

# 2017 Hawaii MQD Health Plan Initiatives

## 2017 Assessment of Follow-Up to Prior Year Recommendations

This is an assessment of how effectively the QUEST Integration health plans addressed the improvement recommendations made by HSAG in the prior year (2016) as a result of the EQR activity findings for compliance monitoring, HEDIS, PIPs, and CAHPS. The provider survey was not performed in 2016 and, therefore, is not addressed in this section. The CCS program members were not separately sampled for the CAHPS survey, as they were included in the QUEST Integrated health plans' sampling; therefore, there are not separate CAHPS results related to CCS members.

Except for the compliance monitoring section and PIPs, the improvements and corrective actions related to the EQR activity recommendations were self-reported by each health plan. HSAG reviewed this information to identify the degree to which the health plans' initiatives were responsive to the improvement opportunities.

## Compliance Monitoring Review

Formal follow-up reevaluations of the health plans' corrective actions to address the deficiencies identified in the 2016 compliance reviews were carried over to 2017 and were completed in early 2017. The specific compliance review findings and recommendations were reported in the 2016 EQR Report of Results. As appropriate, HSAG conducted technical assistance for the plans and conducted the follow-up assessments of compliance either telephonically or on-site as indicated by the significance or number of deficiencies. All health plans were found to have sufficiently addressed and corrected their findings of deficiencies through implementation of corrective action plans and were found to be in full compliance with requirements during the reevaluations conducted by HSAG.

## Performance Improvement Projects

In alignment with the Rapid Cycle PIP process, recommendations are made at the submission of each PIP module. The health plans addressed the recommendations as part of the either the resubmission of the module, or the submission of the next module. Therefore, the 2016 technical report did not contain specific recommendations. All health plans worked with HSAG to implement recommended improvements to subsequent PIP submissions.

## AlohaCare Quest Integration

### *Validation of Performance Measures—NCQA HEDIS Compliance Audits*

## 2016 QI Population Recommendations

HSAG recommended that AlohaCare QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the non-ABD population:

- Access to Care
    - *Adults' Access to Preventive/Ambulatory Health Services*
    - *Children and Adolescents' Access to Primary Care Practitioners*
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- *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
- Children’s Preventive Care
  - *Adolescent Well-Care Visits*
  - *Childhood Immunization Status*
  - *Immunizations for Adolescents*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- Women’s Health
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*
  - *Chlamydia Screening in Women*
  - *Human Papillomavirus Vaccine for Female Adolescents*
  - *Prenatal and Postpartum Care*
  - *Frequency of Ongoing Prenatal Care*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care*
  - *Controlling High Blood Pressure*
  - *Annual Monitoring for Patients on Persistent Medications*

## **QI Population Improvement Activities Implemented**

**Data systems and process:** AlohaCare QI added additional supplemental data sources for HEDIS 2017 in the form of EMR feeds and data files from five Community Health Centers. AlohaCare QI’s focus centered on implementing the data extracts, satisfying the requirements of the Roadmap, obtaining auditor approval, and the testing of these data sources. AlohaCare QI’s objective was to gather as much data as resources allowed for the HEDIS 2017 season and evaluate the rate impact by each supplemental data

The benefit to AlohaCare QI data aggregation of data from its Community Health Center partners goes beyond the impact on HEDIS rates. As a result, establishing the connections to the data sources and streamlining this process took a priority focus over assessing the cost of producing these files against the impact on rates.

## **2016 Non-ABD Population Recommendations**

HSAG recommended that AlohaCare QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the non-ABD population:

- Access to Care
    - *Adults’ Access to Preventive/Ambulatory Health Services*
    - *Children and Adolescents’ Access to Primary Care Practitioners*
    - *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
  - Children’s Preventive Care
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- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
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- Care for Chronic Conditions
  - *Comprehensive Diabetes Care*
  - *Controlling High Blood Pressure*
  - *Annual Monitoring for Patients on Persistent Medications*
- Behavioral Health
  - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*
  - *Follow-Up After Hospitalization for Mental Illness*

### **Non-ABD Population Improvement Activities Implemented**

AlohaCare QI’s 2017 Provider Incentive Program targeted select HEDIS measures to help improve rates for the QUEST Integration populations. Providers were reimbursed for meeting the HEDIS criteria of each measure that their members were selected for. The payment methodology was revised to better reward providers who improved year-over-year for the specified HEDIS measures. ABD and non-ABD populations were not distinguished in the provider Incentive Program.

Incentivized HEDIS measures included:

- Childhood Immunization Status – Combination 3
- Prenatal and Postpartum Care
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Comprehensive Diabetes Care
  - HbA1c Outcome of below 8%
  - Eye Exam

### **2016 ABD Population Recommendations**

HSAG recommended that AlohaCare QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the ABD population:

- Access to Care
    - *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
  - Effectiveness of Care
    - *Medication Reconciliation Post-Discharge*
  - Children’s Preventive Care
    - *Adolescent Well-Care Visits*
    - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
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- Women's Health
  - *Cervical Cancer Screening*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care*
  - *Controlling High Blood Pressure*

### **ABD Population Improvement Activities Implemented**

**Data systems and process:** AlohaCare QI added additional supplemental data sources for HEDIS2017 in the form of EMR feeds and data files from five Community Health Centers. AlohaCare QI's focus centered on implementing the data extracts, satisfying the requirements of the Roadmap, obtaining auditor approval, and the testing of these data sources. AlohaCare QI's objective was to gather as much data as resources allowed for the HEDIS 2017 season and evaluate the rate impact by each supplemental data source file.

The benefit to AlohaCare QI data aggregation of data from its Community Health Center partners goes beyond the impact on HEDIS rates. As a result, establishing the connections to the data sources and streamlining this process, took a priority focus over assessing the cost of producing these files against the impact on rates.

### **CAHPS—Adult Survey**

#### **2016 Recommendations**

Based on an evaluation of AlohaCare QI's results, the priority areas identified by HSAG were *Getting Needed Care*, *Customer Service*, and *Getting Care Quickly*. The following are recommendations of best practices and other proven strategies that may be used or adapted by the health plan to target improvement in each of these areas.

#### **Improvement Activities Implemented**

**Access to Care:** AlohaCare QI removed the referral requirement for in-network specialist appointments, as of 8/1/2017, to better assist members and ensure they are receiving the care and services most appropriate for their healthcare needs. In addition, AlohaCare QI has strengthened its Transition of Care program through 2016/2017 to better facilitate coordination of required services for members experiencing a transition through care settings.

**Timely Access to Care:** The Provider Services department performed network analyses to identify provider shortages and access to care issues. The timely access survey targeted both providers and members. This survey is conducted on quarterly basis and serves to gain feedback concerning the timely access to appointments and to measure appointment standard adherence. Based on survey outcomes, AlohaCare QI crafted a targeted provider education letter that was distributed to providers who do not meet the appointment standards. AlohaCare QI regularly publishes a provider newsletter that includes best practices for appointment standards. The GeoAccess report was utilized to identify network gaps specifically concerning member-to-provider ratio as well as deficiencies related to distance/miles. Recruiting strategies continue to be focused on addressing any network gaps identified on the report.

AlohaCare QI also implemented specific processes to decrease member no-shows. Specifically, AlohaCare QI has been working with targeted network providers concerning frequent appointment

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reminders including reminders about necessary pre-appointment/visit preparation that a member is responsible to complete to ensure a successful medical visit. To eliminate added administrative burden, AlohaCare QI removed the specialist referral requirement which sometimes lead to a no-show or delay in receiving an appointment.

Customer Service: AlohaCare QI continued to develop its high-touch model of member engagement through 2017, and this will be fully implemented in 2018. All AlohaCare QI members will have a central lead and this will be consistent across both Medicare and Medicaid lines of business.

The Customer Service department assesses its ability to adequately provide for member needs on an ongoing basis based on internal and state-specified Key Performance Indicators. Monthly tracked measures (and acceptable standards) include:

- Call abandonment rate - five percent (5%) or less;
- Average speed of answer - thirty (30) seconds or less;
- Average hold time - two (2) minutes or less;
- Blocked call rate - does not exceed one percent (1%)
- Longest wait in queue - four (4) minutes or less

Internally AlohaCare QI's internal KPIs are consistent with Hawaii requirements and are tracked on an organizational dashboard, which is reported regularly.

The Customer Service department has also implemented an extensive training program that consists of Benefits, Service Coordination, Special Projects, Systems, Non-ACD special projects, Telephone Training, and Medicare. A checklist is now given to each new customer service employee, and trainings are conducted on a yearly basis as a refresher. The training program was reviewed and is updated as necessary according to benefit and/or changes in the law.

## **Provider Survey**

### **2016 Recommendations**

The Provider Survey revealed opportunities to improve provider satisfaction. Based on these results, HSAG provided general quality improvement recommendations that plans should consider to increase or maintain a high level of provider satisfaction.

### **Improvement Activities Implemented**

In response to Provider feedback and surveys, AlohaCare QI successfully removed the referral requirement for services rendered by network providers.

AlohaCare QI has also been working on improving its prior authorization requirements and processes taking into consideration information received from providers via surveys as well as practitioner advisory group. Unnecessary prior authorization requirements are being identified and removed where possible. AlohaCare QI will be implementing its revised authorization requirements, including an authorization look-up tool, in 2018.

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## **HMSA Quest Integration**

### *Validation of Performance Measures—NCQA HEDIS Compliance Audits*

#### **2016 QI Population Recommendations**

HSAG recommended that HMSA QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the QI population:

- Access to Care
  - *Adults' Access to Preventive/Ambulatory Health Services*
- Effectiveness of Care
  - *Medication Reconciliation Post-Discharge*
- Children's Preventive Care
  - *Childhood Immunization Status*
  - *Immunizations for Adolescents*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- Women's Health
  - *Human Papillomavirus Vaccine for Female Adolescents*
  - *Prenatal and Postpartum Care*
  - *Frequency of Ongoing Prenatal Care*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care*
  - *Controlling High Blood Pressure*
  - *Annual Monitoring for Patients on Persistent Medications*
- Behavioral Health
  - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*

#### **QI Population Improvement Activities Implemented**

##### **Access to Care**

HMSA QI's Online Care (HOC) offers members an alternative source to care with 24/7 telephone or web access to providers. HOC continued to expand and provide innovative services to members, including offering web consultations or follow-up appointments for certain specialties.

Another option available to members that improves access to care is urgent care providers located in clinics on Oahu, Maui, Hawaii Island and Kauai. The urgent care clinics offer extended weekday hours, weekend and holiday hours and can treat a wide range of conditions, except life-threatening emergencies.

In addition, HMSA QI continued to provide member education materials, such as articles in our quarterly member magazine or line of business specific newsletters, to increase member awareness of their care options and to help members understand their role in obtaining appropriate care in a timely and satisfactory manner.

##### **Effectiveness of Care**

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***MRP Template and Training:*** In September 2016, HMSA QI created a standard template for providers to report medication reconciliation after inpatient discharge. The template was discussed with providers at a Physician Organization (PO) level through webinars and one-on-one as their patients became eligible for the measure. HMSA QI also worked with Queens Medical Center to discuss how providers can report and close gaps in their electronic medical record, Epic. In addition, HMSA QI did an advance review with Hawaii Pacific Health for sample medication reconciliation to use as a teach-back opportunity.

### **Children's Preventive Care**

***Pay-for-Quality and Payment Transformation:*** In 2016, HMSA QI's Pay-for-Quality program continued to include the Childhood Immunization "combo 3" which included Diphtheria, tetanus, pertussis, polio, mumps, measles, rubella, haemophilus influenza type b, Hepatitis B, and varicella.

In 2016, HMSA QI launched the value-based Payment Transformation program with a pilot set of provider offices. Payment transformation measures included *Childhood Immunization Status*, *Immunizations for Adolescents*, and *Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*.

