



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

**Medicaid Managed Care Plans
2008 Performance Improvement Projects**

October 2009

Introduction

This compendium of Performance Improvement Projects (PIP) summarizes the various projects conducted by New York State Medicaid managed care plans in 2008. These projects have been reviewed by IPRO, our external quality review organization, in accordance with the protocol developed by the Centers for Medicare and Medicaid Services in response to the Balanced Budget Act of 1997.

If you have any questions or comments about this Compendium, please contact Patricia Gutierrez of the Division of Quality and Evaluation at 518-486-9012 or at pbg01@health.state.ny.us.

GLOSSARY OF ACRONYMS

AAP – American Academy of Pediatrics
ADHD – Attention Deficit/Hyperactivity Disorder
CAHPS – Consumer Assessment of healthcare Providers and Systems Survey
CDN – Clinical Directors Network
CHCS – Center for Healthcare Strategies
CHP – Child Health Plus
CI – Confidence Interval
CKD – Chronic Kidney Disease
CM – Case Management
CRC – Colorectal Cancer
DMC – Division of Managed Care
DPRP – Diabetes Physician Recognition Program
DSM-IV – Diagnostic and Statistical Manual of Mental Disorders, 4th edition
ED – Emergency Department
EMR – Electronic Medical Record
FHP – Family Health Plus
HbA1c - Glycated hemoglobin
HEDIS – Healthcare Effectiveness Data and Information Set
HMO – Health Maintenance Organization
IPRO – Island Peer Review Organization
LDL-C – Low-Density Lipoprotein Cholesterol
NCQA – National Committee for Quality Assurance
NICHQ – National Initiative for Children’s Healthcare Quality
OB/GYN – Obstetrics and Gynecology
Pb – Lead
PCAP – Prenatal Care Assistance Program
PCM – Prevention Care Manager
PCP – Primary Care Provider
PN – Patient Navigator
PSA – Physician Self-Assessment
QARR – Quality Assurance Reporting Requirements
QCMD – Quality Care Management Incentive
QI – Quality Improvement
RCT – Randomized Controlled Trial
REACH – Resource for Advancing Children’s Health Institute
RQI – Regional Quality Improvement
STD – Sexually Transmitted Disease
SWA – Statewide Average
UBH – United Behavioral Health

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ADHD

Affinity

Use of an Academic Detailing Approach to Improve ADHD Diagnosis and Follow-Up in Young Children.

1. Project Topic / Rationale / Aims

Attention Deficit Hyperactivity Disorder (ADHD) is one of the common behavioral health problems affecting children. A 2006 New York State Department of Health (NYSDOH) ADHD study showed that less than half of Affinity Primary Care Providers (PCP) were using a standardized tool for ADHD diagnosis.

This study aims to improve the diagnosis of ADHD by advocating a standardized tool and to improve the follow-up rates for members with ADHD.

2. Methodology

Members with ADHD were identified via claims data, and information on use of screening tools and/or ADHD criteria was collected via medical record review. The pre-intervention measurement period was June – November 2006 while the post-measurement period was June – November 2008.

Thirteen providers were selected for the study by using two main performance indicators:

- Use of a standardized tool.
- Follow-up visits with the PCP for members.

3. Interventions

A behavioral health expert from Beacon Health Strategies conducted academic detailing sessions at the study sites. All PCPs at the study sites who provide care to children aged 6 - 12 years were invited to the academic detailing sessions. Topics discussed included use of DSM-IV (Diagnostic and Statistical Manual) criteria for diagnosing ADHD as well as the importance of follow-up visits for members with ADHD. An ADHD resource toolkit was compiled and distributed to all academic detailing participants.

4. Results/Conclusions

Twenty-four members were included in the final sample for the pre-intervention and post-intervention analysis. There was minimal change in the use of standardized tools, and follow-up visits showed only a slight improvement. The ratio of members referred to a specialist versus being treated by the diagnosing PCP increased three-fold.

The main objective of the study – improving the use of a standardized tool for diagnosis of ADHD – was not met. The use of ADHD screening criteria increased while the use of ADHD assessment criteria decreased over the period of the study. This may be due to a better understanding of ADHD and to increased awareness about the appropriate use of screening and assessment criteria. A higher proportion of members diagnosed with ADHD by the PCP were being referred to a specialist for further management. Increased awareness about the availability of behavioral health resources (Beacon Health Strategies) may have been a contributing factor.

ADHD

AmeriChoice

Improving Care for Members with Attention Deficit Hyperactive Disorder (ADHD)

1. Project Topic / Rationale / Aims

United HealthCare/AmeriChoice (UHC/AC) participated in a New York State ADHD two-year Collaborative to improve assessment, diagnosis and treatment for children with ADHD.

Studies sponsored by the NYSDOH/Division of Managed Care (DMC) observed gaps in care for children and families with ADHD when comparing actual care with recommendations from the American Academy of Pediatrics. Plan-level objectives included the Healthcare Effectiveness Data and Information Set (HEDIS) measure "Follow-up Care for Children Prescribed ADHD Medication." Practice-level objectives included measurement of:

- The percentage of newly diagnosed patients with DSM-IV criteria addressed.
- The percentage of newly diagnosed patients with a standardized assessment tool.
- The percentage of new and existing patients with a documented treatment plan.
- The percentage of new and existing patients with standardized tools for follow-up.
- Measurement of new and existing patient by mode of ADHD therapy.
- A composite measure for diagnosis and treatment of new patients.

2. Methodology

The ADHD patient target population was derived from two primary care physician practices and included new and existing patients age 6 - 21. A combination of sources was used to identify the sample including medical record and claims data. New ADHD patients were defined by one visit with evidence in the chart of a diagnosis of ADHD. Existing ADHD patients were identified by an ADHD diagnosis code for two or more visits, and/or member prescribed first line ADHD medication, and/or other documentation of provider diagnosis of ADHD.

3. Interventions

Interventions targeted both providers treating children with ADHD as well as their parents and/or caregivers. The following interventions were implemented:

- Dissemination of guidelines for ADHD assessment and treatment.
- Dissemination of National Initiative for Children's Healthcare Quality/American Academy of pediatrics (NICHQ/AAP) standardized tools to facilitate monitoring and treatment plans.
- Implementation of an ADHD Care-manager to assist provider practices and families.
- Sponsoring participant provider education ADHD training conference at the REACH (Resource for Advancing Children's Health) Institute.
- Educational materials and community resource referrals for support groups and training.
- Informational handouts and/or websites for the two practices and their family participants.
- The Plan identified other practices beyond the two participating practices that have large ADHD populations. Based on that information, we provided face-to-face academic detailing between our medical director and key stakeholders at the practice.

4. Results/Conclusions

Between the first and fourth quarters, there were statistically significant increases of new patients who had a parent assessment tool and in the percentage of new patients who utilized the Connors Parent Assessment Tool. Among new patients, 22 percent met all criteria for DSM-IV diagnosis. Ninety-five percent had a treatment plan.

We believe this project was markedly successful in that fourth quarter figures show that participating practices instituted the standardized assessment tools. Increases in recorded goals for home and goals for school within the treatment plans are also indicative of a positive trend.

