



**New York State Department of Health
Division of Managed Care and Program Evaluation
Bureau of Program Quality, Information and Evaluation**

**Medicaid Managed Care Plans
2006 Performance Improvement Projects**

October 2007

Introduction

This compendium of Performance Improvement Projects (PIP) summarizes the various projects conducted by Medicaid managed care plans in 2006. 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.

The projects described cover a wide range of topics encompassing such issues as: Child and Adolescent Health, Women's Health, Depression Screening, Cardiovascular Health, and other topics important to the health and well being of New York State residents. A summary of the projects conducted under the Best Clinical and Administrative Practices Collaborative (BCAP) to improve asthma care in NYS is also included in this compendium.

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 Patricia Gutierrez of the Division of Managed Care, Bureau of Program Quality, Information and Evaluation at 518-473-2941 or at pbg01@health.state.ny.us.

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Community Choice Health Plan of Westchester, Inc. (CCHP)

Getting Children the Immunizations They Need

The aim of this project is to determine if a small, resource limited, managed care organization could implement a targeted intervention that would result in an increase in childhood immunization rates including the rate of influenza immunization among children with asthma.

We also planned to assess the completeness of Community Choice Health Plan providers' reporting to the *Citywide Immunization Registry (CIR)*.

Methodology

Childhood Immunizations - The eligible populations who were continuously enrolled in the Plan that had not been completely immunized prior to turning two years old in 2006. HEDIS/QARR technical specifications were used to determine and identify eligible populations throughout the project from baseline to final measurement and the vaccination guidelines as described in the United States Recommended Childhood Immunization Schedule was also used.

Influenza Vaccine- The eligible population consists of continuously enrolled children between the ages of 2-14 years with asthma. CCHP utilized its own internal plan measure that includes the baseline and re-measurement rate of influenza vaccine for children with asthma between the ages of 2-14 years during 2005 and 2006. The denominator includes children ages 2-14 with asthma that reside in the Bronx, Westchester and Rockland counties. The numerator includes all children between ages 2-14 with asthma that received the influenza vaccine.

The data collection process used for both measurements included submitted claims and encounter data received from providers allowing for a three month lag for submissions and medical record reviews.

Interventions

Outreach and educational activities were implemented during the period of April 2006 through March 2007

- A letter was sent to all parents with children aged 2-14 having a diagnosis of asthma, advising them to take the asthmatic child to their primary care physician to obtain an influenza immunization.
- An incentive was offered to the parents of children who turned 2 years old in 2006 in return for supporting documentation that their child had received needed immunizations.
- A letter was sent to providers located in Bronx County reminding them of their responsibility to register children's immunization data via the CIR.

- A telephone campaign was performed to identify PCP's offering the influenza vaccine to members with asthma.
- An internal "*No-Hit*" data list defined as children between the ages of 2-14 with asthma that did not receive the influenza vaccine. A "No-Hit" list was also used for children that did not receive age appropriate vaccines. These "No-Hit" lists were used to contact the members / member parent via mail and or telephone outreach advising them to see their PCP's for up-to-date influenza immunizations.

Results and Conclusions

The results of this project showed a favorable outcome when compared to the previous year. The immunization rates increased across all sub-measures. Comparing the baseline measurement in 2005 to the re-measurement performed in 2006 there was an increase in immunizations for each antigen.

The rate of vaccination against influenza for children that fell between the ages of 2 and 14 years during 2005 was 24.67% compared to 25.20% in 2006. Of significance, of the three service areas (Bronx, Rockland and Westchester) there was a significant decrease of influenza vaccines in Bronx County.

Our efforts to reinforce our providers' obligation to submit immunization data to the CIR did improve the submission rate as anticipated. The assessment of CCHP provider submission data completeness to the Citywide Immunization Registry showed that 32.73% were found in the CIR in 2006 compared to 27.59% of our providers in 2005. Our efforts to reinforce our providers' obligation to submit immunization data to the CIR did improve the submission rate as anticipated.

Community Choice Health Plan is committed to intensify its outreach efforts to members and participating providers via media campaigns, direct mailings, phone calls, provider/parent education and monetary incentives with the purpose of impacting member behavior and provider compliance.

Interventions will continue to be used to increase the rate of immunizations, to monitor provider CIR compliance and influenza vaccines for children with asthma 2-14 years. The Plan influenza vaccine measure will continue to be monitored for the 2007 season with the intent that visits to the Emergency Room for children 2-14 years will be less frequent.

The barriers that CCHP faced are challenging but not insurmountable. Community Choice Health Plan will continue to educate its enrollees and engage in contacting providers regarding the need to report changes in telephone numbers and residential address and, to supply the Citywide Immunization Registry with all immunizations administered.

GHIHMO

Medicaid Adolescent Well Care Initiative

The aim of the GHIHMO Medicaid Adolescent Well Care Initiative was to improve Medicaid adolescent compliance with annual well care visits by implementing educational initiatives targeted at members, their parents, and Primary Care Providers. The objective of this initiative was to improve the GHIHMO well care visit rate of adolescents ages 12-21 to 45% in 2005 and to 47% in 2006.

Methodology

2006 HEDIS/2005 QARR measure specifications were used to identify the population. The rates were calculated using administrative/claims data. The baseline period is measurement year 2004, with interim measurement occurring in 2005 and final re-measurement in 2006. GHIHMO followed the HEDIS/QARR reporting cycle. Interim measurement 2005 was reported in June 2006 and final measurement 2006 in June 2007.

Interventions

Member incentive program (Reward Yourself – The Gift of Health) –Members receive a gift card to a local store or movie tickets upon submitting proof of a well visit.

Telephone campaign to remind members about the importance of an annual well care visit, offer to assist them to make an appointment, and the incentive program.

Provider Service Reports – Periodic notification to Primary Care Providers of members in need of a well visit.

Provider Incentive Program – Program beginning in 2006 for Primary Care Providers. Monetary incentive sent to providers for each member receiving a well visit.

Distribution of a Teen Newsletter (inserted in the Member newsletter) targeted to teens. Newsletter included health education material about mental health, sexual health, nutrition, exercise, and tobacco, alcohol and illegal drug avoidance.

Distribution of a Women's Health Insert in the Member Newsletter targeted at women to assist in making appointments for their children.

Primary Care Capitation study - Review to determine if PCP payment type may be source of a claims data collection issue.

Review of Provider encounter/claim submission methodology – Review in 2007 to determine if primary care providers in a clinic setting are submitting encounters correctly.

Results and Conclusions

Using administrative claims data, the Medicaid/FHPHMO Adolescent Well visit rate improved from 27.45% in 2004 to 35.8% in 2005 and to 37.6% in 2006. The objective of the study was not met. The interventions designed to educate members and providers about the importance of an annual well visit appeared to have an impact on compliance during the first year. Although the interim goal of 45.0% was not achieved the rate improved eight percentage points.

MetroPlus Health Plan

Use of a Network Management Model to Improve Adolescent Health Screening and Counseling with Community-Based Providers

Although MetroPlus performed above the state average on the first IPRO study, significant opportunity existed for improvement in our Adolescent Health Screening and Counseling Rates. Only community based providers were included in this study, because most lack a standardized medical record or an EMR, and many lack support staff to assist with health education functions. MetroPlus had success with a provider site visit and tool kit methodology deployed by student interns on two prior occasions. However, MetroPlus lacked an ongoing infra-structure for provider QI. The feasibility of using paraprofessional Provider Service Representatives for a deployment of a Provider QI module was also investigated through this study.