***Mailers to Parents:*** Mailers that included an immunization schedule and a well-child message were sent to parents of member ages 6, 12, and 15 months old. The members' providers were also sent a notification of the mailer.

***Provider and Member Nurse Reminder Efforts:*** Continued from 2015, Provider and Member Nurse Reminder efforts involved providing vaccination status of members to providers. HMSA QI field staff and nurses outreached providers with their members' reports of vaccines received and not received. Vaccination reports for this intervention targeted members who turned two years of age from February to June 2015. In 2016, the second phase of this intervention used the data gathered from the first phase and identified members and providers at greater risk of not getting vaccines. For these members, a nurse called and reminded the member about the importance of immunizations and discussed potential barriers to receiving the vaccines. Providers were outreached to discuss processes and barriers based on potential issues raised by members.

***Early and Periodic Screening, Diagnostic and Treatment (EPSDT):*** The Early and Periodic Screening, Diagnostic and Treatment program outreached members about preventative care measures for newborns to 20 years of age. Outreach included well-child appointment reminder letters.

Other information available in this program included:

- Growth and development
- Nutrition, physical activity and safety
- Early screening and treatment for medical or behavior problems
- Receiving vaccinations timely

### **Women's Health**

***Pregnancy Support Program:*** The Pregnancy Support Program provided telephonic support to members from maternity registered nurses (RN). Support included education, referrals, and encouragement to obtain regular prenatal and postpartum care. Members were identified through claims

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and were mailed an invitation and enrollment form. In addition, providers could refer their patients into the program.

HMSA QI published an article and advertisement in the Island Scene Magazine providing resources for pregnant HMSA QI members.

***Your Pregnancy and Childbirth:*** This book provided information for pregnant women such as diet, exercise, and common questions or concerns related to pregnancy. The book was available as a maternity health resource to HMSA QI members at no cost.

**Chronic Conditions**

***Pay-for-Quality and Payment Transformation:*** In 2016, HMSA QI’s Pay-for-Quality program continued to include measures for Comprehensive Diabetes Care and Controlling High Blood Pressure.

In 2016, HMSA QI launched the value-based Payment Transformation program with a pilot set of provider offices. Payment Transformation measures included *Comprehensive Diabetes Care* and *Controlling High Blood Pressure*.

***Senior Fair Outreach:*** In support of coordination of care with providers, HMSA QI offered a mini health clinic at the 2016 Senior Fair. The mini health clinic included blood pressure and body mass index (BMI) reading, as well as flu shot clinic that HMSA QI co-sponsor with CVS Health. Health information such as blood pressure, flu vaccinations, and BMI were given as a hard copy to the member and another copy was mailed to the member’s primary care provider. Kahu Malama nurses were involved in this outreach to potentially increase the likelihood of provider entering data into medical records.

***Disease Management Program:*** HMSA QI’s Disease Management (DM) Program aims to provide support to members through education materials and classes. Classes are free and are offered by HMSA QI and affiliated partners. In coordination with providers, HMSA QI’s goal is to provide awareness of managing chronic conditions such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), and hypertension.

Group	Definition
Group 1	Well controlled disease
Group 2	Not known to be in control
Group 3	Severe condition

Outreach in 2016 included:

Member Group	Intervention	
Group 1 Well controlled condition	All members in a disease state	Member: Annual condition-specific introduction letter, e.g. Action Plan
Group 2 Not known to be in control	a. Members whose provider belong to a Physician Organization (PO)	a. Provider: DM materials, support services and member list to POST



	b. Members whose provider does not belong to a PO c. Members not attributed to a PCP	b. Provider: DM materials, support services and member list to POST c. Member: Referral to CareFinder; Quarterly mailings based on condition specific information & action plan
Group 3 Severe condition	All members in a disease state	Member: In addition to the above interventions, outbound calls to either their PCP or to the member to assure engagement, and/or coordination with Beacon Case Management, Care Mode, Special Health Care needs (SHCN), Model of Care, and Long Term Support Services (LTSS)

**Behavioral Health**

**Aftercare Program:** Beacon continued its Aftercare Program, which incorporates systematic ambulatory follow-up coordination services and quality management practices. The following were included in the Aftercare Program:

- Coordination process began as soon as member was admitted for mental illness
- Beacon Aftercare coordinator outreached to members via phone call to ensure follow-up appointment was made or to remind member to schedule a follow-up appointment
- If coordinator was unable to reach member, a reminder letter was sent
- Outreach to provider was made after appointment date to verify whether member attended follow-up appointment\
- If member did not attend follow-up or cancelled, coordinator outreached member to attempt to reschedule appointment

**Face to Face Engagement (Pilot):** Beginning in April 2016, in addition to the Beacon Aftercare program, Aftercare coordinators completed face-to-face outreach with members at Castle Medical Center at least twice a week. Face-to-face engagements were done when members had an inpatient visit or on day of discharge. HMSA QI collaborated with the line-level staff at the facility to ensure post hospitalization follow-up care and assisted the facilities with discharge planning.

Beacon also launched pilots at the following facilities: Maui Memorial Medical Center, Hilo Medical Center, and Queens Medical Center.

The following table represents the process and outcome measure of this pilot activity by facility.

Facility	Pilot period evaluated	Total # of members who had F2F	% of members seen by SC/CC who attended their 7-day FUH
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Castle	April 1 - Dec 1	121	49%
Maui	May 1 - July 31	9	33%
Hilo	May 1 - July 31	11	82%
Queens	Sep 1 -Nov 30	43	44%

## 2016 Non-ABD Population Recommendations

HSAG recommended that HMSA QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the non-ABD population:

- Access to Care
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  - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*

## Non-ABD Population Improvement Activities Implemented

### Children’s Preventative Care

***Pay-for-Quality and Payment Transformation:*** In 2016, HMSA QI’s Pay-for-Quality program continued to include the Childhood Immunization “combo 3” which included Diphtheria, tetanus, pertussis, polio, mumps, measles, rubella, haemophilus influenza type b, Hepatitis B, and varicella.

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    - *Cervical Cancer Screening*
  - Care for Chronic Conditions
    - *Comprehensive Diabetes Care*
    - *Controlling High Blood Pressure*
  - Behavioral Health
    - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*
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## **ABD Population Improvement Activities Implemented**

### **Access to Care**

***Provider Education and Awareness:*** Early identification of alcohol or drug dependence allows for proper treatment planning. That planning includes regular follow-up meetings with a behavioral health practitioner. Beacon launched a campaign in April 2016, targeting the top 20 diagnosing behavioral health providers with a commercial population. HMSA QI's commercial population historically, has significantly lower rates than QUEST Integration members. The top 20 providers were identified based on HEDIS 2016 specifications which measured members with an alcohol and other drug dependence identified from January 1, 2015, to November 15, 2015. The top 20 providers by volume of members, accounted for 491 of 990 commercial members with an average initiation rate of 49.5 percent.

Some of the key features of the activity included:

- Telephonic outreach and face to face office visits to identified high volume BH OP providers
- Mailings to providers with satisfactory performance
- Reminders on the importance of early identification and treatment of substance use disorders
- Shared provider level data that includes HEDIS rates with member level detail
- Dissemination of provider tools (Behavioral Health/Substance Abuse Referral Form, Leave-Behind Card with Beacon/HMSA QI contact information, and approved patient educational materials)

The top 20 diagnosing providers IET initiation and engagement rates were measured pre- and post-implementation utilizing Beacon-Hawaii's local HEDIS proxy program. The results indicated IET initiation rates improved for 11 providers, while 8 provider IET initiation rates declined. IET engagement rates improved for 8 providers, while 8 provider engagement rates declined. The volume of eligible members by provider also declined.

Furthermore, Beacon continued to raise awareness around the IET measure at the quarterly Provider Advisory Council (PAC) meetings, and facilitated discussion regarding the measure with the behavioral health providers in attendance. This forum occurred on June 16, 2016, where best practices were shared, and the importance of early identification and treatment of substance use disorders was discussed.

***PCP Record Reviews (Pilot):*** Beacon launched a pilot activity and conducted chart reviews on IET eligible members who had a visit to a PCP within 14 days of when they were diagnosed. The purpose of the chart reviews was to identify if there were appropriate treatment plans for AOD dependence documented by the PCP. This activity garnered from data analysis conducted on IET eligible members with initial diagnosis dates between January 1, 2016, and April 9, 2016, which identified that 22 percent (2,639) IET eligible members had a visit to a PCP within 14 days of IESD. However, only 4 percent initiated treatment.

Beacon requested a total of 46 records from various PCP offices and received back a total of 29 records (63%). The records reviewed indicated that 24% of members had evidence in the clinical notes the PCP initiated an appropriate treatment plan however this was not captured in the claim due to absence of an AOD diagnosis code. Other reviews conducted indicated there was no evidence that the PCP addressed AOD dependence or initiated treatment for the member. Based on the findings of the pilot, there is an

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opportunity to collaborate with PCPs on appropriate treatments steps when alcohol or drug dependence is identified. This is also an opportunity to remind providers to list all applicable diagnosis codes when submitting a claim.

### **Effectiveness of Care**

***MRP Template and Training:*** In September 2016, HMSA QI created a standard template for providers to report medication reconciliation after inpatient discharge. The template was discussed with providers at a Physician Organization (PO) level through webinars and one-on-one as their patients became eligible for the measure. HMSA QI also worked with Queens Medical Center to discuss how providers can report and close gaps in their electronic medical record, Epic. In addition, HMSA QI did an advance review with Hawaii Pacific Health for sample medication reconciliation to use as a teach-back opportunity.

### **Children's Preventative Care**

***Payment Transformation:*** In 2016, HMSA QI launched the value-based Payment Transformation program with a pilot set of provider offices. Payment transformation measures included Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents.

***Early and Periodic Screening, Diagnostic and Treatment (EPSDT):*** The Early and Periodic Screening, Diagnostic and Treatment program reached out to members about preventative care measures for newborns to members 20 years of age, that included outreach reminder letters for well-child appointment.

Other information available in this program included:

- Growth and development
- Nutrition, physical activity and safety
- Early screening and treatment for medical or behavior problems
- Receiving vaccinations timely

### **Chronic Conditions**

***Pay-for-Quality and Payment Transformation:*** In 2016, HMSA QI's Pay-for-Quality program continued to include measures for Comprehensive Diabetes Care and Controlling High Blood Pressure.

In 2016, HMSA QI launched the value-based Payment Transformation program with a pilot set of provider offices. Payment Transformation measures included Comprehensive Diabetes Care and Controlling High Blood Pressure.

***Senior Fair Outreach:*** In support of coordination of care with providers, HMSA QI offered a mini health clinic at the 2016 Senior Fair. The mini health clinic included blood pressure and body mass index (BMI) reading, as well as flu shot clinic that HMSA QI co-sponsor with CVS Health. Health information such as blood pressure, flu vaccinations, and BMI were given as a hard copy to the member and another copy was mailed to the member's primary care provider. Kahu Malama nurses were involved in this outreach to potentially increase the likelihood of provider entering data into medical records.

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**Disease Management Program:** HMSA QI's Disease Management (DM) Program aims to provide support to members through education materials and classes. Classes are free and are offered by HMSA QI and affiliated partners. In coordination with providers, HMSA QI's goal is to provide awareness of managing chronic conditions such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), and hypertension.

Members are put into different groups based on emergency or inpatient use, complications, comorbidity, and control value.

