2016 PrimeTime Health Plan Quality Program Evaluation

General Overview

The purpose of this report is to summarize the ongoing quality improvement activities and to evaluate the overall effectiveness of the PrimeTime Health Plan Quality Improvement (QI) Program. The evaluation is focused on activities completed between January 1, 2016 and December 31, 2016. The PrimeTime Health Plan Quality program monitors performance for both clinical and non-clinical measures and compares results to past performance, internal goals and external benchmark standards.

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

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

Leadership

PrimeTime Health Plan Medical Directors provided oversight for the Quality Management Performance Improvement Program in 2016. The composition of the Quality Committee includes vice presidents and management from across the corporation in addition to network practitioners and internal clinical and operational staff, and is designed to provide comprehensive prioritization and evaluation of quality improvement throughout PrimeTime Health Plan. Leadership was evaluated at the end of 2016 and it was decided that no changes were necessary.

Quality Program Committee Structure

The Quality Improvement Committee met quarterly in 2016. The scheduling provided adequate time for presentation of material and discussion. The meetings focus on clinical, administrative and accreditation areas. The committee structure allowed for attendance of practitioners and active participation in the quality program in 2016. Information flow between committees continues to allow for a comprehensive approach to quality management. An opportunity for improved behavioral health care oversight was identified in late 2014 and was implemented for 2015. A new behavioral health committee was developed and approved by the Board for 2015. This new structure ensures complete oversight across all committees for the behavioral health care aspects of all programs, including quality, utilization management, case management, disease management, and pharmacy and therapeutics programs. The behavioral health committee met quarterly in 2016 and allowed for a concentrated discussion and action on behavioral health aspects of care. Evaluation of the committee structure identified a need for population health management activities across committees. Therefore, a new Population Health Committee was added to the committee structure in mid-2015. This committee is provides population health oversight for all clinical committees, however all committees still report directly to the Board of Directors.

Practitioner Participation in the QMPI Program

Participation by actively practicing practitioners in quality activities occurred in 2016 through the committee structure. Physician membership on the Quality Management and Performance Improvement Committee provided significant input to quality program activities. Physicians provide input to our Quality Management Performance Improvement Committee, Utilization Management Committee, Pharmacy Committee and Peer/Credentialing Committees. These committees have decision-making authority that affects the network

composition and coverage of therapeutic tools for member treatment. A further need was identified for hospitalist physician involvement. Two hospitalist physicians were appointed to the Quality Management and Process Improvement Committee for 2017.

Quality Program Structure

Personnel responsible for the implementation of the Quality Management and Performance Improvement Program are under the direction of the medical director. There were no vacancies in the personnel responsible for the quality program in 2016 therefore there was no need for interim responsibility fulfillment. The medical director is responsible for oversight and direction of all clinical aspects of the Quality Management and Performance Improvement Program. The medical director is instrumental in the development, implementation and maintenance of the overall function of the program. The medical director maintains a current, unrestricted license as a doctor of medicine and is board certified in Family Practice.

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

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

Throughout 2016 personnel from many operational areas were utilized as sources for identifying possible concerns regarding quality of care and service and are part of quality improvement teams identified to impact member quality of care and service. These areas include: Data Reporting and Analysis for data and analytical resources, Information Systems, Utilization Management, Case Management, Disease Management, Claims, Customer Service, Member Services, Provider Credentialing, Marketing, Customer Satisfaction and Provider Relations.

Enrollee Input

Focus groups were held in 2016 to obtain member opinions regarding various areas of PrimeTime Health Plan. Other sources of enrollee input into the QMPI program include member satisfaction surveys and analysis of inquiries, complaints, grievances, and appeals. The Services Committee is charged with overseeing member satisfaction and identifying opportunities for improvement as indicated by enrollee input.

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Resources
Staffing resources for 2016 were adequate. Staff members continued to utilize the same medical management information system in 2016 for the Commercial and Marketplace populations, but transitioned to a new medical management system for the Medicare (PrimeTime Health Plan) population effective 1/1/2015. Both data collection systems (InforMed and Clinical Care Advance) provide integrated member, provider and service data needed to meet the quality program requirements.

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

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

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

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

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

5. Remain in compliance with federal, state, local and accrediting bodies, while meeting the expectations of our members, practitioners, employers and other customers. Maintain accreditation for QHP product as required.

The remainder of the evaluation documents the extent to which 2016 activities met these goals.