Methodology

At the outset of the study, MetroPlus had 7812 Medicaid or CHP eligible adolescents assigned to 707 providers, 302 of which were office or Community-based practices. A sample was taken of Community-based providers with ≥ 10 members in eligible population. The final sample consisted of 66 providers (at 60 sites) serving 1287 eligible adolescents. Medical record review measuring Adolescent Health Screening and Counseling was performed for a minimum of 10 records for each of the final study providers, and results reports were generated.

After the first round of site visits, re-measurement based on a sample of medical records from these providers was performed 8 months later, and a second round of site visits was conducted. At the follow-up site visits, post intervention data was reviewed, use of the tool kit reinforced and a provider experience survey administered. A comparison of the pre and post intervention rates was made, and the results of the Provider Experience Survey as well as a Provider Service Representative Experience survey were aggregated.

Interventions

Provider Service Representatives conducted site visits to final sample providers to discuss baseline and post intervention data, and to review use of a practice improvement tool kit, which included an Annual Well Care & Preventive Health Care for Adolescents (Age 11-21 yrs) Guidelines Summary, a Medical Record Documentation Standardized Form for Initial/Annual Comprehensive Adolescent (11-18yrs) Visit, Provider Interviewing Guidelines and an Adolescent Health Resource Guide. Also, at the request of CDOHMH, a Well Care Visit Reminder was mailed to overdue adolescents in August 2006.

Results and Conclusions

Statistically significant improvement was obtained on all components of the Adolescent Health Screening and Counseling Indicator. The largest gain was in the calculation and documentation of BMI, with the rate increasing from 21% to 55%. Adolescent well care visits also increased significantly between 2005 and 2006.

77% of providers responding to the Experience Survey rated MetroPlus's approach to QI in this study as excellent, and 89% reported it was useful. They reported that the most valuable resource was the Adolescent Preventive Health Guideline Summary. 78% of surveyed providers would have some interest in participating in similar projects in the future.

The Provider Service Representatives accepted this new role and reported that they benefited from the training offered by the Quality Management Staff. Most of the Representatives rated their experience with the study as "good", but some were ambivalent about their participation in future projects of this nature.

A Network Management model with community- based practitioners improved significantly Adolescent Health Screening and Counseling Rates. Providers overall found the method useful and would be interested in similar efforts in the future.

MVP Health Care

Adolescent Well Care

Increasing the percent of adolescents who obtain an annual well care visit was selected as an area of opportunity for our Medicaid population. The American Medical Association Guidelines for Adolescent Preventive Services and the AAP guidelines both recommend comprehensive annual check-ups for adolescents. Teens go through many changes during this time of their lives. Risky behaviors contribute to the leading causes of death among young adults and are often preventable.

The project is designed to increase the number of Medicaid and Family Health Plus members between the ages of 12 and 21 who receive an annual well care visit by June 2007. The goal is 67.9 %, which represents a statistically significant improvement from our baseline, using a two-sample test for binomial proportions (z-test). The benchmark is based on the HEDIS 2006 90th percentile, which is 54.5%.

Methodology

MVP focused our efforts on the 12-21 year olds enrolled in our Medicaid and Family Health Plus products. We used our certified HEDIS software to produce the results for the baseline (HEDIS 2006/QARR 2005) and each re-measurement period (July 2005-June 2006 and HEDIS 2007/QARR 2006).

Interventions

Member Education:

- Placed articles in MVP Medicaid Member Newsletter
- New members receive a Welcome Packet with information on the importance for teen well care
- Mailed internally developed Teen Risky Behavior brochure and letter highlighting the importance of an annual well care visit to parents of teens encouraging them to discuss together
- Sent letters out on behalf of PCP's to adolescents and their parents to explain the importance of an annual well care visit and encourage them to make an appointment to see their PCP

Provider Education and Outreach:

- Developed an easy to use flow sheet/screening tool for PCPs in collaboration with CDPHP
- Sent physicians a list of their Medicaid adolescent members who had not had an annual visit and also included the above mentioned flow sheet/screening tools in the mailing

Results and Conclusions

Adolescent screening rates decreased from 55.8% at baseline to 51.0% at re-measurement 1. The numerator for all measurements included only continuously enrolled members as per HEDIS specifications. Although we did not see an improvement we are pleased that our results are above the QARR 2005 statewide average of 45.0%. Our hope is that the additional interventions around pay for performance incentives that were implemented after the re-measurement time period will yield an improvement in our rates. We plan to continue to monitor our performance in this measure and will alter or add interventions as we get more experience with the Medicaid product.

The New York-Presbyterian Community Health Plan

Improving Adolescent Well Care in the Medicaid Population

Adolescents represent approximately 11% of NYPCHP's overall population and reflect a high volume of potential services within the Plan. This population typically under-utilizes services, which is illustrated by the lower than state-wide average rates of adolescent well care NYPCHP has reported for the past several years. Realizing that it is a challenge to get the adolescent into care, NYPCHP felt it was important to make the most of the opportunity when the adolescent did present to the PCP. Therefore, PCPs were encouraged to perform all of the components required for an adolescent well care visit and to document them accordingly.

The main objective of this study was to assure that accurate and complete documentation of the components of well adolescent visits were captured in the medical record. For the purposes of this study, the Plan chose to focus primarily on the documentation issues, although interventions were designed to address the rate of well care visits as well

Methodology

QARR methodology was utilized for the study. The population included adolescents 14 to 18 who were continuously enrolled during the measurement year and had at least one well care visit with a primary care practitioner or OB/GYN during the measurement year. A sample of 100 members was randomly chosen for the study according to QARR specifications. The initial measurement period was calendar year 2005 and the re-measurement period was calendar year 2006. Data was collected through medical record review after identification of the sample and the corresponding primary care practitioner or OB/GYN provider.

Interventions

Interventions were targeted at both members and providers. Member interventions included a Teen Newsletter for adolescents containing topics of interest to them, member incentives for proof of a well-care visit, and reminder letters to adolescents encouraging a visit to their PCP.

Provider interventions included articles in the Provider Newsletter reminding providers to perform complete well care visits on their adolescent members and to document the components of the visits completely and accurately. Additionally, an adolescent flow-sheet was designed and distributed to all PCPs to facilitate documentation of well care visits.

Results and Conclusions

The results of the re-measurement for all three study indicators were encouraging and surpassed the original goals set for the study:

- Documentation of BMI increased from 27% to 45% (Goal 30%);
- Documentation of Tobacco Use increased from 57% to 65% (Goal 63%);
- Documentation of Substance Use increased from 56% to 66% (Goal 62%)

Although the goals for improvement were modest, the re-measurement rates exceeded them in every case.

The Teen Newsletters will continue because experience has shown that it often takes years before the full impact of this type of intervention is seen. Also, due to the constant “churning” of members in Medicaid managed care, there will be members that come on and off the Plan’s roster and therefore will receive the newsletter and associated educational information for the first time.

All providers will be encouraged to submit claims and encounter forms in order to assure that all well care visits are captured. An analysis of encounter rates will be conducted to identify potential low-reporting providers. Proper coding of well care visits will also be stressed. Provider education in terms of the required components of well care visits will continue and the importance of appropriate documentation will be highlighted. Providers will be queried regarding the adolescent flow sheets and their usefulness and the Plan will solicit provider input to make these tools more useful.

WellCare of New York, Inc

Lead Screening before the 25th Month of Life in WellCare Medicaid Members

Lead poisoning continues to be a serious health risk for children in New York, particularly for those between six months and three years of age. Lead can affect the normal growth and development of a child's central nervous system and cause tissue damage to the kidneys and bone marrow. Prevention, early detection and monitoring of children with elevated Lead levels is a public health challenge and a major initiative in this region.