<b>Group</b>	<b>Definition</b>
Group 1	Well controlled disease
Group 2	Not known to be in control
Group 3	Severe condition

<b>Member Group</b>	<b>Definition</b>	<b>Intervention</b>
Group 1 - Well controlled condition	All members in a disease state	Member: Annual condition-specific introduction letter, e.g. Action Plan
Group 2 - Not known to be in control	<ul style="list-style-type: none"> <li>a. Members whose provider belong to a Physician Organization (PO)</li> <li>b. Members whose provider does not belong to a PO</li> <li>c. Members not attributed to a PCP</li> </ul>	<ul style="list-style-type: none"> <li>a. Provider: DM materials, support services and member list to POST</li> <li>b. Provider: DM materials, support services and member list to POST</li> <li>c. Member: Referral to CareFinder; Member: Quarterly mailings based on condition specific information &amp; action plan</li> </ul>
Group 3 - Severe condition	All members in a disease state	Member: In addition to the above interventions, outbound calls to either their PCP or to the member to assure engagement, and/or coordination with Beacon Case Management, Care Mode, Special Health Care needs (SHCN), Model of Care, and Long Term Support Services (LTSS)

**Behavioral Health**

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**Aftercare Program:** Beacon continued its Aftercare Program, which incorporates systematic ambulatory follow-up coordination services and quality management practices. The following were included in the Aftercare Program:

- Coordination process began as soon as member was admitted for mental illness
- Beacon Aftercare coordinator outreached to members via phone call to ensure follow-up appointment was made or to remind member to schedule a follow-up appointment
- If coordinator was unable to reach member, a reminder letter was sent
- Outreach to provider was made after appointment date to verify whether member attended follow-up appointment
- If member did not attend follow-up or cancelled, coordinator outreached member to attempt to reschedule appointment

**Face to Face Engagement (Pilot):** Beginning in April 2016, in addition to the Beacon Aftercare program, Aftercare coordinators also completed doing face-to-face outreach to members at Castle Medical Center at least twice a week. Face-to-face engagements were done when members had an inpatient visit or on day of discharge. HMSA QI collaborated with the line-level staff at the facility to ensure post hospitalization follow-up care and assisted the facilities with discharge planning.

Beacon also launched pilots at the following facilities: Maui Memorial Medical Center, Hilo Medical Center, and Queens Medical Center.

The following table represents the process and outcome measure of this pilot activity by facility.

Facility	Pilot period evaluated	Total # of members who had F2F	% of members seen by SC/CC who attended their 7-day FUH
Castle	April 1 - Dec 1	121	49%
Maui	May 1 - July 31	9	33%
Hilo	May 1 - July 31	11	82%
Queens	Sep 1 -Nov 30	43	44%

### CAHPS—Adult Survey

#### 2016 Recommendations

Based on an evaluation of HMSA QI’s results, the priority areas identified were *Customer Service*, *Getting Care Quickly*, and *Coordination of Care*. The following are recommendations of best practices and other proven strategies that may be used or adapted by the health plan to target improvement in these areas.

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## Improvement Activities Implemented

### Customer Service

**Call Centers:** In addition to 24/7 general call center access and after-hours access to QUEST integration executive staff for urgent situations, HMSA QI provides a 24-Hour Nurse Advice Line that members can call to talk with a nurse, answer questions, and determine whether a member should see a doctor or go to the emergency room. HMSA QI's 24-Hour Nurse Advice Line can also refer a member to a participating provider.

With regard to call center training, QUEST Call Center management staff continued to conduct a 15-minute meeting with call center representatives each morning, utilizing this time to review issues that have been identified via member and provider calls, updates regarding current mail outs to members and providers, provider/network issues and any other recurring issues identified by staff or management that all representatives need to be informed of. Weekly 1-hour trainings were also conducted for more in-depth topics that included improvement opportunities identified from member and provider calls, new or revised benefit as well as system changes, or process improvement implementation efforts.

**Cultural Competency Focused Training:** HMSA QI is committed to continually improving and enhancing the level of service provided to our members through ongoing training focusing on the unique needs of our membership. HMSA QI recognizes the cultural diversity of our membership and has focused training efforts around this. In 2017, HMSA QI partnered with a consultant who had significant experiencing engaging with culturally diverse populations to conduct cultural competency training. Over the course of two months, six (6) training sessions were provided (two on the neighbor islands, two in Kapolei, one at the HMSA QI offices in Kaimuki and one and HMSA QI Center) to further support our efforts to communicate with our QUEST Integration members in a meaningful way that takes into account the multicultural, diverse beliefs, values, health practices and socioeconomic needs of our population.

The training, entitled "The Pacific Islander Experience Cultural Competency Training" focused on cultural sensitivity and how western vs native ideals impact perception. The sessions were extremely successful with more than 135 HMSA QI employees across the organization from medical management, service coordination, customer service and program administration in attendance. Those attending were asked to complete a short satisfaction survey – results are shown below:

Overall Workshop	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. The purpose of the training was clearly communicated.			1	27	107
2. The slides and materials enhanced the presentation.			3	40	91
3. The training effectively engaged the audience.			0	19	116
4. The trainer spoke clearly and effectively.			1	13	121
5. I learned at least one new skill, attitude, or idea.			3	21	111

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Overall Workshop	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
6. It made me think of things in a new way or see a different perspective.			2	28	105
7. I found the training to be beneficial to my life and my work.			2	23	110

Free text comments regarding what attendees found most helpful were:

- The personal stories/real life examples
- Reminds (me) of (our) purpose
- Felt connected to presenters
- Reconnection with culture
- “This was one of the most powerful ‘trainings’ that I’ve EVER attended. It spoke to us as people and united us (member/Service Coordinator) in a way that we have not been before.”
- “One of the Best Trainings I’ve ever had”

Based upon the success of these cultural competency training sessions, HMSA QI is exploring ways to ensure that what was learned during these sessions are remembered and put into practice throughout the year in order to optimize communication, engagement and connections to our members, providers and with each other.

**Customer Service Performance Measures:** HMSA QI has established plan-level customer service standards that are consistent with MQD requirements with regard to both member and provider call centers. Results of these monitoring metrics, which include call volume, average speed of answer and abandonment rates, are reviewed and discussed monthly at the highest levels (e.g. the HMSA QI QUEST Integration Executive Steering Committee) to ensure that HMSA QI continues to meet the needs of our members and providers.

### **Access and Availability to Care**

**Patient Access and Availability:** HMSA QI conducts quarterly surveys of both member and providers to determine access to primary care, specialty care and behavioral health care for the following types of visits: Adult Sick, Urgent Care Appointment, Pediatric Sick, Routine PCP, Routine Behavioral Health, Specialist and Non-Emergency Hospital Stays.

Results over the past year have shown that appointment access for child/pediatric specialist visits warrants further investigation and has negatively impacted HMSA QI’s overall CAHPS *Getting Needed Care* composite. Analysis is in process to identify the top high-volume specialists and conduct a rapid cycle improvement activity focused on specialty appointment access.

HMSA QI also uses geo mapping and other data analytic tools to convert the vast amounts of data into actionable information. Beyond the conventional participating provider penetration reports, turnover ratios, geo-access reports, and geo-access maps, we further analyze our networks by specialty, patient panel size, drive times, appointment wait times, and other important criteria identified by our members

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and customers. We also have several ongoing programs to build primary and specialty care to ensure availability of providers representing primary and specialty care, are available to members on the Neighbor Islands.

- A recruitment package for Neighbor Island hospitals, Federally Qualified Health Centers (FQHC), clinics, and medical groups subsidies to cover the costs of physician recruitment, allowing physician groups and hospitals to offer more attractive arrangements to prospective physicians.
- Provider practice start-up cost subsidies help providers set up their practice by giving them a source of revenue while they are building their business. This incentivizes physicians to set up independent practices on the Neighbor Islands. This program helped a primary care physician on Oahu relocate to Hawaii Island.
- HMSA QI provides travel subsidies to Specialists who are willing to travel to the Neighbor Islands. This improves access to specialty care providers in rural areas that cannot sustain specialists on their own.
- We are providing support to the Queens' specialty clinics and Straub specialty clinics as well as individual providers, all of whom are available to see QI members. The traveling specialists help to fill specialty shortages, such as nephrology (Hilo and Kona), otolaryngology (Kona), neurosurgery (Hilo), orthopedic surgery (Hilo and Kona), plastic surgery (Hilo), rheumatology (Hilo and Kauai), ophthalmology (Hilo), oncology, obstetrics/gynecology, endocrinology, such as nephrology (Hilo, Kona, Waimea, Kauai, Lanai, and Kona), otolaryngology (Kona), neurosurgery (Hilo, Kona), orthopedic surgery (Hilo, Kona, Waimea, Maui and Kauai), rheumatology (Hilo, Kauai), ophthalmology (Hilo), gastroenterology (Maui), as well as oncology, obstetrics/gynecology, cardiology, and endocrinology.

***Decrease No Show Appointments:*** To decrease no show appointments, providers can refer their patients for Service Coordination. The assigned Service Coordinator will assist the member in identifying barriers, developing a service plan, and coordinating services that will support the member's needs and reduce no shows.

### **Coordination of Care**

HMSA QI has established a Service Coordination program to ensure the appropriate identification and engagement of HMSA QI QUEST Integration members into Service Coordination, to ensure that members with Special Health Care Needs (SHCN), those who are dually eligible, At-Risk, or those needing Long-Term Services and Supports (LTSS) receive the best possible care and service.

The Service Coordination System utilizes a member-centric, holistic approach to coordinate care for members across all providers and settings, evaluating all options and services available to meet member's healthcare needs as well as promoting quality outcomes. This includes developing strategies for meeting the needs of members with both medical and behavioral health conditions.

HMSA QI continued to promote the use of technology to improve the health and well-being of our members in a variety of ways. Cozeva is a Web-based platform that promotes communication between providers and their patients. It allows providers to see their HMSA QI quality measures and correlating patient information. Through Cozeva, they are able to identify gaps in care and address them in an upcoming visit. In the event a member needs to see a specialist, PCPs can ensure their patients can get the appropriate care by using Cozeva to create/track referrals and request/track prior authorizations. In addition, members can review prior authorization requests, status, and decisions through Cozeva's member platform. For members who are in HMSA QI Service Coordination, the PCP can view their

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patients Care Plan in order to most effectively work with the members Service Coordinator to assure that care plan goals are being met.

In 2017, HMSA QI also launched an innovative new mobile application called Sharecare which gives members easy access to a variety of tools and trackers to help them keep all their health information in one place as well as to motivate members to manage their own health and well-being. Some of the apps features include: finding a doctor, AskMD, the “Real Age” assessment, and trackers that link to Fitbit and other health related iOS / android fitness apps. HMSA QI will continue to evolve this innovative technology to most effectively engage members in their health in a personalized way that is most relevant and comfortable for them.

## ***Provider Survey***

### **2016 Recommendations**

The Provider Survey revealed opportunities to improve provider satisfaction. Based on these results, the following are general quality improvement recommendations that plans should consider to increase or maintain a high level of provider satisfaction. HMSA QI’s performance was not statistically different than the aggregate performance of other plans in the areas of Formulary, Access to Non-Formulary Drugs, Helpfulness of Service Coordinators and Adequacy of Behavioral Health Specialists. These general recommendations should be evaluated in the context of each plan’s operational and quality improvement activities. Improvement Activities Implemented

### **Improvement Activities Implemented**

To maintain and improve provider satisfaction, HMSA QI has implemented the following:

**Medical Management—*Prior Authorizations*:** Staff dedicated to improving electronic prior authorizations (iExchange). Over the last two years, HMSA QI has dedicated staff to training and educating providers (via phone, online meetings and face to face) regarding the use of HMSA QI’s electronic precertification processes called iExchange. This electronic precertification portal enables providers to submit their requests electronically, provides an avenue to submit additional clinical information if needed and improves the overall precertification review/decision experience.

As a result of education and training efforts, the use of iExchange (as of July 2017) has increased to more than 350 requests per month compared to 200 per month during the same period last year. Providers who have transitioned from paper to electronic precertification have been extremely positive citing the speed of decision making as well as the ability to upload large clinical records to support the precertification request electronically as the primary reasons.

HMSA QI will continue to expand the use of electronic precertifications through iExchange and enhance these capabilities as part of improving this shared workflow between providers and HMSA QI.

