2013 – 2014 Performance Improvement Project Abstracts featuring

Improving Performance in Chronic Disease Prevention and Management

Introduction

This compendium of Performance Improvement Projects (PIP) summarizes the two-year projects conducted by New York State Medicaid managed care plans in 2013 and 2014, as well as one two-year project conducted by WellCare in 2012 and 2013. There were a total of 18 PIPs in 2013 to 2014 focusing on improving performance in chronic disease prevention and management.

In late 2012, the New York State Department of Health (NYSDOH) proposed the topic "Improving Performance in Chronic Disease Prevention and Management" for a two-year common PIP for plans for 2013-14. The focus of this PIP was two-fold: 1) to partner in the Medicaid Incentives for the Prevention of Chronic Disease (MIPCD) program; and, 2) to develop, implement and evaluate a supplementary intervention that aims to prevent or control chronic disease. The second aspect of the PIP required each plan to design and evaluate an intervention to support chronic disease management or prevention. This supplementary intervention was required to be within one of the four chronic disease and related areas of the MIPCD program: 1) diabetes onset prevention; 2) smoking cessation; 3) diabetes management; and, 4) hypertension. Each plan was responsible for designing and conducting a project, which included the appropriate measurement tools.

The PIP projects were evaluated by IPRO, the External Quality Review Organization for New York State, in accordance with the protocol developed by the Centers for Medicare and Medicaid Services in response to the Balanced Budget Act of 1997.

In addition to being a contractual requirement, these projects are an integral part of the quality improvement process. We hope that you use this Compendium to assist in the development of future quality improvement activities in your plan. We also encourage you to use this opportunity to contact other plans to consult and, possibly collaborate on future performance improvement projects.

If you have any questions or comments about this Compendium, please contact the Office of Quality and Patient Safety at 518-486-9012 or at qi@health.state.ny.us.

GLOSSARY OF ACRONYMS

BMI – Body Mass Index
BP – Blood Pressure
CDC – Comprehensive Diabetes Care
CM – Case Management
CMS – Centers for Medicare and Medicaid Services
HEDIS – Healthcare Effectiveness Data and Information Set
IVR – Interactive Voice Response technology
LDL – Low Density Lipoprotein
MIPCD – Medicaid Incentive Payment for Chronic Disease
MY – Measurement Year
PCP – Primary Care Provider
QARR – Quality Assurance Reporting Requirements
SCM – Specialized Care Management
SWA – Statewide Average

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Affinity Health Plan
MIPCD Part II

Project Topic / Rationale / Aims
Affinity Health Plan contracted with The Quality and Technical Assistance Center (QTAC) of the Center for Excellence in Aging and Community Wellness to train staff in Community Health Centers and Federally Qualified Health Centers (FQHCs) to organize and implement the Stanford Diabetes Self-Management Program (DSMP), a 6-week participatory program, in their respective practices. The goal was to recruit 180-200 Affinity members to participate in this program. The target population was invited to join the 6-week DSMP. Affinity Health Plan incentivized members to attend the program. Participating members received $40 for completion of 4 out of the 6 classes and $60 for completion of all 6 classes.

Goals were to increase the number of members with diabetes who participated in the DSMP who:

- have an annual retinal exam with a specialist by 10%,
- have an annual visit to the dentist by 10%,
- increase the number of hours they exercise per week by 50%, and
- increase the number of servings of fruits and vegetables that they consume by 50%.

Methodology
Process indicators included the proportion of members, 18 – 64 years old with a diagnosis of diabetes who attended <4 classes, 4 classes, and 6 classes, measured and tracked through the QTAC portal. Outcome Indicators included the number of members with diabetes who: (a) had an annual retinal exam with an eye specialist, (b) had an annual visit to the dentist, (c) increased exercise and (d) increased the number of servings of fruits and vegetables that they consumed. Data were collected from pre and post questionnaires results and claims data.

Interventions

- Member intervention: Offered 6-week DSMP via participating PCP sites. Six workshops were held at 4 sites with a total of 25 attendees.
- Provider Interventions:
  - Affinity partnered with QTAC who provided leadership training to PCPs. These practices were to organize and implement the 6-week program for their patients with diabetes.
  - Affinity provided clinical practice guidelines and links to related resources to all practitioners via the Affinity website.
- Community Interventions: Affinity partnered with QTAC to train staff in Community Health Centers and FQHCs to implement the DSMP in their sites and through these program goals were encouraged to have annual visits to the dentist and to an eye care professional(s). Participants were also encouraged to increase exercise time and increase the servings of fruits and vegetables consumed.

Results / Conclusions
Twenty five individuals attended 5 DSMP classes. The targeted rate of having 180 Affinity members attend the DSMP was not met. The number of questionnaires distributed was 25 pre-survey and 7 post-survey. Survey results indicated 89% of members reported they had an eye exam pre-survey and 100% post-survey. For dental exams, the rates were 78% for 2013/2014 and 30% for 2014/2015 pre-survey, and 57% and 43% post-survey, respectively.

Amida Care
Improving Control of Hypertension by Use of Home Blood Pressure Monitoring

Project Topic / Rationale / Aims
The project was designed to evaluate the effectiveness of telehealth monitoring in controlling hypertension in a select cohort of members. Amida Care partnered with five providers sites (Callen Lorde, Village Care, HELP/PSI, Harlem United, and BOOM) to ensure appropriateness of member enrollment and ongoing provider involvement. Provider site partners were involved in developing, implementing, and monitoring the project. The aims of the project were:

- To develop a patient-level intervention to improve hypertensive patients' engagement in self-management behaviors using principles of home-based monitoring.
- To study the effectiveness of the patient-level intervention to improve patient self-management behaviors and BP.

The overall project aim was for interventions to result in maintenance of a BP below 140/90 in 10% of participants in the intervention group.

Methodology
The member population consisted of two groups. Group 1, control group, was comprised of members who received the general hypertension educational mailings and had access to the Amida Care Integrated Care Team to coordinate any identified services. The population was defined as a member having at least one outpatient claim with a diagnosis of hypertension and/or prescribed hypertensive medications. Group 2, the intervention group, had access to the same services as Group 1, but also had an at home BP monitoring device and medication device (whenever possible).

Members identified for each group were based on a state list received and supplemented with Amida Care data. The HEDIS measure for hypertension served as the key performance indicator for the Group 2 intervention. Adequate control of BP was defined by HEDIS as below 140/90.

