New York State Department of Health
Office of Health Insurance Programs
Division of Quality and Evaluation

Medicaid Managed Care Plans
2007 Performance Improvement Projects

October 2008

Introduction

This compendium of Performance Improvement Projects (PIP) summarizes the various projects conducted by New York State Medicaid managed care plans in 2007. These projects have been reviewed by IPRO, our external quality review organization, in accordance with the protocol developed by the Centers for Medicare and Medicaid Services in response to the Balanced Budget Act of 1997.

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Table of Contents

Topic	Page
CHILDREN'S HEALTH	
Amerigroup	
Improvement in childhood immunization administration and reporting through targeted provider interventions and member outreach.	4
Neighborhood	
Utilization of BMI by PCPs	5
Suffolk Health Plan	
Reducing use of urgent care resources for children with asthma	6 - 7
The New York-Presbyterian Community Health Plan	
Improving the rate of annual dental visits in the Medicaid population	8 - 9
Univera Community Health	
Improving well visit rates in the under 2 year old Medicaid population	10
WellCare of New York, Inc	
Thirty (30) day follow-up after hospitalization for mental illness in WellCare Medicaid / FHP members	11 – 12
DIABETES	
Independent Health	
Diabetes disease management initiative	13 – 14
Total Care	
Comprehensive diabetes care	15
PROGRAM ADMINISTRATION	
Southern Tier Pediatrics and Southern Tier Priority	
Improving completion rate of new enrollee health screening report	16
WOMEN'S HEALTH	
Broome Max	
Improving the rate of screening mammography for low income women (Age 40 to 63)	17
Fidelis and Center Care	
Improving breast cancer screening in women (40 to 69 Years) and Improving cervical cancer screening in women (21 to 64 Years)	18
GHI HMO	
Cervical cancer screening	19 – 20
PCMP II-A-Gold Choice	
Use of telephonic case management to improve screening mammography rates in women with mental health and substance abuse issues	21 - 22

Amerigroup

Improvement in childhood immunization administration and reporting through targeted provider interventions and member outreach.

1. Project Topic / Rationale / Aims

Improvement in childhood immunization administration and reporting through targeted provider interventions and member outreach. The Plan's goal is to increase the final HEDIS childhood immunization rate by 5% from 40.8% (HEDIS 2006) to 46% as measured by the childhood immunization (combination 2) specifications HEDIS 2008 (for 2007 data).

2. Methodology

The Plan selected five high volume pediatric providers, identified barriers to immunization administration and reporting and intervened to improve compliance with immunization administration guidelines and participation in the Citywide Immunization Registry (CIR). Members who were turning two in 2007 and were missing immunizations were notified and monitored for compliance with their immunizations.

3. Interventions

- Educated providers on the need to report all immunizations to the Citywide Immunization Registry and assisted providers in utilizing online CIR.
- Educated providers on Vaccines for Children program including the linkage between CIR reporting and vaccine supplies.
- Educated providers on clinical guidelines for immunizations.
- Educated providers on available tools for scheduling and tracking immunizations at an individual patient level.
- Encouraged providers to participate in the NYC Immunization Spread Project.
- Supported providers through Plan-based member outreach and education.
- Member Telephonic Outreach (to members turning two in 2007)
- Member Mailing (unable to contact by phone)

4. Results/Conclusions

The HEDIS 2008 administrative rate for childhood immunization (combo two) is 46.55% as compared to the 2006 administration rate of 40.8% (baseline). The HEDIS 2008 final hybrid rate is 80.3% as compared to the 2006 final hybrid rate of 68.88%. The administrative HEDIS rates for childhood immunization for three out of the four providers that used the electronic data submission method to report to the CIR were significantly higher than the rate of the one provider that used the paper method of data submission (73.90%, 84.20% and 71.20% vs. 27.50%). It is possible that one provider was not submitting data to the CIR consistently based on the large difference between the administrative rate (27.5%) and the final hybrid rate (71.40%).

It is evident that a multi-faceted approach to member and provider outreach and education about timely childhood immunization and use of the CIR supports providers in delivering and tracking timely immunizations. Providers that use the CIR and submit the data electronically have a significantly higher rate of timely childhood immunization (based on HEDIS data) than those that do not use the CIR or use the paper method of submitting data to the CIR. AMERIGROUP will continue to outreach and educate providers related to the need to provide timely childhood immunization and the benefits of using the CIR to collect and report immunization data.

Neighborhood Health Providers

Utilization of BMI by PCPs

1. Project Topic / Rationale / Aims

Neighborhood Health Providers (NHP) conducted a study on the utilization of Body Mass Index (BMI) Measurement by PCPs as a tool to monitor and control adolescent weight for children 14 – 18 years of age. NHP found as per QARR 2005 that the PCPs and/or office staff are not calculating or utilizing the Body Mass Index Measurement (BMI).

While conducting this study NHP wanted to find out:

- Why are PCPs and office staff not calculating the Body Mass Index Measurement (BMI) and recording this information in the members Medical Record?
- How can the Plan effectively educate the PCPs and office staff on the importance of calculating and recording the Body Mass Index (BMI) in the member's medical record?
- Will education of PCPs and office staff regarding BMI, increase the utilization of the BMI?

2. Methodology

The Plan set up a (18) month timeframe for this study which was:

a. January 2007 – June 2007: Aggregate information through Medical Record Review baseline.
b. July 2007 – December 2007: Intervention.

