th>
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<tbody>
<tr>
<td>C02</td>
<td>Colorectal Cancer Screening</td>
<td>Process Measure</td>
<td>HEDIS</td>
<td>1</td>
<td>Evidence of appropriate screening</td>
<td>Direct with lab</td>
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<tr>
<td>C03</td>
<td>Annual Flu Vaccine</td>
<td>Process Measure</td>
<td>HEDIS</td>
<td>1</td>
<td>Yes vaccine within last year</td>
<td>Direct through Member PIP of Pharm &amp; Provider Summary which lists gaps &amp; encourages PCP follow up</td>
</tr>
<tr>
<td>C07</td>
<td>Adult BMI Assessment</td>
<td>Process Measure</td>
<td>HEDIS</td>
<td>1</td>
<td>BMI calculation based on height and weight</td>
<td>Direct - BMI weight and measures member and assessment tool calculates BMI</td>
</tr>
<tr>
<td>C08</td>
<td>Special Needs Plan (SNP) Care Management</td>
<td>Process Measure</td>
<td>HCP Plan Reporting</td>
<td>1</td>
<td>Number of SNP members who receive a HRA</td>
<td>Direct</td>
</tr>
<tr>
<td>C09</td>
<td>Care for Older Adults – Medication Review</td>
<td>Process Measure</td>
<td>HEDIS</td>
<td>1</td>
<td>Percent of members who take every thing they take both RX and non RX including vitamins and herbs reviewed at least once a year by doctor or pharmacist</td>
<td>Direct through Medication Therapy Management Module</td>
</tr>
</tbody>
</table>

Provide Detailed Timeline, Roles, & Responsibilities

SAMPLE

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Milestones</th>
<th>Key Date</th>
<th>Accountability Party</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation</td>
<td>Approval</td>
<td>90 days</td>
<td>Provider Practice Office</td>
<td>90 days with provider</td>
</tr>
<tr>
<td>Implementation</td>
<td>Key Dates</td>
<td>30 days</td>
<td>Provider Practice Office</td>
<td>30 days with practice</td>
</tr>
<tr>
<td>Education</td>
<td>Key Dates</td>
<td>60 days</td>
<td>Provider Practice Office</td>
<td>60 days with practice</td>
</tr>
<tr>
<td>Feedback</td>
<td>Key Dates</td>
<td>90 days</td>
<td>Provider Practice Office</td>
<td>90 days with practice</td>
</tr>
</tbody>
</table>

Advances Health will begin testing soils.
Detailed Insights – Reporting

• Vendor provides **complete transparency**

• Clients receive **detailed reporting** such as reporting for each market

• Program activity **shared on a weekly basis**, but daily activities are available via electronic feed

---

Coordination with HEDIS Team / Impact

**HEDIS Report**

• Breast Cancer Screening
• Physical Exam
• Colorectal Screening
• Discussion of Advance Directives
• Improving or Maintaining Physical Health
• Adult BMI Assessment
• Diabetes Care
• Risk of falling or a safety concern
• Spirometry Screening

**Additional Reporting**

• Tobacco usage
• HICN
• Anticonvulsants
• Current / ongoing pain problems
• Weight
• Blood Pressure
## Coordination / Reporting with HEDIS Team

<table>
<thead>
<tr>
<th>Breast Cancer Screening - CO1</th>
<th>Physical Exam</th>
<th>Colorectal Screening - CO2</th>
<th>Discussion of Advance Directives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammogram Completed?</td>
<td>Height</td>
<td>Colonoscopy Completed?</td>
<td>Completed WRT?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Completed URG?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improving or Maintaining Physical Health - C07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI Assessment - CB8</td>
</tr>
<tr>
<td>Diabetes Care - Eye Exam - CD1</td>
</tr>
<tr>
<td>Diabetes Care - Kidney Disease Monitoring - CD6</td>
</tr>
<tr>
<td>Diabetes Care - Cholesteral Controlled - CD18</td>
</tr>
<tr>
<td>Diabetes Care - Cholesteral - CHA</td>
</tr>
<tr>
<td>None HEDIS None HEDIS screenings</td>
</tr>
<tr>
<td>None HEDIS screenings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you exercise?</th>
<th>BMI</th>
<th>Diabetes w/ Ophthalmic Manifestations</th>
<th>Diabetes w/ Renal Manifestations</th>
<th>LDL Value?</th>
<th>Diabetes w/ No Manifestations</th>
<th>Diabetes w/ Other Specific Manifestations</th>
<th>Current Tobacco Usage?</th>
<th>Diabetes w/ Unspecified Complications</th>
<th>HICN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Adult BMI Assessment - CB8 | Diabetes Care - Eye Exam - CD1 | Diabetes Care - Kidney Disease Monitoring - CD6 | Diabetes Care - Cholesteral Controlled - CD18 | Diabetes Care - Cholesteral - CHA | None HEDIS None HEDIS screenings | None HEDIS screenings | None HEDIS screenings | None HEDIS screenings | None HEDIS screenings | Diabetic Care - Blood Sugar Controlled - C17 |

| None HEDIS screenings | None HEDIS screenings | None HEDIS screenings | None HEDIS screenings | None HEDIS screenings | None HEDIS screenings | None HEDIS screenings | None HEDIS screenings | None HEDIS screenings | None HEDIS screenings | Diabetic Care - Blood Sugar Controlled - C17 |

<table>
<thead>
<tr>
<th>Anticonvulsants?</th>
<th>Do you have current or ongoing pain problems?</th>
<th>Urine Microalbumin?</th>
<th>Weight</th>
<th>Blood Pressure Sitting</th>
<th>Is there a risk of falling or a safety concern?</th>
<th>Glaucoma Screening?</th>
<th>Spirometry Screening?</th>
<th>Pain Location?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

## Flexibility

- Effective vendors are agile – able to change
- Provide **custom solutions** to meet each client’s unique needs
Find a Technological Advantage

A technology platform is important to providing plans and their members with a superior experience.

An Advance Health Example:

- **AWV**
  - Stratification for CHF, Diabetes, COPD, Hypertension, CAD and Chronic Pain; meets all standards of an Annual Wellness Visit; collects demographic data, behavioral risks, ADLs, home safety, and cognitive impairment

- **Risk Strat.**
  - Factors that contribute to poor health quality outcomes ranked and stratified for post assessment follow-up
  - Identifies gaps; rapid generation & delivery of Plan of Care & Assessment Summary; integrates into plan CM systems
  - Post-assessment PCP scheduling, activity monitoring, & member re-engagement

- **ICD-10**
  - Provides a higher degree of specificity in capturing clinical information
  - Enhance provider’s ability to deliver expert clinical documentation

- **Scheduling**
  - Atlas logistics & scheduling system
  - Higher scheduling throughout

Real World Examples of Closing Gaps
Member Engagement

**EXHIBIT 2**

<table>
<thead>
<tr>
<th>2010 patient activation level</th>
<th>Predicted per capita billed costs ($)</th>
<th>Ratio of predicted costs relative to level 4 PAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 (lowest)</td>
<td>966**</td>
<td>1.21**</td>
</tr>
<tr>
<td>Level 2</td>
<td>840</td>
<td>1.05</td>
</tr>
<tr>
<td>Level 3</td>
<td>783</td>
<td>0.97</td>
</tr>
<tr>
<td>Level 4 (highest)</td>
<td>799</td>
<td>1.00</td>
</tr>
</tbody>
</table>

*Source* Judith H. Hibbard, Jessica Greene, and Valerie Overton, “Patients with Lower Activation Associated with Higher Costs; Delivery Systems Should Know Their Patients’ Scores,” Health Affairs 32, no. 2 (2013): 216–22. *Note* Authors’ analysis of Fairview Health Services billing and electronic health record data, January–June 2011. Inpatient and pharmacy costs were not included. PAM is Patient Activation Measure. **p < 0.05

Member Engagement Strategies

*There is not one solution, but many efforts that improve results.*

- **55% Improvement**  
  Member Contact Data

- **1.5% Improvement**  
  Unable to Reach Postcards

- **2% Improvement**  
  Refusal Letters

- Client-specific communications and call scripts

- Earlier start leads to higher success rates
Member & PCP Follow-up

Deliver personalized, actionable information to members.

- NP schedules post-assessment PCP follow-up within 3.7 days
- AH follows-up within 14 days if member refuses
- AH follows-up within 30 days of PCP visit; if appointment cancelled or no-show, rescheduling attempt is made

Every PCP relationship is verified 100% of providers

Enhanced Engagement

- Gaps in Care Closure
  - Colonoscopy: 68% improvement
  - Dexa Scan: 79% improvement
  - FOBT: 80% improvement

- Total Number of RX per group
  - Control: 12,815
  - Treatment: 13,928

- Office visits
  - Control: 10,461
  - Treatment: 11,555

- Inpatient Admission Cost
  - Control: $2,211,816
  - Treatment: $1,940,553

Confidential & Proprietary
THE 10 MOST SIGNIFICANT CHALLENGES OF HEDIS

Mallory Van Horn, Sr. Director, Consulting
OPTUM
Mallory Van Horn leads the Quality consulting practice for Optum. She has 15 years of health care experience, focused on assessing, designing, implementing, and launching Quality Improvement and Quality Management and Performance business solutions for the payer and provider market.

Mallory’s area of expertise includes HEDIS® and Stars with a particular focus on clinical quality measurement and reporting, state regulatory clinical quality reporting requirements, and administrative data improvement strategies.

Prior to joining Optum, Mallory served as the National HEDIS® Director for United Healthcare Community and State. In that role, she had accountability for over 80 HEDIS® and CAHPS submissions on an annual basis. In addition, Mallory served as the Manager of Informatics Consulting for APS Healthcare where she oversaw quality data analysis initiatives for both the Oklahoma and Florida State Medicaid programs.
The 10 Most Significant Challenges of HEDIS®

Mallory Van Horn, MBA, MPH
Sr. Director, Consulting

1. So much to do………and so little time to do it!

Increased and changing audit requirements are putting extreme downstream pressures on both time and resources. As a result, formal planning and execution is more critical than ever:

- Integrate additional staff
- Transition from volume to value
- Increase formal training
- Assign accountability
- Manage expectations
- Provide increased transparency
- Communicate often and broadly
- Celebrate victories along the way
2. You survived HEDIS 2016……now what?

Identify and examine major challenges in an effort to transfer this year’s “learnings” to next year’s “lift”

- Post-mortem Review
- Plan Your Attack
- Work the Plan

3. Even the best laid plan…needs a “plan B”!

- Communicate and manage expectations
- Fully vet a viable plan B with escalation points
- IDSS Submission
- MRRV Audit
- Chart Chase / Abstraction
- Chase Logic / Abstraction
- Rate Benchmarking
- SDS Approval
- Roadmap
- Mock Audit / Training
- Audit Prep
- Complete PSV Audits
- Examine Initial Rates
- Manage MRR

Level of detail should include contingency plans
4. Avoid mucking the audit….don’t skimp on mock audits!

Don’t “mock” the value of mock audits….it may save you critical time on the back end!

- Reducing amount of post-audit follow-up work
- Allowing more time and resources to be spent on more critical tasks

It’s not just about “passing” the audit, but reducing the amount of follow-up work on the back-end to allow more time to be spent on more pressing tasks.

5. You mean my PLD has to match my ART exactly?

- Not just for Medicare anymore
- Test early & often
- Examine year round at regular intervals to avoid pitfalls during reporting period

Audit Review Table
6. Manage your MRRV…..don’t let it manage you!

**Be strategic in your planning**
Segment measures, be resourceful with your resources, beef up your training and double-down on remediation training.

- **MEASURE SEGMENTATION**
  - Group A & B
  - Group C & D
  - Group E & F
  - Assign staff to measures based on experience
  - Comprehensive measure level training
  - 25% INITIAL OVER-READ
  - 50% FINAL OVER-READ

- **ENABLING TECHNOLOGY**
  - Performance management and reporting
  - Continuous Quality Assurance

7. Administrative supplemental databases… timing is everything!

1. **Prioritize by volume AND impact** to obtain approval prior to sample creation
2. **Strengthen documentation** to reduce amount of follow up questions and facilitate quicker approval
3. **Communicate early and often** with auditor to create awareness and level set expectations
4. **Bring high-volume and high-impact sources** to auditors first for PSV to move more quickly
8. You’re sitting on a treasure trove… search for those “hidden gems”

9. Less rigidness….more nimbleness is required!
Invest in building proper infrastructure to allow for more flexibility:

- Not every ‘hit’ is equal
- Need to be able to pivot on a dime
10. Maintain your sanity….be calm and carry on!

- It’s a marathon...not a sprint!
- Celebrate milestones
- Acknowledge team contributions
- Live to fight another day!

Thank you

Contact information:
Mallory Van Horn, MBA, MPH
Sr. Director of Consulting
Phone: 612.632.2804
Email: mallory.van_horn@optum.com
MOVING THE NEEDLE ON DIFFICULT QUALITY MEASURES

Cassandra Caravello, MPH, Program Manager, Population Health
SAN FRANCISCO HEALTH PLAN

Crystal Pike, RN, MSN, Quality Manager
TRIAD HEALTHCARE NETWORK

Melanie Richey, VP, Quality
CENTAURI HEALTH SOLUTIONS
Cassandra (Sandy) Blair, RN, CHC

Director, Stars and Oversight Government Programs

Sandy Blair is the Director, Stars and Oversight Government Programs for Memorial Hermann Health Solutions, Inc. in Houston, Texas. She is responsible for the implementation and strategic planning for the Stars program for the organization’s Medicare Advantage-Prescription (MA-PD) HMO/PPO plans (effective 2015), as well as supporting new business development. She plays a key supportive role in the government programs oversight of relevant business operations impacting Stars performance (e.g. Customer Services, Quality, ODAG and CDAG).

Prior to assuming her current role, Sandy was the VP, Customer Experience for Universal American overseeing the Appeals & Grievances/CTM operations. During her five-year tenure at UAM, Sandy also served as Director of Compliance, Delegation and Monitoring Oversight.

Sandy has also worked with WellCare, Inc. (Tampa, FL) responsible for Part D Compliance and for six years at Blue Cross Blue Shield of Georgia (Atlanta, GA) where she served as Government Programs Compliance Officer including the oversight of A&G operations. Prior to her days with the Blues, Sandy led the UM/QM department as Director at Principal Health Care in Dallas, TX. Other lead roles include serving as Director of Medical Management, Director of Operations, and then later Director of Compliance Operations at Harris Methodist Health Plan (Arlington, TX). Sandy started her career in health care delivery at All Saints Episcopal (Now Baylor) Hospital specializing in Critical Care and Hemodialysis nursing, as well as implementing and managing the facility’s Pre-Admission Center during her 15 years of service. She received her nursing degree at Tarrant County College and attended University of Texas at Arlington. Sandy successfully completed the Health Care Compliance Association (HCCA) Academy earning her the Certified Healthcare Compliance designation in 2011 and is an active HCCA member; as well as a VIP member of the National Association of Professional Women.
Crystal Pike, RN, MSN

Bio

Crystal Pike RN. MSN is the Manager for Quality Performance and Clinical Informatics, a division Triad Healthcare Network (ACO). Her team is responsible for quality metric outcomes for all ACO Medicare Advantage risk contracts and the NextGen population of Medicare. Her team also works with ambulatory practices regarding EMR connectivity, workflows, processes, and development and deployment of quality tools for providers to utilize for quality outcome improvements and population health outcomes.

Crystal is a qualified Registered Nurse and holds her Masters of Science in Nursing- Education from Grantham University in Missouri.

Crystal has more than 18 years’ experience as a nurse. Prior to holding her current position, her career has consisted of providing patient care in multiple settings (inpatient and outpatient), management in inpatient settings, and progressive leadership/management in hospice care.

Crystal provides education, monitoring, team building, and serves as a resource for physician practices.

