AultCare Quality Improvement Program Evaluation Executive Summary 2012

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General Overview

The purpose of this report is to summarize the ongoing quality improvement activities and to evaluate the overall effectiveness of AultCare Quality Improvement (QI) Program. The evaluation is focused on activities completed between January 1, 2012 and December 31, 2012. The AultCare program monitors performance for both clinical and non-clinical measures and compares results to past performance, internal goals and external benchmark standards.

AultCare monitored and analyzed several performance measures over the past year. These measures covered clinical performance, access, administrative performance, claims, eligibility, and utilization. Performance measurements were monitored and reviewed with specific department managers. When standards were not met, corrective action plans were instituted.

Topics presented to the Quality Committee most often reflect activities represented in the Quality Management Performance Improvement Work Plan. Other topics reflected new findings, requirements or changes in customer expectations.

Leadership

AultCare Medical Directors provided oversight for the Quality Management Performance Improvement Program. The composition of the Quality Committee includes vice presidents and management from across the corporation in addition to network practitioners and internal clinical and operational staff, and is designed to provide comprehensive prioritization and evaluation of quality improvement throughout AultCare.

Quality Program Committee Structure

The Quality Improvement Committee met quarterly in 2012. The scheduling has provided adequate time for presentation of material and discussion for AultCare. The meetings focus on clinical, administrative and accreditation areas. The committee structure allowed for attendance of practitioners and active participation in the quality program in 2012. Information flow between committees continues to allow for a comprehensive approach to quality management. No need for any committee structure changes in 2013.

Practitioner Participation in the QMPI Program

Participation by actively practicing practitioners in quality activities occurred in 2012 through the committee structure. Physician membership on the Quality Management Performance Improvement Committee provided significant input to quality program activities. Physicians provide input to our Quality Management Performance Improvement Committee, Utilization Management Committee, Pharmacy Committee and Peer/Credentialing Committees. These committees have decision-making authority that affects the network composition and coverage of therapeutic tools for member treatment.

Quality Program Structure

Personnel responsible for the implementation of the Quality Management and Performance Improvement Program are under the direction of the medical director. There were no vacancies in the personnel responsible for the quality program in 2012 therefore there was no need for interim responsibility fulfillment. The medical director is responsible for oversight and direction of all clinical aspects of the Quality Management and Performance Improvement Program. The medical director is instrumental in the development, implementation and maintenance of the overall function of the program. The medical director maintains a current, unrestricted license as a doctor of medicine.

The behavioral health medical director is responsible for oversight and direction of all behavioral health aspects of the Quality Management and Performance Improvement Program. The behavioral health medical director is instrumental in the development, implementation and maintenance of the overall function of the behavioral health program. The behavioral health medical director maintains a current, unrestricted license as a doctor of medicine with board certification in the field.

The Senior Vice President of Operations/Clinical Services has daily operating authority for the Quality Management and Performance Improvement Program. The Senior Vice President works in concert with the medical director to develop, implement, and maintain the organizational program. The Senior Vice President is responsible for advancing AultCare's strategic quality initiatives.

The Associate Vice President of Quality Management is responsible for assisting the Quality department in day-to-day operational activities. The Associate Vice President's primary role is to coordinate organization-wide quality processes and activities, to ensure compliance with accreditation standards, provide staff support to the Quality Committee structure and educate the organization regarding NCQA quality standards. The Associate Vice President works in concert with the medical director and Senior Vice President of Operations/Clinical Services to develop, implement, and maintain the organizational program. The Associate Vice President in concert with the Senior Vice President of Operations/Clinical Services and medical director is responsible for advancing AultCare's strategic quality initiatives by designing and implementing a plan of continuous evaluation of the care and services delivered to members, customers, providers, and facilities. The quality Associate Vice President has training and expertise in quality assessment and improvement methodologies, and the development and implementation of quality management programs in clinical and/or managed care settings.

Throughout 2012 personnel from many operational areas were utilized as sources for identifying possible concerns regarding quality of care and service and are part of quality improvement teams identified to impact member quality of care and service. These areas include: Data Reporting and Analysis for data and analytical resources, Information Systems, Utilization Management, Case Management, Disease Management, Claims, Customer Service, Member Services, Provider Credentialing, Marketing, Customer Satisfaction and Provider Relations.

Enrollee Input

Focus groups were held in 2012 to obtain member opinions regarding various areas of AultCare. Other sources of enrollee input into the QMPI program include member satisfaction surveys and analysis of inquiries, complaints, grievances, and appeals.

Resources

Staffing resources for 2012 were adequate. In an effort to streamline processes in the medical management continuum, the UM departments began reporting through a centralized management structure. Staff members utilize the same medical management information system. The data collection system provides integrated member, provider and service data needed to meet the quality program requirements.

Program Goals

The goals and objectives of the Quality Program are broad in scope reflecting the range of clinical care and service issues that are relevant to our membership. Goals are comprised of both internal goals and national benchmarks and are incorporated throughout program plans in all departments.

1. Ensure appropriate access and availability to both practitioner and plan services to all our members.

2. Improve member clinical and health outcomes for acute and chronic condition needs and behavioral health care through prevention and education.

3. Improve member satisfaction and our internal understanding of what factors contribute to satisfaction.

4. Promote efficient, safe and cost-effective use of health care resources, while promoting best practices from our practitioners.

5. Meet or exceed the expectations for quality-related activities of government agencies, accreditation agencies and purchasers. Remain in compliance with federal, state, local and accrediting bodies, while meeting the expectations of our members and practitioners.

The remainder of the evaluation documents the extent to which 2012 activities met these goals.