PCPs and office staff were educated on the importance of completing the Body Mass Index (BMI) Measurement and appropriate documentation through:

- Personal Letters
- Provider newsletters
- Provider manual
- NHP Website
- Educational lectures by NHP's Chief Medical Officer

Members were educated on obesity, encouraged physical activity and maintaining a healthy lifestyle through:

- Member Newsletters
- NHP website
- Personal Letters

c. January 2008 – June 2008: Review Medical Records and Comparison of results after Interventions. Sample size for QARR 2005 and 2006 were 100 charts for Medicaid/FHP and CHP. For 2007 sample size was 411 for Medicaid/FHP and CHP.

The Baseline for this study used QARR 2005 results of 30% for Medicaid / FHP and 18% for CHP.

3. Interventions

NHP did Interventions from July 2007 – December 2007 which were previously stated. Barriers for this study were that we did not have enough educational materials (BMI wheel calculators) to send to all providers.

4. Results/Conclusions

NHP's preliminary results for QARR 2007 showed an increase in performance of BMI calculation for CHP (from 18% in 2005 to 23% in 2007, but a decline in BMI calculation for Medicaid (from 30% in 2005 to 25% in 2007).

Based on the above result we can conclude that our interventions during this study had some effect on the increase of the QARR 2007 results for CHP only. NHP will continue to educate its providers and members on the importance of BMI documentation in the medical record and calculation in the charts. We will continue to monitor it's improvement of BMI usage based on future QARR results.

Suffolk Health Plan

Reducing use of urgent care resources for children with asthma

1. Project Topic / Rationale / Aims

Suffolk Health Plan recognizes the burden of asthma in its pediatric population and sees an opportunity for coordinating and refining the efforts that have already been put in place by implementing a comprehensive partnership between provider and patient, with an emphasis on patient/family centered self management skills.

2. Methodology

Population:
Members were initially included in this project if, by June 1, 2007, they were under the age of 19 years in either the Medicaid or the CHP product line and had a claim received by the Plan for dates of service between March 1, 2006 – March 1, 2007 for an emergency room visit or an inpatient admission for a diagnosis of asthma. There were originally 122 children identified by this method. Of these 122, only 92 met continuous enrollment criteria and of these 92, only 86 were confirmed to have a true diagnosis of asthma after review of the medical record.

Performance Indicators:
The main indicator for this project is the post intervention measurement of the same rates for those same members for an emergency room visit or an inpatient admission for a diagnosis of asthma. Specifically, what difference has the intervention made for these specific members as measured by use of urgent care resources from one year to the next?

Data Collection:
Suffolk Health Plan identified the study group from claims made available through the third party administrator. Measurement of the baseline and post intervention rates was performed using administrative data from these claims. Any claim with an ICD9 code in the 493.xx family was included if the member was aged 19 or younger.

3. Interventions

- Use of evidence based practice guidelines for the treatment of asthma in children
- Support of provider adherence to these guidelines by medical record audit and feedback on performance
- Discussion of billable above capitation payments for in office spirometry and education / counseling of members with asthma
- Support of member compliance through telephone contact, pharmacy utilization review, claims and encounter analysis for compliance with appointments and incentive program utilizing a gift card in response to member’s keeping an appointment for asthma follow-up
- Education directed to member / family to specifically enhance self management skills. These educational materials were provided by the Asthma Coalition of Long Island, a subsidiary of the American Lung Association. Materials were made available in English and in Spanish at a 6th grade literacy level
- Patient specific interventions were made on an as needed basis such as referral for consultation with pulmonary specialist, home environmental assessment by public health nursing and/or reminder phone calls in advance of scheduled appointments to members who may have had a history of missing such appointments.

4. Results/Conclusions

Of the 92 children identified in the original sample, 6 were eliminated when review of their medical records failed to confirm a diagnosis of asthma. Of the 86 remaining children in the project, baseline claims data revealed that 36% had at least one ER visit for asthma and 14% had a hospital admission within the last year for asthma. Post intervention rates showed a decrease in the overall percentage of members with an ER evaluation to a rate of 31% but that several individual members had a greater number of visits post intervention than preintervention. The overall rate of hospitalization declined slightly to 10%. These decreases met the Plan's original goal of decreasing utilization of these resources by 10%.

Next steps include continuing the intensive provider and member/family educational focus, including working jointly with the Department of Health's "Asthma Medicaid Demonstration Project" and establishing an ongoing monitoring system for provider compliance with treatment and classification guidelines as updated by the NIH in 2007. With the impending dissolution of the Plan, follow up data from the Asthma Medicaid Demonstration Project which is ongoing within the Division of Preventive Medicine, will serve as a proxy for member level outcomes. This demonstration project will focus on County residents with asthma who are Medicaid recipients. As such, the data will contain within it, the results applicable to Plan members.

New York-Presbyterian Community Health Plan

Improving the rate of annual dental visits in the Medicaid population

1. Project Topic / Rationale / Aims

NYPCHP's 2005 rate for Annual Dental Visits was 35% - low as compared to the State-wide average of 43%. In addition to the concern regarding the overall rate, another focused area for improvement was noted in the rate of dental visits for members in the two-to-three year age range. While the rates for the remainder of the eligible population ages four to twenty-one ranged from the mid 30's to mid 40's, the rate for two to three year olds was only 14%.

