Quality Improvement Program Annual Work Plan Evaluation for Massachusetts 2016

Boston Medical Center HealthNet Plan
Quality Improvement (QI) Program Work Plan for Massachusetts
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Section I. Executive Summary

Section 1: Executive Summary

The Massachusetts 2016 Quality Improvement (QI) Work Plan Evaluation is based on the QI program's 2016 Annual QI Work Plan, developed in 2015. The document is displayed in a grid format providing information on ongoing quality activities including project names, goals, baseline data, actions taken during 2016, outcome data, analysis, identification of opportunities for improvement and recommendations for improvement activities.

Boston Medical Center HealthNet Plan's (the Plan) quality measure performance indicates when compared to national benchmarks, the Plan is maintaining quality of care and services to members, and supports safe clinical practices.. Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data along with supplemental data from other QI initiatives are utilized to establish performance baselines and performance targets.

The Plan reported hybrid and administrative rates for HEDIS 2017 (data year 2016) measures to the National Committee for Quality Assurance (NCQA). Rates were generated for MassHealth (including CarePlus members) and for the Qualified Health Plan (QHP). CAHPS was completed for the Qualified Health Plan; however, results will not be available until October 2017. The MassHealth child CAHPS survey was conducted along with the adult CAHPS survey this year. Moving forward, the Plan will report and establish benchmarks for both CAHPS surveys.

The 2016 QI Work Plan Evaluation includes a recommendation for the 2018 QI Work Plan as to whether or not projects or measures should continue or be retired. If the recommendation is a project should be continued, the framework of the project is re-evaluated prior to the development of the 2018 QI Work Plan. Project measures and goals are also reassessed to determine whether any changes need to be made based on lessons learned, or barriers identified. In addition to the project evaluations displayed in the grids, separate listings of trended HEDIS and CAHPS data are appended to this report.

Overall Accomplishments

- The Plan's MassHealth product was rated 4.5 out of 5 according to NCQA's Medicaid Health Insurance Plan Ratings, 2016-2017. NCQA ratings are based on three types of quality measures: measures of clinical quality; measures of member satisfaction; and results from NCQA's review of a health plan's health quality processes. The clinical quality measures include prevention and treatment measures, which are a subset of the HEDIS measures. Member satisfaction measure data come from CAHPS.
- The Plan piloted a member rewards program for select diabetes care measures (HbA1c testing, eye exam and nephropathy screening) and postpartum care.
- The Plan began working with a vendor to implement a text messaging program to help close gaps in care for select HEDIS measures. The contract was signed September 30, 2016. Scripts were developed and approved and the program was implemented in 2017. The text messaging campaigns range in topics from chronic disease management

to prevention and wellness topics such as: diabetes management, controlling blood pressure, adolescent and childhood immunizations, breast and cervical cancer screenings.

Overall Barriers

- Several HEDIS measures for QHP had small denominators in 2015 due to continuous enrollment criteria not being met. This prevents the Plan from conducting a year to year analysis of those measures.
- Most HEDIS measures were not reported for Senior Care Options (SCO) because of the small membership resulting in only two reportable measures.

Clinical Improvements

The goals in the 2016 MA QI Work Plan were set based on the 2014 NCQA Quality Compass HEDIS Medicaid HMO benchmarks since they were the most recent benchmarks available at the time the Work Plan was written and approved. The projects in the Work Plan were evaluated on the goals and benchmarks. The tables below compare the Plan's performance to the 2016 NCQA Quality Compass HEDIS Medicaid HMO benchmarks that are the most current data available.

The HEDIS measures in Table 1 exceeded the 2016 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile benchmarks.

Table 1: Measures Exceeded 2016 NCQA Quality Compass HEDIS Medicaid HMO 90th Percentile Benchmark

Measure	HEDIS 2017 rate for MassHealth (Data year 2016)	2016 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile
Childhood Immunization Status (Combination 2)	82. 89%	82. 88%
Childhood Immunization Status (Combination 10)	48. 92%	46. 47%
Appropriate Treatment for Children With Upper Respiratory Infection	97. 60%	96. 08%
Appropriate Testing for Children With Pharyngitis	91. 96%	86. 59%
Controlling High Blood Pressure- <140/90	71. 03%	70. 69%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	44. 03%	38. 91%
Chlamydia Screening in Women (Total Rate)		
All Ages	72. 86%	68. 92%
16-20	73. 40%	66. 67%
21-24	72. 31%	72. 06%
Adult BMI Assessment	93. 68%	92. 54%
Pharmacotherapy for COPD		
Bronchodilators	90. 26%	88. 78%

Measure	HEDIS 2017 rate for MassHealth (Data year 2016)	2016 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile
Systemic Corticosteroids	82. 43%	79. 07%
Weight Assessment and Counseling		
BMI	91. 64%	86. 37%
Nutrition Counseling	86. 96%	79. 52%
Physical Counseling	84. 62%	71. 58%
Initiation and Engagement of alcohol and other drug (AOD) Treatment		
All ages Engagement	18. 75%	16. 93%
≥18 engagement	19. 10%	16. 65%

MassHealth Service Improvements

MassHealth Adult CAHPS in Table 2 and Child CAHPS in Table 3 measures improved and exceeded the 2016 NCQA Quality Compass HEDIS Medicaid HMO 75th percentiles.

Table 2: Adult CAHPS Measures Exceeding 2016 NCQA Quality Compass HEDIS Medicaid HMO 75th Percentile Benchmark

Measure	Adult CAHPS 2016	CAHPS 2017	2016 NCQA Quality Compass HEDIS Medicaid HMO Percentile
Rating of Health Plan	78.0%	80.0%	75th (78.78%)
Rating of Specialist	77.9%	84.2%	75th (82.78%)
Getting Needed Care	81.0%	83.8%	75th (83.36%)
Getting Care Quickly	79.9%	85.6%	90th (85.67%)

Table 3: Child CAHPS Measures Exceeding 2016 NCQA Quality Compass HEDIS Medicaid HMO 75th Percentile Benchmark

Measure	Child CAHPS 2017	2016 NCQA Quality Compass HEDIS Medicaid HMO Percentile
None of the Child CAHPS measures exceeded the 2016 NCQA Quality Compass HEDIS Medicaid HMO 75th percentile benchmark		

MassHealth Opportunities for Improvement

Clinical Opportunities for Improvement

The measures listed in Table 3 are at or below the 2016 NCQA Quality Compass HEDIS Medicaid HMO 25th percentile.

Table 3: Measures At or Below 2016 NCQA Quality Compass HEDIS Medicaid HMO 25th Percentile Benchmark

Measure	HEDIS 2017 (CY 2016)	HEDIS Percentile*
Antidepressant Medication Management		
Acute Phase	44. 74%	< 25th (48.32%)
Continuation Phase	31. 59%	< 25th (32.77%)
Medication Management for People with Asthma (All Ages) Compliance 75%	29.35%	25th (25.08%)
Asthma Medication Ratio (All Ages)	52. 22%	<25th (54.55%)
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	80. 35%	25th (76.99%)

*2016 NCQA Quality Compass HEDIS Medicaid HMO percentiles

Service Opportunities

MassHealth Adult CAHPS composite measures in Table 4 and Child CAHPS measures in Table 5 are below the 2016 NCQA Quality Compass HEDIS Medicaid HMO 75th percentiles.

Table 4: Adult CAHPS Measures Not Exceeding 2016 NCQA Quality Compass HEDIS Medicaid HMO 75th Percentile Benchmark

Measure	CAHPS 2016	CAHPS 2017	2016 NCQA Quality Compass HEDIS Medicaid HMO Percentile
Rating of Health Care	71.9%	75.7%	50th (74.06%)
Rating of Doctor	80.0%	80.9%	50th (80.58%)
How Well Doctors Communicate	91.8%	90.4%	25th (89.48%)

Table 5: Child CAHPS Measures Not Exceeding 2016 NCQA Quality Compass HEDIS Medicaid HMO 75th Percentile Benchmark

Measure	CAHPS 2016	2016 NCQA Quality Compass HEDIS Medicaid HMO Percentile
Getting Needed Care	77.1%	<25th (83.33%)

Measure	CAHPS 2016	2016 NCQA Quality Compass HEDIS Medicaid HMO Percentile
Getting Care Quickly	86.1%	<25th (90.57%)
How Well Doctors Communicate	94.1%	25th (93.12%)
Customer Service	86.1%	<25th (87.46%)
Rating of All Health Care	85.8%	50th (84.06%)
Rating of Personal Doctor	88.5%	25th (86.81%)
Rating of Health Plan	83.0%	25th (82.34%)

Section 2: QI Project Summaries Grid
Section II. Quality Improvement Work Plan Grids

Diabetes Disease and Care Management

Project Title: Diabetes Disease and Care Management		Post-Approval Change Log
Quality Improvement Project		
Program Description		
According to the 2014 National Diabetes Statistics Report (released June 10, 2014), diabetes affects 29. 1 million Americans (20 and over {diagnosed and undiagnosed}). Approximately 9,000 BMCHP members have diabetes. Diabetes causes increased risk of heart attack and stroke, blindness, kidney disease and neuropathy. Research demonstrates that effective management reduces these complications. The program is aimed at improving the quality of life and self-management skills of members through educational materials, care management and actionable provider reports.		
Measurement & Goal		
HEDIS 2017 specifications and rates.		
Measure	**Goal**	
MassHealth (including CarePlus)		
HbA1c testing	91. 73% 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile.	
Eye exams	68. 04% Maintain performance at or above the 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile.	
Medical Attention for Nephropathy	86. 86% 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile (86. 86%).	
BP < 140/90	72. 48% Close the gap by 50% from current rate to the 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile (75. 18%).	
Poor HbA1c Control (> 9. 0%)	30. 28%* 2014 NCQA Quality Compass Medicaid HMO 90th percentile	
Qualified Health Plan		
Comprehensive Diabetes Care (CDC) Measures	Set baseline and establish goal	
Project Team		
Lead: Karen Szvoren, RN		
Medical Director: John Wiecha, MD		**Was:** Pablo Hernandez-Itriago, MD; Karen Boudreau, MD

**A lower rate indicates better performance for this measure.*

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Continue to provide a link on the Plan's website to the most recent American Diabetes Association clinical practice guideline.	01/2016	A link to the current American Diabetes Association clinical practice guideline is available on the Plan's provider website.	01/2016 and ongoing
Continue diabetes Care Management (CM) and Disease Management (DM) programs.	01/2016	CM is offered to members with diabetes identified through the Plan's registry (run monthly), Health Needs Assessment, and provider or member referrals.	01/2016 and ongoing
Continue use of HEDIS and CM registries to identify members for possible CM, DM and interventions.	01/2016	The HEDIS and CM registries are used to identify members for the care management program. The HEDIS registry is used to identify members for DM and educational mailings.	01/2016 and ongoing
Collect, store and utilize lab data from high volume labs, and include results on provider reports.	01/2016	Lab result data are collected on a monthly basis from high volume laboratories and stored in the Plan's data warehouse. The data are included on the Diabetes Treatment Advisory Report.	01/2016 and ongoing
Continue to promote website as additional resource for educational material on diabetes for members and providers.	01/2016	Member and provider mailings refer members to the Plan's diabetes webpage for additional education and information. The diabetes webpage had approximately 754 page views in 2016.	01/2016 and ongoing
Utilize external vendor to promote and fulfill member incentive program to close gaps in care.	01/2016	Finity, Inc., an external member incentive vendor, was utilized to educate members and promote screenings for diabetes eye exams, HbA1c testing, and nephropathy screenings. During the course of this campaign, letters were mailed and calls were placed to 6,434 noncompliant members. Members were encouraged to get appropriate diabetes tests and screenings. Incentives for obtaining tests and screenings were offered in the form of "points" that members could use to shop from a catalog developed by the Plan and the vendor. See Final Analysis section for results.	01/2016-12/31/2016

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Continue to send diabetes self-management materials to all members with diabetes.	• 03/2016 • 09/2016	The goal of the diabetes mailing is to promote self-management of diabetes and to educate members on the importance of recommended screenings and targets. The Plan provides diabetes self-management information to members with diabetes 18-75 years old identified using HEDIS specifications suppressing continuous enrollment. The Diabetes self-management information was sent to all BMCHP MassHealth and QHP members with diabetes: May 2016: • English: 7,334 MassHealth; 1,496 QHP • Spanish: 670 MassHealth; 132 QHP December 2016: • English: 7,906 MassHealth; 1,856 QHP • Spanish: 725 MassHealth, 223 QHP	• 05/2016 • 12/2016
Continue to alert providers to the Diabetes Clinical Screening Report semi-annually, and track provider access to the report.	• 05/2016 • 09/2016	The Diabetes Clinical Screening Report identifies members with diabetes per HEDIS specifications and the date(s) of their last screenings to assist providers in identifying gaps in care. In May 2016, the Diabetes Clinical Screening Reports were made available on the Plan's provider portal to practices treating identified members. A postcard was sent notifying providers of the availability of the Diabetes Clinical Screening reports on the provider portal. In November 2016, due to the low rate of report downloads from the Plan's provider portal for the May 2016 report and reports in 2015, the Diabetes Clinical Screening Reports were sent by mail to provider practices treating identified members. • May 2016: 416 provider/provider groups identified. • November 2016: 392 provider/provider groups identified.	• 05/2016 • 10/2016
Continue to alert providers to the Diabetes Treatment Advisory Report (DTAR) semi-annually, and track provider access to the report.	• 02/2016 • 11/2016	The DTAR identifies members with diabetes per HEDIS specification who are on 3 or more noninsulin anti diabetic agents and/or with the following lab results HbA1c ≥ 8 and/or LDL-C ≥ 100 mg/dL.	• 01/2016 • 09/2016

