2011 – 2012 Performance Improvement Project Abstracts featuring

Reducing Potentially Preventable Readmissions Projects and

Eliminating Disparities in Asthma Care Projects

Introduction

This compendium of Performance Improvement Projects (PIP) summarizes the two-year projects conducted by New York State Medicaid managed care plans in 2011 and 2012, as well as one-year projects conducted by the two HIV Special Needs Plans (SNPs) in 2012. There are 18 PIPs in all, with 10 focusing on Reducing Potentially Preventable Readmissions, 5 focusing on Eliminating Disparities in Asthma Care (EDAC), and 3 (Amida Care, MetroPlus SNP, and United Healthcare Community) focusing on topics not related to readmissions or EDAC.

Below is a summary of the two common PIP topics, Readmissions and EDAC, encompassing 15 of the plan PIPs.

In late 2010, the NYSDOH proposed the topic "Reducing Potentially Preventable Readmissions" for a two-year common PIP for plans for 2011-12. The objective of this PIP was to reduce potentially preventable readmissions by implementing proven interventions such as early hospital discharge planning, post-hospital follow-up, and enhanced care coordination. Over a two year period of study, participating plans were to investigate the root causes of potentially preventable readmissions in their provider networks, identify barriers, and design appropriate interventions to affect change. Identified barriers to quality transition care include inadequate communication of discharge instructions, inadequate medication reconciliation, and lack of timely and appropriate follow-up care after hospital discharge. Plans were expected to partner with one or more hospitals for the conduct of this PIP as well as with associated high volume primary care practices. The project allowed for plan choice of targeted populations, interventions, and measurement tools, although the primary end point of measurement was readmission rates.

In September, 2009 the New York State Department of Health (NYSDOH) received funding from the Centers for Disease Control and Prevention (CDC) to develop, implement, and evaluate an intervention designed to impact a specific population within the state that is experiencing a disproportionate burden of asthma as compared to the general population. To achieve this end, the Eliminating Disparities in Asthma Care (EDAC) Collaborative was developed. NYS Medicaid managed care data revealed the greatest disparities in asthma health care utilization and outcomes in NYC are experienced by African Americans, consistent with national data. Accordingly, NYSDOH selected four neighborhoods in Brooklyn as the focus for the EDAC Collaborative work, because of the high concentration of African American Medicaid Managed Care plan members with asthma residing in these neighborhoods. Designed as a partnership between the NYSDOH, New York City-based Medicaid managed care plans, and health care practices, project teams tested and implemented changes in their systems to improve asthma care processes and health outcomes.

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

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

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

GLOSSARY OF ACRONYMS

CM – Case Management
HEDIS – Healthcare Effectiveness Data and Information Set
NYS – New York State
PCP – Primary Care Provider
QARR – Quality Assurance Reporting Requirements

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Affinity Health Plan
Reducing Potentially Preventable Readmissions

Project Topic / Rationale / Aims
Asthma and Congestive Heart Failure were the top diagnoses related to readmissions. The health plan sought to reduce readmissions, increase PCP follow up after discharge, increase medication self-management education and to increase communication between inpatient providers and primary care providers.

Methodology
The health plan targeted actively enrolled Medicaid members who experienced inpatient admissions for target diagnoses of asthma or CHF during the baseline measure periods (2009-2010). The health plan tracked ED visits, Inpatient admissions, PCP visits and medication refills using encounter data and/or electronic medical records.

Interventions
Telephonic outreach by health plan resources during the hospitalization, 7-days, 14 days and 21-days post-discharge were used as Phase I interventions. Pre-discharge face-to-face outreach, 7-day and 10-day telephonic outreach and face-to-face outpatient clinic interventions conducted by the partner facility were used in Phase II. Transient contact data, member refusal to participate and no-show for clinic appointments were barriers to successful intervention. Inability to access electronic medical records during Phase I negatively impacted post-discharge communication with PCP.

Results/Conclusions
Although decreases in ED visits, admissions and readmissions were observed, the project did not achieve a 10% decrease as planned. Although PCP visits increased, they were not timely (within 30 days of hospital discharge). Face-to-face engagement attempts had a higher rate of success than telephonic attempts. A small subset of users with outlier utilization patterns were drivers for elevated rates of ED, admission and readmission utilization.

Project objectives were not met. The initial design of the project included solely telephonic interventions which proved to be largely unsuccessful. Transition to a combination of face-to-face and telephonic interventions improved contact rates for a smaller cohort and long term impact was not measurable before the conclusion of the project. Changes to the health plan's system of record resulted in slight differences in assessment tools and potential impact to validity of outcome measures. Next steps will include increase partnerships with provides which support face-to-face interventions along with implementation of a field-based component to the health plan's care management staff.

Capital District Physicians' Health Plan (CDPHP)
Partnering to Reduce Behavioral Health, Obstetrical, and Complex Medical Readmissions.

Project Topic / Rationale / Aims
For this project, "Partnering to Reduce Behavioral Health, Obstetrical, and Complex Medical Readmissions," CDPHP intended to reduce the number of potentially preventable behavioral health, obstetrical, and complex medical readmissions for a targeted group of NYS Medicaid Managed Care members at Ellis Hospital, Schenectady, New York. Ellis Hospital was selected as a partner because it is the primary hospital for Schenectady County, and it serves approximately 20% to 25% of CDPHP's Medicaid members. The project goal was a one percentage point reduction in the rate of readmissions (target goal of 5%).

Methodology
To establish a baseline for the project, Ellis Hospital admission data was reviewed for the period September 2009 through August 2010. Among the 1,311 admissions, 83 or 6.33% met the definition of readmission within 30 days. Expressed as a percentage of members, 58 unique members, or 5.19% of 1,117 total members had a readmission within 30 days. Behavioral health, complex medical (including heart failure, diabetes, and asthma) and pregnancy related conditions represented the top three categories of readmissions.

The methodology also included performance indicators for readmission rates calculated through claims data, and HEDIS/QARR measures: Plan All-Cause Readmission (PCR), Prenatal Care measures (PPC and FPC), and Follow-Up After Hospitalization for Mental Illness (FUH).

Interventions
Interventions included early identification of high-risk members and community based follow-up, primarily to ensure compliance with provider appointments. For the Behavioral Health population, CDPHP was successful in implementing the Community Transitions Program (CTP) in conjunction with Family and Children's Services of the Capital Region. For the obstetrical members, engagement was coordinated through CDPHP's Birth to Better Health (BTBH) program. Both programs focused on face-to-face contact with members prior to discharge, assistance with scheduling the follow-up provider appointments, and educational interactions. Where indicated, referrals were made to other services, such as CM.