Performance targets were set at ten percent improvement for the two to twenty-one age band and at twenty percent improvement for the two to three year old age band.

NYPCHP also recognized the fact that good oral hygiene begun early in life will lead to the continuation of the same throughout childhood and into the adult years. Studies also suggest a connection between good oral hygiene and overall good health.

2. Methodology

The population chosen for this project included Medicaid members ages two through twenty-one that met the continuous enrollment requirements for the HEDIS/QARR measure. The entire eligible population was included.

The study indicators were taken directly from the HEDIS specifications: the percentage of children and adolescents that met the eligibility requirements and that had at least one dental visit in the measurement year. These visits were determined through claims using the HEDIS specified ICD-9 and CPT codes. This project encompassed two specific indicators:

1. The overall rate of Annual Dental Visits for members ages two through twenty-one and
2. The rate of Annual Dental Visits for children ages two and three (this is a subset of indicator number 1).

The baseline measurement period was calendar year 2006, with the remeasurement occurring two years later calendar year 2007. All data was administrative in nature and was based on claims submissions.

For the purposes of this study, Family Health Plus members were included in the Medicaid population as this is how the HEIS/QARR measure is reported.

3. Interventions

The interventions were educationally focused and targeted both members and practitioners. In this case practitioners included the members' PCPs and dental care providers. Due to the third-party relationship with the dental network, direct dental provider interventions were somewhat compromised, although the vendor did assist in some interventions at both the member and provider level.

As is typical with Medicaid populations, reaching the members (or in this case the parents of the members) was at times difficult. Inaccurate or incomplete addresses and telephone numbers were the cause of most of this difficulty. A vendor that was contracted to do automated member reminder calls was able to provide some assistance with this situation and future plans are to increase the success of this type of outreach.

Provider intervention was aimed primarily at dental care providers and included reiteration of the guidelines for dental visits, with a particular focus on very young children (ages two and three). This was accomplished with assistance by NYPCHP's dental vendor, Doral Dental. Additionally, PCPs were reminded of the importance of annual dental visits for their members and were provided with a list of those members that as of mid-year had not accessed these services. The PCPs were asked to partner with NYPCHP in encouraging parents to make a dental appointment for their child.

4. Results/Conclusions

The results for both study indicators (annual dental visit rates for ages two through twenty-one and annual dental rates for ages two through three) improved significantly and met the performance goals set for this project. The rate of dental visits for the 2-21 age band increased from 35.15 % to 44.20% and surpassed the performance goal which was set at 10% above baseline at 39%.

The rate for the 2-3 year olds increased from 14.42% to 25.69%; also surpassing the performance goal of 17% which was again set at 10% over baseline.

Member interventions in conjunction with provider involvement will continue for these indicators as well as other initiatives which require improvement. The types of interventions may vary depending on the audience and the message that needs to be delivered. A combination of member and provider interventions seems to be the most effective way of increasing member awareness regarding the importance of certain health screenings.

Project limitations included staffing issues and competing priorities for those staff assigned to this project. Additional issues included the inability to interact directly with the dental care providers and the prolonged contract negotiations with Doral Dental which are still in progress.

Univera Community Health

Improving well visit rates in the under 2 year old Medicaid population

1. Project Topic / Rationale / Aims

Well visits are the vehicle by which most preventive services are delivered to the under 2 year old population. Included in these preventive services are immunizations and blood lead testing. Children who do not receive the recommended number of well visits (2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months) are at risk for non-compliance with immunizations and lead testing. The MCO community-wide pediatric preventive health care guidelines, based on American Academy of Pediatrics (AAP) and New York State regulations for Medicaid, indicate that children should receive 9 well care visits by age two. The MCO tested an automated telephonic reminder to assess if this would impact the well visit rate. The well visit rate (for the First 15 Months of Life (5 visits) for January 1, 2005 through December 31, 2005) is 63%. Statewide average is 65% for this time period. The goal was to exceed the statewide average. The study question to be answered was *Will telephonic outreach to non-compliant members increase the well-visit rate.* The health plan's objective was to determine if an automated telephonic message, targeting the parent/guardian of 9 month olds who had completed 3 or less well visits, would prompt them to schedule and keep a well visit appointment. The study indicator was the well visit measure First 15 Months of Life (5 visits).

2. Methodology

HEDIS administrative methodology for the Medicaid managed care population using January 1, 2005 through December 31, 2005 compared to January 1, 2007 through December 31, 2007. Both the baseline and the remeasure were calculated administratively, per HEDIS specifications, based on Univera Community Health members age 0 to 15 months.

3. Interventions

Monthly beginning in March 2007, all Medicaid children in the UCH population who were continuously enrolled from 31 days to 9 months of age, who turned 9 months old, and who had 3 or less well visits were referred to TeleVox for telephonic outreach. TeleVox delivered a customized message encouraging the parent/guardian to contact the PCP to schedule needed services, including immunizations and well care.