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
		The report includes the date and results of the last HbA1c and LDL-C tests if available (in the last 12 months), prescription data for anti-diabetic agents and statins (in the last 6 months), and the dates of diabetes related emergency department (ED) and/or inpatient discharges (in the last 12 months). Providers are encouraged to review medications, compliance with treatment goals, coordinate care, and initiate insulin therapy if appropriate. In February 2016 the DTAR reports were made available on the Plan's provider portal to practices treating identified members. Practices were notified of the report's availability via postcard. • 208 provider/provider groups identified In September 2016, due to the low rate of report downloads from the Plan's provider portal for the February 2016 report and reports in 2015, the Diabetes Treatment Advisory Reports were sent by mail to provider practices treating identified members. September 2016 • 194 provider/provider groups identified	
Measure effectiveness of the Diabetes Treatment Advisory Report (DTAR) six months after distribution of the report (members identified on the report with a new start of insulin six months after distribution of the report).	01/2016	Six months after the distribution of the DTAR members identified on the report and still active with the Plan with a new start of insulin are identified. See Final Analysis section for results.	01/2016 and ongoing
Utilize monthly HEDIS Dashboard to track diabetes measures.	01/2016	A HEDIS dashboard is used to track measure trends month to month for specific HEDIS measures compared to administrative rate trends from previous years, benchmarks and goals. The HEDIS dashboard is reviewed by the MA Quality Committee each month to determine if additional interventions are needed	01/2016 and ongoing
Continue to promote the YMCA Diabetes Prevention Programs available to members at risk for diabetes.	01/2016	The Plan continues to promote the YMCA Diabetes Prevention Program to members at risk for diabetes through referrals from care management.	01/2016 and ongoing

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Mail 2017 diabetes calendar to members with diabetes.	12/2016	The 2017 Living Well with Diabetes calendar and recipe cards were mailed to all MassHealth/QHP members with diabetes in both English and Spanish. The calendar provides information about diabetes, lists healthy recipes, and provides reminders and a place to track pertinent lab values through the course of the year. The mailing was sent to 10,559 members: • English: 7,753 MassHealth; 1,866 QHP • Spanish: 708 MassHealth; 232 QHP	Delayed. See barrier section.

Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**
Pay for Performance (P4P)	Provider groups were given the opportunity to participate in the Plan's P4P program. In calendar year 2016, 37 provider groups participated in the program which was focused on rewarding providers for closing gaps in care. 28/37 groups participated in diabetes screening measures. See Final Analysis section for P4P results.	05/2016 – 12/2016
Quality Outreach Coordinators (QOC)	Two Quality Outreach Coordinators placed outbound calls educating members due for HbA1c testing, nephropathy screening, and/or eye exams about the importance of preventive care and encouraging members to schedule appointments to obtain diabetes related preventive tests and screenings. See Final Analysis section for QOC results.	07/2016 and ongoing
HEDIS care gaps made available to CM	HEDIS care gaps were made available on the registry to help CM identify preventive care gaps for diabetes screenings while interacting with members with diabetes in CM.	09/2016 and ongoing
Community Health Workers (CHWs)	CHWs received training specific to diabetes and began performing home visits based on referrals from care management. CHWs work as a bridge between the members and health care providers to prevent complications through self-care management education, social support, coordinating appointments and appointment reminders. As of December 2016 2 CHWs were trained specific to diabetes.	12/2016 and ongoing

Barriers Encountered

- Members with diabetes may be unaware of their benefits and coverage for routine diabetes screenings.
- Some members identify more complex conditions as a priority and do not get the routine diabetes screenings.
- Psychosocial barriers such as homelessness, health literacy and food insecurity impede the likelihood of getting routine diabetes screenings.
- A few of the provider and member interventions planned for 2016 were slightly delayed due to configuration issues with reports and unanticipated delays with vendors handling member mailings.
- Reports downloaded from the provider portal continued to be low in 2016. The Plan re-instituted mailing reports to providers.
- Members with diabetes may not understand the importance of diabetic testing, or what test results can tell them about their condition.

Measurement Milestones

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	Goal	Progress toward goal	Goal met?
MassHealth (including CarePlus)						
HbA1c testing	90. 99%	91. 10%	88. 38%	91. 73%		No
Eye exams	67. 67%	63. 88%	64. 61%	68. 04%		No
Medical Attention for Nephropathy	85. 51%	90. 21%	90. 49%	86. 86%		Yes
BP <140/90	69. 79%	68. 86%	73. 59%	72. 48%		Yes
Poor HbA1c Control * (> 9. 0%)	33. 39%	32. 21%	32. 57%	30. 28%		No
Qualified Health Plan						
HbA1c testing	N/A	N/A	88. 63%	Set Baseline		Yes
Eye exams	N/A	N/A	63. 98%	Set Baseline		Yes
Medical Attention for Nephropathy	N/A	N/A	86. 49%	Set Baseline		Yes
HbA1c Control (<8. 0%)	N/A	N/A	55. 92%	Set Baseline		Yes

**A lower rate indicates better performance for this measure.*

Final Analysis

MassHealth HEDIS (including CarePlus members)

- HbA1c Testing: the HEDIS 2017 rate decreased 2. 99% from the HEDIS 2016 rate. The decrease is not statistically significant (p = 0.1316) and is below the 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile (91.73%).
- Eye Exam: the HEDIS 2017 eye exam rate increased 1.14% from the HEDIS 2016 rate. The increase is not statistically significant (p = 0.7970) and is below the 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile (68.04%).
- Nephropathy Screening: the HEDIS 2017 rate increased 0. 31% from the HEDIS 2016 rate. The increase is not statistically significant (p = 0.8736) however, is above the 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile (86.86%).
- BP 140/90: The HEDIS 2017 rate increased 6. 87% from the HEDIS 2016 rate. The increase is not statistically significant (p= 0.7901) however, did not exceed the goal to close the gap by 50% to the 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile (75.18%).
- HbA1c control >9% (members with HbA1c greater than 9%): the HEDIS 2017 rate increased 1.12% from the HEDIS 2016 rate and did not meet or exceed the 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile (30. 28%)*

*Lower is better

Final Analysis

QHP: The Plan successfully established a baseline for the QHP population in each measure. The initial comparison between the baseline rates for QHP and the HEDIS 2017 rates for MassHealth, the HbA1c testing, eye exam and nephropathy screening rates for QHP are all slightly below the MassHealth rates.

Diabetes Treatment Advisory

- Six months after the January 2016 DTAR was produced, 4.72% (5/106) of the members identified on the report and still active with the Plan had a new prescription for insulin.
- Six months after the September 2016 DTAR was produced, 7.32% (6/82) of the members identified on the report and still active with the Plan had a new prescription for insulin.

Member Rewards Program

Finity, Inc. engaged members to participate in the rewards program through phone calls and a mailing. The program was explained and members were eligible to earn rewards points for closing a gap in HbA1c, eye exam and/or nephropathy screening. Claims data were used to determine compliance.

- 49% (3165/6434) of the members that were engaged (contacted by phone and mailing) were eligible to select a reward from the catalog for compliance with diabetic screening (s)
- 67% (919/1658) of the members completed an HbA1c test
- 56% (2668/5588) of the members completed an eye exam
- 75% (1245/2086) of the members completed a nephropathy screening

Although there was an increase in compliance among the members targeted, there was no impact on the annual HEDIS rates. Based on the results as well as the financially unsustainable platform offered by the vendor, the program was stopped at the end of the pilot timeframe.

P4P

There were 1,164 gaps in diabetes screenings among the providers participating in the P4P program. Claims data were used to determine compliance.

- 17. 35% (202/1,164) of all of the diabetes screenings gaps were closed
- 17. 93% (26/145) of the HbA1c tests were completed
- 15. 87% (136/857) of the eye exams were completed
- 24. 69% (40/162) of the nephropathy screenings were completed

QOC

There were 147 gaps in diabetes screenings among the members the QOCs reached and stated would follow up with the doctor to obtain the screenings. Claims data were used to determine compliance.

- 35. 37% (52/147) of all of the diabetes screenings gaps were closed
- 50. 00% (8/16) of the HbA1c tests were completed
- 32. 11% (35/109) of the eye exams were completed
- 40. 91% (9/22) of the nephropathy screenings were completed

Recommendation for 2018

Continue as a quality improvement project.

Asthma Disease and Care Management

Project Title: Asthma Disease and Care Management		Post-Approval Change Log
Quality Improvement Project		
Program Description		
According to the Center for Disease Control and Prevention (Child and Adult Asthma Prevalence by Age and Sex: United States, 2006-2010), asthma affects 25. 7 million people, including 7 million children less than 18 years of age. Without proper management, asthma can result in frequent emergency department (ED) visits and hospitalizations. This project aims to improve the health of members with asthma by promoting interventions that improve member self-management and raise provider awareness of asthma guidelines and medication compliance.		
Measurement & Goal		
HEDIS 2017 specifications and rates.		
Measure	**Goal**	
MassHealth (including CarePlus)		
Medication Management for Asthma 75% Compliance (5-64 years of age)	26.94% Close the gap by 50% to the 2014 NCQA Quality Compass HEDIS Medicaid HMO 50th percentile (30. 16%)	
Asthma Medication Ratio	53.29% 2014 NCQA Quality Compass HEDIS Medicaid HMO 10th percentile.	
Qualified Health Plan		
Medication Management for Asthma 75% Compliance (5-64 years of age)	Establish baseline	
Asthma Medication Ratio	Establish baseline	ΔThis measure was not included in the QHP measure set therefore data are not available
Project Team		
Lead: Karen Szvoren, RN		
Medical Director: John Wiecha, MD		**Was:** Pablo Hernandez-Itriago, MD; Karen Boudreau, MD

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Continue to provide a link on the Plan's website to the most recent asthma clinical practice guideline from the National Heart, Lung and Blood Institute.	01/2016	A link to the current asthma clinical practice guideline is available on the Plan's website.	01/2016 and ongoing
Continue asthma CM and DM programs.	01/2016	Care Management is offered to members with asthma identified through the Plan's registry, Health Risk Assessment, and provider or member referrals.	01/2016 and ongoing

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Continue use of HEDIS and CM registries to identify members with asthma for possible CM, DM and interventions.	01/2016	The HEDIS and CM registries are utilized to identify members for CM, DM and mailings.	01/2016 and ongoing
Continue to alert providers to the annual asthma profile trigger reports available on the provider portal and track provider access to the report.	01/2016	The asthma profile trigger report was mailed to all providers prescribing asthma medications to members with persistent asthma per HEDIS specifications. The report includes the asthma medications filled within the previous six months and the prescriber and date(s) of any inpatient hospitalizations. In February 2016, the Asthma profile trigger report was sent to 1,102 PCPs, 86 specialists, and 191 other prescribing providers.	02/2016
Continue to alert providers to the semi-annual Asthma Treatment Advisory Reports (ATAR) available on the provider portal and track provider access to the reports.	• 03/2016 • 09/2016	The ATAR report identifies members with asthma per HEDIS specifications who have not filled an asthma controller medication within the previous 60 days and have filled one or more rescue medications within the same timeframe. It also identifies any asthma-related emergency department visits or inpatient utilization in the previous 12 months. A postcard was sent notifying providers of the availability of the ATAR reports on the provider portal. April 2016 • 271 provider/provider groups • 403 members (19 Spanish and 298 English) Due to the low rate of providers pulling reports from the Plan's portal for the April 2016 report and reports in 2015, these reports were mailed to providers. October 2016 • 223 provider/provider groups identified • 767 members (25 Spanish and 742 English) See Final Analysis section for results.	• 04/2016 • 10/2016

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Continue to promote and send the Asthma Control Test (ACT) and begin sending an Asthma Self-management Checklist to members identified in ATARs, encouraging them to bring the completed ACT to their provider and discuss asthma medication management.	• 03/2016 • 09/2016	In 2016, the ACT and letter sent to members identified on the ATAR were discontinued. In their place, members identified on the ATAR report were sent the newly-developed asthma self-management checklist/postcard in both English and Spanish. Asthma self-management postcards mailed to members in 2016: • April 2016: 403 members (287 English adult, 12 Spanish adult, 98 English child, 6 Spanish child) • October 2016: 767 members (597 English adult, 16 Spanish adult and 145 English child, 9 Spanish child)	• 04/2016 • 10/2016
Measure the effectiveness of the ATAR six months after distribution of the report.	01/2016	Six months after the distribution of the ATAR, the Plan identifies members on the report and still active with the Plan that filled a prescription for an asthma controller medication. See Final Analysis section for results.	01/2016 and ongoing
Utilize monthly HEDIS Dashboard to track asthma measures.	01/2016	A HEDIS dashboard is used to track measure trends month to month for specific HEDIS measures compared to administrative rate trends from previous years, benchmarks and goals. The HEDIS dashboard is reviewed by the MA Quality Committee each month to determine if additional interventions are needed.	01/2016 and ongoing
Continue to promote Plan website as resource for additional educational material on asthma for members and providers.	01/2016	The Plan's website address is included on the asthma postcards. Asthma self-management tools are promoted on the Health Topics page of the Plan's website.	01/2016 and ongoing

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Send updated asthma postcards with targeted messages to members with asthma.	• 02/2016 • 08/2016	The Plan mailed updated asthma postcards to members with persistent asthma per HEDIS specifications. The number of postcards was reduced from four (winter, spring, summer, fall) to two (warm weather, cold weather) to decrease the risk of members ignoring the mailing if received too many times in the year. Postcards included messages promoting self-management of asthma, providing education on seasonal triggers, medication utilization, and the importance of asthma control. May 2016 mailing: • English: 2,848 postcards, 167emails • Spanish: 293 postcards, 2 emails December 2016 mailing: • English: 3,058 postcards, 271 emails • Spanish: 298 postcards, 2 emails	• 06/2016 • 12/2016
Develop asthma self-management checklist for adults and children.	02/2016	The Plan developed an asthma self-management checklist/postcard for members identified on ATAR reports. The postcard educates members on asthma symptoms, triggers, asthma control, medications, and the importance of developing an asthma action plan with their provider. This mailing is sent in both English and Spanish. See ACT intervention above.	04/2016
Identify additional asthma interventions based on age, cultural needs and other demographic information.	02/2016	The Plan identified and implemented five additional interventions in 2016: • Quality outreach coordinators • HEDIS care gaps available to CM • Community Health Workers • Prednisone burst CHW program • Pay for performance program See Additional Actions Implemented section for details.	02/2016 and ongoing

Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**
Quality Outreach Coordinators (QOCs)	Two quality outreach coordinators (QOC) placed outbound calls educating members about the importance of preventive care	07/2016

Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**
	and encouraging members to schedule appointments to discuss medication adherence with asthma controller medications with the doctor. The QOCs focused most calls on gaps in care for diabetes, well visits, and cancer screenings, however if the member was also identified as not being adherent with their asthma medication, the QOCs would advise the member on the importance of medication adherence.	
Community Health Workers (CHWs)	In September 2016, two CHWs completed training specific to asthma and began performing home visits based on referrals from care management. CHWs work as a bridge between the members and health care providers to prevent complications through self-care management education, social support, coordinating appointments and appointment reminders.	09/2016 and ongoing
HEDIS care gaps made available to CM	HEDIS care gaps were made available on the registry to help care managers identify preventive care gaps for asthma management while interacting with members in CM.	09/2016
Prednisone burst CHW program	CHWs provide outreach and home assessments to members with an ED visit for asthma and prednisone burst therapy within the same month. See Final Analysis section for initial results	04/2016
P4P	Provider groups were given the opportunity to participate in the Plan's P4P program. In calendar year 2016, 37 provider groups participated in the program which was focused on rewarding providers for closing gaps in care. 26/37 groups participated in asthma medication adherence measures. See Final Analysis section for P4P results.	05/2016 – 12/2016

Barriers Encountered
• Members with asthma may not understand the importance of self-management for their condition, or the importance of recommended medications. • Members with asthma may not have access to easy-to-use tools to assist them in managing their condition throughout the year. • Members with asthma may not understand the difference between long-term control medicines and quick-relief medicines, or the importance of taking long-term medicines as prescribed. • Members with asthma may not understand what triggers exacerbations of their condition, or how to avoid interior and seasonal asthma triggers. • Reports downloaded from the provider portal continued to be low in 2016. The Plan re-instituted mailing reports to providers. Members are identified as having persistent asthma per HEDIS specifications, however may instead have seasonal asthma which does not require ongoing long term controller medication throughout the year. • Members have difficulty paying the copay and may not be aware that they can pick up their medication without paying a copay if they are unable to and can be billed by the pharmacy for later payment.

Measurement Milestones						
Measure	**HEDIS 2015**	**HEDIS 2016**	**HEDIS 2017**	**Goal**	**Progress toward goal**	**Goal met?**
MassHealth						
Medication Management for Asthma 75% Compliance (5-64 years of age)	23. 72%	24. 97%	29. 35%	26. 94%		Yes
Asthma Medication Ratio	45. 96%	49. 75%	52. 22%	53. 29%		No
Qualified Health Plan						
Medication Management for Asthma 75% Compliance (5-64 years of age)	N/A	N/A	41. 67%	Establish baseline		Yes
Asthma Medication Ratio	Removed – measure not included for QHP					In progress

Final Analysis

MassHealth HEDIS (including CarePlus members)

- Medication Management for Asthma 75% Compliance (5-64 years of age): the HEDIS 2017 rate increased 17. 54% from the 2016 rate. The increase is statistically significant (p = 0.0013) and exceeded the goal to close the gap by 50% to the 2014 NCQA Quality Compass HEDIS Medicaid HMO 50th percentile (30. 16%).
- Asthma Medication Ratio: the HEDIS 2017 rate increased 4. 96% from the HEDIS 2016 rate. The increase is statistically significant (p < 0.0001); however remains below the 2014 NCQA Quality Compass HEDIS Medicaid HMO 10th percentile (53. 29%). The QHP Asthma Medication Ratio is not available for HEDIS 2017 due to the two year enrollment requirement.

QHP

The Plan successfully established a baseline for the QHP population for the HEDIS Medication Management for Asthma 75% Compliance. Initial analysis shows that the baseline rate for QHP is considerably higher than the HEDIS 2017 rate for MassHealth.

Asthma Treatment Advisory Report (ATAR)

- Six months after the April 2016 ATAR was produced, 3.42% (10/292) of the members identified on the report and still active with the Plan filled a prescription for an asthma controller medication.
- Six months after the October 2016 ATAR was produced 2.48% (7/282) of the members identified on the report and still active with the Plan filled a prescription for an asthma controller medication.

Asthma Prednisone Burst CHW Program

Members engaged in the asthma prednisone burst CHW program were compared to members that did not engage to determine the effectiveness of the program.

- ED utilization decreased 38. 65% from six months prior to identification to six months after identification for members engaged in the program. This was a greater decrease than the 36.57% decrease for members that were not engaged in the program.
- Inpatient utilization decreased 23. 89% from six months prior to identification to six months after identification for members engaged in the program. This was a greater outcome than the 2.53% increase in inpatient utilization for members that were not engaged in the program.
- The asthma controller versus reliever ratio increased 8.28% from six months prior to identification to six months after identification for members engaged in the program. This was a greater increase than the 6.72% increase for members that were not engaged in the program.

P4P

Final Analysis
There were 1,090 gaps in the AMR and MMA measures among the providers participating in the P4P program. Since the P4P program began in (June 2016), providers had less of an opportunity to impact the overall HEDIS rates. Claims data were used to determine compliance. • 12. 39% (135/1,090) of all of the asthma adherence gaps were closed • 13. 70% (67/489) of the asthma medication ratio gaps were closed • 11. 31% (68/601) of the medication management for patients with asthma gaps were closed.

Recommendation for 2018
Continue as a quality improvement project.

Well Child and Adolescent Care

Project Title: Well Child and Adolescent Care		Post-Approval Change Log
Quality Improvement Project		
Program Description		
This project is designed to improve the health of children and adolescents by promoting appropriate well child visits for all ages for early identification and treatment of any behavioral or developmental issues.		
Measurement & Goal		
HEDIS 2017 specifications and rates.		
Measure	**Goal**	
Well Visits in the first 15 Months of Life (6 or more)	76. 92% Maintain or exceed the 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile.	
Well-Child Visits in the 3rd, 4th, 5th and 6th years of life	82. 69% Maintain or exceed the 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile.	
Adolescent Well Care Visits	65. 56% 2014 NCQA Quality Compass Medicaid HMO 90th percentile.	
Project Team		
Lead: Sharon Wai		
Medical Director: John Wiecha, MD		**Was:** Pablo Hernandez-Itriago, MD; Karen Boudreau, MD

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Provide a link on the Plan's website to the most recent MHQP Pediatric Preventive Care Guideline and Immunization recommendations.	01/2016	A link to the current Massachusetts Health Quality Partners (MHQP) Pediatric Preventive Care clinical practice guideline is available on the Plan's website.	01/2016 and ongoing
Provide educational material and resources on the Plan's website.	01/2016	A link is available on the Plan's website to educational material and resources including: Body Mass Index calculator, tips on healthy eating, Krames OnLine HealthSheets™, Nurse Advice Line, Wellness Guide etc.	01/2016 and ongoing

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Identify children birth up to age 21 in need of an annual well visit and encourage behavioral health screen.	• 05/2016 • 10/2016	The early and periodic screening, diagnostic and treatment (EPSDT) provider report identifies members birth to 21 years of age with the date of their last well visit (based on claims information), date the next well visit is due or overdue. The report also encourages behavioral health screening and a link to the MassHealth approved behavioral health screening tools. The report was added to the provider portal and a postcard was sent to providers to inform them of the availability of the report. June 2016 • 824 provider/provider groups identified Due to the low rate of providers pulling reports from the Plan's portal for the June 2016 report and reports in 2015, these reports were mailed to providers. November 2016 • 1,449 provider/provider groups identified	• 06/2016 • 11/2016
Educate parents/guardians on the importance of well visits and age appropriate screenings.	01/2016	On a monthly basis, parents/guardians of children turning 9 months of age are mailed a birthday card promoting well visits and age appropriate screenings up to age two.	01/2016 and ongoing
Develop additional interventions to encourage parents/guardians and members to have an annual well visit.	03/2016	The Plan identified and implemented two additional interventions in 2016: • Quality outreach coordinators • Adolescent Well Visit IVR Campaign See Additional Actions Implemented section for details.	07/2016 and ongoing
Utilize monthly HEDIS Dashboard to track well visit measures.	01/2016	A HEDIS dashboard is used to track measure trends month to month for specific HEDIS measures compared to administrative rate trends from previous years, benchmarks and goals. The HEDIS dashboard is reviewed by the MA Quality Committee each month to determine if additional interventions are needed.	01/2016 and ongoing

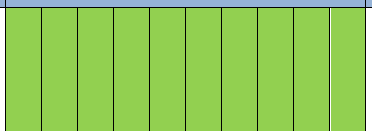
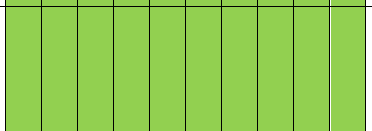
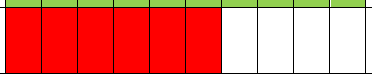
Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**
Quality Outreach Coordinators (QOCs)	Two Quality Outreach Coordinators placed outbound calls educating members and parents of members about the	07/2016

Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**
	importance of preventive care and encouraging members to schedule well visits. See Final Analysis section for results.	
Adolescent Well Visit IVR Campaign	The Plan implemented an IVR campaign to members aged 18-21 who have not yet had a yearly physical/well visit. The campaign promoted the importance of having an annual well visit. See Final Analysis section for results.	09/2016

Barriers Encountered

- Transportation difficulty for members that live in Metro Boston and are not eligible for PT1 services.
- Some parents of members expressed difficulty convincing the members to see the PCP for a well visit.
- Members may be receiving treatment for complex conditions and do not schedule a well visit due to the many appointments for the condition.
- Psychosocial barriers such as homelessness, health literacy and food insecurity impede on the likelihood of getting routine preventive well visits.

Measurement Milestones

Measure*	HEDIS 2015	HEDIS 2016	HEDIS 2017	Goal	Progress toward goal	Goal met?
Well-Child Visits in the First 15 Months of Life (6 or more)	84.57%	77.78%	80.27%	76.92%		Yes
Well-Child Visits in the 3rd, 4th, 5th and 6th years of life	84.91%	89.74%	83.91%	82.69%		Yes
Adolescent Well Care Visits	64.48%	70.10%	62.50%	65. 56%		No

Final Analysis

MassHealth HEDIS (including CarePlus members)

- Well Visits in the first 15 Months of Life (6 or more): the HEDIS 2017 rate increased 3. 20% from the HEDIS 2016 rate. The increase is not statistically significant (p = 0. 4824) and remains above the 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile (76. 92%).
- Well-Child Visits in the 3rd, 4th, 5th and 6th years of life: the HEDIS 2017 rate decreased 6. 50% from the HEDIS 2016 rate. The decrease is not statistically significant (p = 0. 0804) and remains above the 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile (82. 69%).
- Adolescent Well Care Visits: the HEDIS 2017 rate decreased 10. 84% from the HEDIS 2016 rate. The decrease is statistically significant (p = 0. 0287) and is below the 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile (65. 56%).

QOC

The QOCs reached and were informed that a follow up appointment would be made for 151 members 3-6 years old or 12-21 years old due for a well visit. Claims data were used to determine compliance.

- 33. 11% 50/151) of all of the members reached had a well visit
- 36. 59% (15/41) of the members 3-6 years old had a well visit
- 26. 92% (35/130) of the members 12-21 years old had a well visit

Recommendation for 2018
Continue as a quality improvement project.