To contact Crystal Pike, RN, MSN- please email her at crystal.pike@conehealth.com or call 919-548-4262.
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SAN FRANCISCO HEALTH PLAN: HEDIS IMPROVEMENT STRATEGIES

Cassandra Caravello, MPH
Program Manager, Population Health
RISE HEDIS Forum
June 27-28, 2016

Agenda

1. SFHP’s HEDIS Improvement Strategy
2. Controlling High Blood Pressure Program
3. Diabetes Program
4. Postpartum Care Focus Groups
About SFHP

- SFHP is a licensed **community health plan** that provides affordable health care coverage to over 145,000 low and moderate-income people
- SFHP is San Francisco’s **#1 Choice for Medi-Cal!** 8 out of every 10 San Francisco Medi-Cal managed care enrollees choose SFHP
- SFHP had the **third highest ranking** HEDIS Aggregated Quality Factor Score of any Medicaid plan in California in 2015 (following South and Northern CA Kaiser plans)

SFHP’s Provider Incentive Program

- Practice Improvement Program (PIP) provides financial incentive to provider sites and medical groups
  - Partner with network to prioritize measures
  - Large voluntary withholding from capitation
SFHP’s Member Incentive Programs

<table>
<thead>
<tr>
<th>Incentive Program</th>
<th>Gift Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood Immunizations</td>
<td>$50</td>
</tr>
<tr>
<td>Well Child Visits</td>
<td>$25</td>
</tr>
<tr>
<td>Prenatal Care</td>
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</tr>
<tr>
<td>Postpartum Care</td>
<td>$25</td>
</tr>
<tr>
<td>Hypertension</td>
<td>$25</td>
</tr>
<tr>
<td>Diabetes Screenings</td>
<td>$25</td>
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<tr>
<td>Diabetes Eye Exams</td>
<td>$25</td>
</tr>
<tr>
<td>Asthma</td>
<td>$25</td>
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</table>

Blood Pressure Control Program

- Blood pressure (BP) control for members between 18-85 who have a diagnosis of hypertension
- $25 gift card available if member gets their BP checked at their PCP office and writes a brief “healthy heart action plan”

Healthy Heart Action Plan:
- “Relax more and slow down more. Take my hypertension medicines, get more sleep and take it easy. Eat smaller portions.”
- “Lay off the potato chips and drink only one drink a week.”
Program Outcomes

<table>
<thead>
<tr>
<th>CBP Rates MY 2012-2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>2012</td>
</tr>
<tr>
<td>CBP</td>
</tr>
<tr>
<td>Medicaid 90th</td>
</tr>
</tbody>
</table>

Diabetes Program

- Annual screenings for members 18-75 with a diagnosis of diabetes
- TWO $25 gift cards available if member receives diabetes screenings:
  - $25 for retinal/dilated eye exam
  - $25 for HbA1c test, BP check, and nephropathy screening
- Program has existed since 2007, but in MY15 SFHP separated the eye exam incentive
- Part of larger Diabetes Disease Management Program
Program Outcomes

**CDC-E Rates MY 2012-2015**

<table>
<thead>
<tr>
<th>Year</th>
<th>CDC-E</th>
<th>Medicaid 90th</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>67.59%</td>
<td>69.72%</td>
</tr>
<tr>
<td>2013</td>
<td>62.41%</td>
<td>67.64%</td>
</tr>
<tr>
<td>2014</td>
<td>68.91%</td>
<td>68.04%</td>
</tr>
<tr>
<td>2015</td>
<td>74.07%</td>
<td>67.74%</td>
</tr>
</tbody>
</table>

Postpartum Program

- $25 gift card available if member receives a postpartum visit 21-56 days after delivery
- SFHP’s rate in 2014 was in the 75th percentile
  - However, large disparities were found by race/ethnicity in postpartum care rates

**Postpartum Care Disparities**

- African American
- White
- Latina
- Asian/Pacific Islander
- SFHP’s overall rate
Postpartum Focus Groups

- SFHP conducted a series of member focus groups to try to understand what is behind the disparity

Focus groups conducted Oct-Dec 2015
4 focus groups total
(2 English, 1 Spanish, 1 Cantonese)
32 participants total

$50 incentive plus food, bus tokens, child care

Collaborations with community partners for recruitment and facilitators

Focus Group Findings

Perinatal Education and Support

- Some participants were concerned about the quality of care and patient education they received during and after pregnancy
- More classes, groups, emotional support and resources are needed for new moms

“[We need] more information about what’s going to happen to our bodies. We’re first time moms and not prepared for postpartum [care] because we don’t know what to prepare for. We just need more information, details and step by step, because we’re new to this.” (English FG)

“We should have] a small group, discussion group…good for pregnant [and postpartum] women and babies. Everyone has some experiences and all the mothers get to know each other…[this would be] good for new immigrants and mothers could share their experiences. (Cantonese FG)
### Focus Group Findings

#### Barriers and Facilitators of Postpartum Care

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation and childcare are important barriers</td>
<td>&quot;I had a nurse come to my house. And that made it a lot easier… I don’t know how hard it is but, that was helpful just having someone come to my house and check everything out.&quot; (English FG)</td>
</tr>
<tr>
<td>Incentives work with some communities better than others</td>
<td>&quot;I didn’t have a way to get back to the hospital and couldn’t climb the stairs of the bus… [Having a baby] isn’t a disability, but in this moment we are disabled. I was in a lot of pain and everything was very difficult for me.&quot; (Spanish FG)</td>
</tr>
<tr>
<td>Appointment access is a concern</td>
<td></td>
</tr>
<tr>
<td>Home visits would address many barriers, but it is important to build and maintain trust</td>
<td></td>
</tr>
</tbody>
</table>

### HEDIS Improvement: Key Takeaways

1. Member and provider incentives can make a big impact
2. PDSA projects before doing full roll-out
3. Integrate member voice into your process
Questions?

Cassandra (Cassie) Caravello  
Program Manager, Population Health  
San Francisco Health Plan  
ccaravello@sfhp.org
How Do You Corral Over 2,000 Providers Into the Quality Care Arena?

Crystal Pike RN, MSN
Quality Manager
Crystal.pike@conehealth.com

THN Quality Performance and Clinical Informatics

www.TriadHealthCareNetwork.com

Triad Healthcare Network

• Located in Greensboro, NC
• Comprised of primary care providers and specialists
• Includes both independent practices and all providers in the Cone Health System
  • 6 Hospitals
  • 2,100 Providers (600 Primary Care)
  • 450 Practices (400 Unique Locations)
• MSSP: 36,000 beneficiaries
• MA plans: 30,000 beneficiaries
• At risk for up to 100% for all plans
• Approximately 45 different EMRs (Primary Care and Specialist)
  – Our data warehouse vendor is connected to approximately 65% of all EMRs
Triad Healthcare Network

Goal

Create a clinically and financially aligned partnership to improve access and quality of care and decrease medical cost.

Triad Healthcare Network

History

• Began in 2012
• Achieved savings for year 2013- quality metrics were reporting only, saved $22 million and receive $10.5 million in savings
• Reviewed improvement opportunities for quality metrics for quality performance reporting
How do you corral over 2,000 providers into the quality care arena

---

**2013:**
1. Conducted quarterly dashboard reviews with quality metric performance rates and patient specific data with practice providers and site administrators.

2. Conducted gap analysis on how to improve quality metrics. We discovered the following gaps:
   a) Our data warehouse vendor was not capturing the correct data fields in EMRs
   b) Providers were unaware of metric definitions
   c) Quality metrics were not being completed
Strategies for 2014 and beyond:

1. Quantified the number of patients that were needed to achieve the 90th percentile benchmark (or 4 STAR rating), then targeted metrics that were achievable and worked with our practices in these measures
2. EMR mapping
3. Upgrade of quality metric dashboards
4. Gaps in care report
5. Patient outreach- EMMI vendor
6. Point of Care Tool

---

Humana 2014 vs. 2015 HEDIS Metrics

- Increased our overall STAR rating from 3 to 3.5.
- We moved up a STAR Level in 8 metrics and down in 2
UHC 2014 vs. 2015 HEDIS Metrics

- Increased our overall STAR rating from a 3 to a 4.
- We moved up a STAR Level in 6 out of the 10 Metrics

<table>
<thead>
<tr>
<th>Measure</th>
<th>% Pass</th>
<th>2014</th>
<th>2015</th>
<th>2014 Level</th>
<th>2015 Level</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>76%</td>
<td>81%</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>71%</td>
<td>79%</td>
<td>3</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1C/HbA1c Assessment</td>
<td>73%</td>
<td>92%</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol Management</td>
<td>47%</td>
<td>57%</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Care - Eye Exam</td>
<td>58%</td>
<td>70%</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Care - Medical Attention for Nephtropathy</td>
<td>89%</td>
<td>96%</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-Hypertensive Drug for HT</td>
<td>82%</td>
<td>82%</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Adherence for Oral Diabetes Medication</td>
<td>78%</td>
<td>78%</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Adherence for Hypertension (ACE or ARB)</td>
<td>77%</td>
<td>80%</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Adherence for Cholesterol (Statin)</td>
<td>70%</td>
<td>73%</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary-

- Great example of how to work smarter - not harder
- It’s not just one thing that makes a difference
Moving the Needle on Difficult Quality Measures: Controlling High Blood Pressure

Melanie Richey, Vice President of Quality
June 27, 2016

Quick Facts

• 1 in 3
  • American Adults have hypertension
• Approximately 52%
  • Individuals with hypertension that have their condition under control
• $46 billion
  • Annual costs nationally in healthcare services, medications to treat hypertension and in missed days of work

Improving Blood Pressure Control

High Performing Organizations:
• Are committed to quality
• Have high quality data
• Effectively align resources
• Engage stakeholders:
  • Staff
  • Members
  • Providers

Engaging Stakeholders

Best Practices:
• Education
• Communication
• Incentives
• Teamwork
• Innovation

"Stakeholder engagement is a never-ending process. We have to continually earn stakeholders' confidence. It's a relationship."

--- Wouter Vermeulen
Corporate Responsibility Director, Health and Well-being Coca-Cola Europe
Creating a Pilot Member Incentive Program

Early in the HEDIS® Season
• Robust Data and Analytics
• Global Approach
  • Stratified Population
  • All Providers
• Broader Range of Interventions
  • Newsletter Articles
  • Annual Reminders
  • SVR and Live Outreach Calls
  • Care Management/Health Navigator
    • In provider offices
    • Outreach to members with care gaps
• Worksite Wellness Programs
• Care Gap Closure Rewards
  • Gifts
  • Money and/or Gift Cards
  • Reduced Premium
  • Partial Reimbursement of Gym fees
• Year Round Initiatives

Late in the HEDIS® Season
• Robust Data and Analytics
• Highly Focused Approach
  • Narrow Population
  • High Volume Providers
• Limited Interventions
  • Care Gap Closure Rewards
    • Money and/or Gift Cards
  • Home Assessments
  • Provider Office Support
    • Member Scheduling
    • Hypertension Clinic
• “Sprint” Initiatives

Improving Access to Care

Successful Strategies:
• Appointment Scheduling
  • Advanced Access
  • Online Scheduling
• Non-Traditional Visits
  • Group Visits
  • Hypertension Clinics
• Care Managers Embedded in Provider Offices
• Alternative Care Settings
  • Workplace
  • Community Centers
  • Churches
Controlling Blood Pressure Success Stories

Presbyterian Healthcare Services
• 18% increase in hypertension control (2012-2014)

WinMed Health
• 7% increase in hypertension control (2013-2014)

Kaiser Permanente Northern California
• 45% increase in hypertension control (2001 to 2013)

River Falls Medical Clinic
• Nearly 6% increase in hypertension control (April 2012 to July 2013)

Post Rock Family Medicine
• Dr. Jennifer Brull achieved a hypertension control rate of 87% in 2013

Millgrove Medical Center
• Dr. Nilesh Patel achieved a hypertension control rate of 94.9% in 2013


Questions

Contact Information:
Melanie Richey
melanie.richey@centaurihs.com
CASE STUDY: MEMBER ENGAGEMENT-MAXIMIZING EFFECTIVENESS BY COMBINING CLINICAL AND ANALYTICAL STRATEGIES

Kerri Hill, Director, Clinical Quality & Wellness
THE HEALTH PLAN

Valerie N. Ogilbee, MPH, Director of Quality Analytics
THE HEALTH PLAN
Kerri Hill
Director, Clinical Quality and Wellness

Kerri brings to The Health Plan over 22 years of nursing experience with an emphasis in critical care and recovery. Since 2013, Kerri has been active in various roles within the health and wellness department of The Health Plan. She developed practices involving point-of-care testing for biometric screenings and led the member/physician driven hypertension initiative. She serves as CLIA lab director and has established numerous policies and procedures and training manuals for staff in this area.

Currently, in her role as Director of Clinical Quality & Wellness, she directs and coordinates the health and wellness processes to ensure member engagement and preventive health guidelines are followed and in compliance. Kerri is responsible for the clinical quality improvement processes, standards of care and quality guidelines throughout the company. She serves as a departmental representative on agency-wide committees and task forces for wellness and quality issues. Kerri is also responsible for coordination and oversight of all NCQA activities and accreditation and developing methods and projects to improve quality in all areas and departments of The Health Plan.

Kerri received her associate degree in applied science - nursing. She has previous national certification in peri-anesthesia nursing and trauma nursing. She is nationally certified by the American Lung Association as a Freedom From Smoking Facilitator.

Established as a community health organization, The Health Plan delivers a clinically-driven, technology-enhanced, customer-focused platform by developing and implementing products and services that manage and improve the health and well-being of our members. We achieve these results through a team of health care professionals and partners across our community.
Valerie joined The Health Plan in April 2001 as an intern. She worked in the QI Department for several years prior to being transferred to the Finance Department. As a health data analyst, Valerie completed a variety of projects including contract analysis, financial analysis, and reinsurance reporting. Valerie has implemented software programs for fraud, waste and abuse identification and predictive modeling and provider profiling. She served as the manager of health economics in the Business Intelligence Unit prior to assuming her current role as Quality Analytics Director.

Valerie is responsible for working with staff to analyze data relevant to The Health Plan’s various quality initiatives. Through analysis of data, she works with the quality improvement teams on the development and implementation of programs aimed at improving the quality of care and service provided to members. She is also responsible for HEDIS reporting, Medicare data projects and member outreach efforts.

Valerie received a Bachelor of Science Healthcare Administration degree from Ohio University in June 2001. While working at The Health Plan, Valerie earned a Master of Public Health degree from West Virginia University in 2006. In December 2015, she completed the University of California, Davis Healthcare Analytics Certificate Program.

OUR MISSION

Established as a community health organization, The Health Plan delivers a clinically-driven, technology-enhanced, customer-focused platform by developing and implementing products and services that manage and improve the health and well-being of our members. We achieve these results through a team of health care professionals and partners across our community.
Member Engagement
Maximizing Effectiveness by Combining Clinical & Analytical Strategies

introductions

Kerri Hill, RN
Director, Clinical Quality & Wellness

Valerie Ogilbee, MPH
Director, Quality Analytics
Established as a community health organization, The Health Plan delivers a clinically-driven, technology-enhanced, customer-focused platform by developing and implementing products and services that manage and improve the health and well-being of our members.

We achieve these results through a team of health care professionals and partners from across our community.

We are committed:

To advancing the **QUALITY** of care delivered by our providers and received by our members using the best available practices.

To providing superior **SERVICE** using the highest set of standards for personal respect, courtesy and compassion for our members, providers and other health care systems.

To **GROWING** through innovation, creativity and hard work.

To offering the highest level of **INTEGRITY** and **RESPECT** for our employees, members, providers and partners through a positive attitude of honesty, sincerity and determination.

To each of our **COMMUNITIES** that our products and services support.

To supplying a positive atmosphere for our **EMPLOYEES**, allowing them the opportunity for personal growth that meets the needs of our company, our clients and our members.
quality improvement
The Quality Improvement & Wellness Department encompasses all aspects of The Health Plan.

Our framework for success comes from our diversified clinical & analytic approach.

Our Department recognizes the need for our analytic & clinical team to be aligned under separate directors but unified as one team. This is a key factor in promoting our quality initiatives & other department/company endeavors.