Interventions
There were 3 categories of interventions for Group 2 members (unless otherwise noted):
1 - Provider and member education conducted via mail, in person or telephonically; 2 - Member and vendor surveys; and 3 - Provider, member, and Amida Care Staff program communication.

Member participants were required to conduct daily BP readings. Based on BP readings, survey responses and provider review, members who showed improvement were graduated from the program. Member surveys were completed at or before the installation of the at home BP device (baseline measure). The same survey was conducted upon reassessment or when a member was disenrolled from the program.

Results / Conclusions
Group 2 consisted of 69 members who participated in the telehealth hypertension program. Of the members identified for the program, 20% enrolled. Of the members who participated, 46% (31 members) graduated. BP improvement was noted in all participants regardless of whether a member graduated. Forty-seven percent (32 of 68) had two final readings of <140/90. Goal was met. Average diastolic readings were lower in members who graduated (89mmHg) versus those that did not (90mmHg). All member participants reported an increased knowledge of how to check their own BP.

Capital District Physicians' Health Plan
Improving Hypertension Control

Project Topic / Rationale / Aims
CDPHP elected to focus on "improving hypertension control". The decision to concentrate in this area was significantly impacted by declining HEDIS/QARR rates for the Controlling High Blood Pressure (CBP) measure. The goal for the project was a three (3) percentage point improvement in hypertension control for Medicaid members, to be measured during QARR/HEDIS review. Additionally, a goal of increasing the number of members with a reduction in systolic and diastolic measurement was pursued.

Methodology
The HEDIS CBP measure was used to measure whether or not a member was in control. This included the percentage of members 18-85 years of age diagnosed with hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year. CDPHP utilized cohort specific CBP rates to measure and evaluate this intervention.

The study focused more specifically on a cohort of Medicaid members linked to a large enhanced primary care (EPC) community practice. Chart review was then completed by the quality nursing staff to confirm the diagnosis of hypertension and to obtain baseline and follow-up BP readings at three and six months post intervention. Member self-report was not accepted.

Interventions
A cohort of Medicaid members linked (i.e. imputed; claims data shows that these members regularly receive care with a PCP in this practice) to a large enhanced primary care (EPC) community practice was identified. Chart review was then completed by the quality nursing staff to confirm the diagnosis of hypertension and to obtain baseline BP readings. Embedded Case Managers (CM) initiated outreach activities. The intervention consisted of engaging members in a pilot program that included face-to-face meetings, education, and use of a free BP device for home tracking. Members who received care in an EPC office that did not have an Embedded Case Manager were contacted by Telephonic Case Managers and where possible, face-to-face meetings were completed with this cohort as well.

Results / Conclusions
BP "control" was measured for 25 members who received a BP monitoring device. Several members had reduction in systolic or diastolic readings, but fewer had reduction in both areas. A total of 15 members (60%) met the control rate per HEDIS.

In order to assess the effectiveness of the interventions, BPs for the members who declined to participate in the project were also re-measured. The group started with 43 members. Results show that the engaged members scored higher on improving diastolic rates, and higher on meeting HEDIS criteria of BP < 140/90: 60% vs. 53%.

Despite the small cohorts and limited numbers, 60% of members who received intervention met BP control rates vs. 37% of members who did not receive intervention. In addition, members who received BP devices were 2.5 times more likely to be in control.

Alternative ways to engage members and providers will continue to be explored through ongoing work with providers and members. Providers will receive education on proper coding for hypertension and on the new HEDIS clinical guidelines for BP control.

EmblemHealth
Improving Diabetes Onset Prevention Supplemental Project

Project Topic / Rationale / Aims
This two-year project was developed in response to the alarming, increased rate of adults with pre-diabetes. Recent evidence shows that people with pre-diabetes will likely go on to develop type 2 diabetes within 10 years unless they make modest changes in their diet and level of physical activity. EmblemHealth focused on participants on making changes in diet and physical activity to achieve modest weight loss in the range of 5% to 7% of baseline body weight, with an emphasis on accomplishing lasting lifestyle changes. Emblem developed a structured evidence-based lifestyle change program encompassing convenient mobile engagement through telephonic IVR outreach based on the Diabetes Prevention Program (DPP). Goals included:

- A 2% enrollment rate among members offered the program.
- A 20% completion rate among members enrolled in the program.
- A 15% achievement of 5-7% weight loss among members completing the course.

Methodology
The NYSDOH provided a file of the Plan's adult Medicaid members aged 18-64 identified as pre-diabetic. The specifications used to identify the pre-diabetes eligible population were members who had a visit in 2012 where any date of service included a diagnosis code of '790.29'. Members with a diagnosis of pregnancy during their participation in the study and pre-diabetics who self-identify that they did not need to lose weight were excluded.

Program completion was defined as listening to 12 out of 16 modules over the course of 16 weeks and recording at least two weights. As a targeted outcome metric, the Plan used the percentage of members who achieved a 5-7% weight loss at completion of the course. A member's self-reported weight was used to calculate the 5-7% weight loss.

Data collection for this project was through administrative methodology including capture of claims and/or encounter data. The eligible population was identified and selected based on member eligibility, age, date of service, and the diagnosis code for Pre-Diabetes.

Interventions

- Promotional Mailing sent to 5,072 members, with letter describing the 16-week telephonic DPP.
- Accepted member registration forms and inbound calls for additional information, explaining the program, enrolling the member into the program, and appointment to track weight, diet, and physical activity.
- Mailed enrolled members their *Getting Started Kit* containing welcome letter, DPP participant binder, first two sessions of program curriculum, Calorie King ® Book, and activity and food template.
- 16 Weekly Outbound Calls to actively engage participants in reducing weight through lifestyle modifications. Participants listened to National DPP curriculum content, reported weight and physical activity, and were given weekly tasks to reinforce lifestyle changes.

Results / Conclusions
The Plan enrolled 472 members (9.3%) in the program, which exceeded the Plan's goal of 2% enrollment. A total of 8.8% of members completed the course; therefore, the Plan failed to meet its goal of 20%. Of the 39 members who completed the course, 9 members (23%) had a weight loss of at least 5% of their baseline weight. Therefore, although the Plan was dissatisfied with the low overall completion rate, the project objective of motivating at least a 5% weight loss was met.

Empire Blue Cross Blue Shield HealthPlus
Improving Diabetes Care

Project Topic / Rationale / Aims
Diabetes is a serious disease that can be prevented and controlled. The goal is for Empire BCBS HealthPlus to be among the forerunners in improving the health of its diabetic members. The aim of this project was to improve the rate of dilated retinal eye exam screenings and HbA1c control by 2 percentage points and 2.5 percentage points, respectively, among Empire BCBS HealthPlus adult diabetic members, over a 2 year period. This was achieved through a comprehensive approach of member education, outreach initiatives, and provider education.

