

2015 to 2016 Health Plan Initiatives

Improvement Activities Implemented

Incentive Programs

- One plan implemented a three-year provider incentive program to help improve rates in targeted HEDIS measures during 2015. As a part of this program, providers are incentivized for improving performance over their individual 2015 baseline performance. Incentives were for care that included the following: Childhood Immunization, Prenatal Care, Controlling High Blood Pressure, and Diabetes Care.

The difference between the incentive program payment methodology for 2015 and 2016 was that they were being reimburse for improvement of their own performance and prior it was just for services completed.

- Another plan also made a shift from volume to value with its Pay-for-Quality program wherein part of a physician's compensation is tied to specific quality metrics. This program included Childhood Immunization, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents and Diabetes Care. For another plan, the Pay-for-Performance bonus program was just being introduced to certain provider groups.

Care for Chronic Conditions

- One plan adopted the Patient-Centered Medical Home (PCMH) model of primary care where they incentivizing members incrementally as the provider demonstrates greater adherence to the PCMH model of care. Mailers with a well-child message with the immunization schedule were sent to children at 6, 12 and 15-month old intervals. Furthermore, the plan sent out nurse and staff out in the field. They left report sheets of children's vaccination status at providers as prompts to complete immunization schedules. Then, they called members to remind and discuss immunizations and called providers to discuss processes and barriers. This plans pharmaceutical manager also made calls to increase adherence of members to medications along with mail order scripts and 90-day scripts. Providers sent out informative letters to their patients with gaps in care about diabetes, hypertension and COPD, etc. to connect with them better. This was part of the plan's Disease Management program.
- For another plan, they had HEDIS practice advisors conduct quality-focused provider visits to distribute education and HEDIS toolkits and care gap reports and coaching on the measures and how to improve their rates. They also published articles for members and providers' newsletters on chronic condition management, well visits, immunizations, women's health, pre/postpartum care and behavioral health. Reminders were also sent for preventive screenings and importance of PCP visits. Community case management agencies (thru gap reports and scorecards) and members were outreached to close the care gaps. Outreach was done thru their Centralized Telephonic Outreach Program, their Early and Periodic Screen, Diagnostic and Treatment coordinators and Service Coordinators.

- Outreach, training and education tools, such as a picture frame refrigerator magnet with immunization schedule, were initiatives of another health plan. Another creative way this health plan reached out to members was conducting a baby shower event to educate pregnant mothers about the importance of prenatal care. The Hapai Malama Pregnancy Program was also launched to actively reach out to them as well. This focused on Childhood Immunization and Frequency of Prenatal Care. Collaboration with Department of Health to increase chlamydia screening. This plan also disseminated educational materials to their members and practitioners about ADHD and ADHD management and medications.

Data Systems and Processes

One health plan made changes for improvements in their enrolment process, practitioner data process, and data transfer process.

Access to Care

- One health plan outreached to Healthy Mothers, Healthy Babies, March of Dimes and Kapiolani Medical Center’s Hapai to improve their ability to offer additional pregnancy information and resources to members. They also connected with physicians as to how they can support obstetricians and their patients.
- Another plan strived to improve the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment-Initiation of AOD Treatment measure. Once they identified members with appropriate diagnoses, they developed workflow changes around data files to get members seen quicker, this led to improved referral to Chemical Dependency staff.

Utilization

After-hours clinic hours were extended for one plan to relieve stress on outpatient clinics caused by an increase in membership.

Effectiveness of Care

- To improve the Follow-Up After Hospitalization for Mental Illness (FUH) measure, one plan’s behavioral health vendor incorporated systemic ambulatory follow-up coordination services and quality management practices to ensure that members received aftercare appointments within seven and 30 days of discharge. They identified barriers and responded by reaching out to members to give reminders and assistance and worked with facilities to encourage proactive discharges planning, scheduling of FUH appointments and follow-up. This vendor also did outreach and distributed provider and member materials to raise awareness and to promote education of follow-up care for children prescribed ADHD medications to improve results for the corresponding measure. Furthermore, the ADHS Stop Gap Quality Improvement Activity was launched help parents or legal guardians to improve the continuous and maintenance medication requirement.
- Although there was improvement in the 50 percent compliance rate for one plan’s performance in the Medication Management for people with Asthma, the 75 percent

compliance has plateaued or slightly decreased. The health plan's electronic medical record was modified to include drug/dose alerts to providers. Also, they established coordination among PCPs and pediatric providers and their internal pharmacy to improve rates.

