2014 to 2015 Health Plan Initiatives

HEDIS Performance Measures

Improvement Activities Implemented

- One health plan's organization implanted the following:
    - Received re-organization for authority and accountability for the quality of services provided to members and oversight of the development, implementation and evaluation of the QI Program.
    - QI Department was also restructured to better engage staff in a continuous quality improvement program.
- Another plan collaborated with a HEDIS consultant and a HEDIS software vendor to develop and implement a HEDIS plan that is focused on maximizing performance. This plan entailed a Data Warehouse, State Registry and Pay for Performance. New ideas were implemented to capture complete data to reflect the work being done by the network providers. So, even though there were some failures, there were lessons learned.
- And, one health plan has a process in place to evaluate the previous year's data and look at root causes to rule out system/process gaps. They have identified some areas such as data submitted from the providers, process maintaining the providers' contact info and status and Supplemental Day and will have quality checks in their processes.

Childhood Immunization Status

Here are the efforts one plan made to address their incomplete vaccination data:

- Implemented ongoing provider educational interventions.
- Used its data to predict which immunizations were likely given.
- Conducted outreach to all providers with patients under two years of age who had not yet received their full vaccinations to focus their intervention efforts.
- Risk members receive phone calls to remind them of the need for vaccinations. All members receive regular reminders about vaccinations.
- Providers who are not shown to be high performers through the plan's hybrid chart reviews and pay-for-quality program outcome receive educational visits to look at their processes.
- Also, information on office practices is gathered for broader improvement activities.
- Lastly, providers receive lists of children who need vaccinations.

Comprehensive Diabetes Care

The health plans worked on the following:

- To monitor testing rates, lab data files monthly from Diagnostic Laboratories Services and Clinical Laboratories. Comprehensive Diabetes Care is multifaceted and includes medication choice, medication adherence, medication acceleration and lifestyle changes.

- For medication adherence the plan collaborates with its partner, CVS Caremark. Physicians receive notification when a member's first prescription is returned to stock (primary non-adherence).
- Physicians are also notified when a member fails to pick up a refill for an anti-diabetic medication. Members also receive notification when a refill is not picked up.
- To address medication choice and medication acceleration, one plan's approach is to present the provider with data and ask the physician to facilitate an informed treatment decision with their patient. The health plan has developed a prototype report that would show the provider his/her diabetes caseload, depict where the patient is along the ADA guideline related to medication choice and acceleration, and to identify groups of patients for treatment modification. The health plan is currently developing this prototype further based on physician feedback and plans to pilot the prototype report with select providers.
- For lifestyle changes, one health plan offers and encourages wellbeing connection which includes telephonic health coaching and health education workshops which are available to support members attain their health goals.
- One health plan's Quality Improvement Intervention Workgroup (QIIW) and Quality Improvement (QI) Team HEDIS Focus Workgroup met regularly to review performances of HEDIS measures, complete causal barrier analysis, and monitor status updates of interventions developed specifically to improve HEDIS rates. Smaller workgroups were also developed to address specific HEDIS measures, such as BH and child related measures. The following are improvement activities that were continued or implemented in 2014:
- One health plan continued to receive lab results directly from lab vendors, Clinical Laboratories, and Diagnostic Laboratory Services. In addition, providers who performed their own blood tests in-house (not at a diagnostic laboratory) were identified through claims data. During the quality focused provider visits, the QI staff discussed the importance of receiving lab results from the provider and retrieved appropriate medical records. These medical records were reviewed and data entered into an auditor-approved supplemental database.
- HEDIS Practice Advisors (HPA) were hired to conduct quality-focused provider visits. In partnership with the Provider Relations Representatives, providers received education and coaching on HEDIS measures, as well as resources in improving HEDIS rates, including HEDIS tool kits, Preventive Care Checklist, and care gap reports. In addition, providers received education on the HEDIS On-line Tool (via provider portal) as an additional method to look up members care gaps and close HEDIS gaps in care by submitting medical records through the online tool. Information on the Disease Management program and instructions on how to refer a member to the program were also provided. The health plan's Medical Director attended some of these provider visits to assist with provider education.
- Pay-for –Performance bonus program was offered to top volume providers.
- The health plan partnered with a mobile provider, FirstVitals to complete retinal eye screenings within health centers and PCP offices.