Women's Preventive Health

Project Title: Women's Preventive Health		Post-Approval Change Log
Quality Improvement Project		
Program Description		
This project is designed to improve the health of women by promoting appropriate cervical, breast cancer and chlamydia screenings for early identification and treatment of any cancer or conditions.		
Measurement & Goal		
HEDIS 2017 specifications and rates.		
Measure	**Goal**	
MassHealth (including CarePlus)		
Cervical Cancer Screening	78. 55% Statistically significant increase from the HEDIS 2015 rate (70. 91%).	
Breast Cancer Screening	71. 35% 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile.	
Chlamydia Screening	67. 19% Maintain or exceed the 2014 NCQA Quality Compass Medicaid HMO 90th percentile.	
Qualified Health Plan		
Cervical Cancer Screening	Set baseline and establish goal	
Breast Cancer Screening	Set baseline and establish goal	
Chlamydia Screening	Set baseline and establish goal	
Project Team		
Lead: Sharon Wai		
Medical Director: John Wiecha, MD		**Was:** Pablo Hernandez-Itriago, MD; Karen Boudreau, MD

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Provide a link on the Plan's website to the most recent MHQP Adult Routine Preventive Care Guideline.	01/2016	A link to the current Massachusetts Health Quality Partners (MHQP) Adult Preventive Care clinical practice guideline is available on the Plan's website.	01/2016 and ongoing
Provide educational material and resources on the Plan's website.	01/2016	A link is available on the Plan's website to educational material and resources including: Body Mass Index calculator, tips on healthy eating, Krames OnLine HealthSheets™, Nurse Advice Line, Wellness Guide etc.	01/2016 and ongoing

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Identify and implement interventions to improve screening rates.	01/2016	The Plan implemented multiple interventions to educate members of the importance of having a breast and/or cervical cancer screening. The following interventions were implemented and are described further in the Additional Actions Implemented table below: • Member Services educated members identified as due or overdue for breast and/or cervical cancer screenings during inbound calls. • Quality Outreach Coordinators called members due for breast and/or cervical cancer screenings. • Care Management identified and educated members in care management due for breast and/or cervical cancer screening.	01/2016 and ongoing
Educate members on the importance of age appropriate screenings.	01/2016	Members are educated on the importance of cervical and breast cancer screenings and are encouraged to make an appointment for screenings through interactions with CM, outbound calls placed by Quality Outreach Coordinators and through inbound calls with Member Services.	01/2016 and ongoing
Utilize monthly HEDIS Dashboard to track preventive screenings measures.	01/2016	A HEDIS dashboard is used to track measure trends month to month for specific HEDIS measures compared to administrative rate trends from previous years, benchmarks and goals. The HEDIS dashboard is reviewed by the MA Quality Committee each month to determine if additional interventions are needed	01/2016 and ongoing

Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**
On hold messages	Preventive screenings including breast and cervical cancer screenings were promoted during on hold messages for Member Services.	06/2016
Quality Outreach Coordinators (QOCs)	Two Quality Outreach Coordinators placed outbound calls educating members about the importance of preventive care and encouraging members due for screenings to schedule appointments to obtain breast and/or cervical cancer screenings. See Final Analysis section for results.	07/2016 and ongoing

Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**
Member Services "Pop Up Messages" for members due for breast and/or cervical cancer screenings during inbound calls.	Pop-up preventive health reminders were developed to trigger Member Services to remind members due for breast and/or cervical cancer screenings to schedule an appointment during inbound calls. See Final Analysis section for results.	08/2016 and ongoing
HEDIS care gaps made available to CM	HEDIS care gaps were made available on the registry to help care managers identify preventive care gaps for breast and cervical cancer screenings while interacting with members in CM.	09/2016 and ongoing

Barriers Encountered

- Members may not be aware of the importance of screening for breast cancer and cervical cancer.
- Transportation difficulty for members that live in Metro Boston and are not eligible for PT1 services.
- Members may be receiving treatment for complex conditions and do not feel like they can prioritize preventive screenings.
- Psychosocial barriers such as homelessness, health literacy and food insecurity impede on the likelihood of getting routine preventive screenings.
- Some members expressed concern about exposure to radiation during a mammogram.
- Some members already have cancer and do not see the point of having additional cancer screenings.

Measurement Milestones

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	Goal	Progress toward goal	Goal met?
MassHealth (including CarePlus)						
Cervical Cancer Screening	70. 91%	75. 35%	67. 60%	78. 55%		No
Breast Cancer Screening	71. 12%	72. 06%	70. 44%	71. 35%		No
Chlamydia Screening	70. 59%	71. 75%	72. 86%	67. 19%		Yes
Qualified Health Plan						
Cervical Cancer Screening	N/A	N/A	83. 10%	Set baseline		Yes
Breast Cancer Screening	N/A	N/A	76. 45%	Set baseline		Yes
Chlamydia Screening	N/A	N/A	67. 65%	Set baseline		Yes

Final Analysis

MassHealth HEDIS (including CarePlus members)

- Cervical Cancer Screening: the HEDIS 2017 rate decreased 7.84% from the HEDIS 2016 rate. The decrease is statistically significant (p = 0.0257) and is below the goal (78.55%).
- Breast Cancer Screening: the HEDIS 2017 rate decreased 2.25% from the HEDIS 2016 rate. The decrease is statistically significant (p = 0.0198) and is below the 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile (71.35%).
- Chlamydia Screening: the HEDIS 2017 rate increased 1.55% from the HEDIS 2016 rate. The increase is not statistically significant (p = 0.1454) and remains above 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile (67.19%).

QHP: The Plan successfully established baseline rates for the QHP population. Initial analysis shows that the cervical cancer and

Final Analysis
breast cancer screening rates for the QHP population were considerably higher than the MassHealth population rates. However, the chlamydia screening rate for the QHP population was lower than the MassHealth population rate. **QOC** The QOCs outreached to members with care gaps and were informed by 439 members that a follow up appointment would be made for breast and cervical cancer screenings. Using claims data to determine compliance, the result of the intervention is: • 13. 90% (61/439) of all of the breast and cervical cancer screenings gaps were closed • 23. 19% (16/69) of the breast cancer screenings were completed • 15. 96% (45/282) of the cervical cancer screenings were completed **Member Services "Pop up Messages"** In 2016, 440 members called into the Plan and were given a reminder to have a breast and/or cervical cancer screening. The following were the responses Member Services received among the members given a reminder: • < 1% (3/440) requested help with scheduling an appointment • 89. 32% (393/440) of the members were going to follow up with their doctor • 4. 09% (18/440) of the members were not going to follow up with their doctor • 5. 91% (26/440) did not want any more reminders and were removed from the list

Recommendation for 2018
Continue as a quality improvement project.

Care Management

Project Title: Care Management		Post-Approval Change Log
Quality Improvement Project		
Program Description		
The care management program will continue to be refined as needed to improve the percentage of members successfully reached and engaged in care management. This program will test a social model of care for complex members in Massachusetts that expands BMCHP's care management capabilities. The social model based program supports the homeless, members with co-morbid behavioral health disorders and complex members/super utilizers/high cost members while improving the health of these members. The care management program will also introduce a social model based program that supports the homeless, members with co-morbid behavioral health disorders and complex members/super utilizers/high cost members while improving the health of these members.		
Measurement & Goal		
Measure	**Goal**	
% of members identified who were outreached for care management	75%	
% of members who were successfully reached and engaged in care management	60%	Δ Updated the definition of engagement. In CY 2015, engagement was defined as having a completed assessment and/or a case type of Community Resource. Engagement is now defined as having a case that was outreached and then moved to active.
Project Team		
Lead: Jeanne Murphy, RN		
Medical Director: John Wiecha, MD		**Was:** Karen Boudreau, MD

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Continue to review and update the Plan's registry to identify actionable members for CM.	01/2016	The Plan annually reviews and updates the registry for identification of actionable members for care management.	01/2016 and ongoing
Identify staff training needs and utilize the Care Management Clinical Trainer and/or external trainers as needed.	01/2016	All CM staff received training on CM communication, motivational interviewing, domestic violence, safety, supporting resistant members, and care plan development.	01/2016 and ongoing
Provide training and ongoing monitoring, advanced communication skills, and motivational interviewing skills.	01/2016	Managers continue to monitor sample calls to evaluate communication and motivational interviewing skills. This year, the ability to monitor calls through a call recording tool was implemented. This provides the opportunity for management and staff to listen to and evaluate calls. Opportunities for improvement are identified and coaching takes place.	01/2016 and ongoing

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Review member engagement rates with CM staff on a quarterly basis and provide feedback.	• 01/2016 • 04/2016 • 07/2016 • 10/2016	Member engagement rates are reviewed with CM staff on a quarterly basis.	01/2016 and ongoing
Utilize the CM Dashboard to monitor CM identification and engagement rates.	01/2016	The Plan developed a CM Dashboard to monitor identification and engagement rates, trends, and address barriers.	01/2016 and ongoing
Continue to send letters to PCPs and OB/Family Practice for members enrolled in CM and Sunny Start Program.	01/2016	Letters are mailed to PCPs and OB/Family Practice notifying them of a member's enrollment in CM.	01/2016 and ongoing
Continue face to face visits for high risk members and those at most risk using ED utilization and other risk factors.	01/2016	The Plan continues to encourage face to face visits with members, particularly, high risk members. In 2016 there were 257 face to face care management visits with members.	01/2016 and ongoing
Identify and engage members in Social CM.	01/2016	Cases are referred to Social CM through a variety of mechanisms utilizing the assessment of social determinants.	01/2016 and ongoing
Continue to refer members to Beacon Health Strategies when appropriate.	01/2016	Staff continue to refer members to Beacon Health Strategies for behavioral health needs.	01/2016 and ongoing
Review Community Health Worker (CHW) training programs for pregnant members.	02/2016	CHWs have been trained in programs for asthma and diabetes. CHWs are also able to assist and educate pregnant members and refer them to the Plan's Maternal Child Health Care Management Program if needed.	07/2016 and ongoing
Encourage CHW interventions with appropriate members.	02/2016	The Plan continues to encourage referrals to the CHWs for appropriate interventions.	02/2016 and ongoing

Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**
Social CM Documentation	A template to document implementation of Social CM and follow up assessment was developed.	4/1/2016
Updated Beacon Referral process	The Beacon referral process was updated to include mothers of complex newborns for BH support and services.	2/17/16
Assessment Review	Assessments reviewed to be sure they are aligned with clinical practice guidelines.	08/2016

Barriers Encountered
• The New Bedford and Springfield offices closed and the transition to teleworking resulted in some initial technical difficulties impacting staff outreaching to members. • The ability for staff to utilize tablets or laptops to document assessments was not implemented in 2016 due to prioritization of IT resources. • Individual CM's ability to engage members varies among the care management staff which impacts the overall member engagement rate.

Barriers Encountered
• Lack of accurate member demographic information impacts outreach efforts.

Measurement Milestones						
Measure	**Baseline (CY 2014)**	**CY 2015 Rate**	**CY 2016 Rate**	**Goal (CY 2016)**	**Progress toward goal**	**Goal met?**
% of members identified who were outreached for care management	70.86%	69.65%	72.11%	75%		No
% of members who were successfully reached and engaged in care management	58.3%	60.97%	59.28%	60%		No

Final Analysis
• The percentage of members identified and outreached for care management increased 3.53% from 69.65% in CY 2015 to 72.11% in CY 2016. The goal of 75% was not met, and the increase was not statistically significant. • To align with the Plan's internal Care Management engagement report, the Plan used a different definition to measure engagement in CY 2016. In CY 2015, engagement was defined as having a completed assessment and/or a case type of Community Resource (i.e. transportation, food resources etc.). Engagement is now defined as having a case that was outreached and then moved to active. Using the updated engagement definition, the percentage of members who were outreached and engaged in care management increased 1.68% from 58.3% in CY 2014 (baseline) to 59.28% in CY 2016, but decreased 2.77% from 60.97% in CY 2015 to 59.28% in CY 2016. The changes were not statistically significant. Despite significant barriers, the outreach rate improved from 2015 and engagement remained fairly stable.

Recommendation for 2018
Retire as quality improvement project and replace with Special Needs Project in 2018.

Postpartum Care

Project Title: Postpartum Care		Post-Approval Change Log
Quality Improvement Project		
Program Description		
Postpartum care is an important factor of quality health care outcomes for women giving birth. A postpartum visit 21-56 days after delivery is an opportunity to address important postpartum care needs of the mother. These include pregnancy complications, chronic conditions, inter conception care, postpartum depression screening, and providing guidance on breastfeeding and other issues. Assessment of postpartum care allows for early identification of risk and timely intervention. This project is designed to improve the rate of postpartum visits for pregnant members 21-56 days after delivery.		
Measurement & Goal		
Performance Improvement Project		
HEDIS 2017 specifications and rates.		
Measure	**Goal**	
MassHealth Postpartum Visits	74. 03% 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile (74. 03%).	
QHP Postpartum Visits	Set baseline and establish goal	
Project Team		
Lead: Jeanne Murphy, RN		
Medical Director: John Wiecha, MD		**Was:** Pablo Hernandez-Itriago, MD; Karen Boudreau, MD

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Continue to provide a link on the Plan's website to the most recent Massachusetts Health Quality Partners (MHQP) Perinatal clinical practice guideline and Institute for Clinical Systems Improvement (ICSI) Prenatal Care Guideline.	01/2016	A link to the current MHQP Perinatal clinical practice guideline and Institute for Clinical Systems Improvement (ICSI) Prenatal Care Guideline is available on the Plan's website.	01/2016 -12/2016
Continue the Maternal Child Health Care Management Program providing care management for high risk pregnant members during prenatal and postpartum as well as for complex newborns.	01/2016	The Plan continues the Maternal Child Health Care Management Program providing care management for high risk pregnant members during prenatal and postpartum as well as for complex newborns.	01/2016 and ongoing

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Utilize external vendor to provide and fulfill member incentive program for compliance with postpartum visits.	01/2016	An external vendor provided member incentives to educate members on the importance of a postpartum visit 21-56 days after delivery. During the course of this campaign, 2,534 members were called approximately 2 weeks after delivery to encourage a postpartum visit. Incentives for a timely postpartum visit were offered in the form of "points" that members could use to shop from a catalog developed by the vendor. See Final Analysis section for results.	01/2016- 10/2016
Encourage providers to submit the ACOG form for early identification and risk stratification of pregnant women.	01/2016	Providers are encouraged to submit ACOG prenatal care forms to the Plan after the first prenatal visit. The information is used to identify pregnant women earlier than using claims and stratify by risk for appropriate care management outreach throughout the pregnancy and postpartum. In Fiscal Year 2016 (October 1, 2015 to September 30, 2016) 429 ACOG forms were received by the Plan.	01/2016 and ongoing
Continue to provide diaper incentive.	01/2016	817 members with a confirmed postpartum visit 21-56 days after delivery returned a form completed by their provider and were mailed a box of diapers.	01/2016 and ongoing
Continue to promote text4baby.	01/2016	Text4baby is promoted to pregnant members on the Plan's website, during care management interactions and in member materials mailed to pregnant members. Text4baby was added to the MHQP Perinatal clinical practice guideline.	01/2016 and ongoing
Continue to include the postpartum postcard with car seats and breast pumps sent to members.	01/2016	The postpartum postcard highlights the importance of the postpartum visit. Since not all pregnant women receive car seats or breast pumps the process of providing postpartum postcards exclusively with these items was discontinued in August of 2016. As of December 2016 the process of providing the postpartum postcard was changed to be included in the prenatal and postpartum packets. This mailing is in the process of being revised and developed into two separate mailings comprised of a prenatal checklist and a postpartum checklist.	01/2016 to and ongoing

Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**

Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**
Postpartum Visit Rate Monitoring in CM	The MA Quality Committee reviews data collected by CM staff to confirm a postpartum visit 21-56 days after delivery. The Committee monitors the postpartum visit rate to identify any issues during the year that may require additional interventions.	01/2016 and ongoing
Trimester Calls	Care Management workflows were updated to include prenatal trimester calls with a postpartum reminder for members with low risk pregnancies	01/2016 and ongoing
On hold messages	The Maternal Child Health Program is promoted during on hold messages for Member Services. The program includes assistance throughout pregnancy and the postpartum period.	06/2016

Barriers Encountered

- Pregnant members may not be aware of the importance and benefit of going to the postpartum visit.
- Some members do not attend the postpartum visit within the recommended HEDIS timeframes, but ultimately receive appropriate clinical care outside of the timeframe.
- Members are being treated for more chronic conditions such as substance use and may not consider the need for the postpartum visit if they are seeing a doctor already regarding the other condition.
- It is difficult to track the progress of this measure accurately throughout the year due to global billing which includes pregnancy-related antepartum care, admission to Labor and Delivery, management of labor including fetal monitoring, delivery, and uncomplicated postpartum care until six weeks postpartum.
- Some providers do not have the resources to implement a process to submit Category II CPT 0503F codes which identify a postpartum visit to the Plan.
- Although providers are aware of the recommended timeframes for postpartum visits, they also have difficulty contacting the members or the members end up not showing up to the postpartum visit.
- Although the sample used for the hybrid report is expected to represent the overall population, there is a risk of a sample being used that does not reflect the rate for the whole population.
- There is potential difficulty getting the medical records during HEDIS review.
- It is difficult to extract data from electronic health records (EHR) at this time due to the variability in EHRs used by different provider offices.