Results/Conclusions
CDPHP was successful in achieving a slight decrease in readmission rates for Ellis Hospital, from 2010 to 2011. Behavioral health readmission rates also decreased. For the PCR measure, Ellis' rate was lower than the Plan-wide rate in 2011. For women in the BTBH program, post-partum visit rates were higher than the Plan-wide HEDIS rate. FUH rates for Ellis were also higher than the Plan rate in 2011. With regard to complex medical programs for members with cardiac disease, specifically CABG surgery patients, Ellis did not experience any readmissions for CDPHP Medicaid members for 2011. Data for 2012 is pending.

Readmission rates for the three years of the project were 7.05% for 2010, 6.80% for 2011, and 8.22% for 2012. The readmission rate increased from 2011 to 2012. Performance on all HEDIS indicators except the postpartum visit also demonstrated decreased performance when compared to plan rates for 2012.

While first year results were encouraging, the gains were not sustained. Since the inception of this project, the CDPHP Medicaid population has increased, and the care needs appear to be more complex than in recent years. All of this is requiring a closer look at the programs.

EmblemHealth
Reducing Potentially Preventable Readmissions Performance Improvement Project

Project Topic / Rationale / Aims
The topic of this PIP was reducing potentially preventable readmissions among Medicaid members. The primary aim of this project was to achieve at least a 10% reduction in hospital readmissions and associated costs among Medicaid members hospitalized for a non-maternity, medical condition. The PIP project also aimed to determine if the reduction in readmissions could achieve a 10% reduction in the overall inpatient admissions per 1,000 members. The project also include secondary goals, including a program enrollment rate greater than 75% and satisfaction survey result averages greater than 8 out of 10 on each survey item.

Methodology
The population consisted of Medicaid members hospitalized for a non-maternity, medical condition. Each discharge was followed for thirty days to determine if a readmission occurred. The project originally began with one CM team delivering services to members of four medical offices of one medical group in Manhattan. Over the course of the project, the program expanded to include three teams delivering services to members of seven offices of three medical groups across Manhattan, Staten Island, and Brooklyn. A historical, baseline cohort design was used to assess changes in readmissions. A one year time period prior to program implementation was identified and utilization information was gathered for discharges meeting program criteria. The criteria used to identify members during the baseline period was the exact same criteria used during the intervention period.

Interventions
The intervention for the PIP project was integration of a CM team into medical offices. These teams consisted of nurse case managers, social worker case managers, health navigators, and pharmacists. The teams provided care transition interventions and short term CM services to Medicaid members hospitalized for non-maternity, medical conditions.

Results/Conclusions
Analyses of the baseline and intervention groups demonstrated that these groups were similar with respect to the risk of readmission for discharges occurring during the baseline and intervention time periods. Results indicated that the thirty day readmission rate was reduced from 17.09% to 12.71%. This 24% reduction met the project's goal of a 10% reduction. The average readmission cost per member was reduced by $742.58 per member, representing a 30.6% reduction which also met the project's goal of a 10% reduction. The overall inpatient admission per thousand rate did not meet the project's goal of a 10% reduction. The program enrollment rate of 82.68 met the goal of achieving a 75% enrollment rate and each satisfaction survey item had an average result greater than 9 out of 10 which also met the goal for the project.

The point of care CM project met goals related to reducing readmissions for Medicaid members. The program also exceeded all expectations related to member satisfaction. As a result, the program expanded quickly to additional medical groups and medical offices over the course of the PIP project. It was well received by members and medical staff at each new location. The most important lesson learned was the impact a team case managers with diverse specialties can have on the plan's most vulnerable members, when the team is delivering services at the time they are needed most in the setting that is most convenient for members.

Excellus Blue Cross Blue Shield
Reducing Potentially Preventable Readmissions: Transition Care Program

Project Topic / Rationale / Aims
The Transition Care Program was implemented to determine if the introduction of a Transition Care Coach would decrease the number of individuals who are re-hospitalized for PQI (Preventive Quality Indicators) conditions that could be managed on an ambulatory basis. The goal of the program was to produce a 2% point decrease in preventable readmissions with the individuals who received the Transition Care Coach as opposed to the group with no coaching. The foundation of the program was based upon the Coleman Model for Care Transitions.

Methodology
The targeted population included patients over 18 years of age with a condition related to Diabetes, Circulatory or Respiratory conditions. All individuals who were admitted to the hospital were screened for admission into the program. Data was collected to determine the percentage of patients who entered the program, the percentage who completed the program, the percent of change in the patient's activation level for self-management, patient and provider satisfaction and readmission rates for program participants. Information was obtained through insurance claims, patient, family, provider and Transition Care Coach Feedback.

Interventions
The interventions for the program included an on-site hospital visit to the patient by the coach prior to discharge, a home visit within 2-3 days following discharge and subsequent phone support/home visits for a 4-6 week period following discharge. Using a patient centered approach; the coach promotes patient and family self-management of their condition through education and skill development in The Four Pillars: Medication Self-Management, use of a dynamic patient centered Personal Health Record, Primary Care and Specialist follow up and knowledge of "Red Flags", knowing when to contact the doctor for a change in condition. In most cases, the patient was coached to initiate communication with his/her provider to set appointments, report concerns or obtain answers to questions about their condition.

Two community hospitals agreed to participate. The smaller community hospital was unable to consistently identify eligible participants via their insurance product due to systems issues. The larger hospital linked the coach to the Social Work Department Manager, who in turn was able to facilitate the coach's access to the EMR (Electronic Medical Record). This enabled the coach to have real time information through the hospital data system. Eligible individuals were "flagged" at the time of admission and when discharge planning was happening so that the coach could connect with the person prior to discharge.

Results/Conclusions
A total of 307 individuals were admitted into the Transition Care Program. Of significance was a noted increase in the individuals' activation for self-management. The goal of a 2% point decrease in readmissions was met and exceeded for the program participants as compared to a control group of individuals who were not part of the program. Patients who participated in the program reported a high level of satisfaction with the coach and the program content. Less than 50% of the patients attended a follow up visit with their provider within 7 days of discharge.

The importance of this model for transitions is the positive impact reported by the participants. The majority of the participants (72%) noted that they felt more confident in relation to managing their heath and that they could do this on their own in the future. This is significant for those with chronic conditions who need to self-monitor and manage in order to maintain their health.

HealthNow
Reducing Potentially Preventable Readmissions

Project Topic / Rationale / Aims
Reducing potentially preventable readmissions can improve quality of care while reducing cost. From April 2009 to March 2010, there were 3,185 total plan Medicaid member admissions and 446 All Cause readmissions for an average readmission rate of 14.0%.

HealthNow's aim was to reduce the Medicaid readmission rates and improve member understanding and compliance with discharge plans. Three main components of the multifaceted approach included Case and Disease Management (CM/DM) services, provider engagement, and development and implementation of a Hospital Discharge Program. CM/DM outreach to identified Medicaid members by the clinical staff provides services which included telephonic health education, medication counseling, and assistance with referrals, linkage with providers, and ongoing follow up and interaction with practitioners as needed. The Hospital Discharge program was implemented in two large health systems in the Western New York area.

