2012
Medicare Dual Choice/Model of Care
Annual Evaluation
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Executive Summary
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**Model of Care/Annual Evaluation Executive Summary:**

IEHP is organized as a Joint Powers Agency, not for profit public health plan. We serve over 600,000 residents of Riverside and San Bernardino counties through the Medi-Cal, Healthy Families, Healthy Kids and Medicare Advantage Special Needs Program. IEHP has seen significant growth in membership over the past year.

The Medicare Dual Choice Special Needs Plan serves over 9,000 Members with special needs. The average age of this population is 56 with the majority of them being women (53%). This population is primarily English speaking with Spanish as the second most prevalent language. The most common diagnosis for this population is obesity, diabetes and visual impairments.

Annually, IEHP's Quality Management Department in collaboration with the Healthcare Analytics and Reporting Department under the leadership and direction established by the IEHP Governing Board and Quality Management Committee, conduct a series of activities that assess the overall quality and effectiveness of the Model of Care program. This report covers activities conducted in the 2012 measurement year. The goal of these activities is to assess current processes to identify areas for improvement and to note the areas of success.

**Access:**

IEHP strives to improve access to medical, mental health and social services. The goal is that all Medicare Dual Choice Members will be able to access appropriate and timely services 100% of the time. Access is monitored through variety of means such as network status reports, grievance data, Member and Provider satisfaction surveys and utilization trends.

- **A. 2012 Network Status Report:**
  This report was reviewed and discussed at the QM Committee. The Special Needs Plan (SNP) network was evaluated and it was determined that IEHP's overall SNP network is compliant with requirements. In addition to the PCP and Specialist network adequacy study, IEHP performed a Behavioral Health network assessment. This study assessed the appropriate access to Psychiatrists, Licensed Clinical Social Workers, Psychologists and Marriage and Family Therapists. The assessment indicated adequate network capacity to serve Members with behavioral health conditions.

- **B. 2012 CMS Part C Provider Network Adequacy Report:**
  This is the second report that IEHP does to assess the IEHP network for sufficient Providers (Physicians and Facilities) coverage for IEHP Medicare Dual Choice Members. In the PCP reporting elements, the largest variance was due to changes in the CMS requirements. The specialty category “State Licensed Nurse Practitioners” was modified to include Physicians Assistants and the specialty category “Internal Medicine” was modified to include Geriatric Physicians. There was also an initiative by the Contracting Department to increase the number of Medicare Dual Choice PCP contracts. In the Specialist/Facility reporting elements, the largest variance were due to increased contracting efforts,
specifically in the areas of BH hospitals, Home health, Skilled Nursing Facilities, and Rheumatology. Cardiology, Oncology, Pulmonologist, Endocrinology, Ophthalmology and Urology stayed stable throughout the year, but compared to the previous year, showed a large variance in several reporting elements due to the small number of Providers in this study with those specialties. The results of the study support the goal, which is to show an increase in Providers to the Network compared to the previous year. No deficiencies were noted for the 2012 rates.

C. 2012 Appointment Availability Survey:
In 2012, IEHP surveyed its Provider network against the IEHP and DMHC access standards. IEHP engaged the Myers Group to field the Provider Appointment Availability Survey and the Afterhours Access Survey. The 2012 Appointment Availability study met IEHP’s goal of at least 90% compliance referring a patient appropriately in a life-threatening emergency situation, Routine Appointment, Physical Exam Appointments, Well Child Appointments, Child Immunization Appointments and Ancillary Service Appointments. All other areas assessed fell below the 90% target rate. Only 76.1% of the PCPs met the DMHC Urgent Visit appointment standard of 48 hours and 71.2% met the IEHP Urgent Visit appointment standard of same day which was a decrease from the 2011 rate of 75.4%. In 2012 the BH appointment availability met the IEHP goal of at least 90% compliance in Routine Appointments. Improvement was seen in urgent and non-life threatening emergencies. This was an improvement from the 2011 rates when the BH appointment availability study did not meet the IEHP goal of 90% in any category.

D. 2012 After Hours Study:
This study demonstrated that the majority of the after hours calls are handled by an auto-attendant or via a recording. Appropriate life-threatening emergency call instructions were provided consistently among PCPs, Specialty Providers and BH providers at least 80% of the time; however the goal of 90% was not met. For urgent, non-emergent calls, PCPs, Specialists and BH providers failed to meet the 90% goal.