Measurement Milestones						
Measure	**HEDIS 2015**	**HEDIS 2016**	**HEDIS 2017**	**Goal**	**Progress toward goal**	**Goal met?**
MassHealth Postpartum Visit	71. 55%	66. 94%	72. 59%	74. 03%		No
QHP Postpartum Visit	N/A	N/A	78. 70%	Set baseline		Yes

Final Analysis

Final Analysis

MassHealth HEDIS (including CarePlus members)

- Postpartum Care: Although the HEDIS 2017 rate increased 8. 44% from the HEDIS 2016 rate, the goal was not met. The increase is not statistically significant (p = 0. 0915) and is below 2014 NCQA Quality Compass HEDIS Medicaid HMO 90th percentile (74. 03 %).

QHP: The Plan successfully established a baseline rate for the QHP population. Initial analysis shows that the HEDIS Postpartum visit rate for the QHP population is considerably higher than the rate for the MassHealth population.

Member Rewards Program

Finity, Inc. engaged members to participate in the rewards program through phone calls and a mailing. The program was explained to members eligible to earn rewards points for compliance with a postpartum visit. Due to global billing, self-attestation was used to determine compliance.

- 68. 6% (1738/2534) members were engaged by phone
- 91. 4% (1589/1738) members self-attested that they had a postpartum visit 21-56 days after delivery

Recommendation for 2018

Continue as a quality improvement project.

Antidepressant Medication Management

Project Title: Antidepressant Medication Management (AMM)		Post-Approval Change Log
Quality Improvement Project		
Program Description		
Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide, the 11th leading cause of death in the United States each year. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness and identifying and managing side effects. http: //www. ncqa. org/Portals/0/Newsroom/2014/SOHC-web. pdf Current recommendations suggest that antidepressant medications should continue between four to nine months after depressive symptoms go away. Studies have shown that achieving remission and continuing antidepressant therapy long after the initial symptoms subside can protect against relapse (an early return or worsening of symptoms) or recurrence (later episodes occurring after remission) of the depressive episode. Discontinuing antidepressant treatment too soon may increase the risk of relapse or recurrence. http: //www. pdrhealth. com/antidepressants/antidepressant-treatment-timeline		
Measurement & Goal		
Performance Improvement Project		
HEDIS 2017 specifications and rates.		
Measure	**Goal**	
MassHealth (including CarePlus)		
AMM Acute Phase	49. 66% 2014 NCQA Quality Compass Medicaid HMO 50th percentile (49. 66%)	
AMM Continuation Phase	33. 93% 2014 NCQA Quality Compass Medicaid HMO 50th percentile (33. 93%)	
Qualified Health Plan		
AMM Acute Phase	Establish baseline	
AMM Continuation Phase	Establish baseline	
Project Team		
Lead: Sharon Wai		
Medical Director: John Wiecha, MD		**Was:** Pablo Hernandez-Itriago, MD; Karen Boudreau, MD

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Continue to provide a link on the Plan's website to the most recent Institute for Clinical Systems Improvement (ICSI) Adult Depression in Primary Care clinical practice guideline.	01/2016	A link to the current ICSI Adult Depression in Primary Care clinical practice guideline is available on the Plan's provider website.	01/2016 and ongoing

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Continue to work collaboratively with Beacon to identify AMM interventions.	01/2016	BMCHP included Beacon in the Wellness and Disease Management workgroups to review the root cause analysis data for the AMM measures and identify additional interventions. Additional interventions are documented in the "Additional Actions Implemented" below.	01/2016 and ongoing
Continue to track AMM rates using HEDIS dashboard.	01/2016	A HEDIS dashboard is used to track measure trends month to month for specific HEDIS measures compared to administrative rate trends from previous years, benchmarks and goals. The HEDIS dashboard is reviewed by the MA Quality Committee each month to determine if additional interventions are needed.	01/2016 and ongoing
Explore early identification of members starting antidepressant medications using more frequent pharmacy data.	01/2016	The Plan developed a bi-weekly general medication adherence mailer based solely on pharmacy data targeting members newly prescribed with a Selective Serotonin Reuptake Inhibitor (SSRI). The mailer encourages compliance with medication, and is written and sent in both English and Spanish.	01/2016 Mailing started in 05/2016 and ongoing.
Refer members with diabetes and asthma that are non-compliant with antidepressant medication to Beacon Health Strategies.	01/2016	The Plan's medical care managers discuss AMM with members with diabetes and/or asthma that are non-compliant with antidepressant medications, and consult with Beacon as appropriate in weekly CM rounds.	01/2016 and ongoing
Continue monthly educational mailing including pill box to members 18 and over with a new start of antidepressant medication.	01/2016	The Plan continues to send a monthly educational mailing to members 18 years of age and older identified with a new prescription for antidepressant medication. The mailing promotes the importance of staying on the prescribed antidepressants, taking medication as ordered and to discuss any issues with the provider. The mailing also addresses concerns about taking antidepressants while pregnant, and promotes physical activity. A pill box is included with the mailing to help members keep track of their medication. In 2016: • English – 4999 members • Spanish – 443 members	01/2016 and ongoing

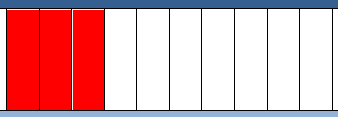
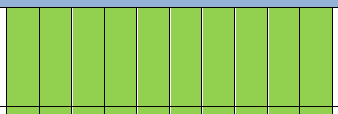
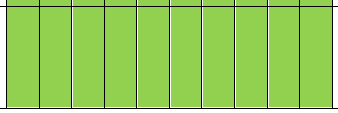
2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Share quality performance data with providers.	03/2016	The Plan analyzed AMM performance by provider groups and identified select high and low performing provider groups. A questionnaire was developed to discuss medication prescribing and processes with the low performing providers. Provider groups were contacted and meetings were set up to discuss their internal processes, barriers and barriers. The group's recent rates along with national thresholds will be shared with the provider groups during the meetings with Quality.	11/2016
Identify and implement interventions to decrease the disparity in the Hispanic population.	03/2016	The Plan developed a bi-weekly medication adherence mailer targeting members newly prescribed with an SSRI without waiting for a medical claim for depression. The content of the mailer does not specifically address antidepressants, which may carry a stigma in the Hispanic population, but provides information on medication adherence and encourages compliance with medication. It is written and sent in both Spanish and English. In 2016, 5,757 members received the mailer. The Plan also developed a survey to help identify barriers and opportunities to improve adherence to the antidepressant medications among the Hispanic population. The survey was done by phone in April 2017.	05/2016 and ongoing.

Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**
Revise and enhance the PCP Toolkit to improve accessibility to PCPs and members.	The revised Toolkit includes the following tools for providers to use with members: "You and Your HealthCare Provider Working Together to Treat Depression" Depression Treatment Tool, "What you Need to Know about Antidepressants" Poster, "Depression Brochure," and the "Healthwise: Depression" Overview. The toolkit includes the following screening tools: "Beacon Health Strategies recommended screening for Depression" program description, "PCP Depression Assessment," and "PHQ-9 Questions." The PCP toolkit includes the American Psychiatric Association's Practice Guideline for the Treatment of Patients with Major Depressive Disorder. The PCP Toolkit was reviewed and updated and is now linked interactively with Achieve Solutions, the Beacon Health Options health and wellness information library. One of the highlights of these revisions allows interactive screening tools for members.	2/2016 and Ongoing

Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**
Quality Packet distributed during audits and site visits.	Beacon clinicians provide copies of the Beacon Quality Packet to behavioral health providers which include an AMM Best Practice bulletin. These best practices are captured during Beacon's audits of inpatient and outpatient records.	Inpatient Chart Reviews: 06/2016 to 08/2016 Outpatient Chart Reviews: 01/2016-12/2016
Managers of Provider Partnerships (MPP) present HEDIS Best Practice Guidelines to strategic providers.	Beacon MPPs work with strategic BH providers in Massachusetts to drive collaboration, performance improvement and innovation with Beacon's provider network. MPPs educate BH providers on best practices to improve HEDIS performance.	01/2016 and Ongoing
Provider Postcard – includes reference to the CPG and other depression tools on the Beacon website.	All network behavioral health providers receive a postcard annually which references the APA "Practice Guideline for the Treatment of Patients with Major Depressive Disorder". The postcard also references other resources for depression including screening tools for providers, self-screening tools for members, educational brochures on depression detection and treatment.	1/2016 and On-going
Beacon/BMCHP intervention Psychotropic Drug Interaction Program (PDIP) /.	Beacon identifies members that fall within the AMM cohort and sends an informational letter about AMM. The letter provides information about the PDIP program, ability to self-refer into the program, and information about depression and antidepressant medication therapy.	1/2016 – 8/2016

Barriers Encountered
• The two to three month medical claims lag to confirm the diagnosis of depression delays identifying members for the AMM mailing and the AMM Member Outreach Program. • Members may not understand the importance of taking antidepressants as ordered and that changes in dosage or medication may be required to achieve therapeutic results. • Members may experience side effects to medications and stop taking them. Hispanic members may be resistant to treating depression with medication due to social stigma or cultural barriers. • Women who are pregnant or thinking of becoming pregnant may have concerns about the potential health risks antidepressants may have for their baby. • Members with chronic or comorbid conditions may need additional help with managing depression. • Laws preventing the dissemination of behavioral health information to the PCP without permission from the member limit the Plan from involving PCPs in the outreach effort to help members understand and stay on their antidepressant medication. • The Beacon PDIP and AMM Member Outreach Programs were put on hold in August 2016 due to a joint desire to better understand data issues by both organizations. • PCPs may not be aware of available support tools, best practice recommendations and guidelines for the effective treatment of depression. • Members may not fill their antidepressant medication due to the copay and are not aware that the medication can be filled and paid at a later date.

Measurement Milestones						
Measure	**HEDIS 2015**	**HEDIS 2016**	**HEDIS 2017**	**Goal**	**Progress toward goal**	**Goal met?**
MassHealth (including CarePlus)						
AMM Acute Phase	44. 25%	44. 85%	44. 74%	49. 66%		No

Measurement Milestones						
AMM Continuation Phase	30. 02%	30. 97%	31. 59%	33. 93%		No
Qualified Health Plan						
AMM Acute Phase	N/A	N/A	59. 76%	Set baseline		Yes
AMM Continuation Phase	N/A	N/A	47. 71%	Set baseline		Yes

Final Analysis

MassHealth HEDIS (including CarePlus members)

- AMM Acute Phase: the HEDIS 2017 rate decreased 0. 25% from the HEDIS 2016 rate and did not meet the goal. The decrease is not statistically significant (p = 0. 9090) and remains below the 2014 NCQA Quality Compass HEDIS Medicaid HMO 50th percentile (49. 66%).
- AMM Continuation Phase: the HEDIS 2017 rate increased 2. 00% from the HEDIS 2016 rate and did not meet the goal. The increase is not statistically significant (p = 0. 4938) and remains below the 2014 NCQA Quality Compass HEDIS Medicaid HMO percentile (33. 93%).

QHP

The Plan successfully established baseline rates for the QHP population. Initial analysis shows that the HEDIS AMM Acute Phase and Continuation Phase rates for the QHP population are considerably higher than the rates for the MassHealth population.

Beacon PDIP AMM Member Outreach Program

From January through July 2016, Beacon's PDIP AMM Member Outreach Program contacted 131 members by the interactive voice recognition (IVR) system who met the eligibility criteria to participate in the program (antidepressant prescription, negative medication history and diagnosis of depression).