Methodology
The eligible population was comprised of Medicaid members who had an index medical or surgical admission for any diagnosis with the exception of noted exclusions to the denominator, followed by an inpatient readmission for any cause within 30 days of discharge. The goals were a 3% improvement in overall All-Cause Medicaid 30 day readmission rate, readmission rate by hospital facility, and readmission rate by Health System, and a 5% increase in the percentage of members completing a provider follow up visit within 14 days of discharge.

Interventions
- Development and implementation of the Hospital Discharge Program, which provides a home visit by a specially trained Home Care agency nurse within 48-72 hours after discharge.
- Collaboration with strategic partners in the community (home care agencies, hospital facilities discharge planning departments and participating practitioners)
- Hospital Quality measures and incentives to include a focus on readmission reduction.
- PCP education via Provider Newsletter articles, staff interaction, and planned webinars
- Provider incentive for PCPs focused on improvement in completion of follow up visits within 7 days of hospital discharge.
- Focused CM/DM services which included post discharge outreach, assessment, education and referral to other services as needed
- Member educational materials included use of a health history and disease specific materials.

Results/Conclusions
Overall, the goal of 3% reduction in the All-Cause 30 Day Readmission Rate was not met, with rates of: Baseline-14.00%, Measurement #1-13.73%, Re-measurement #2-13.80%, and Re-measurement #3-13.64%. Positive results to improve care for members were obtained:
- Statistically significant change was achieved in the percentage of members completing a post discharge follow up visit within 7-14 days. The project goal was met.
- The goal of a 3% improvement (reduction) in readmission rate was achieved by some facilities.
- Overall readmission rate for one of the healthcare systems showed a 10% improvement. The project goal of a 3% aggregate improvement was met, but not for the other large health system.
- Readmission rate of 9.3% in 2011 and 7.87% in 2012 for members completing a post discharge visit was significantly lower than the overall Medicaid readmission rate of 13.64% for the last measurement period. This leads to the conclusion that the Hospital Discharge program has been successful in helping to reduce and prevent readmissions.

Hudson Health Plan
Reducing Preventable Readmissions

Project Topic / Rationale / Aims
Hudson has participated in the PIP Reducing Preventable Readmissions to reduce 30-day readmission, by improving the transition of information between hospitals and PCPs for Medicaid populations and by increasing the proportion of discharged patients who review their medication reconciliation with their PCPs. Hudson's primary aim was to improve care coordination as demonstrated by the percent of patients who have timely follow-up post discharge.

Methodology
The study population was all Hudson members who were admitted to acute care hospitals. Hudson used 2010 claims data as baseline data, and 2012 claims data as remeasurement data to identify all medical/surgical (med surg) discharges and any subsequent admissions within 30 days post discharge. For outcome measures, Hudson first calculated crude readmission rate – all cause and Med Surg (excluding maternity) and then Hudson calculated age, race and age-race adjusted readmission rates for only Med Surg admissions. The outcome study indicators are:

1. All-cause 30 day readmission rate – Crude;
2. Med Surg 30 Days readmission rate – Crude, and Adjusted by age, race, and age-race
3. Percent of admissions that were followed by an outpatient visit (both PCP and specialty);
4. Percent of members who had medication reconciliation billed by PCP groups within 14 days following a med-surg admission.

Interventions
Hudson intervention strategies were:

1. To improve information sharing between hospital and PCPs by receiving discharge information from a few participating hospitals, and transmit discharge instructions to PCPs.
2. To develop a Hospital Census Report based on authorization requests made to Hudson by Hospitals at the time of admission. For a select group of collaborating PCPs these reports were generated daily and delivered to the PCP facility via secure e-mail.
3. To have a CM assistant call recently discharged members following med-surg admissions to review key information and facilitate making a follow-up visit.
4. To reimburse select PCPs for medication reconciliation post discharge.

Results/Conclusions
Plan wide, no improvement in PCP follow up visit rate was observed. One participating hospital and three participating PCP groups showed improvement in PCP follow up visit rate. Two participating hospitals and three participating PCP groups showed increased specialty visit rate. PCP groups that participated in the project showed higher follow up visit rate than non participating PCP groups.

Plan wide, crude readmissions rate was increased from 2010 to 2012. However, at all three participating hospitals, specific crude readmissions rates decreased from 2010 to 2012, though not statistically significant. Participating hospitals showed decrease though not significant in readmission rate after age-race adjustment while non participating hospitals showed significant increase. Participating PCP groups showed significant increase in readmission rate after age-race adjustment.

Correlation analysis showed lower readmission rate was associated with higher post discharge PCP follow up rate. Hudson believes that providing a daily census report to the participating PCP groups and allowing them to bill for medication reconciliation is helpful in bringing in more patients for follow up visit post discharge and therefore lowering the readmission rate.

Independent Health
Care Transitions Program

Project Topic / Rationale / Aims
In 2010, Independent Health (IH) launched a Care Transitions (CT) Program to help members transition to home from the hospital. The criteria for the program included members who had been discharged from an inpatient stay for respiratory issues or cardiac-related diagnoses. The CT Program is a modified version of the Coleman Care Transitions Intervention, which is a 4-week intervention that supports the patient from hospital discharge to home. The objectives were:
- To reduce potentially preventable readmissions (PPRs) by implementing proven interventions such as early hospital discharge planning, post-hospital follow-up and enhanced coordination.
- To improve the transitions process between the providers, payers, community and member

Methodology
The analysis consisted of all IH Medicaid inpatient admissions from 2010 through 2012 who participated in the CT program. A control group consisting of IH Medicaid members who were eligible to participate but who were not enrolled in a CT program was used to compare outcomes and evaluate program effectiveness. The primary outcome measure was the PPR rate at 30 days. Additionally, the time between discharge and CT program enrollment and time between discharge and follow-up physician office visit were analyzed.

Interventions
- The Home Health Agency (HHA) contacted patient/caregiver and scheduled a home assessment visit to be done within 48-72 hours of hospital discharge, including a CT Risk Assessment Summary (RSA) and a Medication Reconciliation Form (MRF). The CT RSA contained information regarding hospitalization, health status, care providers, and any potential barriers to plan of care. The MRF contained the patients' medication history.
- The CT RN reviewed and assisted the member in completing the Self-Management Guide with instructions to take the document to their PCP appointment.
- The IH pharmacist reviewed the CT RSA and the MRF information, faxed recommendations for the patient back to the CT Health Coach, and notified the PCP if there was a need for a medication change due to adverse drug reaction, duplications and/or a contraindication.
- The HHA staff on post hospital discharge completed telephonic follow-up with member.
- The HHA staff at the end of 30 days completed a discharge summary. The discharge summary highlighted the various interventions for the last 30 days, any potential barriers and/or any identified continued care needs. The discharge summary was faxed to IH for review by the CM/DM staff and the member's PCP.