ADHD

Blue Cross Blue Shield of Western New York

Improving Initial Follow-up Care for Children Newly Prescribed ADHD Medication

1. Project Topic / Rationale / Aims

The purpose of this project is to improve the rate of members (ages 6 - 12 years) newly started on ADHD medications to obtain a follow-up visit within 30 days of the start of medication therapy.

2. Methodology

Indicators to measure the objectives of this study would be an increased compliance of follow-up visits by members newly prescribed ADHD medication as reported in HEDIS measurement year 2007 and 2008. The measure reads as follows:

Follow-up Care for Children Prescribed ADHD Medication:

- Initiation Phase: The percentage of members 6 - 12 years of age with a follow-up visit with a provider with prescribing authority within 30 days of the ADHD medication being dispensed.
- Continuation and Maintenance (C&M) Phase: the percentage of members 6 - 12 years of age, who remained on the ADHD medication for at least 210 days, and had at least two visits in addition to the Initiation Phase visit within 270 days (9 months) after the Initiation Phase ended.

3. Interventions

Within 14 days of the onset of therapy and using the member list of new ADHD prescription fills, the plan will populate a letter template to the prescribing practitioner with information regarding practice recommendations of a face-to-face follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.

Simultaneously with the physician intervention, a letter will be generated to the parent/guardian of the selected member indicating information regarding practice recommendations of a face-to-face follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.

4. Results/Conclusions

Initial follow-up rates for Medicaid enrollees increased from 37.5 percent in 2006 to 40.9 percent in 2008 (3.4 percentage point increase). For CHP enrollees, initial follow-up rates increased from 41.3 percent in 2006 to 51.8 percent in 2008 (10.5 percentage point increase). The continuation and maintenance rates also showed increases between 2006 and 2008 for both Medicaid and CHP enrollees of eight and nine percentage points respectively.

The purpose of the project, to raise awareness of the need for follow-up visit after newly prescribed ADHD medication was met.

ADHD

CDPHP – Capital District Physician Health Plan

Improving the Care of Children with ADHD Final Report

1. Project Topic / Rationale / Aims

CDPHP partnered with United Behavioral Health (UBH) to better understand the challenges of treating ADHD, and to optimize the ways in which CDPHP can best assist its participating providers in achieving desired outcomes.

CDPHP's aims for this project included:

- Increase or optimize access to behavioral health consultation and treatment.
- Improve follow-up rates.
- Increase medication safety by detecting any patterns of unsafe or excessive medication usage, and educate providers accordingly.
- Improve the diagnosis and treatment of ADHD by promoting the use of standardized tools.

2. Methodology

CDPHP used both visit and medication claims data to identify the eligible population, which consisted of both newly diagnosed and existing members with ADHD, ages 6 - 12. Although this project is focused on the Medicaid population, interventions were extended to all members. Additional claims analyses were conducted to determine medication safety and access to behavioral health care, as well as follow-up for children prescribed ADHD medications. Use of standardized tools was measured through medical record review.

3. Interventions

Interventions included development and distribution of an ADHD provider toolkit, pharmacy claims analysis to detect potential safety issues, and member and provider mailings, including both targeted mailings or faxes, and general newsletter articles. The ADHD toolkit included:

- CDPHP's ADHD Guidelines for Primary Care.
- ADHD Screening Criteria.
- ADHD Medication Tip Sheet, including information on maximum recommended doses.
- Tip sheet on accessing clinical services, including the PsychInfo consultative line.
- Information about how to access United Behavioral Health's (UBH) comprehensive website, www.Liveandworkwell.com.
- Listing of UBH Medicaid providers with an interest in ADHD.
- Appointment planners to distribute to patients.

4. Results/Conclusions

Although unable to demonstrate an improvement in the HEDIS/QARR (Quality Assurance Reporting Requirements) rate of follow-up care for children prescribed ADHD medication within the study time frame, CDPHP was successful in increasing access to behavioral health as measured by the rates of children with ADHD receiving treatment from behavioral health practitioners. Usage of standardized tools for diagnosis and treatment of ADHD also increased, as did the percentage of charts that included documentation of at least three DSM-IV indicators for ADHD. Finally, no significant medication safety issues were discovered, although a small percentage of members were being treated with an off-label medication. Preauthorization requirements were initiated to prevent use of this medication in the populations for whom CDPHP controls the pharmacy benefit, and this information was shared with the NYSDOH.

ADHD remains an area where continued improvement in diagnosis and treatment should yield optimized outcomes. CDPHP will continue to work with its medical and behavioral health providers to improve access and coordination of care.

ADHD

HIP Health Plan

Collaborative Initiative to Diagnose and Treat ADHD

1. Project Topic / Rationale / Aims

The goal of this initiative is to improve the care of children, ages 6 - 12, with ADHD in HIP Health Plan. ADHD is defined using HEDIS-modified specifications. Newly diagnosed children and children with an existing diagnosis of ADHD are included in the project.

2. Methodology

The ADHD sample included new and existing patients age 6 - 12. HIP identified members by a prescription of first line ADHD medication using pharmacy utilization data. The indicators for the Plan interventions were the HEDIS measures for Follow-up Care for Children Prescribed ADHD Medication. Baseline measures were determined at the beginning of the project period, followed by re-measurements at the completion of the project.

3. Interventions

The interventions on the Plan level included:

- Establishing a disease management services program that reached out to parents of newly prescribed members.
- Educating parents about ADHD.
- Mailing National Initiative for Children's Healthcare Quality (NICHQ) materials to diagnosing providers.
- Meetings with providers and their staff to educate them about the use of standardized tools.
- Publishing the Resource for Advancing Children's Health Institute (REACH) training on the HIP and GHI health plan websites.

The Interventions on the Practice level included:

- Incorporate the Vanderbilt assessment parent/teacher forms and the Vanderbilt follow-up parent/teacher forms into practice.
- Incorporate the Vanderbilt follow-up parent/teacher forms into Dr. Skoworn's practice and practice workflow.

4. Results/Conclusions

Three of the four HIP HEDIS results, initiation and continuation for the Commercial population as well as continuation for the Medicaid population achieved statistically significant improvement. The only measure that did not was the Initiation phase for the Medicaid population. The main reason for that is the delay in transferring pharmacological data from NYSDOH to the Plan.

On the plan level, HIP was able to rapidly and efficiently institute changes that had an impact on the care that newly-prescribed members receive. The most efficient one was the disease management services program. This program helped improve the HEDIS results and the level of care that the Plan's members receive. HIP is planning to continue the operation of its disease management services program and to expand the use of the Vanderbilt tool in the diagnosis and treatment of ADHD.

ADHD

Hudson Health Plan

ADHD PIP

1. Project Topic / Rationale / Aims

The aim of the Hudson project was to improve the care of children with ADHD. The specific aims of Hudson's projects were to: (1) improve diagnostic precision in identifying ADHD using DSM-IV-TR criteria; (2) improve the HEDIS measure for ADHD follow-up care for children prescribed ADHD medication; and (3) identify the types of clinicians providing care to enrollees with ADHD to foster better care communication among the clinician specialties.