- The health plan continued to insource the process of scheduling and retrieving of medical records. Thirty temporary staff members were on-boarded to schedule and retrieve records. This resulted in an increase of approximately 15% more records retrieved as compared to the health plan's previous vendor, Outcomes, who managed medical record retrieval.
- Chronic condition and preventive screening articles for both member and provider newsletters were published. Also, Periodicity letters were mailed to members to remind them of preventive screenings and the importance of seeing their PCP.
- Community Case Management Agencies (CCMA) were provided care gaps reports, and a scorecard was developed to monitor the CCMA's progress in closing care gaps. In addition, the health plan partnered with Clinical Laboratory to provide FOBT kits. These FOBT kits were distributed to the Community Case Management Agencies (CCMA). The CCMA hand delivered the kits to their foster home caregivers to complete the FOBT for the members with colon cancer screening care gaps.
- Several outreach programs to educate members on chronic condition management and preventive screenings were completed. The following lists the health plan's various outreach programs:
    - Centralized Telephonic Outreach program consisted of a vendor, Results, conducting calls to members with HEDIS care gaps and assisting with scheduling an appointment with their physician and arranging transportation when needed.
    - The EPSDT Coordinator outreached parents and guardians of pediatric members to educate and assist with scheduling appointments for well-visits and to get their immunizations updated.
    - The Service Coordinators addressed care gaps with members during their home visits or follow-up phone calls. In addition, one designated Service Coordinator focused on outreaching members discharged from a mental health facility to close FUH care gaps.
    - After Hospitalization Outreach Program was implemented, which consisted of the Disease Management nurse following up on members who were discharge from the hospital and who had a diagnosis of CHF, Diabetes, CAD, or Asthma. The nurse called members within 48 hours from discharge, provided medical condition and medication education, and assisted with scheduling a follow-up with PCP.
- A Preventive Care Checklist which incorporated HEDIS-related tests and procedures was implemented and distributed to ICF level of care members. The reader-friendly checklist doubles as an educational tool explaining in simple layman's terms the "why" behind the age-specific, gender-specific, and disease –specific tests and procedures on the list. The SCs / DM RNs discussed the checklist with members and instructed them to bring the checklist to doctor's office during a follow-up visit for completion.
- One health plan's Disease Management (DM) program educated members about their disease, setting disease-specific target goals, and improving member's self-management skills, all which will positively impact members' health outcomes and increase compliance with chronic conditions HEDIS measures. The importance of preventive visits and timely tests/screenings were addressed during each member contact. As needed, the DM nurses reached out to the treating providers to assist with scheduling a follow-up visit. A post hospital discharge management program (AHOP = After Hospital

Outreach Program) has been added as a subprogram under DM with the goal of reducing 30-day readmission of members with discharge diagnosis of Heart Failure, Diabetes, Asthma or CAD. AHOP's interventions include improving member's understanding of their medical condition, medications, post discharge instructions as well as importance of timely follow-up visits with their PCP/Specialists.

Community Care Services (CCS)

Specifically for CCS members, one health plan worked on these strategies:

- Worked with other health plans to receive file information for HEDIS measures that are based upon medical services. The Behavioral Health (BH) Case Management agencies received education on the different HEDIS measures. The Inpatient Notification form, which is used to notify BH Case Managers of an admission to the hospital, was modified to include a section for FUH appointments.
- Collected behavioral health assessments from CCS BH Case Management agencies.
- A focused CCS BH Case Management agency meeting was held to educate the case management agencies on the HEDIS measures. As a follow up, the health plan hosted a detox in service for CCS BH Case Management agencies to help the agencies understand their options in helping members close care gaps for the Initiation and Engagement of Alcohol and Other Drug Abuse Treatment (IET) measure.

Plan All Cause Readmissions (PCR)

One health plan QI staff met with hospitals to discuss readmissions, as related to the HEDIS measure PCR and educated on the importance of scheduling a follow up appointment for members, as related to the FUH and IET HEDIS measures.

The Quality Improvement (QI) Program for one health plan describes the coordinated and collaborative activities and initiatives of one health to provide the services necessary to meet the needs of its members and to continuously improve physical and behavioral health care outcomes. In order meet the need of members with multiple healthcare needs; the health plan utilizes an integrated care model employing systematic coordination of physical, pharmacy and behavioral healthcare integrating mental health, substance abuse and primary care service management to produce better outcomes.

Well-Child Visits in the First 15 Months of Life

Implemented and ongoing activities by health plans:

- EPSDT education was provided at Health Fairs by Registered Nurses to educate members about the importance of completing all well-child visits within the appropriate timeframes. This will ensure identification of potential health problems and provide early intervention. Members who have not completed their well child visits are contacted via phone calls and letters to encourage them to complete their well child visits with their Primary Care Providers and to develop a positive relationship and continued engagement with the health care system. EPSDT reports are delivered to providers to identify members who are in need of a Well child visit. In mid-2014, one of the health plans launched the Clinical Practice

Consultants (CPCs) program, where the CPCs worked with the providers and office staffs to provide education, develop processes and workflows and tools to assist the Primary Care Provider to re-engage these members.

- Health plan Activities include coordination of internal Marketing, Quality and Provider Network departments to identify member and Primary Care Providers to target interventions to improve completion of well child visits in the first 15 months of life.

CDC/CBP measure Improvement Initiatives

Implemented and ongoing activities by health plans:

- Additional Clinical Practice Consultants were added to the Quality Staff to focus on provider quality performance interventions.
- Additional Provider Network Advocates were also added to improve assistance and training of providers.
- Quality Team members were added to focus on quality performance improvement.
- Trainings were provided to Service Coordinators to address HEDIS gaps in care.
- Training on Quality Performance measures were provided to all staff to promote quality within the organization culture.
- Members with Diabetes are identified and are enrolled in the health plan's Disease Management Program. Disease Management members are regularly sent materials on diabetes disease management which includes education around blood pressure control.
- Articles on Diabetes, Diabetic Kidney disease, and class schedules for Diabetes, preventive health care, and disease management were released in 2014 and 2015 through the health plan's Member HealthTalk newsletter.
- Providers were educated on HEDIS requirements and clinical practice guidelines semi-annually. The health plan organized and held the first Hawaii Provider Quality Conference in February 2014 and again in May of 2015 where Primary Care Providers were educated on HEDIS and important updates.
- CPC program was implemented in mid-2014; CPCs provided education for the providers and their office staff around HEDIS (including CDC and CBP requirements) and information on the health plan's available support services.
- Implemented the Accountable Care Communities program to improve on the utilization and quality metrics.