We have more comprehensive streamlined process & improved member engagement.

Our dedicated teams relate to wellness & member engagement under an analytic team focused on our government programs and a clinical team focused on HMO and TPA business.

<table>
<thead>
<tr>
<th>member engagement team</th>
</tr>
</thead>
</table>

**Quality Analytics Director oversees a team that includes:**

**Member Engagement Coordinator**
Works in tandem with quality analysts and clinical quality nurse manager to develop programs that promote quality initiatives, Medicaid incentives, accreditation status, gaps in care, HEDIS & Star ratings.

**Member Engagement Representatives**
Telephonic outreach and other outreach methods to promote engagement and impact gaps in care, etc.

**Quality Improvement Analysts**
Works with analytic software and other member data to provide accurate and timely data and identify areas for improvement.
Clinical Quality & Wellness Director oversees a team that includes:

**Health & Wellness Manager**
Works with online wellness portal venue and facilitates other programs based on needs assessment.

**Community/Corporate Health & Wellness Development Coordinator**
Works with employees and employer group population, as well as community and develops programs based on needs assessments.

**Health & Wellness Nurse**
Works in tandem with key team members for holistic clinically-driven, comprehensive health and wellness initiatives.

**Member Engagement Representatives**
Telephonic outreach and other outreach methods to promote engagement and impact gaps in care, etc.

Using analytical and clinical tools to monitor quality and effectiveness
Measuring improvement and compliance on an ongoing basis
Member and provider engagement strategies
SETTING THE FOUNDATION FOR SUCCESS

In order for member engagement to be successful, sophisticated strategies and analytics are essential, setting the foundation for the success of the program.

- RIGHT Strategies
- RIGHT Members
- RIGHT Method
- RIGHT Message
- RIGHT Time

Our focus is to have engagement delivered in a manner that is relatable to our members and their families!

ACHIEVING DESIRED RESULTS

Targeting the Right Member
Quality analytic reporting, gaps in care reporting helps to identify members who could benefit from improved health outcomes. This is done with a proactive approach utilizing the data in tandem with our clinical quality arena.

Target Communications
Recognizes needs & lifestyle, Allows flexibility and choice thus promoting engagement. All communication, regardless of the method, focuses on member education, member compliance to their treatment plan, member health risk and a needs assessment. Member Website - Mobile Wellness Portal - Letters & Postcards to Members & Their Providers - Telephonic Outreach - Health Education Material - Member Health Fairs.

Member Incentives
Incentives are used to help promote behavioral modification and member engagement for perinatal care, preventive health and well visits.

Point of Care Testing
Onsite health fairs to promote gap closure & member engagement. Biometric Labs - Flu Vaccinations - Vital Signs - BMI & Body Fat % - 1:1 Result Counseling - Nutrition Counseling Health-Related Topics (Nutrition, Stress Reduction, Preventive Health, etc.)
Adaptive wellness programs based on Need's Assessment to promote healthier behaviors and positive health outcomes

Program components are realistic and measurable
Comprehensive and interactive with app integration wellness platform portal
Aggregate reporting capabilities
Nationally certified smoking cessation and tobacco cessation facilitators on staff
Biometric point-of-care testing completed by our fully trained nursing staff and regulated by CLIA (Clinical Laboratory Improvement Amendments of 1988) to assure quality laboratory testing

In-house Wellness Department with dedicated staff striving to increase well-being and productivity of participants by enhancing all aspects of health.

We help members and providers navigate to the right care, at the right place and right cost.
Wellness Team:
Engagement Coordinators & Health and Wellness Nurse
Dedicated staff on site for company-wide/community-wide initiatives for optimal participant health outcomes

Health & Wellness Education
- Classes
- Wellness Coaching
- Workshops
- Lunch & Learns

Preventative Outreach
- Women’s Health
- Disease Specific
- Immunizations
- Testing and Prevention

Wellness Assessments
- Health Risk Assessments
- Readiness to Change Assessments

Programs
- Fitness
- Smoking Cessation
- Nutrition & Weight Loss
- Stress Management

Quality Analytics
- Identifying Gaps in Care
- Analyzing Health Outcomes

Challenges Health & Wellness
- Fun, Interactive activities
- Individual and team challenges

Health Promotion Activities
- On-site vaccinations
- Biometric screenings

Wellness Team:
Engagement Coordinators & Health and Wellness Nurse
Dedicated staff on site for company-wide/community-wide initiatives for optimal participant health outcomes
**Areas of Improved Medicaid Member Engagement**

<table>
<thead>
<tr>
<th>Service</th>
<th>2015 (%)</th>
<th>2014 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemoglobin Alc (HbA1c) Testing</td>
<td>81.11</td>
<td>78.87</td>
</tr>
<tr>
<td>Well-Child Visits - Years 3, 4, 5, &amp; 6 of Life</td>
<td>73.97</td>
<td>70.56</td>
</tr>
<tr>
<td>Adolescent Well-Care Visits</td>
<td>47.20</td>
<td>46.47</td>
</tr>
</tbody>
</table>

**Areas of Improved Medicare Member Engagement**

<table>
<thead>
<tr>
<th>Service</th>
<th>2015 (%)</th>
<th>2014 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>71.21</td>
<td>66.84</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>65.69</td>
<td>60.34</td>
</tr>
<tr>
<td>Preventive/Ambulatory Health Services</td>
<td>97.48</td>
<td>96.79</td>
</tr>
</tbody>
</table>
**Meeting the Needs of Members**

One size does not fit all when it comes to member engagement & education.

Ongoing communication with the members and their providers has proven to be beneficial in identifying barriers to care and education.

We are continuously customizing our processes based on the feedback from our members and our providers.

Interdepartmental team meetings with ongoing communication and training is crucial to keep our member engagement effective and realistic!
questions?

choose the health plan
I. IMPROVING THE INTEGRITY, QUALITY AND TIMELINESS OF THE DATA YOU USE

Managing HEDIS: a 12 month approach

Janine Sala, Associate Director Clinical Quality—HEDIS® Operations
UNITEDHEALTHCARE

Value-Based Payment Data Challenges: Getting Ahead of the Curve

Justin Spencer, Senior Director, Analytics
STEWARD HEALTH CARE
Janine Sala oversees the HEDIS Operations team for the UnitedHealthcare Nevada market and has over 10 years of experience in the areas of Quality and Performance Improvement. Her HEDIS tenure and subject matter expertise has helped grow a successful internal operations team that is directly responsible for improving HEDIS ratings in all lines of business. Janine has a strong background in analytics, audit activities, technical specifications and Medicare Part C Star ratings as well as all aspects of NCQA IDSS and PLD submission requirements.

Janine is a strong-willed success driven professional, who possesses an exceptional determination to get the job done. When she is not at work, Janine enjoys spending time with her family and running. She prides herself in her philanthropic work, and has lead several successful Man & Woman of the Year campaigns for the Leukemia & Lymphoma Society raising a combined total of over $175,000! Janine welcomes you to reach out to her via janine.sala@uhc.com or on LinkedIn.
Justin C Spencer, MPA
Bio

Justin Spencer is the Executive Director of Commercial Accountable Care at Steward Health Care Network, which is the largest community-based physician organization in Massachusetts with over 2,500 physicians. Justin oversees the Commercial Accountable Care business and all population health analytics and reporting. He also leads analytic initiatives designed to enhance system performance, including the development of physician incentive models and business intelligence applications. Prior to joining Steward, Justin held roles in private and non-profit healthcare organizations, including Dana-Farber Cancer Institute. He holds a Masters in Public Administration/Health Administration from Suffolk University in Boston, Massachusetts.
MANAGING HEDIS:  
A 12-MONTH APPROACH

Presented by:  
Janine Sala, Associate Director, HEDIS Operations  
UnitedHealthcare Quality Improvement  
Nevada Market

Agenda:

• Meet our HEDIS Team
• Our Purpose
• Strategy and Approach
  • January-June
  • June-December
• Off season work flow
• Nurse Team
• Analyst team
• Data
• Questions
Meet the HEDIS Operations Team

**QI HEDIS Operations**
- Associate Director
- Analytics Team
  - Manager
  - 5 HEDIS analysts
- Nurse Review Team
  - RN Manager
  - 7 FTE RN’s
  - 2 Per diem RN’s

**Analytics Team**
- Trending and analysis of current and retrospective data
- Barriers and impact analysis
- Year over year & month over month
- All aspects of auditing and NCQA submission for 7 Lines of business (Part C Medicare, Medicaid, Commercial and Marketplace)

**Nurse Team**
- HEDIS “on-season”
  - Chart chase and abstraction
  - MRRV
- HEDIS “off-season”
  - Provider education
  - Gaps in care reports
  - Provider chart audit for educational purposes

Our Purpose

The purpose of the HEDIS operations team is to:

- Develop initiatives that drive compliance toward nationally accepted standards of care
- **Capture data and report it at a national level:**
  - Ensure our data set is accurate and complete
  - Use Medical Record Review (MRR) to supplement compliance on services not submitted via claims/encounters
- Monitor and predict outcomes
- Provide Targeted Clinical Engagement
Strategy and Approach

Our strategic vision is to partner with internal and external stakeholders to ensure remarkable levels of care and compliance capture.

What does HEDIS look like to the Nevada Market?

Responsible for ALL lines of business:
• Commercial
• Marketplace (aka exchange)
• Medicare
• Medicaid

HEDIS submission and NCQA accreditation

HEDIS: January - June
Strategy and Approach

12-Month Approach

January-June: HEDIS “on-season”

HEDIS record retrieval cycle:
- Supplemental data-PSV
- Production
- Record review and abstraction

Self-supported in all aspects-no vendor

Nurses: support chase retrieval, prioritization of offices and abstraction.

Analysts: support fax mail campaign and escalations, tracking and reporting.
Strategy and Approach

HEDIS: June-December

vacation!
Strategy and Approach

12-Month Approach

June-December: HEDIS “off-season”

HEDIS Hindsight
- Analysis
  - Lessons learned
  - Chase closure and non-responsiveness
- Plans for off season activities based on final analyses
- On-going improvements-moving forward
Strategy and Approach

Off Season Work Flow: Nurse Team

Targeted Clinical Engagement
- Provider office visits:
  Based on offices with highest empanelment (highest ROI)
  - Feedback and Education
    - Retrospective
      - final rate review
      - blinded studies
      - bookmarks
      - opportunities for improvement
    - Prospective
      - gaps in care reporting
      - HEDIS spec education and best practices

The secret sauce!

BUILDING AND MAINTAINING RELATIONSHIPS

Health Plan Consulting
improve quality and promote the value of our company to our providers by strengthening the provider/plan relationship in order to improve performance.
Strategy and Approach

What does Health Plan Consulting look like?

- PROVIDER INFORMATION GATHERING & ANALYSIS
- LEADING INTERVIEW AND SCHEDULING
- MID SEASON MEDICAL RECORD REVIEW
- TEMPLATE REVISIONS
- FEEDBACK AND EDUCATION
- QI CONSULTING & IMPROVEMENTS

UnitedHealthcare

Strategy and Approach

HEDIS ADULT MEASURES

<table>
<thead>
<tr>
<th>Measure</th>
<th>Incremental Change</th>
<th>Recommended Change</th>
<th>Action Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABA</td>
<td></td>
<td></td>
<td>SEND template with PHV calculators for managing chronic conditions.</td>
</tr>
<tr>
<td>BCS</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RECOMMENDED SCREENINGS & IMMUNIZATIONS TO KEEP YOU HEALTHY

<table>
<thead>
<tr>
<th>AGE</th>
<th>18+</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer (for women)</td>
<td>Beginning at age 25, have a mammogram every 1 to 2 years up to the age of 74.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer (for women)</td>
<td>Have a PAP test every 3 years starting at age 21. Beginning at age 25, have a Pap and HPV test every 3 years up to the age of 65.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

WCC Nutrition & Physical Activity Categories/Examples:

- Top 5 Tips Every Provider needs to know to improve HEDIS Scores!

NUTRITION CATEGORIES

1. Discussion of current nutrition behaviors (e.g., eating habits, exercise behaviors) – Noted in Assessment
   - “Discussed good nutrition”
   - “Nutrition reviewed: good with a variety of fruits and veggies”
   - “Uses well, protein, vegetables, fruits”
   - “The child’s current diet is diverse and healthy”
Dear Provider,

Thank you for cooperating with the recent medical record review. Your participation in this annual HEDIS reporting is greatly appreciated. As always, it is a pleasure working with you.

Sincerely,

Health Plan of Nevada and Sierra Health and Life

---

Off Season Work Flow: Analyst Team

Retrospective

- Final rate review and trending
- Bookmark reporting (non-compliance)
- Blinded studies
- Review and revision of chase logic
- Fax campaign
  - Non-responders
- Opportunities for improvement-HEDIS Operations
Strategy and Approach

Off Season Work Flow: Analyst Team

Prospective

• Empanelment data
• Interim data benchmarking
  • Gaps in care report preparation
  • Barriers analysis based on low performing measures
    • Priority based on matrix
    • Use of QI tools: (RCA, affinity diagram, SWOT analysis)
• Initiative development and deployment
  • Impact analysis

Data

Snapshot of success:

Provider 1: WCC Nutrition measure-Medicaid

<table>
<thead>
<tr>
<th>HEDIS 2015</th>
<th>HEDIS 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>50.00</td>
<td>71.43</td>
</tr>
</tbody>
</table>

Provider 2: BCS measure-Commercial

<table>
<thead>
<tr>
<th>HEDIS 2015</th>
<th>HEDIS 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>71.43</td>
<td>83.30</td>
</tr>
</tbody>
</table>
Questions
II. LEVERAGING THE LATEST INNOVATIONS IN ANALYTICS TO BOOST YOUR RATINGS

Nicole Johnson, Director, Performance Outcomes
CARESOURCE

Janine Sala, Associate Director Clinical Quality—HEDIS® Operations
UNITEDHEALTHCARE

Michael Blumental, Chief Executive Officer
HEALTH DATA DECISIONS
Biography

Nicole Johnson is the Director, Performance Outcomes for CareSource. Nicole leads three teams that are responsible for all analytic, operational and submission activities for HEDIS and Stars for the enterprise, including multi-state Medicaid, Medicare Advantage, Marketplace, and Dual-Eligible Demonstration plans. She has been with CareSource for nearly nine years with increasing responsibility, with roles in business analysis, IT, regulatory and analytics. Nicole has in-depth knowledge of health care quality metrics, managed care operations and health policy. She is an alumna of Brown University in Providence, RI.
Janine Sala oversees the HEDIS Operations team for the UnitedHealthcare Nevada market and has over 10 years of experience in the areas of Quality and Performance Improvement. Her HEDIS tenure and subject matter expertise has helped grow a successful internal operations team that is directly responsible for improving HEDIS ratings in all lines of business. Janine has a strong background in analytics, audit activities, technical specifications and Medicare Part C Star ratings as well as all aspects of NCQA IDSS and PLD submission requirements. Janine is a strong-willed success driven professional, who possesses an exceptional determination to get the job done.

When she is not at work, Janine enjoys spending time with her family and running. She prides herself in her philanthropic work, and has lead several successful Man & Woman of the Year campaigns for the Leukemia & Lymphoma Society raising a combined total of over $175,000! Janine welcomes you to reach out to her via janine.sala@uhc.com or on LinkedIn.
Michael Blumental

- Health Data Decisions
- Founder and CEO
- 25 years in health data management
- Prior work experience in multiple Blues, Harvard Pilgrim, Optum and independent consulting firms
- Expert in HEDIS, STARS, Risk Adjustment, Predictive Analytics and Data Validation
Leveraging the Latest Innovations in Analytics
to Boost Your Ratings

HEDIS® Best Practice Conference
27 JUNE 2016

About the Panel

Michael Blumenthal
Health Data Decisions
Founder and CEO
25 years in health data management
Prior work experience in multiple Blues, Harvard Pilgrim, Optum and independent consulting firms
Expert in HEDIS, STARS, Risk Adjustment, Predictive Analytics and Data Validation

Janine Sala
United Healthcare
Associate Director
Clinical Quality – HEDIS Operations
Over 10 years of experience in Quality and Performance Improvement
Over 5 years with UnitedHealthcare
Subject matter expertise in HEDIS analytics, technical specifications and Medicare Part C Star ratings and all aspects of NCQA IDSS and PLD submission requirements.