4. Results/Conclusions

The performance goal of exceeding statewide average (65%) was met. Of the 447 eligible members, 302 completed at least 5 visits, for a rate of 68%. The results were not statistically significant ($p = 0.1936$). Additional results, assessing the number of well visits completed within 2 months following the intervention month for the children who were referred to Televox ($n = 327$) and the message was delivered ($n = 140$) compared to children who were referred but the message delivery failed ($n = 187$), demonstrated no difference in the percentage of children who completed 4, 5, 6 and 7+ visits. The discrepancy between the HEDIS denominator ($n = 447$) and the members who were referred for outreach ($n = 327$) is accounted for by children not referred for outreach due to no phone, or had already received 4 well visits by 9 months of age.

Though the goal of 65% was exceeded by 3 points, the comparison of children who received the telephonic message with those who did not demonstrated no difference in the percentage of children completing 4, 5 6 and 7+ visits. Additionally, the unavailability of phone numbers and lack of personalization with automated messaging are barriers. Automated telephonic outreach at the plan level appears ineffective at driving well visit utilization.

WellCare of New York, Inc

Thirty (30) day follow-up after hospitalization for mental illness in Wellcare Medicaid / FHP members

1. Project Topic / Rationale / Aims

Follow-up after hospitalization for Mental Illness in Medicaid/FHP Members: WellCare elected to pursue this topic because of its relevance to the Medicaid population and the documented impact of behavioral health issues on overall health management. Mental illness can influence the onset, course, and outcome of other illnesses and often correlates with detrimental health risk behaviors such as physical inactivity, tobacco use and substance abuse. Appropriate follow-up may reduce the duration of disability, prevent repeat hospitalizations, and identify individuals who need additional interventions before the individual reaches a crisis point. Furthermore, a review of HEDIS/QARR rates for this measure, from 2003 – 2004 demonstrated a need for improvement in this measure. The rates at baseline measurement for the seven (7) and thirty (30) day follow-up were 45% and 64% respectively. Both rates were below the State-wide average for CY2005, the baseline measurement year. The aim of this project was to attain statistically significant improvement of the rates for the seven (7) and thirty (30) day follow-up indicators from the baseline measurement year (2005) to the re-measurement year (2007).

2. Methodology

HEDIS2006 Technical Specifications for the measure Follow-Up after Hospitalization for Mental Illness was followed for the baseline measurement of this study. HEDIS 2007 was used for the Interim measurement and HEDIS2008 for the re-measurement period. WellCare Medicaid/FHP members six (6) years of age and older as of the date of discharge, continuously enrolled in the plan on the date of discharge through thirty (30) days after discharge, having inpatient and outpatient medical and mental health benefits and who were discharged from an inpatient setting of an acute care facility with a discharge date occurring on or before December 1st of the measurement year with a principal ICD-9-CM diagnosis codes as specified in HEDIS Technical Specifications for the follow-up after hospitalization for mental illness measure. The indicators for the baseline and re-measurement periods are:

- The percentage of members receiving follow-up within 7 days of discharge
- The percentage of members receiving follow-up within 30 days of discharge

3. Interventions

Two types of interventions were implemented: A telephonic outreach targeting the member, the mental health provider, and the Primary Care Provider and; articles in the Member and Provider Newsletters emphasizing the importance of following up after a hospitalization for mental illness.
The Outreach Specialist

- Reviewed the daily census, admission notes and authorizations to identify members admitted to the hospital with the qualifying diagnoses.
- Tracked discharge plans for each member; obtained place and time of the initial appointment, name of the provider and or facility and current contact information for the member.
- Called the facility to verify date & time of initial appointment, to verify appointment was kept and/or to reschedule missed appointments
- Called the member to remind them of upcoming appointments, to identify barriers to keeping appointments and or to reschedule missed appointments
- Verified that the claim for the service was received and processed.
- Members who could not be reached by telephone were sent a letter from the Behavioral Health Vendor
- The PCP of record was contacted to obtain current contact information. If new information was obtained outreach was attempted using this information

4. Results/Conclusions

The entire eligible population of 227 members was used for the denominator of the study at re-measurement. Rates enhanced by Medicaid data were not available at the conclusion of this study so, comparison was made using the un-enhanced rates.

While we observed an increase of seven percentage points in the rates between interim measurement and re-measurement, the increase from baseline to re-measurement was only two percentage points for the 7 day follow-up indicator. A similar pattern was observed for the 30 day follow-up indicator from interim measurement to re-measurement. But, there was a decrease of one percentage point from baseline to re-measurement for the 30 day follow-up indicator. As observed from the un-enhanced rates, we did not achieve the goal of increasing the rate at re-measurement by a statistically significant margin from the baseline measurement for either indicator, but, performance level was maintained.

We did not achieve a statistically significant increase in the rates of the study indicators probably due to a combination of factors including:

- The HEDIS rates reported did not include an enhancement by Medicaid data
- Staffing issues at the Behavioral Health Vendor may have negatively impacted discharge planning follow-up and timely reporting of discharges resulting in missed opportunities for outreach
- Interventions were not conducted on a daily basis as originally planned. Due to competing priorities outreach staff was shifted to other projects on an as needed basis.
- Interpretation of confidentiality laws by the providers of services are a problem when trying to locate or coordinate care for these members
- Frequent changes in living arrangements of these members makes tracking and outreach difficult

The results of this study indicate that we need to reassess the current processes involving this measure. The current Mental Health Outreach Program will be re-evaluated to modify or add to the current interventions. Staffing issues within the plan will be re-assessed and appropriate corrective changes such as re-allocation of staff will be instituted to prevent recurrence of the problem. Staffing issues at the Behavioral Health Vendor are currently being addressed, Technical and clinical staff has been hired and, it is expected this will prevent recurrence of the problems.