As a result of member, provider and health plan interventions, all but 1 of the CDC sub measures in a plan showed an increase in HEDIS 2015 and rated above the 2014 NCQA 50th percentile. The CDC HbA1c < 7% for a selected population decreased but remained above the 2014 NCQA 50th percentile.

One plan also showed increases in their CDC BP < 140/90 and Controlling High Blood Pressure (CBP) measures. However, the CDC BP <140/90 measures continues to be below the 2014 NCQA 25th percentile. The health plan will continue to work on improving the CDC measure especially the sub measures that are below the 25th percentile.

Note that the CDC BP <140/80 and LDL-C < 100 measures were retired in HEDIS 2015.

Performance Improvement Projects Recommendations

In 2015, the new Rapid Cycle methodology was implemented for the new PIPs. This was a new methodology with accountability for each module, had to be passed in order to proceed to the next. This method surely involved both internal and external disciplines. The health plans follow practices of Plan, Do, Study, Act in the development and implementation of our strategies. On a regular basis they evaluate intervention efficacy and conducts causal/barrier analysis. As a result, interventions can be discontinued, revised or new interventions implemented as needed throughout the year. Hence, a rapid cycle.

Improvement Activities Implemented

The health plans have identified the following SMART Aim as part of the 2015 Performance Improvement Project (PIP) - By June 30, 2016, increase the percentage of QUEST Integration members with a Hemoglobin A1c less < 8 from 51% to 60% at one of the clinics who have Provider A, B, and C as their PCP.

To address the 2015 Diabetes Care PIP one health plan has 1) identified the key drivers and interventions 2) developed the data collection process and 3) determined failures that warrant quality improvement. See below for a summary on each of the three phases.

I. Key Drivers and Interventions

Key Drivers:

1. Medications
2. Continuity of Care
3. Member Education and Engagement
4. Provider Awareness
5. Access

Interventions:

1. Synchronize medication refills for all medications to streamline process for member and decrease medication confusion around when meds are due to be refilled.
2. Dispense 90 day supply of medication to member to ensure better compliance.
3. Encourage members to sign up for mail order service, which sends medications directly to the member's home via the US mail.
4. PSS staff based in the clinic will introduce themselves to the member and focus on educating and supporting the member with managing diabetes through telephonic support.

5. Patient Support Services will round with PCPs regularly about the members they support. This partnership will provide PCP with awareness of members' challenges and elicit their suggestions.
6. Service Coordinators will assist members to eliminate barriers to keeping clinic appointments, engaging with PSS, and filling their meds. Coordinators to perform home visit for members PSS have difficulty contacting.

II. Data Collection Process

1. On the tenth business day of each month, Pharmacy analyst will extract from the health plan Disease Registry aka "Mana ku" a list of eligible Quest Integration diabetes members, with Hemoglobin AlC > 8, home clinic location of Nanaikeola, and Provider A, B or C as their PCP. The Pharmacy analyst will send the list via secure encrypted e-mail to the Patient Support Services (PSS) staff. Throughout the month, the PSS staff will outreach to the identified QUEST Integration members with Hemoglobin A1C > 8. The PSS staff will contact the member via telephone. After two unsuccessful telephone calls, a letter will be sent requesting the member call the clinic.
2. The rate calculation will be performed by Pharmacy analyst using the excel spreadsheet formula division function and the result will be that month's % of eligible QUEST Integration diabetes members with Hemoglobin a1c rates < 8 with home location of the clinic who have Provider A, B or C as their PCP.
3. The SMART Aim will reach meaningful and sustained improvement when the SMART Aim goal has been met.

III. Intervention Determination

One health plan has developed a high level process map from the perspective of the customer that captures where breakdowns in the process may occur that would affect diabetes care. From this map three sub-processes were selected that had the most potential to make the greatest impact. Failure modes, causes, effects and priorities were also identified for each sub-process. Based on these results the failures modes were ranked from the highest priority to the lowest and the failure modes that warranted quality improvement were identified. The result of this analysis is the final Intervention Determination captured below.

Intervention Determination		
Failures	Potential Interventions	Consideration for Reliability
Patient isn't ordering medication refills	Dispense 90 day supply of medication	Dispensing a 3 month supply will increase likelihood of medication compliance since

Intervention Determination		
		member doesn't have to go to clinic every month for medication refill.
Patient isn't picking up medication refills from clinic	Send medication refills to patient via mail. (Mail order)	Receiving medications via U.S. Mail will eliminate barriers that make it difficult for patient to pick up medication at clinic.
Patient isn't taking medications	PSS staff will assess barriers to medication compliance. (i.e. intolerance to medication or side effects)	Barriers to medication compliance may be eliminated and this will increase the likelihood of medication regimen compliance.

Improvement Activities Implemented

One health plan has identified the following SMART Aim as part of the 2015 PIP - Reduce readmission rate of QUEST Integration members hospitalized at one of the hospitals for all ages who do not meet the exclusion criteria from 13.2% to 12.7% by June 30, 2016.