- 118 members agreed to speak to an AMM specialist.
- 64 of the 118 (54. 2%) members who spoke to the AMM specialist enrolled in the program.
- Of the 54 members who declined participation in the program, 2 completed a declination survey inquiring about reasons for declining participation.
    - 1 of the members who completed the survey said their doctor is managing, and 1 member said reason is not listed

Medication Adherence Mailing

The Plan developed and implemented a medication adherence educational mailing in May 2015 targeting members 18 years and older who were newly prescribed with an SSRI using pharmacy claims. In the 6-month effectiveness analysis of the medication adherence member mailing, the Plan compared the adherence rates of members in the 2016 cohort with an Index Prescription Start Date (IPSD) between May 2016 and October 2016 in March 2017 to members in the 2015 cohort with an IPSD between May 2015 and October 2015 in March 2016. Additionally, the Plan further analyzed the results by race. The findings were:

- There was an increase in the AMM Effectiveness Acute Treatment rate between the 2015 cohort (members did not receive the mailer) and 2016 cohort (members received the mailer). The AMM Effectiveness Acute Treatment rate increased by 1.44% percentage points from 46.52% (808/1,737) to 47.19% (756/1,602); however the increase was not statistically significant.
- Among the Hispanic population, the AMM Effectiveness Acute Treatment rate increased 6.83% from 34.86% (145/416) to 37. 24% (124/333) and the AMM Effectiveness Continuation Treatment rate increased 10.05% from 20.19% (84/416) to 22.22% (74/333); however, the increases were not statistically significant.

Recommendation for 2018

Continue as a quality improvement project.

Cultural and Linguistic Needs

Project Title: Cultural and Linguistic Needs		Post-Approval Change Log
Quality Improvement Project		
Program Description		
Racial and ethnic disparities in health care have been well documented. Data analysis has demonstrated that racial and ethnic disparities contribute to lower HEDIS effectiveness of care scores. This project seeks to improve overall care of members by identifying the racial and ethnic composition of BMCHP membership so that potential health care disparities can be identified.		
Measurement & Goal		
Measure	**Goal**	
Direct data collection of MassHealth member level Race, Ethnicity and Language (R/E/L).	Maintain direct collection of R/E/L data for 50% of the Plan's MassHealth membership.	
Direct data collection of CarePlus member level R/E/L	Maintain direct collection of R/E/L data for 50% of the Plan's CarePlus membership.	
Direct data collection of QHP member level R/E/L	Maintain direct collection of R/E/L data for 50% of the Plan's QHP membership.	
Direct data collection of SCO member level R/E/L	Maintain direct collection of R/E/L data for 50% of the Plan's SCO membership.	
Project Team		
Lead: Ana Berridge		
Medical Director: John Wiecha, MD		**Was:** Pablo Hernandez-Itriago, MD; Karen Boudreau, MD

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Continue to provide Cultural Competency training to all new employees through the new hire orientation/training.	01/2016	BMCHP provides cultural competency training to all employees through the new hire orientation/training. Starting March 2016 BMCHP included cultural competency information within the Senior Care Options model of care training. This training is required for all BMCHP staff to complete annually.	01/2016 03/2016
Continue to collect R/E/L data in a sensitive manner.	01/2016	The Plan collected R/E/L data in a sensitive manner through member services, care management, and the health needs assessment.	01/2016

<table>
<tr><th colspan="4">2016 Actions</th></tr>
<tr><th>Action</th><th>Expected date</th><th>Description</th><th>Implementation date</th></tr>
<tr><td>Continue to collect preferred written language data in a sensitive manner.</td><td>01/2016</td><td>The Plan collected both preferred spoken and preferred written language from members.</td><td>01/2016</td></tr>
<tr><td>Use available R/E/L data and HEDIS rates to identify possible disparities and barriers to care.</td><td>11/2016</td><td>The Plan performed drilldown analysis by race and language for HEDIS 2016 rates to identify potential disparities. Based on the analysis the following disparities were identified:
<table>
<tr><th>HEDIS 2016 Measure</th><th>REL categories with a statistically significant (p<0. 05) disparity (lower compliance)</th></tr>
<tr><td>Diabetes HbA1c Testing</td><td>White/Caucasian</td></tr>
<tr><td>Diabetes Eye Exams</td><td>White/Caucasian, English speaking</td></tr>
<tr><td>Diabetes HbA1c Control</td><td>English speaking</td></tr>
<tr><td>Appropriate Testing for Children with Pharyngitis</td><td>Hispanic</td></tr>
<tr><td>Breast Cancer Screening</td><td>White/Caucasian, English speaking</td></tr>
<tr><td>Antidepressant Medication Management (Effective Acute and Continuation Treatment)</td><td>Black/African American and Hispanic
Spanish speaking</td></tr>
<tr><td>Medication Management for People with Asthma (75%)</td><td>Black/African American</td></tr>
<tr><td>Asthma Medication Ratio (50%)</td><td>White/Caucasian, English speaking</td></tr>
<tr><td>Human Papillomavirus Vaccine (HPV)</td><td>White/Caucasian</td></tr>
</table></td><td>10/2016</td></tr>
<tr><td>Use R/E/L data to implement culturally and linguistically appropriate interventions if identified.</td><td>12/2016</td><td>The Plan used R/E/L data to implement culturally and linguistically appropriate interventions. Interventions included sending materials in the most prevalent languages and outreaching to members by telephone in their preferred spoken language to close gaps in care and targeting barriers based on cultures as they were encountered.</td><td>01/2016</td></tr>
</table>

Additional Actions Implemented

Additional Action	Description	Implementation date
N/A		

Barriers Encountered

- There was a recent increase in membership which resulted in a reduction in the overall rate of R/E/L data collected directly from members eligible in the Plan.

Measurement Milestones

Measure	CY 2015	CY 2016	Goal	Progress toward goal	Goal met?
Direct data collection of MassHealth member level R/E/L	54.60%	55.51%	50%		Yes
Direct data collection of CarePlus member level R/E/L	56.22%	54.55%	50%		Yes
Direct data collection of QHP member level R/E/L	45.05%	32.56%	50%		No
Direct data collection of SCO member level R/E/L	N/A	23.57%	50%		No

Final Analysis

In 2016 the percentage of R/E/L data collected for all eligible members decreased from CY 2014; however the goal was met for MassHealth and CarePlus members.

The Plan continues to increase collection of R/E/L data among the eligible population through multiple sources including health needs assessments, member services, and care management.

We implemented an additional intervention for the antidepressant medication management measure to reduce the disparities among Hispanics. Biweekly members are identified based on the first time they fill an SSRI and are sent a mailer encouraging medication adherence and communicating with the provider before making changes or stopping. The mailer is sent in English and Spanish and removes the depression topic which is sent in the monthly mailer which may help reduce the stigma among the Hispanic population.

We also identified additional disparities within diabetes, asthma medication adherence, HPV immunizations, appropriate testing for pharyngitis and breast cancer screening. The Plan is researching the disparities and identifying potential interventions where appropriate. The Plan will also continue to analyze R/E/L data to identify and address any new disparities in care among the membership.

Recommendation for 2018

Continue as a quality improvement project.

Member Satisfaction

Project Title: Member Satisfaction		Post-Approval Change Log
Quality Improvement Project		
Program Description		
This project is designed to improve member satisfaction with customer service as well as the rating of the health plan.		
Measurement & Goal		
Adult CAHPS 2017 specifications and rates.		
Measure	**Goal**	
Customer Service: Composite Score	87. 3% CAHPS 2015 Medicaid 50th percentile	
Rating of Health Plan	81. 2% CAHPS 2015 Medicaid 90th percentile	
Project Team		
Lead: Charles Isaac		
Executive Sponsor: Petrina Cherry		**Was**: Eric Hunter

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Continue CAHPS Improvement Workgroup meetings every other month.	01/2016	CAHPS Work Group meetings were held.	01/2016 - ongoing
CAHPS Improvement Workgroup will identify interventions designed to improve Customer Service Composite Score and the Rating of Health Plan score	01/2016	The following 10 Member Service interventions were identified: • Implement Member Services Assist Line to provide real-time assistance to less experienced member services representatives • Implement Member Services Skills Based Progression to identify staff that are available for advancement opportunities • Implement Member Services Concierge Team in BMCHP call center. • Explore Feasibility of Implementing a Work Force Management System for Member Services • Revamp Member Services Training Program • Explore Feasibility of Developing Knowledge Management System by Consolidating and Enhancing Job Aid Materials • Align Member Services Quality Program and Business Priorities • Develop Side-by-Side Coaching Procedure for Member Services Representatives	01/2016

		• Align Vendor Service Standards with BMCHP/Well Sense Service Standards • Develop Process that Holds All Internal Business Partners to a Common Set of Service Standards	
CAHPS Improvement Workgroup will develop a project plan for each intervention	01/2016	Project plans for each of the 10 planned interventions were developed.	01/2016
CAHPS Improvement Workgroup will implement and monitor the progress of each intervention, and report results to the Quality Improvement Committee.	01/2016	Met with Member Services management bi-monthly to review work plans and to monitor progress on the 10 planned interventions. Project plans for each of the 10 planned interventions were developed.	01/2016
Align Vendor Service Standards with BMCHP/Well Sense Service Standards	5/2016	Service metrics/ expectations for all vendors were developed and communicated to vendor managers, who will work with vendors to ensure plans are in place to meet service standards. A tracking/ reporting program was developed	See barrier Section
Develop Process that Holds All Internal Business Partners to a Common Set of Service Standards	06/2016	The Plan determined best practices in monitoring quality and identified departments to be monitored. A tracking and reporting process was created, and monitoring was implemented.	See barrier section
Explore Feasibility of Implementing a Work Force Management System	8/2016	Turnkey options were identified and capabilities/investment requirements were reviewed. The Plan determined it was most feasible to proceed with an in-house solution.	8/2016
Explore Feasibility of Developing Knowledge Management System by Consolidating and Enhancing Job Aid Materials	12/2016	Staffing and resource needs required for implementation were identified. Existing job-aid materials were identified and cataloged and high-impact materials were prioritized. A process for the approval/maintenance of job-aid materials was developed.	09/2016
Align Quality Program and Business Priorities	10/2016	A new Quality Measurement Form was developed and implemented. The percentage of member calls that are monitored was increased to 20%. The percentage of SCO calls that are monitored was 100%. The Plan will explore the feasibility of recording 100% of inbound member calls for all product lines.	10/2016
Implement Assist Line	12/2016	The Member Services Assist Line was implemented and Assist Team members were coached on how to train Member Service staff in the use of available tools. Member Services staffing levels were continuously monitored to ensure appropriate levels of available experienced Assist Team members.	11/2016

Implement Skills Based Progression	12/2016	The Skills Based Progression policy was implemented, and Staff were coached twice per month. Staff were assessed and evaluated for available advancement opportunities. Assessment and coaching materials were reviewed and revised.	11/2016
Implement Concierge Team	12/2016	Appropriate staff were Identified to become concierge team members. Issue escalation workflow was designed and implemented Quality Assurance Management of Concierge Team conducted on ongoing basis.	11/2016
Revamp Training Program	12/2016	Existing Member Services training materials were reviewed and improvement opportunities were identified. Training materials were improved by revising existing content and incorporating new content. A new 5-week training program for new hires was implemented, and existing staff were retrained using the new training materials.	12/2016
Develop Side-by-Side Coaching Procedure	12/2016	A schedule was developed for Team Assists and Supervisors to perform side by side coaching sessions during live calls. Outcomes of coaching include: supervisors were assisted in recognizing training needs for representatives, supervisors were provided the opportunity to coach in real-time and supervisors were able to provide feedback to the trainers to assist in the overall training program.	12/2016

Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**
Member Services Survey	The Plan piloted a survey to measure member's satisfaction with their call to the Plan's Member Services Department. The NCQA certified vendor contacted members by phone within two weeks of their call to the Member Services Department.	01/2016 – 04/2016

Barriers Encountered
• The action to Align Vendor Service Standards with BMCHP Service Standards was partially completed. This is underway with Beacon Health Strategies and the final details to begin work with Envision has begun. • The action to develop a process that holds all internal business partners to a common set of service standards was not completed due to staffing constraints, however work to ensure completion is in process. • Restructuring the vendors' contractual service standards is sometimes dependent on the term of the contract.

Measurement Milestones

Measurement Milestones						
Measure	**Adult CAHPS 2015**	**Adult CAHPS 2016**	**Adult CAHPS 2017**	**Goal**	**Progress toward goal**	**Goal met?**
Customer Service	84. 5%	86. 4%	82.6%	87. 34%		No
Rating of Health Plan	78. 0%	78. 0%	80. 00%	81. 16%		No

Final Analysis
The CAHPS 2017 Customer Service rate (82.6%) decreased 4.4% from the CAHPS 2016 rate (86.4%) and did not meet the goal. The decrease may have been influenced by redetermination efforts that were initiated by the state. The December baseline results of the Member Services Survey question "How satisfied were you with the services you received" averaged 85.4% very satisfied or satisfied, and tracks fairly close to overall CAHPS results for Customer Service. The survey will continue through 2017. The CAHPS 2017 Rating of Health Plan rate (80.0%) improved 2.6% from the CAHPS 2016 rate of 78.0%; however it did not meet the goal.

Recommendation for 2018
Continue as a quality improvement project.

2016 MA QI Work Plan Evaluation

Project Title: 2016 MA QI Work Plan Evaluation	Post-Approval Change Log
Quality Improvement Project	
Program Description	
The QI Work Plan is evaluated annually and results are used to develop the QI Work Plan for the following year.	
Measurement & Goal	
Evaluate the effectiveness of the 2016 MA QI Work Plan for all MA Products using HEDIS, CAHPS, and other data.	
Project Team	
Lead: Karen Szvoren, RN	

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Evaluate the effectiveness of the 2016 QI Work Plan when HEDIS and CAHPS data are available.	08/2017	The projects included on the 2016 QI Work Plan were evaluated. HEDIS and CAHPS scores were used to measure progress toward goals and targets. The work plan evaluation included documentation of successes and opportunities for improvement. The evaluation was presented to the Quality Improvement Committee for approval.	08/2017

Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**
N/A		

Barriers Encountered
N/A

Measurement Milestones		
Goal	**Progress toward goal**	**Goal met?**
Evaluate the effectiveness of the 2016 MA QI Work Plan for all MA Products using HEDIS, CAHPS, and other data.		Yes

Final Analysis
The Plan reported both CAHPS rates and hybrid and administrative rates for HEDIS 2017 (data year 2016) measures for MassHealth and QHP. While some measures improved, many goals were not met in the 2016 QI Work Plan. The Plan will evaluate the opportunity for more effective interventions for the measures that did not meet the goal.