2. Methodology

The ADHD population Hudson identified included patients age 6 - 12 with one or a combination of the following: a) an ADHD diagnosis code for two or more visits, and/or b) member prescribed first line ADHD medication. The initial study design encompassed three time periods: baseline in 2007 (04/01/06 - 03/31/07), mid-intervention in 2008 (04/01/07 - 03/31/08), and post-intervention in 2009 (04/01/08 - 03/31/09). For the analysis of utilization-based study indicators, data was abstracted with these criteria in June 2009. Hudson identified a universe of 344 members who had at least one PCP visit with an ADHD diagnosis.

3. Interventions

Practices with a high prevalence of members with ADHD were offered face-to-face on-site training in ADHD management and all primary care medical groups received an ADHD "toolkit." The intervention employed "academic detailing" by Hudson Health Plan provider relations representatives to distribute a compact disc containing bi-lingual standardized clinical tools and other resources. Beacon Health Strategies, Hudson's delegated behavioral health vendor, collaborated with Hudson in the development of the ADHD "toolkit" and provided clinical staff for the on-site training sessions.

4. Results/Conclusions

DSM-IV Diagnostic Criteria: We reviewed the primary care records of 205 patients with PCP visits for ADHD and found a 68 percent, rate of compliance with the major diagnostic criteria that symptoms/behaviors are problematic in at least two settings. ADHD Medication Management: We did not improve our score for this QARR measure because many mental health agencies do not provide the level of provider identification detail needed to satisfy this measure. Care Coordination: We found evidence of care coordination; among the 205 primary care charts reviewed there were 132 letters from specialists addressing ADHD. Utilization of Services for ADHD: Among identified members, 76 percent had two or more ambulatory visits associated with ADHD care; 53 percent of those identified with ADHD in this project filled a prescription for ADHD medication, 24 percent of those with a prescription had fewer than two visits.

Hudson successfully distributed clinical tools for the management of pediatric ADHD to network primary care physicians and, with Beacon Health Strategies, provided on-site clinician training in the management of ADHD to six offices with a concentration of Hudson members. Most ADHD visits occur with social workers who do not have prescriptive authority. Working with our behavioral health vendor, we hope to hold behavioral health agencies accountable for ensuring that their ADHD clients are appropriately monitored.

ADHD

MVP Health Plan

Improving Diagnosis and Treatment of ADHD

1. Project Topic / Rationale / Aims

This project included multiple interventions to improve ADHD care, consistent with current evidence and established guidelines. The aim of the project was to improve the care of children with ADHD through a learning collaborative of health plans, with interventions designed to improve the diagnosis and management of ADHD consistent with clinical practice guidelines. MVP partnered with two pediatric practices in the Mid-Hudson region to encourage the consistent use of appropriate standardized tools and protocols in the assessment and management of children with ADHD.

2. Methodology

The ADHD patient target population proposed for the collaborative practice participants included new and existing patients, and those prescribed first line ADHD medications. Children with ADHD along with psychiatric co-morbidities were not excluded. MVP included patients ages 6 - 20 who are enrolled in MVP Care. Selection for chart review measures was based on administrative data. Existing ADHD patients were identified by ADHD diagnosis code for two or more visits, and/or prescription of first line ADHD medication. New ADHD patients were defined by one visit with evidence in the chart of provider. Chart review measures were collected quarterly for one year, from July 2007 through June 2008.

3. Interventions

- ADHD information distributed via member newsletter 'Health Talk.'
- Links to updated ADHD guidelines and NICHQ Toolkits are included in MVP's Quality Improvement Tool Kit for practitioners.
- Participating provider-developed screening and monitoring documentation tools were submitted for NYSDOH/IPRO and Dr. Peter Jensen's review and suggestions.
- MVP reviewer detailed ADHD documentation tools and reviewed relevant data with office staff during quarterly visits for chart reviews.
- MVP encouraged physician participation in REACH Institute mini-fellowship, June 2008 and provided stipends for two participating physicians to attend.
- MVP staff participated in ADHD education webcast: *Improving ADHD Outcomes - Recommendations for Managed Care*.

4. Results/Conclusions

HEDIS/QARR measures for ADHD medication follow-up care increased significantly for initiation phase among Medicaid managed care members from 2006 to 2007 (33.3 percent to 60.0 percent), and decreased in 2008 (to 36.1 percent). Denominators for continuation/maintenance phase for Medicaid members, and both phases for CHP members, were too small to analyze or report. An increase was seen in the use of standardized follow-up tools over the measurement period and members reviewed were followed with a comprehensive, provider-developed documentation tool.

No significant opportunities for improvement were identified based on chart review baseline measures. The pediatric practices that participated in this collaborative expressed special interest in ADHD, and had developed their own comprehensive tools for documenting and monitoring these patients.

Cancer Screening

Health Plus

A Randomized Controlled Trial to Increase Colon Cancer Screening in Medicaid Managed Care/New York Prevention Care Manager (PCM) Project 2

1. Project Topic / Rationale / Aims

Health Plus was one of three New York City (NYC) health plans participating in this project. The Clinical Directors Network (CDN), a practice-based research network in New York City, served as the intermediary organization for this translation project, providing training to Health Plus staff. Eleven Community Health Centers with a sufficient number of potentially eligible Health Plus enrollees and previous research experience were selected to participate.

The objective of this project was to promote colorectal cancer screenings in women in the context of other indicated screenings for breast and cervical cancer. Colorectal cancer screening rates lag behind screening rates for breast and cervical cancer, especially for ethnic minorities and individuals with low socioeconomic status.

2. Methodology

The eligible population was women, identified through Health Plus's database, aged 50 to 64 years, who received care at one of eleven Community Health Centers, had been enrolled with Health Plus for at least twelve months and were overdue for colorectal cancer screening. Health Plus identified 1,238 potentially eligible members; 751 members who were randomized into the study; 188 were assigned to the PCM intervention arm; and the remaining 563 were assigned to receive usual care.

3. Interventions

The randomized controlled trial (RCT) was launched on January 30, 2009. All 188 patients who were randomized to the Prevention Care Manager arm of the study were mailed a Provider Recommendation letter from the medical director of their primary care site indicating if the member was overdue for colorectal, breast and/or cervical cancer screening tests. On January 12, 2009, the Health Plus Care Managers began telephone outreach. Following the initial call, all members who were still due for colorectal screening were mailed a patient activation card and patient educational materials on colorectal cancer screening. The Health Plus Care Manager conducted a series of up to three subsequent calls to provide support and assistance in helping the member to get up to date on their screenings. Care managers also scheduled appointments and provided accurate information about screenings over the telephone and by mail.

4. Results/Conclusions

During the period of February 12, 2009 – May 29, 2009, a total of 548 telephone contact attempts were made. Database checks were performed prior to each call attempt and a total of 17 members were excluded from the study. At the initial call, twenty women (27 percent) reported that they were up-to-date on colorectal cancer screening. Of the 20 women who reported being up to date on colorectal cancer screening, 18 had received a colonoscopy within the past ten years, and two had completed a Home Fecal Occult Blood Test kit in the previous 12 months. Five (7 percent) members reported having a GI consult scheduled. As of this report 21 (29 percent) of the 73 women in the RCT were brought up to date for colorectal screening.