To address the 2015 Readmissions PIP the health plan has 1) identified the key drivers and interventions 2) developed the data collection process and 3) determined failures that warrant quality improvement. See below for a summary on each of the three phases.

I. Key Drivers and Interventions

Key Drivers:

1. Discharge Instructions/Education
2. Patient Barriers
3. Follow up/Access
4. Care coordination between inpatient and outpatient
5. Medications

Interventions:

1. Service coordinators to perform a 2 business day post discharge telephone call to assess patient, clarify discharge instructions, remind or make follow up appointment, identify patients requiring home visit, earlier clinic appointments, or other care coordination
2. Service Coordinators will assist members to eliminate barriers to keeping appointments, for example arrange transportation for clinic visits and/or arrange home care nurse visits.

3. Schedule appointment for post-hospital follow up appointment with PCP or specialty clinic.
4. Social Worker support Service Coordinators for members with social barriers.
5. Standardized discharge summaries with clear instructions to the outpatient team about follow up.
6. Transitional Care Pharmacists to do bedside medication reconciliation and education pre-discharge
7. Clinic based Pharmacist to do medication reconciliation and education post-discharge.

II. Data Collection Process

1. On the first business day of each month, the Supervisor of Quality Management Consulting and Analysis will run a report in Clarity to generate a list of eligible QUEST Integration members readmitted to the hospital within 30 days of discharge. An excel spreadsheet with a list of QUEST Integration members readmitted to the hospital within the last 30 days will be sent via encrypted email to the Readmission Performance Improvement Plan (PIP) Team members. The Readmission PIP team will evaluate this list monthly.
2. The rate calculation will be performed using an excel spreadsheet formula division function and the result will be that month's % of eligible QUEST Integration members readmitted to the hospital within 30 days of discharge.
3. The health plan has selected a conservative SMART Aim goal of reduce readmission rate from 13.2% to 12.7%. The Readmission SMART Aim will reach meaningful improvement when six out of eight consecutive data points is trending toward the goal.

III. Intervention Determination

The health plan has developed a high level process map from the perspective of the customer that captures where breakdowns in the process may occur that would affect hospital readmissions. From this map three sub-processes were selected that had the most potential to make the greatest impact. Failure modes, causes, effects and priorities were also identified for each sub-process. Based on these results the failures modes were ranked from the highest priority to the lowest and the failure modes that warranted quality improvement were identified. The result of this analysis is the final Intervention Determination captured below.

Intervention Determination		
Failures	Potential Interventions	Consideration for Reliability
Patient doesn't answer call or return messages	Chart review will include: review of reason for admission to assess for risk of readmission. Check if discharge medications were picked up; confirm patient attended hospital follow up appointment. If patient missed appointment, chart review will be performed to assess via triage criteria if service coordinator should perform visit to member's home.	Chart review will identify patients at higher risk for readmission. If service coordinator performs home visit; barriers to patient's post hospital recovery may be identified and this process may decrease readmissions.
Patient doesn't understand discharge medication instructions	Discharge medication instructions and comprehensive medication review will occur during post discharge follow up telephone call. Medication reconciliation will be performed to reduce duplicate medications.	Medication reconciliation will decrease duplicate medications and unnecessary medications. Medication review will increase the likelihood of compliance with discharge medication regimen.

The above PIP feedback was addressed in the final 2014 PIP submission in August 2014.

- For the All-Cause Readmissions PIP, the resubmission still included "Observed to Expected Ratio" in the study indicator title. The health plan removed this in the final submission.

- For the Diabetes Care PIP, the health plan corrected the interpretation for Study Indicator 2 to state the correct goal.

- For the Diabetes Care PIP, the health plan corrected the p value for Study Indicator 2 from baseline to the first re-measurement.

Previous PIP methodologies were retired and replaced with the rapid cycle improvement process as trained by HSAG. Diabetes has been re-selected for the new PIP rapid cycle improvement process. Through the new PIP rapid cycle improvement process, the health plan has re-visited the causal/barrier analysis process, verified that the proper barriers are being addressed and are reviewing new interventions. Processes will be revisited as often as needed during the duration of the PIP.

The BMI PIP, with its successful and sustained improvement, has been retired.

Improvement Activities Implemented

CAHPS

Getting Needed Care/Getting Care Quickly

In the first quarter of 2015, an annual assessment was done on the Accessibility of Providers.

Surveys

a. Member and Provider appointment survey
   A comparison of the survey results indicates disparities between member and provider perception of compliance with appointment standards.
b. Behavioral Health Care Practitioners Survey
   The appointment standards for behavioral health routine, behavioral health urgent, and behavioral health non-life threatening emergency were not met.

c. After-hours access to care surveys—

d. Member grievances were reviewed and there were no member grievances related to appointment timeliness and behavioral health appointment timeliness.

Community Relation Events

The Community Relations Department has been hosting community events throughout the island of Oahu with the goal of facilitating better care, healthcare education and connecting the community with much needed resources. These events are geared towards connecting the community with healthcare resources that the community is not aware of.