The goal of this study is to increase the percentage of WellCare Medicaid members who receive at least one Lead screening before the 25th month of life to greater than or equal to the 2003 statewide average of 74%.

Methodology

HEDIS 2004/QARR 2003 Technical Specifications for Lead screening were followed for sampling methodology and definition of population for the baseline measurement of this study. HEDIS 2007/QARR 2006 Technical Specifications for Lead screening were followed for the re-measurement year. Year 2003 was selected as our baseline year because this measure was rotated in 2004. Thus, 2003 was the last available reported rate. The QARR measure: Lead screening before the 25th month of life is used as the indicator for both the baseline measurement and the re-measurement period of this study.

Interventions

- 1) A telephonic outreach targeting all New York City members and their assigned Primary Care Provider (PCP) was conducted for members who turned 2 years of age in 2006 who had not received at least one Lead screening. Plan staff called every household with a non-compliant member and their PCP to encourage members to come into the office to be screened.
- 2) A mailing was sent to all non-compliant members' parent/guardian providing educational material on Lead poisoning prevention and screening. The mailing also identified the member's PCP and included encouragement for follow-up with member's PCP.
- 3) A Provider Incentive targeting PCPs with members who were non-compliant for Lead screening as of August 2006. PCPs were sent a list of their non-compliant members and an incentive was offered to the provider for outreaching to the member before the end of the year. All members who would turn 2 years of age in 2006 were targeted by this intervention.
- 4) A Member Newsletter article regarding need for regular screenings recommended timeframes for Lead screening and/or sources and effects of Lead poisoning and ways to prevent Lead poisoning.

- 5) Provider Newsletter article regarding requirements of Public Health Law to screen children for Lead poisoning at 1 and again at 2 years of age.
- 6) Distribution by plan Provider Service Representatives of the New York City Health Information publication, December 2005 issue on Childhood Lead Poisoning to Primary Care providers (All Pediatricians and Family Practice specialties were targeted).
- 7) Periodicity letters targeting members, sent on the member's first and second birthday, listing preventive services recommended at each age group. Lead screening is recommended at 12 and 24 months.
- 8) Dissemination of the NYS/NYCDOH&MH Lead Poisoning Prevention protocols in the electronic Provider Manual available at our website.

Results and Conclusions

Significant improvement in the percentage of WellCare Medicaid members who received at least one Lead screening by the 25th month of life was obtained from the baseline calendar year 2003 at 65% to the re-measurement calendar year 2006 at 83%. An interim measurement was also calculated for calendar year 2005 of 77%.

The objectives of the project were met. The plan's QARR rates for Lead Screening before the 25th month of life increased from 65% at baseline measurement to 83% at Re-measurement. Despite barriers encountered during the member outreach, including reluctance of the membership to be tested and inability to make contact with member's parent/guardian, the project was successful as evidenced by the eighteen percentage point increase in the rate.

Capital District Physicians' Health Plan

Increasing Mammography Screening Rates in the Medicaid Population

Although CDPHP's mammography screening rate had been slowly increasing from 55% in 2000 to 59% in 2004, it still fell significantly below the 2004 QARR statewide rate of 69%. Regular mammograms increase the likelihood that breast cancers will be detected at an early stage, thereby allowing more treatment options and optimizing member outcomes.

The aim of this study was to increase the percentage of Medicaid and Family Health Plus members who are appropriately screened for breast cancer by having at least one mammogram within 2 years, with the goal of increasing the plan's rate to meet or exceed the state average of 69%.

Methodology

In addition to using the QARR-eligible population to determine final impact of the initiative, an additional cohort was tracked and measured, consisting of women ages 40-52 otherwise meeting all HEDIS/QARR criteria for inclusion. Interim measurements were conducted on a quarterly basis throughout 2006 to determine the impact of various interventions employed. Administrative data was used, consisting of claims that meet the HEDIS/QARR specifications for breast cancer screening. Results were tested for statistical significance using a Chi square test. Interventions started in October of 2005, and continued through the end of 2006.

Interventions

Interventions included multiple levels of outreach to both members and practitioners. Members received newsletter articles on a quarterly basis. Members who had not received services in the previous two calendar years were called and educated about the importance of regular screening and early detection. They were also informed about mobile screening events in their counties of residence.

Providers received actionable listings of their members who had not had a mammogram. These lists were distributed to both primary care and ob/gyn practitioners. PCPs also received a report of their breast cancer screening rate specific to their members, along with peer comparative data.

Results and Conclusions

CDPHP's breast cancer screening rate for Medicaid and Family Health Plus women decreased 2 percentage points, from 59% (QARR 2005) to 57% (QARR 2006). Community events were well attended, with an average of 13 women screened per event.

42% of the women screened were uninsured and therefore had no other access to services. There was no direct effect of these events on screening rates for the QARR-eligible population.

The lack of success of this initiative underscores the difficulties inherent in working with the Medicaid population. It is difficult to perform effective outreach when contact information is incorrect or missing. Medicaid members face increased societal barriers and issues that may preclude them from obtaining age-appropriate preventive services. This age and sex cohort may be particularly affected by such difficulties due to the high percentage of SSI members. Approximately 53% of the women in this measure for QARR 2006 were members of the SSI subpopulation.

Many enhancements and new initiatives are being implemented for 2007. These include additional mid year outreach to practitioners to encourage them to facilitate breast cancer screening for their members, and use of different venues for mobile events. Early results of an on-going barrier analysis indicate a need for continuing education to help members overcome their fears of both the procedure and the potential for negative results.

Health Plus PHSP, Inc.

Improving Mammography Rates among Women 40-69

Health Plus was interested in increasing the percentage of female members ages 40-69 who have a mammography. The plan has almost 14,000 women in this age group eligible to have a mammogram. Breast cancer is the most common cancer and the second leading cause of cancer-related deaths among women in the United States.

Our goal was to improve our screening rate by 10% by the end of 2006. It was determined that one way to accomplish this was to look at what influences plan members to have mammograms and what are the barriers to members being tested for breast cancer screening.

Methodology

Two member surveys were developed and mailed out in late February of 2006 to members in the age group 40-69.

- Survey I was used to determine what facilitates breast cancer screening and it was sent to women who had a mammogram in 2005.
- Survey II was used to determine barriers in breast cancer screening for women and was sent to women who did not have a claim for a screening in 2005.

The survey questions differed slightly and were sent out in English and Spanish. Both surveys were used to assess members' social network experience, testing accessibility, rating importance of provider recommendation for screening, member attitudes and beliefs.

An automated phone service was used to call the survey recipients just prior to mailing. Members received a message about the forth coming survey and a reminder to get screened for breast cancer. Upon receipt of the surveys all answers were entered into a database and the frequency of question responses were calculated. The questions were then grouped into the various categories and analyzed. Interventions were then planned to address barriers to breast cancer screening.