### **Formulary Management**

***Prior Authorizations/Step Therapies/Addition of Non-Formulary Drugs:*** HMSA QI uses an evidence-based prior authorization program that ensures our members receive the most appropriate medications that are safe, effective, and provide the greatest value (i.e. reducing waste, unnecessary drug use, and cost). Prior authorization criteria are reviewed and updated regularly to ensure they are working as-intended and to minimize the burden on providers and members as well as to ensure member access to

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drugs. Over the past year, HMSA QI has made several changes based upon ongoing review as noted below:

- Amicar, Premarin vaginal cream, levocarnitine were added to the HMSA QI QUEST Integration formulary since it had a high non-formulary exceptions approval rate
- Step therapy was removed from Advair since it had a high prior authorization volume and high approval rate
- Flovent was added to the HMSA QI QUEST Integration formulary based on feedback we received from pediatricians in the community
- Zolpidem ER was added to the HMSA QI QUEST Integration formulary to provide a long-acting sleep aid on the formulary
- Prior authorization was removed from Suboxone to ensure members with opiate agonist dependence have easy access to this drug

***Specialty Drug Online Prior Authorizations:*** Providers who need a prior authorization for a medical specialty drug can submit their request through NovoLogix, an online prior authorization tool. Online prior authorizations save providers time and reduce the need to phone or fax prior authorization requests for medical specialty drugs because the system allows them to:

- Easily create a request online
- Track the authorization status online
- View request determinations in NovoLogix

***Physician Organization Pilot:*** HMSA QI is working with physician organizations to pilot a program where pharmacists would work with providers to offer pharmacist support. Part of the resource will be for pharmacists to help providers with prior authorizations and educate them on the formulary process. This program will help minimize prior authorizations and the administrative burden associated with them.

***Provider Recruitment/Network Management:*** Recruitment support to hospitals, medical groups and FQHCs to assist with efforts to attract additional providers to the Neighbor Islands. HMSA QI has paid for recruiter fees, moving expenses, practice start-up expenses, and travel for interviews. This support, unique among Hawaii health plans, has been instrumental in adding to the PCP and specialist complement on the Neighbor Islands.

HMSA QI is actively working with existing providers or provider organizations on expanding access to primary and specialty care on the Neighbor Islands. HMSA QI has established relationships with Neighbor Island provider entities that recruit physicians, and recruitment support is dependent on the organizations undertaking activities to hire new providers. HMSA QI continues to fund this initiative in 2017, with these recent additions to the provider network:

- North Hawaii – 1 ob/gyn, 1 general surgeon, 1 otolaryngologist
  - West Hawaii – 1 APRN,
  - East Hawaii – 1 pediatrician, 1 APRN
  - Kauai – 1 urologist, 1 infectious disease specialist, 1 ob/gyn, 1 gastroenterologist
  - Maui – 1 ob/gyn, 1 APRN
-

***Funding a subsidy for travel by Oahu specialists to the Neighbor Islands:*** In a continuation of a successful program that enhances access to care, HMSA QI paid travel subsidies at \$170 (\$190 to Hilo) per roundtrip to specialists who traveled from Oahu and provided care on the Neighbor Islands. This program continues to have active participation by our traveling specialists. From January to May 2017, HMSA QI paid stipends for 690 Neighbor Island trips.

The traveling specialists continue to help to fill specialty shortages, such as nephrology (Hilo, Kona, Waimea, Kauai, Lanai, and Kona), otolaryngology (Kona), neurosurgery (Hilo, Kona), orthopedic surgery (Hilo, Kona, Waimea, Maui and Kauai), rheumatology (Hilo, Kauai), ophthalmology (Hilo), gastroenterology (Maui), as well as oncology, obstetrics/gynecology, cardiology, and endocrinology.

In communities that are not large enough to support a specialty services, the traveling specialist program has brought needed specialty care. HMSA QI continues to work with health systems on care delivery models that might include more regularly scheduled specialty care or expanded use of telehealth.

***Physician Liaison Committees:*** Three times a year, HMSA QI Provider Services management and Medical Directors conducts Physician Liaison Committee meetings with eight geographic groups of physicians in Honolulu, Windward Oahu, West Oahu, Hilo, Kona, North Hawaii, Maui and Kauai. We use the Physician Liaison Committee meetings as a forum to gather physician feedback and input on processes and programs that need improvement. Specialty shortages and challenges with patient travel from the Neighbor Islands are among the issues that have been raised by doctors at these meetings.

### **Payment Transformation**

HMSA QI has and will continue to invest significant resources (people, tools and technology) to refine and improve value driven health care through its Payment Transformation initiative which aims to transition all PCPs into a new value-based payment model which will reward physicians for improvements in health and well-being, patient satisfaction, timely access to care and care efficiency. HMSA QI's Payment Transformation pilots began in April of 2016 with a goal of having 100% of all PCPs reimbursed under this model by 2018. The new Payment Transformation model will tie a larger portion of each provider's reimbursement to meeting population health and wellness goals, including measures related to access to and the cost and quality of care

The Payment Transformation program pays physicians per member per month amount based on the number of attributed patient lives. The program encourages primary care providers to more willingly accept QUEST Integration members and to effectively coordinate and manage their care.

As part of Payment Transformation, HMSA QI worked with Neighbor Island medical groups involved in primary care to support their urgent care services. In recognition of the need for care options on the Neighbor Islands, we also contracted with specific PCPs to continue providing specialty care while being reimbursed a global monthly payment as a PCP.

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## Kaiser Foundation Health Plan (KFHP) QUEST Integration

### *Validation of Performance Measures—NCQA HEDIS Compliance Audits*

#### 2016 QI Population Recommendations

HSAG recommended that Kaiser QI focus on improving performance related to the following measure with rates that fell below the national Medicaid 25th percentile for the QI population:

- Care of Chronic Conditions
  - *Medication Management for People With Asthma*

#### QI Population Improvement Activities Implemented

The following table depicts the 3-year trend results for *Medication Management for People with Asthma* measure recommended for improvement. HEDIS 2017 results indicate that improvement was achieved during 2016 measurement.

<b>Medication Management for People With Asthma (MMA)</b>	<b>HEDIS 2015 Rate</b>	<b>HEDIS 2016 Rate</b>	<b>HEDIS 2017 Rate</b>
Total Medication Compliance 50%	33.75%	35.75%	42.02%
Total Medication Compliance 75%	13.25%	15.46%	18.59%

An evaluation of the activities implemented as part of our Quality Improvement process are also outlined as follows:

Improvement has been seen in both the 50% compliance rate and the 75% compliance rate.

Activities conducted include the following:

- Education by clinical pharmacy specialist in the third quarter of 2016 was provided to Providers who were prescribing more than one short acting beta agonist or prn refills.
- During the first quarter 2016 Education provided to clinical pharmacists and QUEST Integration RN case managers to review treatment algorithms and the Asthma Control test. Asthma Control test scores are used to assess clinical control. Results of the Asthma Control test were plotted on the treatment algorithm to determine follow up treatment. Depending on the score, asthma controller medication usage was started, increased or decreased.
- Reprioritizing of job duties for Clinical pharmacists to monitor appropriateness of asthma medication management.
- Physician specialist performed Chart Reviews and sent notices to Primary Care Practitioners (PCPs) to educate members regarding asthma management.

#### 2016 Non-ABD Population Recommendations

HSAG recommended that Kaiser QI focus on improving performance related to the following measure with rates that fell below the national Medicaid 25th percentile for the non-ABD population:

- Care for Chronic Conditions
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– *Medication Management for People With Asthma*

### **Non-ABD Population Improvement Activities Implemented**

The following table depicts the 3-year trend results for *Medication Management for People with Asthma* measure recommended for improvement. The Non-ABD population was carved out for only HEDIS 2016. Displayed in total QI population, the HEDIS 2017 results indicate that improvement was achieved during 2016 measurement.

An evaluation of the activities implemented as part of our Quality Improvement process are also outlined as follows:

<b>Non-ABD Medication Management for People With Asthma (MMA)</b>	<b>HEDIS 2015 Rate</b>	<b>HEDIS 2016 Rate</b>	<b>HEDIS 2017 Rate</b>
Total Medication Compliance 50%	33.75%	35.75%	42.02%*
Total Medication Compliance 75%	13.25%	15.46%	18.59%*

\* HEDIS 2017 reporting required only reporting of Total QI population. Non-ABD population carve out was not required.

Improvement has been seen in both the 50% compliance rate and the 75% compliance rate.

Activities conducted include the following:

- Education by clinical pharmacy specialist in the third quarter of 2016 was provided to Providers who were prescribing more than one short acting beta agonist or prn refills.
- During the first quarter 2016, education was provided to clinical pharmacists and QUEST Integration RN case managers to review treatment algorithms and the Asthma Control test. Asthma Control test scores are used to assess clinical control. Results of the Asthma Control test were plotted on the treatment algorithm to determine follow up treatment. Depending on the score, asthma controller medication usage was started, increased or decreased.
- Reprioritizing of job duties for Clinical pharmacists to monitor appropriateness of asthma medication management.
- Physician specialist performed Chart Reviews and sent notices to Primary Care Practitioners (PCPs) to educate members regarding asthma management.

### **2016 ABD Population Recommendations**

There were no recommendations for the 2016 ABD results; no improvement activities were implemented.

### **CAHPS—Adult Survey**

#### **2016 Recommendations**

Based on an evaluation of Kaiser QI's results, the priority areas identified were *Getting Needed Care*, *Customer Service*, and *Getting Care Quickly*. The following are recommendations of best practices and other proven strategies that may be used or adapted by the health plan to target improvement in these areas.

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## **Improvement Activities Implemented**

### **Access to Care**

KFHP QI utilizes encounter data to identify members from all plans who have care gaps to conduct both in-reach and outreach activities (equivalent to “Max-Packing”). The Mana Ku Tool, How Are We doing (HAWD) Tool, and Super-list Population Outreach Tool (SPOT) draw data from our electronic medical records (HealthConnect) to identify members in need of prevention screenings such as cancer screenings, immunizations, chronic care services or medication follow up.

- **In-reach activity:** Any member who is physically present in the clinic for an appointment will have their “Mana Ku” profile opened, and the medical assistant will “pend” any due/overdue prevention screenings or care monitoring tests for the provider to review and order.
- **Outreach activity:** KP utilizes Mana Ku and HAWD to generate lists of patients who are due or overdue for prevention screenings, laboratory tests, chronic disease management, or medication management. Staff will perform targeted outreach to members via emails, letters, and/or phone calls (both live and by IVR technology). In addition to staff outreach, with information from HAWD and Mana Ku, we can “batch” outreach for laboratory tests and screening tests.

The Patient Support Service (PSS) is a model for population care which utilizes the skills of clinical pharmacists, pharmacy technicians, advance practice RNs, registered nurses, medical assistants and clerical staff to support physicians, help reach defined quality goals, and assist with regional priorities through an evidence-based, whole member care approach to improve the health status of patients with chronic illnesses.

The PSS team currently helps manage patients with chronic conditions including diabetes, hypertension and cardiovascular disease, gout, osteoporosis, depression and other conditions. The team utilizes several tools including the Care Management Tracking System (CMTS), HAWD and Mana Ku to provide real time data on targeted populations for feedback, monitoring, and management of the quality of care being delivered as measured against regional clinical standards.

### **Customer Service**

Member Services performance of telephone access is monitored daily, and performance metrics are set to the MQD requirements to monitor compliance. Non-compliance metrics are analyzed for root cause and corrective actions are taken.