In summary, the Prevention Care Manager and Patient Navigation program provided a unique approach to increasing cancer screenings among minorities and low income women. The results presented for the randomized controlled trial represents only 5 months of the 18 months that the program will continue to run.

Cancer Screening

MetroPlus

Use of Care Management to Improve Colorectal Cancer (CRC) Screening Rates in Female Medicaid/FHP Enrollees

1. Project Topic / Rationale / Aims

Colorectal cancer (CRC) screening was not routinely measured and monitored by the plan and based on an initial data run, the rates were low especially compared to other cancer screening rates for the same population. An opportunity existed for MetroPlus to improve access to screening in this area while also promoting screening for breast and cervical cancer.

This study evaluated whether different care models led to higher CRC screening rates. The goal was to provide different levels of support to the sample population and assess which level of support maximizes CRC screening.

2. Methodology

The CRC screening measure included women aged 50 to 64 years enrolled in Medicaid managed care and Family Health Plus who were continuously enrolled for more than 12 months. Participants also had to be non-compliant for CRC screening based on claims data. This cohort received a letter encouraging them to visit their primary care provider and discuss getting a colon cancer test along with informational materials about colon cancer screening.

3. Interventions

The interventions were executed within four study arms:

- Prevention Care Management (PCM): Scripted telephone-based case management support was provided to facilitate an appointment for a CRC screen.
- Patient Navigators (PN): The goal of the program is to increase colonoscopies through case management and outreach.
- Prevention Care Management and Patient Navigator: A combination of both telephonic and face-to-face support was provided to members in this group.
- Primary Care Provider (PCP) Engagement: This group is considered our control group because it represents the usual and customary process we would follow to help facilitate a CRC test for non-compliant women.

4. Results/Conclusions

Looking strictly at the screening rates across the four intervention arms, the results were as follows:

- PCM Engagement (N = 87): 52 percent
- PN Engagement (N = 249): 42 percent
- PCM/PN Engagement (N = 8): 38 percent
- PCP Engagement (N = 14,175): 25 percent

Based on the results to date, the likelihood of getting a CRC test is lower for the PCP Engagement Group versus the PCM Group and PN Group. The same is true when the PCP Engagement Group was considered against the PCM Group, and when the PCP Engagement Group was considered against the PN Group. When reviewing the likelihood of getting a CRC test between the PCM Group and the PN Group, there was no statistical significance in the likelihood of getting a CRC test. The project has provided valuable insight into the CRC screening process and the measures that need to be taken in order for women enrolled in a Medicaid managed care plan to get the screening.

Child Health

Broome Max

Increasing Lead Screening Rates for Medicaid Children Up to Age Two

1. Project Topic / Rationale / Aims

Lead poisoning is the leading preventable environmental health threat to children in New York State. Exposure to lead can cause impairments in memory, abstract thinking, attention and fine motor skills, as well as behavioral changes, and speech and hearing issues. Children residing in Broome County are at a high risk for lead poisoning because about eight of every ten houses or apartments were built before 1980, most in an era when lead based paint was the standard for window frames, doors and baseboards.

The goal of our study was to raise the percentage of members screened for lead by age two from 22 percent to 33 percent.

2. Methodology

HEDIS 2008 specifications were used to calculate the 2007 lead screening rate and to identify 100 percent of children in the Medicaid fee-for-service Broome MAX Managed Care Program turning two years of age during the measurement year and continuously enrolled in the plan at least 12 months, with no more than a one-month gap in coverage. HEDIS 2009 specifications were used to calculate the 2008 lead screening rate. The rates were calculated using hybrid methodology. Data was collected by medical records and claims reviews.

3. Interventions

Our interventions were targeted at both providers and parents/guardians of children in the project.

Informational letters were mailed to all pediatric and family practice providers in the plan. After each medical record review, providers were contacted by phone, fax or letter for follow-up on children due or overdue for lead screening.

Informational letters and NYSDOH educational materials were mailed to parents/guardians. Follow-up letters or reminder cards were mailed to parents/guardians whose children had not been screened or had failed to follow through with screening referrals, and one week later, follow-up phone calls were conducted in order to educate, answer questions, address concerns and to stress the importance of lead screening. Parents/guardians were assisted with obtaining transportation to appointments and/or screening on an as needed basis.

4. Results/Conclusions

We surpassed our goal of 33 percent by achieving a lead screening rate of 62 percent.

We believe that informing providers that children are still at risk for lead poisoning, despite having lower lab values or few risk factors, was beneficial in helping to increase referrals for lead screening.

The most valuable intervention, however, was the follow-up phone calls to parents/guardians one week after mailing letters or reminder cards. Only ten parents/guardians called during the entire study in response to our letters or reminder cards. By conducting one-week follow-up phone calls, we were able to educate parents/guardians about lead screening, many of whom would not have received the information because of change of address or illiteracy.

We are proposing that one-week follow-up phone calls to parents/guardians become a permanent intervention as part of our quarterly chart audits and reminder card mailings.

Child Health

Southern Tier Pediatrics Health Plan

Improve Lead Testing/Screening Rates

1. Project Topic / Rationale / Aims

Chemung County has historically had one of the lowest rates of lead (Pb) testing for one and two year old children in the state. Southern Tier Pediatrics (STP) was approached by the Chemung County Health Department to participate in a grant, which would attempt to increase the percentage of children in the county who are successfully screened for lead toxicity.

The goal for improvement is lead screening-testing rates will improve to 85 percent or above.

2. Methodology

STP providers began universal Pb screening on all children starting in the Elmira office May 1, 2008. The goal was to have all children have at least one Pb level obtained between 9 and 12 months of age. A second level was to be obtained around 2 years of age. Since many children between 12 and 23 months of age had had no successful Pb screening done prior to the initiation of this study, these children also had a Pb level obtained (a “catch up” Pb level). Elevated Pb results were determined to be ≥ 8 mg/dl.

3. Interventions

Patients with elevated fingerstick Pb levels were sent to have venipuncture Pb levels for confirmation. All Pb screening information was shared with the Chemung County Health Department. The review, of STP Pb testing / screening results, included patients seen for well child care visits from May 1, 2008, through December 31, 2008.

4. Results/Conclusions

Elevated Leads – Overview of results:

Total patients tested for Pb in STP offices = 1,113.

- No elevated leads detected out of Horseheads office.
- Elevated fingerstick Pbs, confirmed by venous sample = 16.
- Elevated fingerstick Pbs, unconfirmed by venous sample = 7.
- Confirmed elevated Pb patients = $16 / 1113 = 1.5$ percent.
- Total “possible” elevated Pb patients = $23 / 1113 = 2.1$ percent.

All elevated samples obtained on STP patients were less than 40 ug/dl. However, the large acceptable range of error ± 6 ug/dl would seem to easily account for the false positive rate. Since this test was designed for mass screening, a high false positive rate is therefore expected performing Pb screening with this equipment.