Results/Conclusions
- Mean time between hospital discharge and enrollment into the CT program was 8.6 days.
- Less than 40% of the Medicaid CT members had a physician office visit within 7 days of hospital discharge which was a decrease from the baseline of 43%. The average time was 25 days (the median was 10 days).
- The 30-day and 60-day all-cause hospital readmission rates increased between 2010 and 2012. The 30-day rate went from 15% to 22%, the 60-day rate went from 23% to 29%, and the 90-day rate increased from 29% to 33%.
- The 30-day PPR rate decreased from 17% in 2010 to 12% in 2012. Outcomes with the control group were analyzed but not included due to significant differences in population characteristics compared to the CT group.

MVP

MVP Health Care's Reducing Potentially Preventable Readmissions – Medicaid Managed Care Performance Improvement Project (PIP)

Project Topic / Rationale / Aim

The aim of the MVP PIP collaborative was to improve CM through high-level communication and coordination of care using proven interventions such as the Coleman Model of care transitions coaching program and to facilitate access to care for at-risk, vulnerable members by improving follow-up primary care office visit rates post-hospital discharge. MVP also worked with collaborative partners to coordinate community interventions to avoid overlap and duplication of efforts, and addressed barriers to forward progress as they arose. MVP's partners include Strong Memorial Hospital, Highland Hospital, and The Visiting Nurse Service (VNS).

Methodology

The main objective was to collaborate with MVP's partners to improve CM processes by creating safe and timely care transitions and timely follow-up post-hospital discharge. The primary indicators were:

- PCP office visit follow-up rates at 7- to 14- days post-hospital discharge (claims based).
- 7- and 30- day readmission rates (HEDIS specifications used for All-Cause Readmissions).

The goals were to achieve statistically significant reduction in readmission rates and statistically significant improvement in follow-up rates.

Interventions

MVP implemented the Transition Coaching program (Coleman Model) with VNS. The program is intended to create synergies with the hospital system inpatient program by building on the hospital interventions and maintaining the patient relationship post-hospital discharge. Members with select Prevention Quality Indicator (PQI) diagnoses such as Diabetes were eligible and invited to participate in the program. Key components were encouragement of patient self-management skills, medication reconciliation and facilitation of the PCP follow-up visit.

The hospital system implemented the "*Safe Transitions Initiative*". The focus was on the inpatient facility-side with primary interventions of assessment of patient risk, discharge planning, medication reconciliation and facilitation of the PCP follow-up visit. Supplemental interventions included provider outreach to assess reporting needs, development and implementation of provider 'gaps-in-care' claims-based reports with follow-up clinical detailing for select PQIs, and encouragement of member engagement with their PCP via reminders and office visit incentives.

Results/Conclusions

Through the collaborative efforts MVP has enhanced discharge processes, including sharing of hospital discharge information with affiliated PCPs, enhanced processes for identification of patients at high-risk for readmission, and put actions into place to facilitate targeted early home care and timely primary care follow-up post-hospital discharge.

Claims trends for readmissions and primary care office visit appointment follow-up are still incomplete for year-end 2012 but MVP has seen improvement at the program level and in PQI trend data. Transition coaching outcomes - Medicaid members who participated in this activity showed significant reductions in claims-based utilization for inpatient admissions, observation stays and emergency department visits. MVP looked at members with an anchor date of 3/30/12 and reviewed claims one year prior to and one year post intervention. In some cases a 30% reduction in utilization in the post- intervention compared to the pre-intervention period was found.

Total Care
Reducing Potentially Preventable Readmissions

Project Topic / Rationale / Aims
Total Care chose the topic of Reducing Potentially Preventable Readmissions. The goal was to focus on admissions for members with a diagnosis of Diabetes and reduce admissions through hospital care coordination and the plan's CM activities to improve outcomes.

Methodology
The performance indicators were measured using quarterly assessments of the admission data to determine decreases in admissions by quarter. Total Care expected to see a decrease by 2 percentage points from 19% in 2010 to 17% in 2011 and 15% in 2012. The exclusion criteria from the denominator or numerator were any admissions for the sole purpose of Mental Health, Chemical Dependency and Obstetrics.

Total Care tracked the number of members who were triggered and enrolled into the CM program. Review of daily inpatient census from hospital identified newly admitted members. The authorization was forwarded to the Quality Assurance nurse who tracks inpatient stays and collects clinical review data from the hospital.

Prior to discharge, the plan case manager collected information from the hospital regarding discharge plan information (including diabetic teaching done in the hospital, medications and follow up appointment with PCP) as well as current member demographic information to optimize contact with the member.

Interventions
Began discussion of the project with the CM staff at Upstate University Hospital and a few months later replicated process at Crouse Hospital. Total Care determined specific information that hospital CM staff will provide to plan/member.

Total Care developed a CM packet which included several items. For example, a refrigerator magnet for members which detailed the list of expected testing (Hemoglobin A1c, LDL, microalbuminuria), dilated eye exam, visit with podiatry, dental exam and blood pressure check as well as frequency in which member should expect these items to be ordered. In addition, a Diabetic member "Newsletter" was included in the CM mailings.

A letter was mailed to the PCP after the member was discharged from the hospital to alert them of need for follow up. Members were referred for 2 Skilled nursing Visits for Diabetic teaching upon Hospital Discharge (in collaboration with PCP recommendations). Referrals were made for Diabetic Members to Crouse Hospital Diabetes Wellness Program. Program components focused on Individualized one-on-one counseling around diabetes care and nutrition small group education classes relating to diabetes management by dietician and certified Diabetes Educators.

Results/Conclusions
The goal was to reduce readmissions for Diabetes from 19% to 15% by 2012. The baseline rate was 19% in 2010. During the project, the readmissions dropped to 17% in 2011 and 16% in 2012.

Although the readmission rate is still 1% above goal, great strides were made. In addition to the decrease in the readmission rate, of the 119 readmissions in 2012, 71% were enrolled in the CM Program. These members accepted and remain in the CM Program in 2013.

Univera Community Health
Reducing Potentially Preventable Readmissions: Care Coordination Program

Project Topic / Rationale / Aims
The Univera Community Health (UCH) Care Coordination Program sought to assist with the transition of Medicaid and Family Health Plus members from an inpatient to an outpatient setting through the coordination of care and services. The goal of the program was to ensure members received the highest quality and effective care, thus lowering the risk of potentially preventable readmissions. The project aim was to determine whether inpatient face to face engagement and education based on the Coleman model could reduce 30 day readmissions.

Baseline data showed increased readmissions (2007 – 20%; 2008 – 22%). The objectives of the Care Coordination Program were satisfied by targeting inpatient members with medical and/or surgical diagnoses and assisting them in understanding their discharge plan prior to leaving the facility resulting in increased participation in CM program, improved quality of care, and decreased potentially preventable readmission rate.

Methodology
Buffalo General Hospital (BGH) was selected as a partner site for the program due to the high volume and complexity of admitted members' conditions. Seven medical/surgical floors within Buffalo General Hospital were included in this project to ensure a wide sample population.