Program Effectiveness

AultCare categorizes projects into two main areas: Quality of Service and Quality of Care. Project outcomes are analyzed for their effectiveness. Details about these improvements and project outcomes are detailed in the following pages. Below is a listing of measures that have shown improvement in 2012 as a result of QI program initiatives.

Operational Improvement

(The following non-clinical measures improved by 2% or more from 2011 to 2012)

Measure Name	2011	2012	% improved
Claims payment TAT – Self-funded	9.1 days	8.3 days	9%
Claims payment TAT – Insured	5.7 days	5.6 days	2%
Claims on hand – Self-funded	14,679	13,157	10%
Pharmacy claims TAT – Insured	5.7 days	4.4 days	33%
Service center telephone hold time – Self-funded	38.1 sec	30.0 sec	21%
Service center telephone hold time – Insured	41.7 sec	30.4 sec	37%
Service center telephone abandonment rate – Self-funded	2.7%	2.3%	15%
Service center telephone abandonment rate – Insured	2.8%	2.3%	18%
Service center telephone abandonment rate – Timken	1.9%	1.7%	11%
UM pre-determ/referral pre-service TAT – Commercial HMO	9.1 days	8.4 days	8%
UM pre-determ/referral post-service TAT – Commercial HMO	13.5 days	11.2 days	17%
Provider maintenance TAT	32.37 days	17.7 days	45%

Non-Clinical Improvement (CAHPS®)

(The following non-clinical measures improved by 2% or more from 2011 to 2012)

Measure Name	Commercial HMO 2011	Commercial HMO 2012
Q18. Doctors spending enough time with you	92.6%	95.4%
Q10. Health provider talked about pros/cons of choice of treatment	68.4%	71.4%
Q8. Health Promotion and Education	67.1%	72.5%
Q20. Coordination of Care	80.9%	83.9%
Q21. Rating of Personal Doctor	88.1%	90.3%
Q42. Rating of Health Plan	86.5%	89.7%

Measure Name	Commercial HMO 2011	Commercial HMO 2012
Advising Smokers to Quit	83.5%	86.1%
Discussing Cessation Strategies	57.4%	62.1%
Discussing Aspirin Risks and Benefits	49.7%	52.9%
Flu Shots (Adults 50-64)	44.0%	47.2%

Measure Name	Commercial PPO 2011	Commercial PPO 2012
Q23. Ease of getting appointment w/ specialist	88.9%	91.3%
Q15. Doctors explaining things in an understandable way	95.8%	97.9%
Q17. Doctors showing respect for what you had to say	96.1%	98.2%
Q8. Health Promotion and Education	61.9%	65.0%
Q12. Rating of Health Care	82.2%	86.8%
Q21. Rating of Personal Doctor	85.7%	88.3%
Q42. Rating of Health Plan	67.1%	71.4%
Discussing Cessation Medications	47.3%	53.6%
Discussing Cessation Strategies	36.1%	38.9%
Aspirin Use	39.8%	42.7%

A summary of these results, initiatives, and action plans are described in the *Quality of Service/Operational Monitoring Activities* section of this evaluation.

Clinical Improvement (HEDIS®)

(The following clinical measures improved by 2% or more from MY 2010 to MY 2011)

Measure Name	Commercial HMO MY 2010	Commercial HMO MY 2011
Annual Monitoring for Patients on Persistent Meds – ACE inhibitors/ARBs	85.35	89.00
Appropriate Treatment for Children w/ Upper Respiratory Infection	78.69	87.50
Cervical Cancer Screening	72.60	76.25
Chlamydia Screening (16-20 years)	22.22	39.29
Chlamydia Screening (combined rate)	26.88	42.06
Colorectal Cancer Screening	69.83	74.07
Comprehensive Diabetes Care – Retinal Eye Exam	72.16	75.63
Comprehensive Diabetes Care – Nephropathy Screening	88.97	92.86
Comprehensive Diabetes Care – Blood Pressure < 140/80	49.02	55.46
Comprehensive Diabetes Care – Blood Pressure < 140/90	69.02	75.63
Controlling High Blood Pressure	64.86	70.16
Flu Shots for Adults	44.0	47.2
Inappropriate Treatment for Adults w/ Acute Bronchitis	19.28	22.95

Measure Name	Commercial PPO MY 2010	Commercial PPO MY 2011
Annual Monitoring for Patients on Persistent Meds – ACE inhibitors/ARBs	76.05	81.06
Annual Monitoring for Patients on Persistent Meds – Digoxin	72.13	83.33
Annual Monitoring for Patients on Persistent Meds – Diuretics	76.81	80.91
Annual Monitoring for Patients on Persistent Meds – Combined Rate	75.89	80.44

Measure Name	Commercial PPO MY 2010	Commercial PPO MY 2011
Colorectal Cancer Screening	52.93	60.09
Comprehensive Diabetes Care – HbA1C Testing	89.40	91.64
Comprehensive Diabetes Care – Control <100mg/dl	42.24	46.80
Comprehensive Diabetes Care – Nephropathy Screening	82.85	88.97
Comprehensive Diabetes Care – Blood Pressure < 140/90	60.44	66.90
Controlling High Blood Pressure	60.95	64.29
Post-partum Care	79.67	81.80
Persistence of Beta-blocker Treatment after a Heart Attack	77.38	84.62

Quality of Service

Availability of Practitioners (QI 4)

Because managed care plans require members to utilize a designated practitioner network, the organization must ensure there are adequate numbers and geographic distribution of primary care, behavioral health, and specialty care practitioners to meet member needs. AultCare monitors practitioner availability annually against its standards, and initiates actions as needed to improve practitioner availability.