E. 2012 Provider Language Competency Study:
The results of the 2012 Provider Language Competency Study revealed an overall compliance rate of 97.1% which was an increase from 2011. PCP offices compliance rate had a statistically significant increase in compliance compared to the 2011 rate. No deficiencies were noted for 2012 rates.

F. 2012 Grievance Data:
To assist in the evaluation of access, IEHP reviews grievance data to determine access related trend. In 2012, IEHP received 289 which was an increase from 193 grievances. Trends noted in the grievances showed areas of dissatisfaction around access. These were further analyzed to determine access types, and the findings demonstrated that these issues were related to referral related issues and access to
medications. IEHP continues to monitors all grievances and performs a drill down analysis of access related grievances. Processes have been put in place to address these concerns such as Provider and Member education, simplifying UM processes, focused audits and trainings.

**Coordination of Care:**

In 2012, IEHP saw significant growth in the Medicare Dual Choice program. The SNP population is a more medically complex membership. This membership also shows an increase in behavioral health conditions which increases the need for care management to assist Members in coordinating their behavioral health and medical care needs. IEHP assesses coordination care through a variety of ways. This vulnerable population is also at risk for poor outcomes in the transition from one care setting to another care setting. These medically complex Members have difficulty navigating the health care system, poor understanding of their disease process and discharge plan as well as poor socioeconomic status. These all can result in poor outcomes for the Member that is transitioning from a hospital to home/facility.

IEHP monitors coordination of care and the transition of care process through the Model of Care Member Satisfaction Survey, Transitions of Care Effectiveness Study, Behavioral Health Coordination of Care Study, annual NCQA Structure and Process SNP audit as well as review of grievances related to coordination or care or transition issues.

A. **2012 IEHP Medicare DualChoice Member Satisfaction Survey:**
This survey is used to determine the satisfaction with the care that they received from the Dual Choice care manager. A total of 659 Members were successfully contacted which equates to an 11.9% response rate. Overall the survey concluded that Members were satisfied with their interactions with their care manager meeting the goal of 80%. One of the main barriers identified included an automated call system to perform the survey (outbound calls from a health plan staff resulted in higher reach rate). It may be that this special needs population may respond better to live person doing the survey rather than an automated system.

B. **2012 Measuring Care Transitions Effectiveness Study:**
This study assesses the CMS Structure and Process Measure SNP 4 elements. The quality indicators are as follows; effective identification of transitions, the effective sharing of care plans between settings during each transition process, the effective communication with the Member’s PCP regarding all transitions within specified timeframes and effective communication with the Member during the transition process. Results of the TOC study identified that IEHP failed to meet the goals set for all quality indicators, however overall improvement was observed in ten of the measures. Multiple barriers were addressed in this study which included timely notification of admission and discharged, claims coding practices are inconsistent and numerous other. Many interventions were put into place to address the barriers and assist in the improvement of the overall transition of care program.
C. 2011 Complex Care Management Measuring Effectiveness Study:
This study assesses the CMS Structure and Process Measure SNP 1 elements. The results of the 2012 CCM measuring effectiveness studies show a decrease in utilization rates in ED visits that met the 2012 goal. Trend analysis revealed that the decrease in ED visits and inpatient days were statistically significant. The disease specific measures were evaluated and revealed lower compliance rates in 2012 compared to 2011 for all measurements. Although significant focus was place on improving HEDIS rates overall for the population, this sicker CCM population has shown to be less motive to receive preventative screenings. One barrier maybe that other more complex conditions are ailing these members which leaves the more basic preventative screenings a low priority. Satisfaction rates remain high with this program indicating Members are generally engaged and satisfied with CCM staff.

D. 2012 Continuity and Coordination of Care Study:
To assess the effectiveness of the exchange of information between medical care and behavioral healthcare, IEHP performs an annual Continuity and Coordination of Care Study. The study assesses the effective exchange of information between IEHP’s Behavioral Health Specialists and Primary Care Physicians. The 2012 study demonstrated that 96.90% of BH cases were exchanged with the PCP via the coordination of care form completed by the BH provider. IEHP did not meet the 100% goal for this measurement, and was a slight decrease from 2011 (97.65%).

Preventive Care

IEHP strives to improve access to preventive care and assesses the membership’s compliance with preventative care guidelines by measuring the annual HEDIS rates.