Independent Health

Diabetes disease management initiative

1. Project Topic/Rationale/Aims

Diabetes has remained in the top ten most frequent diagnoses for the past three years in Independent Health's (IH) Medicaid population. Complications due to diabetes have been consistently among the top diagnoses for inpatient admissions. The Diabetes Control and Complications Trial (DCCT) was a 10 year study which proved that tight blood glucose control prevents or delays complications. Keeping blood glucose levels close to normal reduces damage to the eyes by 76%, to the kidneys by 35 to 56%, and to the nerves by 60%. Most experts agree that appropriate medical management and patient self-management can improve the quality of life for people with diabetes and at the same time help to control complications.[1] The Medicaid population has significantly lower rates of compliance. This project takes a comprehensive approach to the management of care for our diabetic members. How can IH provide a comprehensive diabetic management program that will show improvement in the diabetic outcomes for our Medicaid population? How can we raise the HEDIS diabetic rates so there is parity amongst all lines of business? The aim of this project was to build a comprehensive diabetes management program through evidence based guidelines for practitioners, empowering our diabetic members to make informed lifestyle choices through health coaching, engaging these members to partner with physicians to ensure best practice and identify diabetics who would benefit from care coordination.

Objective 1: Provide practitioners with evidence-based (EB) clinical guidelines
Objective 2: Educate members about the importance of self-management
Objective 3: Identify patients who would benefit from case management (CM) and care coordination

2. Methodology

The HEDIS Comprehensive Diabetes Care Measures (hybrid methodology) will be used to measure improvement. Identify the percentage of Independent Health's Medicaid members', ages 18-75, with diabetes (type I & type II) with the following: HbA1c Test, Poor HbA1c Control (>9%), Diabetic Retinal Exam, Lipid Screening Test, LDL Control (< 100 mg/dL) and Nephropathy Monitoring. The performance goals established for these measures are 87.7%, 34.8%, 67.6%, 88.0%, 43.6% and 72.9%, respectively. Results will be tracked from 2005 baseline measurement to 2007 remeasurement period.

3. Interventions

A combination of three access methods, noted below, improves participation compared to programs offering only telephone or telephone and mail access:

<u>Member Interventions</u>

Print materials: Newsletters, personalized letters addressing gaps in care, educational materials.
Electronic communication: IH Website that includes Nurse Chat Line, membership information, claim status, wellness programs, disease specific information, links to helpful websites.
Telephonic health coaching: Outreach calls to moderate and high risk diabetic population for assessment of diabetes, co-morbid condition, and healthy lifestyle.

Practitioner Interventions

Print materials: Monthly newsletter, diabetic registry, personalized letters with patient's gaps in care.

Electronic: Provider section of web-site has clinical practice guidelines, educational materials and links, provider tools for organizing their office. Health Coaches use fax and phone to communicate with physicians.

Collaborative Programs/Projects: Diabetes Practice Excellence Program improves quality of care and patient outcomes through improved adherence to EB guidelines and physician identification of gaps in care.

Provider Collaborative Group Project works with a large medical group to identify and manage high-risk patients/members with diabetes.

4. Results/Conclusions

From 2005 to 2007, for the Medicaid population four out of the six HEDIS Comprehensive Diabetes Care measures demonstrated a trending improvement: HbA1c Test from 82.2% to 82.5%; Poor HbA1c Control (>9.0%) from 42.3% to 38.9% (lower is better); LDL Control (<100 mg/dL) from 37.0% to 40.6% and Nephropathy Monitoring from 66.7% to 86.6%. Only the nephropathy monitoring measure demonstrated a statistically significant improvement ($p < 0.0001$) and surpassed the performance goal (72.9%). Two of the six measures showed deterioration in the rate: DRE from 61.1% to 60.1%; Lipid Screening Test from 83.2% to 79.3%; however, these changes were not statistically significant. These results were based on the HEDIS hybrid methodology and consisted of a relevant sample size of 411.

[1] Preventive diabetes services fall far short of the mark. *The Genesis Report/MCx*, 9-13, May, 1997.

Total Care Health Plan

Comprehensive diabetes care

1. Project Topic / Rationale / Aims

Total Care has chosen the topic of Comprehensive diabetes care. Our goal is to increase laboratory testing (LDL and HgbA1c), medical attention for nephropathy, blood pressure control and retinal eye exam. Over the past four years, Total Care's rates for CDC (Comprehensive Diabetes Care) indicators have varied. This topic is reasonable and worthwhile due to our increasing eligible population for this measure. Approximately 3% of Total Care members have Type 1 or Type 2 Diabetes so there is a significant enough number to make this project meaningful.

2. Methodology

The patient population was Medicaid managed care members with Type I or Type II Diabetes using claim /encounter data and pharmacy data. In 2006, we began a pilot project with 2 health centers –one in an urban setting and one in a rural setting. Activities related to diabetes continued through 2007.

Data collection source was hybrid-a combination of administrative and medical record data. The entire population of eligible members at two health centers was followed. The eligible population at Health Center A is 37 and Health Center B is 154.