Commercial geographic analysis at the plan level for Ohio enrollees demonstrated that all standards were met for General and Family Practitioners, Internists, Pediatricians, Cardiologists, Ophthalmologists, Orthopedists, Psychologists, Psychiatrists, Clinical Counselors (LPCCs), and Social Workers (LISWs).

Based on analysis of results, AultCare has exceeded all performance goals. AultCare will continue to monitor access via GeoAccess annually for compliance. Grievances and complaints will also continue to be reviewed for any areas of access to providers that would identify areas of needed improvement.

Cultural Diversity

In an effort to identify and address any cultural, ethnic and linguistic needs of our membership, AultCare performed an analysis of our member needs in relation to the composition of our provider network. National research has shown that member understanding of health care issues impacts overall quality of care and addressing barriers related to cultural or linguistic needs is an important step to improving understanding of our population.

AultCare monitors member cultural, ethnic and linguistic needs through the Consumer Assessment of Health Plan Study (CAHPS) surveys, internal member satisfaction surveys, grievances related to cultural, ethnic and/or linguistic needs and perform an assessment of provider composition to determine any network needs.

The census data for the five-county service area confirms that AultCare's members are consistent with the CAHPS data retrieved. AultCare's membership is not very diverse, with about 96.12% indicating they are Caucasian. The census data also confirms that only 4.8% of the five county population indicated that they speak English "less than very well". Member satisfaction surveys indicated a very small population of members indicating that they have special needs such as hearing impaired (0.75%), prefer female physicians (1.49%), language preference (0.75%), and other (0.75%). The current provider network distribution of language spoken indicated in Table

7, was analyzed and determined to be sufficient for the small population reported that does not speak English. The Commercial PPO product does have some members outside of the 5-county service area, therefore, a custom question was asked of them on the CAHPS survey. That question indicates that only 1.3% of the respondents to the CAHPS survey reported a big problem getting a personal doctor who met their special cultural and /or language needs, confirming no issue with that population as well. There were no grievances or complaints related to member language needs not being met during 2012. It was concluded that no additional actions are needed to meet the cultural and linguistic needs of our membership. We will continue to monitor the needs of our members and perform an ongoing annual analysis to address any future needs.

Accessibility of Services (QI 5)

The primary care practitioner (PCP) is the key to coordination and provision of preventive, chronic and acute care services to members. AultCare established and communicated standards of accessibility for primary care services and behavioral health care as measured by timeliness of appointments for preventive, routine, urgent care and after hour's accessibility. Performance is assessed against these standards through a survey of practitioner offices, the tracking of member complaints and grievances regarding accessibility, and analysis of Consumer Assessment of Healthcare Providers and System (CAHPS®) Survey. Customer service telephone accessibility is measured through abandonment rates and average speed of answer measurements.

Analysis of PCP survey feedback indicated 100% compliance with all appointment access standards. Analysis of behavioral health survey outcomes for BH appointment availability indicated 100% compliance with all appointment access standards.

The commercial PPO CAHPS questions which gauge member satisfaction with the access to needed care quickly experienced a decrease from 2011. These results are also under goal. By design a member of the commercial PPO can utilize a non-panel provider which can make the results challenging to impact. The results are just under industry average.

An analysis of grievances and complaints do not indicate an issue with accessibility in 2012.

AultCare will continue to monitor member appointment access to care by monitoring complaints, grievances, CAHPs results, and survey results. Plan to continue accessibility of services survey in 2013 and institute any corrective action plans as needed.

Analysis of customer service accessibility showed that all areas are meeting goal. Will continue to monitor in 2013.

The organization plans to continue the accessibility of services survey and institute any corrective action plans as needed. Non-compliance with standards will be addressed on a case-by-case basis in collaboration with Provider Credentialing when identified.

Member Satisfaction (QI 6)

Analysis of member satisfaction information helps managed care organizations identify aspects of performance that do not meet member expectations and initiate actions to improve performance. AultCare monitors multiple aspects of member satisfaction, including:

- Member complaints and grievances

- Member appeals
- CAHPS results
- Internal member satisfaction surveys

The top member complaints for Commercial for 2012 were *Quality of Care/Service-Complaint regarding a provider, Internal processes-Claim Info/Status,* and *Plan Design/Benefits* which is consistent with the previous year. There were no identified trends for 2012. Will continue to monitor complaints in 2013 and implement action plans as necessary.

The top three grievances for Commercial products for 2012 were I*nternal processes-Benefit/Contractual Issues/Concerns, Internal processes-Misinformation given by a CSR,* and *Quality of Care-Coordination of Care* which is consistent with the previous year. There were no identified trends for 2012. Will continue to monitor grievances in 2013 and implement action plans as necessary.

The top three appeals for Commercial products were *Quality of Care-Chiropractic, Plan Design/Benefits-Plan Language,* and *Access & Availability-Panel vs. Non-Panel. Quality of Care-Chiropractic* appeals increased significantly from 2011 to 2012, however, after further analysis, over half of the appeals were related to one provider requiring billing education. *Plan Design/Benefits-Plan Language* appeals also increased for 2012, however, there was no specific trending of plan design issues identified. Will continue to monitor appeals in 2013 and implement action plans as necessary.

CAHPS

Response rates have continued to decline over the past 2 years for Commercial products. AultCare can only minimally affect response rates for the CAHPS survey, therefore no action plans will be initiated.