Recommendation for 2018
Continue as a quality improvement project.

Prescription Drug Monitoring Program (Patient Safety Project)

Project Title: Prescription Drug Monitoring Program	Post-Approval Change Log
Patient Safety Project	
Process Improvement Project	
Program Description	
Prescription Drug Monitoring Program (PDMP) helps to improve the management of clinical conditions that require therapy with controlled substance medications and non-controlled substance medications that have high potential for abuse. The program monitors appropriate use of these medications and intervenes as necessary to promote member education and assist providers with improved coordination of care. The program utilizes interventions such as direct provider communication, pharmacy and/or provider restrictions to encourage more appropriate use of these medications, and referrals to fraud and abuse for further evaluation. Plan pharmacists and pharmacy coordinators evaluate several data elements including ED visits, geography, patterns of medication use, gaps in coordination of care among providers, and amount and frequency of medication filling to determine appropriate intervention actions	
Measurement & Goal	
Goal	
Evaluate program impact and effectiveness.	
Identify opportunities for improvement.	
Establish improvement measures.	
Project Team	
Lead: Tina Bandekar, RPh	
Medical Director: John Wiecha, MD	**Was:** Cynthia Cooper, MD

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Identify members monthly for the program using criteria algorithms incorporating pharmacy and medical claims.	01/2016	Members who have met PDMP criteria are being identified every month. In 2016, 467 members were identified through the registry or referred into the program by providers, CM, or pharmacy benefit manager (PBM) as meeting the criteria for the PDMP Program. See results section.	01/2016 and ongoing
Implement member specific interventions as appropriate, including sharing the member's pharmacy profile with the prescriber, member or provider outreach, pharmacy and/or provider lock-in, referral to fraud and abuse.	01/2016	Member specific interventions including sharing the member's pharmacy profile with the prescriber, member or provider outreach, pharmacy and/or provider lock-in, and referral to fraud and abuse are implemented for members identified each month.	01/2016 and ongoing

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Utilize reporting tool to monitor and evaluate program.	01/2016	Evaluation of the PDMP has started.	01/2016 and on going
Identify and leverage resources for provider and member education.	01/2016	Resources identified and leveraged include the CM team by referring high risk cases and resources that can be utilized to promote member awareness on Opioid medications. The provider community is engaged by provider relations through education about utilizing the programs the plan offers.	01/2016 and ongoing

Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**
N/A		

Barriers Encountered
Members are allowed to change pharmacies one time during the lock-in period to make the program effective. Some members who move frequently may find it inconvenient to request frequent changes. The plan does accommodate reasonable pharmacy change requests like if the member is no longer in the geographic vicinity of the locked-in pharmacy.

Measurement Milestones		
Goal	**Progress toward goal**	**Goal met?**
Evaluate program impact and effectiveness.		Yes
Identify opportunities for improvement.		N/A
Establish improvement measures.		N/A

Final Analysis

- Criteria used to identify and stratify high risk members, has been effective. Members that retrigger are being evaluated for potential referral to a Substance Use Disorder program.
- In 2016, 467 cases were identified using the registry criteria, provider, care management referral or referrals from the Plan's Pharmacy Benefit Manager. The following interventions were implemented:
  - 39. 61% (185/467) members were identified and locked in to a Pharmacy
  - 28. 70% (134/467) members were identified for provider lock-ins; however only 3 members were locked into a provider due to patient and provider consent
  - 4. 92% (23/467) general provider notifications were sent
  - 26. 77% (125/467) members were identified for pharmacist review
  - Manual review by pharmacy staff did not result in any members being locked in to providers or pharmacy
- After evaluation there were no opportunities identified and therefore no improvement measures were established.

Recommendation for 2018
Continue as a process improvement project.

SCO Quality Measurement

Project Title: SCO Quality Measurement	Post-Approval Change Log
Process Improvement Project	
Program Description	
This project is designed to establish measurement processes, workflows and reporting mechanisms for the broad range of quality process, outcome and operational /compliance processes across the SCO program. The initial one year period will establish baseline performance and allow analysis for improvement opportunity identification and planning. These metrics will ensure that our SCO members are receiving timely and high quality assessment, care and support services, and that our Plan performance meets or exceeds program requirements.	
Measurement & Goal	
Goal	
Establish baseline rates for measures in Section 4.	
Project Team	
Lead: Nathalie Nopakun	**Was:** Lisa Feingold
Executive Sponsor: Judy Levy	**Was:** Karen Boudreau, MD

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Develop data collection and reporting specifications	01/2016	Reporting specifications were developed for CMS Part C/D reports as well as internal metrics to monitor compliance with program requirements. Pharmacy developed a Patient Safety Dashboard and Medication Therapy Management program data review process.	01/2016 04/2016
Collect and analyze baseline data	06/2016	Data related to STAR Measures, including pharmacy (medication adherence, high risk medications) and call center monitoring (Part C and D) collected for review.	06/2016
Share baseline results broadly with internal stakeholders	06/2016	Established monthly STARS Workgroup to review baseline results of available measures and identify improvement opportunities.	04/2016

Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**
N/A		

Barriers Encountered
The low membership limited the Plan's ability to run most of the quality measures in 2016.

Measurement Milestones		
Goal	**Progress toward goal**	**Goal met?**
Establish baseline rates for measures in Section 4.		No

Final Analysis

Final Analysis
Due to low membership, HEDIS measures will be reviewed in 2017 and data will be added to dashboard for review monthly.

Recommendation for 2018
Continue as a process improvement project.

DSNP Most Vulnerable Population Identification

Project Title: DSNP Most Vulnerable Population Identification	Post-Approval Change Log
Process Improvement Project	
Program Description	
This project is designed to establish identification and monitoring processes for the Most Vulnerable (see Section 5) segment of the DSNP population. Completion rates of assessments and stratification of DSNP members will be tracked and monitoring systems developed to measure the impact of care management on the experience and outcomes for the Most Vulnerable segment of membership. Continuous improvement techniques will be applied to iteratively improve identification and monitoring methods based on early learning from this population.	
Measurement & Goal	
Goal	
Establish measurement and reporting specifications and collect baseline data	
Project Team	
Lead: Jeanne Murphy, RN	
Medical Director: John Wiecha, MD	**Was: Karen Boudreau, MD**

2016 Actions			
Action	**Expected date**	**Description**	**Implementation date**
Collect initial Health Risk Assessment (HRA) data for prospective stratification	01/2016	HRAs are completed within 30 days of enrollment into the Senior Care Options (SCO) program and member care plans are built from the HRA. The HRA serves as a trigger for complex members. The HRA, clinical registry, and clinician judgement are used to stratify member risk and frequency of outreach.	01/2016 and ongoing
Develop data collection, registry criteria and reporting specifications	01/2016	Registry requirements are complete and are utilized to identify and stratify members for care management.	07/2016
Run registry and analyze data	06/2016	The registry was implemented to identify members for care management. Data analysis is ongoing.	09/2016

Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**

Additional Actions Implemented		
Additional Action	**Description**	**Implementation date**
New question added to HRA for tracking and reporting	A question was added to the HRA to capture the type of assessment: Initial Assessment or Ongoing Assessment. This allows for tracking and reporting of compliance of the HRA.	07/2016
CM checklist for CM to use when completing job functions	A checklist was developed to assist care managers in the steps required to complete HRA and other in job functions.	12/2016

Barriers Encountered
Reporting is a manual process. The report includes completed assessments; however the details about the finding the member and next steps are not available on the report.

Measurement Milestones		
Goal	**Progress toward goal**	**Goal met?**
Establish measurement and reporting specifications and collect baseline data		Yes

Final Analysis
The Plan reports the assessments completed within 30 days to the MassHealth Gateway using the Material Data Set and shares information with providers. Members with a status of Community Well (able to live in their home or community with assistance) are not included in the report.

Recommendation for 2018
Continue as a process improvement project.

Section 3: HEDIS 2016 Medicaid Measures MassHealth		2015 Data Year 2014	2016 Data Year 2015	2017 Data Year 2016
Annual Monitoring for Patients on Persistent Medications (MPM)		86. 90%	85. 92%	86. 65%
Antidepressant Medication Management (AMM)	Acute Phase*	44. 25%	44. 85%	44. 74%
	Continuation Phase*	30. 02%	30. 97%	31. 59%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)*		97. 00%	97. 58%	97. 60%
Appropriate Testing for Children With Pharyngitis (CWP)*		90. 15%	90. 57%	91. 96%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) *		37. 19%	39. 12%	44. 03%
Adult BMI*		91. 24%	82. 00%	93. 68%
Breast Cancer Screening (BCS)*		71. 12%	72. 06%	70. 44%
Cervical Cancer Screening (CCS)*		70. 91%	75. 35%	67. 60%
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)		2. 50%	1. 55%	0.81%
Childhood Immunization Status (CIS)	Combo 2*	84. 21%	79. 37%	82. 89%
	Combo 10	57. 18%	53. 40%	48. 92%
Chlamydia Screening in Women (CHL)*		70. 59%	71. 75%	72. 86%
Comprehensive Diabetes Care (CDC)	Eye Examination*	67. 67%	63. 88%	64. 61%
	HbA1c Blood Test*	90. 99%	91. 10%	88. 38%
	HbA1c- Poorly Controlled > 9. 0%	33. 39%	32. 21%	32. 57%
	<8%	53. 36%	55. 52%	54. 75%
	<7%	35. 92%	35. 04%	38. 36%
	Nephropathy Monitoring*	85. 51%	90. 21%	90. 49%
	BP<140/90	69. 79%	68. 86%	73. 59%
Statin Therapy for Patients With Diabetes (SPD)	*Received Statin Therapy*	N/A	64. 35%	65. 67%
	Statin Adherence 80%	N/A	54. 83%	55. 32%
Controlling High Blood Pressure (CBP)*		67. 72%	65. 27%	71. 03%
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)		80. 41%	79. 27%	80. 08%
Follow-Up After Hospitalization for Mental Illness (FUH)	7 day rate*	73. 02%	65. 37%	61.42%
	30 day rate*	85. 04%	80. 46%	77.16%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Initiation*	42. 39%	48. 99%	49. 13%
	Continuation*	51. 43%	54. 40%	55. 90%
HPV		23. 39%	21. 90%	25. 24%
Immunizations for Adolescents (IMA)	Combo 1	80. 00%	83. 70%	84. 38%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)		86. 79%	86. 36%	83. 90%
Statin Therapy for Patients With Cardiovascular Disease (SPC)				
	Received Statin Therapy-Total	N/A	83. 24%	84. 89%
	Statin Adherence 80%-Total	N/A	83. 16%	59. 46%
Medication Management for People w Asthma (MMA) *(2012 1st year measure)*				
	Age 5-11 Med Compliance 75%	20. 14%	19. 78%	23. 49%
	Age 12-18 Med Compliance 75%	16. 43%	14. 63%	20. 56%
	Age 19-50 Med Compliance 75%	25. 19%	25. 18%	31. 67%
	Age 51-64 Med Compliance 75%	37. 14%	40. 83%	39. 12%
	Total Med Compliance 75%	23. 72%	24. 97%	29. 35%
Pharmacotherapy Mg of COPD Exacerbation				
	Systemic Corticosteroids*	82. 89%	82. 81%	82. 43%
	Bronchodilator*	83. 27%	88. 69%	90. 26%
Asthma Medication Ratio				
	Age 5-11	56. 32%	62. 83%	63. 58%
	Age 12-18	47. 43%	47. 45%	52. 32%
	Age 19-50	37. 82%	42. 49%	45. 84%

Section 3: HEDIS 2016 Medicaid Measures MassHealth	2015 Data Year 2014	2016 Data Year 2015	2017 Data Year 2016
Age 51-64	50. 49%	54. 78%	55. 79%
Total	45. 96%	49. 75%	52. 22%
Weight Assessment & Counseling for Nutrition & Physical Activity (WCC) BMI Percentile*	83. 69%	86. 74%	91. 64%
Counseling for Nutrition*	77. 01%	81. 70%	86. 96%
Counseling for Physical Activity*	66. 58%	77. 19%	84. 62%
Well-Child Visits 0-15 months (W15)	84. 57%	77. 78%	80. 27%
Well-Child Visits 3-6 years (W34)	84. 91%	89. 74%	83. 91%
Adolescent Well Care	64. 48%	70. 10%	62. 50%
Adults' Access to Preventive/Ambulatory Health Services (AAP) 20-44 years	79. 60%	82. 16%	80. 08%
45-64 years	86. 85%	88. 28%	87. 62%
Use of Imaging Studies for Low Back Pain (LBP)	75. 88%	77. 83%	78. 02%
Lead Screening for Children (LSC)	87. 56%	87. 38%	86. 51%
Spirometry Use with COPD*	34. 79%	31. 58%	36. 88%
Children and Adolescents' Access to Primary Care Practitioners (CAP)			
12-24 months	96. 35%	93. 70%	92. 66%
25 months-6 years	94. 00%	93. 63%	91. 99%
7-11 years	97. 19%	96. 99%	96. 50%
12-19 years	95. 23%	95. 11%	94. 69%
Initiation & Engagement of Alcohol & Other Drug Dependence Tx (IET) Initiation	49. 03%	42. 82%	41. 22%
Engagement	20. 54%	20. 58%	18. 75%
Frequency of Ongoing PNC >81%	70. 99%	63. 61%	68. 78%
Prenatal and Postpartum Care (PPC) Postpartum Visit*	71. 55%	66. 94%	72. 59%
Timeliness of Prenatal Care*	90. 06%	87. 22%	90. 86%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	79. 52%	79. 98%	80. 35%
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	67. 54%	68. 93%	66. 14%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC) (very small eligible population)	N/A	100. 00%	62. 50%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	57. 79%	53. 13%	54. 23%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)	6. 02%	1. 44%	0.74%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	87. 62%	89. 66%	85. 71%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	31. 13%	33. 64%	33. 53%

*Used for accreditation

* HEDIS 2017 reported rates. Other measures were not reportable due to low denominators or HEDIS continuous enrollment criteria.