Community Event Focus

- Free Dental Services
- Healthcare Educational Services
- Medicare and/or Medicaid Educational Services
- Community Health Center Services
- Homeless Shelter Services

One health plan is also:

- Partnering with Social Service Agencies to facilitate better care for our Members in need of services.
- Building better partnerships with Community Health Centers to facilitate better member compliance, medication adherence and faster access to care for members.
- Continue to grow and enhance our member events to cover the full spectrum of services our members need. This includes partnerships and events on Maui, Kauai and the Big Island.

Member Communications

The Member Handbook was updated in 2015 to provide more useful information to all members, including information about when to see a PCP versus going to urgent care or the emergency room. All members received an updated copy of the handbook in January 2015.

All members were also notified about resources available on our website. The notice was mailed to members in March 2015. Our website contains health and wellness information that may be pertinent to many of our members, and includes health education and preventive health care information.

We also post health tips and links to healthy recipes on our social media accounts and is increasing this type of content in 2015 and beyond.

Provider Communications

Provider Newsletters resumed their quarterly distribution to all providers in 2015. Topics included access and availability standards as defined by the State, as well as instructions for after-hours call best practices. Additional topics relevant to getting needed care and getting care quickly is slated for the remaining 2015 and future 2016 issues.

Customer Service

Call Center:

- One health plan's call center hours are from 7:45am – 8pm Monday – Friday and after-hours phone is from 8pm – 7:45am Monday – Friday, Weekends and holidays. The after-hours phone can answer eligibility questions for members and providers. If further assistance is needed, the after-hours phone service will call the health plan's after-hours to assist with travel, authorizations and all other emergent issues that are not able to wait until the next day.
- One health plan's call center hours are from Monday through Friday from 7:45 am - 4:30 pm, and walk-in service at a health plan Neighborhood Center Monday through Friday from 8:00 am – 6 pm and Saturday from 9:00 am – 2:00 pm. After-hours call center servicing is able to assist with eligibility inquiries, finding a participating specialist or non-emergent transportation and accommodations. All other inquiries are forwarded the next business day to normal hours servicing staff that follows up with the member or provider. 8

- One health plan's call center representatives are required to attend the Ulysses Training program which focuses on achieving greater call control in order to provide an optimal experience for embers and providers, while consistently meeting call handling guidelines. Highlights of the Ulysses training include greeting the caller in a professional manner, acknowledging the callers issue and emotion, asking member permission before asking questions, identifying concerns by asking questions regarding the situation or issues to validate inquiries, assisting the caller by providing solutions with options to gain acceptance, recapping and providing next steps to resolution, and ending each call by asking if there is anything else that servicing staff can help with.
- In addition to the formal Ulysses training, one health plan conducts bi-weekly training, covering topics brought up by staff or identified by leadership based upon recorded/live call monitoring. One on one coaching is also done as needed. To address performance, call center representatives have daily unit huddles, weekly call audits which identify potential issues or gaps as well as provide positive feedback, and side by side coaching.

Getting Care Quickly

- The health plan value-driven health care initiative consists of a Patient Centered Medical Home (PCMH) program and a pay-for-quality program. One of the expectations of PCMH PCPs is that they work to improve care coordination and can demonstrate this by implementing open scheduling, and providing additional ways for members to access a care team through telephone, secure electronic messaging, or other means.
- Cozeva is a Web-based platform that promotes communication between providers and their patients. It identifies gaps in care and sends reminders to members in preferred formats (i.e. email, phone, or text). Cozeva allows members to communicate electronically with their PCP, make appointments, receive individualized reminders, request prescription refills and access their medical records.
- One health plan provides a 24-Hour Nurse Advice Line that members can call to talk with a nurse, ask questions and obtain guidance regarding whether the member should see a doctor or go to the emergency room. One health plan's 24-Hour Nurse Advice Line can also refer a member to a participating provider.
- For members that are chronic no-shows, providers have the option of referring the member for service coordination. The service coordinator assigned to the member will assist with identifying barriers, developing a service plan, and coordinating services that will support the member's needs and reduce no-shows.

Getting Needed Care

- One health plan promotes living life to the fullest with healthy lifestyle habits through health education workshops. These workshops use fun, interactive methods to teach fitness, nutrition, stress management, and other aspects of health and well-being that can impact physical, emotional, and social health. The workshops are engaging and designed with varying learning formats and levels of participation from a scale of low, medium and high. Workshops are offered throughout the year at no cost. To simplify and streamline the referral process and to ensure members have access to care when they need it, the health plan revised its referral process for specialty care.

- Beginning in January 2015, PCPs only need to register referrals with the health plan for off-island specialty care, referrals to non-participating providers, plastic surgery, rehabilitation services, and dermatology services. Although a registered referral is no longer required, PCPs and specialists must still keep records of referrals in their patient's record.