Interventions

Due to the tight time frames for this project we pre-planned a couple of interventions so that they could be implemented in the second quarter of 2006. These interventions included:

- Breast Cancer Screening added to our pay for performance program
- Automated phone message to the members who received Survey II advising them of the importance of getting a mammography

Based on results of the two surveys, we put several additional interventions into place. On the *provider* side:

- Sent letters to radiology facilities reminding them that members did not need a referral or prescription for the test
- Published an article in our Provider newsletter about the study results and how important their role was in recommending the test
- Conducted in office education when visiting the providers for medical record reviews

For the *members* we provided:

- Article in the Member newsletter reminding them to get screened and that a referral or prescription was not needed
- Breast Cancer Screening (BCS) fact sheet addressing the barriers identified in Survey II
- Reminder letter and BCS fact sheet to members not having a mammography in the fall of 2006
- Cancer screening guidelines inserted in Fall Member newsletter

Results and Conclusions

The QARR/HEDIS rate for Breast Cancer Screening for the 52 – 69 year age group increased from 63% in 2004 to 68% in 2006. Two surveys were sent out to our members to help us determine the barriers and facilitators for our members. The women surveyed rated provider recommendation as very important.

The survey results from the project gave us a basis for developing member and provider education on not only breast cancer screening but other cancer screenings. We learned from our members the importance of physician recommendations and their education of patients. The survey indicates that providers need to be aware of patient attitudes and beliefs when recommending a cancer screening test.

HIP Health Plan of New York

Improving Screening Mammography Rates

The project topic is to improve screening mammogram rates in the HIP Medicaid membership for women ages 52-69 years old.

HIP breast cancer screening rates are suboptimal and have remained at or below the statewide average since 2003. Women who do not avail themselves of screening mammograms miss the opportunity to detect breast cancer at an early and more easily treated stage. HIP's suboptimal breast cancer screening rates indicate that many of HIP's female members over 50 may be missing this opportunity.

Methodology

The population for this study included female Medicaid members who were 52-69 years of age as of December 31 of the measurement year.

The administrative method of data collection was used, consisting of a pull of administrative data from claims/encounter files for all eligible members.

Interventions

1) Telephonic Outreach Intervention - HIP's Wellness Outreach department called female members who were 52-69 years of age and who appeared to be lacking breast cancer screening to remind them that they should obtain a mammogram, and to determine what barriers exist for these members in obtaining a mammogram.

2) Physician Outreach Letters – Physicians were sent a letter with a list of their patients who appeared to be lacking breast cancer screening. Physicians were urged to outreach to these patients to encourage them to obtain a mammogram.

Results and Conclusions

The percentage of women ages 52-69 who had a mammogram during the measurement year or the year prior to the measurement year increased from 58.99% in 2003-2004 to 65.34% in 2005-2006.

Overall, the objective of increasing the breast cancer screening rate was achieved. There was a statistically significant increase in the breast cancer screening rate. It appears that a multifaceted approach to improving mammography screening may work best to help women overcome the barriers they face. To sustain improvements, we will continue a multifaceted approach that includes telephone reminder calls, preventive health guideline updates, focused newsletter articles as well as provider outreach letters with patient panel reports.

Suffolk Health Plan

Reducing Barriers to Screening Mammography in Medicaid Members

Annual screening mammography is recommended by the American Cancer Society and the National Cancer Institute, for women beginning at age forty. It has been shown to lower the death rate from breast cancer in women over age fifty by 25% and enable detection of cancer at earlier stages when it is easier to treat and to cure. Suffolk Health Plan has had suboptimal rates for this screening since 2002.

The Plan set a goal to increase the screening rate by 10% over the 2005 rate for a rate of 67% of eligible members in 2006.

Methodology

Members were included in this project if, on January 3, 2006, they met the HEDIS 2005 criteria for inclusion in the denominator for the Breast Cancer Screening measure aside from the continuous enrollment aspect. The Plan followed the HEDIS specification using a two year measurement period for rate reporting. Rates for screening mammography in this population were compared using as a baseline 2005 QARR rate of 57%, and a post intervention rate calculated from QARR 2006.

Interventions

The interventions used included letters to both members and doctors, reminding them of the open access policy for mammography. A listing of the Plan's participating mammography facilities was also circulated to all providers and members in the study population. Each member was assigned a Plan representative as a "navigator" for the duration of the study, whose function was to reach out to them and explain the importance of having this screening done and explore potential barriers that the member may have been experiencing. Navigators used a prepared script in speaking with members. A modification to the original interventions proposed was that we felt the need to add an incentive when we realized mid-way through the intervention period that our rates had not improved significantly. A \$25 Modell's Sporting Goods Store gift card incentive was offered to members who completed the screening process during the remaining intervention period.

Results and Conclusions

Of the 289 women in the population, 170 of them had a screening mammography performed within the intervention period, for a rate of 62%.

The Plan was unable to raise the rate of screening mammography appreciably by way of this performance improvement project. In speaking with the women in the study group,

there was no consistent reason given for not undergoing recommended screening. There seemed to be a lack of concern with breast cancer screening as a priority in their lives. We found that members seemed to be receptive to outreach by Plan staff and appreciated the active involvement in terms of contacting them by mail and phone. However, reminding them of the importance of screening, emphasizing the open access to screening policy, the use of a navigator to help them make an appointment, and offering an incentive to them did not result in an overall increase in utilization of this service.

The Plan will undertake a corrective action which includes a review of the medical records of the members in this study population to see whether the PCP recommended mammography screening and when. In cases where the provider did not recommend mammography, we will attempt to reeducate them, and in cases where members were noncompliant with provider recommendations, we will attempt to determine the reason in their particular cases.

Affinity Health Plan

Improving Antidepressant Medication Management Adherence

As cited in the Take Care New York (TCNY) depression screening action kit from February 2006, “depression is one of the most commonly seen conditions in primary care. One in 4 women and 1 in 10 men will suffer from a major depressive episode during their lifetime. Nearly 6%, or 380, 000 of all adult New Yorkers each year report clinically significant emotional distress. Depressive disorders play an important role in the etiology, course and outcomes associated with chronic diseases, and if untreated, depression can lead to increased disability and suicide.” The treatment of depression is one of the 10 priority interventions named in the TCNY Policy for a Healthier New York City.

The objective of this study was to achieve a 10% performance gap reduction for all 3 antidepressant medication management measure indicators; 3 provider visits in 84 days, medication adherence for 84 days and medication adherence for 180 days.

The goal was that through collaboration with Beacon Health Strategies (BHS), Affinity Health Plan would determine if increased member education and telephonic support with concurrent primary care provider education and notification would result in improved Antidepressant Medication Management adherence as evidenced by improved QARR rates.

Methodology

The population for this study included all of the members 18 years of age and older that filled a prescription for an antidepressant medication beginning in January 2006 through December 2006. The sample was obtained through direct pharmacy claims from our pharmacy benefits manager (PBM) and from Medicaid utilizing a modified list of HEDIS medications. The diagnosis of depression was not utilized in calculating the study population for the intervention; therefore some members in the QARR sample were not included in the intervention group.

The baseline rates were the 2005 reported QARR performance rates. The QARR eligible criterion includes a corresponding diagnosis of depression with the antidepressant medication event. These members also had to have a 4 month negative medication history for antidepressants to be included in the performance rate, resulting in a significantly lower denominator. The re-measurement rates are the reported 2006 QARR performance rates for those members in the outreach group that were eligible for the denominator.

Interventions

The intervention included sending an educational letter to all of the members that filled a prescription for an antidepressant medication from January to December 2006.

Concurrently if the primary care provider (PCP) was identified as the prescriber for the antidepressant they also were sent educational material. A total of 30 members were randomly selected from the sample each month for telephonic outreach attempts. Telephonic outreach was attempted 3 times for each member with a phone number. If the member had an answering machine, or if someone other than the member answered the phone, a message was left for the member to call back. Follow-up phone calls were made if a message was left for a total of 3 attempts. Called members were given the BHS number to call back at any time. Members who actually spoke to an outreach specialist were educated on the importance of antidepressant medication management. Member questions included whether they were continuing to take their antidepressant medication as originally prescribed, if they were experiencing barriers to their adherence and if the phone call was helpful to them. The Members received education on medication adherence and provider visits and follow-up.