Interventions
The UCH Care Coordination Program was originally implemented as a telephonic program with BGH in 2009. In 2011, the program was modified to include face to face contact, while inpatient, with all eligible members. Once enrolled in the program, care coordinators assessed member concerns and needs for post-discharge care, and assisted with coordination of care and discharge planning before and after discharge. Coordinators engaged with discharge planning staff to better identify potential members who may benefit from the program. It was felt the face to face contact with members would increase member engagement upon discharge.

The Coleman Model was the foundation for the Care Coordination program. The Key Elements were the 4 pillars: Medication self-management with medication reconciliation between levels of care; Primary care and/ or specialist follow as soon as possible after discharge; Knowledge of red flags; and Patient personal health record helped the member record key information and events to share with his/her providers.

Results/Conclusions
Care Coordination staff triaged 626 admissions for inclusion into the program with 459 successfully engaged. The program achieved an overall engagement rate of 93% which exceeded the previous 39% rate for the telephonic program. The program consistently demonstrated a 12% all-cause readmission rate throughout the 2 year period. The 2012 BGH readmission rate saw a decrease from benchmark. Of note, 26% of the admissions were driven by 43 individuals who had multiple admissions throughout the program. These individuals also had a higher average CRG score than those with single admissions.

It was originally thought that a lack of reliable transportation may have a negative impact the physician follow up visits. However, both groups indicating they had transportation and those reporting no transportation had a sixty-three percent physician follow-up visit rate.

The Care Coordination Program demonstrated a decrease in readmission rate. The onsite visits had a positive impact on engagement into the Care Coordination and CM programs.

Amida Care (SNP)
Increasing Timely Assessment for Case Management Services: Part II

Project Topic / Rationale / Aims
Amida Care SNP PIP for 2012 was "Increasing Timely Assessment for Case Management Services". The goal was to assess if enhancements to the CM processes would improve timely linkage to support services for new enrollees and improve overall CM. This goal was split into six aims:

- Initial needs screen within 30-days of enrollment; Goal: 80%
- Referral of needs within 14 days; Goal: 80%
- Comprehensive CM completed within 60 days of enrollment; Goal: 65%
- Reassessment completed within 180 days of initial comprehensive assessment; Goal: 80%
- Initial assessment declined and reassessment re-offered within 180 days; Goal: 80%
- All cause hospital readmission rates within 30-days of index admission decreased by 15%

Methodology
Process measures were built into a re-engineered Amida Care member database for tracking purposes. New enrollees into Amida Care Special Needs Health Plan were tracked via a new needs screen module. This process also checks if the identified needs were referred to an appropriate support service. The percentage of new enrollees, who accepted CM and had an initial comprehensive CM assessment done within the first 60 days of enrollment, was also tracked. Part of the CM redesign process assessed what percentage of those enrollees that had an initial CM assessment done, had a re-assessment done within 180-days, and those that declined CM initially, what percentage now accepted. The CM intervention arm included up to six contacts with CM team over a 60-day period. The outcome measure for all cause hospital re-admission rate within 30 days, per thousand, over a 12-month period was based on claims from utilization data. Rationale for readmission review was that CM would facilitate linkages to services and thus prevent complications and help remove barriers to healthy behavior.

Interventions
Major themes by intervention type were: (1) task-technology fit - resources, time and workflow; (2) individual-task fit - training and technical support; and 3) individual-technology fit – electronic data base report functionality. A need service module was created and put into production in order to track and monitor enrolled members' CM processes. Once enrolled, members' health activities were monitored to ensure proper and cost effective care.

Results/Conclusions
A high proportion, 81%, of the eligible 474 enrollees, had an initial needs screen done and referrals of needs was facilitated in 97% of the cases. Comprehensive CM within 60-days of enrollment was only completed for 13% of the eligible enrollees. Re-assessment within 180-days for those that had accepted CM was completed in 24% of the cases. Re-assessment offered to those who originally declined and completed CM within 180-days of enrollment was 61%. This increased rate of participation in the reassessment process demonstrated the need for re-assessment for both those that had accepted and those that declined initially. All cause hospital re-admission rates within 30-days of index admission increased per thousand. A brief needs screen done by trained members of the enrollee's support team showed a significantly higher rate of successful linkage to support services.

The findings provide evidence for the applicability of the electronic database framework to explore CM processes and outcomes. Assessment of fit among individuals, tasks, and technology is critical to successful adoption of health information technology as a strategy to improve quality and efficiency in health care.

MetroPlus SNP
Improving retention in care of members with CD4 count <200

Project Topic / Rationale / Aims
Engagement and retention in HIV clinical care is associated with improved adherence to antiretroviral therapy (HAART) and improved health outcomes for People Living With HIV/AIDS (PLWHA). Clinic visits provide an opportunity for provision of ancillary services such as treatment adherence counseling, mental health services, HIV CM, and nutrition evaluation/counseling. MetroPlus SNP aimed to examine the effectiveness of reminder letters followed by reminder calls and then outreach visits (if indicated) as strategies aimed at improving retention and engagement in HIV clinical care of members with CD4 counts <200/mm3. Through the above activity the plan hopes to identify and help resolve barriers (such as lack of transportation, appointment scheduling difficulties) that may prevent members from being engaged and retained in HIV clinical care. The plan aimed to improve the proportion of established members with CD4 < 200/mm3 with at least one visit in the preceding 4 months by 10% over the baseline rate at the conclusion of the project.

Methodology
The following indicators were tracked monthly over the course of the study:
- The proportion of participants with no PCP visits in the preceding 90 days
- The proportion with no PCP visits in the preceding 90 days who have no claims for an HIV primary care visit
- The number of letters sent out (one per participant)
- The number of calls made (only one call will be counted per unique participant)
- Proportion of calls made that were successfully completed (per unique participant)
- Proportion of participants with successful calls who received letters
- The number of participants referred for outreach
- The proportion of participants referred for outreach who were successfully contacted
- The proportion of participants with at least one PCP visit in the trimester was tracked on a quarterly basis

Interventions
Each month over the course of the study, a list of members with no visits within the preceding 90 days were abstracted. These members were sent letters reminding them of the importance of engagement in care. Within a week of the letters outreach calls were made to participants. If these calls were unsuccessful, second rounds of calls were made within a week of the first set of calls. If these calls were unsuccessful, members were referred for community outreach. Members who reported barriers with keeping appointments were assisted as indicated.

Results/Conclusions
Initially a substantial proportion of participants were found not be engaged in care based on the study definition (no PCP visits in the preceding 90 days). This number was reduced from 157 participants at the beginning of the study to 77 participants at the conclusion of the study. The number of participants referred for community outreach and engagement was at the peak (45 referrals) during the first month of the study and also was reduced at the end of the study and it appeared that towards the end of the study, outreach was more likely to be successful. A substantial proportion of participants contacted (32-56%) did not have an appointment to see their PCPs and 18-39% subsequently had a PCP visit within 30 days of successful contact. The barriers most often reported by participants were lack of transportation and depression.