Rating of Specialist Seen Most Often

- Skills training for specialists have been occurring over the past several months which included a specialized workshop focusing on cultural competency to facilitate and improve physician-patient communication. The workshop included:
  - Cultural background and values shape member views
  - Members have a right to be treated with courtesy, consideration, and respect
  - Respect diversity and eliminate biases and preconceptions that can be barriers to successful delivery of health services
  - Provider foreign language capabilities
  - Outreach and care assistance to members should be sensitive to their beliefs but aimed at improving their health outcomes.
  - Debunking myths about public assistance members (e.g. they are all non-compliant, providers have to make all healthcare decisions, those with disabilities are incapable of discussing their own health)
- As part of health plan's strategy to improve CAHPS, multiple member focused communications were implemented as well and were aimed at improving the provider-patient relationship and increasing member engagement in their care. Several informative articles were published.
- Training Program
  - Customer Service staff goes through a 3-week training program once hired. The training program consists of system knowledge, benefit training, phone skills and conflict resolution. There is also a Supervisor on the floor in the call center to assist with all escalated issues. Customer Service staff has a weekly meeting to go over refresher trainings and does grievance appeals training annually.
- Performance Measures
  - Customer Service has required measurements. Reports are tracked and reported to staff members monthly.

Rating of Specialist Seen Most Often

- One health plan's members have access to online tools that make communication with their providers easy and at the member's convenience. Communication tools include email, the ability to check test results, send pictures to their specialists, make appointments online, etc. QUEST Integration Service Coordinators and Customer Service Representatives also reinforce access to these tools when communicating with members.
- Annual cultural competency training is delivered to all of the health plan's medical staff. The Affiliated Care manual sent to each provider also includes Health plan's Cultural

Competency plan and providers are credentialed every 24 month which includes a cultural competency review.

- The health plan has a standardized process in place that prompts follow up with members who have upcoming appointments to ensure all key activities are completed prior to their appointment. Members also receive a patient satisfaction survey after their visits and feedback is delivered to Physicians based on member responses.
- Lastly, the plan is working with MQD to understand the guidelines on leveraging telemedicine.

Getting Needed Care

- "Max-packing" is one of several strategies which the hospital's uses especially for non-compliant patients or those with transportation needs. We are able to consolidate appointments around a member's transportation availability (i.e., when they have someone who can drive them), and meet with the member face to face while they are at one location for multiple appointments.
- The health plan's Health Education Department offers a variety of classes to members in both individual and group settings (i.e. Diabetes and Chronic Kidney Disease). Class offerings are posted online and also printed and available at each of the health plan's clinic. The plan's Patient Support Services team is also actively focused and engaged with members on care management.
- As mentioned above Health plan members have access to online tools that make getting the care needed easy. Communication tools include email, the ability to check test results, send pictures to their specialists, refilling prescriptions, make same-day appointments online, etc. Health plan Members can also call and speak with a Nurse or Physician Assistant at any time.
- Health plan also uses an electronic referral system and a standardized referral form.

Getting Care Quickly

- A no-show appointment follow-up process is in place at each of the Health plan clinics. Additionally, the QUEST Integration Service Coordinators follow up with high risk no-show patients and utilize other strategies to facilitate a member's appointment compliance, including but not limited to checking for future appointments with different providers and meeting the member at the appointment, conducting home visits, analyzing and working with the members on barriers identified, etc.
- As mentioned above Health plan members have access to online tools that make getting care quickly easy. Communication tools include email, the ability to check test results, send pictures to their specialists, refilling prescriptions, make same-day appointments online, etc.
- Patient flow analysis is performed on an as needed basis at the Health plan clinics and results are analyzed to identify areas for improvement. In 2014 Health plan focused heavily on improving access to same day appointments by performing extensive data

analysis, increasing staffing and standardizing processes to ensure appropriate availability and coverage.

- Health plan clinics and call centers also utilize a standard triage process to ensure members receive the right care quickly.

Appropriate Health Care Providers

Health plan does not require a PCP to obtain authorization for a referral to an in-network specialist. This eliminates the time it takes to process an authorization for a specialty referral and allows the member to access care in a timely manner. Customer Service Representatives will also assist members in accessing care by helping members through the "find a provider tool" available via the health plan web portal. If a member is unsuccessful using the online tool to locate a provider, local Customer Service representatives will partner with Provider Relations to support ensuring the member has access to the needed care in the nearest most appropriate clinical setting. Our EPSDT Coordinator also follow up on referrals documented on the EPSDT forms to ensure our pediatric members follow through on referrals made by their PCP.

Interactive Workshops

- One health plan conducts ten education sessions per month across Oahu, Maui, Hawaii, and Kauai. In addition, we participate in and provide health educational information sessions at 11 major events on Oahu, 16 in Maui County (all Islands), 5 on Kauai, and 10 on the Big Island for a total of 41 events during 2015. This gives us an opportunity to discuss important health topics including chronic conditions, women's health, and children's health.
- The health plan recognizes that educating members about their disease, setting disease-specific target goals and improving member's self-management skills positively impact their health outcomes. Their Disease Management (DM) program has continued to put premium focus on high member engagement during health coaching sessions and using member-driven goals to measure progress. The importance of preventive visits and timely tests/screenings are addressed during each member contact.
- Members who have special health care needs or need long term services and supports are assigned a service coordinator. The service coordinator will do a home visit and complete and health and functional assessment. During the assessment, Service Coordinators ask disease specific question related to Asthma, Cancer, Diabetes, End State Renal Disease, Heart Disease, Hepatitis B/C, High Blood Pressure, HIV/AIDS, Seizures, and Shortness of Breath. A Service Plan is developed to address identified problems and interventions. Service Coordinators also educate members with chronic conditions on the availability of the DM program. If members decline enrollment in DM, Service Coordinators offered to provide members with educational materials about their health condition and the recommended tests/procedures needed per chronic condition.