Results and Conclusions

A total of 2448 members were identified as filling an antidepressant medication prescription and mailed an educational letter. There was a total of 62 letters that were returned to Beacon Health Strategies as undeliverable. Of the 518 random members selected for telephonic outreach 330 members or 64% were reached directly or left a message to call back BHS. Out of the 330 members reached, 161 or 49% actually engaged in a conversation with an outreach person. Of the 161 members that were contacted, 31 refused to discuss the program. Of the 161 members that spoke with an outreach person a total of 92 or 51% responded that they were continuing to take their medication as originally prescribed.

The percent of enrollees with 3 visits in 84 days decreased from 28% in 2005 to 26% in 2006; treatment for 84 days decreased from 46% in 2005 to 44% in 2006; and treatment for 180 days declined from 30% in 2005 to 27% in 2006.

The project objective was not achieved for any of the indicators and the QARR performance rates actually dropped for two of the measures for 2006 as compared to 2005.

Based on the results of this study, at least for members diagnosed with depression and filling a prescription for an antidepressant medication, these techniques did not show a measurable benefit. Based on these results, Affinity would recommend a small scale study specifically focused on promoting continued medication therapy for 180 days since this is the indicator with the lowest compliance rate.

Healthfirst

Improving the Process of Identification, Diagnosis and Management of Depression in a Medicaid Population

Mental health disorders including Major Depressive Disorders (MDD) are one of HealthFirst's top ten diagnoses. Depression is a common and costly mental health problem. The National Co-morbidity Survey- Replication (NCS-R) states that very substantial lag exists between illness onset and diagnosis and treatment. Delays and inadequate treatment are far more common among poor, poorly educated and people of color.

Depression often goes unrecognized in the primary care setting despite its high prevalence. A focused study on this topic would allow the plan to examine and analyze the factors that affect patient care and to measure indicators such as submission method, reimbursement, provider practice, and member compliance. This study aims to attain the following objectives:

- increase the number of primary care physicians educated about the identification, diagnosis and management of depression
- increase the use of the PHQ-9 screener in the primary care setting
- measure impact of outreach and case management on cohort population
- improve the QARR Antidepressant Medication Management Measure to the statewide average
- evaluate antidepressant medication adherence (persistence/possession ratio)

Methodology

A prospective intervention-comparison study with claim/encounter analysis and medical record review was used for the process measure indicators:

1. Utilization of PHQ-9 tool by Providers
2. Administration of PHQ-9 tool to Members
3. Member Outreach/Case Management

The administrative methodology from the QARR/HEDIS Vol. 2 Technical Specifications on Antidepressant Medication Management was used to identify the study population for comparing QARR/HEDIS performance for the Antidepressant Medication Management measure.

Claims databases of known antidepressant prescription records were obtained for Antidepressant Medication Adherence analysis and results were analyzed using the Standardized Therapy Adherence Research Tool (START). The population identified for the Antidepressant Medication Management measure is only a cohort of this population. The observation for the indicators below represents behavior of the entire membership prescribed with antidepressant medication and not just the population identified in the Antidepressant Medication Management measure.

Interventions

A series of interventions were implemented from the fourth quarter of 2005 and sustained up to the present:

Provider Interventions

Provider mailing
Telephone outreach, and on-site visits.
Article about Depression Study published in the provider newsletter and web portal

Member Interventions

Outreach by phone
Mailing for those who refuse case management
Case management referral per protocol
Article about Depression and Take Care New York Initiatives published in member newsletter and web portal.

Data monitoring

QI staff track and trend encounter and PHQ-9 submission by Providers
Registry to track members diagnosed with depression and prescribed antidepressant medication

Results and Conclusions

The results of this study indicated that HealthFirst PHSP has demonstrated improvement in attaining its objective of increasing the use of PHQ-9 screener to a small population of providers in the primary care setting. This improvement can be attributed to providers outreach and the incentive payment offered for administering the screening tool.

- Providers administering PHQ-9 tool rose from 2.27% in 2005 to 19.33% in 2006, a significant increase of 16.17 percentage points
- Providers administering PHQ-9 tool post treatment rose from 0.46% in 2005 to 3.57% in 2006, an increase of 3.11 percentage points
- Records identified with positive scores on the PHQ-9 tool rose from 1.07% in 2005 to 1.70% in 2006, a slight increase of 0.63 percentage points
- HEDIS eligible audit members who were case managed increased from 35.6% in 2005 to 40.71% in 2006, an improvement of 5.11 percentage points
- Between 2004 and 2006 HEDIS scores increased from 41.0% - 46.0% for effective acute treatment phase (84 days); remained the same for effective continuation phase treatment (180 days) at 28.0%; and the rate of optimal practitioner contact declined from 35.0% to 28.0%

The increase of members diagnosed with depression and prescribed antidepressant medication from 2004 to 2006 demonstrated the need for outreach and case management to encourage member compliance to follow-up visits and to the medication regimen. The Plan's rate for the Antidepressant Medication Management Measure particularly 'Optimal Practitioner Contact', declined over the three-year period.

A Plus

Improving the Process of Identification, Diagnosis and Management of Depression in a Medicaid Population

Mental health disorders including Major Depressive Disorders (MDD) are one of A Plus's top ten diagnoses. Depression is a common and costly mental health problem. The National Co-morbidity Survey- Replication (NCS-R) states that very substantial lag exists between illness onset and diagnosis and treatment. Delays and inadequate treatment are far more common among poor, poorly educated and people of color.

Depression often goes unrecognized in the primary care setting despite its high prevalence. A focused study on this topic would allow the plan to examine and analyze the factors that affect patient care and to measure indicators such as submission method, reimbursement, provider practice, and member compliance. This study aims to attain the following objectives:

- increase the number of primary care physicians educated about the identification, diagnosis and management of depression
- increase the use of the PHQ-9 screener in the primary care setting
- measure impact of outreach and case management on cohort population
- improve the QARR Antidepressant Medication Management Measure to the statewide average
- evaluate antidepressant medication adherence (persistence/persistence ratio)

Methodology

A prospective intervention-comparison study with claim/encounter analysis and medical record review was used for the process measure indicators:

1. Utilization of PHQ-9 tool by Providers
2. Administration of PHQ-9 tool to Members
3. Member Outreach/Case Management

The administrative methodology from the QARR/HEDIS Vol. 2 Technical Specifications on Antidepressant Medication Management was used to identify study population for comparing QARR/HEDIS performance for the Antidepressant Medication Management measure.

Claims databases of known antidepressant prescription records were obtained for Antidepressant Medication Adherence analysis and results were analyzed using the Standardized Therapy Adherence Research Tool (START). The population identified for the Antidepressant Medication Management measure is only a cohort of this population. The observation for the indicators below represents behavior of the entire membership prescribed with antidepressant medication and not just the population identified in the Antidepressant Medication Management measure.