The project demonstrated that outreach efforts are an important way of re-engaging and retaining members in care. Mail outreach is a useful tool that can be incorporated into outreach and re-engagement efforts.

United Healthcare Community Plan
Enhancing Smoking Cessation Interventions

Project Topic / Rationale / Aims
Smoking cessation interventions are effective, cost-effective, and produce a return on investment, yet for a variety of historical, cultural, and economic reasons, health plans have avoided this type of project. Given the burden of tobacco related disease on morbidity, mortality, and the overall cost of healthcare, the identification and promulgation of tactics shown to be effective in promoting quit attempts and eventually sustained cessation are an important preventive measure for a health plan to consider.

The specific goals of this intervention were:
1. To increase fourfold the number of members calling the NYS Quitline
2. To improve performance on each Consumer Assessment of Health care Providers and Systems (CAHPS) measure associated with smoking by 5 percentage points

Methodology
The goal of this project was to create a framework that systematically applies smoking cessation interventions and that evaluates the effectiveness of such a method. The intent was to increase the number of health plan members utilizing smoking cessation resources and decreasing the prevalence of smoking in the adult population.

Three types of process measures were considered to evaluate program performance:
1. Referrals to the NYS Quitline
2. Provider Claims for Smoking Cessation Counseling
3. Pharmacy Claims

Interventions
While a variety of interventions were employed for this project, the primary focus was education on resources available to staff, plan membership and providers. Direct member outreach, member mailings and newsletters, provider toolkit documentation, and staff training were some of the major initiatives rolled out for this project.

Results/Conclusions
Due to changes in how the NYS Quitline collects, manages, and reports data, there are limits in the complete interpretation of the final data. Baseline data were not available in the same format as interim and remeasurement data. The number of members identifying as United members when calling the hotline over the last two years did not show any significant change. While slight increases were demonstrated in provider claims and pharmacy, it cannot be considered significant given the fluctuation in plan providers and members. United CAHPS scores did not show significant change in any of the areas related to smoking cessation efforts and therefore did not meet the goals initially established for the project. The prevalence of smoking may not reflect the impact of this program but as smoking cessation programs are known to be effective, the impact may occur long after the program is completed.

Two of the specific goals for this project were not met – an increase in Quitline calls and changes in CAHPS data. Preliminary analysis shows an increase in prescriptions for smoking cessation products but more work is needed to increase both the number of prescribers writing for medication and the number of prescriptions filled. Additional communication and education to the many new providers in the plan’s network is warranted in order to reach the goals established for this project. It is necessary for the Plan to monitor member-level data to determine if members who completed a course of therapy are followed for maintenance of non-smoking status.

Fidelis Care New York
Eliminating Disparities in Asthma Care

Project Topic / Rationale / Aims
This project was established with the objective of eliminating disparities in asthma care among African American members at the Bedford Stuyvesant Family Health Center (BSFHC). Two populations were used for baseline comparison, along with comparing improvement over time in the population of focus (POF) itself. These were: 1) 94 BSFHC patients who had an asthma visit between May and July 2011 and 2) the universe of continuously enrolled BSFHC patients with asthma in 2010. There were three goals for improvement: (1) The percentage of members receiving prescription for a long-term controller (LTC) medication would increase over targets of 65% in Year 1 and 95% in Year 2; (2) The percentage of members refilling prescriptions for LTC medications would increase over targets of 65% in Year 1 and 95% in Year 2; and (3) ER visits and inpatient admissions would decrease compared to baseline.

Methodology
The POF was comprised of 18 members who presented for asthma care at BSFHC from May through July 2011. For the POF, data on asthma medication utilization was collected over time using the following project indicators: medication fill rates among persistent asthmatics, ER visits and inpatient hospitalizations, and rates of not having an outpatient visit for asthma among the universe of asthmatics. The Plan also included the following clinical chart review indicators: use of Asthma Action Plans, documentation of asthma severity, control and triggers, including tobacco exposure assessments. The chart review included evidence of CM assessments on these members.

Interventions
Interventions included: implementing an asthma control and severity testing questionnaire; training for PCPs using a CD-ROM on standards of asthma care; providing technical assistance to the healthcare facility; implementing standing orders to test peak flow on all patients with asthma; sending monthly reports to the facility on inpatient, outpatient and pharmacy utilization of their patients with asthma; including listings of patients who had not had a recent outpatient visit; incorporating the use of the Asthma Action Plan (AAP); development of an electronic asthma template to improve documentation; and, asking patients about individual and household smoking.

Results/Conclusions
The program was successful at meeting goals 1 and 3, with partial success at meeting goal 2. Eight of the 14 African-American Fidelis Care members for whom charts were reviewed were classified as having persistent asthma. Ninety percent of these members received a prescription for a LTC medication in 2011 and 100% received a prescription in 2012, as compared with 82% (and 75% of African-Americans) among the universe of 94 patients during the baseline period.

The rate at which POF members filled their prescriptions for LTC medications improved from 0% (0/7) in 2010 to 71.4% (5/7) in 2011 and 83.3% (5/6) in 2012. The benchmark target was met in Year 1 but not in Year 2. Trending for all continuously enrolled BSFHC patients with persistent asthma revealed an initial improvement in LTC medication fill rates which was not sustained (84.2% in 2010, 95.8% in 2011, and 78.8% in 2012). None of the POF members had an inpatient hospital admission related to asthma throughout the study period and only one member had an ER visit related to asthma in 2012.

Results show improvements in most chart review related measures, including compliance for severity and control documentation, documentation of triggers, use of AAPs and smoking assessment. Environmental smoke exposure assessment did not improve over baseline.

Health Plus Amerigroup
Eliminating Disparities in Asthma Care Project

Project Topic / Rationale / Aims
The NYSDOH's Eliminating Disparities in Asthma Care (EDAC) was a 5-year initiative to identify key strategies for reducing racial/ethnic disparities in the clinical care of asthmatic African Americans in the central Brooklyn area. A review of NYS Medicaid managed care data revealed that the greatest disparities in asthma health care utilization and outcomes in NYC are experienced by African Americans; this is consistent with national data.

The Eliminating Disparities in Asthma Care project was designed to develop implement and evaluate small scale healthcare system change interventions that aim to improve asthma control and reduce racial and ethnic disparities.

Methodology
The project was directed at a sample of children and adult Health Plus Amerigroup members seen at Caribbean Family Health Center (CFHC). Health Plus Amerigroup identified all of the members with an asthma diagnosis that had CFHC as their health care provider. The sample included 26 African Americans, 6 Hispanics and 6 members with other ethnicities. The following measures were selected by NYS EDAC team: Asthma Action Plan; Severity Classification; Control Classification; Long Term Controller Prescribed to Persistent Asthmatics; Environmental Tobacco Smoke Assessment; Assessment of Environmental Triggers; Smoking Status Assessment; Smoking Cessation; Education and Counseling; and Race and Ethnicity.