### **Timely Access to Care**

2016 Primary Care Improvement activities included the following:

- Open Panels and Direct Online Booking to members
  - Primary Care appointments for routine office visits, same day visits and phone appointments
  - Appointments for same day care provided by PAs or physicians other than member’s PCP
  - Appointments to check vital signs including blood pressure and weight
  - Pediatric well child visits and telephone appointments
  - Extended After Hours Care and Urgent Care Hours
-

- Telephone appointments
- Secure messaging
- Internal Medicine Residency Program

#### 2016 Specialty Care Improvement Activities:

- Member Direct Online Booking for select Specialty Care appointments (Sports Medicine, Physical Therapy consults)
- Telederm and flexible provider scheduling templates

The Strategy and Operations Work Team developed to leverage and optimize Telehealth visits based on which technology fits best for the respective specialty or visit type. These strategies will be used with MQD members now that telehealth has been approved in 2017.

### *Provider Survey*

#### **2016 Recommendations**

The Provider Survey revealed opportunities to improve provider satisfaction. Based on these results, the following are general quality improvement recommendations that plans should consider to increase or maintain a high level of provider satisfaction. These general recommendations should be evaluated in the context of each plan's operational and quality improvement activities. Improvement Activities Implemented

#### **Improvement Activities Implemented**

As noted in the CAHPS section, KFHP QI has implemented several activities to improve access to Specialist and Behavioral health providers. The number of specialty providers that members can directly book on-line has been increased. Expanded use of programs like tele-derm and flexible provider scheduling templates have increased panel capacity for specialists. A Strategy and Operations Work Team was developed to leverage and optimize Telehealth visits based on which technology fits best for the respective specialty or visit type. These strategies will be used with MQD members now that telehealth has been approved in 2017.

#### **Behavioral Health**

Efforts to fill staffing vacancies was a top priority in 2016 along with growing the network of external providers. The Integrated Behavioral Health (IBH) Department aggressively and proactively recruited to fill vacant positions however, it continues to experience challenges due to the nation-wide shortage. Throughout 2016, the strategy remained the same which is to fill internal staffing vacancies, grow the network of external providers, and refer members out to external providers as needed. Kaiser has partnered with Staffing Temp Agencies for internal staffing needs.

KHFP continued to utilize the patient-centered medical home (PCMH) model of care as guiding principles. The organization is currently recognized at the highest level of status (Level 3) and is in the process of renewing their recognition of all 15 primary care sites under the 2017 redesigned program.

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## **‘Ohana Health Plan (‘Ohana) QUEST Integration**

### *Validation of Performance Measures—NCQA HEDIS Compliance Audits*

#### **2016 QI Population Recommendations**

HSAG recommended that ‘Ohana QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the QI population:

- Access to Care
  - Adults’ Access to Preventive/Ambulatory Health Services
  - Children and Adolescents’ Access to Primary Care Practitioners
- Effectiveness of Care
  - Medication Reconciliation Post-Discharge
- Children’s Preventive Care
  - Adolescent Well-Care Visits
  - Childhood Immunization Status
  - Immunizations for Adolescents
  - Well-Child Visits in the First 15 Months of Life
  - Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Women’s Health
  - Cervical Cancer Screening
  - Chlamydia Screening in Women
  - Prenatal and Postpartum Care
  - Frequency of Ongoing Prenatal Care
- Behavioral Health
  - Follow-Up After Hospitalization for Mental Illness

#### **QI Population Improvement Activities Implemented**

‘Ohana QI’s Quality Improvement Intervention Workgroup (QIIW) and Quality Improvement (QI) Team HEDIS Focus Workgroup met regularly to review trending data for HEDIS measures, complete causal barrier analysis, and monitor status updates of interventions developed specifically to improve HEDIS rates. Smaller workgroups were developed to address specific HEDIS measures, such as behavioral health, women and children related measures. The following are improvement activities that were continued in 2016:

- ‘Ohana QI continued to receive lab results directly from lab vendors, Clinical Laboratories, and Diagnostic Laboratory Services.
  - HEDIS Practice Advisors (HPA) currently known as Quality Practice Advisors (QPAs) conducted quality-focused provider visits. In partnership with the Provider Relations Representatives (PR Reps), providers received education and coaching on HEDIS measures and how to improve in their rates. The HPA and/or PR Reps distributed HEDIS tool kits and care gap reports to providers, and taught providers how to use the HEDIS on-line tool (via provider
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portal) as an additional method to look up members care gaps and close care gaps by submitting medical records through the online tool.

- Pay-for-Performance bonus program was offered to certain provider groups.
- During the 2017 HEDIS Season, ‘Ohana QI contracted approximately sixteen (16) temporary staff to collect data medical records and over-reading of medical records used for HEDIS®. ‘Ohana QI also contracted an external vendor, Altegra, for the abstraction of medical records used for HEDIS® both Oahu and Neighbor Islands. Six (6) of the total temporary contracted staff, were registered nurses (RNs) who focused mainly on inter rater reliability (IRR) or over reads of medical records. From this effort, ‘Ohana QI exceeded its targeted 2017 goal from 85% to 96% of medical records retrieval.
- ‘Ohana QI registered nurses (RNs) to conduct the annual Medical Record Review (AMRR) audit as well as assess compliance with the Plan’s medical record standards and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) documentation standards.
- Articles for both member and provider newsletters were published for the following: Chronic condition management, well-visits for children and adolescents, immunizations, women’s health, prenatal and postpartum care, and behavioral health. 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 continued to monitor the CCMA’s progress in closing care gaps.
- A Preventive Care Checklist which incorporated HEDIS-related preventive screenings was distributed to all members assigned to a Service Coordinator (SC). The reader-friendly checklist doubled 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 and Disease Management nurses discussed the checklist with members and instructed them to bring the checklist to doctor’s office during a follow-up visit for completion.
- Letters were mailed to providers to address members who have persistent asthma (based on claims data) and are on a controller medication. The letter included recommendations and a reminder to outreach member to schedule a doctor’s appointment.
- Mommy Baby Matters Booklets were mailed out to pregnant members, which included educational information on prenatal and postpartum care.
- Several outreach programs to educate members on chronic condition management and preventive screenings were completed. The following lists ‘Ohana QI’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 and SCs outreached parents and guardians of pediatric members to educate and assist with scheduling appointments for well-visits and to get their immunizations updated.

‘Ohana QI Health Plan’s comparison rates of HEDIS 2016 to the HEDIS 2017 rates for the relevant measures that have improved are as follows:

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Measure	HEDIS 2017 Rate	HEDIS 2016 Rate	% Point Improvement	% Improvement
Children's Access 17 (CAP17) Members 12 to 24 Month of Age	89.25%	85.25%	4.70%	5.51%
Chlamydia Screen 17 (CHL17) Total	53.06%	50.15%	2.91%	5.80%
Follow-Up Hosp MH 17 (FUH17) Follow Up within 30 days	61.17%	43.73%	17.44%	39.88%
Follow-Up Hosp MH 17 (FUH17) Follow Up within 7 days	37.80%	24.71%	13.09%	52.97%
Freq Ongoing PNC 17 (FPC27) <21 percent of expected visits	14.60%	12.53%	2.07%	16.52%
Freq Ongoing PNC 17 (FPC27) -60 percent of expected visits	11.92%	11.08%	0.84%	7.58%
Prenatal Post Care 17 (PPC27) Timeliness of prenatal care	76.40%	69.16%	7.24%	10.47%
Well Child 15 Month 17 (W1517) Four well child visits	9.94%	7.32%	2.62%	35.79%
Well Child 15 Month 17 (W1517) One well child visits	4.70%	3.79%	0.91%	24.01%
Well Child 15 Month 17 (W1517) Three well child visits	8.01%	6.78%	1.23%	18.14%
Well Child 15 Month 17 (W1517) Two well child visits	5.80%	5.15%	.065%	12.62%
Well Child 15 Month 17 (W1517) Zero well child visits	96.13%	94.04%	2.09%	2.22%

The following relevant measures have shown improvement towards meeting the 50th percentile, as indicated by a 10 percent or less *Gap to 50th percentile* target (see table below):

- Adults' Access to Preventive/Ambulatory Health Services

- Children and Adolescents' Access to Primary Care Practitioners
- Adolescent Well-Care Visits
- Childhood Immunization Status
- Chlamydia Screening in Women
- Prenatal and Postpartum Care
- Frequency of Ongoing Prenatal Care
- Follow-Up After Hospitalization for Mental Illness
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Measure	HEDIS 2017 Rate	50 <sup>th</sup> Percentile Target	Gap to 50 <sup>th</sup> Percentile Target
Adult Access 16 (AAP17) Total	74.57%	82.15%	7.58%
Childhood Immunization 17 (CS17) Combination 10 Immunizations	25.46%	32.64%	7.18%
Childhood Immunization 17 (CS17) Combination 6 Immunizations	32.89%	39.14%	6.25%
Childhood Immunization 17 (CS17) Combination 8 Immunizations	32.36%	38.20%	5.84%
Childhood Immunization 17 (CS17) Combination 9 Immunizations	25.99%	33.10%	7.11%
Children's Access 17 (CAP17) Members 12 to 19 Years of Age	79.79%	89.37%	9.58%
Children's Access 17 (CAP17) Members 12 to 24 Years of Age	89.95%	95.74%	5.79%
Chlamydia Screen 17 (CHL17) Total	53.06%	55.16%	2.10%
Follow-Up Hosp MH 17 (FUH17) Follow Up within 30 days	61.17%	63.94%	2.77%
Follow-Up Hosp MH 17 (FUH17) Follow Up within 7 days	37.80%	44.05%	6.25%
Freq Ongoing PNC 17 (FPC27) <21 percent of expected visits	14.60%	8.22%	-6.38%
Freq Ongoing PNC 17 (FPC27) -40 percent of expected visits	13.14%	5.82%	-7.32%
Freq Ongoing PNC 17 (FPC27) -60 percent of expected visits	11.92%	7.92%	-4.00%
Freq Ongoing PNC 17 (FPC27) -80 percent of expected visits	16.30%	14.95%	-1.35%
Initial Engagement AOD 17 (IET17) Engagement Total	10.79%	9.63%	-1.16%

Measure	HEDIS 2017 Rate	50 <sup>th</sup> Percentile Target	Gap to 50 <sup>th</sup> Percentile Target
Initial Engagement AOD 17 (IET17) Initiation Total	35.88%	38.07%	2.19%
Prenatal Post Care 17 (PPC27) Timeliness of prenatal care	76.40%	82.25%	5.85%
Well Child 15 Month 17 (W1517) Five well child visits	14.64%	16.49%	1.85%
Well Child 15 Month 17 (W1517) Four well child visits	9.94%	9.16%	-0.78%
Well Child 15 Month 17 (W1517) One well child visits	4.70%	1.95%	-2.75%
Well Child 15 Month 17 (W1517) Six or more well child visits	53.04%	59.57%	6.53%
Well Child 15 Month 17 (W1517) Three well child visits	8.01%	5.42%	-2.59%
Well Child 15 Month 17 (W1517) Two well child visits	5.80%	3.19%	-2.61%
Well Child 15 Month 17 (W1517) Zero well child visits	96.13%	98.29%	2.16%

## 2016 Non-ABD Population Recommendations

HSAG recommended that ‘Ohana QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the non-ABD population:

- Access to Care
    - *Adults’ Access to Preventive/Ambulatory Health Services*
    - *Children and Adolescents’ Access to Primary Care Practitioners*
  - Children’s Preventive Care
    - *Adolescent Well-Care Visits*
    - Childhood Immunization Status
    - Immunizations for Adolescents
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
    - Well-Child Visits in the First 15 Months of Life
    - Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
  - Women’s Health
    - Cervical Cancer Screening
    - Chlamydia Screening in Women
    - Prenatal and Postpartum Care
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- Frequency of Ongoing Prenatal Care
- Care for Chronic Conditions
  - Comprehensive Diabetes Care
  - Controlling High Blood Pressure
- Behavioral Health
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia
  - Follow-Up After Hospitalization for Mental Illness