Interventions

A series of interventions were implemented from the fourth quarter of 2005 and sustained up to the present:

Provider Interventions

- Provider mailing
- Telephone outreach and on-site visits
- Article about the Depression Study published in the provider newsletter and web portal

Member Interventions

- Outreach by phone
- Mailing for those who refuse case management
- Case management referral per protocol
- Article about Depression and Take Care New York Initiatives published in member newsletter and web portal

Data Monitoring

- QI staff track and trend, on a daily basis, encounter and PHQ-9 submission by Providers.
- Registry to track members diagnosed with depression and prescribed antidepressant medication

Results and Conclusions

No providers administered the PHQ-9 tool to any A+ members; therefore no claims were submitted. This result can be attributed to the small size of eligible population for this study. A comparative analysis was also unattainable since there was not enough data to effectively measure the impact of the interventions and programs put in place by the plan to address this particular study's indicators.

AMERIGROUP Community Care

Appropriate Diagnosis and Management of Pharyngitis

Appropriate diagnosis and management of pharyngitis was selected for this performance improvement project. Our objective was to evaluate and improve the use of diagnostic testing for children with pharyngitis and to reduce the over-utilization of antibiotics in treatment. This is a problem-prone measure for the plan, reflected by QARR scores that are significantly below the state-wide average for MY 2005 and 2006. Current research supports the premise that only a small portion of pharyngitis cases require antibiotic treatment and that definitive diagnosis should be completed prior to antibiotic utilization.

Methodology

Providers with a fail rate >95% were the main focus of this study. QARR results of measurement year 2005 and 2006 were used as a baseline and re-measurement periods.

Interventions

Provider offices with high fail rates (>95%) were visited. Rapid strep kits were given out, and provider information was included with member handouts. The information gained from this office interaction was documented in a letter and was distributed to other providers that had a high fail rate (>60%).

Results and Conclusions

There was a 12 and 16 percentage point increase in Medicaid and CHP QARR rates respectively from 2004 QARR to 2006 QARR. Provider specific data based on 10 providers showed that all had improved their previous rates or had a considerable decrease in their denominators.

Several factors seemed to contribute to the poor QARR scores for pharyngitis. Coding, reimbursement, documentation of co morbidity and parental pressure to give antibiotics were all findings in provider offices with high fail rates. These were documented and distributed to many providers. There was an overall improvement and there is an anticipated annual increase in this QARR measure. However, there must be a continual effort by our health plan to sustain this improvement.

Neighborhood Health Providers

Appropriate Testing for Pharyngitis 2006

NHP chose to conduct this study based on the 2004 QARR NHP rates for pharyngitis which were lower than the (SWA) statewide average (Neighborhood 2004: 34%; Statewide Average; 49%)

Based on these findings of the 2004 QARR scores, the plan conducted this study to answer the following questions:

1. Was the test done but not documented?
2. Was the test not done?
3. Did the member refuse testing?
4. Did the member see the PCP/ER for test and follow up or got prescription over the phone?
5. Will the education of members, PCPs and ER personnel result in better testing for pharyngitis?

Methodology

The population for this study included all children, 2-18 years of age regardless of line of business, who were diagnosed with pharyngitis and prescribed an antibiotic. The study was conducted over an 18 month period (January 2006 - July 2007). The plan conducted two rounds of medical record review for this study:

1. Baseline January 2006 – June 2006;
2. Second measurement January 2007 – July 2007

Interventions

1. Educate members on the appropriate protocol for "Testing for Pharyngitis" via member newsletter.
2. Educate Providers on the appropriate protocol for "Testing for Pharyngitis" and regarding the appropriate coding and submission of claims via Provider newsletter, letter and lectures by NHP's CMO.

Results and Conclusions

Sixty-five percent of the medical records reviewed showed that providers are following the appropriate protocol for testing for pharyngitis and documenting it in the chart. However, 35% of medical records did not have any documentation of a throat culture being performed but the provider did prescribe an antibiotic for Pharyngitis. After interventions were implemented we reviewed medical records for the same providers and found that 90% of medical records showed that providers are following the appropriate protocol for "Testing for Pharyngitis" and documenting it in the medical record, however

10% of medical records showed that providers were not following the appropriate protocol when "Testing for Pharyngitis". The preliminary results of the 2006 QARR (for NYSDOH) showed that NHP results were better than the SWA for the Medicaid population.

In conclusion, we learned that the majority of providers are following the appropriate protocol for testing for pharyngitis and performing a throat culture before prescribing antibiotics. The plan will continue to educate our providers on the appropriate protocol for testing for pharyngitis and will re-evaluate the providers during our 2008 Annual Medical Record Review.

AmeriChoice NY (AC-NY) / United HealthCare NY (UHC-NY)

Appropriate Treatment of Members with High Blood Pressure

UHC-NY and AC-NY conducted a project to improve the quality of hypertension treatment provided to its members in accordance with nationally recommended guidelines regarding the use of blood-pressure lowering medication.

Preliminary data analysis revealed that two-thirds of members in UHC-NY and AC-NY were prescribed anti-hypertensives (60.4% and 63.2%, respectively). Thus, the primary goal was to increase the number of members with uncontrolled hypertension who are prescribed appropriate medication. The long-term goal was to decrease the risk and costs associated with more serious health conditions and mortality due to high blood pressure.

Methodology

The inclusion criteria was members aged 18 and over with two physician office visits and documented blood pressure in excess of 140mm Hg, and/or diastolic blood pressure greater than 90mm Hg. The prescription of an antihypertensive medication for eligible patients with high blood pressure was used to determine a quality indicator of success or failure, with the goal of decreasing the failure rate in antihypertensive use by 10% for both plans.

As a secondary focus, UHC-NY and AC-NY attempted to examine the rationale for not prescribing blood pressure lowering medication to eligible patients and whether patients were prescribed medication but did not adhere to physician recommendations. For this endeavor, chart review was conducted on a small number of members from each health plan who were not prescribed anti-hypertensives.

Interventions

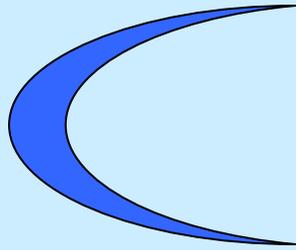
Interventions were implemented over a one year period (01/01/2006–12/31/2006) and targeted both physicians and patients who were identified as having uncontrolled blood pressure and no pharmacologic treatment. Physicians received laminated practice guidelines, drug formulary information, and system change interventions. UHC-NY and AC-NY members received telephonic outreach and care management, and informational mailings.

Results and Conclusions

UHC-NY and AC-NY demonstrated a final rate of antihypertensive use that exceeded their target rate (a 10% decrease in the failure rate of antihypertensive use). UHC-NY experienced a 32% decrease in the failure rate, while AC-NY decreased the failure rate by 38%. Both results were statistically significant. In terms of percentage point change,

approximately 73% of UHC-NY members with elevated blood pressure were prescribed antihypertensive medication at follow-up, compared to 60% at baseline. For AC-NY, approximately 77% of members were prescribed anti-hypertensives, compared to 63% at baseline. Chart review revealed that when medication was not prescribed, patients were often encouraged to make lifestyle modifications and to return for follow-up.

Marked improvement in pharmacologic treatment of elevated blood pressure was shown among members of UHC-NY and AC-NY in this one-year quality improvement study. The adoption of best practices by physicians and increased patient compliance may be the result of a two-pronged intervention approach that involved repeated patient-focused educational outreach, as well as provider outreach.



Best Clinical and Administrative Practices Collaborative (BCAP)

Improving Asthma Care in New York State by Building Cross-Stakeholder Partnerships

With support from The Robert Wood Johnson Foundation, the Center for Health Care Strategies (CHCS) worked with the New York State Department of Health, managed care plans, providers and consumer-focused organizations to develop and implement clinical and administrative practices to improve asthma care for New York State Medicaid beneficiaries.