Interventions
- Trainings and activities conducted on-site and offsite for the practice clinical and administrative staff included: Pre work Chronic Illness Assessment; in-service on usage of EMR; webinar on asthma treatment guidelines and environmental management of asthma; and educational packets which included clinical practice guidelines, NYS DVD "Asthma in the Primary Care Practice", and asthma action plan.
- Member education included: Monthly workshops in CFHC's lobby on asthma management and related topics of obesity, diabetes, nutrition and exercise; telephonic outreach and education to members; asthma well visit reminder; refilling controller medication; knowing asthma triggers and proper use of maintenance and rescue medications; and, distribution of asthma resource guides at every asthma workshop conducted by health educators for health center clients.
- Chart Reviews and CM for members that needed more intensive services.

Results/Conclusions
There was moderate to marked improvement in documentation in five of the seven measurements that were monitored. Measured results are indicated below:
1) Asthma Action Plan - moderate success from 0% to 13% of members
2) Severity Classification Documentation - increased from 62% to 94%
3) Control Classification - Moderate success from 0% to 32%
4) Long Term Controller Prescribed to Persistent Asthmatics - 11% to 94%
5) Environmental Tobacco Smoke Assessment – 68% to 52%
6) Assessment of Environmental Triggers - 34% to 61%
7) Smoking Status Assessment. No change 60% (No smokers identified in sample)

There was a small improvement in documentation of Asthma Action Plans completed and no significant improvement in the Smoking Status Assessment. The practice made significant improvements in the Prescribing Controller Medication to Persistent Asthmatic measure and Severity Classification measure.

Healthfirst, PHSP
Eliminating Disparities in Asthma Care in Specified Locale in New York City

Project Topic / Rationale / Aims
This project was focused on developing and implementing strategies to close the gaps in asthma care and improve the overall health outcomes of Central Brooklyn's African-American Medicaid recipients with persistent asthma. Healthfirst aimed to reduce Inpatient (IP) hospitalizations/ Emergency Department (ED) utilization due to uncontrolled asthma by increasing the performance of the following quality indicators for asthma care:

- Level of asthma control will be improved to "well-controlled" for 90% of members who have mild persistent asthma, 75% of members who have moderate persistent asthma, and 50% of members who have severe persistent asthma.
- Long-term Controller (LTC) medication fill rate for members with persistent asthma will be improved by 25%.

Methodology
Healthfirst implemented EDAC initiatives with a targeted provider group consisting of two asthma specialty centers – the Adult Allergy & Asthma Center (AAAC) and the Pediatric Asthma Center of Excellence (PACE). They were identified through claims/encounter data to have had a high volume of Healthfirst Medicaid member receiving asthma specialty care in 2010. The Population of Focus (POF) was a cohort of members comprised of 51 patients in AAAC and 115 patients in PACE who had a diagnosis of asthma and had an outpatient visit at AAAC or at PACE.

Interventions
The following focused interventions were implemented:

- Member education through educational mailings, newsletter articles, website posting of asthma resources, and CM referrals.
- Provider/member reminder systems were utilized to support medication monitoring and patient feedback (i.e. member outreach calls, provider letters with a list of members non-adherent to their LTC medication regimen, IP/ED reports to AAAC and PACE, and LTC medication refill reminder letters to members).
- Provider reinforcement of the National Heart, Lung & Blood Institute's Expert Panel Guidelines and education on best practices were emphasized at the Learning Sessions, onsite visits, EDAC teleconferences, clinical tools, newsletter articles, and website postings.

Results/Conclusions
The level of asthma control for AAAC's mild asthmatics improved by 20 percentage points from a baseline of 0% to a final rate of 20%. Their moderate asthmatics increased from 0% to 42%, but there was no movement in members with severe asthma. For PACE's members with mild asthma, 74% became well-controlled which represents a 36 percentage point increase from their baseline rate of 38%. There was also an upswing of moderate asthmatics from 55% to 70%, and there was a 10 percentage improvement of the severe asthmatic children from 8% to final rate of 18%.

In contrast to PACE's marked improvements in documenting and classifying the risk and impairments (i.e. asthma control) of their persistent asthmatics, this clinic experienced a decline in their LTC medication fill rate from a baseline of 68% to a final measurement of 35%. AAAC, on the other hand, had an increase of 5 percentage points.

While the plan did not meet the target rates for the level of asthma control or for the LTC medication fill rate, it should be noted that there were positive outcomes. For IP hospitalizations due to an asthma diagnosis, AAAC's utilization went from a baseline rate of 25% to a final rate of 0% while PACE had no admissions throughout any of the measurement periods.

MetroPlus Health Plan
Eliminating Disparities in Asthma Care

Project Topic / Rationale / Aims
This project was developed to evaluate small scale healthcare system change interventions to improve asthma care outcomes in areas such as emergency room utilization, inpatient admissions, and controller medication compliance. Disparities in asthma care in the African American community are well-documented with national and NYS data. Within New York City, the greatest disparities in asthma care were seen in the African American communities in Central Brooklyn. Kings County Hospital Center (KCHC) is a major provider of medical services in Central Brooklyn. With a high concentration of African American plan members with asthma and disparities in outcomes in areas such as emergency room utilization, inpatient admissions, and controller medication compliance, the project aim was to reduce pediatric emergency department (PED) visits and inpatient (PIS) admissions by 10% through better preventive care and post treatment following emergency department visits and inpatient admissions.

Methodology
To identify the eligible population, the asthma initiative identified African American enrollees among the 2008 HEDIS cohort within 7 zip codes of Brooklyn. The KCHC practice site specifically targeted pediatric members because of a high rate of PED and PIS for asthma. The practice site population consisted of pediatric members enrolled in Medicaid with asthma that had at least one inpatient or emergency department visit with asthma. The subsequent population of focus (POF) for this project included 224 members referred to the Pediatric Asthma Clinic (PAC) between May 1 and November 30, 2011 after an emergency room or inpatient discharge. Study indicators for the population of focus included nine measures: Asthma action plan; Control classification; Race/ethnicity; Severity classification; Evaluation of environmental triggers; Smoking status assessment; Smoking cessation education and counseling; Environmental tobacco smoke assessment; and Prescribed long-term asthma controller medication.

Interventions
The PAC wanted to: improve member self-management, ensure providers have access to evidence-based information (decision support), optimize use of the existing computer-based clinical information systems (including the web-based Patient Registry, the computerized PED census, and the EHR-based PED discharge summary) to monitor, track, and engage asthma patients, and improve the process for asthma follow up care through better collaboration with the Plan's CM department.

To improve member self management of asthma, educational outreach was conducted by the Pediatric Asthma program staff that provided bedside asthma education to hospitalized members. The Director of the Pediatric Asthma program provided routine asthma education for pediatric inpatient and emergency attending and resident physicians. Educational activities covered asthma guidelines, proper discharge planning including prescription of daily asthma controller medications, preparation of the Asthma Action Plan in the electronic health record, and proper techniques for use of spacers, nebulizers, and peak flow meters.