Methodology
The first goal was to increase the rate of retinal eye exam screenings of diabetic members between 18-75 years old from 66% to 68% over 2 years. The second goal was to improve HbA1c compliance amongst diabetic members ages 18-75 by increasing the rate of HbA1c control less than 8 from 55.5% to 58%.

CDC data were collected based on the HEDIS hybrid methodology for each of the three measurement periods, 2012, 2013, and 2014, and included medical records, claims data and lab data.

Interventions
- Conducted telephonic outreach to all diabetic members who were missing any of the 4 components to encourage them to get screened for the 4 diabetes components (Hemoglobin A1c testing, retinal eye exam, LDL screening, and nephropathy testing).
- Disseminated member educational tools such as the Personal Diabetes Care Card to diabetic members to manage their diabetes.
- Referred non-compliant plan diabetic members who had an HbA1c rate greater than 8 to case management for follow up and support.
- Referred diabetic members to Neighborhood Diabetes to increase diabetes self-management education, medication monitoring and reconciliation, and HbA1c testing.
- Referred diabetic members to health education workshops on diabetes self- management and control.
- Offered incentives to members who complete HbA1c testing and retinal eye exams.
- Worked with vision vendor Block Vision to provide Eye Exam Screening events for members who have not had a retinal eye exam
- Provided educational information to providers with a large volume of non-compliant members.

Results / Conclusions
The rate of retinal eye exam screenings increased from 66% to 68.98% from baseline to re-measurement, which was slightly over the intended goal of 68%. The rate of HbA1c control less than 8 increased from 55.5% at baseline to 59.73% at interim (which was a 4 point increase), and 53.94% at re-measurement, which was below the project goal. The drop in screening rates in 2014 might be due to the incentive only being offered at the Clinic Day events and not to large sample of diabetic population as it was done in 2013. The Plan incentivized the members who had a combination of HbA1c screening and eye exam. The total number of members that received incentives was 563 in 2013 and 300 for 2014. The main challenge that Empire BCBS HealthPlus encountered was the large population of members that met the criteria for HBA1C and Eye Exam screenings. In 2013 alone there were over 13,000 members identified.

Excellus BlueCross Blue Shield
The impact of planned interventions with comorbid conditions of schizophrenia and diabetes in a pilot study with Medicaid Managed Care enrollees

Project Topic / Rationale / Aims
This project aimed at providing individual interventions to members impacted by diabetes and schizophrenia with education, support, and assessment of resources for their health. The plan partnered with several community agencies to promote education and resources regarding diabetes screening, monitoring, and administration of antipsychotic medications with clients.

Targeted goals for outcome measures included 5% improvement for diabetes measures, such as LDL and HbA1c, physician visits, and medication compliance. HEDIS measures were projected to improve, with a statistically significant increase.

Methodology
Inclusion criteria included ages 18-64 and diagnosis of both diabetes and schizophrenia. Study Indicators included:

- Performance measures for the SCM Member Pilot Intervention
- Compliance with diabetic screening, monitoring and cardiovascular measure compliance for population compliant with antipsychotic medications at 80% and non-compliant with medications
- Utilization rates comparison with members engaged in SCM and control group (non-engaged members with diagnosis of diabetes and schizophrenia)
- HEDIS reported rates from 2012-15 for measures related to diabetes and schizophrenia

Interventions

- Members and their family or significant others included in an outreach program. SCM Pilot was implemented to provide direct member and family contact.
- Provider: Medical and behavioral health interventions focused on providing evidence-based clinical guidelines for metabolic screening, diabetes, and cardiovascular monitoring with members prescribed antipsychotic medications.
- Community: The health plan partnered with three community partners. A member-specific awareness article was provided to these agencies for their client newsletters. This intervention promoted metabolic screening, diabetes, and cardiovascular monitoring and treatment compliance.
- Health plan: The development of an internal SCM program utilized care management staff with prior expertise in diabetes and or behavioral health.

Results / Conclusions
The member direct outreach intervention was successful in engaging 50 percent of members with diabetes and schizophrenia. Antipsychotic medication adherence for the SCM intervention group did not meet the target goal nor were the results considered statistically significant. Diabetic medication compliance met the target goal of improvement but failed to demonstrate statistical significance. The HEDIS measures improved slightly from baseline to the conclusion of the project but were not within the target goal for improvement with any statistically significant change from baseline. Another goal of the SCM intervention was the promotion of member engagement with their primary medical provider. While the data indicates a very slight rate of improvement, this was not found to be statistically significant and did not meet the performance goal for the project.

Fidelis
Improved Care for High-Risk Diabetics through Participation in a Diabetes Self Management Education Training Program

Project Topic / Rationale / Aims
The project topic is diabetes self-management training (DSMT) delivered in accordance with national standards. DSMT helps people with diabetes to initiate effective self-management skills and maintain a healthy lifestyle in order to optimize glycemic control and prevent complications. This project identifies a cohort of members with diabetes and at least one other chronic condition, encourages them to engage in a DSMT program, and determines the impact of DSMT on their diabetes outcome measures, HbA1C, LDL and BMI.

The primary project questions whether participation in DSMT improves members' diabetes outcomes, and whether a provision of an incentive increases the proportion of individuals completing DSMT. The goal for improvement was to decrease HbA1c rates by 0.5 for members who have a baseline HbA1c rate of 7.0% and over, and maintain levels under 7.0% for those who are already in this range.

Methodology
The project population is composed of members who have a diagnosis of diabetes and one or more of the following medical conditions: congestive heart failure, renal disease, or high BP, having had at least one ER visit or inpatient admission related to diabetes in 2012 or 2013. Baseline and post-DSMT data for HbA1c, BMI, and LDL were gathered from members' medical records. Participation in the training was assessed via claims data and reports from providers who manage the DSMT. Study indicators included HbA1c test performed, HbA1c level, BMI, and LDL level. Members were scheduled to be assessed pre-intervention, and again 3 and 6 months post completion of DSMT training.

Interventions
Eligible members were notified via letters and phone. Providers were also recruited; those who joined the project were required to complete each participant's training. Participants who completed 5 hours were eligible for a $25 incentive payment. Those who completed 10 hours were eligible for a $50 incentive payment.

Barriers included having the program administered by a number of different providers, all having different programs for diabetes intervention and training; member transportation issues; provider compliance issues; and the reliance on claims data to tally the number of DSMT hours, since the lag time required for claims delayed the final analysis.