Nicole Johnson
CareSource
Director, Performance Outcomes
Responsible for all analytic and submission activities for HEDIS and Stars.
She has over 15 years of professional experience and has been with CareSource for nearly nine years with increasing responsibility.
Nicole has in-depth knowledge of health care quality metrics, managed care operations and policy.
Interactive Polling Instructions

• Send a text message to 22333 with ‘hdd2016’ in the body
• You will receive a confirmation message in return
• Enter A,B,C,D,E… for your response

Developing an Analytic Plan

- Resources
- Data Availability
- Software
- Timelines
Resourcing

- Resource composition
  - Staff/contractor/consultant
- Departmental alignment?
- Scope of responsibilities?

HEDIS
Analytics
Clinical
IT

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## CareSource Resourcing

<table>
<thead>
<tr>
<th>HEDIS Operations</th>
<th>HEDIS Analytics</th>
<th>Medicare Stars Analytics</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Manager &amp; 5 operation analysts</td>
<td>• Manager &amp; 7 analysts</td>
<td>• 1 Manager and 1 analyst</td>
</tr>
<tr>
<td>• Responsible for all HEDIS, PLD, and QRS submissions; additional temporary staff is hired during HEDIS season to assist with medical record efforts.</td>
<td>• Responsible for in‐depth analysis of HEDIS measures, delivering key findings and outcomes to assist in creating interventions for HEDIS improvement, and providing VBR support to health partners</td>
<td>• Newly created team; CareSource entered MA in Jan 2016.</td>
</tr>
<tr>
<td>• Processing monthly data runs, including QA activities</td>
<td>• Partner with dedicated IT team for support of internally hosted HEDIS software</td>
<td>• Responsible for analyzing MA Stars data, both Part C and D, for trending, root cause analysis, program development/interventions, and outcomes.</td>
</tr>
</tbody>
</table>

## UHC Resourcing

<table>
<thead>
<tr>
<th>HEDIS Operations</th>
<th>HEDIS Analytics</th>
<th>Medicare Stars Analytics</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Associate Director</td>
<td>• Trending and analysis of current and retrospective data</td>
<td>• HEDIS “on-season”</td>
</tr>
<tr>
<td>• Analytics Team</td>
<td>• Barriers and impact analysis</td>
<td>• Chart chase and abstraction</td>
</tr>
<tr>
<td>• Manager</td>
<td>• Year over year &amp; month over month</td>
<td>• MRRV</td>
</tr>
<tr>
<td>• 6 HEDIS analysts</td>
<td>• All aspects of auditing and NCQA submission for 7 Lines of business (Part C Medicare, Medicaid, Commercial and Marketplace)</td>
<td>• HEDIS “off-season”</td>
</tr>
<tr>
<td>• Nurse Review Team</td>
<td></td>
<td>• Provider education</td>
</tr>
<tr>
<td>• RN Manager</td>
<td></td>
<td>• Gaps in care reports</td>
</tr>
<tr>
<td>• 7 FTE RN's</td>
<td></td>
<td>• Provider chart audit for educational purposes</td>
</tr>
<tr>
<td>• 2 Per diem RN's</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- MRRV: Medical Record Review and Validation
## Typical HDD Client Profile

<table>
<thead>
<tr>
<th>HEDIS Operations</th>
<th>HEDIS Analytics</th>
<th>Chart Review</th>
</tr>
</thead>
</table>
| • Quality Director  
  • Part time HEDIS PM  
  • 1-2 data analysts  
  • 1 Clinical / RN  
  • Part time Coordinator  
  • 3-4 rate updates per year  
| • Data is pulled into HEDIS tables by IT  
  • Minimal analytics expertise in HEDIS/quality department  
  • No HEDIS data repositories  
| • Outsourced chart review  
  • Limited internal overread capability  
  • Separate from certified vendor  
  • Some custom large site retrieval  
  • Some remote EMR retrieval and coding  

## Data Availability

- Frequency of data refresh
- Number of delegated vendors (PBM, BH, Lab, Vision, supplemental, registries)
- Time of Year
- EHR Access
- Technical Constraints
- Claims lag
- Data access constraints
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Software & Vendor Transparency
Your poll will show here

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or Open poll in your web browser

**Typical HEDIS Analytics Timeline**

<table>
<thead>
<tr>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Report submission</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Chart retrieval &amp; review</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HEDIS tracking &amp; trending</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Gaps in care analysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Intervention &amp; gap closure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HEDIS production run prep</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HEDIS tracking &amp; trending</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Effective use of prospective and retrospective data
### Year over Year Trending

<table>
<thead>
<tr>
<th>Hybrid/Method</th>
<th>Measure</th>
<th>2015 Results</th>
<th>2016 Results</th>
<th>Change (2016 Final - 2015 Final)</th>
<th>Current Rate</th>
<th>2016 Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hybrid/CDC</td>
<td>Comprehensive Diabetes Care - HbA1c Test</td>
<td>82.25%</td>
<td>87.37%</td>
<td>5.12%</td>
<td>58.63%</td>
<td>63.84%</td>
</tr>
<tr>
<td>Hybrid/EMR</td>
<td>Comprehensive Diabetes Care - Patient Registry</td>
<td>95.18%</td>
<td>96.21%</td>
<td>1.03%</td>
<td>91.12%</td>
<td>92.23%</td>
</tr>
<tr>
<td>Hybrid/ICD</td>
<td>Comprehensive Diabetes Care - Eye Exams</td>
<td>90.35%</td>
<td>92.46%</td>
<td>2.11%</td>
<td>87.02%</td>
<td>89.16%</td>
</tr>
<tr>
<td>Hybrid/MMI</td>
<td>Comprehensive Diabetes Care - Blood Pressure</td>
<td>85.96%</td>
<td>89.07%</td>
<td>3.11%</td>
<td>81.52%</td>
<td>84.64%</td>
</tr>
<tr>
<td>Hybrid/PMH</td>
<td>Comprehensive Diabetes Care - Smoking Cessation</td>
<td>70.90%</td>
<td>75.30%</td>
<td>4.4%</td>
<td>67.51%</td>
<td>70.91%</td>
</tr>
<tr>
<td>Hybrid/SHR</td>
<td>Comprehensive Diabetes Care -/HbA1c Control ≤ 7.0</td>
<td>90.16%</td>
<td>92.21%</td>
<td>2.05%</td>
<td>86.52%</td>
<td>88.57%</td>
</tr>
<tr>
<td>Hybrid/TGH</td>
<td>Comprehensive Diabetes Care - Foot Care</td>
<td>95.20%</td>
<td>94.01%</td>
<td>-1.19%</td>
<td>90.18%</td>
<td>91.07%</td>
</tr>
<tr>
<td>Hybrid/VHA</td>
<td>Comprehensive Diabetes Care - Preventive Care</td>
<td>80.05%</td>
<td>82.46%</td>
<td>2.41%</td>
<td>76.03%</td>
<td>78.44%</td>
</tr>
<tr>
<td>Hybrid/WIC</td>
<td>Comprehensive Diabetes Care - Social Determinants</td>
<td>85.32%</td>
<td>87.56%</td>
<td>2.24%</td>
<td>81.72%</td>
<td>83.96%</td>
</tr>
</tbody>
</table>

### Forecasting Rates

- Real time forecasting of hybrid measures
- Use of retrospective, prospective and expected data
Your poll will show here

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Rolling 24 month tracking

CareSource Ohio
Medicaid HEDIS Administrative Measures
February 2014 through February 2016

12-month % change is percentage difference of current and prior year averages
Beginning September 2015, HEDIS 2016 specifications reported.

URI - Appropriate Treatment for Children with Upper Respiratory Infection

Current 12 Month Average 93.1%
Prior 12 Month Average 95.7%
12 Month % Change - 4.7%
HEDIS 2013 Admin Rate 93.2%
HEDIS 2013 Final Rate N/A
Measure Analytic Reporting

Pre and Post Intervention Tracking

Urgent Care A ranks 59 out of 290 Providers with 58 or more URI patients
Provider Segmentation

<table>
<thead>
<tr>
<th>Provider</th>
<th>Type</th>
<th>BeforeCareSource Contact</th>
<th>Feb 2012 to Jan 2013</th>
<th>AfterCareSource Contact</th>
<th>Jul 2013 to Jun 2014</th>
<th>AfterCareSource Contact</th>
<th>Jul 2014 to Jun 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Received</td>
<td>Members</td>
<td>Rate</td>
<td>Received</td>
<td>Members</td>
<td>Rate</td>
</tr>
<tr>
<td>Provider A</td>
<td>Urgent Care</td>
<td>12/2/2013</td>
<td>204</td>
<td>416</td>
<td>51.7%</td>
<td>180</td>
<td>352</td>
</tr>
<tr>
<td>Provider B</td>
<td>Emergency Physician</td>
<td>11/7/2013</td>
<td>303</td>
<td>416</td>
<td>51.7%</td>
<td>214</td>
<td>352</td>
</tr>
<tr>
<td>Provider C</td>
<td>Urgent Care</td>
<td>10/20/2013</td>
<td>104</td>
<td>240</td>
<td>43.3%</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Provider D</td>
<td>Urgent Care</td>
<td>10/20/2013</td>
<td>131</td>
<td>242</td>
<td>54.1%</td>
<td>7</td>
<td>72</td>
</tr>
<tr>
<td>Provider E</td>
<td>Urgent Care</td>
<td>11/9/2013</td>
<td>118</td>
<td>192</td>
<td>61.3%</td>
<td>18</td>
<td>83</td>
</tr>
<tr>
<td>Provider F</td>
<td>Urgent Care</td>
<td>11/9/2013</td>
<td>105</td>
<td>191</td>
<td>54.8%</td>
<td>22</td>
<td>119</td>
</tr>
<tr>
<td>Provider G</td>
<td>Urgent Care</td>
<td>11/7/2013</td>
<td>85</td>
<td>156</td>
<td>54.2%</td>
<td>22</td>
<td>119</td>
</tr>
<tr>
<td>Provider H</td>
<td>Urgent Care</td>
<td>11/10/2013</td>
<td>61</td>
<td>124</td>
<td>49.2%</td>
<td>1</td>
<td>46</td>
</tr>
<tr>
<td>Provider I</td>
<td>Urgent Care</td>
<td>12/2/2013</td>
<td>118</td>
<td>265</td>
<td>43.3%</td>
<td>12</td>
<td>114</td>
</tr>
<tr>
<td>Provider J</td>
<td>Urgent Care</td>
<td>10/26/2013</td>
<td>44</td>
<td>118</td>
<td>66.1%</td>
<td>17</td>
<td>92</td>
</tr>
<tr>
<td>Provider K</td>
<td>Urgent Care</td>
<td>10/26/2013</td>
<td>59</td>
<td>106</td>
<td>55.5%</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>Provider L</td>
<td>Group</td>
<td>1/3/2014</td>
<td>53</td>
<td>83</td>
<td>63.9%</td>
<td>15</td>
<td>28</td>
</tr>
<tr>
<td>Provider M</td>
<td>Group</td>
<td>11/15/2013</td>
<td>58</td>
<td>83</td>
<td>69.9%</td>
<td>11</td>
<td>38</td>
</tr>
<tr>
<td>Provider N</td>
<td>Family Practice</td>
<td>10/18/2013</td>
<td>57</td>
<td>78</td>
<td>72.0%</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Provider O</td>
<td>Urgent Care</td>
<td>11/5/2013</td>
<td>57</td>
<td>74</td>
<td>76.3%</td>
<td>8</td>
<td>22</td>
</tr>
<tr>
<td>Provider P</td>
<td>Emergency Physician</td>
<td>11/13/2013</td>
<td>39</td>
<td>66</td>
<td>58.4%</td>
<td>5</td>
<td>11</td>
</tr>
</tbody>
</table>

Total | 2,175 | 3,614 | 39.8% | 559 | 1,737 | 67.8% | 603 | 2,993 | 79.9% |

(Chart Chase) Forecasting High Density Provider Sites

- Prescheduling
- EMR access
- EMR configuration support & guidance

Site count = 494
Chase count = 14,515
### Barriers Analysis Considerations

**Member Focused:**

- Dissect the population
- Demographics:
  - Use various demographics to attempt to identify what is driving noncompliance:
    - Zip code
    - Age group
    - Socio-economic status
    - Pharmacy compliance ratio (Pharmacy related measures)
      - Pharmacy locations

**Provider Focused:**

- Identify provider groups with low compliance
- MD vs. NP or PA
- Underutilized Codes
  - CDC eye
- Access to Care/scheduling issues?
  - Compare to total empaneled population and non-compliance
Affinity Diagrams

- Record each idea on cards or notes
- Look for ideas that seem to be related
- Sort cards into groups until all cards have been used

Developing and Deploying Initiatives for Improvement
A CAP Case Study

PROCESS
An in-depth analysis was conducted on the Medicaid population to identify schools in the Las Vegas area with the greatest opportunity to increase CAP compliance through a school-based health clinic. The analysis looked at the following:

- CAP Population with age stratifications
- Zip code analysis of the highest CAP concentration in LV
- The concentration rates of free and reduced price lunch at each LV area school.
- Total populations of each CCSD school

By focusing in on certain demographic areas and schools, the following can be achieved:

- Increased access to care
- Mitigation of transportation related barriers
- Reduced absenteeism for the student
- Limited barriers related to parental work leave conflict
- Possible reduction in hospitalizations and emergency room usage

YIELD

A CAP Case Study

Legend:
- AAP Top 10 Non-Compliant
- CAP Top 10 Non-Compliant
- CAP & AAP Top 10 Non-Compliant
- Mobile Clinic Sites
A CAP Case Study

ANALYSIS DRIVEN RESULTS

New Clinics!
Several new clinics opened in areas where the highest concentration of Medicaid members reside

Mobile Clinic!
To be deployed in areas of low compliance and high Medicaid concentration.

Initiatives for improvement

- Analyze variations in measure compliance across member demographics
- Age
- Zip Code
- Gender
- Length of Enrollment
- Race

Success Segmentation Criteria

Compliance

Population factors influencing non-compliance

Provider Density by Zip Code Analysis

Provider Density Sufficient?

Population factor

Population Factor / Access to Care

Population Factor / Yes
**Initiative Hierarchy**

- **Medicare**
  - Member based initiatives and outreach

- **Medicaid**
  - Provider based initiatives and outreach

- **Commercial**
  - Employer group based initiatives and outreach

**Contact Info**

**Mike Blumental**

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- 774 213 5050 or 781 718 2118
- www.healthdatadecisions.com

**Janine Sala**

- Janine.sala@uhc.com

**Nicole Johnson**

- Nicole.Johnson@caresource.com
Cocktail Hour
CHAIRPERSON’S RECAP OF DAY ONE

Melanie Richey, VP, Quality
CENTAURI HEALTH SOLUTIONS
VP of Quality, Centauri Health Solutions

As VP of Quality, Melanie Richey has more than 20 years of healthcare experience with deep expertise in quality management strategies, regulatory compliance, operations and product development.

Ms. Richey's experience includes a broad healthcare background across payers, providers and employer groups, commercial, Medicare and Indigent programs as well as care delivery re-design.

Prior to joining Centauri Health Solutions, Ms. Richey served as the senior director, Quality Solutions for Verisk Health, leading all aspects of quality management and improvement products for commercial, Medicaid, Medicare and QHP clients.

Prior to joining Verisk Health, Ms. Richey was responsible for launching and expanding a network model quality management program for Kaiser Permanente Colorado. During her tenure at Kaiser Permanente, Ms. Richey oversaw a broad range of network operations for the organization including risk adjustment, disease management, accreditation and regulatory compliance, wellness and P4P programs.