Just a review of raw numbers alone demonstrates how more effective STP providers were at obtaining Pb levels on their patients by performing Pb testing at their office sites. Over the study period over 1100 Pb patient levels were obtained at STP offices. If the ultimate goal is to increase Pb testing rates, STP has certainly accomplished this via the Lead Care II in office testing equipment.

Child Health

Total Care

Adolescent Well Care

1. Project Topic / Rationale / Aims

Over the past four years, Total Care's rate for Adolescent Well Care has remained at or below the statewide average. Because the adolescent population comprises 30 percent of the total membership, there is a significant opportunity to impact QARR rates while providing improved quality of care.

Our goal was to increase the rate that Total Care members age 12 - 21 visit their Primary Care Provider for an annual well child visit to the statewide average.

2. Methodology

The target population was members ages 12 - 21 years who received primary care at three high volume provider groups. Data collection method was hybrid using the HEDIS 2008/QARR 2007 specifications for the Adolescent Well Care measure. The entire population of eligible members at the three provider groups was followed.

The performance indicators were measured using the HEDIS 2008/QARR 2007 specifications for the Adolescent Well Care measure. The methodology differed from the baseline because the HEDIS 2007/QARR 2006 specifications utilized administrative data and the current HEDIS/QARR specs allow hybrid methodology. These results showed the percentage of members who received expected services in 2007. Interim measurement occurred in July 2008 and re-measurement occurred in January 2009.

3. Interventions

- Reminder mailing to PCPs of members not meeting criteria for 2007.
- Mailing to all PCPs of members who had not received a well child visit.
- Article in provider newsletter referencing Adolescent Care guidelines.
- Telephone calls every one to two months to Office/Nurse Manager at each Practice Site to check on the progress of the project.
- Targeted mailing sent to members.
- Assistance offered in making appointments and obtaining transportation, etc.
- Mailing to members who had not received a well child visit in 2008.
- Article in member newsletter included what a teen should expect during their well visit and offered a tip to schedule their annual visit around the time of their birthday.

4. Results/Conclusions

The eligible populations at the three provider sites varied. The goal of Statewide Average – 58 percent, was not met for Sites 1 and 2, but was met for Site 3.

- Site 1 eligible - population 1778 – 44 percent;
- Site 2 eligible - population 373 – 35 percent; and
- Site 3 eligible - population 344 – 58 percent.

We learned through this project that collaboration and outreach by the provider site together with the plan is important and necessary for success. More focus should have been placed on close interaction with the member population to obtain more favorable results. Interventions continue on this topic as part of Total Care's Quality Improvement Program.

Child Health

Univera Community Health

Improving the Testing Rate for Children Being Treated for Pharyngitis

1. Project Topic / Rationale / Aims

Univera Community Health (UCH) addressed the utilization of throat cultures to establish a diagnosis of streptococcal infection (pharyngitis) prior to the prescribing of an antibiotic for sore throat. The plan rate of 61 percent fell below statewide average and the 75th percentile.

The objective of this initiative was to provide outreach to the outlier physicians and facilities who appear non-compliant with performing a test for group A streptococcus when an antibiotic is prescribed to a child with a diagnosis of pharyngitis. The goal for this initiative was to improve the testing rate to 67 percent.

2. Methodology

The Medicaid managed care population was identified using HEDIS administrative criteria, including all eligible children 2 - 18 years in the measurement year, who were enrolled 30 days prior to, through three days after, the episode date. The episode is an outpatient or Emergency Department (ED) visit with only a diagnosis of pharyngitis and a dispensed antibiotic within three days after episode date. The numerator event is the performance of a group A streptococcus test in the seven-day period from three days prior to and three days after, the index episode start date. The description is the percentage of children 2 - 18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus test. The baseline period was July 1, 2005, to June 30, 2006, and the re-measurement period was July 1, 2007, to June 30, 2008.

3. Interventions

UCH engaged in clinical outreach through mail and personal contact with practitioners and facilities that were identified as non-compliant, advising them of evidence of treatment principles and/or appropriate billing practices for children presenting with pharyngitis.

4. Results/Conclusions

The performance goal of exceeding 67 percent was met. Of the 467 eligible members per HEDIS criteria, 342 children who were diagnosed with pharyngitis and received an antibiotic also had a throat culture performed, for a final rate of 73 percent. Additionally, 83 percent of physicians who received a targeted mailing concerning appropriate coding for throat cultures adopted the more appropriate code, and 71 percent of physicians who received a targeted mailing regarding treatment principles (performing throat cultures for children presenting with sore throat before dispensing antibiotic) who diagnosed pharyngitis and prescribed an antibiotic in the seven month post-intervention measurement timeframe began testing for 100 percent of their patients.

The project objectives were met. An evaluation of a full 12 months of data for the post-intervention period may provide further support that targeted outreach to outlier physicians addressing the specific barrier to care that they encounter is an effective methodology to implement change. Evaluation of the full 12 months of data may also identify physicians who did not adopt the recommendations for coding and/or service.

Depression

Independent Health Association

Depression Disease Management Initiative

1. Project Topic / Rationale / Aims

Major depressive disorder is the leading cause of disability in the U.S. and affects about 6.7 percent or 14.8 million American adults in a given year. Depression causes people to lose pleasure from daily life, can complicate other medical conditions and can even be serious enough to lead to suicide. Unfortunately, though treatment for depression is almost always successful, fewer than half of those suffering from this illness seek treatment. In addition, depression is under diagnosed in the primary care office, where the depressed person is likely to present in connection with other health care concerns.

The goal for Independent Health is to build a comprehensive depression management program based upon Evidence Based clinical guidelines and the Depression Risk Stratification Pyramid which outlines a process by which Independent Health attempts to intervene at the earliest opportunity on behalf of members with depression.

2. Methodology

Identify the percentage of members with a diagnosis of major depression, who remained on antidepressant medication for 84 days and then continuously for 180 days, and to identify the percentage of members who were hospitalized for treatment of selected mental health disorders who had a follow-up visit within 7 and 30 days after discharge with a mental health practitioner. Independent Health Association (IHA) plans to track results from 2006 baseline measurement to 2008 re-measurement period.

3. Interventions

Interventions are provided to members and providers along a continuum of care based upon identified risk levels - Level 1 Risk (Low), Level 2 Risk (Medium) and Level 3 Risk (High).

Member Interventions: Print materials (newsletters, personalized letters, educational materials); electronic communication (website with membership information, claim status, wellness programs, disease specific information); telephonic case management (outreach and a 24 hour Help Line); coordination of care home visits (for members following hospital discharge and those unable to be reached by telephone).

Provider Interventions: Print materials (newsletter, episode registry, personalized letters); electronic communication (clinical practice guidelines, educational materials and office tools); telephonic (Fax and telephone outreach); collaborative programs (educational tool kits and antidepressant medication treatment packets and a Behavioral Health Clinical Advisory Group).

4. Results/Conclusions

From 2006 to 2008, the Antidepressant Medication Management and Follow-up after Hospitalization for Mental Illness did not result in measurable improvement. The Antidepressant Medication Management Acute Phase measure showed a decrease from 50.8 percent to 49.0 percent while the Continuation Phase measure showed an increase (33.5 percent to 35.1 percent). The Follow-up after Hospitalization for Mental Illness measures showed a statistically significant decrease for both the 7 Day Follow-up (66.2 percent to 46.5 percent) and 30 Day Follow-up (75.9 percent to 59.4 percent).