For Commercial HMO, areas that increased by 2% or more from 2011 to 2012 included, *Doctors spending enough time with you, Health provider talked about pros and cons of choice of treatment, Health promotion and education, Coordination of care, Rating of personal doctor, Rating of health plan, Flu shots for adults, Advising smokers to quit, Discussing cessation strategies,* and D*iscussing aspirin risks and benefits.* Area's that decreased by 2% or more from 2011 to 2012 included, *Claims handled correctly* and *Rating of specialist*. Accuracy of claims processed is monitored on a monthly basis through quality measures. In 2012 the average claims accuracy for Commercial HMO was 99.84%, which is meeting the internal goal of 99.5%.

For Commercial PPO, areas that increased by 2% or more from 2011 to 2012 included, *Ease of getting appointment with a specialist, Doctors explaining things in an understandable way, Doctors showing respect for what you had to say, Health promotion and education, Rating of health care, Rating of personal doctor, Rating of health plan, Discussing cessation medications, Discussing cessation strategies, and Aspirin use*. Area's that decreased by 2% or more from 2011 to 2012 included, *Obtaining needed care right away, Shared Decision Making, Health provider talked about pros and cons of choice of treatment, Doctor/provider asked which choice you thought was best, Flu shots for adults, Advising Smokers and Tobacco Users to Quit, and Discussing Aspirin Risks and Benefits.*

Access to care is continuously monitored through analysis of grievances, complaints, appeals, and internal member satisfaction surveys, there were no identified issues with access to needed care therefore we will continue to monitor in 2013 for identified issues. AultCare monitors provider performance through the Quality Performance Program for Physicians. The program is designed to encourage communication between providers and AultCare members to improve clinical quality outcomes. Our goal is to continually enhance this program to recognize providers for meeting or exceeding identified quality measures established for particular medical specialties. To assist providers with meeting these measures, we offer quality improvement tools such as patient registries that identify those members needing preventive screenings/tests. Analysis of compliance with flu vaccinations is measured for diabetics through practice guidelines effectiveness and for Complex Case Management members through CCM effectiveness. Both analyses identified the need for increased education for benefits and the inherent risks of the influenza virus. While the analysis is measured for diabetics and members in CCM, action plan are initiated for the entire population. Smoking cessation discussion is monitored through medical records analysis. Providers are educated on medical record standards through the provider newsletter, office manager meetings, and in the provider handbook to ensure communication with members.

Member Satisfaction Survey

In August 2012 web-based member satisfaction survey capabilities were initiated, allowing all members to complete a member satisfaction survey annually online. An article was placed in the semi-annual member newsletter notifying members that the survey is now available online. There was no other notification or reminder sent out for 2012. For Q1 2013, a pilot will be initiated where a letter will be mailed to a random sample of members advising of the availability of the web-based survey instead of sending a paper survey. It will be determined after seeing Q1 2013 response rate on how to proceed moving forward.

Member satisfaction survey outcomes show satisfaction in all areas surveyed. Will continue to monitor in 2013.

Operational Monitoring Activities

Plan Operations and Access routinely monitor the delivery of AultCare internal services that pertains to both providers and enrollees. AultCare compares its performance against both national benchmarks and internal standards for telephone accessibility, claims timeliness and accuracy. The information is provided to the Operations Managers on a monthly basis and the Services and Quality Committee on a quarterly basis.

Operational performance measurements not meeting goal are assigned a focus level assignment to allow for prioritization of quality improvement efforts. Focus level 1 is assigned to measurements where the goal is not met for three consecutive months or off goal by 20% in any one month. Further barrier analysis and institution or adjustment of action plan needed. Focus level two measurements define that a measurement continues to not meet the goal but is showing improvement towards the goal with current action plan.

Claims Payment Turn Around Times (TAT)
The Self-funded, Insured, and Timken units all did not meet claims TAT goal for 2012. Improvement was seen from 2011 to 2012 for Self-funded and Insured. Barriers and action plans are addressed.

Claims Payment Accuracy
All commercial areas met goal for 2012.

Claims on Hand
All commercial areas met goal for 2012.

Pharmacy Claims TAT
Insured unit meeting goal for 2012. Self-funded unit not meeting goal for 2012 and no improvement shown from 2011. Barriers and action plans are addressed.

Service Center Telephone Call Hold Time
Insured unit not meeting goal for 2012. Barriers and action plans are addressed.

Service Center Telephone Abandonment Rate
All product lines were able to meet goal in 2012. No barriers or action plans identified for 2012.

Utilization Management Pre-determination and Referral TAT
All product lines were able to meet goal in all areas in 2012. No barriers or action plans identified for 2012.

Retention
Commercial products met goal for retention for 2012.

Will continue to monitor all operational performance measures for 2013 and implement action plans as needed.

Member Grievance Turn Around Time
AultCare monitors response turn-around time to member grievances. The goal is to respond within 30 days of receipt of information. AultCare defines a grievance as a written or oral expression of dissatisfaction. Upon receipt of verbal or written grievances, each one is assigned a category code based upon the main issue in the grievance, they are then further defined and assigned subcategories. This categorization process assists in identifying areas of needed improvement. Some grievances relate to multiple issues.

Therefore, this data reflects the number of grievances received from members, but may understate the exact number of grievance issues raised by members. Grievances are routinely monitored for all aspects including turn-around time, indicators and trends.

On an aggregate basis, AultCare met the 30 day TAT goal in 2012, remaining consistent with the previous year. Each grievance against a provider includes notification of the grievance to the provider and an opportunity for review, feedback and research. Once the information is received back from the provider, it is then reviewed on a case by case basis. The investigation and resolution process for grievances against a provider can sometimes contribute to an increased resolution time. Provider education is completed annually. No barriers or action plans were identified for 2012.

Will continue to monitor member grievance TAT for 2013 and implement action plans as needed.