Overall Program Effectiveness

PrimeTime Health Plan categorize projects into two main areas: Quality of Service and Quality of Care. Project outcomes are analyzed for their effectiveness. Details about these improvements and project outcomes are detailed in the following pages. Below is a listing of measures that have shown improvement in 2016 as a result of QI program initiatives.

Operational Improvement
(The following non-clinical measures improved by 2% or more from 2015 to 2016)

Measure Name	2015	2016	% improved
Claims payment TAT – PTHP	20.1 days	7.6 days	62.2%
UM referral TAT preservice - PTHP	7.0 days	5.5 days	21.4%
UM referral TAT post-service- PTHP	10.1 days	6.3 days	37.6%
UM referral TAT expedited - PTHP	0.8 days	0.3 days	62.5%
New contract TAT	7.7 days	5.5 days	28.6%

Non-Clinical Improvement (CAHPS®)

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(The following non-clinical measures improved by 2% or more from 2015 to 2016)

Measure Name	Medicare HMO 2015	Medicare HMO 2016
Ease of getting appointment with a specialist	83.5	85.60
Doctors spending enough time with you	89.6	91.60
Coordination of Care	88.7	90.60
Personal doctor's office followed up to give you test results	89.6	91.9
Got help managing care	91.3	98.0
Ease of using health plan to fill prescriptions by mail	85.3	90.2
Getting information needed about cost of medications	85.5	88.5

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

Clinical Improvement (HEDIS)

(The following clinical measures improved by 2% or more from MY 2014 (HEDIS 2015) to MY 2015 (HEDIS 2016)

Measure Name	Medicare HMO MY 2014	Medicare HMO MY 2015	2016 QC 50th percentile
Annual Monitoring for Patients on Persistent Meds - Digoxin	48.66	57.63	53.64
Colorectal Cancer Screening	71.76	74.07	74.07
Comprehensive Diabetes Care - Comprehensive Diabetes Care	91.86	95.36	96.09
Disease Modifying Therapy for Rheumatoid Arthritis	81.51	84.17	80.00
Follow-up after Hospitalization for Mental Illness - 30 day follow-up	36.11	65.22	56.56
Follow-up after Hospitalization for Mental Illness - 7 day follow-up	13.89	32.61	33.65
Non-Recommended PSA-Based Screening in Older Men	44.74	42.32	32.30
Osteoporosis Management	31.64	41.49	41.49
Pharmacotherapy Management of COPD - Systemic Corticosteroid	77.14	87.50	77.38
Pneumonia Vaccine for Older Adults	83.00	82.00	78.00
Potentially Harmful Drug-Disease Interactions in the Elderly - Dementia (Rate 2)	45.29	41.67	42.73
Use of Spirometry in Assessment & Dx of COPD	34.56	40.13	35.91
Use of High Risk Medications in the Elderly - One Prescription	8.34	5.77	8.11

Overall effectiveness of the 2016 Quality Program and its initiatives is evaluated through analysis of the quality program goals. Effectiveness in all areas is demonstrated by significant improvement in clinical, member experience, and operational improvement measures. 5 operational performance measures, 7 member experience (CAHPS) measures, and 13 clinical (HEDIS) measures all showed improvement in 2016. The improvement in clinical measures can be attributed to clinical interventions such as reminder notifications, nurse outreach, patient-centered medical home (PCMH), quality improvement projects (QIPs), chronic care improvement projects (CCIPs), and other provider interventions as described in the Quality of Care section of this evaluation. The improvement in member experience measures can be attributed to member-focused interventions developed and implemented by Services Committee. The improvement in operational measures can be attributed to the development of action plans by internal departments. The organization continues to focus on patient safety by using initiatives that include member education through newsletters and the plan websites, the medication therapy management (MTM) program, oversight of drug-drug interactions, and Case/Disease Management nurse interventions. The organization also continues to meet expectations of government and accrediting bodies, including the Ohio Department of Insurance (ODI), the Centers for Medicare and Medicaid Services

(CMS), and the National Committee for Quality Assurance (NCQA) by remaining compliant with standards, rules, and regulations.

While improvement was shown in many areas, there were other areas that were identified for opportunities for improvement. The Quality Committee will continue to oversee clinical interventions throughout 2017 to help improve clinical measures. The Services Committee will continue to oversee member-focused interventions throughout 2017 to help improve areas of member experience. Department managers and the Quality Department will continue to oversee operational measures to help identify areas for improvement and develop actions plans as necessary. All of the interventions mentioned above will continue in 2017 to allow for additional improvement in clinical, member experience, and operational areas. Barriers and additional opportunities for improvement will continue to be identified as necessary throughout 2017 and those opportunities will be evaluated at the end of 2017.