Ms. Richey holds a Master's degree in Business Administration from the University of Phoenix and a Bachelor's in Nursing from Wright State University.
FOLLOW THEIR EXAMPLE: LEARN FROM THESE INNOVATORS THE STEPS YOU CAN TAKE TO BOOST YOUR QUALITY SCORES

Improving Measures Across the Board by Integrating Population Health Management Strategies

Colleen Walsh, Assistant Vice President, Clinical Affairs and Quality Improvement
UPMC HEALTH PLAN
Colleen Walsh is the Associate Vice President of Clinical Affairs and Quality at UPMC Health Plan. Colleen has over 30 years of experience in managing quality strategy and outcomes, both at the hospital and managed care arenas. At UPMC Health Plan, Colleen is responsible for eleven different products for HEDIS and NCQA accreditation, quality improvement as well as specialty provider profiling, provider credentialing, and clinical programs for Patient Centered Medical Home, Medicaid, and Special Needs products.
Steps to Take to Boost your Quality Scores in HEDIS Integrating Population Health Strategies

Colleen Walsh
AVP Clinical Services and Quality Improvement
June 2016

UPMC Health Plan

Health Plan in Western Pennsylvania – About 1.2 million members

Part of UPMC an integrated delivery system

Products: Medicare, D-SNP, I-SNP
Commercial, CHIP, Marketplace, Medicaid
UPMC Health Plan Quality Results

NCQA Ratings
- Commercial HMO achieved a level 5 rating
  - 491 plans rated, ratings given are 1 to 5
  - One of 11 health plans nationally to earn a five level rating and the only plan in Pennsylvania
- Medicaid and Medicare HMO achieved a level 4 rating
  - 149 Medicaid plans and 376 Medicare plans rated

CMS Star Scoring – 369 health plans scored
Medicare HMO achieved a 4.5 score out of a possible 5 star score
- A 4.5 star is achieved by 18% of plans scored
Medicare PPO and Special Needs Plan achieved a 4.0

Alignment of Goals

Clinical Reporting
Quality Reporting
Finance Reporting
Care Managers
Lower MER
Increase Quality
Member and Provider Engagement
UPMC Health Plan Supports Medical Homes Focusing on Whole Person Care, Virtual Teams and Community Resources

Key Supports for Population Health Approach

**Physician and Member Supports**

- PBCM office support
- Shared savings incentive program
- Prescription for Wellness
- Mobile events
- Community Team approach
- Point of care or contact (inpatient discharges, Member Service touch)
**Provider Focus – Population Health Approach**

- Practice Based Care Managers in PCP offices – Physician the Lead
- Health Plan supports a practice’s entire health plan population
  - Population health approach versus disease, single gaps in care
  - Focus unplanned care
  - Community resource identification and member linkage
  - Community Team meets member where they live

- Health Plan Medical Director assigned to practices for support and collaboration
- Shared savings incentive program based on OVER ALL quality score

---

**Physician Collaborative Initiatives**

- **Total Population**: 307,390
- **Total Physicians**: 937
- **Active Sites**: 396
- **Shared Savings Sites**: 20

**CM**: 160,364
**MA**: 71,787
**MC**: 62,342
**SNP**: 9,765
**CHP**: 3,132

**PCMH – Health Plan Staff in Offices**
Prescription for Wellness – Notable Visit for Member

Prescribe it, and they will come...

Physician writes a patient an order (prescription) for Wellness
• What is important to patient
  • Losing weight
  • Stop smoking
  • Diabetes and wants to get HbA1c in control
  • Hypertension and wants to get BP in control

Physician writes prescription to join HP Clinical programs – sends automated referral

Strategy to Improve Member Engagement

What members have the greatest potential for improvement (Medicare and SNP)
• Smart Stars Methodology
  – Analytical modeling used
  – Which members have the highest number of gaps
  – Which members will assist move to next star level
  – What are measure star weights
  – What gaps are most easily closed (clustered)
  – Which members are the most likely to engage
  – Above elements determine member outreach priority
  – Managed monthly – member outbound calls
Physician Strategy to Improve Stars

Physicians Need Detail

- **Data**
  - Reports that are easy to understand
  - Reports that are *actionable*.
  - Timely reporting
  - Results – how are we doing?

- **Clarity on what is the ask**
  - What is the measurement of medication adherence
  - What is the timeframe for osteoporosis screening or treatment
  - What medications are on the high risk medication list
  - Education on new Statin measures

Provider and Member Collaborative Initiatives

Mobile events at physician office, community locations or high rises where our members live – Health Plan manages

- Members invited with gaps in care
- Labs drawn, retinal eye exam, colorectal screening kits distributed, Adult BMI and BP done and gets into chart, osteoporosis screening.
- Preventive – no member copayment
- Diabetes educators present
- Pharmacist present for medication review
- Flu vaccines in season
Community Collaborations

Created a Community Team of nurses, social workers and community health workers

• Nurses visit member while inpatient (criteria based)
• Coordinate care on discharge and assess needs
• After discharge dependent on needs, member is visited in home by the nurse, social worker or a community health worker

The Community Health Worker is a non professional who lives in the member’s community. They understand the area, help keep contact with our member and helps member connect to available community resources. Becomes a trusted connection.

Live Chat via Secure Mobile App

Mobile Chat
UPMC Health Plan
Mobile
Motivation – Support in your wellness journey

Interactive Texting Campaigns (Complete)

Reminder Texting Campaigns (Complete)

Created interactive texting campaigns with quiz questions and hyperlinks (Home Run for Health, Weight Race)

Implemented about 7 different reminder texting campaigns for TracFone users (MA redetermination, SNP redetermination, flu shots, pediatric dental visits, mammograms, SNP health assessments, HEAC meetings)

HEDIS focus across the products

- Focus on HEDIS key metrics by Product and by overall populations
  - Measures we are less than the NCQA 75th percentile
  - Medicare and SNP Star metrics
  - On Marketplace measures 2nd year trend
  - Off Marketplace impact on Commercial PPO results

- Identify measures where interventions go across products
  - Colorectal cancer screening
  - Maternity Prenatal and Postpartum
  - Diabetes
  - Controlling high blood pressure
  - PCR – readmissions
  - High Risk Medications
  - Behavioral health measures
Population Based Initiatives

• Colorectal
  – Encourage provider use of colorectal screening kits
  – Provide practices with data, physicians use of the kit to close gaps in care and compare to rest of network.
  – Distribute kits at member point of service (in-home assessments, get kits to physician offices – free to physicians, health plan mobile events, community team interactions
  – PBCM facilitate office kit distribution
  – Shared saving metric

• Prescription for Wellness
  – Diabetes
  – Controlling high blood pressure
  – Smoking cessation
  – Asthma
  – Cardiac disease

Population Based Initiatives

• Maternity prenatal and postpartum
  – OB Needs Assessment Form
    • OB providers asked to complete and submit form at time of first prenatal visit
    • Documentation on form Identifies OB history including high risk pregnancies, medical history including depression, guidance given such as smoking cessation
    • Have automated if OB on EPIC
    • Provider incentive – pay for each form submitted that is complete
    • Let’s us know where care rendered, supports medical record review which can be difficult (high risk pregnancies)
### Population Based Initiatives

**Readmission (PCR)**
- Transition Coordinator on-site high volume hospitals
- Sees all members, on discharge conducts medication review and schedules follow-up appointment, hopefully within 5 days post discharge
- PBCM follows up on every discharge for the practice
- Shared Saving metric
- Referrals to Community Team for members who meet criteria
- Hospital P4P program includes readmission rates, 20% of total score for incentive gain.
- Real time notification of admissions and discharges large percentage readmissions, remainder notification from UM

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**High Risk Medications**
- Provider education on list of medications
- Shared savings metric
- Worked with network hospitals to coordinate their high risk medication list with the Health Plan – order stopped at point of ordering inpatient till discussion with hospital Pharmacist

**Rheumatoid Arthritis Drug Therapy**
- What provider placed member in denominator – trends for coding errors
- If Rheumatologist placed member in denominator why not on DMARD medication
- Trending and education
Population Based Initiatives

- Behavioral Health Measures - *New*
  - 11 different measures
  - PH/BH physician and internal workgroups analyze and implement interventions across appropriate products
  - Strong collaboration with BHMCO if covering members

Questions
Thank You!
SPECIAL FEATURE: IMPROVING SCORES BY BRINGING CARE TO MEMBERS

Joy Bland, RN, MA, CCM, CPHQ, Regional Vice President Clinical Quality Management, CA Medicaid

ANTHEM BLUE CROSS
Joy Ann Bland, RN, MA, CCM, CPHQ

Joy has more than 21 years of experience both as a registered nurse and as a senior healthcare leader with expertise in Quality Improvement and Performance. Joy has achieved certification as a Certified Professional in Health Care Quality, is a Certified Case Manager and holds a Registered Nursing License in California and Arizona. She is currently pursuing a Doctorate in Behavioral Health from Arizona State University.

Joy has broad expertise in creating and managing programs that use clinical quality and metrics to increase cost effective delivery of care. Her dual leadership roles reflect the strong partnership between clinical and operations that is needed in the management of health care services to improve compliance and encourage patient-centered care.

Joy’s prior experience includes the Associate Vice President of Quality at Molina Healthcare, West Regional Director of Quality at United Healthcare, and the National Director of Quality for a Home Health Agency. She has also held roles as the Director of Medical Management focused on Utilization and Case Management.

Joy is currently the Regional Vice President of Clinical Quality Management for Anthem Blue Cross in California. In just a few short months Joy has been able to establish a regionally focused Quality Management team to serve the needs of members in our Northern, Central and Southern regions. Under Joy’s strong leadership these regional teams have been able to improve quality scores by member outreach, provider collaboration and identification and implementation of best practices. Joy’s dedication to quality management has led Anthem through a successful NCQA Accreditation, improved HEDIS scores and state audits with minimal findings. Joy’s collaborative and team-oriented leadership skills and her ability to distill best practices allow her to deliver consistent and high quality results.
KEY PRESENTATION OBJECTIVES

1. History of Medi-Cal Program
2. Who we Are? Anthem
3. Department of Health Care Services Structure by County
4. California County Breakdown
5. Population Health Management
6. HEDIS Key Points
7. Case Study Diabetes
8. Vendor Collaboration
9. Geo-Mapping
10. Outcomes of Interventions
MEDI-CAL HISTORY

In 1966, Medi-Cal was created to provide health coverage to low-income families, children, pregnant women and the disabled.

Now, 50 years later, Medi-Cal:
- is the state’s largest health insurer
- provides coverage to 1 in 3 Californians (more than 13 million people)

Our Story and Who We Are

History
Anthem, Inc. is one of the largest health benefits companies in the United States. Through its affiliated health plans, Anthem companies deliver a number of leading health benefit solutions through a broad portfolio of integrated health care plans and related services, along with a wide range of specialty products such as life and disability insurance benefits, dental, vision, behavioral health benefit services, as well as long term care insurance and flexible spending accounts.

Mission Statement
Together, we are transforming health care with trusted and caring solutions

Vision Statement
To be America’s valued health partner

Core Values
Accountable
caring
Easy-to-Do Business With
Innovative
Trustworthy
THE NEW
Medicaid Health Plan

Structure/Culture
- Regional HP Model with certain statewide functions
- Culture of Quality, Compliance, Controlling Medical Costs
- Data driven programs and measured results

Tools
- Clinical analytics now used in quality and cost monitoring
- Reports now being shared with measurable actionable results

Programs
- Medicaid specific programs launched with significant results
- Built on best practice programs with refinement and tailored to our membership

Department of Health Care Services
Medi-Cal Plans by County

Geographic Managed Care (GMC)
- GMC serves about 920K beneficiaries in two counties: Sacramento and San Diego.

How it works: In GMC counties, DHCS contracts with several commercial plans. This provides more choices for the beneficiaries.

Two-Plan
- Two-Plan serves about 5.7M beneficiaries in 14 counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus and Tulare.

How it works: In Two-Plan Model counties, there is a Local Initiative (county organized) and a Commercial Plan. The Department of Health Care Services (DHCS) contracts with both plans.

Information from DHCS Medi-Cal Managed Care Program Fact Sheet
http://www.dhcs.ca.gov/progmpapr/Documents/MCModelFactSheet.pdf
California County Breakout

Medi-Cal (non-Rural): (10 counties)
  Northern:  5 counties
  Central:  4 counties
  South:  1 county

Medi-Cal (Rural):  (19 counties)
  Northern:  13 counties
  Central:  6 counties

Population Health

Defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group.

An approach to health that aims to improve the health of the entire population.
HEDIS is a performance measurement tool that is coordinated and administered by the NCQA (National Committee for Quality Assurance). Administrative and Hybrid data are both used to determine our rates.

**HEDIS KEY POINTS**

- Measures performance, identifies quality initiatives and provides educational programs for providers and members.
- USED BY MORE THAN 90% OF AMERICA’S HEALTH PLANS
- Medical record abstraction process for all measures must be completed by May 12 with final rates locked by June 15.
- Measurement requirements and calendar can change on an annual basis.
**ADMINISTRATIVE HEDIS measures**

Administrative data comes from claims, encounter data and data captured prior to the HEDIS project

- AAB: Avoidance of Antibiotic Treatment in Adults with acute Bronchitis
- MMA: Medication Management for People with Asthma
- LBP: Use of Imaging Studies for Low Back Pain
- MPM: Monitoring of Persistent Medications (ACE/ARB and Diuretics)

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**HYBRID HEDIS measures**

Hybrid measures are a combination of administrative data and data collected during the HEDIS project by conducting medical record reviews

- WCC: Weight assessment/counseling for nutrition and physical activity for children/adolescents
- W34: Well-child visits in the third, fourth, fifth and sixth years of life
- CBP: Controlling high blood pressure
- CDC: Comprehensive diabetes care
- CCS: Cervical cancer screening
- IMA: Immunizations for adolescents
- PPC: Timeliness of prenatal and postpartum care
- CIS: Childhood immunization status
Comprehensive diabetes care

HbA1c testing  Eye exam  Nephropathy  Blood pressure

Members 18-75 years of age with type 1 and type 2 diabetes, who had a retinal eye exam performed during the measurement year.

- A note or letter from an ophthalmologist, optometrist or other healthcare professional summarizing the date the procedure was performed, and the results of the retinal exam
- A dated retinal chart, photograph or fluorescein angiography report
- A note, prepared by the PCP, indicating the date of the procedure and that an ophthalmoscopic exam was completed by an eye care professional, including the results of the exam
- Documentation of therapeutic retinal surgical procedures done by the eye specialist

Common chart deficiencies:
- Incomplete information in the PCP charts
- Incomplete information related to yearly eye exams and results
The High Cost of Poor Vision

The United States spends more than $50 Billion a year on vision problems.

**What can be done...?**

Only optometrists and ophthalmologists can detect the signs of retinopathy.

**Why is it important to see the optometrist/ophthalmologist...?**

Eye damage can occur before symptoms are noticed.

The earlier the detection the better.