Results / Conclusions
A total of 115 participants completed at least one training program during the study. Of these, 84 members completed less than 5 hours of DSMT, 20 completed between 5 and 9.5 hours, and 11 completed 10 or more hours. An association between the member incentive and the number of DSMT hours received was identified, leaning toward statistical significance.

Participants with a baseline HbA1c level of >7% had an observed HbA1c change of baseline decrease of 1.0, which was above the target of 0.5. There were 21 members who had a baseline HbA1c <= 7%. Of these, 13 (61.9%) remained <=7% post-DSMT.

Clinical outcomes (change of baseline for HbA1c, BMI, and LDL levels) revealed that the only statistically significant association from the analysis was for BMI.

Healthfirst
Improving the Health Outcomes for the 18- 64 year old Medicaid Population with Type 2 Diabetes through Increased Medication Adherence to Oral Diabetic Medications – A Pilot Study

Project Topic / Rationale / Aims
In an effort to reduce the health risks and improve the quality of life of our adult diabetic Medicaid membership, Healthfirst conducted a pilot study that targeted a provider group consisting of 131 PCPs from the Corinthian Medical Independent Provider Association with a panel of 18-64 year old Healthfirst members who had Type 2 Diabetes and were on oral diabetes medications. These members comprised our PIP's Population of Focus (POF). The aim of this study was to increase the POF's baseline rate of 59% for Medication Adherence to Oral Diabetes Medication to a final rate of 64% by the end of HEDIS 2015.

Methodology
The eligible population was identified as the number of Medicaid members 18-64 years of age that had claims submitted for at least two fills of medications across any of the six drug classes of oral diabetes medications during the measurement year. The POF was a cohort of members from the entire eligible population who were assigned to one of the PCPs from the targeted provider group. The POF's medication adherence to refilling their 6 prescribed oral diabetes medications represented the PIP's Outcome Measure. Its calculation was based on the CMS patient safety measure (Part D Medical Adherence to Oral Diabetes Medications) and the Proportion of Days Covered (i.e., the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category).

Interventions
- Member education was executed through educational mailings, newsletter articles, member website postings, and Care Management outreach and referrals.
- Diabetes awareness, self-management tool distribution, and member education on required screenings for diabetes management were promoted at community health and wellness events.
- Member IVR outreach calls/refill reminder letters were sent to members non-adherent with filling their oral diabetes medications. The targeted provider group received reminder letters with a list of their POF members who were <80% adherent.
- Provider education was presented via "Dinner & Learn" event, in provider bulletins, the best practice performance summary report, the Medication Adherence Report, newsletters, and website postings.

Results / Conclusions
The POF's medication adherence performance (Outcome Measure) went from a baseline rate of 59% in 2012 to a rate of 63% in the final measurement year.

To assess member barriers to medication adherence, Healthfirst staff administered a telephonic survey with a random sample of 100 POF members who were <65% adherent in August 2013. This poll revealed that 45% of the members "forget" to take their medications.

A major finding from this pilot study was that a multipronged approach was essential in improving provider adherence to the diabetes clinical guidelines and member compliance with taking oral diabetes medications as prescribed. It was discovered that members with a lower adherence rate (i.e., 50%-80% members) required more time and engagement to effectively address their medication-taking behaviors during the final measurement period.

Health Now New York, Inc.
Diabetes Management

Project Topic / Rationale / Aims
Our aim for this project was to improve member knowledge of diabetes, increase compliance with standard of care guidelines, and encourage a relationship between members and their primary care providers. The goals were to improve HEDIS and QARR rates for Diabetes specific measures and continue referrals to Hospital Discharge Programs focusing on members with a high risk of readmission and a primary diagnosis of diabetes.

Methodology
Indicators included:

- HEDIS CDC indicators: HbA1c test, HbA1c results (>9 Poor control, <8 Good control, <7 Good control), Diabetic Eye Exam, Monitoring for Nephropathy, and BP Controlled <140/90. The hybrid method of data collection was used.
- Medicaid 30 Day Readmission Rates with a primary diagnosis of diabetes.
- Percentage of Medicaid members completing a provider follow-up visit within 7-14 days post discharge from an inpatient hospitalization with a primary diagnosis of diabetes: Data identified Medicaid members,18 years and older who completed a follow up visit, including evaluation and management with an MD, DO, PA or NP.

Interventions

- Member: Telephonic outreach to address gaps in diabetic care; Care management outreach; mailing to inform members of gaps in diabetes care; mailing educating on care management services; Collaborate with Visiting Nurse Association to implement Telehealth for Diabetes, with information from glucometer sent directly to provider; For post inpatient stays, provided telephonic outreach and facility onsite visit by case manager.
- Provider: Gap in care reporting - Outreach to providers who have high volume of members with diabetes who have a gap in care and support practice outreach; Pay for Performance; Quarterly Provider newsletter; PCMH Partnerships with high volume Medicaid practices; Best Practice Forum regarding discharge planning, transition in care and care coordination.
- Community: Worked with area churches, in high volume Medicaid areas, to publish diabetes information in church bulletins; used zip code analysis that identifies Medicaid population by diagnosis to target outreach at community events, fairs, block clubs, and other events.
- Health plan: New Risk Manager software with a provider portal component that can be accessed by providers to pull data to identify gaps in care, ER and inpatient utilization; Partnership with Kaleida Healthcare Systems to place Care Coordinators in provider offices to assist with members.

Results / Conclusions
The HEDIS and QARR goals were not met. While there have been slight increases from the baseline, twice in four years, (2012 baseline + 3 years of HEDIS data), the plan rotated the measure due to declining rates. This issue was attributed to a change in HEDIS software in 2013. In 2014, the most recent QARR data show four of nine numerators were below the SWA.

The goals for the readmission rate for diabetes and 7 and 14 day follow up visits post inpatient discharge for diabetes exceeded the goals set against the baseline data. The 30 Day Readmission Rate was 25% in 2012, 35% in 2013, and 17% in 2014. The 7 day Follow Up after Hospitalization was 16% in 2012, 21% in 2013, and 38% in 2014. The respective 14 day rates were 32%, 30%, and 57%.

Hudson Health Plan
There Are Many Reasons To Quit PICK ONE! - Tobacco Cessation Program

Project Topic / Rationale / Aims
Hudson chose tobacco cessation as the area of focus and evaluated the impact of a waiting room tear-off pad to promote tobacco cessation as measured by an increase in PCP delivered tobacco cessation counseling to adult enrollees. Each pad included 50 individual two-sided flyers designed to attract patient attention and to encourage patients who smoke to discuss tobacco cessation with their PCP. Our goal was to increase the percentage of adults who had a visit and received tobacco cessation counseling from their PCP to 8% or higher.