Member Appeal TAT
Appeals are routinely monitored for all aspects including turn-around time, indicators and trends. AultCare defines an appeal as a formal request by a practitioner or member for reconsideration of a decision with the goal of finding a mutually acceptable solution. Upon receipt of appeals, each one is assigned to a unit, and then is assigned a category code based upon the main issue in the appeal, they are then further defined and assigned sub-categories. This categorization process assists in identifying areas of needed improvement.

Member appeal TAT
The goal is to respond within 30 days of receipt of information for level 1 appeals and within 60 days for level 2 appeals.

AultCare HMO and PPO met the 30 day appeal TAT goal for all member level 1 appeal types in 2012. Level 2 appeals are sometimes handled externally (depending on type of contract with employer group). For those level 2 appeals that were resolved internally, all met the 60 day turn-around time. The appeals that were forwarded to the employer or the Ohio Department of Insurance are outside the scope of TAT.* No barriers or action plans were identified for 2012.

Will continue to monitor member appeal TAT for 2013 and implement action plans as needed.

Non-Clinical QIAs

Web-Based Provider Information Accuracy
The purpose of the Website Accuracy QIA is to enhance the accuracy and reliability of information displayed on the AultCare website. Enrollee and provider feedback from focus groups and survey data confirmed AultCare's internal assessment of the improvement opportunity.

The objectives of the quality improvement activity are to ensure the automatic feed for the web-based provider directory is 100% accurate, and take action to eliminate any discrepancies between our payment system (RIMS) and the credentialing database (Oracle).

Provider Information Audit Outcome
To increase the quality of information displayed on our website, we initiated and continued a number of projects which include the following interventions:

- Ongoing analysis and audits
- Continued collaboration between departments to correct errors and prepare for overall system re-write of provider information in claims processing system.
    - 75 providers are randomly chosen for audit each quarter

Results for 2012: 87.25% accuracy

Planned for 2013:

- Continue audits
- Continued creation of provider database

Quality and Accuracy of Communicated Benefit Info (MEM 5)

Call Track Monitoring
AultCare conducts monitoring for quality and accuracy of information customer service representatives (CSR) provide to members related to non-pharmacy and pharmacy benefit questions. Calls are reviewed and any errors are written up on a review sheet and sent to the customer service coordinator for review. The six areas of review are: Caller Type, Inquiry Type, Benefit Type, Benefit, Validation, and Disclaimer. The performance goal is 97.5% accuracy. All products are currently meeting the performance goal. Will continue to monitor in 2013. A detailed summary of 2012 results can be found in Appendix L (MEM 5 analysis)

Call Monitoring Program
The quality and accuracy of information customer service representatives provide to members and providers is monitored. The quality monitoring program allows for improved communication with the CSR as well as standardized reporting for performance review. Program goals are to promote consistency and accuracy of information provided by CSRs, reduce call backs and increase same day call resolution and provide feedback to CSR on opportunities for improvement. Performance goal is 98.5% accuracy. The total average score for Commercial calls monitored was 99.47%, which is meeting goal. CSRs are monitored on an individual basis, therefore they are able to be educated on specific areas where performance is low. Unit meetings are also used to discuss and educate CSRs on any deficient areas of performance.

Email Correspondence Monitoring
AultCare also monitors email correspondence between Customer Service Representatives and members for quality and accuracy of benefit information provided. New software was implemented in 2012 to track email correspondence sent through the "Contact Us" webpage the AultCare website. The Internal Audit Department is charged with the monitoring of email correspondence and related call tracks. Areas such as caller type, inquiry type, validation, disclaimer, benefit communication accuracy, and turn-around time (TAT) are monitored. The performance goal for all areas is 97.5%. The total average score for content accuracy for Commercial emails monitored was 97.75%, which is meeting goal.

Utilization Management Pre-determinations/Referrals TAT
AultCare monitors the responses to provider and member requests for consideration, this includes both referral requests and pre-determination requests. The goal for pre-service requests is to respond to a request within fifteen business days of receipt, post-service within 30 days of receipt, and expedited within 72 hours of receipt.

All product lines were able to meet goal in all areas in 2012. No barriers or action plans identified for 2012. Will continue to monitor UM pre-determination/referral TAT outcomes for 2013 and implement action plans as needed

Ongoing Provider Monitoring

AultCare's Credentialing Program ensures that all practitioners are re-credentialed to verify that they remain qualified to provide services to members. In addition to formal re-credentialing, practitioners are also evaluated on the following performance data:

- Quality of care concerns
- Peer review
- Professional conduct
- Professional liability experience
- Member complaints.

In 2012 the Membership Services Committee reviewed the qualifications and performance records of many practitioners, approving new practitioners to the AultCare network. In reviewing practitioner quality, no practitioners met the quality non-compliance threshold in 2012, therefore no there were no identified actions for 2012. Will continue to monitor practitioner quality in 2013.

Quality of Care

Healthcare Effectiveness Data Information Set (HEDIS®)

In 2012 the AultCare PPO CAHPS and HEDIS® results were reported to the National Committee for Quality Assurance (NCQA). Clinical HEDIS® data elements were collected and reported to our Quality Management Performance Improvement Committee for analysis, discussion and input. AultCare HMO HEDIS® results were reported to NCQA and the Office of Personnel Management for the Federal employees benefit plan members.

HEDIS Interventions

MEMBER INTERVENTIONS

Reminder Notifications

Letters or notices are communicated to active members to address various HEDIS measures.