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**CURRENT STATE**

- 9 Medi-Cal Counties in CA primary focus
- Sacramento County Eye Clinic Pilot
- Geo Mapping to target zip codes in Sacramento County
- Identify Vision Providers near target zip codes
- Schedule Clinic Day
- Identify members to call to schedule for the clinic day
- Will include rural counties in 2016
- Implement vendor collaboration with mobile eye machine in Federally Qualified Health Centers
VENDOR TECHNOLOGIES

- EYE Parks: putting technology in the offices by providing equipment in collaborating with UC Berkley
- Clinics: bringing technology to the patient by providing nearby clinics
- Innovation: collaboration with vision vendor to bring technology and mobile eye care to our large provider groups

Member Disparities

- Member calls with bilingual staff or interpreters
- Transportation services available
- Bringing care to member's home
- GEO Mapping to provide access
- Anthem is an active member of the Community Advisory Committee
- Member incentive material includes additional languages
- On-Site Health Educators

Putting Members Needs First
CLINIC DAY

MEMBERS
Members Receive Eye Exam
Health Education for Member and Family
Discuss Needs of Member/Family
Schedule Additional Appointments as Needed

COLLABORATION

_PROVIDERS

WHAT IS REQUIRED

VISION VENDOR
Collaborate with Health Plan to develop process
Identify providers who can provide services at clinic day
Identify location to host the eye clinic day

HEALTHPLAN
Collaborate with Vision Vendor to develop process
Identify Members who need service
Schedule members for clinic day
Provide health educators on site at clinic day

KEYS TO SUCCESS

Regularly meet with vision vendor
Identify other needs to manage care with standing orders
Provide resources to members to ensure they keep their clinic day appointment
Educate members on health care needs for the whole family
Eye Exam Rates MY 2013, MY 2014 and MY 2015

<table>
<thead>
<tr>
<th>County</th>
<th>MY 2013</th>
<th>MY 2014</th>
<th>MY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda</td>
<td>35.51</td>
<td>38.32</td>
<td>53.52</td>
</tr>
<tr>
<td>Contra Costa</td>
<td>32.14</td>
<td>36.54</td>
<td>52.76</td>
</tr>
<tr>
<td>Sacramento</td>
<td>37.96</td>
<td>38.39</td>
<td>48.98</td>
</tr>
<tr>
<td>San Francisco</td>
<td>42.75</td>
<td>52.97</td>
<td>44.67</td>
</tr>
<tr>
<td>Santa Clara</td>
<td>32.75</td>
<td>37.12</td>
<td>42.37</td>
</tr>
<tr>
<td>Fresno</td>
<td>49.78</td>
<td>45.25</td>
<td>40.35</td>
</tr>
<tr>
<td>Kings</td>
<td>40.35</td>
<td>44.89</td>
<td>40.60</td>
</tr>
<tr>
<td>Madera</td>
<td>47.69</td>
<td>49.78</td>
<td>48.61</td>
</tr>
<tr>
<td>Tulare</td>
<td>47.02</td>
<td>51.16</td>
<td>52.67</td>
</tr>
</tbody>
</table>

Note: The MY 2015 mean is 47.06%
CONCLUSION

Collaboration with vision vendor
Identified target populations
Services and education provided
Improvement in rates
High Quality Care to the members we serve

FOCUS ON QUALITY
Together we can transform a community

QUESTIONS
MTM SPOTLIGHT: HOW WE ACHIEVED CONSISTENT IMPROVEMENT IN MEDICATION ADHERENCE MEASURES:

CASE STUDY: How We Achieved Consistent Improvement in Medication Adherence Measures

Jennifer Strohecker, PharmD, BCPS | Director Medicare Pharmacy, Clinical Operations
Molina Healthcare, Inc.
Jennifer Strohecker, PharmD, BCPS

Dr. Strohecker is the Director of Pharmacy, Clinical Operations, for Molina Healthcare, in Long Beach, California. She oversees clinical pharmacy initiatives which span MTM services, adherence interventions for STAR and HEDIS metrics, and corporate quality improvement projects. She is actively involved in outcomes research within Molina Healthcare. Her areas of expertise include clinical research, components of effective pharmacist/patient communication, medication adherence, and pharmacy process improvement.

Dr. Strohecker has practiced as a pharmacist for 17 years in a variety of settings including the pharmaceutical industry, community pharmacy, pediatric intensive care unit, cardiology ambulatory care, and as full-time faculty with a college of pharmacy. In 2010, her research with patient-physician communication regarding warfarin and herbal supplements was recognized at The American Heart Association Scientific Sessions Meeting in Chicago, Illinois and the Heart Rhythm Society Meeting in Denver, Colorado as notable media pieces. She is a nationally recognized speaker for MTM and has chaired several MTM conferences. Dr. Strohecker participates in annual mission trips to Cuba and Guatemala and is an active member of several national pharmacy organizations.

Dr. Strohecker received a Doctor of Pharmacy degree from the University of Florida, followed by postgraduate training, including Board Certification as a Pharmacotherapy Specialist.
HOW WE ACHIEVED CONSISTENT IMPROVEMENT IN MEDICATION ADHERENCE MEASURES

June 28', 2016 | Presented by: Jennifer Strohecker, PharmD, BCPS
Director Medicare Pharmacy, Clinical Operations

Background
Outline

• Outline the gap our organization is closing
• Define who Molina Healthcare is and why we developed coordinated interventions
• Detail the process our team used and how you might use a similar one
• Report our results, applicability to others, limitations – where are we going next?
• Q&A

The Cost of Medication Non-Adherence
Economic Pressures on Healthcare

- Population expansion with multiple morbidities
  - ACA – 12 million Americans in 2014, possibly adding up to 26 million by 2024

- Avoidable healthcare costs
  - Up to $300 billion in avoidable costs

- Specialty pharmacy
  - Projected to consume 50% of medication dollars

- Transitions of care
  - High rates of avoidable medication errors leading to readmission

Non-Adherence Contribution to Total Avoidable Costs

Exhibit 1: Avoidable U.S. healthcare costs add up to $213 billion

Who We Are and Why Did We Need To Improve

Molina Healthcare

- Founded in 1980 by Dr. C. David Molina
- Single clinic to many clinics
- Commitment to provide quality healthcare for those most in need and least able to afford it
- Fortune 500 company that touches over 4.1 million Medicaid/Marketplace & over 100K Medicare lives
- 17 states & 2 Territories
Socially High-Risk Populations

- Within Medicare, Molina focuses on the neediest Medicare members
- Many have physical and social barriers that layer on top of motivational barriers
- Approaches prior to 2013 were not sensitized to members’ unique needs
- Approaches also tried to touch all members with poor success rates

Our Comprehensive Approach to Medication Adherence
Evolution of the Medication Adherence Program

Past
Vendor executed process

Today
Centralized, in-house program

Personalized, high touch, coordinated model

Medication Adherence Intervention Template

High Touch Model Built on Medication Therapy Management Platform

Interactive conversation
Repeated
Individualized
Aimed at resolving barriers

Open ended questions, use of Motivational Interviewing (MI)
Assesses knowledge of disease, fears, and goals
Multiple touch points to promote changes
Unique approach based on patient concerns or desires
Identification and removing barriers
Coordination of care, communication with providers
Training of Pharmacy Team

- Modules on health literacy, motivational interviewing, cultural competency and patient-centric care
- Sample questions
  - Do you understand how your medications work to treat your conditions?
  - Do you believe that your medications can improve your health?
  - [From a clinical staff person]: I have many questions for you, but before I begin can you tell me what questions or concerns you have for me about your medications?
- Health literacy awareness is key
  - Incomplete or misunderstood patient-provider communications can be a barrier to achieving health outcomes
  - Using words that are clear and easy, in a language that is understood... is our top priority

A Team-Based Approach

PCP

- Patients
- Social worker
- Care manager
- Mid-level providers
- Pharmacist
Example Patient and Management

Intake = prior year patient 50% non-adherent on diabetic medication

Outcome = Adherence thru end of year after intervention

Program Rollout

Direct Medicaid and Exchange HEDIS

Medication Adherence Supporting Other HEDIS Metrics

Medicare Advantage Medication Adherence
Using Analytics to Prioritize Where to Start

Predicting Motivation – Our Objectives

Molina Healthcare wanted a comprehensive, multi-faceted intervention staffed with Pharmacy department full-time employees and Pharmacy student interns.

The model would be fully internal, with leadership and support from Quality, Healthcare Services and Medical Affairs, and minimal support from our external Pharmacy Benefit Manager.

The key need: identify members that would have the greatest need for management and would result in the greatest impact ... YET would also have the motivation to participate and change.
Methodology

- We used LexisNexis MEDai®, a proprietary predictive analytics software that uses historical inputs available in an organization to output predictive indices for risk stratification.
- Their stated R², a measure of predictive power, is 0.28; however, Molina could not confirm whether this value applied to their motivational metrics.
- The software has multiple metrics; for ease of use, we chose motivational category, a 0-6 scale, in which most individuals will fall in categories 1-5.

Key Inputs to the Model

- OP Visits
- IP Visits
- ER Visits
- Preventive Care
- Chronic Care Med Adherence
- Psych Med Adherence
- Age
- Gender
- Ethnicity / Race
- Care Gap Closure
- Miscellaneous
Criteria for the Intervention

- Motivation category = 3 or 4; OR
- Detected adherence care gap; OR
- Known behavioral health diagnosis

Category 1: Very poorly engaged
Category 2: Poorly engaged
Category 3: Not highly engaged
Category 4: Likely highly engaged
Category 5: Highly engaged

Initial cohort was approximately 14,000, or 30% of total covered lives, refreshed monthly

Outcomes
General Barrier Analysis Summary

<table>
<thead>
<tr>
<th>Barrier to Adherence</th>
<th>Reported Rate (n=2578 patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indication (”What is it for?”)</td>
<td>65%</td>
</tr>
<tr>
<td>Forgets to take (”When do I take it?”)</td>
<td>42%</td>
</tr>
<tr>
<td>Forgets to refill (”When do I refill it?”)</td>
<td>16%</td>
</tr>
<tr>
<td>Cost (”How do I afford it?”)</td>
<td>12%</td>
</tr>
<tr>
<td>Transportation (”How do I get it?”)</td>
<td>11%</td>
</tr>
<tr>
<td>Side effects (”Why does it make me feel…?”)</td>
<td>3%</td>
</tr>
</tbody>
</table>

A substantial number of patients could be identified who wanted help and who we could help with concrete actions.

Results from the Medicare Intervention

Table 3 - Number of plans achieved at least 4 stars in the Medicare Part D Medication adherence metrics.

<table>
<thead>
<tr>
<th>STARS Metric</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2015 – 2016 Change in Stars&lt;br&gt;^&lt;br&gt;^&lt;sup&gt;1&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Adherence for Diabetes Medication</td>
<td>Plans 3+ Stars</td>
<td>2 / 8</td>
<td>3 / 8</td>
<td>8 / 8</td>
</tr>
<tr>
<td></td>
<td>Plans 4+ Stars</td>
<td>2 / 8</td>
<td>1 / 8</td>
<td>3 / 8</td>
</tr>
<tr>
<td>Medication Adherence for Hypertension (RAS antagonists)</td>
<td>Plans 3+ Stars</td>
<td>2 / 8</td>
<td>1 / 8</td>
<td>6 / 8</td>
</tr>
<tr>
<td></td>
<td>Plans 4+ Stars</td>
<td>0 / 8</td>
<td>0 / 8</td>
<td>3 / 8</td>
</tr>
<tr>
<td>Medication Adherence for Cholesterol (Statins)</td>
<td>Plans 3+ Stars</td>
<td>2 / 8</td>
<td>6 / 8</td>
<td>8 / 8</td>
</tr>
<tr>
<td></td>
<td>Plans 4+ Stars</td>
<td>2 / 8</td>
<td>0 / 8</td>
<td>3 / 8</td>
</tr>
</tbody>
</table>

CMR Completion Rate (%)<br>10.7% | 21.6% | 53.4%<br>

^<br>^<sup>1</sup>The measurement period for Stars reporting is the year prior to the reporting period.<br>^<br>^<sup>1</sup>The average change in STARS from 2015 to 2016 reporting periods between the 8 health plans reporting since 2014

**Rates for Adherence to RAS Antagonists**

![Graph showing rates of adherence for different plans from 2013 to 2016.]

- **Plan A**
- **Plan B**
- **Plan C**
- **Plan D**

Average 9.8 percentage point increase over 2.5 years of intervention

**Antidepressant Medication Specific Barriers**

- “I feel better – why do I need to keep taking the medication?”
- “No one explained to me that I had to take it every day…”
- “I didn’t feel better and didn’t know what to do next.”
- “I had [???] side effect and stopped the medication.”

Some barriers are similar to the physical health intervention; others are mental health specific.
Rates for Antidepressant Medications (Plan E)

Acute Phase
2016 = 52.6%
2015 = 47.3%

Continuation Phase
2016 = 38.4%
2015 = 34.4%

Note: Motivational targeting was not used in this population.

Lessons Learned / Further Investigation
Lessons Learned

A comprehensive intervention strategy works

The high touch model is effective when non-medical barriers exist

Involving the PCP and office staff has been a key success factor

Innovative approaches helped improve ROI

Further Investigation

What works in high engagement populations - IVR, IVR with auto-referral?

Should motivational targeting be used in all populations?

What are the strategies for low motivation clients?

What makes each medication intervention unique?
Appendix 1: Validation of the Model
Validation Using HEDIS Anti-Depressant Measure

Molina wanted to confirm that using motivational category was at a minimum non-inferior to using no targeting – in other words, we still wondered whether we would have gotten better results if we had not used motivation at all.

To do this, we retrospectively examined results from our Anti-Depressant Medication Management Continuation Phase measure, which used a similar intervention strategy, EXCEPT:
- Molina Health Plans managed or co-managed the interventions with Pharmacy
- Predictive modeling was not used in any way
- NOTE: Metrics have improved for these measures as well, yet with substantially more effort used

Results – Motivation Category Frequency

<table>
<thead>
<tr>
<th>Motivation Category</th>
<th>Number of Members</th>
<th>Percentage of Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>17</td>
<td>1.73%</td>
</tr>
<tr>
<td>1</td>
<td>206</td>
<td>20.98%</td>
</tr>
<tr>
<td>2</td>
<td>235</td>
<td>23.93%</td>
</tr>
<tr>
<td>3</td>
<td>353</td>
<td>35.95%</td>
</tr>
<tr>
<td>4</td>
<td>126</td>
<td>12.83%</td>
</tr>
<tr>
<td>5</td>
<td>45</td>
<td>4.58%</td>
</tr>
</tbody>
</table>
Results – Successful Outreach by Category

Correlation between outreach completion and higher motivation

Results – Successful Outreach by Category

Correlation between adherence to depression medications and higher motivation
MTM SPOTLIGHT: HOW WE ACHIEVED CONSISTENT IMPROVEMENT IN MEDICATION ADHERENCE MEASURES:
CASE STUDY: PROVIDER ENGAGEMENT

Elaine Rosenblatt, MSN, FNP-BC, Director of Quality and Care Management
UW HEALTH

Lydia Simon, PharmD, Clinical Performance Improvement Manager
MEMORIALCARE HEALTH SYSTEM
ELAINE ROSENBLATT MSN, FNP-BC – BIOGRAPHICAL SKETCH

Elaine Rosenblatt is the Director of Quality and Care Management at UW Health in Madison Wisconsin. Since October 2005 she has responsibility for the strategic oversight of quality initiatives for Unity Health Insurance, which is part of the UW Health integrated health system. Her responsibility includes providing leadership for the Health Services and Medical Management Departments in their disease management programs, clinical quality improvement, health education, prevention and wellness programs and utilization management for Unity Health Insurance. Adhering to NCQA standards and continually evaluating improvements in HEDIS™ measures, Unity continues to maintain its Excellent accreditation with NCQA.

Elaine is also a nurse practitioner in the Internal Medicine clinic at UW Health for almost 39 years, with a specialty in pre-travel health. In this role as well as her role as a Clinical Associate Professor in the School of Nursing, University of Wisconsin-Madison, she has teaching responsibilities for medical residents, medical students, nurse practitioner students and pharmacy students.
Biography

Lydia Simon, PharmD, Performance Improvement and Quality
Greater Newport Physicians, MemorialCare Medical Foundation

Dr. Simon is the Manager of Performance Improvement and Quality for Greater Newport Physicians (GNP), the affiliated physician group for the MemorialCare Medical Foundation. She is responsible for the California Pay for Performance program initiatives, CMS 5 Star project strategies, and innovative quality solutions for the physician members. GNP is an IPA with various risk arrangements for commercial HMO and Medicare Advantage plans and has earned recognition for providing high level standards of care.

Dr. Simon has 20 years of healthcare experience including Integrated Delivery Systems, Physician Organizations, Healthcare Quality, Medicaid and Medicare Advantage. She has spent the last 5 years working in the P4P, CMS 5 Star, and more recently the ACO arenas for Greater Newport Physicians.