3. Interventions

- Reminder mailing to PCP's and Diabetes Center regarding Diabetes Guidelines. Included names of members not meeting criteria for 2006.
- Contact office manager of diabetes specialty care center regarding importance of forwarding office visit notes /laboratory results to PCP for review.
- Send targeted mailing to members with diabetes notifying them of the importance of PC follow up and to request /expect specific screening procedures. Provide tool to track specific indicators. Will offer case management services to assist in coordination of care, making appointments, obtaining transportation etc. Will offer $20 phone card to members receiving all expected services in 2007.
- Met with staff at 2 health centers to review current work plan. Obtained suggestions for additional interventions. Determined what outreach was already planned by provider groups so interventions are not duplicated.
- Follow up with staff at health centers to determine progress made and next steps.
- Article in provider newsletter referencing diabetes guidelines.
- Provider incentive tied to performance goals.

4. Results/Conclusions

In the case of each health center, rates for individual diabetic indicators increased, while overall the rates were not statistically improved

We learned through this project that collaboration and outreach by the provider site together with the plan is necessary for success. More focus could have been placed on specific indicators to obtain more favorable results instead of attempting to improve all diabetes indicators.

Southern Tier Priority Healthcare

Improve completion rate of new enrollee health screening report

1. Project Topic / Rationale / Aims

Southern Tier Priority Healthcare in collaboration with Southern Tier Pediatrics seeks to increase Primary Care Providers' knowledge of new enrollees' current health status by completion of the new enrollee health screening, thereby increasing the ability to identify and assist enrollees with special healthcare needs.

2. Methodology

The entire population was used in this study, specifically utilizing all new enrollees into the plans. Health screening completion rates will be utilized from 2006 and compared to completion rates of 2007. Any members that could not be contacted either via mail or by phone were excluded.

3. Interventions

The interventions for this study include sending all new enrollees a health screening form with their new member welcome packets. All new enrollees with active phone numbers received a new member orientation via phone which included completion of a health screening.

4. Results/Conclusions

The percentage of new enrollee health forms increased from 23% in 2006 to 42% in 2007. Although we did not meet the desired 20% increase, the 19% increase can be attributed to a Member Service Representative (MSR) completing assessments via phone as 23% of the totals assessments were completed this way. The large amount of new members without telephones and those who do not answer or return messages remain barriers in increasing completed screenings. The MSR will continue to attempt to contact all new enrollees via telephone for new member orientation and completion of health assessment forms. Southern Tier Priority Health (STPH) will continue to forward all completed health assessments to Primary Care Physicians in a timely manner. STPH MSR will also continue to encourage enrollees to establish with their chosen PCP as soon as possible and continue to mail out letters reminding them of the same.

It is well worth the extra time that it takes to complete the screenings over the telephone. We now realize the amount of enrollees with special needs in our plan. MSR will continue to complete as many screenings via phone as possible. We are now adding stickers to all new enrollees ID cards asking them to call our office upon receipt. This should increase the number of phone contacts which should increase the number of completed screenings.

Broome Max

Improving the rate of screening mammography for low income women age 40 to 63

1. Project Topic / Rationale / Aims

We chose "Improving the Rate of Screening Mammography for Low Income Women Age 40 to 63" as a performance improvement project because it has been shown that screening mammograms can reduce breast cancer mortality by more than 30%, and approximately 54% of Broome MAX female members (age 40 to 63) still do not get regular screening mammograms. The goal of the project was to raise the mammography rate from approximately 46% to 56%. The indicator is the rate of women aged 40 to 63 who had at least one mammogram during the past two years.

2. Methodology

Our population consisted of all women age 40 to 63 who were continuously enrolled in the Broome MAX Program for 2 years. We chose 63 as the cut-off age because the length of this study is 18 months, and when members turn 65 they become Medicare eligible and are excluded from enrollment in a Medicaid managed care plan. We had 2 exclusions; women who had a bilateral mastectomy and those who had more than a 1 month break in coverage. Indicators were measured based on HEDIS 2007 specifications. Baseline rate was measurement year 2006 (HEDIS 2007) and re-measurement was measurement year 2007 (HEDIS 2008). The methodology did not change between the two measurement periods. The HEDIS numerator criteria had to be changed, in order to reflect the addition of new CPT codes.

3. Interventions

Since notifying providers of the need for client mammograms has proven to be as effective as notifying members, we took a "two prong" approach as follows:

1. Alerted providers, by the use of pink chart notices and follow-up phone calls of clients who were due or over-due for screening mammograms
2. Notified members of the study by letter. NYS Department of Health mammogram brochure and a Broome MAX 2007 women's health pocket calendar were included with the letter. Our hope was that the pocket calendar would not only educate members about the need for screening mammograms, but also aid them in making and keeping appointments. Member follow-ups were accomplished by phone calls and letters. Members were assisted with scheduling mammograms and/or obtaining transportation to appointments on an as needed basis.

4. Results/Conclusions

Our goal, based on measurement year 2006 (HEDIS 2007), was 56%. The re-measurement, based on measurement year 2007 (HEDIS 2008), was 48.5%, which was below our goal but above our baseline rate of approximately 46%.

Although we did not reach our goal, some improvement was seen. We believe that our interventions were helpful in alerting providers of patients due or overdue for mammograms and in educating members of the need for screening mammograms.