- Improvement activities by another plan focused on improving their FUH measure performance by providing HEDIS measure education to the behavioral health (BH) case management agencies and increased tracking of hospital admissions, discharges and follow-up appointments by BH case managers and BH care coordinators.

As part of its strategy to improve CAHPS, the health plans supports and promotes the following activities that build the provider-patient relationship and the importance of members' engagement in their care, which can lead to better satisfaction and access to care.

Rating of Health Plan and Customer Service

Ways The Health Plans Assessed And Evaluated The Membership Experience With The Health Plan:

- Quicker turnaround time of internal reporting to create provider HEDIS rate summary and care gap reports. Also, provider segmentation reports were created monthly to analyze any provider and measure-specific trending.
- Workgroups worked on provider support which included visits, education, coaching, resource tools, care gap reports and provider portal.
- QUEST Timely Access and telephonic timely access Surveys monitored access to care to measure appointment availability.

Actions Taken By Health Plans To Ensure Personnel Are Equipped To Address And Take Care of Member Concerns:

CUSTOMER SERVICE

- Conducted Service Coordination operations on all Hawaiian Islands. This put licensed nurses and social workers in the community, conducting face-to-face visits to assist members with coordinating their needs. They provided a higher level of 1:1 intervention individuals' own homes, to meet their needs.
- One plan joined the national team of Member Services Contact Centers. Through this partnership Hawaii Customer Service became Hawaii Member Services, and it gained access to a vast array of customer service and quality training as well as provided guidelines and metrics for which the department would be held accountable.
- Face-to-face or virtual training
- Online training
- New hire onboarding and on-going training provided

- Training for customer service staff includes average speed of answer, service levels, average handling time, customer satisfaction, first call resolution, and quality to measure the success of service and the ability to assist members.
- Focuses on various metrics which are tracked monthly and evaluated. When metrics are not met, analysis is conducted and corrected accordingly.
- Quality Improvement Team- quality-focused in-service training sessions for all departments.
- Member surveys done to gather member perception regarding wait time standards and experiences in getting in to see a provider.

WORKGROUPS CREATED TO IMPROVE HEALTH CARE PROCESSES

- Utilization Medical Advisory Committee (UMAC) - Engages in the plan's processes with physician attendance and reviewing and monitoring of processes and data, making recommendations as needed.
- Quality Improvement Intervention Workgroup (QIIW) - Takes a collaborative approach to improving quality health care.
- Members Matter Advisory Committee (MMAC) - To have and strengthen a formal means of communication with members.
- Member Advisory Group (MAG) - Advises on issues concerning the overall member experience.

Getting Needed Care & Getting Care Quickly Initiatives

Efforts by the Health Plans to Expand Access to a Provider:

- Utilization Management Department more consistently implemented the "Extension to Review" process that allowed more time (i.e., an additional 14 calendar days) to review authorization requests when additional information pertinent to the decision was required.
- Offered more peer-to-peer review of authorization requests to engage providers more.
- Enhanced the authorization system functionalities for better analysis and trending for continued process improvement.
- Established a Transition of Care team to conduct face-to-face, community and facility member outreach to at-risk members to avoid unnecessary admission or emergency department encounters.
- After analysis to identify provider shortages and access to care issues, recruited new rheumatologists and gastroenterologists as well as established a special program to allow specialist with a closed panel to receive new members.
- Clinics provided same-day appointments as well as telephone appointments to meet members' needs. Select same-day appointment slots were made

available the prior evening so members could book an appointment for the following day. Also, appointments were held open to ensure there was an adequate supply of appointments still available for same-day appointment calls or walk-ins.