The collaborative focused on two major goals: 1) implementing the recommendations from the state's *Asthma Care Guideline* to establish practices that improve clinical quality for enrollees with asthma, and 2) maximizing limited resources by coordinating interventions and sharing information across stakeholder groups.

Eleven Medicaid managed care plans from NYS participated in the project:

- CenterCare
- Excellus BCBS, Preferred Care, Monroe Plan
- Fidelis
- Hudson Health Plan
- Independent Health, Univera Community Health, HealthNow
- MetroPlus
- SCHC Total Care



CenterCare Health Plan

Best Clinical and Administrative Practices Collaborative (BCAP): Improving Asthma Care in New York State

Asthma, although a controllable chronic disease remains a significant public health problem in New York's Medicaid population. Many New Yorkers do not receive the care they need and deserve and there is substantial evidence that opportunities remain to further reduce the burdens associated with the disease. The objective of the project was to determine if increasing physician awareness of members who should be on asthma controller medications, via the distribution of provider "Report Cards", can change prescribing practices with respect to controller and rescue medications.

Methodology

The objective was based on the Asthma Care Guidelines of the New York State Department of Health and the project was facilitated by Center for Health Care Strategies (CHCS). The project was monitored through the use of rapid PDSA cycles within the CHCS typology for improvement: identification of population, stratification of population, outreach to providers and intervention. Data was collected over a six (6) month period via questionnaires mailed to providers and review of pharmacy data on asthma medication usage. Measurement was based on two process measures:

1. Percent of Primary Care Physicians (PCP) who returned the questionnaire
2. Percent PCPs who found report card useful.

The one outcome indicator was the HEDIS measure Use of Appropriate Medications for People with Asthma.

Intervention

Identified 100% of members with persistent asthma, ages 5 to 56 and stratified them according to use of long term controller medications. "Report Cards" containing information related to the use of controller medications, ER usage, and inpatient stays were distributed to 634 providers who had members with asthma identified through 2004 claims data. Follow-up surveys were sent in 2005 to the same 634 providers requesting their input on the value of the "Report Card" and to determine whether changes in prescribing patterns had occurred.

Results and Conclusions

Seventy of 634 questionnaires were returned yielding an 11% return rate. The results indicated that the providers (82%) found the "Report Cards" helpful. The HEDIS 2003 Medicaid baseline rate was 77% for the use of controller medications, and the re-measurement rate in 2005 was 87.24%.

Baseline and re-measurement rates showed a ten percentage point difference. However, a conclusion cannot be drawn regarding the impact of report cards on physicians' prescribing practices due to a change in methodology for the re-measurement year.

Excellus Blue Cross Blue Shield Rochester, Monroe Plan for Medical Care, Preferred Care

Rochester Asthma Collaborative: Improving Asthma Care for Children

Collaborators worked with support from the Center for Health Care Strategies (CHCS), the New York State Department of Health, other Medicaid managed care plans, and community providers to develop implement and evaluate clinical and administrative practices to improve asthma care for New York State Medicaid managed care enrollees.

The aim of the local Rochester collaborative was to improve asthma care for Medicaid Managed Care enrollees by increasing the rate of asthma education conducted by providers caring for Medicaid managed care members age 2 to 17 years with a diagnosis of asthma in Monroe County.

The local collaborative pilot project focused upon achieving the following objectives:

- Identify 100% of children (2-17 years of age) in the Medicaid program with asthma enabling an increase in the prevalence rate by at least 1 percentage point
- Identify the high-volume practices which, when combined, managed at least 60% of the targeted population
- Provide outreach assistance such that eighty five percent (85%) of the identified high-volume practices would successfully achieve certification to provide asthma education
- Achieve a goal for the intervention of twenty five percent (25%) of children in the target population in high-volume targeted/trained practices receiving asthma education within 12 months of provider office training and certification

Methodology

Select high-volume Monroe County Medicaid managed care providers and their pediatric patients with a diagnosis of asthma were identified for participation. HEDIS/QARR technical specifications were used to identify children ages 2 to 17 years of age in the Medicaid population with persistent asthma. The measure was reported administratively. No sampling was done. Pharmacy claims data was used to augment the identification of children with a diagnosis of asthma. Provider practices were rank ordered by number of members with asthma. A pre/post testing process was employed to measure practitioner education effectiveness. Administrative claims data was used to report on the number of members who received asthma education provided by trained practices. Claims data was analyzed to assess utilization of CPT codes allowed for reimbursement for asthma education provided in the office setting.

Interventions

- Augmented existing claims data by using Medicaid pharmacy data to identify children with asthma
- Implemented measure methodology rank ordering practices by number of members meeting targeted population criteria
- Developed and disseminated collaborative communication and a shared vision for the project
- Provided cost-free training and incentives for provider participation
- Trained participants to use an asthma education process modeled after a proven program and tied to established evidence based clinical practice guidelines for Asthma management
- Offered trained and certified providers the opportunity to bill the collaborating health plans for Asthma education conducted in the office setting using a defined/common set of CPT codes

Results and Conclusions

- Identified eligible children enabling an increase in the prevalence rates for collaborating plans, ranging from 2 – 7%
- Identified and engaged high-volume practices managing at least 60% of the targeted population
- Nine targeted practices successfully completed training and registration to provide asthma education
- 16% of children in the targeted high-volume practices received asthma education within 12 months of program implementation

Based on retrospective medical record review asthma was assessed 95% of the time and asthma education was provided at a similar rate. Future considerations for the project include:

- A successful model of office-based education could be expanded to include case and disease management services where there is health plan facilitation at the point-of-service for care management (CM-DM services) offered in the provider office setting.
- Consider community collaborative quality improvement activities in response to improvement opportunities observed in HEDIS/NYS QARR measure performance.

Fidelis Care New York

Best Clinical and Administrative Practices Collaborative (BCAP): Improving Asthma Care in New York State

The objective is to improve the efficiency of asthma care by:

- 1) Decreasing the number of member emergency room visits for treatment of acute asthma
- 2) Increasing the number of member PCP follow-up visits after an acute asthma episode and
- 3) Providing preventive education and facilitate access to care by developing links between members, disease management associates and PCPs.

Methodology

Rapid PDSA cycles were used to test change within the framework of population identification, stratification, outreach and intervention. The process began with the selection of hospitals. A collaborative process of case finding was set up between Fidelis Care New York (FCNY) and hospitals, whereby Emergency Room (ER) staff notified FCNY whenever a member accessed care in the ER for asthma. A FCNY Disease Management Associate was to contact the member and/or family for preventive education and to schedule an appointment with the Primary Care Physician (PCP). As a result of the ER not notifying FCNY when members sought asthma care in the ER, FCNY changed the initiative to utilize claims data to identify members who had accessed care. Another hospital was selected to participate. Four indicators based on pre-intervention and post-intervention data were selected for measurement.

Intervention

Members were to be contacted by telephone or by mail. A follow-up appointment was to be made with PCP within 2-3 weeks of member's ER visit. The PCP would have been made aware of the recent ER visit by mail, telephone or fax with instructions to evaluate and educate the member on asthma. Also, appointments for home nursing visits for environmental assessment and/or appointments for pulmonologist were to be made when necessary after the PCP visit or after a conversation with the PCP.

Results and Conclusions

Sufficient data was not available to make an objective conclusion on the primary objective of the study which was to decrease the number of asthma visits to the ER. Supplemental data from claims review and questionnaires supplied information for process improvements. In this study, the Health Plan/ER Notification Mechanism was not an effective method for identifying and reaching out to plan members with poorly controlled asthma.