Members' failure to make and keep appointments continues to be a problem. Follow up phone calls to members not only provided additional opportunities for educating them of the need for screening mammograms, but also answered their questions, addressed their concerns and stressed the need for making and keeping appointments. Members who change addresses and telephone numbers frequently also posed a problem, resulting in returned mail without forwarding addresses and lack of current addresses and phone numbers for the plan.

We are looking into the feasibility of tying these interventions in with our chart audits, which are regularly performed on a quarterly basis, and of mailing educational material and women's health pocket calendars to all Broome MAX female members age 40 and above during January of each year.

Fidelis and Center Care

Improving breast cancer screening in women (40 and 69 years) and improving cervical cancer screening in women (21 to 64 years)

1. Project Topic / Rationale / Aims

Early detection of breast and cervical cancer by performing routine screening reduces mortality. Members may not fully understand the importance of early detection and the role mammography and Pap tests play in early detection. Members may also be reluctant to have the screenings done due to misconceptions about the tests. The purpose of this project is to study the effectiveness of the interventions in each of three study groups for mammography and three groups for Pap tests and the goal is to see a statistically significant difference among the three interventions for this study.

2. Methodology

HEDIS guidelines were used to select female members who are continuously enrolled, meet age criteria for breast and cervical cancer screenings, and who have not had a screening in the timeframes that meet measure criteria (current year and year prior for breast cancer screening, current year and 2 years prior for cervical cancer screening). Women who live in a high risk geographical area (Brooklyn and Manhattan) were selected and broken into 3 study groups. Interventions were carried out in 2007.

3. Interventions

Each intervention group contained 250 members. Interventions for Group 1 included: Televox (automated phone message), newsletter, member incentive (for mammography only) and mailed educational material. Group 2 interventions were the same as Group 1 with the addition of a second Televox call. Group 3 interventions were the same as Group 1 with the addition of a live call from a Member Services representative.
Provider reports containing information on members who had not received a cervical cancer screening and/or a mammogram were sent to all PCPs.

4. Results/Conclusions

For mammography, the percentages of women who received a screening were:
Group 1 – 3.6%, Group 2 – 3.1%, Group 3 – 6.0%.
For Cervical Cancer screening the percentages of women who received a screening were:
Group 1 – 3.8%, Group 2 – 2.7%, Group 3 – 5.2%
A one tailed z test (for proportions) at a 90% confidence interval was used to determine the significance between Groups 1 and 2 and Groups 1 and 3. The results showed that the study groups did not differ significantly on the percentage of women receiving screenings in 2007.

Members who have a history of non-compliance with recommended screenings are at risk for continued non-compliance. Providing members with information through multiple channels about services needed and services available is vital to achieving greater numbers of members accessing care. However, the more interventions that are in place, the less likely you are to see any one item making any significant impact on behavior. This study demonstrated that an automated phone-based intervention with the addition of a Member Services staff phone call increased the percent of members receiving interventions but the difference was not statistically significant. Lack of accurate demographic information (e.g., address and phone number) is a severe limiting factor in the Medicaid managed care population and leads to many members either not receiving the interventions or having an unknown status of whether or not they received the interventions.

GHI HMO

Cervical cancer screening

1. Project Topic / Rationale / Aims

Once the leading cause of death for women in the United States, the incidence and mortality of cervical cancer have declined significantly due to widespread use of the Pap test to detect cervical changes. Compliance with Pap test at recommended intervals will enable GHI HMO members to seek treatment for pre-cancerous cells early and may prevent invasive cervical cancer.

GHI HMO Clinical guidelines state: All women who are or have been sexually active and who have a cervix should receive a routine cancer screening with Papanicolaou (Pap) testing. A Pap test should be performed at the beginning of sexual activity and should continue at a minimum of every 3 years for those who have had a normal Pap smear.
These guidelines adhere to recommendations by CDC, NCI and ACS.

The aim of the cervical cancer screening project is to increase compliance with cervical cancer screening in the GHIHMO Medicaid/FHP HMO population in women 21-64 years of age. The GHI HMO 2005 QARR rate for cervical cancer screening in the Medicaid population is 63%. The NYS 2004 average (rotated in 2005) is 72%. The goal of this project is to improve the GHI HMO rate to 67% in 2006 and to 72% in 2007.

2. Methodology

HEDIS 2006/QARR 2005 methodology was used for the baseline measurement with the exception of the age parameter to determine eligibility. The age span was changed from 18-64 to 21-64 to reflect the change in the HEDIS 2007 specifications. Women who meet the denominator criteria for this measure (21 to 64 years of age as of 12/31/06) were assessed for evidence of at least one Pap test in 2004, 2005 or 2006 to determine the interim rate using 2007 HEDIS/2006QARR. The final rate was reported in June 2008 using 2008 HEDIS/2007QARR specifications.

HEDIS Volume II Specifications were used to collect the data. The procedures and results were audited by an NCQA accredited HEDIS auditor. The hybrid methodology for data collection was used for the baseline and subsequent measurements. Use of a provider abstraction tool was approved by the auditor.

3. Interventions

Member Incentive Program (*Reward Yourself – The Gift of Health*) – Program launched in 2005 and continued through 2006 and 2007. Members receive a $10.00 gift card to a local store. Effective October 2007, the gift card increased to $20.00.
Telephone Campaign - Reminder to members about the importance of a Pap test and the incentive program.
Provider Service Reports - Periodic notification to Primary Care Providers and OB/GYNS of members who did not have Pap tests. Mailings to providers with a list of members who did not receive care, and a provider sample letter for providers to mail to members.
Member Survey - Survey mailed to members to determine reason for noncompliance and if member had a Pap, but not submitted as encounter. Provider verification that member received a Pap was included.
Member Newsletters – Preventive Health Guidelines and Cervical Cancer Screening articles in Newsletters.