"Max-Packing"

The HEDIS Practice Advisors and Provider Relations Representatives distributed HEDIS tool

kits to providers, which included a Personal Preventive Care Checklist. Providers were encouraged to use this checklist for each patient. It included a list of screenings for preventive care and chronic condition management and the last date the screenings were performed. It served as a reminder for the providers of which screenings were due for the patient in order to help them maximize each patient office visit. In addition, they assisted providers with updating their EMR tickler system to include the appropriate screenings and due dates. This tickler system flagged the provider during the patient's office visit of any screenings due.

Referral Process

In order to allow members quick and timely access to care, health plan does not require a referral to an in-network specialist. In the event that providers do provide a referral to another provider, health plan has a number of ways in which we assist the member in getting in to see a specialist.

The Customer Service Representatives (CSR) assists by using an internal provider directory to locate participating specialists for members. CSRs also advise members that they can locate specialist directory on the health plan website located at www.health planhealthplan.com. When members are looking only for contact information that is provided to them and CSRs are also encouraged to offer to call provider and verify that the provider will see member. The following additional scripting was added for HI members in the PCP Change work flow "If you are receiving care from a specialist it is essential that you let your new primary care doctor know so that he/she can coordinate your care. You receive the best care when your doctors talk to each other. You can help by asking each of your doctors to complete a consent form. If you have any questions please speak with your doctor or call Customer Service at the number on the back of your ID card."

In instances when members advise that they have been unable to locate a specialist, a template including all pertinent case information is emailed to Service Coordination and is processed in conjunction with Provider Relations in attempt to either locate participating specialist or develop contract agreement for member to visit a non-participating provider.

The EPSDT Coordinator also reviews EPSDT forms for any referrals marked by PCP and outreached those members. The EPSDT Coordinator assists members with scheduling an appointment with the specialist or therapist by placing a three-way call to the provider to schedule. Upon request from the specialist of therapist, the EPSDT Coordinator faxes the EPSDT form to the provider to show that the PCP made the referral.

Decreasing No-Shows Appointments

One health plan works with our transportation vendor closely to ensure members are picked up and taken to their appointments timely. The Service Coordination Triage Team works collaboratively with Customer Service to locate specialists for member's, based on member needs and provider choice. A members request for a Specialist may be unusual and require the Triage Team to contact the PCP for clarification or assign a Field Service Coordinator to do a home visit and communicate with PCP to determine Specialists and other providers the member may need.

Electronic Communication

One health plan understands the value electronic communication and our provider community does as well. One of our largest lab vendors has now started to provide online access to lab test results, in which members can access at their convenience. Another large lab vendor is in the process of allowing the same capability. We run a monthly report to identify new pregnant members and mail them a flyer informing them of the Text-4-Baby national program in which a pregnant mom may receive important health information and reminders via text on their phones.

Open Access Scheduling

Some health plan providers have adopted the open access scheduling model. One provider in particular has found that this model has worked to help decrease his members ER utilization. Health plan has shared this info with other providers to encourage some to try this model.

Patient Flow Analysis

One health plan has educated providers the importance of reducing wait times via provider newsletters.

Alternatives to One-on-One Visits

One health plan has partnered with First Vitals to bring retinal screening in the PCPs office and onsite within the health clinics on a regular basis. This screening allows members to get their diabetic retinal screening while seeing their PCP during the same office visit. If the result of the retinal screening shows concerns, the PCP is able to follow through and ensure the member goes to see an eye care professional for more thorough care, if needed.

As previously discussed, one of the largest lab vendors has now started to provide online access to lab test results, in which members can access at their convenience. Another large lab vendor is in the process of allowing the same capability. This helps alleviate the need for members to have an appointment to see their doctor to hear about their lab test results. They have also educated providers on the advantages of telemedicine via provider newsletter article.

Health plan Operations

One health plan considers the provider network as part of their microsystem. For example, our Utilization Medical Advisory Committee (UMAC) engages in the processes with physician attendance and reviewing and monitoring of processes and data, making recommendations, as needed. We also held regular manager meetings and meetings with Senior Leadership in which functional operations were discussed and workgroups created when needed to further analyze an issue or concern.

Promote Quality Improvement Initiatives

Quality remained the top of our organization's goals and continues to date. We understand the importance of organization-wide engage in the effort to improve the quality care our members receive and therefore have continued to carry forth our Quality Improvement Interventions Workgroup in which we have representation of all functional departments meet, discuss and track our progress with key quality initiatives. In addition, the Quality department continued to provide quality-focused education (HEDIS, CAHPS, quality of care, etc.) in functional team meetings. The intent is to emphasize each person's importance in contributing and improving our quality performance. In addition, quality is highlighted and educated upon during each new hire's onboard orientation training.