Methodology
The primary outcome measure was the percentage of all adult members who had one or more visits and who received one or more smoking cessation counseling services from the PCP sites. For each PCP site, the outcome measure was the percentage of all adult members who had one or more visits, and who received one or more intermediate or intensive smoking cessation counseling services from the PCP site. Practice sites were divided into two groups: Practices using the pads and those not using the pads. Hudson also conducted a secondary study to understand plan-wide changes in the prevalence of smoking and the frequency of treatment for tobacco dependence. Hudson calculated the prevalence of the tobacco use disorder, the frequency of tobacco cessation counseling, and the frequency with which adults fill prescriptions for smoking cessation aids.

Interventions
Hudson created a waiting room tear-off pad promoting tobacco cessation that was delivered by the Provider Relations Representatives to practice sites in the network. Barriers were that some practices did not like the material for cultural reasons, and some did not see any added value to the pads because these practices have already been involved in smoking cessation campaigns with embedded EHR/EMR templates.

Surveys were sent to identify whether the pads were used by providers. Barriers were that some practices did not take the time to meet with Provider Relations staff and the survey was not completed by some practices.

Other interventions included provider and member newsletters; mailings and phone calls to members identified as smokers; online targeted outreach aimed to use online venues, e.g., www.hudsonhealthplan.org, Facebook, Twitter, and provider portals to distribute PDF versions of the waiting room tear-off sheet and member card; and community events, which featured campaign literature (tear-off pad and member card).

Results / Conclusions
Hudson's goal to increase the percentage of adults who had a visit and received tobacco cessation counseling from their PCP to 8% or higher was not accomplished. Of the 68,766 adult enrollees who had one or more PCP visits, 5.78% received one or more tobacco counseling services, a slight increase from 5.19% in 2012. The plan-wide tobacco cessation counseling rate rose from 7.69% to 10.98%, but the unique member rate only increased six-tenths of a percentage point. Hudson did not see a meaningful increase in counseling for all enrollees, but we did see a 6% increase in adult enrollees who were diagnosed with tobacco disorder, with rates increasing from 35.05% in 2012 to 41.32% in 2014. Nicotine replacement therapies prescription fill rates decreased for the overall enrollees (3.67% in 2012 to 2.67% in 2014) and for smokers (29.15% to 18.82%).

Independent Health
Diabetes Disease Management Initiative

Project Topic / Rationale / Aims
The Diabetes Disease Management (DM) Initiative at Independent Health (IH) is an intervention that supports patients with gaps in care related to the management of their diabetes. Patient specific skills and diabetes self-management educational resources are reinforced by the IH Health Coaches, Certified Diabetes Educators (CDEs), Case Management (CM), and Community Health Outreach Workers (CHOWs). The goal of this initiative was to improve health and quality of life through the treatment of secondary risk factors for diabetes; and the prevention of disease progression among members with Type 2 diabetes:

- To identify high-risk members with diabetes, heart disease, and other comorbid conditions.
- To promote lifestyle modifications, nutrition education, and medication compliance to manage risk through Health Coaching, CM and CHOW interventions.
- Increase use of guidelines to improve HEDIS diabetic metrics through collaboration with physicians.

Methodology
The following process, outcome, and satisfaction measures were evaluated:

- Rates for members with an LDL-C test, LDL-C level, and documented BMI (HEDIS)
- Hospitalizations/1000 members with a diagnosis of complications from diabetes (Internal Benchmark)
- Overall Utilization: Inpatient admissions and ER Visits per 1000 for diabetes (Population Analysis)
- Overall Cost Data: Total allowed cost for diabetes (Population Analysis)
- Member Satisfaction with Case and Disease Management (Internal Benchmark)

Interventions

- Practice Excellence Program for Diabetes Management: Performance based program for physician groups with diabetic patients. The self-reported chart audits are based on clinical practice guidelines with the goal of improving quality of care.
- CM outreach phone calls to members following an ER visit or hospitalization for diabetes: Hospital admissions are reviewed daily and referred directly to CM if complex care issues are evident.
- Health Coach, Case Manager, and CHOW Tools: Claims are reviewed monthly.
- Good for the Neighborhood Community Events: The events include free Health Screenings for BP and cholesterol, vision screenings, as well as links to health insurance options, physicians, education on healthy living, nutrition, and medication adherence.
- CHOW Home Visits for Members with Diabetes: New tools for assessment to medication adherence, health literacy and need for community support.

Results / Conclusions

- LDL-C Screening rate increased from 78.3% to 78.5%; LDL-C Level rates increased from 39.8% to 40.7%; Adult BMI showed a significant improvement from 67.7% to 87.4%.
- Significant improvements were seen in both the inpatient rate for diabetes (78/1000 to 54/1000; 30.8%↓) and the ER rate for diabetes (222/1000 to 162/1000; 27.0%↓).
- The Episodes/1000 decreased from 48 to 40 while the Services/1000 increased from 15,180 to 20,030.
- CM respondents have higher satisfaction with their medical management program than respondents in DM (85.9% vs. 70.8%).

MetroPlus Health Plan and MetroPlus Partnership in Care
Improving Care for MetroPlus Health Plan Members with Diabetes

Project Topic / Rationale / Aims
Approximately 20,000 MetroPlus Medicaid and HIV Special Needs Population (SNP) members or 5% of the plan population is diagnosed with diabetes. Through the use of targeted member and provider mailings and case management, we attempted to help members gain a greater understanding of the importance of managing their diabetic condition. With a high concentration of the Plan's members with diabetes and disparities in outcomes in areas such as inpatient admissions and controller medication compliance, the project overall aim was to ultimately improve performance on the HEDIS CDC measures by 5%, reduce adult admissions for diabetes by 5% and improve medication adherence to oral diabetic, RAS antagonists, and statins by 5%.

Methodology
The study population for the project included all Medicaid and HIV SNP MetroPlus members with diabetes. Study indicators for the project included the following: HEDIS CDC measures (HbA1c control < 8%, LDL-C control < 100, BP control < 140/90, eye exam, and nephropathy); Prevention Quality Indicator (PQI) inpatient data (short and long term diabetes complications, uncontrolled diabetes); medication adherence measures (oral diabetic, hypertension, and statins). Data collection and sampling for the CDC measures followed HEDIS methodology; data source for the PQI measures was claims. The medication adherence measures followed CMS Star methodology for oral diabetes, hypertension, and statin medications. The baseline period for the diabetes measures was changed from 2012 to 2011 because only final administrative HEDIS data is stored for multiple years. Furthermore, 2014 administrative rates for eye exam and nephropathy are reported because the diabetes care measures were rotated.