A. 2012 HEDIS/Stars Results

IEHP received 5 stars in seven areas (improving/maintaining mental and physical health, controlling blood pressure, complaints about the health plan, beneficiary access and performance problems, members choosing to leave the plan and health plan quality improvement. Areas below 3 stars included preventative screening measures, care of the older adult measures and access to care measures as reported through CAHPS. IEHP has put several programs into place to address HEDIS/Star ratings. IEHP now has a designated HEDIS improvement manager and a committee that monitors all HEDIS measures. Star measures will be monitored through the Medicare Task force as well as QI committee. A separate stars committee will be put into place late 2013 and will report up to QI subcommittee.

Appropriate Utilization of Services

Appropriate utilization of services is monitored in several ways. IEHP monitors the use of nationally recognized clinical criteria through the UM review process. The UM department performs an annual Inter-rater Reliability Study on all UM staff making UM decisions. IEHP
also monitors utilization trends such as ER rates, bed days, lengths of stay and readmissions. This data is reviewed at the UM subcommittee to identify opportunities of improvement.

A. 2012 IEHP Direct Denial Review Scores:
The overall Denial File Review Scores for 2012 averaged a score of 98.33 which was an increase from the previous year but did not meet the 100% goal for 2012. IEHP Direct consistently uses the correct templates, but a few areas of improvement noted were the turnaround time compliance, verbiage, and appropriate use of criteria.

B. 2012 Inter-Rater Reliability Audit:
Annually, IEHP conducts an inter-rater reliability audit to ensure all licensed personnel making clinical decisions are appropriately applying the approved clinical criteria and guidelines. The 2012 findings are as follows:
- 3 of 3 Physicians met the requirements (all scored 100%)
- 13 inpatient nurses all scored about 95%. 2 reviewers scored 100%.
- 24 outpatient nurses all scored 90% or above. 15 scored 100%.

The review of the results revealed consistency in applying clinical criteria for all reviewers.

Health Outcomes

IEHP is committed to improving the health outcome of our Members. The goals of the Dual Choice program are to reduce hospitalizations and skilled nursing placement.

A. 2011 UM Utilization Reports:
This is monitored through the UM department through utilization reports. For the calendar year 2011, IEHPs acute admits/1000 was 297 which is lower than the previous year which was 308. This met the goal of 300-400 admits/1000. The acute bed day goal was met with 1379 bed days/1000. The goal for this measure is 1200-1500. The SNF admission/1000 rate was 30.26 /1000 compared to 26.63 in 2011. This did not meet the goal of 20-25 SNP admits/1000. The 2012 SNF bed days were 584 which were within the goal set by IEHP of 400-650/1000.

IEHP continually monitors utilization data to assist in developing programs to help reduce admissions and bed days. In 2012, IEHP collaborated with programs to assist in the transitioning of Members from one care setting to another care setting. Additional staff were hired in the UM/CM and BH units to assist with the coordination of care for this complex membership. Utilization data will continue to be monitored and processes will be put into place to achieve the goals that IEHP has set.

B. 2012 Independence and Obtaining Self Management Goals Assessment:
Improving Member’s health outcomes involves assisting the Members with achieving a level of independence and obtaining their self management goals.
IEHP assesses through the Annual Evaluation of the Health Risk Assessment (HRA). The results of the 2012 DualChoice Annual Evaluation of the Health Risk Assessment demonstrated mixed results. One major limiting factor in the analysis of year to year HRA effectiveness is the fact that the HRA survey tool has been modified multiple times during the initial year (2010) and continuing throughout 2011 and part of 2012. There were no changes after September 2012. Although the modifications were made to ensure adequate capture of valuable medical and psycho-social risk factors that may affect a Member’s ability to self manage, comparisons of a defined set of metrics have been very difficult to follow over a period of three (3) years.

The HRA survey tool has been significantly modified and is scheduled to be implemented in March 2014. The PHQ-9 has been replaced with the Veterans Rand (VR-12) survey questions with validated scoring. Additionally, the HRA is being enhanced to ensure it captures valuable medical and psycho-social risk factors that may affect a Member's ability to self manage. Future modifications will continue to be limited to no more frequently than every 6 months to allow for more consistent trending of health status of DualChoice Members.

HRA indicators will continue to be tracked for all DualChoice Members. The staff utilizes every opportunity to educate Members while intervening on the phone to resolve coordination of care issues. Educational opportunities for the Staff related to communication skills have included workshops. The MOC workgroup will continue to monitor the HRA for effectiveness as well as monitor any changes made to the HRA.