Hudson Health Plan

Improving Adherence to New York State Asthma Guidelines

Hudson Health Plan (HHP) in 2005 joined the New York State Collaborative for Asthma Care, a collaborative of Medicaid managed care plans formed under the auspices of the Center for Health Care Strategies to address the delivery of asthma care in New York State.

The primary aim of the project was to improve the use of controller medications by the HHP population with persistent asthma by 10 percentage points. Secondary aims included reducing ER visits and inpatient days – “bad days” – in the target population and ensuring that asthma members had 2 PCP (primary care provider) visits a year.

Methodology

HHP adopted a randomized cluster design for the Asthma PIP study in order to determine whether there is a relationship between types of asthma intervention and health outcomes for asthma members. Primary care medical practices were randomized to one of four study arms;

1. Usual and customary care;
2. Provider outreach;
3. Case Management;
4. Provider outreach and case management combined.

One year’s enrollment was required and the age band was expanded to 5-64 years, enlarging the study population.

Interventions

Members whose medical groups were randomized to study arm 1 received customary and usual care, which meant no special programs were offered members and no customized provider outreach conducted. However, any requests for asthma information or case management were honored, and any ER visit or hospitalization automatically triggered case management by HHP’s clinical department. Medical groups randomized to study arm 2 received customized packets of information that included patient “alerts,” an HHP-developed “asthma management score” of physician asthma care and NYS Asthma Care Guidelines. Members whose medical groups were randomized to study arm 3 were asked whether they wished to receive case management and if so were enrolled in CM and stratified as to the severity of their asthma. The stratification process put them on a timetable for outreach by case managers. Members in study arm 4 received the CM option, and their providers received patient information profile and the scores.

Results and Conclusions

The primary aim of raising controller medication use from 71% of the cohort to 81% of the cohort was not achieved – indeed, adherence dropped nearly 10 percentage points for the entire cohort, with similar declines for all study arms. “Bad days” improved (fell) for study arms 1, 2, and 3 but deteriorated (increased) for study arm 4. The changes were not statistically significant. Members with more than 2 PCP visits showed no improvement in 2006 for the overall cohort. Results for the HEDIS 2007-defined subgroup showed improvement in medication adherence from a higher baseline, with the largest percentage gain in study arm 1 – usual and customary care.

Independent Health - Health Now - Univera Community Health

Standardized Physician Profile for Asthma Care in Western New York

Asthma continues to be the leading pediatric chronic disease for Western New York as well as a growing health problem. It is a major cause of morbidity in WNY.

Independent Health (IH) with Health Now of Western New York and Univera Community Health (UCH) worked together to develop and implement a standardized approach to physician profiling of asthma care for Medicaid members 5 – 17 years of age.

Methodology

Identified 100% of children age 5 – 17 years in all 3 plan's Medicaid managed care program with persistent asthma who resided in Erie County. The 2004 HEDIS/QAAR technical specifications were used to identify children 5 – 17 years of age with persistent asthma. This was done administratively. 2003 was used as the measurement year to identify the population. Next the high volume practices who managed at least 60% of the targeted population were identified and were ranked ordered by number of members with persistent asthma. Administrative claims data was also used to report members' utilization of the ER, office PCP visits, office specialist visits, and pharmacy services.

Interventions

- Developed the Asthma Care Profile including demographics, asthma related drug utilization, and visit utilization
- Developed a cover letter explaining the profile and the collaborative project
- Developed a practitioner satisfaction survey
- Distributed standardized patient Asthma Care Profiles, the cover letter and the satisfaction survey
- Mailed cycle 2 profiles and surveys

Results and Conclusions

Of the 321 profiles delivered in the first cycle, 157 profiles (or 49%) were returned with comment or action taken. In cycle two, 62% of the profiles were returned with comment or description of action taken.

The project objectives were met. Based on survey results, the practitioners found academic detailing helpful and an effective method for dissemination of interactive tools. Based on surveys, practitioners found the Asthma Care Profile to be a useful tool and took action based on receipt of the Profile.

All three health plans would like to continue the profile in some format but the profile will be adapted to each individual health plan's data system.

MetroPlus Health Plan

Telephonic Asthma Outreach

From February 2005 to October 2006, MetroPlus initiated a telephone outreach program for asthma patients who were selected based on a recent severe medical event. We wanted to compare certain educational interventions to a control group to see if we could demonstrate a clinical difference that could be carried forward to future programs. Members were enrolled and reassessed at 6 and 12 months using the metrics below. Our main objective was to determine if we could measure improvement in patient outcomes through telephonic education.

Methodology

We identified 1100 members who had valid phone numbers who had either 2 ER visits, 2 admissions, or one of each in the year prior to the study period. 172 members were entered into the program and received a standardized initial assessment. The enrollment was limited by the available resources and the desire to rapidly complete the first cycle in order to quickly make adjustments before expanding the program. The study plan called for the completion of additional assessments at 6 and 12 months after enrollment. Interim periods of contact were at the discretion of the case manager. 65 members completed the study; other members were lost to follow-up because we were unable to contact the member or they lost enrollment. Measurements used:

1. Use of an Asthma Action Plan
2. Peak flow measurements
3. Symptom free days.
4. Reduction in ER use, admissions, and rescue medicine refills during the study year.

Intervention

Telephonic educational outreach to members.

Results and Conclusions

1. The use of an Asthma Action Plan increased 42%, The use of a Peak Flow meter increased 15%, the number of members reporting 14 symptom free days increased 36%.
2. A new case management database was developed.
3. Motivational interviewing techniques were included in the program.
4. Completion of the study led to better design of future outcome measures.
5. Persistent educational effects were documented at 12 months.
6. Only adults showed a reduction in ER visits; no effect on rescue medication use.
7. Dedicated resources are very important.

SCHC Total Care

NYS Asthma Collaborative

Our aim is to determine if intervention from the plan could decrease emergency room visits related to asthma. By encouraging Primary Care Provider follow up, we expect to see a decrease in repeat emergency room visits and thus improve the overall health of the member.

Methodology

Population:

- All Total Care Members seen at 3 major hospital Emergency Rooms for asthma symptoms
- Baseline measurement period January to June 2005 compared to data after interventions

Study Indicators

- Percentage of members that utilized ER with Asthma diagnosis, contacted by mail or phone
- Percentage of Providers responding to notification of member ER visit
- Percentage of follow up appointments made & kept with PCP after ER visit

Data collection procedures

- Roster Data from Hospitals
- Authorization/Claims Data

Interventions

Member

- Daily census was received from hospitals
- Claims/authorizations investigated to determine ER usage history, inpatient admissions, and referrals to specialists
- Calls placed to members to discuss ER visit
- Members were asked a series of questions including: previous diagnosis of asthma, previous inpatient admissions, known asthma triggers; and current medications.
- PCP assignment and correct contact information confirmed
- Member asked if they thought they would benefit from the case management plan

Provider

- The 2 participating facilities modified daily ER roster by adding address and telephone number
- After modification of roster, member contact rate increased to 26% in Month 3

- PCP letter sent for those who had a patient seen in ER. PCP could fax info back to plan regarding follow up appointment and case management recommendations

Results and Conclusions

- Primary Care follow-up within 3 weeks of an ER visit increased from 43% before the intervention to 63% after the intervention.
- PCP response was favorable throughout the network
- Interventions have become a part of Utilization Review /Case Management Program
- Project was successful due to cooperation of hospital staff, based on relationships built by QA/UR nurses
- Outreach directly to members and to providers yielded the best results