### **Non-ABD Population Improvement Activities Implemented**

‘Ohana QI’s Quality Improvement Intervention Workgroup (QIIW) and Quality Improvement (QI) Team HEDIS Focus Workgroup met regularly to review trending data for HEDIS measures, complete causal barrier analysis, and monitor status updates of interventions developed specifically to improve HEDIS rates. Smaller workgroups were developed to address specific HEDIS measures, such as behavioral health, women and children related measures. The following are improvement activities that were continued in 2017

- ‘Ohana QI continued to receive lab results directly from lab vendors, Clinical Laboratories, and Diagnostic Laboratory Services.
  - HEDIS Practice Advisors (HPA) conducted quality-focused provider visits. In partnership with the Provider Relations Representatives (PR Reps), providers received education and coaching on HEDIS measures and how to improve in their rates. The HPA and/or PR Reps distributed HEDIS tool kits and care gap reports to providers, and taught providers how to use the HEDIS on-line tool (via provider portal) as an additional method to look up members care gaps and close care gaps by submitting medical records through the online tool.
  - Pay-for-Performance bonus program was offered to certain provider groups.
  - During the 2017 HEDIS Season, ‘Ohana QI contracted approximately sixteen (16) temporary staff to collect data medical records and over-reading of medical records used for HEDIS®. ‘Ohana QI also contracted an external vendor, Altegra, for the abstraction of medical records used for HEDIS® both Oahu and Neighbor Islands. Six (6) of the total temporary contracted staff, were registered nurses (RNs) who focused mainly on inter rater reliability (IRR) or over reads of medical records. From this effort, ‘Ohana QI exceeded its targeted 2017 goal from 85% to 96% of medical records retrieval.
  - ‘Ohana QI contracted registered nurses (RNs) to conduct the annual Medical Record Review (AMRR) audit as well as assess compliance with the Plan’s medical record standards and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) documentation standards.
  - Articles for both member and provider newsletters were published for the following: Chronic condition management, well-visits for children and adolescents, immunizations, women’s health, prenatal and postpartum care, and behavioral health. 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 continued to monitor the CCMA’s progress in closing care gaps.
  - A Preventive Care Checklist which incorporated HEDIS-related preventive screenings was distributed to all members assigned to a Service Coordinator (SC). The reader-friendly checklist doubled 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 and
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Disease Management nurses discussed the checklist with members and instructed them to bring the checklist to doctor's office during a follow-up visit for completion.

- Letters were mailed to providers to address members who have persistent asthma (based on claims data) and are on a controller medication. The letter included recommendations and a reminder to outreach member to schedule a doctor's appointment.
- Mommy Baby Matters Booklets were mailed out to pregnant members, which included educational information on prenatal and postpartum care.
- Several outreach programs to educate members on chronic condition management and preventive screenings were completed. The following lists 'Ohana QI'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 and SCs 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.

## **2016 ABD Population Recommendations**

HSAG recommended that 'Ohana QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the ABD population:

- Access to Care
    - *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
  - Effectiveness of Care
    - Medication Reconciliation Post-Discharge
  - Children's Preventive Care
    - Adolescent Well-Care Visits
    - Immunizations for Adolescents
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
  - Women's Health
    - Cervical Cancer Screening
    - Chlamydia Screening in Women
    - Prenatal and Postpartum Care
    - Frequency of Ongoing Prenatal Care
  - Behavioral Health
    - Follow-Up After Hospitalization for Mental Illness
  - Utilization and Health Plan Descriptive Information
    - Ambulatory Care
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## **ABD Population Improvement Activities Implemented**

The following are improvement activities that were continued in 2016:

- HEDIS Practice Advisors (HPA) conducted quality-focused provider visits. In partnership with the Provider Relations Representatives (PR Reps), providers received education and coaching on HEDIS measures and how to improve in their rates. The HPA and/or PR Reps distributed HEDIS tool kits and care gap reports to providers, and taught providers how to use the HEDIS on-line tool (via provider portal) as an additional method to look up members care gaps and close care gaps by submitting medical records through the online tool.
  - Pay-for –Performance bonus program was offered to top volume providers.
  - During the 2017 HEDIS Season, ‘Ohana QI contracted approximately sixteen (16) temporary staff to collect data medical records and over-reading of medical records used for HEDIS®. ‘Ohana QI also contracted an external vendor, Altegra, for the abstraction of medical records used for HEDIS® both Oahu and Neighbor Islands. Six (6) of the total temporary contracted staff, were registered nurses (RNs) who focused mainly on inter rater reliability (IRR) or over reads of medical records. From this effort, ‘Ohana QI exceeded its targeted 2017 goal from 85% to 96% of medical records retrieval.
  - ‘Ohana QI contracted registered nurses (RNs) to conduct the annual Medical Record Review (AMRR) audit as well as assess compliance with the Plan’s medical record standards and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) documentation standards.
  - HPAs educated providers on the importance of chlamydia screening and collected medical records to enter into the pseudo claims supplemental database.
  - Articles for both member and provider newsletters were published for the following: Chronic condition management, well-visits for children and adolescents, immunizations, women’s health, prenatal and postpartum care, and behavioral health. 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 continued to monitor the CCMA’s progress in closing care gaps.
  - A Preventive Care Checklist which incorporated HEDIS-related preventive screenings was distributed to all members assigned to a Service Coordinator. The reader-friendly checklist doubled 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.
  - Letters were mailed to providers to address members who have persistent asthma (based on claims data) and are on a controller medication. The letter included recommendations and a reminder to outreach member to schedule a doctor’s appointment.
  - Mommy Baby Matters Booklets were mailed out to pregnant members, which included educational information on prenatal and postpartum care.
  - Several outreach programs to educate members on chronic condition management and preventive screenings were completed. The following lists ‘Ohana QI’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.
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- The EPSDT Coordinator and SCs 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.

## **CAHPS—Adult Survey**

### **2016 Recommendations**

Based on an evaluation of ‘Ohana QI’s results, the priority areas identified were *Getting Needed Care*, *Customer Service*, and *Rating of Health Plan*. The following are recommendations of best practices and other proven strategies that may be used or adapted by the health plan to target improvement in each of these areas.

### **Improvement Activities Implemented**

#### **Access to Care**

The following quality improvement activities were conducted to address CAHPS findings in 2016:

- During 2016, ‘Ohana QI’s Community Advocacy department presented a total of 46 times on five islands. The presentations included topics such as fall prevention, diabetes, healthy eating, lowering your blood pressure, depression, chronic kidney disease, nurturing gratitude, and more. In addition, the department attended thirteen major health fairs on five islands. At these events, the department answered questions and distributed NIH and SAMSHA originated literature.
- Provider Relations Representatives encourage providers to adhere to appointment agenda letters that lists individual preventive health measures. It is suggested these agendas are put in the patient’s chart as a reminder for the next appointment.
- Service Coordinators encourage members to see their providers for needed care. They partner with the patient, family members, and the medical provider to provide maximum care plan for the member.

#### **Customer Service**

‘Ohana QI monitors call volume and hours of operation from our Kapolei office daily to ensure real time accessibility. We also monitor the statistics on a weekly, monthly, quarterly, semi-annual and annual basis to evaluate staffing, identify trends and discuss opportunities for improvement. Our call center is open during appropriate hours of operation based on our customer’s needs. Members have access to leave a non-urgent message after-hours as well. The call center can also provide assistance through social media which includes a Customer Service handle on Twitter. We have agents dedicated to log on every day and close out for the night. We have an on call Social Media team to handle all after hour inquiries. We do ask our members to complete a survey at the end of each call. These responses are part of each center agents’ performance goals. Content is reviewed as suggestions are made to provide a better member experience next time they call.

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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. Leadership from across the organization are encouraged to come into the class and introduce topics to create a solid support structure. It also allows the agent to feel connected to the team while they are in training. The Step Up Program has been deployed to assist new agents with the transition from the training environment to the production floor. The Step Up Program is designed to supply agents who just finished training with a controlled environment in which they begin to take live calls. Agents 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 agents receive daily quality audits which help them gauge their performance and they must meet certain benchmarks 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, agents 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.

Periodic refresher trainings are conducted to ensure that all agents 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. We have also done training exercises to focus on effective communication both written and verbal which creates an overall better experience for the members.

Customer Service focuses on various metrics, including Average Speed of Answer (ASA), Service Level (SL), Abandonment Rate (ABA), 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 agents on a consistent basis. The number of audits conducted for each agent 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 agent utilizing notes provided by Quality Auditor.

### **Rating of Health Plan**

The following quality improvement activities were conducted to address CAHPS findings in 2016:

- Telemedicine is an option where the provider can close gaps in patient care. Providers are encouraged to use this service as an alternative to face to face visits when appropriate.
  - ‘Ohana QI recognizes the importance of a microsystem to effectively provide high quality care to our members and providers. We rely on our network of providers, their staff, our internal leadership, processes and our systems to be able to deliver services to our members.
  - A portion of our microsystem is our providers. ‘Ohana QI contracts with quality providers that serve our members. Provider Relations staff complete quarterly visits to provide training or answer questions they may have about our plan or our processes. We routinely engage providers
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in our operational processes through our quarterly Utilization Medical Advisory Committee (UMAC).

- In 2016, ‘Ohana QI continued our Members Matters Advisory Committee. This group brings together members and staff from our ‘Ohana QI team to discuss various topics. The focus is hearing about their experiences with our microsystem and how we might be able to improve.
- Metrics for our operations were measured in 2016 and reported to our quarterly Quality Improvement Committee (QIC) where we review, track and trend our regulatory reports that are submitted to the state which include but are not limited to Member Grievance and Appeals, Provider Complaints, PCP Assignment, Geo Access, Timely Access, Translation and Interpretation and Members Requesting Alternate Languages. Through these reports and many others, we can drive change effectively.
- ‘Ohana QI engages members through interactive workshops, community events and fairs. ‘Ohana QI holds classes about members’ health condition and how to improve their overall health. Sometimes, this includes cooking classes for healthy eating. Additionally, ‘Ohana QI continuously engages members through one-on-one education, mailers, and social media. Members who were assigned a SC were contacted regularly by the SC, and issues regarding their health condition. During the visit or phone conversation, members are engaged in how to improve their condition and overall health. ‘Ohana QI’s educational mailers and social media sites showcases information about several health topics and how to improve overall medical and behavioral health. Educational mailers are sent to members with chronic conditions to enable members to maintain and improve their health.

### ***Provider Survey***

#### **2016 Recommendations**

Based on these results, the following are general quality improvement recommendations that plans should consider to increase or maintain a high level of provider satisfaction. These general recommendations should be evaluated in the context of each plan’s operational and quality improvement activities.