SoundCare - Audio program that promotes health issues, such as Cervical Cancer Screening, which is broadcasted when members are placed on hold during telephone calls.
Member Educational Mailings – Mailing to member informing them of the importance of cervical cancer screening.

4. Results / Conclusions
The Medicaid/FHPHMO interim rate of 70% surpassed the goal of 67%. However, the final goal of 72% was not achieved. The rate declined four (4) percentage points from the interim rate (70%) to the re-measurement rate (66%).

Although the interim rate of 70% surpassed the goal of 67%, the objective of the study was not met. The data collection of field medical record abstraction in addition to provider abstraction proved to be beneficial during 2006, but was not sustained in 2007. Since the HEDIS continuous enrollment criteria is required only during the measurement year, there was a greater emphasis on medical record abstraction for those members not enrolled in the plan in the previous two years. However when comparing the source of numerator positives i.e. administrative data versus medical record review, an analysis shows that in HEDIS 2008 13% of the collection of the numerator positives were from medical record review, while only 10.3% were from medical record review in HEDIS 2007 collection. This indicates that field abstraction did not have as great an impact as originally proposed.

A focus will be placed on provider and medical record abstraction in addition to the continuation of direct member outreach, and provider education with an expectation that the rate will improve. GHIHMO will continue to assess members’ reported barriers to obtaining care.

Gold Choice

Use of telephonic case management to improve screening mammography rates in women with mental health and substance abuse issues

1. Project Topic / Rationale / Aims

It is well known that annual mammogram screening for women forty years and over saves lives and reduces morbidity from breast cancer. Women with mental health and substance abuse issues have additional challenges in receiving this important care. The women, in the past, have identified lack of education about mammography, lack of pro-active promotion of mammography, and long waits to get the appointment and referral from their primary care physician (PCP) as barriers to care. In order to encourage mammography screening Gold Choice has devised an intervention. Our first goal will be to receive permission from the women's PCP to allow Gold Choice to send out a letter/referral annually to all women in their practice 40 and over. This will alleviate the need for the women to go to the PCPs office to acquire the referral. Along with the automatic referral Gold Choice will offer concurrent telephonic case management with one-on-one discussions that encourages compliance with annual screening. If necessary, Gold Choice will also schedule the appointments for the women. Our main objective is to determine the effectiveness of telephonic case management to encourage mammography screening among an under-served population. We also propose to use the telephonic case management as an attempt to determine reasons why the women are reticent to obtain their screening so future interventions can result in continuous quality improvement.

2. Methodology

The population we will target for this intervention is women age 40 and over enrolled in Gold Choice, PCMP IIA, who have been diagnosed with a mental illness and/or chemical dependency who have not received a mammogram in one year or more. Approximately 1281 women are targeted for this project.

Gold Choice will determine whether or not the women have received their mammograms by first contacting their PCPs by mail. In this mailing we will inquire whether or not, according to their records, there was screening in 2006. The PCP will then either fax or mail their response. Based upon these results, Gold Choice will send the members the automatic referral and the case managers will contact the women by phone to encourage screening and to determine why the women are not getting the mammograms. Our case managers will also schedule the screenings for the women in an effort to increase cooperation.

In order to capture all the data pertaining to the intended project we will have our Management Information Services (MIS) Manager design a database that will house the records. Included in this database will be the information necessary to track whether the women have received mammograms, if and when they are scheduled to receive them, as well as when they are due to receive them. It will also denote those women that we were unable to contact either by phone or mail. Our success will be measured by an increase in the amount of mammograms that are obtained by the women due to telephonic contact.

3. Interventions

The intervention Gold Choice is proposing is that of a Physician Self Assessment (PSA), along with the use of telephonic case management. It is our conviction that the case management, coupled with the automatic referral, will positively affect the amount of screenings that occur. The outcome measure will be comprised of the percentage of women that receive mammograms as a direct result of our case management.

4. Results / Conclusions

Approximately 1281 women were targeted for this intervention. Based on our results, 143 mammograms were completed in 2007 (~11%), 47 mammograms were scheduled (~4%), and a total of 1041 calls were made (~81%). Of the 47 scheduled mammograms, 8 women completed their screenings and this is reflected in the total 143.

The use of telephonic case management as an intervention, coupled with an initial Physician Self Assessment (PSA), and an automatic referral, proved to be quite successful. The biggest barrier to the project's success was the inability of our case managers to successfully reach the women by phone, or "No Contact" calls. The Gold Choice population is highly transient and therefore their phone numbers are not always current. In an effort to circumvent this limitation the case managers regularly checked the Department of Social Services rosters and called the PCP offices and mental health agencies for updated information. Even when the information was updated, messages left by case managers were not always returned.

The next step in this project will involve training the women's' mental health providers to refer women 40 and over for a mammogram. Current literature suggests that patients with mental illnesses or substance use disorders see these providers on a regular basis, which provides opportunities for patient education about cancer screening and reminders (Friedman et al 1999; Friedman et al 2005; Carney et al 1998).