2020 Quality Improvement Program description overview

Introduction and purpose

CarePlus' Quality Improvement (QI) Program helps achieve lifelong well-being of its members by providing the trend information that will improve care and treatment.

The QI Program establishes a monitoring plan that measures quality indicators of members' care based on contractual, governmental, accreditation and organizational requirements and guidelines. Data are tracked and analyzed for monthly, quarterly and/or annual patterns, and identified improvement opportunities are shared with you.

Scope

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

Program objectives

Our quality improvement program goals and objectives include:

- Developing clinical strategies and providing clinical programs that look at the whole person, while integrating behavioral and physical health care.
- Identifying and resolving issues related to member access and availability to health care services.
- Providing a mechanism whereby members, physicians and providers can express concerns to CarePlus regarding care and service.
- Providing effective customer service for member and provider needs and requests.
- Providing a process through which pertinent member information is collected and analyzed and improvement actions are implemented by a health plan committee comprised of participating physicians and health plan staff.
- Monitoring coordination and integration of member care across provider sites.
- Providing a comprehensive strategy for population health management that addresses member needs across the continuum of care.
- Providing mechanisms where members with complex needs and multiple chronic conditions can achieve optimal health outcomes.
- Guiding members to achieve optimal health by providing tools that help them understand their health care options and take control of their health needs.
- Monitoring and promoting the safety of clinical care and service.
- Providing providers with comparative data regarding quality pricing information to support achievement of population health management goals.
- Promoting better communication between departments and improved service and satisfaction to members, providers and associates.
- Promoting improved clinical experience for physicians and all clinicians to promote member safety, provider satisfaction, and provider retention.

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 for use in improving patient health and wellness.

- **Patient Safety Program**
  Prioritized safety initiatives throughout CarePlus are reviewed and aligned with national safety issues that focus on three key areas:
  - Reduction of 30-day hospital readmissions
  - Elimination of medication errors
  - Avoidance of inpatient and surgical complications

  Claim information and case reviews are used to identify potential improvement opportunities in each area.

- **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 promotes clinically appropriate, safe and cost-effective drug therapies that evaluate safety and efficacy when developing formularies and procedures. Those therapies are designed to ensure appropriate

drug class review and inclusion, and regular review of drug policies.

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

2019 Clinical Process and Outcome Indicators

In 2019, CarePlus' QI Program set three program goals: case management, clinical and preventive health initiatives and service and availability. The 2019 results are listed in the tables below.

- **SNP Case management.** The case management program supports patients by helping use the best healthcare services to meet their needs and guide them along the healthcare continuum.

2019 goals	2019 outcomes
• Improve post-discharge assessment completion to 100 percent • Improve timely individualized care plan documentation to 100 percent • Decrease readmissions to 18 percent	• Post-discharge assessment completion was at 93 percent • Timely individualized care documentation was at 95 percent • SNP Readmission rate was at 20 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.

  Since 2012, CMS has mandated three topics:

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

  This QIP provides an opportunity to improve health outcomes through enhanced notifications (i.e. "real-time" communications regarding admissions, discharges and transfers) to CarePlus physicians and nurses when their CarePlus-covered patients visit an emergency department. The new "Follow up after ED Visit for People with High-risk Multiple Chronic Conditions" HEDIS measure is the results metric that will be monitored over the three-year study, which is mandated by CMS.

- **Chronic Care Improvement Programs (CCIPs**). CMS also requires internal oversight and documentation of CCIPs as part of the mandated QI program under the federal regulations. The topic that CMS communicated in 2012 involved the reduction of cardiovascular disease (CVD in Medicare-covered patients. The interventions were implemented to impact CVD patients were in care management and used RxMentor. The expected outcomes were improvements in control of blood pressure (CBP), completed medication reviews (CMR) and completion of health-

risk assessments (HRAs).

Effective January 2018, the COPD QIPs transitioned to CCIPs and continued to be monitored and updated each year.

Each year, CMS expects CarePlus to have QIPs and CCIPs 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 HEDIS measures, which are developed and maintained by the National Committee for Quality Assurance (NCQA).

  The 2019 goal was 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 (BMI) assessment
- Breast cancer screening
- Colorectal cancer screening
- Use of spirometry testing in the assessment and diagnosis of COPD
- Pharmacotherapy management of COPD exacerbation
- Controlling high blood pressure
- Persistence of beta-blocker treatment after a heart attack

- Comprehensive diabetes care
- Disease-modifying antirheumatic drug therapy
- Osteoporosis management
- Antidepressant medication management
- Medication reconciliation post discharge
- Access to preventive/ambulatory health services
- Use of high-risk medications in the elderly (2 or more Rx)
- Adults' access to preventive/ambulatory health services (45 years above)
- Cardiovascular conditions on statin therapy (18-64 years)

- **Service and Availability.** Pursuant to the Medicare Communications and Marketing Guidelines (MCMG) CMS requires compliance with three customer service call standards. CarePlus continuously monitors these service indicators and determines appropriate actions, if necessary.

Goals	Outcomes
• Answer more than 80% of incoming calls within 30 seconds • Limit the disconnected rate of all incoming calls 5% or less • Limit patient average hold time to two (2) minutes or less	• Did not meet goal with 77% of incoming calls answered within 30 seconds • Met goal at 3% disconnected call rate • Met goal at 31 seconds hold time

Conclusions and Priorities

In 2020, CarePlus' QIP continues to develop and implement healthcare solutions that provide CarePlus 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 CarePlus 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 our QI Program structure for any changes needed to address future regulations

IMPORTANT!

2018 **At CarePlus, it is important you are treated fairly.**

CarePlus Health Plans, Inc. does not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion. Discrimination is against the law. CarePlus complies with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by CarePlus, there are ways to get help.

- You may file a complaint, also known as a grievance, with:
  CarePlus Health Plans, Inc. Attention: Member Services Department.
  11430 NW 20th Street, Suite 300. Miami, FL 33172.
  If you need help filing a grievance, call **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 one business day.
- 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, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

2019 **Auxiliary aids and services, free of charge, are available to you. 1-800-794-5907 (TTY: 711).**

CarePlus provides free auxiliary aids and services, such as qualified sign language interpreters and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 1-800-794-5907 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis. **Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique. **Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer. **Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

ગુજરાતી (Gujarati): નિ:શૂલ્ક ભાષા સહાય સેવાઓ પ્રાપ્ત કરવા માટે ઉપરોક્ત નંબર પર કૉલ કરો.

ภาษาไทย (Thai): โทรติดต่อที่หมายเลขด้านบนนี้เพื่อรับบริการช่วยเหลือด้านภาษาโดยไม่เสียค่าใช้จ่าย.

Diné Bizaad (Navajo):

ةيبرعلا (Arabic): ءاجرلا لاصتلاا مقرلاب نيبملا هلاعأ لوصحلل ىلع تامدخ ةينامجم ةدعاسلل كتغلب

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