CAHPS Medicaid Adult	2015 Data Year 2014	2016 Data Year 2015	2017 Data Year 2016
Customer Service	84. 5%	86. 4%	82.6%
Ease of Filling Out Forms	88. 5%	92. 5%	91.5%
Getting Care Quickly	83. 1%	79. 9%	85.6%
Getting Needed Care	80. 4%	81. 0%	83.8%
How Well Doctors Communicate	92. 5%	91. 8%	90.4%
Providing Needed Information	67. 6%	60. 6%	N/A[1]
Rating of Health Plan	78. 0%	78. 0%	80.0%

Rating of Personal Doctor	80. 9%	80. 0%	80.9%
Rating of Specialist Seen Most Often	81. 0%	77. 9%	84.2%
Rating of Health Care	73. 6%	71. 9%	75.7%
Flu Vaccinations (Adults 18-64)	38. 7%	39. 9%	40.7%
Medical Assistance With Smoking Cessation - ASTQ (MSC)	81. 8%	82. 0%	82.0%
Advising Smokers to Quit- Strategies for Quitting	53. 3%	48. 6%	51.4%
Advising Smokers to Quit- Medications for Quitting	64. 9%	65. 6%	60.5%

1. Did not meet the minimum number of respondents (n=100).

CAHPS Medicaid Child	2015 Data Year 2014	2016 Data Year 2015	2017 Data Year 2016
Customer Service *	N/A	N/A	86.1%
Getting Care Quickly *	N/A	N/A	86.1%
Getting Needed Care *	N/A	N/A	77.1%
How Well Doctors Communicate *	N/A	N/A	94.1%
Rating of Health Plan *	N/A	N/A	83.0%
Rating of Personal Doctor*	N/A	N/A	88.5%
Rating of Specialist Seen Most Often*	N/A	N/A	N/A[1]
Rating of Health Care*	N/A	N/A	85.8%

*Used for accreditation HEDIS 2017 rates.
1. Did not meet the minimum number of respondents (n=100).

Section 3: HEDIS 2016 Medicaid Measures QHP		2016** Data Year 2015	2017 Data Year 2016
Annual Monitoring for Patients on Persistent Medications (MPM)		77. 95%	81. 12%
Antidepressant Medication Management (AMM)	Acute Phase	59. 32%	59. 76%
	Continuation Phase	46. 33%	47. 71%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)		88. 89%	100. 00%
Appropriate Testing for Children With Pharyngitis (CWP)		100. 00%	80. 00%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) *		55. 22%	55. 40%
Adult BMI*		90. 00%	93. 79%
Breast Cancer Screening (BCS)		79. 38%	76. 45%
Cervical Cancer Screening (CCS)		79. 93%	83. 10%
Childhood Immunization Status (CIS)	Combo 3	100. 00%	66. 67%
Colorectal Cancer Screening (COL)		63. 58%	64. 65%
Chlamydia Screening in Women (CHL)	16-20 years	74. 51%	59. 55%
	21-24 years	69. 05%	69. 25%
		70. 11%	67. 65%
Comprehensive Diabetes Care (CDC)			
	HbA1c Testing	92. 56%	88. 63%
	<8%	56. 98%	55. 92%
	Eye Examination	61. 86%	63. 98%
	Nephropathy Monitoring	86. 74%	86. 49%
Controlling High Blood Pressure (CBP)		69. 74%	70. 35%
Follow-Up After Hospitalization for Mental Illness (FUH)	7 day rate	60. 00%	60. 49%
HPV		0. 00%	11. 11%
Immunizations for Adolescents (IMA)	Combo 2	0. 00%	11.11%
Medication Management for People w Asthma (MMA)			
	Age 19-50 Med Compliance 75%	29. 69%	43. 27%

Age 51-64 Med Compliance 75%	38. 10%	39. 22%
Total Med Compliance 75%	33. 02%	41. 67%
Weight Assessment & Counseling for Nutrition & Physical Activity (WCC) BMI Percentile	77. 78%	91. 43%
Counseling for Nutrition	73. 33%	88. 00%
Counseling for Physical Activity	72. 22%	85. 14%
Well-Child Visits 0-15 months (W15)	100. 00%	33. 33%
Well-Child Visits 3-6 years (W34)	60. 00%	64. 18%
Use of Imaging Studies for Low Back Pain (LBP)	78. 34%	83. 25%
Initiation & Engagement of Alcohol & Other Drug Dependence Tx (IET) Initiation	35. 71%	29.01%
Engagement	14. 88%	10.49%
Prenatal and Postpartum Care (PPC) Postpartum Visit	83. 33%	78. 70%
Timeliness of Prenatal Care	80. 56%	77. 78%

Please Note: HEDIS 2017 rates for the SCO product were produced for only two measures in 2017 due to the limited SCO membership.

Section 4 SCO Measure Set
HEDIS Measures
Colorectal Cancer Screening (C02/COL)
Glaucoma Screening in Older Adults (C05/GSO)
Care for Older Adults: Advance Care Planning
Care for Older Adults: Medication Review (C11/COA)
Care for Older Adults: Functional Status Assessment (C12/COA)
Care for Older Adults: Pain Screening (C13/COA)
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
Pharmacotherapy Management of COPD Exacerbation (PCE)
Controlling High Blood Pressure (C19/CBP)
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)
Osteoporosis Management in Women Who Had a Fracture (C14/OMW)
Antidepressant Medication Management (AMM)
Follow-up After Hospitalization for Mental Illness (FUH)
Annual Monitoring for Patients on Persistent Medications (MPM)
Medication Reconciliation Post-Discharge (MRP)
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)
Use of High-Risk Medications in the Elderly (DAE)
Plan All-Cause Readmissions (C23/PCR)
Board Certification (BCR)
Breast Cancer Screening (C01/BCS)
Cardiovascular Care – Cholesterol Screening (C03/CMC)
Adult BMI Assessment (C10/ABA)

Diabetes Care – Cholesterol Screening (C04/CDC)
Diabetes Care – Eye Exam (C15/CDC)
Diabetes Care – Kidney Disease Monitoring (C16/CDC)
Diabetes Care – Blood Sugar Controlled (C17/CDC)
Diabetes Care – Cholesterol Controlled (C18/CDC)
Rheumatoid Arthritis Management (C20/ART)
Adults' Access to Preventive/Ambulatory Health Services (AAP)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
Call Answer Timeliness (CAT)
Frequency of Selected Procedures (FSP)
Ambulatory Care (AMB)
Inpatient Utilization - General Hospital/Acute Care (IPU)
Identification of Alcohol and Other Drug Services (IAD)
Mental Health Utilization (MPT)
Antibiotic Utilization (ABS)
Enrollment by Product Line (ENP)
Enrollment by State (EBS)
Language Diversity of Membership (LDM)
Race/Ethnicity Diversity of Membership (RDM)
Total Membership (TLM)
Falls Risk Management (C22/FRM)
Management of Urinary Incontinence in Older Adults (C21/MUI)
Physical Activity in Older Adults (C09/PAO)
Osteoporosis Testing in Older Women (OTO)
Medical Assistance With Smoking and Tobacco use Cessation (MSC)
Pneumococcal Vaccination Status for Older Adults (PNU)
Adults’ Access to Preventive/Ambulatory Health Services
Medicare Stars (non-HEDIS)
Improving or Maintaining Physical Health (C07)
Improving or Maintaining Mental Health (C08)
Complaints about the Health Plan (C30)
Beneficiary Access and Performance Problems (c31)
Members Choosing to Leave the Plan (C32)
Health Plan Quality Improvement (C33)
Getting Needed Care (C24/SNP2A)
Getting Appointments and Care Quickly (C25/SNP2A)
Customer Service (C26/SNP2A)
Rating of Health Care Quality (C27/SNP2A)

Rating of Health Plan (C28/SNP2A)
Care Coordination (C29)
Flu Vaccinations for Adults Ages 65 and Older (C06/FVO)
Plan Makes Timely Decisions about Appeals (C34)
Reviewing Appeals Decisions (C35)
Call Center – Foreign Language Interpreter and TTY/TDD Availability (C36)
Call Center – Foreign Language Interpreter and TTY/TDD Availability (D01)
Appeals Auto–Forward (D02)
Appeals Upheld (D03)
Complaints about the Drug Plan (D04)
Beneficiary Access and Performance Problems (D05)
Members Choosing to Leave the Plan (D06)
Drug Plan Quality Improvement (D07)
MPF Price Accuracy (D10)
Rating of the Drug Plan (D08)
High Risk Medication (D11)
Diabetes Treatment (D12)
Medication Adherence for Oral Diabetes Medications (D13)
Medication Adherence for Hypertension (RAS antagonists) (D14)
Medication Adherence for Cholesterol (Statins) (D15)
Additional CAHPS Measures (Not Captured Above)
How Well Doctors Communicate
Rating of Personal Doctor
Rating of Specialist Seen Most Often
Getting Needed Prescription Drugs
CMS STARS Display Measures
Enrollment Timeliness (Part D)
Enrollment Timeliness (Part C)
Call Center – Pharmacy Hold Time (Part D)
Compliance Measures (Part C)
Serious Reportable Adverse Events (SRAEs)
Grievances (Part C)
Organization Determinations/ Reconsiderations
Plan Oversight of Agents
SNP Care Management
Enrollment/ Disenrollment (Part C)

Compliance Measures (Part D)
Enrollment/ Disenrollment (Part D)
Retail, Home Infusion, and Long Term Care Pharmacy Access
Medication Therapy Management Programs
Prompt Payment by Part D Sponsors
Grievances (Part D)
Pharmacy & Therapeutics (P&T) Committees/ Provision of Part D Functions
Coverage Determinations and Exceptions
Redeterminations
Long-Term Care (LTC) Utilization
Fraud, Waste and Abuse Compliance Programs
Other QI/Model of Care measures
Timeliness of re-credentialing
Site Visit Monitoring
Grievances Regarding Access
Behavioral Health Appointments
Social Worker Visits
American Kidney Fund (AKF) Assistance
Grievances regarding Cost Sharing
Principal Care Nephrologist (PCN) or Nephrology Extender Visit
Care Manager Contact
Targeted Medication Review
Transplant Work Up Services Plan
Flu Vaccine
Hospital Admission Rate
Inpatient Utilization – Nonacute Care (including SNF Discharges/ Placements)
Physical Therapy or Rehabilitation Services Referral
Member Interdisciplinary Care Team (ICT) Participation
Mobility Assessments
Support Services for Activities of Daily Living
Self-Reported Pain Management
Self-Reported Health Status
Implementation of Care Plans
Satisfaction with Care Management Services
Staff Structure and Performance of Roles: Care management staffing ratios
Use of Clinical Practice Guidelines by Providers
Most Vulnerable Subpopulation: Changes in health status

Most Vulnerable Subpopulation: Ability to cope with failing health
Most Vulnerable Subpopulation: Ability for self-care
Most Vulnerable Subpopulation: Delivery of add-on services and benefits
Timeliness of UM decision making
Timeliness of appointment access
ICT's communication strategies and frequency of communication
Service standards for each ICT member
Assessment and administrative data
Inter-rater Reliability Audits
Quality of Care monitoring

Section 5 DSNP Most Vulnerable Criteria and Goals				
Identification Process	Criteria	Goal	Data Source	Frequency of ID
Prospective	Meet any one of the following: • 3 or more chronic conditions • 5 or more medications • Homeless or homebound • BH/SA disorder • Age>=95	100% of members are assessed and prospectively stratified based on HRA results	• HRA • Enrollment • Referral: Physician/ ICT /Home Health/ Hospital/ Family	• On initial assessment and reassessment • Daily (enrollment and referrals)
Concurrent	• Members with an Inpatient stay greater than 21 days • Members with a SNF stay greater than 30 days • Inpatient admissions for delirium or change in mental status	100% of members meeting concurrent criteria are referred to care management for assessment and stratification	• Concurrent review staff • Prior authorization • Referral: Physician/ ICT /Home Health/ Hospital/ Family	• Daily

Section 5 DSNP Most Vulnerable Criteria and Goals				
Identification Process	Criteria	Goal	Data Source	Frequency of ID
	• New Hip Fracture			
Retrospective	Meet any one of the following: • Top 2% prospective DxCG risk score among the DSNP population. • 3 or more chronic conditions • 5 or more medications or triggered via poly pharmacy report or identified with potential drug interactions • Homeless • BH/SA disorder • 2 or more Inpatient medical or BH acute admissions in last 6 months • 1 or more inpatient admissions for delirium or change in mental status • 3 or more Medical, BH or SA ED visits in the past 6 months	100% monthly registry runs by 20th of each month.	• Medical Claims • Pharmacy Claims • Enrollment • PBM DUR report • Polypharmacy report	• Monthly

Section 5 DSNP Most Vulnerable Criteria and Goals				
Identification Process	Criteria	Goal	Data Source	Frequency of ID
	• New Hip Fracture			