Interventions
Interventions were developed to increase member awareness of their disease condition and educate them about ways in which they can better self-manage their care along with developing a working relationship with the provider who directed their care. Another key component to engage members was to reinforce the member and provider relationship. Member mailings were developed for diabetes management, comprehensive chronic disease mailing, and avoidable admission mailing. Our goal was to help the PCP concentrate on the chronic care population identified for this study with development of the medication adherence and diabetes re-admission reports.

Results / Conclusions
With regards to the HEDIS CDC measures, only the BP sub-measure increased by 5% (2011: 61% compared to 2013: 66%). A comparison to 2014 rates was not possible because administrative, not hybrid, rates were reported for this period. The remaining five sub-measures (A1c <8, eye exam, nephropathy, LDL <100, LDL screening) showed minimal increases or decreases in the rates at the re-measurement period. For HIV SNP, negligible increases and decreases were also seen in four sub-measures (A1c <8, nephropathy, LDL <100, LDL screening) with significant declines for eye exam and BP <140/90.

There were mixed results for the diabetes admissions between 2012 and 2014. For Medicaid, there were significant declines in long-term diabetes complication admissions (1.73 to 1.51 admissions per 1000 members) and Uncontrolled Diabetes (0.40 to 0.23 admissions per 1000 members). There was no change in short-term diabetes complications admissions. For HIV SNP, the results were mixed with increases in both short-term complications and long-term complications, and decreases in uncontrolled diabetes. However, the number of admissions for HIV SNP overall was very small.

MVP Health Care
Improving Diabetes Management for our Medicaid Members with a Diagnosis of Diabetes

Project Topic / Rationale / Aims
MVP chose to focus on diabetes management due to the significant burden this chronic disease weighs on MVP's Medicaid membership. Through this PIP, MVP sought to engage members with their providers by facilitating the primary care office visit, and working to reduce gaps in care for key diabetes process steps – HbA1c testing and lipid testing. By identifying members with gaps in diabetes care and providing information to both providers and members we aimed to achieve performance at, or above, the New York State averages for the following: LDL-C testing, LDL-C control (<100), HbA1c testing, HbA1c poor control (>9.0%), and HbA1c control (<8.0%).

Methodology
MVP used HEDIS administrative results for the CDC measure to report outcomes for this project. Claims were extracted using ViPS® MedMeasures software - a relational database that stores all member, provider, claims, and encounter data needed for HEDIS reporting. Data is imported from a variety of sources into the MedMeasures database using MedMeasures import, data mapping, and data validation tools.

Interventions
- Conducted follow-up for members for clinical outreach and connection to the MVP diabetes program. Members were offered an incentive if they visited the doctor and obtained the recommended tests.
- Provided a newsletter to members aimed at promoting member diabetes self-care activities.
- Distributed provider gaps-in-care reports to contracted Medicaid providers.
- Conducted provider clinical detailing for provider gaps-in-care reports.
- Offered a quality bonus payment (P4P) to high-volume Medicaid PCPs for performance on the diabetes measures from Medicaid Accountable Care Metrics (ACM) quality reports.
- Conducted clinical detailing for ACMs for high-volume Medicaid providers and distributed P4P bonuses.
- Collaborated with high-volume Medicaid providers to bring members who are behind in diabetic screening services in for care. The efforts consisted of a co-branded communication to members, explaining the need for these visits and the availability of a member's incentive.
- Developed and implemented a community-based Health Promotions program focused on healthy eating and health recipes for people with diabetes.

Results / Conclusions
Project interventions included approximately 1,200 diabetic Medicaid members. Baseline and re-measurement rates for the sub-measures used in this PIP are shown below. Note: LDL screening and control measures were initially included in PIP but retired by NCQA after HEDIS 2014:
- HbA1c testing – baseline= 85%, re-measurement= 85% (no change)
- HbA1c poor control (>9.0%) – baseline= 64%, re-measurement= 52% (significant improvement)
- HbA1c control (<8.0%) – baseline= 31%, re-measurement= 39% (significant improvement)

MVP's results improved from baseline for the two HbA1c control measures but remained the same for the HbA1c testing measure. MVP encountered barriers with member engagement in programs and a significant inability to contact members via phone which may have contributed to the lack of improvement in HbA1c testing.

Total Care, A Today's Options® of New York Health Plan (TC/TONY)
Improving Performance in Chronic Disease Prevention and Management – Diabetes Control

Project Topic / Rationale / Aims
The goal for this project was to focus on management of members with a diagnosis of diabetes in an effort to increase and improve healthy behaviors and outcomes. The two-pronged approach included outreach, education, and incentives both for member and for providers.

TC/TONY performance in the QARR diabetic measure was suboptimal. In 2011, TC/TONY fell below the NY SWA average in lipid and nephropathy testing, eye exams, and the HbA1c and Lipids controlled measures. The data, combined with anecdotal feedback from the provider network, demonstrated the need for a renewed focus on supporting this population.

Methodology
TC/TONY chose to target members with diabetes diagnoses with PCPs located at the Syracuse Community Health Center (SCHC). SCHC provides primary care to approximately 556 diabetic members, which accounts for approximately 34% of the total TC/TONY diabetic membership. Thus, a concentrated effort to improve quality of care and outreach for necessary screenings at this site was expected to have the most efficient impact on the largest number of our members.

HEDIS specifications were employed to calculate the rates. Because the diabetes measures were rotated for QARR 2015, TC/TONY reviewed a random sample of 100 medical records from four of its large provider groups to evaluate results. The process measures consisted of the four core HEDIS diabetes testing measures plus the number of providers receiving education. The outcome measures included the diabetes control measures (HbA1c, LDL, and BP).

Interventions
TC/TONY implemented interventions that targeted both providers and members. TC/TONY clinical staff visited offices to provide targeted, on-site education on the individual diabetes measures, tools available to help track member results, and lists of members under their care with identified service gaps. An educational campaign targeting members with diabetes diagnoses was also launched. Members were provided with information on available community resources, tools to help them track their results, including a Personal Diabetes Care Card from the American Diabetes Association, diabetes tracking magnets, and a Diabetes newsletter. Each educational tool was designed to increase member awareness of recommended screenings and optimal results, and to provide members with additional information aimed at helping them make healthier life choices. In 2014, TC/TONY introduced a member and provider incentive program.