- One plan does not require a referral to an in-network specialist. Customer Service assist members with any access to care requests. If the customer service representative could not locate a referral provider, then a provider relations representative will step in and conduct a broader search. If that does not work, the Service Coordination team would assist with care coordination.
- In addition, the Service Coordination team assisted providers with barriers that affected access to care. They also assisted members with multiple ER admissions with barriers and also outreached new members and EPSDT referrals.
- Worked with their new transportation vendor more closely to ensure that members were taken to their appointments in a timely manner.
- This plan promoted use of electronic interfaces via training and newsletters. One example is that local lab vendors started to provide online access to lab test results. Another example is a provider tool called RX Effect that allowed providers to perform medication therapy management by viewing nearly real-time data for their members regarding prescribed medications and refill trends.
- Participated in and sponsored several physician community events that promote health education, health literacy and preventive health care.
- Utilization of telehealth specialists such as dermatology.
- "Find a Provider"- An online tool.
- Customer Services
- Robust training for Customer Service staff that includes different phases the agents can graduate to.
- Enhancement of the PCMH model which improved patient access, including assigning patients to a designated primary care team, developing open access scheduling, and redefining care team member roles to free up appointment access and accommodate same day services. Six of these health centers have now received PCMH recognition from NCQA.
- As part of the PCMH program, an incentive to include a stipend to providers who were open panel and willing to accept new 'members.
- Services that are available twenty-four hours day, seven days a week: 24/7 Nurse Call Line, 24/7 Access and Live Nurse Chat are
- In 2014, the Teladoc service, a 24/7 access to a doctor via phone and online video consultations relayed through NurseLine, was upgraded with the NowClinic, an online care solution platform to connect members and providers.
- In-home visits by health care practitioners to assess health conditions and evaluate members' current health care needs and make recommendations.

Methods Utilized by the Health Plans to assist with Preventive Visits, Appointment Scheduling and Screenings Due:

- Cozeva – An online tool that promotes communication between providers and their patients.
- Used geo-mapping and other data analytic tools to convert vast amounts of data into actionable information. They further analyzed its networks by important criteria identified by members. Also, had a number of ongoing programs to build primary and specialty care to ensure appropriate providers are available on neighbor islands. One example is a recruitment package which subsidizes the costs of physician recruitment, allowing physician groups and hospitals to offer more attractive arrangements to prospective physicians.
- Centralized Telephonic Outreach Program - Also includes care gap and assists with transportation and interpretation services when needed.
- “Max-packing”- Appointments are consolidated around members’ transportation availability and is conducive to meeting with the member face to face while they are at one location for multiple appointments.
- Member educations sessions on various health topics as well as emphasizing the need to communicate with their doctors.
- Periodicity letters sent to members are specific to gender, age, and chronic conditions. Also explains the importance of these visits and what to expect. This encourages communication regarding their health care and/or treatment options.

Methods Utilized by the Health Plan to Address and to assist with Care Gaps:

- Personal Health Record (A piloted project) - Remains in member’s home and is updated at each face-to-face visit.
- CARE Connects links to members through the customer service phone lines.
- “Family-Centered Care Self-Assessment Tool”- Increases outpatient health care providers’ and families’ awareness about the implementation of family-centered care
- Information about the referral process and quick reference guides are available on the plans’ website, distributed in-person or by mail.
- No-show appointment follow-up process continued for one health plan
- Care Gap Reports- Given to providers and available via the provider portal. It has a built-in reminder system for services due and overdue.

Rating of Personal Doctor Initiatives

Actions Taken by Health Plans to Ensure Quality Provider Performance:

- Providers are educated about member rights to choose a specialist as a PCP to encourage the right match of providers.

- Surveys are conducted to determine provider compliance with appointment availability standards. Providers identified as noncompliant with the standards are provided direct education and feedback.
- Providers' newsletter and the provider guides distributed.
- Educational and informative articles such as "Communicating Effectively for Coordination of Care" are included.
- Health presentations given monthly throughout the State which integrated the necessity of feeling comfortable talking with one's provider.
- Access to online tools that make communication with their providers easy and convenient
- System enhancements are conducted frequently to remain current with the latest technologies. Those systems assist in completing, tracking, monitoring, and trending reports.
- Providers are encouraged to render the best care to its membership and to promote open communication including nonverbal communication such as ensuring eye contact and active listening.
- Provider relations representatives educate providers on accessibility of timely appointments required by Med-QUEST and NCQA during provider orientation and ongoing education sessions. Providers not meeting requirements may be expected to produce a corrective action plan.
- Providers are trained on members' rights and their responsibilities to adequately care for members. Provider wait times are also monitored and tracked through grievances. If a complaint is received, staff reaches out to the provider, investigates, educates, and provides feedback on findings.

Physicians' Assessment Initiatives

Efforts Made by the Health Plans to Increase Provider Satisfaction:

PCPs may use an online secure portal to request PA for referrals to out-of-network specialists/providers. These requests are reviewed and responded to within the time frame allowed by the MQD. Providers are encouraged to call in "URGENT" requests to ensure timely review and response.