- Childhood Immunizations Reminder – A letter is mailed to the parent of any child who is need of their immunizations. This letter goes out in advance of their 2nd birthday.
- Postpartum Letter – A letter is mailed to the mothers of a live birth to remind them of the importance of postpartum care.
- Heart Attack Follow Up/Statins Letter – A letter is mailed to members who have been discharged from the hospital post heart attack. This letter advises the member to receive the appropriate follow up care with their provider. It also addresses those members who have prescribed a Statin medication to encourage adherence.
- Care Gap Notification – Information on how to access the online care gap information was distributed to all members in the quarterly newsletters and in the member guide. The care gap data is the most current when accessed online as it considers any additional claim data applicable to the member. The care gap online information is also supported by an additional resource called the Blue Button initiative.
- Blue Button Initiative – Initially implemented due to an OPM recommendation, the Blue Button initiative allows members to input information into an online repository about appointments, medications, etc and is then supplemented with claims and care alert data. This resource can be printed and then taken to their provider for review.

Nurse Outreach
Quality uses the abstractors once HEDIS has been submitted to conduct outreach to members who are may need preventive care and/or for measures in line with strategic goals. The calls in 2012 mirrored the preventive screenings outlined in the care gap mailer along with flu shot and pneumonia shots. In 2012 calls were also preformed specific to medication adherence and to the diabetic population. We also used an outside resource to target calls to non PCMH patients who per claims data were recorded as Diabetic.

Ongoing Interventions
Outreach is conducted through the Personal Wellness Profile survey and ongoing through the medical management areas. Ongoing outreach is also continued in the PCMH offices while the onsite nurse reviews member information he/she is also education on the HEDIS specifications to ensure member and provider understanding of applicable compliance.

Health Promotion and Education
Disease management and case management staff members provide health information to enrollees who meet specific criteria. Outcome assessment data identifies target groups in need of education concerning disease state, preventative health and standards of care. Several programs are offered to members such as:

- **Preventative Care Alerts**
- **Case Management**
- **Disease (Chronic Care) Management**

Preventive Care Alert Program
A notification process was developed for AultCare members with recommended preventive health screenings the member should have and did not have on record. This information acts as an educational tool for members to enter in discussion with their primary healthcare provider to determine what screenings were best for the member. This information is available online for members informing the member of screenings that may be beneficial for their health and suggesting the member call their primary care physician to discuss.

Case Management Program (QI 7)
The focus of the Case Management program is to combine coordination of services and education to assist the member through the healthcare continuum for the most effective use of services. Case Management is a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet a member's health needs through communication and use of available resources to promote quality and cost-effective outcomes. Case Management consists of both Basic and Complex Case Management.

Complex case management consists of members who might be newly diagnosed with their disease and may have many questions, concerns, tests, or treatments to deal with. This includes members with high risk stratification and catastrophic disease.

Basic case management consists of members who have been dealing with their disease for some time but may have, for example, an exacerbation or a metastasis.

In 2012 a total of 820 screenings were completed by case management with a total of 284 case management episodes opened. 481 Basic case management and 112 Complex case management.

Case Management Effectiveness (QI 7 I & J)

To gauge the impact of its complex case management program, Aultcare monitors depression risk, influenza vaccine rates, and medication adherence of its members upon initiation of case management services. Members with severe health conditions are at greater risk for co-morbid depression, complications as a result of contracting influenza, and non-compliance of medication adherence.

Depression – It is the goal to have 100% of CCM members screened for depression. AultCare met this goal in 2012. All members were initially screened with the PHQ2 questions, three members screening positive for depression. These three members were then subsequently screening with PHQ9 questions, where a risk score was identified. Identified barriers included member unwillingness to disclose depression signs or symptoms and lack of knowledge of signs or symptoms. Action plans were implemented to continue member education of depression risks, encouraging discussion with their physician if symptoms develop or persist. Will continue to monitor in 2013.

Flu Vaccine – AultCare did not meet goal for 2012, however outcomes reflected positive CCM effectiveness. Barriers identified include member lack of education on the inherent risks of the flu, their benefits for coverage of the vaccine, and member concern of resulting illness from the vaccine. Action plans implemented include member education during initial and reassessment and having reminders added to preventative care alerts and member newsletters advising the member of the benefit coverage. Will continue to monitor for 2012.

Medication Adherence - Overall medication adherence goal was met for 2012, as there were no non-compliant members for 2012. AultCare will continue to monitor for trends, shifts or opportunities for improvement in 2013.

Disease Management Program (QI 8)

The Disease Management Program employs a collaborative process of assessing, planning, facilitating, and advocating appropriate options and services to meet an enrollee's healthcare needs. The DM program targets enrollee populations diagnosed with chronic diseases and conditions to promote health, prevent disease, manage chronic disease and support optimal quality of life. The DM team facilitates collaboration between the enrollee, healthcare providers, community and payer to provide education, support, and promote continuity of care.

The DM Program is provided as an additional benefit of the enrollee's healthcare coverage and the DM staff strives to achieve the following goals:

- Educate enrollees to promote health and prevent disease progression.
- Encourage enrollees to consult regularly with appropriate healthcare providers for recommended evaluations and screenings.
- Promote and encourage adherence to treatment plans.

- Assist enrollees' navigation through the healthcare system by providing information and resources for home-based and community support.
- Provide education on behavioral and lifestyle changes to support the enrollee's self-management, optimize their quality of life and meet their individual goals.
- Evaluate enrollee care through outcome measures and report these results to providers, thereby encouraging evidence-based, enrollee-centered care.

The DM Staff continued utilizing the electronic medical management system, InforMed. System benefits include automated protocols and assessments generated from claims data plus full integration with internal departments such as AultCare Care Coordination (UM/CM/DM) and Wellness. Predictive modeling identifies enrollees with chronic diagnoses and enables DM intervention prior to a health crisis occurrence.