#### **Improvement Activities Implemented**

‘Ohana QI implemented the following quality improvement activities:

- Provider Relations Representatives approach new providers in the community as well as non-par providers who frequently request authorizations to contract. Expansion of Telehealth in our network allows broader coverage of members in our network.
  - Some Medicare codes that formally needed authorizations are no longer required. Waiving authorizations for Medicaid is in process as well. Providers are encouraged to check the authorization look up tool for updates.
  - Health plan’s formulary is always available online ‘Ohana QI website. Providers who refer members to non-formulary medication can fill out a drug evaluation form found on ‘Ohana QI website as well. Peer-to-peer consultation with ‘Ohana QI’s medical director is encouraged when appropriate.
  - Feedback from providers from surveys and face-to-face meetings are always welcome. Performance improvement suggestions are all considered and weighted.
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## **UnitedHealthcare Community Plan (UHC CP) QUEST Integration**

### ***Validation of Performance Measures—NCQA HEDIS Compliance Audits***

#### **2016 QI Population Recommendations**

HSAG recommends that UHC CP QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the QI population:

- Access to Care
  - *Adults' Access to Preventive/Ambulatory Health Services*
  - *Children and Adolescents' Access to Primary Care Practitioners*
- Effectiveness of Care
  - *Medication Reconciliation Post-Discharge*
- Children's Preventive Care
  - *Adolescent Well-Care Visits*
  - *Childhood Immunization Status*
  - *Immunizations for Adolescents*
  - *Well-Child Visits in the First 15 Months of Life*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- Women's Health
  - *Cervical Cancer Screening*
  - *Chlamydia Screening in Women*
  - *Human Papillomavirus Vaccine for Female Adolescents*
  - *Prenatal and Postpartum Care*
  - *Frequency of Ongoing Prenatal Care*

#### **QI Population Improvement Activities Implemented**

The UHCCP QI's Quality Improvement (QI) Program takes a collaborative and multifaceted approach in engaging our members in their care. The following interventions were implemented and ongoing:

- For key HEDIS measures in 2017, UHCCP QI's Clinical Practice Consultants (CPCs) worked with providers on identifying members who had gaps in care present, as well as provided guidance on targeted initiatives, education, and strategies on engaging members.
  - Provider Quality Conferences took place in Honolulu, Hilo, Kona, Waimea, and Kauai to address high-priority HEDIS measures.
  - Directed education and training on HEDIS measures is scheduled to be provided to our Complex Case Management Agencies (CCMAs) to further engage our Adult Foster Homes and caregivers in October of 2017.
  - In early-2017, Advocate4Me was launched, which helped UHCCP QI's Member Services Advocates engage members in addressing their care gaps when they call into the health plan. Utilizing Advocate4Me, Member Services Advocates were able to help our members schedule appointments with their providers beginning mid-2017.
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- Inter-departmental training was provided to health plan staff on HEDIS measures through our “Fast and Furious” training sessions.
- In July of 2017, the Community Plan Primary Care Professional Incentive (CP PCPi) was implemented as an incentive program for our Medicaid participating providers for addressing and closing gaps in care during visits.
- In mid-2017, UHCCP QI launched our Health Disparities Action Plan to improve Adults’ Access to Preventive/Ambulatory Health Services (AAP) rates. While this measure was the primary focus of this particular action plan, the broader goal was for member engagement to cascade to other adult measures that need to be addressed as well when the patient attends their annual well-visit appointment.

The interventions above were implemented to address all key HEDIS measures, including those listed below. Some measures may have had additional interventions as noted below.

- Access to Care
    - Adults’ Access to Preventive/Ambulatory Health Services
      - In 2017, UHCCP QI implemented our Health Disparities Action Plan, which focused on increasing the AAP rates for our membership on the island of Hawai’i, Maui, and Kauai, which were identified as having the most opportunities. Interventions as a part of the Health Disparities Action Plan included outreach via Silverlink Interactive Voice Response (IVR), member education during on PCP assignment and establishing care with a PCP before services are needed, utilizing Advocate4Me to help members schedule appointments, providing a list of members who had not had an outpatient care appointment in 2017 to our Accountable Care Organization (ACO) partners for further member engagement, implementation of CP PCPi program, and reinforcing timely access standards to providers.
    - Children and Adolescents’ Access to Primary Care Practitioners
      - In 2017, UHCCP QI launched a partnership pilot with Ko’olauloa FQHC to address adolescent well-child visits. Our clinic day is scheduled for Q4 2017.
      - Throughout 2017 our CPCs established and built relationships with our Pediatricians through engagement in the CP PCPi program.
  - Effectiveness of Care
    - Medication Reconciliation Post-Discharge
      - A MRP (Medication Reconciliation Post-Discharge stamp was developed and distributed to providers and CCMA’s (Community Case Management Agencies).
      - Partnered with Behavioral Health Team to provide training on BH conditions and importance of medication management.
      - UHCCP QI CPCs provided education to our providers throughout 2017.
      - UHCCP QI Service Coordinators provided education to their assigned members throughout 2017.
  - Children’s Preventive Care
    - Adolescent Well-Care Visits
    - Childhood Immunization Status
    - Immunizations for Adolescents
    - Well-Child Visits in the First 15 Months of Life
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- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
  - In 2017, UHCCP QI launched a partnership pilot with Ko'olauloa FQHC to address adolescent well-child visits and immunizations for adolescents. Our clinic day is scheduled for Q4 2017.
  - Throughout 2017 our CPCs established and built relationships with our Pediatricians through engagement in the CP PCPi program.
  - Initiated partnership with Pfizer VAKs (Vaccine Adherence in Kids) program in 2017. This is a reminder program for vaccinations, targeting parents of kids at ages 6 months, 8 months, and 16 months old. Additionally, there is a well visit reminder for the 1st year checkup, targeting parents of kids at age 10 months to remind them of the need for their child's first well visit doctor appointment.
  - Welltok/Silverlink live call outreach to address AWC, CIS, IMA, W15, and W34 occurred.
  - Our ESPDT RN engaged the pediatric population with a variety of interventions including reminder calls, birthday postcards, and collaborating with our CPCs to provide education to providers on the importance of regularly scheduled well-visits and vaccines.
  - CPCs conducted focused education with providers on AWC, CIS, W15, and W34 measures during Q1 of 2017.
- Women's Health
  - Cervical Cancer Screening
  - Chlamydia Screening in Women
  - Human Papillomavirus Vaccine for Female Adolescents
  - Prenatal and Postpartum Care
  - Frequency of Ongoing Prenatal Care
    - In 2017, UHCCP QI partnered with Waikiki Health to gather data on members who received a chlamydia screening at the health center for which a claim may not have been billed.
    - Throughout 2017 our CPCs established and built relationships with our Obstetricians through engagement in the CP PCPi program.
    - CPCs conducted focused education with providers on PPC and FPC measures during Q2 of 2017.
  - Continued partnership with Department of Health (DOH) to identify barriers regarding women's health.

## **2016 Non-ABD Population Recommendations**

HSAG recommends that UHCCP QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the non-ABD population:

- Access to Care
    - *Adults' Access to Preventive/Ambulatory Health Services*
    - *Children and Adolescents' Access to Primary Care Practitioners*
  - Children's Preventive Care
    - *Adolescent Well-Care Visits*
    - *Childhood Immunization Status*
    - *Immunizations for Adolescents*
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- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- Women’s Health
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*
  - *Chlamydia Screening in Women*
  - *Human Papillomavirus Vaccine for Female Adolescents*
  - *Prenatal and Postpartum Care*
  - *Frequency of Ongoing Prenatal Care*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care*
- Behavioral Health
  - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*
  - *Follow-Up After Hospitalization for Mental Illness*

### **Non-ABD Population Improvement Activities Implemented**

In addition to the interventions listed in the section above that were implemented for all measures, the following additional interventions were implemented for the measures below:

- Access to Care
    - Adults’ Access to Preventive/Ambulatory Health Services
      - In 2017, UHCCP QI implemented our Health Disparities Action Plan, which focused on increasing the AAP rates for our membership on the island of Hawai’i, Maui, and Kauai, which were identified as having the most opportunities. Interventions as a part of the Health Disparities Action Plan included outreach via Silverlink Interactive Voice Response (IVR), member education during on PCP assignment and establishing care with a PCP before services are needed, utilizing Advocate4Me to help members schedule appointments, providing a list of members who had not had an outpatient care appointment in 2017 to our Accountable Care Organization (ACO) partners for further member engagement, implementation of CP PCPi program, and reinforcing timely access standards to providers.
    - Children and Adolescents’ Access to Primary Care Practitioners
      - In 2017, UHCCP QI launched a partnership pilot with Ko’olauloa FQHC to address adolescent well-child visits. Our clinic day is scheduled for Q4 2017.
      - Throughout 2017 our CPCs established and built relationships with our Pediatricians through engagement in the CP PCPi program.
  - Children’s Preventive Care
    - Adolescent Well-Care Visits
    - Childhood Immunization Status
    - Immunizations for Adolescents
    - Well-Child Visits in the First 15 Months of Life
    - Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
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- In 2017, UHCCP QI launched a partnership pilot with Ko’olauloa FQHC to address adolescent well-child visits and immunizations for adolescents. Our clinic day is scheduled for Q4 2017.
  - Throughout 2017 our CPCs established and built relationships with our Pediatricians through engagement in the CP PCPi program.
  - Initiated partnership with Pfizer VAKs (Vaccine Adherence in Kids) program in 2017. This is a reminder program for vaccinations, targeting parents of kids at ages 6 months, 8 months, and 16 months old. Additionally, there is a well visit reminder for the 1st year checkup, targeting parents of kids at age 10 months to remind them of the need for their child’s first well visit doctor appointment.
  - Welltok/Silverlink live call outreach to address AWC, CIS, IMA, W15, and W34 occurred.
  - Our ESPDT RN engaged the pediatric population with a variety of interventions including reminder calls, birthday postcards, and collaborating with our CPCs to provide education to providers on the importance of regularly scheduled well-visits and vaccines.
  - CPCs conducted focused education with providers on AWC, CIS, W15, and W34 measures during Q1 of 2017.
  - Women’s Health
    - Breast Cancer Screening
    - Cervical Cancer Screening
    - Chlamydia Screening in Women
    - Human Papillomavirus Vaccine for Female Adolescents
    - Prenatal and Postpartum Care
    - Frequency of Ongoing Prenatal Care
      - In 2017, UHCCP QI partnered with Waikiki Health to gather data on members who received a chlamydia screening at the health center for which a claim may not have been billed.
      - Throughout 2017 our CPCs established and built relationships with our Obstetricians through engagement in the CP PCPi program.
      - During Q1 of 2017 the CPCs conducted focused education with assigned providers and their office staff on the Breast Cancer Screening measure.
      - Continued partnership with Department of Health (DOH) to identify barriers regarding women’s health.
  - Care for Chronic Conditions
    - Comprehensive Diabetes Care
      - The CPCs conducted focused education with assigned providers and their office staff on the Comprehensive Diabetes measure during Q3 of 2017.
      - Welltok/Silverlink live call outreach to address CDC occurred in 2017.
  - Behavioral Health
    - Adherence to Antipsychotic Medications for Individuals with Schizophrenia
    - Follow-Up After Hospitalization for Mental Illness
      - In 2017, in collaboration with Quality, the Behavioral Health Medical Director and Behavioral Health Team conducted three workshops on Oahu to educate providers on BH-specific HEDIS measures.
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In addition, the Behavioral Health Medical Director facilitated five 2-hour face-to-face and asynchronous trainings on psychotherapeutic medications in the community which included free CEUs to LCSWs and CSACs. In all these trainings, the Behavioral Health Medical Director discussed the high morbidity of diabetes and other chronic medical conditions among adults with schizophrenia.

## **2016 ABD Population Recommendations**

HSAG recommends that UHC CP QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the ABD population:

- Access to Care
  - *Children and Adolescents' Access to Primary Care Practitioners*
- Effectiveness of Care
  - *Medication Reconciliation Post-Discharge*
- Children's Preventive Care
  - *Immunizations for Adolescents*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- Women's Health
  - *Cervical Cancer Screening*
  - *Chlamydia Screening in Women*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care*

## **ABD Population Improvement Activities Implemented**

In addition to the interventions listed in the section above that were implemented for all measures, the following additional interventions were implemented for the measures below:

- Access to Care
    - *Children and Adolescents' Access to Primary Care Practitioners*
      - In 2017, UHCCP QI launched a partnership pilot with Ko'olauloa FQHC to address adolescent well-child visits. Our clinic day is scheduled for Q4 2017.
      - Throughout 2017 our CPCs established and built relationships with our Pediatricians through engagement in the CP PCPi program.
  - Effectiveness of Care
    - *Medication Reconciliation Post-Discharge*
      - A MRP (Medication Reconciliation Post-Discharge stamp was developed and distributed to providers and CCMA's (Community Case Management Agencies).
      - Partnered with Behavioral Health Team to provide training on BH conditions and importance of medication management.
  - Children's Preventive Care
    - *Immunizations for Adolescents*
    - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
      - In 2017, UHCCP QI launched a partnership pilot with Ko'olauloa FQHC to address adolescent well-child visits and immunizations for adolescents. Our clinic day is scheduled for Q4 2017.
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- Throughout 2017 our CPCs established and built relationships with our Pediatricians through engagement in the CP PCPi program.
- Welltok/Silverlink live call outreach to address IMA, and W34 occurred.
- Our ESPDT RN engaged the pediatric population with a variety of interventions including reminder calls, birthday postcards, and collaborating with our CPCs to provide education to providers on the importance of regularly scheduled well-visits and vaccines.
- CPCs conducted focused education with providers on AWC and W34 measures during Q1 of 2017.
- Women's Health
  - Cervical Cancer Screening
  - Chlamydia Screening in Women
    - In 2017, UHCCP QI partnered with Waikiki Health to gather data on members who received a chlamydia screening at the health center for which a claim may not have been billed.
    - Continued partnership with Department of Health (DOH) to identify barriers regarding women's health.
- Care for Chronic Conditions
  - Comprehensive Diabetes Care
    - The CPCs conducted focused education with assigned providers and their office staff on the Comprehensive Diabetes measure during Q3 of 2017.
    - Welltok/Silverlink live call outreach to address CDC occurred in 2017.