Access to Care

- Access to care is monitored through telephonic timely access surveys conducted quarterly; surveying both members and providers interchangeably. When survey results identify a provider or practice as not meeting accessibility and availability standards, Provider Relations Representatives will outreach to and educate the providers on the contractually required accessibility of timely appointments for health plan members. Providers not meeting the requirements may be expected to produce a corrective action plan showing how and when improvement will be seen going forward.
- One plan's Value Based Purchasing Program is also designed to foster care access and coordination. One part of the program rewards providers that have attained NCQA PCMH recognition via a capitated pmpm payment. Providers who were open panel and are willing to accept new health plan members receive an enhanced PCMH pmpm payment.
- They also monitor access to care via our quarterly Geo Access reports. They track the distribution of par providers by geographic region and measure against the number of members in particular region. Access is measured by the drive time to the appointment. They use that information to identify regions that may be deemed a high priority for network enhancement opportunities. Their Network Management Specialist will identify if there are any non-par providers in those regions and reach out to gauge their willingness to contract with health plan.

Patient and Family Engagement Advisory Councils

One health plan recognizes the importance of first-hand feedback on members' experience of the health plan and our provider system from our members directly. For this reason, they established the Members Matter Advisory Committee (MMAC). This is a committee comprised of health plan members and key health plan management staff representing various functional business areas. Their first meeting was held mid-year in 2014 and it continues today on a quarterly basis. They have a total of 4 members who are our official committee members, and we continually outreach to include more members. They included an article in the member newsletter letting members know about the committee and inviting them to join, as the committee is open to any and all health plan members interested in sharing their feedback with us so that we can help

improve their experience with the health plan. The MMAC committee meetings have been beneficial in helping us identify areas of improvement.

Call Centers

- One health plan continues to monitor call volume and hours of operation and have determined that our call center is open during appropriate hours of operation based on our customer's needs. Their call center is appropriately staffed to ensure calls are answered promptly. Currently our phone system is setup to ask customers if they would like to complete a survey following their call. All survey responses continue to be reviewed for possible areas of improvement.
- Department is divided into three separate teams. One team handles provider only calls, another team handles member only, and the third team is a hybrid team that services both member and provider call types. The teams were divided in effort to develop SMEs for each call type and have them evenly spread out throughout call center floor. There are two designated Customer Service Representatives (CSRs) dedicated to monitoring our inbound call queues to ensure we are appropriately staffed to take both member and provider calls. CSRs are reskilled as necessary to be able to absorb any influx of calls on either queue.

Creating Effective Customer Service Training Program

- In effort to ensure that new hires are adequately equipped to address member concerns, each new representative undergoes six (6) weeks of new hire training in classroom. Training is conducted by a dedicated CS Training Specialist. Training modules cover everything from soft-skills and effective communication tools, to HIPAA, cultural competency, Medicaid and Medicare.
- Periodic refresher trainings are conducted to ensure that all CSRs are up to speed on any and all new processes and work flows as well as be aware of all the different resources they have available to them so that they are well equipped to provide customers with the exceptional customer service.
- The Step Up Program has been deployed to assist new CSRs with the transition from the training environment to the production floor. The Step Up Program is designed to supply CSRs who just finished training with a controlled environment in which they begin to take live calls. CSRs are assisted by a supervisor or lead for a period of four weeks at which time they are monitored and assisted where necessary.
- During these four weeks CSRs receive daily quality audits which help them gauge their performance and they must meet certain benchmarks in order to graduate from the program. The quality audits are conducted on calls on same day to provide real time feedback and to discourage the development of bad habits.
- Along with quality audits, CSRs are provided with positive feedback for how they are performing and encouraged to improve through various exercises that they work through with the dedicated lead or supervisor.
- Quality Auditor also participates in actively updating and improving customer service processes as well as being a SME on the production floor should anyone need assistance.

Customer Service processes/work flows are regularly discussed in leadership team meetings and efforts are made to automate processes to reduce call handle times and our dedicated trainer and manager work with both the corporate training teams and operations departments to have job aids and training materials updated and to ensure that CareConnects functions properly.

Customer Service Performance Measures

- Customer Service focuses on various metrics, including Average Speed of Answer (ASA), Service Level (SL), Average Handle Time (AHT), Customer Satisfaction Survey (CSAT), First Call Resolution (FCR), and quality, to measure success. These performance measures are tracked month over month to ensure that regulatory call center metrics are met. When metrics are not met, root cause analysis is conducted and corrective action is taken. The Customer Service Performance measures are trended over the year and are included in the Quality Improvement Evaluation Report. Copies of the report are distributed to the physicians on the Utilization Medical Advisory Board that consists of external physicians.
- A dedicated Quality Auditor was added to staff and daily scheduled quality audits are performed for all CSRs on a consistent basis. The amount of audits conducted for each CSRs increased two fold and audits are conducted daily for calls serviced the day before to provide "real time" performance scores and to identify areas of concern and to spotlight areas that were exceptional. If goals are not met, coaching takes place between supervisor and CSRs utilizing notes provided by Quality Auditor.
- An additional layer of monitoring is conducted by the State who audits ten Medicaid calls monthly using a scorecard of their own design. The scorecards are forwarded to customer service and we respond to any areas of concern and verify that certain action was taken regarding member issues if it was not clear that said action took place during the course of the call that was monitored.
- Through the Quality Committee structure and workgroups, one health plan reviews and analyzes CAHPS results annually and develops plans and initiatives to ensure we continue to provide outstanding services and experience for our members and providers. Their key drivers of satisfaction and the barriers were analyzed. Based on this finding, root cause analysis has been conducted, interventions developed and prioritized the opportunities (see embedded document or details).