Problems accessing pharmacy data were encountered which impacted our ability to build a registry for MediSource members with new depression index episodes. Any value our program initiatives had to offer could not be realized without targeting the right members. During 2008 Independent Health implemented many internal system changes in order to improve its approach to members and providers, including the use of an external vendor to report HEDIS rates.

Depression

Neighborhood Health Plan

Depression Screening in Adolescents

1. Project Topic / Rationale / Aims

Neighborhood Health Providers (NHP) conducted a study on Depression Screening in Adolescents ages 14 -18 years old and found from the 2006 QARR results that the number of adolescents screened for depression was very low (28 percent).

This study was conducted to find out if providers are properly screening adolescents for depression as a preventive measure and documenting screening in the medical records.

2. Methodology

The Plan set up an 18 month timeframe for this study, which was as follows:

- January 2008 – June 2008, encounter data collection.
- July 2008 – December 2008, Intervention to educate PCPs and members regarding the importance of screening for depression in adolescents.
- January 2009 – June 2009, 2008 medical record review and comparison of results after interventions.

3. Interventions

- Personal letters were sent to providers who had no documentation of depression screening in the 2006 QARR Medical Record, and a depression screening tool was attached to explain the process of screening for depression.
- Articles in member and provider newsletters.
- Depression screening tool was placed on Neighborhood Health Provider website and in the provider manual.

4. Results/Conclusions

Once interventions were implemented we saw a score for depression screening of 68.7 percent. During our 2008 medical record review we found that:

- 17.6 percent of the charts had documentation of depression screening in the members' medical record with PHQ 9 Tool.
- 51.1 percent of the charts had documentation of depression screening in the members' medical record without PHQ 9 Tool.
- 31.3 percent of the charts had no documentation of depression screening in the members' medical record or PHQ 9 Tool.

The Plan can conclude that after interventions and educational materials were sent to the providers we saw a major increase of documentation of depression screening in the medical records. A total of 68.7 percent of medical records had documentation of depression screening after interventions.

Diabetes/Chronic Disease

AMERIGROUP

Improving Diabetes Management

1. Project Topic / Rationale / Aims

In 2007, AMERIGROUP Community Care reported 85 percent of diabetics had at least one HbA1c testing and 43 percent of diabetics were poorly controlled. LDL-C screening rate of 86 percent showed 39 percent of diabetics with LDL-C <100.

The goal of this project was to improve comprehensive diabetes care for members by improving rates in the four measures listed below:

- Increase HbA1c rate from 85 percent in 2007 to 90 percent in 2008.
- Decrease HbA1c Poor Control rate by 5 points from 43 percent in 2007 to 38 percent in 2008.
- Increase LDL-C rate from 86 percent in 2007 to 90 percent in 2008.
- Increase LDL-C <100 rate by 5 points from 39 percent in 2007 to 44 percent in 2008

2. Methodology

Using the 2008 HEDIS specifications for comprehensive diabetic care, the eligible population was identified to include diabetic members between the ages of 18 and 75 years of age. Outcomes were determined based upon a comparison between 2008 HEDIS rates and 2009 HEDIS re-measurement rates.

3. Interventions

- Develop a Diabetes Registry to track outreach and self management education activities aimed to improve the health status of our diabetic population.
- Conduct telephonic and mail outreach to members who have an HbA1c or LDL-C testing or are poorly controlled and offer assistance with scheduling an appointment with their provider for diabetic care.
- Refer high risk members to the Plan's Case Management program.
- Utilize Self-Management Education materials developed by the NYC DOHMH and make available as a tool kit.
- Approve and disseminate clinical guidelines to providers and add to the provider website.
- Distribute a list to providers of members who have not had an HbA1c or LDL-C test.
- Mail an "unable to contact you" letter to all members who were not reached by telephone.

4. Results/Conclusions

For the targeted population, a total of 79 percent received either telephonic or mail education on diabetes, and assistance was offered with scheduling an appointment with their provider for diabetic care. Based on administrative data the rate of HbA1c increased from 71 percent to 82 percent and the rate of LDL-C increased from 72 percent to 83 percent.

The case management portion of this study allowed the opportunity to understand the diabetic members' needs from their own perspective. There was clearly an overwhelming need for education and 88 percent of members were receptive to it. AMERIGROUP concluded that members' perceptions of their disease can greatly impact their level of compliance. Assistance with promoting and developing self monitoring skills can help members change their perception and take charge of their disease.

Diabetes/Chronic Disease

Fidelis Care New York

Diabetes Care Management Program to Increase Rates of HbA1C Testing and LDL-C Testing

1. Project Topic / Rationale / Aims

The overall goal of the study was to assure that members and providers have the tools needed to evaluate diabetic control. This goal is in line with the company's mission "To promote health through quality, accessible care and service for all".

The primary objective of the study was to increase the 2008 HbA1c and LDL-C testing rates, to be at or above statewide averages. The study also attempted to demonstrate a correlation between the intensive Case Management (CM) interventions targeting education of members and providers and improvement in testing rates.

2. Methodology

The study included the entire adult population ages 18-75 (6,499) with diabetes, who had been members of the plan for at least 11 of the last 12 months before the start of the study. The baseline data was determined using the plan's QARR rates for 2006 and compared to re-measurement year 2008. The final study total (n= 6,451) included the total number of members who met the HEDIS criteria for continuous enrollment. The numerators and denominators were based on HEDIS® 2008/09 specifications. Members who received screening were determined by lab and provider claims.

3. Interventions

The primary intervention goal was to speak to all diabetic members to discuss diabetic management and to assess for HbA1c and LDL-C testing. Other CM contacts included calls to the member's primary care physician, requests for labs, arrangements and coordination of services. If testing had not been performed, Case Management nurses addressed the rationale, benefits, and recommendations. This was followed with mailing of diabetes information, including a comprehensive newsletter. Report cards were made available to providers to inform them of members missing diabetic tests. A generous incentive was offered to providers through the Quality Care Management Incentive Program (QCMI) to assure that appropriate testing was completed. Visits were made to provider's offices to discuss the advantages of outreach, providing quality care for diabetes, and how providers could benefit from the QCMI program.

4. Results/Conclusions

The study results showed improvement in HbA1c and LDL-C testing rates from 2006 to 2008. HbA1c showed a 4.8 percentage point improvement from 2006 to 2008, compared to a 1.0 percentage point improvement in the SWA from the prior year. For LDL-C, there was an improvement of 3.7 percentage points, compared to a zero percentage point change in the SWA from the prior year. Although it is not possible to attribute improvement in rates solely to Case Management Interventions, the improvements for both LDL-C and HbA1c tests were significant at 95 percent confidence interval (CI) in a z-test for proportion.

The study showed statistically significant improvement in HbA1c and LDL-C testing rates and showed a correlation between Diabetes Case Management and improvements noted in testing rates of HbA1c and LDL-C, however the original goal of improving rates to meet or exceed the SWA could not be evaluated due to the rotation of the measure. Fidelis will continue its efforts to improve the testing rates throughout 2009 and beyond.