## **CAHPS—Adult Survey**

### **2016 Recommendations**

Based on an evaluation of UHCCP QI's results, the priority areas identified were *Getting Needed Care*, *Customer Service*, and *Getting Care Quickly*. The following are recommendations of best practices and other proven strategies that may be used or adapted by the health plan to target improvement in each of these areas.

### **Improvement Activities Implemented**

UHCCP QI addressed recommendations as follows:

#### **Getting Needed Care**

***Interactive Workshops:*** Throughout 2017, UHCCP QI participated in 51 community engagement initiatives. During these events UHCCP QI provided education to the public on the following topics (not limited to): the importance of healthy eating and regular exercise, blood pressure, heart disease and stroke, diabetes management and prevention, asthma management, smoking cessation, water consumption, the importance of prenatal and postpartum care, information on preventative health care for children and adolescents and EPSDT, Dr. Health E Hound's Healthy Tips for Parents, Healthy Recipe Cards, and utilizing the UHC NurseLine™ through active engagement, activities, and educational materials. In addition to active engagement, UHCCP QI regularly sends annual EPSDT appointment reminders to our youth population, and mailers to members in our Diabetes, Asthma, and

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High Risk Pregnancy Disease Management Programs, amongst other topics. UHCCP QI also conducts a quarterly Member Advisory Group (MAG) to provide education to a targeted member focus group and solicit feedback.

***Facilitate Coordinated Care:*** UHCCP QI Service Coordination teams assist in facilitating coordination of care between providers by way of providing Service Plans upon initial entry into service coordination, and reassessments. Service Coordinators also complete provider outreach for coordination of care and to provide/obtain additional information to/from providers that will assist in the member's healthcare needs. UHCCP QI has a process in place to ensure that PCPs regularly receive updates to members Service Plans through fax or mail. In addition, UHCCP QI further supported providers in service coordination by creating a Service Coordination Form and ensuring availability of form in all channels, e.g. provider education materials, provider website, etc. In 2017, UHCCP QI also implemented a hotline to the Service Coordination Department for providers. We collaborated with our ACO partners by starting a Joint Operating Committee (JOC) that included care coordination. In addition, for facilities UHCCP QI implemented fast track availability of our Service Coordination Team to facility ERs and Case Managers to ensure timely coordination.

## **Customer Services**

***Call Centers and User Feedback:*** In 2017, UHCCP QI reengineered the User Experience Survey (UES) to gain better insight on the user experience when contacting the call center. Results of the UES were reviewed on a regular basis to address opportunities for improvement. In addition, UHCCP QI partnered with ELIZA™ to gather more specific data on member's feelings and needs as it relates to CAHPS and target future interventions. UHCCP QI also conducts a quarterly Member Advisory Group (MAG) to provide solicit feedback on the member experience from a small panel of members. These meetings take place on either Oahu or the neighbor islands throughout the year to gather data from various perspectives.

***Creating an Effective Customer Service Training Program:*** In 2017, collaborative training took place with our call center staff and multiple departments including Quality and Behavioral Health. Member Services Advocates received training on Quality Initiatives and HEDIS measures through Fast and Furious Training. In addition, the implementation of Advocate4Me program April 2017 set out to provide a more positive experience for our members by providing Member Services staff with more detailed information about the member and their healthcare needs. All Member Services staff received training on the new program. In addition, Active Listening Training was conducted for all member-facing staff, including Member Services, in collaboration with our Behavioral Health Department.

## **Customer Service Performance Measures**

Throughout 2017, Member Services was assessed on a variety of metrics for both state and NCQA compliance. The data were obtained from the Monthly Call Statistics from the Member Services Call Center. The results evaluated monthly include Average Calls Offers (ACO), Average Calls Handled (ACH), Abandonment Rate (ABN) percentage, Average Speed of Answer (ASA), and Service Level. A goal of Service Level Rate in 30 Seconds was established at 80% and was met in all 3 quarters to date.

## **Getting Care Quickly**

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***Patient Access and Availability:*** Throughout 2017, UHCCP QI monitored provider availability through both our PCP and High Volume Specialist (HVS) and High Impact Specialist (HIS) reports through both numerical availability ratios per county and per island, as well as through GeoAccess, as recommended. In addition, a Timely Access Report Survey was conducted quarterly in 2017 and alternated between surveying both providers and members to gather accurate data of the member experience. The top 10 providers by volume who had missed targets during 2017 were engaged in additional education and training on the importance of meeting timely access standards. In addition, this education is provided at least annually to our providers through education sessions or provider materials.

***Decrease No-Show Appointments:*** In 2017, UHCCP QI partnered with our transportation provider, LogistiCare, to gather data on members prone to no-show for transportation. A monthly roster of members who failed to show up for transportation, and subsequently their appointments, was shared with UHCCP QI Service Coordinators and Behavioral Health Advocates to conduct follow-up with members and engage them in their care. UHCCP QI solicited feedback from the Member Advisory Group on no-shows, how to decrease them, and the barriers that members may be facing leading to them not keeping appointments.

## ***Provider Survey***

### **2016 Recommendations**

The Provider Survey revealed opportunities to improve provider satisfaction. UHCCP QI exhibited the most opportunity for improvement, with rates lower than the aggregate rate of the other plans on nearly all domains. The issues/concerns expressed by providers may cause some providers to leave the Medicaid market.

### **Improvement Activities Implemented**

UHCCP QI addressed recommendations as follows:

#### **Providers and Specialty Care Access**

***Travel Improvements:*** In 2017, UHCCP QI Operations Team implemented face-to-face meetings with the Hawaii LogistiCare Manager at least weekly to address issues such as late provider pickups, member-cancelled trips, coordination of commercial air travel, and to troubleshoot other issues. UHCCP QI also reviewed provider geographic assignments to ensure they were appropriate. UHCCP QI coordinated with the prior authorization team to ensure that if health care services require urgent transportation they are escalated to LogistiCare management immediately for scheduling. UHCCP QI offered mileage reimbursement for mammogram services on the island of Hawai'i due to the only radiology center in Hilo temporarily not having their mammography certificate re-approved by the State of Hawaii Department of Health; to aid members in obtaining transportation for mammograms. LogistiCare initiated a user satisfaction survey (USS) to obtain feedback on services. In addition, LogistiCare is scheduled to add 2 wheelchair providers and 1 gurney provider in Q4 2017, and is consistently expanding their network, for example, using Lyft for recovery when a Transport Provider's vehicle becomes inoperable during a trip.

***Provider Recruitment and Retention:*** UHCCP QI Network team continues to work with our providers to increase their service levels for high touch providers to promote retention and continue to look for opportunities in expanding telehealth services to deliver additional specialty care.

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***Focus on the Patient-Centered Medical Home (PCMH) Model of Care:*** In 2017, UHCCP QI transitioned from our Person-Centered Care Model (PCCM) to the Whole Person Care (WPC) Model of care. Medical, behavioral and social/environmental concerns are targeted by engagement of members, hospitals and physicians working together. The primary goal is to ensure the member receives the right care from the right providers in the right place and at the right time. At a member level, this WPC program targets those individuals who have a higher persistency of healthcare utilization and may have chronic and complex emerging risk. The goal is to focus interventions on members with complex medical, behavioral, social, pharmacy and specialty needs, which results in better quality of life for members, improved access to healthcare, and reducing expenses. The WPC program assesses the member, and provides an integrated team for member with the goal to increase member engagement in the healthcare process, provide resources to fill gaps in care, and develop individualized goals toward a common outcome using evidence-based clinical guidelines. Improving the care experience and member outcomes guides our commitment to whole person care, essential to improving the health and wellbeing of individuals, families and communities. Through the WPC Model we engage with primary care physicians, other health care professionals and key partners to expand access to quality health care so our members can get the care they need when they need the care. UHCCP QI supports the physician/patient relationship by removing barriers to care and ensuring members see their physicians on a regular basis. We empower members by providing the information, guidance and tools they need to make informed personal health care decisions.

***Simplification and Standardization of PA forms and processes:*** In 2016 through 2017, the Pharmacy and Therapeutics Committee added 91 new drugs to the PDL; 56 of them became available as preferred open access (no prior authorization required), and 35 of them became available preferred requiring prior authorization.

***Pharmacy Access and SOP and P&Ps related to Non-Formulary Drugs:*** UHCCP QI Updated its product selection criteria, and provided prescribers with guidance on Non-PDL medications, and well as policies and procedures on obtaining non-PDL medications with a 7-day or 15-day supply override when there is a need for new non-PDL medication, and a prior authorization has not yet been received through the UHCCP QI Health Professionals website.

***Provider Focus Groups:*** At least quarterly, UHCCP QI obtains feedback from our Physician Advisory Committee (PAC). Topics discussed at PAC include (but are not limited to) provider access concerns and recommendations, provider recruitment and retention and evaluation of their experiences with the contracting and credentialing practices, feedback on our prior authorization processes, and quarterly review of Preferred Drug List (PDL) updates and revisions. In addition, the annual Provider Satisfaction Survey and CAHPS results are reviewed and recommendations for improvement are solicited from PAC members. In addition to the in-person focus group, 2017 saw greater engagement with review of UHCCP QI's provider Net Promoter Score (NPS) results and implementation of a subsequent NPS Action Plan.

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## **‘Ohana Community Care Services (‘Ohana CCS) QUEST Integration**

### ***Validation of Performance Measures—NCQA HEDIS Compliance Audits***

#### **2016 Recommendations**

HSAG recommended that ‘Ohana CCS focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the CCS program:

- Behavioral Health
  - Diabetes Monitoring for People with Diabetes and Schizophrenia
  - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

#### **Improvement Activities Implemented**

The following are improvement activities that were implemented or continued in 2016:

- ‘Ohana Health Plan continues to work with other health plans to receive file information for HEDIS measures that are based upon medical services. The BH/CCS Case Management agencies receive on-going education on HEDIS measures.
- Field Coordination, CCS Care Managers and other ‘Ohana Health Plan staff received training on Serious Mental Illness (SMI) and Diabetes to develop understanding of the relationship between Diabetes symptomology, pharmaceuticals, and serious mental health diagnoses.
- CCS Case Management Agencies received Provider Education on Oahu (October 2016), Hilo (July 2016), and Maui (August 2016), which included the above performance measures as well as other BH-specific HEDIS measures.
- CCS Agency providers participated in a Quality Improvement-focused meeting in 2016, which addressed interventions for HEDIS measures, including the above quality measures.

In addition, a shared consent form was created and is currently being reviewed for approval to use in 2017. If approved, the form will be used between PCP and Psychiatrists/other specialists involved in member care to allow providers to collaborate on members’ Diabetes screening and monitoring for those members with Schizophrenia or Bipolar Disorders utilizing antipsychotic medications.

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