Results / Conclusions
The 2015 QARR results did not demonstrate the improvements TC/TONY hoped to achieve. Most individual measures showed no significant change or even dropped slightly. TC/TONY clinical staff educated approximately 325 providers over the course of the project, and provided regular gap in care data to all large providers.

In an effort to improve the diabetes results, in 2015 TC/TONY will:
- Enhance the disease management programs to target those members with gaps in care or those whose diabetes is not controlled, as evidenced by ER or inpatient admissions.
- Modify the incentive program so that providers improve their individual performance on the measures to achieve the maximum reward.

UnitedHealthcare Community Plan
Diabetes Management

Project Topic / Rationale / Aims
This project was aimed at encouraging Medicaid members to enroll into the "Not Me" program, a member benefit that provides private, in-depth consultations with trained pharmacists focused on helping members manage and control diabetes symptoms. Given the burden of diabetes on the plan and the perceived value of one-on-one counseling, the topic was selected with the intent to inform members of this added benefit which they can access in the communities where they live. The overall goal of this project was to determine if engagement in this program would have an impact on diabetes testing rates and hospitalizations.

Methodology
Members in the HEDIS CDC denominator who resided in specific counties (New York, Suffolk, and Nassau) were targeted to enroll in the program. Enrollment and continued engagement in the program was reported from the Diabetes Control Program (DCP). Diabetes measures were members who received the four CDC test measures: HbA1c test, LDL test, Nephropathy monitoring, and Eye exams. Hospitalizations for short-term complications of diabetes were based on the number of discharges with a primary diagnosis of a short term complication of diabetes as defined by AHRQ. The baseline of hospitalizations for short term complications of Diabetes, for the members residing in the catchment area was 167/9,859 or 1.7%.

Interventions
Plan members were mailed an informational letter and brochure about the "Not Me" program. Within the letter and brochure, members were directed to visit www.notme.com or to call a 1-800 number to enroll in the program. The "Not Me" program consists of one-on-one counseling with a trained pharmacist, focused on disease management and symptom control. Discussions include managing medications and improving blood glucose, cholesterol, BP, and BMI. The mailing was followed up with multiple attempts to reach members via phone by plan outreach staff to provide enrollment support in the free program. Supplemental interventions included visits by the plan Quality Director to PCPs with eligible members to encourage them to refer patients to the "Not Me" program. In an effort to improve engagement in the program, the DCP entered into an exclusive, co-branded relationship with Rite-Aid Pharmacy to conduct these interventions. The process for scheduling members with a participating pharmacist was difficult. After the initial call to the program, a second call was required to connect with the participating pharmacy to schedule an appointment with the pharmacists. Despite many efforts to actively address the need for a second call, the requirement from Rite-Aid remained; this barrier was seen as significant and had a direct impact on engagement.

Results / Conclusions
Of the 9,859 members from the specified counties that were included in the multiple mailings and telephonic outreach provided by the plan, 76 eligible members have enrolled in the program, 32 did not complete the step necessary to schedule a meeting with a pharmacist, fewer still had at least one visit with a trained pharmacist and 26 were lost to follow-up. For MY 2012, administrative rates were HbA1C 84%, Eye Exam 49%, LDL Screening 82% and Nephrology Monitoring 78%. For MY 2013, administrative rates were 88%, 52%, 86% and 78%, respectively. For MY 2014, administrative rates were 87%, 49%, LDL Screening Retired per NCQA, and 82%, respectively. According to claims data, hospitalizations for short term complications of Diabetes, for the members residing in the catchment area was 10/9,859 or 0.1%. Of the 10 hospitalizations, none of the members were enrolled in the "Not Me" program. The intervention impacted very few members; therefore the effectiveness cannot be evaluated.

Univera Community Health
The impact of planned interventions with comorbid conditions of schizophrenia and diabetes in a pilot study with Medicaid Managed Care enrollees

Project Topic / Rationale / Aims
This project aimed to provide individual interventions to members impacted by diabetes and schizophrenia with education, support, and assessment of resources for their health. The plan partnered with several community agencies to promote education and resources regarding diabetes screening, monitoring, and antipsychotic medications with their clients.

Targeted goals for outcome measures were five percent improvement for diabetes measures, LDL and HbA1c, physician visits, and medication compliance. HEDIS measures were projected for improvement with a statistically significant increase.

Methodology
Inclusion criteria included members ages 18-64 with diagnosis of both diabetes and schizophrenia. Study Indicators included:

- Performance measures for the SCM Member Pilot Intervention
- Compliance with diabetic screening, monitoring and cardiovascular measure compliance for population compliant with antipsychotic medications at 80% and non-compliant with medications
- Utilization rates comparison with members engaged in SCM and control group (non-engaged members with diagnosis of diabetes and schizophrenia)
- HEDIS reported rates from 2012-15 for measures related to diabetes and schizophrenia

Interventions

- Members and family or significant others: an outreach program, SCM Pilot was implemented to provide direct member and family contact.
- Provider: Medical and behavioral health interventions focused on providing evidence-based clinical guidelines for metabolic screening, diabetes, and cardiovascular monitoring with members prescribed antipsychotic medications.
- Community: The health plan partnered with three community partners. A member-specific awareness article was provided to these agencies for their client newsletters. This intervention promoted metabolic screening, diabetes, and cardiovascular monitoring and treatment compliance.
- Health plan: The development of an internal SCM program utilized care management staff with prior expertise in diabetes and or behavioral health.

Results / Conclusions
The member direct outreach intervention was successful in engaging 64 percent of members with diabetes and schizophrenia. The target goal of five percent improvement for the LDL and HbA1c was obtained at the interim and conclusion of the PIP. The LDL was not statistically significant while the HbA1c improvements at interim and conclusion of PIP were statistically significant. Medication adherence for antipsychotic medications met the target goal of five percent improvement at the interim point but failed at the conclusion of the PIP. The interim and overall results were not statistically significant. Diabetic medication compliance met the target goal of improvement at the interim period but overall the final rate missed the target goal. These results failed to demonstrate statistical significance.