Diabetes/Chronic Disease

Gold Choice

Improving Chronic Kidney Disease in Primary Care Offices: Translating Evidence into Practice

1. Project Topic / Rationale / Aims

The prevalence of Chronic Kidney Disease (CKD) is increasing in the United States. A preliminary study shows marked under-diagnosis of CKD and its complications but improvements are possible. Gold choice has implemented a relatively simple program in an effort to enforce guidelines and to demonstrate noticeable improvements in care.

The overriding goal of this project was to improve physician recognition of CKD and reduce the risk of related complications. The overall aim was to enhance CKD maintenance and diagnosis.

2. Methodology

The target population was Gold Choice members diagnosed with diabetes, hypertension and/or CKD within the last year because diabetes and hypertension are the two main causes of kidney disease. Encounter data was used to determine diagnoses and to systematically sample all of its members with the three chronic conditions. Based on data and preliminary research studies approximately 15 percent were expected to have CKD, which would yield a sample of 188 members.

3. Interventions

Gold Choice used a Physician Self Assessment (PSA) to identify members with CKD. The PSA contained questions related to the screening and lab for indicated and contraindicated medications, and hemoglobin and anemia indicators. A Point of Care tool, medication performance indicators and educational materials were distributed to providers.

4. Results/Conclusions

Based on final results, there were twenty-nine new CKD diagnoses from 2007 to 2008. The final results also indicate an increase in hemoglobin being reported in the patients' charts. The number of patients with an anemia diagnosis increased and the number of CKD patients on medication adherence remained constant throughout the duration of the project.

The use of a PSA and Point of Care guide are relatively useful tools to increase a physicians' knowledge of CKD. Gold Choice's results do not indicate an increase in provider adherence to evidence-based guidelines.

Diabetes/Chronic Disease

Preferred Care and Excellus Health Plan, Inc Rochester

Diabetes - An Assessment of the Rochester Regional Quality Improvement (RQI)

1. Project Topic / Rationale / Aims

In 2006 the Center for Health Care Strategies (CHCS) provided grants to four multi-stakeholder alliances around the country to improve care for people with chronic conditions through partnerships with other health care leaders. Rochester, New York was selected as one of the RQI sites, with the lead organization being the Monroe Plan for Medical Care, a non-profit health care management organization providing services to low income and working poor families. The objective of this initiative was to improve primary care for persons with diabetes in the Rochester area.

2. Methodology

Data for this study were obtained through several collection activities. Two investigators charged with the formal evaluation of the national RQI initiative conducted semi-structured key informant interviews with 16 members of the Rochester RQI leadership team and staff during the planning stages of the intervention. The objective of these interviews was to assess the rationale for the project and better understand the organizational structure and details of the planned interventions. The investigators also reviewed RQI documents, attended several key RQI meetings and participated in quarterly progress telephone calls. They also conducted interviews with practice managers and/or QI specialists employed by the eight participating practice groups at the conclusion of the initiative to obtain their perspectives on the process.

3. Interventions

The Rochester RQI endeavored to stimulate improvements in diabetes care through an intervention consisting of three components. The first component was the provision of incentives to selected local primary care physicians to encourage participation in the National Committee for Quality Assurance's (NCQA's) Diabetes Physician Recognition Program (DPRP). The second component of the intervention was the provision of consulting services to assist participants in planning and implementing QI activities and completing the DPRP application process. The final component of the intervention was the development of a multi-plan, diabetes registry report that was forwarded to physicians participating in the DPRP.

4. Results/Conclusions

The participants represented a wide range of practice structures ranging from a solo practitioner to a large multi-site group affiliated with a health system. In the first round, 42 physicians representing seven practices participated with 12 (28.6 percent) achieving DPRP recognition. The second round had 67 physicians from six practices comprised of 30 physicians who failed to achieve recognition in the first round, 34 additional physicians from a practice that had 3 members who successfully participated in the first round on a trial basis, and 1 physician from a newly enrolled practice. At the end of the initiative, there were a total of 79 participants representing eight practices, with 37 (47 percent) receiving recognition. Practices that achieved recognition had scores ranging from 75 to 90, whereas practices that did not pass had scores ranging from 35 to 70.

One of the side benefits of participating in the DPRP process was recognition by the practices of the value of having good clinical data, both at the practice level and at the point of service. Physician practices with an electronic medical record (EMR) and no registry recognized the utility of having a good registry. Conversely, practices with a registry created by abstracting paper records, recognized the value of an EMR. The Rochester RQI experience suggests that from the perspectives of patient attribution, data timeliness and accuracy and physician access to clinical data, adoption of EMRs and registries by practices is more likely to facilitate improvement efforts than provision of data by third parties.

New Enrollee Orientation

Southern Tier Priority Healthcare

Improve Completion Rate of New Enrollee Orientation

1. Project Topic / Rationale / Aims

Southern Tier Priority Healthcare seeks to increase the Plan's and Primary Care Provider's knowledge of new enrollees' current information by completion of the new enrollee orientation, thereby increasing the ability to identify and assist enrollees with special healthcare needs.

This project also seeks to increase Plan Members' knowledge of Plan benefits and their rights and responsibilities thereby decreasing plan members' missed appointments and inappropriate ER visits.

2. Methodology

This study focused on all new enrollees into the plan. New member orientation completion rates will be compared from 2007 (baseline) to completion rates after the intervention in 2008.

3. Interventions

The interventions for this study include sending all new enrollees on their plan member benefit card a label asking to call our toll free number to verify information we received from the state. The plan will continue to attempt phone calls to plan members.

4. Results/Conclusions

2007

- New enrollees – 2,255.
- New member orientation - completed via telephone with 571 of new enrollees (25 percent).
- ER usage - 171 appropriate and 107 inappropriate visits (12 percent).
- Missed appointments - 122 (5 percent).
- Completed Health Assessments - 949 (42 percent).

2008

- New enrollees – 1,833.
- New member orientation - completed via telephone with 1,211 new enrollees (66 percent).
- ER usage - 251 appropriate and 112 inappropriate (20 percent total).
- Missed appointments - 331 (18 percent).
- Completed Health Assessments - 748 (41 percent).

Our main objective, to increase new member orientation by 20 percent was met. The results for new member orientation completed increased from 25 percent in 2007 to 66 percent in 2008. The proportion of missed appointments and ER visits did not decrease and the rate of completed of Health Assessments did not increase. There is still a large portion of the population that STPH is unable to contact via telephone who did not contact STPH after receiving their ID card with sticker. STPH feels that new member orientation remains beneficial in updating members' information, discussing plan benefits and members' rights and responsibilities.

Satisfaction

HealthFirst

Improving Health Plan CAHPS Scores on Targeted Composites and Questions

1. Project Topic / Rationale / Aims

Improving member satisfaction is one of HealthFirst's overall organizational goals because Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) is the gold standard by which member satisfaction is measured. It is also the primary tool used to gather data and analyze patterns of strengths and weaknesses in order to design and implement action plans that can be sustained by the organization over time to measure success or identify areas for improvement.