Dr. Simon has a doctorate in Pharmacy degree from the University of California, San Francisco and is trained in Lean Leadership. She lives in Southern California and enjoys traveling with her family and friends.
Partnering with Providers to Improve Quality Metrics

- Elaine Rosenblatt MSN, FNP-BC
- Director of Quality and Care Management
- UW Health/Unity Health Insurance
- June 28, 2016

Objectives

- Discuss how health plans can partner with provider groups to improve quality metrics through the use of quality contracts and employing a Quality Care Coordinator
- Discuss process for developing and enhancing quality contracts with provider groups
- Enhance provider’s ability to engage members in cancer screening, immunizations and improving health conditions through data sharing
Who We Are

- Middleton, Sauk City & La Crosse (Onalaska) Wisconsin based HMO: 35 county service area in Wisconsin, Minnesota & Iowa
- Membership: 269,000 (2016 year to date)
- 3rd largest health insurer in Wisconsin
- Net Worth: $1 billion
- Contract with UW Health & Gundersen Health System employees for clinical programs

What Differentiates Unity

- Owned by UW Health (University of Wisconsin) and Gundersen Health System
  - Focus on building a fully integrated delivery system
- Provider Network and Financial Stability
- Outstanding Customer Service
  - Highly personalized approach to service and problem solving - we want to make it easy to do business with us
- Leader in Health and Wellness
Goals of the Provider Partner Program

- Members working directly with their providers
- Providers engaged in quality metrics
- Providers sharing risk with insurance company for improved quality
- Improving HEDIS™ scores and other quality metrics
- Encouraging the medical home model

Advantages of Provider Driven Outreach

- Patients prefer being advised of needed tests by their provider
- Improved efficiency when the clinic calls
  - Appointments can be made directly
  - Tests ordered
  - Questions answered by doctors/nurses
- Supports the medical home
Health Plan Tools

- Health Plan **provider coordinators** meet with clinics to review programs, answer questions
- **Provider Panel** (started 2006)
- **Quality Contracts** (started 2009)
- **Shared funding** by health plan and providers for a clinic **Quality Care Coordinator** (started 2013)

- Member P4P (started 2008) complements the provider incentives

Provider Panel

- Physician champions and clinic quality coordinators meet 1-2 times a year with health plan Medical Director and quality staff
- Discuss quality initiatives, review quality results and share best practices
- New initiatives are reviewed at this forum allowing for provider input and ‘buy-in’
What Unity Offers Quality Contract Providers

- Quarterly membership data feeds for metrics through a secure portal
- Reports on care gaps
- Metrics sampled for at least 30 patients
  - If <30 in HEDIS sample, chart reviews conducted
- Clinic can supply documentation for missing data
  - Data needs to be sufficient to pass HEDIS audit
  - Documentation sent to health plan securely through provider portal

What Unity Offers Quality Contract Providers

- Annual visit with the Medical Director and Director of Quality and Care Management
  - Review results
  - Problem-solve
  - Discuss best practices
- Additional meetings as needed with practitioners and staff to review metrics and discuss initiatives/best practices
Collaboratively pick metrics with providers
- Metrics meeting goal
- Metrics needing improvement (stretch goals)
- Metrics aligning with other quality initiatives

In 2014 mandated that each contract include screening for breast cancer, cervical cancer and colorectal cancer
Contract Measures

- Prevention
  - Eg, BMI, immunizations, cancer screening, chlamydia screening, prenatal/postpartum
- Acute illness
  - Eg, testing childhood pharyngitis
- Chronic disease
  - Eg, asthma medication ratio, controlling high blood pressure, diabetes measures, medication management
- Access to care
  - Eg, well child and adolescent visits, CAHPS™ getting care quickly, CAHPS rating of personal doctor

---

Quality Contract Process

- First 2-3 years clinic receives monetary incentive for reaching goal:
  - 90th Percentile or higher: full incentive
  - 75th Percentile but <90th: ½ incentive
  - <75th Percentile: no incentive
- Benchmark is previous year’s Quality Compass
- Results supplied by June 30th following the measurement year
Quality Contract Process

• Providers encouraged to enter a risk-sharing model
  ➢ Withhold of 5%
  ➢ Receive incentive when meeting goal
  ➢ Owe health plan money if not meeting goal

• Goal is a capitated model

Quality Contract Process

• Provider group for risk-sharing model earns
  ➢ 1 point for each measure at 90th Percentile or higher
  ➢ ½ point for each measure at 75th Percentile but <90th
  ➢ 0 points for each measure <75th Percentile
  ➢ Points added to decide final incentive/withhold

• If 6 measures and provider group gets 3 or more points the health plan pays the withhold plus matches the incentive
• If provider group does not meet any goals, they forfeit the withhold
Quality Care Coordinator/Discharge Planner

Goal:
• Enhance the quality of patient care and satisfaction
• Promote continuity of care
• Promote cost effectiveness

Care Coordinator/Discharge Planner cont.

Responsibilities and Duties
• Conducts concurrent medical record review using specific indicators and criteria as approved medical staff
• Develops and maintains data system to track patients and outcomes
• Identifies potential Quality Improvements initiatives
• Maintains quality service by establishing and enforcing organization standards
Measures Meeting Goal at Hospital Based Providers

- **Care Coordinator**
  - Measures at 90%: 77%
  - Measures at 75%: 13%
  - Measures less than 75%: 8%

- **No Care Coordinator**
  - Measures at 90%: 61%
  - Measures at 75%: 15%
  - Measures less than 75%: 26%

Measures Meeting Goal at Clinic Based Providers

- **Care Coordinator**
  - Measures at 90%: 76%
  - Measures at 75%: 39%
  - Measures less than 75%: 12%

- **No Care Coordinator**
  - Measures at 90%: 50%
  - Measures at 75%: 11%
  - Measures less than 75%: 12%
Next Steps

- Improve communication between Health Services (health plan) and Quality Care Coordinators at contracted clinics
- Offer in-services to clinics to improve staff understanding of quality metrics
- Align health plan outreach efforts with the clinic’s outreach efforts to minimize duplication of services
- Enhance reporting on effectiveness of the outreach efforts
GNP Quality Programs
Provider Engagement – A Physician’s Perspective

Lydia Simon, Pharm.D.
Quality Performance Improvement
Greater Newport Physicians IPA

MemorialCare Health
MemorialCare Health System is a non-profit integrated delivery system
• Five top hospitals
  - Long Beach Memorial Medical Center
  - Miller Children’s Hospital
  - Long Beach Community Hospital
  - Saddleback Memorial Medical Center
  - Orange Coast Memorial Medical Center
• A medical foundation
  - MemorialCare Medical Group
  - Greater Newport Physicians Independent Practice Association (IPA)
Who is GNP?

Greater Newport Physicians

- IPA
  - 180 Primary Care Physicians
  - 1000 Independent Physicians
  - 72,000 patients (54,000 Comm / 18,000 Senior)
- CA P4P and CMS 5-Star Participation
- OPA rankings
  - 3-Star Rating Commercial HMO
  - 4-Star Medicare Rating

Coverage Area

Greater Newport Physicians (GNP)
What Matters Most…

Physicians want to…
• Provide Good Care
• Efficient Processes
• Decrease Administrative Burden
• Minimize “Work After Clinic” (WAC)
• Incentive Programs
• Perform well on Quality Metrics
• Being Heard

Bring Joy to the Practice

WAC: Work After Clinic
Bring Joy to the Practice

Whack the WAC!

What’s more Valuable than Time?

- Medication Refills Protocol
- Triage Incoming and
  - Patient Portal Messages
  - Inbox Messages
- Review Results
Our Magic Carrot(s)

Quality Support Programs

- Ambulatory Clinics
- Centralized Outreach (CPOP)
- Home Visit Program
- Physician Education

Quality Support Programs

Ambulatory Clinics

- Anticoagulation Center
- Diabetes
- Post-hospital Discharge
Ambulatory Care Clinics

- Team Based Care
- SCC and ACTIVE
  - 3 Multidisciplinary Programs
  - IM Medical Director

- ACC
  - Clinical Pharmacist Managed
  - Medical Directors
    - Specialists
      - Hematology/Oncology
      - Cardiology

SCC Example Case
A Different Approach

- 50% reduction in 30 day readmission rates*
- HbA1c 9.8% → 7.7%
  - 1% decrease in HbA1c = 40% decrease in microvascular complications
- Time in Therapeutic Range (TTR) 70%**
  - 41% decrease in ER admissions
  - 53% decrease in hospital admissions

*Compared to usual care
**Gold standard is 63%

Home Visit Program

- Created in 2010
- 1500 participating GNP patients
- HVP Providers
  - 1 Medical Director
  - 3 Physician Assistants
  - 3 FTE Schedulers
Home Visit Program

- Assists to obtain a better picture of our population’s health status
- Improve care coordination
- Promote better outcomes
- Improve HCC and 5-Stars

Home Visit Program

- Chronic Condition Assessment
- Medication Reconciliation
- Nutrition Assessments
- Fall and Bladder control
  - Assessment and counseling
- Environment safety evaluation
- Advance directive review
- Depression / Dementia screenings
- Referrals (Mammograms, Diabetic Eye Exam, FOBT)
- Flu Shots – 4th quarter
Centralized Patient Outreach Program (CPOP)

- Implemented July, 2013
- Began with 3 quality metrics
  - Breast Cancer Screening
  - Colorectal Cancer Screening
  - Diabetic Eye Exam
- Identified 3000 care gap opportunities
- Direct patient outreach via secure email blast or phone
- Overall completion rate = 25%

Centralized Patient Outreach Program or CPOP has helped GNP PCPs improve in these Quality Measures:

- Breast Cancer Screening
- Colorectal CA Screening
- DM Eye Exam
- Osteoporosis Management
- Scheduling New PAP Tests
C.P.O.P.
Centralized Patient Outreach Program

Our Health Coordinators are an extension of your office. We encourage and assist patients to complete their health and quality screenings, utilizing education, technology, central resources and consistent processes.

Quality Measures:
- Colon Cancer Screening – Colonoscopy or FOBT
- Breast Cancer Screening – Mammogram
- Diabetic Eye Exam
- Pap Test
- Osteoporosis in Senior Females with Fractures
- Pilot - Schedule New Medicare Advantage Senior patients

Program Highlights:
- Communicate to patients via email or direct phone calls.
- Documentation of content directly in the chart of patient charts.
- Direct coordination of metric completion with SNP

CPOP PHONE NUMBER: 714 377-6850

---

Success Is...

C.P.O.P. Success Story 2014

Patient Quality ‘opportunities’ processed = 5,918
Total measures completed = 1,884

Overall 2014 Completion Rate for Mammo, Colorectal and Diabetic Eye screenings = 32%

» CPOP 2015 now underway: over 8,600 patients will be contacted!
CPOP Success Story 2015

Patient Quality ‘opportunities’ processed = 6,200
Total measures completed = 2,300
Number of Participating Physicians = 70

Overall 2015 Completion Rate for: Mammo, Colorectal, Diabetic Eye, and Osteoporosis & Fracture screenings = 37%

- CPOP 2016 now underway with > 9000 opportunities
- New: Cervical Cancer Screening

Physician Education

- One-to-one meetings
  - Bonus Incentive Structure
- Bi-monthly All Provider meetings
- Newsletters
- Fax blasts
**Performance Report**

**Pediatrics**

2015 Distribution - Minimum Performance Metric
Clinical Quality Progress Report
Time Frame 1/1/2014 - 10/31/2014

<table>
<thead>
<tr>
<th>Performance Metric</th>
<th>Num/Den</th>
<th>2013 IHA Percentiles</th>
<th>Met IHA 95th Percentile</th>
<th>CMS ≥ 5 Stars</th>
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<td>Adult BMI &gt; 13</td>
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**Performance Report**

**Greater Newport Physicians**

2015 Distribution - Minimum Performance Metric
Clinical Quality Progress Report
Time Frame 1/1/2014 - 10/31/2014

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<th>Num/Den</th>
<th>2013 IHA Percentiles</th>
<th>Met IHA 95th Percentile</th>
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<td>Body Mass Index</td>
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<td>Chlamydia Screening</td>
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(a) The physician's Distribution will be based on the success or failure of the following criteria: Breast Cancer, Colorectal Cancer and OSGC must meet the IHA 95th Percentile; Adult BMI must be at least 3 stars.

(b) The 2014 Distribution will use the IHA Percentile from 2013 Measurement Year which will be finalized and available in August 2014. Currently displaying 2012 percentages.

(c) The 2015 Distribution will use the IHA Percentile from 2013 Measurement Year which will be finalized and available in August 2014. Currently displaying 2012 percentages.

(d) The 2015 Distribution will use the IHA Percentile from 2013 Measurement Year which will be finalized and available in August 2014. Currently displaying 2012 percentages.
Questions & Comments

Lydia Simon, PharmD
lsimon@memorialcare.org
OPTIMIZING SCORES THROUGH INTEGRATION OF BEHAVIORAL HEALTHCARE

James E. Cooper, MHS, Quality Improvement Project Manager
WELLCARE HEALTH PLANS
My Bio:

James E. Cooper joined WellCare SC as Quality Improvement Project Manager, in June of 2014. Currently he is responsible for performing behavioral health quality functions, particularly activities to ensure compliance with NCQA/HEDIS accreditation, behavioral health (BH) provider education and preparing recommendations to increase HEDIS rates as appropriate.

Throughout his over 20 year career in health services, James has held leadership positions in various health care delivery systems. Prior to joining WellCare of SC, he served as Center for Disease Control (CDC) Program Manager for Palmetto AIDS Life Support Services (PALSS); he was responsible for the successful implementation of an HIV/AIDS prevention grant funded by the (CDC). Before PALSS he worked as a Program Coordinator/Child Abuse Investigator for the SC Department of Social Services, he worked as a Medicaid Behavioral BH Specialist for the Carolina Center for Medical Excellence a quality improvement organization (CCME-QIO Medicaid) in SC; he worked as an Area Administrator for Babcock Center Inc. a community residential facility for the Developmentally Disabled, James has worked for Palmetto Place Children’s Emergency Shelter for abuse, abandoned and neglected children as a Shelter services Coordinator and lastly he worked as a Residential Program Administrator for the SC Department of Disabilities and Special Needs and Intermediate Care Facility for the Developmentally Disabled.

James earned his bachelor’s degree in Economics/Business Administration with a second major in Therapeutic Recreation from Benedict College. He obtained his Master’s degree in Health Services Management from Webster University.
Optimizing Behavioral Healthcare (BH) HEDIS scores

“Coordination of Care is Integration of Care”
and
“Integration of Care is Coordination of Care”

James E. Cooper, QI Project Manager

Our Common Challenge

Stigma: A cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses.

About the Presenter

James E. Cooper - Quality Improvement Project Manager, (as of June of 2014)
Currently responsible for performing behavioral health (BH) quality functions, particularly activities to ensure compliance with NCQA/HEDIS accreditation, behavioral health provider education and preparing recommendations to increase BH HEDIS rates as appropriate.

Previous Healthcare Leadership Positions:
Program Manager - Palmetto AIDS Life Support Services Inc. (PALSS)
Responsible for managing the successful implementation of an HIV/AIDS community prevention grant funded by the Center for Disease Control (CDC).

Program Coordinator - SC Department of Social Services (SCDSS)
Responsible for conducting statewide out of home child abuse investigations of foster homes, day cares and facilities.

Medicaid Behavioral BH Specialist - Carolina Center for Medical Excellence (CCME)
Responsible for conducting quality improvement compliance audits of SC state residential facilities for children and adults residing in BH residential facilities.

Area Administrator - Babcock Center Inc. (BC Inc.)
Responsible for managing staff in a 24/7 day to day operations to ensure the health, safety and accountability of 36 Community Training Homes for Intellectually Disabled Adults living with various psychiatric disorder.

Shelter Services Coordinator - Palmetto Place Children’s Emergency Shelter (PPCES)
Responsible for managing staff in a 24/7 day to day operations of care, treatment and training of abused, abandoned and neglected children in temporary foster care residential placement.