C. 2012 Mobility and Functional Status Assessment:
IEHP also assesses the level of mobility and functional status of this membership during the initial health risk assessment and follow-up assessments for complex care management. The goal is to increase the Member’s mobility and functional status. IEHP monitors the assessment of functional status through the HEDIS Care of the Older Adult (COA) Functional Status assessment. The 2012 rate for this measure was 63.66% which was an improvement from the previous year. IEHP continues to develop processes to improve this rate such as the development of a comprehensive adult progress note. In addition, IEHP performs file reviews on all CM cases to ensure that the care managers are adequately addressing issues identified from the risk assessments.

D. 2012 Pain Management Assessment:
Pain management is concern for this vulnerable population. It is important that all Members are provided a comprehensive pain screening and are referred for proper treatment if an issue is identified. Pain screening is monitored through CM file reviews and the HEDIS COA Comprehensive pain screening measure. The 2012 HEDIS rate for this measure was 62.96% which was a significant improvement from the 2011 rates. IEHP developed an adult progress note/adult annual visit program that was instrumental in improving the COA rates.
E. 2012 Quality of Life Assessment:
Improving health outcomes can also improve the quality of life for our Members. The goal is that all Members report a satisfactory quality of life. The quality of life is assessed during the initial health risk assessment and annually thereafter. Also, cohorts of Members are part of the Health Outcome Survey (HOS) that is required by CMS. Several areas of the HOS study assess quality of life. They are the improving or maintaining physical and mental health measures, depression and healthy day measures. The 2013 HOS study which sampled 61 eligible Members determined that 67% of the Members reported their physical health as better or the same as the previous year. IEHP received 5 stars for this measure. The study also determined that 74% of the Members measured stated that their mental health was better or the same as the previous study. The HOS study also assesses how many Members had a positive depression screening. Of the sample surveyed, 55.2% had a positive depression screen which is down from 65.6% at baseline.

IEHP continues to identify ways to improving the quality of life of our Members. The implementation of the Behavioral health unit has allowed IEHP to adequately assess and treat Members with behavioral health conditions. The depression screening is performed on all new IEHP Medicare Dual Choice Members as well as during their annual re-assessment. Educational materials are provided to the Member and the Provider on the signs and symptoms of depression as well as the proper diagnosis and treatment of depression. The Interdisciplinary Care Team (ICT) is available to all Members to assess their medical, cognitive, functional status and psychosocial situation and to develop a careplan that addresses issues that are identifies. The ICT team consists of different disciplines and expertise, knowledgeable in resources that are available throughout both counties that can assist the Member in obtaining the services that they need.

Member and Provider Satisfaction
Member and Provider satisfaction are of the utmost importance to IEHP. Member satisfaction is assessed through the review of grievance data, annual CAHPS survey and annual Provider satisfaction survey.

A. 2012 CAHPS:
IEHP contracted with the Myers group to field the annual Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The CAHPS survey is a tool to evaluate the Member’s experiences with their health care. The survey was conducted over a 10 week period. The Myers group collected 532 valid surveys from 1,544 eligible Members, which equates to a 35.3.1% response rate which is higher as compared to the previous year.

IEHP performed better than the previous year in Customer Service, Annual Flu Vaccine and Pneumonia Shot. Areas of improvement (where IEHP fell below the National average) are overall rating for health care, getting needed care, getting care quickly, doctors who communicate well, advising smokers and tobacco users to quit, influenza and pneumonia vaccination rates and getting medical equipment. There was no measure for which IEHP performed significantly lower than the previous year.
A. 2012 Provider Satisfaction Study:

The 2012 IEHP Provider Satisfaction study revealed significant increases in overall satisfaction among the network Providers. The satisfaction rate was 98.9% compared to 97.6% the previous year. BH provider had a 93.8% satisfaction rate which was a slight decrease from 94.4% the previous year. Overall, IEHP met the goals for overall heal plan satisfaction and loyalty and for being rated higher than “other health plans” in all other areas.

IEHP will continue to monitor all areas for compliance with the Dual Choice program. Process will be put into place to improve HEDIS, CAHPS, Star and satisfaction rates. The membership continues to increase and becomes more complex. IEHP will continue to assess the need for additional staff, innovative health delivery options to care for disabled and home bound members. IEHP will also work closely with community based resources to provide services to his special needs population.