Results/Conclusions
A total of 224 pediatric members were enrolled into the Patient Registry to track their performance measures. At the end of the re-measurement period, MetroPlus met the goal of reducing asthma inpatient admissions and asthma emergency room visits by 10%. This study demonstrates that PED and PIS utilization for acute asthma care members can be reduced through an open exchange of information between the plan and practice. A very important finding, and one supported in the literature, is that a registry is a critical tool in the management of asthma care.

Neighborhood Health Providers
Eliminating Disparities in Asthma Care

Project Topic / Rationale / Aims
Neighborhood Health Providers (NHP's) EDAC project sought to improve asthma control among children and reduce racial and ethnic disparities in care and outcomes. The National Health Care Disparities Report indicated that the prevalence of asthma was much higher and gaps in access to care had widened between African Americans and Whites. African Americans with asthma were more likely to utilize the emergency department (ED) and had more inpatient hospitalizations (IP).

The target population was located in Central Brooklyn and accessed care at two of Brookdale Family Care Center's practice sites. NHP specifically looked at children with persistent asthma who had either an ED or IP visit within the previous year. NHP's project aim was to ensure that at least 95% of the patients with persistent asthma at both sites were placed on long-term control (LTC) medication, and had an updated Asthma Action Plan (AAP) that captured and reflected prescribed medications, medication adherence, and PCP visits. NHP sought to reduce ED utilization and IP hospitalizations by 50% among the identified population with persistent asthma.

Methodology
NHP identified priority populations with persistent asthma and developed a registry that would help practice sites capture and manage patient information. Process measures were tracked via several Plan-Do-Study-Act cycles (PDSA) and members and providers were monitored according to performance indicators that included proper documentation in patient medical records, via the AAP, asthma diagnosis, severity, control classification, documented race/ethnicity, environmental triggers, prescription of a LTC, smoking status, environmental tobacco smoke assessment, and smoking cessation education and counseling.

Interventions
Quality enhancement activities with opportunities for improvement included CM, targeted mailings that included linguistically appropriate educational materials for the targeted population and outreach telephone calls. NHP developed customized patient workflows and arranged for on-site medical record reviews and clinical staff to become certified in asthma. Providers received hands-on quality improvement training to ensure adherence to the Clinical Guideline for the Diagnosis, Evaluation and Management of Adults and Children with Asthma. Performance data such as IP and ED visits as well as pharmacy data were carefully tracked and monitored for impact and communicated back to staff to implement system changes and sustain improvement.

Results/Conclusions
Improvements in care were rapid and sustained at the Flatbush site. All eight applicable measures (from 2011 through 2012) met or exceeded project goals and remained near or above goals through the project's conclusion. The most impressive gains were seen in the proportion of patients who had their level of asthma control documented in their medical record (34% in 2011 to 100% in 2012) and documented asthma severity classification (80% in 2011 to 100% in 2012). Measures at the Urban Strategies site showed greater variation, with five of nine measures meeting or exceeding project goals. Notable were gains in documented control classification (0% in 2011 to 97.3% in 2012), and evaluation of environmental triggers (30% in 2011 to 100% in 2012).

For the Flatbush site the goal of patients receiving a prescription for a LTC was met, with an overall average of 100%, but the goal of having an updated AAP was not met, with an average of 93%. At Urban Strategies the goals of patients receiving a prescription for a LTC or having an updated AAP were not met, with an average of 93% and 46%, respectively.

PIP Summaries
Below are summaries of the outcomes of the two common PIP topics, Readmissions and EDAC.

Readmission PIP Summary

Among the 10 two-year PIPs that focused on readmissions, the primary aim was to reduce potentially preventable readmission rates, with a secondary aim of increasing timely PCP follow-up visits post-discharge. The targeted members for study varied greatly, with most plans focusing on members with selected diagnoses or chronic diseases, such as asthma, diabetes, and cardiac-related conditions; however, some plans did not limit their population based on condition. Plans partnered with hospitals, healthcare systems, and high volume PCP groups. While all plans included readmission rates as their primary performance indicator, some also included assessments of time between discharge and follow-up physician office visits.

The most commonly implemented interventions among the plans included:

- On-site hospital visits to patients prior to discharge.
- Completion of a discharge summary highlighting the various interventions for the last 30 days, any potential barriers, and/or any identified continued care needs.
- Medication reconciliation.
- Sharing discharge records from participating hospitals to PCPs.
- Implementation of a Care Transitions Program.
- Home visit by a specially trained nurse within 2-3 days following discharge.
- Promotion of self-management skills through education.
- Assistance with scheduling follow-up appointments with PCPs and/or specialists.
- Letters mailed to PCPs after member discharged from the hospital to alert them of need for follow up.
- Telephonic outreach post discharge for coaching, medication management, appointment scheduling, and education regarding "red flags".
- Case management for selected members based on needs assessment.
- Collaboration with strategic partners in the community (home care agencies, hospital facilities' discharge planning departments, and practitioners)

Results varied among the plans. For a majority of the plans, the projects demonstrated improvement on at least one measure of readmission rates between the baseline and remeasurement, although not necessarily meeting their goals. In some instances, improvement was achieved for a subset of facilities or health conditions. In addition, some plans found that improvement was detected for the Potentially Preventable Readmission measure, but not for the HEDIS Plan All-Cause Readmission measure. While the former measure focuses on readmissions that are potentially preventable, the latter measure includes all readmissions. For the remaining plans, performance levels were maintained or in some cases, readmission rates increased (due in part to some of the challenges noted in the next paragraph). Among those plans that measured PCP follow-up visits after discharge, most did not achieve significant improvement in rates.

Plans documented several challenges that impacted their results, including the impact of outliers with multiple admissions, significant growth in the Medicaid membership or changes in the demographics of the enrolled population during the project, refusal of members to participate in the program, faulty contact information hindering the ability to contact members, transportation barriers, difficulty engaging hospital staff to adopt work flow changes, small sample sizes of

engaged members, and challenges with members with co-morbid mental health and alcohol and substance abuse issues.

Positive outcomes included satisfaction noted by members and medical staff in relation to the services and programs provided, members noting greater confidence in self-managing their health resulting in positive long term outcomes, enhanced discharge processes and sharing of information with PCPs, positive impacts on enrollment and engagement in the CM programs, a decrease in readmission costs, and enhanced relationships between members and case managers by increasing the face to face interaction provided by the programs. In light of these benefits, some plans noted that they are expanding their programs to other medical groups or hospital units, continuing to explore ways to address complex member management for high-risk Medicaid members, and focusing on facilitating the timely primary care office visit post-discharge. Best practices noted by plans were face to face engagement between case managers and members and real-time intervention before or immediately after discharge.

EDAC PIP Summary

DOH is currently undertaking a formal evaluation of the EDAC projects, and the summary will be posted to the DOH public website when finalized.