The DM Staff continued to target educational efforts on enrollee populations with three trigger diagnoses: heart failure (HF), diabetes mellitus, and a Behavioral Health Program focusing on depression and bipolar disorder.

Disease Management Effectiveness

To gauge the impact of its disease management program, AultCare monitors several measures relating to heart failure and diabetes. These measures examine the identification, compliance and interventions of members with these conditions.

Identification of members and their compliance with medications and appropriate testing can impact the outcome of treatments and effective care. Once identified, disease management programs can provide education aimed at self-monitoring and self-care.

AultCare is meeting goal in all areas of DM effectiveness including Comprehensive diabetes care for HbA1C screening, LDL screening, nephropathy screening, and eye exam and CHF for medication adherence to Beta-blockers and ACE/ARBs. No barriers were identified for 2012. Action plans initiated in 2010 will continue including education, DM outreach, and Preventative Care Alerts. Will continue to monitor in 2013.

Patient Safety

AultCare utilizes several monitors to promote safe health care delivery. AultCare's Pharmacy and Therapeutics Committee monitors and evaluates results such as drug-drug interactions, drug utilization reporting and analyses of prescription data. Top DUR categories by claims for Commercial are refill too late, drug to drug interaction, duplicate therapy, low dose alert and refill too soon. Further analysis completed on drug to drug interactions to show severity levels. Major and moderate severity levels with appropriate action taken. No corrective action needed. Barriers to refill too late/too soon identified as member understanding of medications, side effects and disease processes. Case management intervention related to medication adherence to continue in 2013.

Member Education

Members receive education through multiple avenues including newsletters and the websites.

Newsletter education includes:

- UM decisions based on appropriate care and coverage
- UM policy to make a physician reviewer available to discuss the denial decision
- Members' rights to an external appeal at no cost to member
- Member Rights and Responsibilities
- Interpreter services
- How to contact AultCare for further information, as well as other pertinent topics.
- Advanced Directives
- Preventative Care

Website education includes:

- Care Coordination Services
- Notice of Privacy Practices
- Various disease/condition appropriate resources and tools
- Healthcare reform
- Prescription assistance
- Drug Recalls
- After-hours care

A paper copy of materials on the web is available upon request. Members also receive information about the quality program and accreditation requirements via these communication avenues.

Clinical Practice Guidelines (QI 9)

AultCare has adopted clinical practice guidelines for asthma, diabetes, depression, bipolar disorder, schizophrenia, cancer screening, HIV, cholesterol, COPD, CHF, hypertension, immunizations for adults, children and adolescents, periodic health examinations and pregnancy. AultCare adopts evidence-based clinical practice guidelines which are used to align disease management and case management programs with performance outcomes. AultCare has adopted clinical practice guidelines to improve health care quality, help practitioners and members make decisions about treatment options and reduce unnecessary variation in care.

Guidelines are researched upon change notification and at least annually. During 2012 guidelines were researched for updates on a quarterly basis, and reviewed by the medical directors and specialty group medical directors prior to submission to the Quality Management Program Improvement Committee. Upon committee approval, the practice guideline updates were dispersed to network practitioners via provider newsletters, posted on the internet and reviewed during the quarterly office manager meetings.

Performance measurement evaluation is conducted through monitoring at least two important aspects through collection and analysis of HEDIS results, reported earlier in this document.

Continuity and Coordination of Medical Care (QI 10)

During 2012 AultCare monitored the following aspects of continuity and coordination of medical care:

- Osteoporosis Care
    - The percentage of female members age 67 or older who suffered a fracture and had a bone mineral density (BMD) test in the 180 days after the fracture
        - **Post Fracture Bone Mineral Density Testing**
            - Members suffering a fracture who need a follow-up bone mineral density test to diagnose osteoporosis and determine degree of disease severity and treatment. This measure assesses the proportion of eligible individuals

who had a bone mineral density test within a timely manner after a fracture. Bone mineral density testing is recommended for those who have suffered a fracture to screen for osteoporosis and identify treatment needs to reduce the risk of subsequent fractures

- The percentage of female members age 67 or older who suffered fracture and had a prescription for a drug to treat or prevent osteoporosis in the 180 days after the fracture
  - **Coordination between Physician and Pharmacy**
    - For secondary prevention of osteoporosis in postmenopausal women, drug therapies are found to be effective at decreasing vertebral and non-vertebral fractures including hip fractures. Although physicians may prescribe drug therapies in accordance with the osteoporosis treatment guidelines, members may not fill the initial prescription, may stop taking the medication and not inform their physician or may fail to refill the prescription for a variety of reasons. Currently there is no communication link which informs the prescriber when the member fails to fill and/or refill a prescribed medication. This lack of communication can lead to breaks in medication for individuals with osteoporosis.

- CHF
  - Transition from hospital to home: members discharged following an acute Heart Failure event who had a Primary Care Physician (PCP) or cardiologist visit within 30 days of discharge
    - **Acute Heart Failure Event with follow-up Outpatient Physician Visit**
      - Members transitioning from hospital to home after an acute Heart Failure event need a follow-up outpatient visit with a PCP or cardiologist to ensure continuity of care and long term condition management. Education of Heart Failure patients and their families is critical and complex. Failure of these patients to understand how best to comply with the physicians instructions is often a cause of exacerbation leading to subsequent hospital readmissions, reduced quality of life, and increased costs. This measure assesses the proportion of eligible individuals who initiate timely outpatient care following hospital discharge after an acute Heart Failure event
  - Coordination between physician and pharmacy: members discharged following an acute Heart Failure event compliant with medication adherence
    - **Coordination between Physician and Pharmacy**
      - Clinical practice guidelines recommend ACE/ARB and beta-blocker medications for most patients with Heart Failure. These medications have been shown to favorably influence the long-term prognosis of Heart Failure. Thorough discharge planning of Heart Failure patients that includes post discharge support with a special emphasis on ensuring compliance with an evidence-based medication regimen is associated with improved health outcomes and reduced readmission rates.