This study aims to improve CAHPS performance on selected composites and questions, obtain detailed information to identify factors that affect level of satisfaction and use the survey as a tool to identify opportunities for quality improvement.

2. Methodology

A baseline sample of 4,500 members, one adult per household, was chosen and members were randomly selected to participate. Study indicators consist of the following CAHPS targeted composites/questions and Healthfirst's supplemental questions:

- Customer Service.
- Getting Care Quickly.
- Getting Needed Care.
- Courtesy, Respect and Helpfulness of Office Staff.

There was a Baseline measurement period: 2005, Interim re-measurement: 2007 and Final re-measurement: 2009.

3. Interventions

A workgroup was created composed of staff members from Claims, Member Services, Network Management, Product Management, Quality Improvement, Appeals and Grievances to be facilitated by Project Management. The workgroup facilitated the development of "drill down" questions on selected composites to obtain additional information and coordinated the implementation of interventions for each of the departments involved.

The CAHPS 3.0, survey with HealthFirst supplemental questions was mailed to 9,000 members; 4,500 in the first quarter of 2007 and 4,500 in the first quarter of 2009. There were 992 respondents (22 percent response rate) in 2007 and 1034 respondents (23 percent response rate) in 2009.

4. Results/Conclusions

The results of this study indicated that HealthFirst PHSP demonstrated improvement in the score for one of the composite measures: Courteous and Helpful Office Staff. HealthFirst will continue to focus on strategies or revise interventions to bring the result of all the composites to a higher performance rate. In addition, it will continue to collaborate with its network providers to improve composites that are mainly provider level related functions.

Women's Health

GHI HMO

Postpartum Care in the GHI HMO Medicaid/FHP HMO Population

1. Project Topic / Rationale / Aims

GHI HMO's childbearing membership is increasing as evidenced by the increasing number of deliveries. Excellent postpartum care is necessary to help ensure that women address any difficulties as a result of the delivery and any additional post-delivery needs. The visit, no later than eight weeks post delivery, should include assessment of maternal and infant needs including medical, nutritional, psychosocial and alcohol and drug treatment. The Medicaid postpartum care HEDIS rate in 2006 was 65 percent; five percentage points lower than the 2006 New York State average of 70 percent and two percentage points lower than the plan's previous year results of 67 percent.

The goal of the postpartum care project was to increase compliance with timely postpartum care among GHI HMO members. The objective of this project was to improve the GHI HMO HEDIS® postpartum care baseline rate from 65 percent in 2006 to an interim rate of 70 percent in 2007 and a final rate of 74 percent in 2008.

2. Methodology

HEDIS® 2007 / QARR 2006 methodology was used to establish the baseline measurement and to determine the interim and final rate. The percentage of women delivering a live birth during the measurement year who had a postpartum visit between 21-56 days following delivery is measured to determine timely postpartum care. The hybrid methodology for data collection was used and the procedures and results were audited by an NCQA accredited HEDIS® auditor.

3. Interventions

- Soundcare – An audio program promoting health issues was broadcasted when members were placed on hold during telephone calls made to the plan.
- Provider Incentive Program – The Obstetrics/Gynecology (OB/GYN) providers were offered an incentive based upon compliance with the Prenatal Care Assistance Program (PCAP) standards.
- Member Newsletters – Healthy pregnancy care and postpartum depression articles were included in member newsletters.
- Member Incentives – A member incentive program was implemented to award each member for a postpartum visit received within the prescribed timeframe.
- Member Mailed Reminders – Three mailings were sent to members post delivery explaining the importance of infant and maternity care, and a timely postpartum visit.
- Member Access to Web Information – Members had access to GHI's website which contained information about prenatal and postpartum care.
- Calls to Provider Offices – Calls were made to office managers in provider offices when a response to a medical record request was not received.

4. Results/Conclusions

GHI HMO achieved an interim rate of 72 percent in 2007, surpassing the goal of 70 percent. A final rate of 64.96 percent was reported for 2008; nine percentage points lower than the established goal of 74 percent.

Although the interim goal was surpassed, the final goal was not achieved. The success of this project was impacted by two major project findings: 1) Members continue to have postpartum visits outside the HEDIS guideline parameters. Forty-four members had a visit either before 21 days or after 56 days, and 2). The member incentive program was significantly modified in 2008 resulting in lower member participation. Future plans to improve the postpartum visit rate include steps to enhance member education and to refine medical record data collection methodologies.

Women's Health

WellCare of New York, Inc.

Chlamydia Screening in Sexually Active Women Aged 16 – 25, Enrolled in WellCare of NY, Inc. Medicaid/FHP

1. Project Topic / Rationale / Aims

Chlamydia is the most commonly reported bacterial sexually transmitted infection nationwide and in New York City. Up to 96 percent of cases are asymptomatic and can go undetected. Because some people with Chlamydia infection have no symptoms and do not know that they have an infection, screening healthy people for Chlamydia might identify some in whom treatment could prevent complications and spread of the infection.

The goal of this study was to increase the proportion of women in WellCare of New York, Inc. Medicaid/FHP who received a screening for Chlamydia, thereby increasing QARR rates for the measure by a statistically significant margin.

2. Methodology

The eligible population was all WellCare of NY, Inc. Medicaid/FHP women 16 to 25 years of age as of the measurement year, who were identified as sexually active and continuously enrolled in the Plan during the measurement year.

3. Interventions

The member Intervention target was to raise awareness in WellCare of NY, Inc. members of the seriousness of undetected infection and the importance of getting tested even in the absence of symptoms. Member interventions included:

- Member mailings with educational material sent to the eligible population.
- An incentive in the form of a gift card was mailed to the eligible population to get tested.
- Member newsletters included articles on the importance of getting tested and the complications of undiagnosed infection.

Provider interventions were targeted to raise awareness in network providers of the importance of their role in controlling this sexually transmitted disease (STD) by offering Chlamydia screening and treatment. Provider interventions included:

- Letters sent to primary care providers (PCPs) identified their eligible members who were not compliant for the Chlamydia screening measure.
- A fax blast stressed the importance of the role of the PCP in controlling the spread and complications of Chlamydia infection and the importance of encouraging the member to get tested for Chlamydia.
- Providers of QARR-eligible members were paid an incentive for claims received for Chlamydia screening.
- Providers received newsletters which included articles on Chlamydia testing for those at risk.

4. Results/Conclusions

The baseline measurement in 2006 showed that 39 percent of the women age 16 - 20 years had been screened for Chlamydia. At re-measurement in 2008 the rate increased to 53 percent. The baseline measurement in 2006 showed that 46 percent of the women age 21 - 24 years had been screened for Chlamydia. At re-measurement in 2008 the rate increased to 56 percent.

WellCare of New York, Inc. is continuing ongoing outreach initiatives to target women identified as being eligible for the Chlamydia screening. The WellCare Corporate QI department is implementing and coordinating member outreach interventions across all state markets. In addition, WellCare of NY, Inc. has added another lab vendor thereby increasing reporting and testing facilities. Coordination with NYC and NYS will continue to monitor the use of educational programs to increase awareness and deliver the same message to the target population.