2018 Quality Improvement Program Description Overview

Introduction

CarePlus' Quality Improvement (QI) Program guides activities to help improve the care and treatment of our members. This program will allow CarePlus members to help them achieve lifelong well-being.

The QI program sets up a plan to monitor and measure the quality of care members receive. Data are tracked and analyzed for trends monthly, quarterly and/or annually. Opportunities for improvement are identified, and root-cause analysis is performed as needed.

Purpose

The goal of the QI Program is to monitor, evaluate and facilitate improvement in the services offered to our members.
The program is based on contractual, governmental, accreditation and organizational requirements and guidelines.

Scope

The QI program's scope includes CarePlus' Medicare Health Maintenance Organization (HMO) benefit plans.

Goals and Objectives

The QI program has the following goals and objectives:

- Identify and resolve issues related to member access and availability to health care services
- Provide a mechanism whereby members, practitioners, and providers can express concerns to CarePlus regarding care and service
- Provide effective customer service for members, physicians and other provider needs and requests
- Provide a process through which pertinent member information is collected and analyzed and improvement actions are identified by a health plan committee comprised of participating physicians and health plan staff
- Monitor coordination and integration of member care across physicians and other providers
- Provide mechanisms where members with complex needs and multiple chronic conditions can achieve optimal health outcomes
- Guide members to achieve optimal health by providing tools that help them understand their healthcare options and take control of their health needs
- Monitor and promote the safety of clinical care and service
- Promote better communication between departments and improved service and satisfaction to members, physicians, other providers, and associates

Ongoing Quality Improvement Services

Some of the programs CarePlus uses in its effort to improve the quality of care members receive are:

- **Population Health Management (PHM)**
  CarePlus uses a variety of systems that deliver actionable data to physicians to improve their patients' health and wellness.

- **Member Safety Program**
  Safety initiatives throughout CarePlus are prioritized, reviewed and aligned with national safety issues. CarePlus focuses on three key areas:

  - Reduction of 30-day hospital readmissions
  - Elimination of medication errors
  - Avoidance of inpatient and surgical complications

  The program uses claims information and case reviews to identify potential opportunities for improvement in each of the three areas.

- **Continuity and Coordination of Care**

CarePlus collects and analyzes data from various delivery sites and throughout each disease process. These data are used to identify opportunities to aid in coordination of care and transitions of care from one physician or other provider to another. Examples include:

  - Coordinating home healthcare services
  - Increasing the understanding of discharge plans and instructions
  - Enhancing communication between specialists and primary care providers

- **Pharmacy Management**
  CarePlus follows a process to promote-clinically appropriate, safe and cost-effective drug therapies. This process evaluates safety and efficacy when developing formularies and procedures to ensure appropriate drug class review and inclusion, and regular review of drug policies.

- **Special Needs Plan (SNP)**
  CarePlus continues to focus on implementing the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requirements with regard to SNPs. Medicare requires that a SNP member's care be coordinated using a quality improvement tool called the model of care (MOC). Our dedicated model of care (MOC) implementer in CarePlus is required to develop quality performance metrics and share results with stakeholders.

2017 Clinical Process and Outcome Indicators

As part of its QI Program in 2017, CarePlus set goals in three programs: case management, clinical and preventive health initiatives and service and availability. The 2017 results are listed in the tables below.

- **Case management.** The case management program seeks to support our members by helping them identify and use the best healthcare services to meet their needs and by guiding them along the healthcare continuum.

Goals	Outcomes
• Improve post-discharge assessment completion to 100 percent • Improve timely care plan documentation to 100 percent • Decrease member readmissions to 17 percent	• Post-discharge assessment completion currently 45 percent • Current timely care plan documentation was 45 percent • Current readmission rate is 17.7 percent

- **Quality Improvement Projects (QIPs).** The Center for Medicare & Medicaid Services (CMS) requires the implementation of QIPs as part of their Quality Improvement (QI) Program under federal regulations of the Medicare Managed Care Manual. The QIP must measure and demonstrate improvement in health outcomes.

  CMS has mandated three topics since 2012:

  1. Reducing all-cause readmissions
  2. Promoting effective management of chronic diseases with an emphasis on COPD (chronic obstructive pulmonary disease)
  3. Promoting effective communication and coordination of care, which went into effect in January 2018 and has four sub-requirements. These are:
     - Addressing one or more of the CMS Quality Strategy Goals
     - Improving health outcomes and/or member satisfaction
     - Addressing potential health disparities
     - Producing best practices

  The opportunity exists with this QIP to improve health outcomes through enhanced notifications to CarePlus physicians and nurses when members visit an emergency department (ED). The new "Follow-up after ED Visit for People with High-risk Multiple Chronic Conditions" HEDIS measure will be monitored over the three-year study.