Continuity and Coordination of Behavioral Health Care (QI 11)

In addition to HEDIS measurements, discussed earlier, AultCare conducted initiatives to improve coordination of behavioral health care issues. The monitors set in place related to non-HEDIS and HEDIS measures as well as interventions are discussed below.

Specific areas monitored include:

- Primary care provider satisfaction with quality and timeliness of communication from behavioral health providers about their patients;
- Opportunities for improvement for the HEDIS® ADHD measure;
- Opportunities for improvement of the HEDIS® AMM measure;
- Medication adherence of SSRS or Tryciclics within 100 days of cardiac discharge.
- Depression screening for members with an acute episode of Heart Failure

Satisfaction with quality and timeliness of communication from Behavioral Health Providers about their patients

All PCP providers in the five-county area were sent a survey/questionnaire to determine how the providers are perceiving correspondence between provider offices. Each average score (on four-point scale) of each of the three questions. Each question is to be rated on a four point scale of 1 to 4 for each question. Answers are on the scale of very dissatisfied (1) to very satisfied (4). The survey monitors:

- Satisfaction with clarity and sufficiency of feedback regarding your patients
- Satisfaction with timeliness of feedback
- Overall satisfaction level with behavioral health care practitioner communication

There are also two questions that allow practitioner to express barriers, assets and opportunities for improvement of communication from behavioral health providers to PCPs. Comments/suggestions were categorized from remaining questions and used to identify barriers and areas of needed improvement. Goal for rating questions is 80% of PCPs rate communication from behavioral health providers regarding their patients "satisfied" or above. (3 or 4) Threshold for goal met was set at 80%. .

HEDIS® measurement and opportunities for improvement for ADHD measure.

This HEDIS® measure is for those members age 6 to 12 with a newly prescribed ADHD medication who had one follow-up visit during the 30 day initiation phase. The continuation and maintenance phase looks at members 6 to 12 years of age with an ambulatory prescription dispensed for ADHD medication, remained on the medication for at least 210 days and in addition to the visit in the Initiation Phase, had at least two follow-up visits within 270 days after the Initiation Phase ended. T

HEDIS® measurement and opportunities for improvement for Antidepressant Medication Management

Antidepressant Medication Management, following HEDIS® specifications, members 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication and who remained on an antidepressant medication treatment. This measure has an acute phase as well as an effective continuation phase for monitoring. The acute phase measure is the percentage of members who were newly diagnosed and treated, who remained on antidepressant medication for at least 84 days (12 weeks). The effective

continuation phase measure is members newly diagnosed and treated with anti-depressants who remained on antidepressant medication for at least 10 days (six months). .

An effort to educate members on the importance of continuing medication and keep schedule an appointment within 270 days after Initiation Phase as well as continuing medication prescribe by the provider was completed by Case Management or Disease Management during phone contact follow-up.

Depression Screening of members newly enrolled in case management during measurement period who had a positive depression screening.

The percentage of members assessed during the initial case management assessment of which scored positive on the PHQ 2 initial depression screen.

Actions include sending brochures to providers regarding HEDIS measures, detailing parameters of the measure and appropriate guidelines and coding of treatment. Quarterly mailings with individualized education material and health coaching for support and supplemental information were sent to members during acute and post-acute phases of depression and bi-polar disorder.

Quarterly Disease Management Mailings for Depression and Bi-Polar Disorder

With HEDIS rates below national average on several measures, it was determined that Disease Management could impact those members with depression and bi-polar disorder; providing education concerning appropriate provider follow-up, medications and other self-management issues. When members are identified by an inpatient behavioral health admission, a referral is made to Disease Management for ensuring appropriate follow-up care upon discharge. Initial contact is made within the first seven days of discharge, to assess if member has a scheduled follow–up appointment and if there are existing barriers to member receiving appropriate care.

A second telephone contact is made within thirty days of discharge to ensure member has followed through with keeping appointments and getting prescriptions filled. The third and fourth contacts are by letter reminding the member to keep all appointments and continue medication regimens as instructed. Implementation of this process is intended to increase compliance and address barriers to compliance at the beginning of the treatment plan. Discharge follow up calls will continue for 2012. Further analysis of impact of the primary behavioral health program and its impact will continue.

Accreditation

Quality Improvement objectives for 2012 included remaining compliant with NCQA standards for our Commercial PPO and Commercial HMO product lines. AultCare successfully completed NCQA accreditation of the PPO product in June 2008 and June 2011. During the past year department managers/supervisors have met on a regular basis with the Quality and Accreditation Department to ensure their processes and documentation meets the NCQA requirements. Commercial HMO accreditation was achieved in 2010 and will be continued as well as ongoing monitoring of compliance related to regulations and accreditation standards.

AultCare plans on concentrating on NCQA accreditation in 2013 due to the upcoming accreditation survey in Spring-Summer 2013 for all product lines.

Conclusion

This report serves as a comprehensive summary of the efforts and actions taken during 2012. A large portion of the year was focusing on quality and accreditation standards and monitoring progress made in previous years concerning monitoring and clinical activities.

Overall, AultCare's Quality Program addressed areas outlined in the 2012 Program Description and work plan and it's functioning effectively. The program goals for 2012 were adequately met through Quality Improvement Program operations and collaboration. AultCare has a comprehensive quality management program and is focused on continuous improvement of care and service to both our members and practitioners.