VNSNY CHOICE SelectHealth
Increasing Diabetic Retinopathy Screening for HIV Positive Individuals

Project Topic / Rationale / Aims

This project focused on improving the rate of diabetic retinopathy screening among diabetic HIV positive individuals enrolled in the VNSNY CHOICE SelectHealth Plan. The topic was chosen because ophthalmic disease, which can lead to vision loss and permanent blindness in diabetic HIV positive individuals, is often an overlooked area for screening and prevention in this population. The objective of the project was to improve the rate of diabetic retinopathy screening by 10% from 45% (baseline) to 49.5% (target) over the course of the study period.

The plan developed a multifaceted approach to engage members and their providers and practices in care for the screening and provided information and support and also provided claims and system level reviews to enhance data capture, as needed.

Methodology

VNSNY CHOICE SelectHealth monitored diabetic retinopathy screening performance for the project using the administrative data review for each of the three measurement periods. The population for intervention consisted of members who have diabetes, identified as per the QARR Technical Specifications for the CDC measure, excluding continuous enrollment criteria.

Interventions

- Member
  - Letter and phone script to outreach to members to reduce gaps in care.
  - Members who preferred not to accept mailings were contacted by phone.
  - Members referred to the AIDS Service Center (ASC).
  - Vision provider appointments arranged as needed.
- Providers
  - Letter and phone script to reduce gaps in care.
  - Discussion with providers at Designated AIDS Center (DAC) to reinforce project needs.
  - Data exchange with provider groups to demonstrate gaps in care.
  - Home optometrist for members that need home services.
- Community
  - Channel outreach specialists at each DAC.
- Health Plan
  - Audit eye care vendor for coding issues.
  - Conducted Clinical Evaluation managers (CEMs) and Member Services staff education.

Results / Conclusions

The aim and goal of the project was to improve the rates of diabetic retinopathy screening among HIV positive individuals enrolled in the health plan by 10% from the baseline rate of 45% to 49.5%. The interim QARR-like 2014 rate was observed to be 27.89%; followed by the final QARR like 2015 rate of 31.49%; both were lower than the target of 49.5%. The administrative rate increase, observed from 27.89% to 31.49%, demonstrated a statistically significant increase of 3.3 percentage points.

WellCare of New York, Inc.
Encouraging Tobacco Users to Quit Smoking

Project Topic / Rationale / Aims
WellCare's aim was to educate PCP and OB/GYN providers to:
- Identify and document their findings for tobacco users during their assessments
- Identify and document pregnant women who are tobacco users
- Provide smoking cessation action plans and follow-up for members identified as tobacco users
- Document smoking cessation medications and nicotine replacement therapy in claims and encounters

The target goal was for statistically significant improvement in rates from baseline to re-measurement.

Methodology
Data collection utilized the following methodology:
- Data was generated from WellCare claims and encounter system
- Members who were between 18 years old – 64 years old and:
    - Continuously enrollment during the measurement periods year
    - Identified if members had or did not have a diagnosis of tobacco use or history of tobacco use. The diagnosis was not limited to the measurement year.
    - Identified if the member was pregnant during measurement year

Interventions
Interventions included:
- Educated providers on the documentation of assessments, counseling and coding smoking cessation activities.
- Partnered with OB/GYNs to create intervention aimed at pregnant smokers and to monitor smoking cessation action plans.
- Instructed providers to assess and educate members and create an action plan to support members in their efforts to quit smoking.
- Encouraged follow-up on the smoking cessation action plans.
- Created provider reports to assist in capturing more accurate and valid data.
- Sent member and provider mailings with educational smoking cessation materials

Results / Conclusions
Analyses showed some areas of statistically significant improvement from baseline to re-measurement. The rate of members who attended smoking cessation classes increased from 0.01% to 0.04%. The rate of members identified as tobacco users who attended smoking cessation classes increased from 0.05% to 0.52%. Providers discussing or counseling members to quit also showed an increase from 2.29% to 3.35%.

Several specific goals for this project were not met. The rate of providers discussing or counseling tobacco users to quit and the rate of members who were dispensed a smoking cessation medication were maintained from baseline to re-measurement. The rate for tobacco users who were dispensed a smoking cessation medication had a decline from 14.88% to 11.56%.

No pregnant women were identified as being tobacco users via claims.

WellCare of New York, Inc. (2012 - 2013)
Improving Compliance with Diabetic Retinal Eye Exams in Members with Diabetes

Project Topic / Rationale / Aims
WellCare's rationale for conducting this project was to encourage members with diabetes to seek out preventive care, more specifically, diabetic retinal eye exams. Diabetic retinal eye exams can detect retinopathy early, and is one form of preventive care that can help prevent poor health outcomes like severe vision loss for diabetic members.

WellCare aimed to increase the percent of diabetic members who receive diabetic retinal eye exams. WellCare aimed to improve the overall QARR/HEDIS rate for eye exams and show a statistically significant increase in the percent of diabetic members receiving an eye exam from baseline measurement in QARR 2011/HEDIS 2012 to re-measurement in QARR 2014/HEDIS 2014. Simultaneously, WellCare also strived to reach and/or exceed the SWA for the measure.

Methodology
The study's baseline measurement period was from January 2011 to December 2011, and its re-measurement period was from January 2013 to December 2013. Data collection utilized the HEDIS Technical Specifications for data collection methodology for comprehensive diabetes eye exam measure.

The HEDIS 2012 specifications were used for the baseline, HEDIS 2013 was used for the interim measurement, and HEDIS 2014 was used for re-measurement. The hybrid method was used for collecting the results from claims, encounters and medical record reviews based on a statistical random sample of 411 eligible members according to HEDIS specifications.

Interventions
During the intervention period, WellCare reached out to the target population in several ways, including mailing letters and member newsletters, calling members, distributing gift cards to members who obtained diabetic eye exams, and by hosting community events that included diabetic screenings and member education. WellCare also offered provider education, in the form of newsletters, one-on-one site visits, mailings, and emails. WellCare also created a diabetic cookbook, with multicultural and holiday recipes for a diabetic diet, and information on nutrition and physical activity.

The goal of these interventions was to help improve member quality of life and to educate members and providers about the benefits of obtaining diabetic preventive care, including foot health, frequent HbA1c testing, and most specifically, diabetic eye exams.

Results / Conclusions
The study did find an increase in WellCare's Comprehensive Diabetes Eye Exam score (from 64.23 percent to 64.94 percent); however, this was not a statistically significant increase from the baseline to re-measurement.

Two of WellCare's three project aims were met:
- There was an improvement in the overall QARR/HEDIS rate for eye exams
- This improvement also exceeded the SWA of 64 percent, at 64.94 percent.

However, one of WellCare's three project objectives was not met. Although there was an increase in the overall rate from baseline to re-measurement, it was not statistically significant.