- **Chronic Care Improvement Programs (CCIPs).** CMS also requires the implementation of CCIPs as part of the mandated Quality Improvement (QI) Program under the federal regulations. The topic that CMS communicated in 2012 is reducing cardiovascular disease (CVD) in Medicare members. The interventions were implemented to impact members who have CVD, are in care management and use RxMentor. The expected outcomes are improvements in control of blood pressure (CBP), completed medication reviews (CMR) and completion of health-risk assessments (HRAs).

Effective January 2018, the COPD QIPs will transition to CCIPs and will continue to be monitored and updated each year during the three-year study.

CarePlus is expected to attest each year that QIPs and CCIPs are in progress for each Medicare Advantage and SNP contract. Each study must contain an analysis of the outcomes and intervention data collected, as well as barriers to meeting goals, plans to reduce barriers, best practices and lessons learned.

- **Clinical and Preventive Health Initiatives.** To gauge the effectiveness of clinical and preventive healthcare initiatives, CarePlus uses the Healthcare Effectiveness Data and Information Set (HEDIS®), the most widely used set of performance measures in managed care. HEDIS measures are developed and maintained by the National Committee for Quality Assurance (NCQA).

  The annual goal is to meet or exceed the 50th percentile NCQA benchmark in each measurable category. Goals were met or positive trends noted for the following common measures:

Medicare HMO

- Adult body mass index assessment
- Breast cancer screening
- Colorectal cancer screening
- Pharmacotherapy management of COPD exacerbation
- Controlling high blood pressure
- Persistence of beta-blocker treatment after a heart attack
- Comprehensive diabetes care
- Disease-modifying anti-rheumatic drug therapy
- Osteoporosis management

• Antidepressant medication management • Follow-up after hospitalization for mental illness • Annual monitoring for patients on persistent medications • Access to preventive/ambulatory health services

- **Service and Availability.** CarePlus assesses member satisfaction through call monitoring, member complaints and satisfaction survey reviews. CarePlus continuously monitors these service indicators and determines appropriate actions.

Goals	Outcomes
• Answer more than 80 percent of incoming calls within 30 seconds • Limit the disconnected rate of all incoming calls to less than 5 percent • Limit member average hold time to less than two minutes	• Did not meet goal with 71 percent of incoming calls answered within 30 seconds (on average) • Did not meet goal with 6.25 percent disconnected call rate (on average) • Met goal, with 48 seconds hold time (on average)

Conclusions and Priorities

In 2017, CarePlus' Quality Improvement Program continued to develop and implement healthcare solutions that provide members with choice, independence, education and guidance with their benefits and healthcare. CarePlus is committed to creating solutions that assist members with their healthcare, resulting in improved outcomes and lower costs. Our ultimate goal is to help members improve their overall well-being.

Quality improvement reporting of activities focuses on evaluation of the effectiveness of interventions, learning from past responses and sharing best practices. Where possible, we have moved from operational metrics to outcome metrics.

CarePlus continues to:

- Evaluate progress toward achieving goals, removing barriers and improving efficiency; and facilitate changes as needed with a focus on outcomes
- Evaluate compliance with regulations through internal monitoring of processes
- Encourage adherence to national accreditation requirements
- Evaluate QI Program structure for any changes needed to address future regulations

CarePlus is an HMO plan with a Medicare contract. Enrollment in CarePlus depends on contract renewal.

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- Free assistance and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Video remote interpretation
  - Written information in other formats
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the number on the back of your Member ID Card or contact Member Services using the information below.

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CarePlus Health Plans, Inc. Attention: Member Services Department. 11430 NW 20th Street, Suite 300. Miami, FL 33172.

Telephone: **1-800-794-5907; (TTY: 711**). From October 1 - March 31, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day. Fax: **1-800-956-4288**.

You can file a grievance in person or by mail, phone or fax. If you need help filing a grievance, our Member Services Representatives are available to help you at the contact information listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: **U.S. Department of Health and Human Services.** 200 Independence Avenue, SW, Room 509F, HHH Building. Washington, D.C. 20201. **1-800–368–1019; 800-537-7697 (TDD)** Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

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Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-794-5907 (TTY: 711).
ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-794-5907 (TTY: 711).
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