Residential Administrator - SC Department of Disabilities and Special Needs (SDDS)
Responsible for managing staff in a 24/7 day to day operations to ensure the health, safety and accountability of children and adults with Developmental Disabilities residing in four-32 bed Intermediate Care Residential Facilities.

Education and Training:
Benedict College - Columbia, SC - Bachelor’s degree in Economics/Business Administration with a second major in Therapeutic Recreation
Webster University - Columbia, SC - Master’s degree in Health Services Management
WellCare Health Plans, Inc.

Company Snapshot

OUR PRESENCE

Founded in 1985 in Tampa, Fla.:
- Serving 3.8 million members nationwide
- 367,000 contracted health care providers
- 72,000 contracted pharmacies

Serving 2.4 million Medicaid members, including:
- Aged, Blind and Disabled (ABD)
- Children’s Health Insurance Program (CHIP)
- Family Health Plus (FHP)
- Supplemental Security Income (SSI)
- Temporary Assistance for Needy Families (TANF)

Serving 1.4 million Medicare members, including:
- 354,000 Medicare Advantage members
- 1 million Prescription Drug Plan (PDP) members

Serving the full spectrum of member needs:
- Dual-eligible populations (Medicare and Medicaid)
- Health Care Marketplace plans
- Managed Long Term Care (MLTC)

Spearheading efforts to sustain the social safety net:
- The WellCare Community Foundation
- WellCare Associate Volunteer Efforts (WAVE)
- Advocacy Programs

Significant contributor to the national economy:
- A FORTUNE 500 and Barron’s 500 company
- 6,900 associates nationwide
- Offices in all states where the company provides managed care

All numbers are approximations and are as of December 31, 2015.

WellCare Health Plans, Inc.

Vision
To be a leader in government-sponsored health care programs in collaboration with our members, providers and government partners. We foster a rewarding and enriching culture to inspire our associates to do well for others and themselves.

Mission
Our members are our reason for being. We help those eligible for government-sponsored health care plans live better, healthier lives.

Core Values
- Partnership
- Integrity
- Accountability
- One Team

All numbers are approximations and are as of December 31, 2015.
WellCare Health Plans, Inc.

At WellCare, our members are our reason for being. We work each day to enhance our member's health and quality of life.

- Emphasis on lower income populations and value-focused benefit design
- Communication among members and providers to improve health outcomes
- Focus on preventive care including regular doctor visits
- Community-based solutions to close gaps within the social safety net

WellCare's Integrated Care Model

Members & Caregivers

Community-Based Social Services

- Enhance quality of life for members and family caregivers
- Provide value to state customers and members
- Significantly decrease inpatient readmissions
- Reduce over-utilization across multiple segments
- Reduce non-emergency ground transportation costs
- Reduce inpatient bed days

All numbers are approximations and are as of September 30, 2015.
Integration of Care

• Increase use of prevention and early intervention strategies for common behavioral and physical health conditions.

• Ensure that high-need individuals receive appropriate and timely care management.

• Decrease complications resulting from medication interactions.

• Prevent avoidable admissions and ER visits.

• To better inform providers regarding all treatments and/or conditions, therefore increasing compliance.

• Educate providers on the importance of having members sign a Consent to Release Information form.

Coordination of Care

• Involves deliberately organizing patient care activities and sharing information among all of the participants concerned with patient care.

• Identifying member needs and preferences ahead of time, communicating that information at the right time to the right people, and ensuring the information is used to provide safe, appropriate and effective care to the patient.

• The primary goal is to meet members’ needs so providers deliver high-quality, high-value care.

• When coordination of care occurs, there are fewer opportunities for negative medication interactions, side effects, complications and polypharmacy.

• Coordination of care promotes patient-centered care, improves a member’s overall physical and mental well-being, decreases hospitalizations and ensures an appropriate and smooth transition of care.

• Educate providers on the importance of having members sign a Consent to Release Information form.
Optimizing BH HEDIS Scores

“Integration of Care is Coordination of Care”
and
“Coordination of Care is Integration of Care”

1. Optimizing HEDIS scores by prioritizing behavioral health measures using a three prong approach to effectively overcome identified barriers of the member and provider to determine the health plan's approach.

2. How to articulate the importance of coordination and integration of care between PCP and BH providers. What is Coordination of Care? Why is Coordination of Care important?

3. Utilizing lessons learned to focus on next steps in provider education to improve the quality of health care services for BH members with complex behavioral health needs.

4. Utilizing the denominator/numerator to effectively improve the quality of health for non-compliant members along with addressing the HEDIS education needs of their PCP and BH providers.

5. Understanding the importance of collaboration between the Quality department and other departments to avoid silos in order to promote a well-informed approach.

What is HEDIS?

Health Effectiveness Data Information Set (HEDIS)

• A set of performance measures utilized by American health plans to compare how well a plan performs in these areas:
  1. Quality
  2. Access to Care
  3. Member Satisfaction with health plan and doctors
• Developed by The National Committee for Quality Assurance (NCQA)

Key Points:
1. Most HEDIS measurements use claims information (“administrative data”) for evaluating HEDIS performance. Diagnosis and/or procedure codes are often used.
2. If a service is not billed or submitted correctly, the service may not be captured for HEDIS and reflected in performance scores.
HEDIS STUMBLING BLOCKS

- Members are assigned to the wrong PCP provider or information is not properly transferred to new PCP
- Claims are submitted without the proper ICD-10 or CPT codes that count toward the measure
- Provider specialty does not count for the measure
- Member’s are not continuously enrolled
- Services are not documented properly in the member’s medical record
- All components of the required measure where not met
- BH Provider sees the member, however the provider does not order screenings or lab work
- Decreased appointment availability to members and provider’s openings

Key Terms to Know

- **Denominator** = Eligible members of the population.
- **Numerator** = Members that met the criteria of a measure. (Compliant Members)
- **Numerator Negative** = Members that did not meet the criteria for a measure. (Non-Compliant Members)
- **Anchor date** = The specific date the member is required to be enrolled to be eligible for the measure.
- **Provider Specialty** = Certain measures must be provided by a specific provider specialty.
- **Pseudo-claims** = The process of capturing data that was not billed appropriately.
Antidepressant Medication Management (AMM)

The percentage of members 18 years of age and older with a diagnosis of major depression and were treated with antidepressant medication, and remained on antidepressant medication treatment.

Effective Acute Phase Treatment - the percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks)

GOAL - 25th Percentile = 46.71%
Denominator = 369
Numerator (Compliant) = 127
Numerator Negative (Non-Compliant) = 242
Calculated Rate = 34.42%

Effective Continuation Phase Treatment - the percentage of members who remained on an antidepressant medication for at least 180 days (6 months)

GOAL - 25th Percentile = 30.99%
Denominator = 369
Numerator (Compliant) = 75
Numerator Negative (Non-Compliant) = 294
Calculated Rate = 20.33%

Antidepressant Medication Management (AMM)

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AMM: Effective Acute Phase

<table>
<thead>
<tr>
<th>Numerator Negative Total = 242</th>
<th>Categorical Breakdown</th>
<th>Actions Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>125</td>
<td>Require Medical and Behavioral Case Management</td>
<td>Referred based on research of claims data, history of minimal PCP visits and multiple ER, Ambulance, lengthy BH contacts</td>
</tr>
<tr>
<td>40</td>
<td>Behavioral Health Provider</td>
<td>Referred based on research of claims data history, The member does not have any contact with assigned PCP, only has contact with the BH providers, ER visits and Psych. Facilities</td>
</tr>
<tr>
<td>11</td>
<td>Lost to Follow Up</td>
<td>Unable to contact member</td>
</tr>
<tr>
<td>16</td>
<td>Not Eligible</td>
<td>Certification to be determined</td>
</tr>
<tr>
<td>50</td>
<td>Pseudo-claims</td>
<td>Outreach to providers to collect lab and screening results that were not administratively captured</td>
</tr>
</tbody>
</table>

*Mid and end of year data

Results of Behavioral Health (BH) Look up:
- Identify BH Specialist by name, location, BH gaps in care and labs on and/or off-site.
- Identify Primary Care Providers (PCP) by name, location and care gaps.
- Identify members in need of Medical & BH Case Management.
- Identify members who only utilize BH providers and need to be connected to their assigned PCP.
## AMM: Effective Continuation Phase

<table>
<thead>
<tr>
<th>Numerator Negative Total = 294</th>
<th>Categorical Breakdown</th>
<th>Actions Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>75</td>
<td>Require Medical and Behavioral Case Management</td>
<td>Referred based on research of claims data, history of minimal PCP visits and multiple ER, Ambulance, lengthy BH contact</td>
</tr>
<tr>
<td>120</td>
<td>Behavioral Health Provider</td>
<td>Referred based research of claims data history. The member does not have any contact with assigned PCP, only has contact with the BH providers, ER visits and Psych. Facilities</td>
</tr>
<tr>
<td>25</td>
<td>Lost to Follow Up</td>
<td>Unable to contact member</td>
</tr>
<tr>
<td>10</td>
<td>Not Eligible</td>
<td>Certification to be determined</td>
</tr>
<tr>
<td>64</td>
<td>Pseudo-claims</td>
<td>Outreach to providers to collect lab and screening results that were not administratively captured</td>
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- Identify members in need of Medical & BH Case Management.
- Identify members who only utilize BH providers and need to be connected to their assigned PCP.

## Antidepressant Medication Management (AMM)

**Talking Points to Providers:**

- Encourage providers to schedule a f/u appointment for members diagnosed with major depression and starting a new antidepressant medication
- Encourage the member to refill their medication on time.
- Encourage providers to refer their depression patients to BH specialist for counselors/support groups as applicable.
- Providers should play close attention to side effects and tailor dosage and type of medication accordingly, emphasizing to patients that there is a several week adjustment phase to achieve therapeutic levels and to address the possible side effects
- Members should be screened for Cardiovascular Disease (CVD) and Diabetes Mellitus (DM) - NCQA factor as there is a high prevalence with depression.
- Sometimes patients stop taking their meds when they start feeling better. Research indicates if they continue taking them for at least six months, this will prevent future episodes of depression

***Please emphasize close medication management during the first two weeks and referral to BH and encourage yearly labs/screening for diabetes prevention.***
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

The percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

GOAL - 25th Percentile = 65.22%
- Denominator = 71
- Numerator (Compliant) = 44
- Numerator Negative (Non-Compliant) = 27
- Calculated Rate = 61.97%

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

**Results of Behavioral Health (BH) Look up:**
- Identify BH Specialist by name, location, BH gaps in care and labs on and/or off-site.
- Identify Primary Care Providers (PCP) by name, location and care gaps.
- Identify members in need of Medical & BH Case Management.
- Identify members who only utilize BH providers and need to be connected to their assigned PCP.

<table>
<thead>
<tr>
<th>Numerator Negative Total = 27</th>
<th>Categorical Breakdown</th>
<th>Actions Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Require Medical and Behavioral Case Management</td>
<td>Referred based on research of claims data, history of minimal PCP visits and multiple ER, Ambulance, lengthy BH contacts</td>
</tr>
<tr>
<td>8</td>
<td>Behavioral Health Provider</td>
<td>Referred based on research of claims data history, The member does not have any contact with assigned PCP, only has contact with the BH providers, ER visits and Psych. Facilities</td>
</tr>
<tr>
<td>1</td>
<td>Lost to Follow Up</td>
<td>Unable to contact member</td>
</tr>
<tr>
<td>1</td>
<td>Not Eligible</td>
<td>Certification to be determined</td>
</tr>
<tr>
<td>9</td>
<td>Pseudo-claims</td>
<td>Outreach to providers to collect lab and screening results that were not administratively captured</td>
</tr>
</tbody>
</table>

*Mid and end of year data*
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

Talking Points to Providers:

- Communication and coordination are essential. Please encourage the providers to make the applicable procedures and f/u to make sure that the member had the procedure.
- Have providers incorporate involvement of family members to ensure compliance with the procedure. Educate providers regarding correct CPT codes for procedures.
- Educate providers on the importance of having members sign a Consent to Release Information.
- Reference BH Clinical Practice Guidelines as applicable for additional information.
- Importance of metabolic monitoring because children who are prescribed antipsychotics are more at risk for serious health concerns including weight gain, extrapyramidal side effects (The American Academy of Child and Adolescent Psychiatry (AACAP) recommends “start low and go slow” approach with antipsychotics)
- AACAP and the American Psychiatric Association both recommend using psychosocial treatments before antipsychotics for non-primary indications

Take Away To Improving BH HEDIS Scores

- Subtract the number of compliant members from the number of eligible members: (Denominator - Numerator = Negative Numerator/Non-Compliant members)
- Identify non-compliant members in a specific BH measure. (Start with 4th quarter push-year end, mid-year data and or quarterly data)
- Use claims data history to identify PCPs and BH specialist who provide services to members in a specific BH measure.
- Assess BH specialist and PCPs who need HEDIS education and/or technical assistance to improve performance in specific BH measures.
- Use claims data history to identify and refer members with complicated BH needs to case management as applicable to improve the quality of services for the member and caregivers.
## Three Prong Approach

<table>
<thead>
<tr>
<th>Member</th>
<th>Provider</th>
<th>Health Plan Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Incentives/Benefits</td>
<td>• Encourage member outreach activities</td>
<td>• Who are the Specialists?</td>
</tr>
<tr>
<td>• Educational Materials</td>
<td>• Identify members needs</td>
<td>• Where are the Specialists?</td>
</tr>
<tr>
<td>• Member Experience Survey</td>
<td>• EMR set up</td>
<td>• What reports or tools do they need?</td>
</tr>
<tr>
<td>• Outreach Calls/Brochures</td>
<td>• High Performers</td>
<td>• What are the high performers doing?</td>
</tr>
<tr>
<td>• Identify Member Barriers</td>
<td>• Low Performers</td>
<td></td>
</tr>
</tbody>
</table>

### Focusing on PCP and BH HEDIS Provider Education

**Focus on Provider Education:**
- Provide HEDIS Education visits: BH practices and PCP practices: initial visit, bi-monthly and follow up visits as applicable.
- Provide HEDIS Education conference calls: initial, bi-monthly and follow up calls.
- Distribution of and Review of BH Resource Guide.
- Utilize specific talking points to address BH measures below 25th percentile.
- Make Reference to Provider Newsletters about Depression and resources available on the WellCare Website.
- Provide BH information to Clinical HEDIS Practice Advisors, HEDIS Practice Advisors and Project Managers.
- Educate PCP & BH providers about coordination of care and the positive impact on member health outcomes.
The Importance of BH Screening

Behavioral Health Screening in Primary Care for Depression, Anxiety, and Substance Abuse (including tobacco use).

PCP and BH provider education regarding:

- Promote communication with PCPs and BH provider(s)
- BH screening instruments (PHQ-2, PHQ-9, EPDST, SBIRT)
- Pertinent CPT codes for required screening and labs
- Referring complex cases to BH providers/BH Case Management
- Refer to BH CPGs and Evidence Based Practice Guidelines and Provider News Letters on the WellCare Provider Portal

What does a Health Plan Want from a BH Provider?

- Improved member care experience through a more efficient, patient/member centered and coordinated system with less system fragmentation and less inpatient care and more integrated community based care
- Movement from a re-active, provider-focused system to a pro-active, patient/member focused system
- A more collaborative process that reflects the needs of the populations we serve. Care provided in the communities where our members live and all treating providers communicate directly
- Provider networks that are held to common performance standards and timeliness where funding is directly tied to reaching mutually established goals and provider incentives are aligned with program goals
- Focus is on increasing value to members, community and other stakeholders
Summary - Quality Staff Mind Set

Most Quality staff focus on the following:

• **Structure** – What is in place to support the effort? What else is needed?

• **Process** – Are we using all the items we have at our disposal? Is it working? What else do we need?

• **Outcome** – Are we getting the results we want? If not, what in the structure or processes need to be tweaked?

The End
Thank You!