

## **15 - Quality Improvement Program**

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Health Plan of Nevada (HPN) promotes continuous improvement in the quality of member care and service through the health plan's Quality Improvement (QI) Program. As part of the health plan's QI Program, HPN routinely monitors and evaluates indicators of performance, such as mammography screening rates, wait times for routine appointments and member satisfaction. Health care and service outcomes are also measured through special projects or quality initiatives (QI studies).

### **15.1 HPN's NCQA Accreditation**

HPN is accredited by the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to measuring the quality of America's healthcare. Accreditation is for the commercial Health Maintenance Organization (HMO), commercial Point of Service (POS), commercial Marketplace, and Medicaid product lines in Nevada.

NCQA accreditation surveys include rigorous on-site and off-site evaluations of over 80 standards, selected Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures and member satisfaction survey measures. A team of physicians and managed care experts conducts accreditation surveys. A national oversight committee of physicians analyzes the survey team's findings and assigns an accreditation status and star rating.

NCQA's Accreditation standards are publicly reported.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

### **15.2 QI Program Structure**

The HPN Quality Improvement Program structure includes a Quality Improvement Committee and several quality improvement subcommittees and task forces. The Quality Improvement Committee is made up of practitioners, medical directors, HPN administrators, and other staff throughout the health plan.

The Quality Improvement Committee is responsible for setting quality improvement goals for the health plan, monitoring indicators of performance, and approving and evaluating quality improvement initiatives.

Some of the areas the QI subcommittees, and related task forces, address include:

- Health outcomes and preventive services,
- Management of chronic conditions related to medical and behavioral health,
- Child and adolescent health,
- Women's and neonatal health and
- All areas affecting health care and services related to federal and state regulatory requirements and voluntary accreditation.

Members of the Quality Improvement subcommittees and task forces are carefully selected to ensure representation by providers, multiple disciplines, administrators, and hands-on staff.

The most important component of the health plan's QI Program is the active participation of the health plan's provider network. HPN providers have the opportunity to participate on QI subcommittees and task forces or serve as "champions" for QI studies. If you are interested in participating in the Quality Improvement Program, or would like more information on the program, please contact the Member Services Department at: 1-877-291-4894.

### **15.3 QI Initiatives**

QI initiatives include methodologically sound projects focusing on areas of high volume, high-risk or state/federally mandated projects. Annually, HPN reviews a profile of its membership in an effort to design initiatives that represent the demographic and epidemiological characteristics and needs of the health plan members. As a result HPN carefully selects clinical, preventive health, and service improvement areas for study.

### **15.4 Member and Practitioner Satisfaction Surveys**

Member and practitioner satisfaction surveys provide important feedback on performance in a number of areas. HPN conducts an annual member satisfaction survey entitled the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey using an NCQA-Certified survey vendor. Routine patient satisfaction surveys are also conducted of HPN members who access primary and specialty care. In addition, HPN conducts annual satisfaction surveys of its provider network. Data collected from these surveys are analyzed by HPN and opportunities for improvement are identified. The member and practitioner satisfaction surveys frequently result in the creation and implementation of focused quality improvement activities.

### **15.5 HEDIS Measures**

Annually, HPN collects and reports on data to prepare a full set of Healthcare Effectiveness Data and Information Set (HEDIS®) performance indicators. HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare health care quality. HEDIS is also the measurement tool used by the nation's health plans to evaluate their performance in terms of clinical quality and customer service. The following is a list of key HEDIS Measures:

- Adult BMI Assessment
- Breast Cancer Screening
- Child and Adolescent Access to Primary Care Practitioners
- Cervical Cancer Screening
- Childhood Immunization Status (Combo 10, and 2)
- Colorectal Cancer Screening
- Comprehensive Diabetes Care (i.e., Hemoglobin A1C testing, Retinal Eye Exam, Medical Attention for Nephropathy and Blood Pressure Control)
- Controlling High Blood Pressure
- Follow-up for Children Prescribed ADHD Medication (ADD)
- Immunization for Adolescents (Combo 1, Combo 2)
- Medication Management for People with Asthma
- Prenatal & Postpartum Care
- Weight Assessment and Counseling for Nutrition and Physical Activity (Children and Adolescents)

- Well-Child Visits in the first 15 months of life, and the Third, Fourth, Fifth, and Sixth years of life.
- Member Satisfaction

HPN prepares a full set of HEDIS measures annually through the analysis and reporting of data collected through medical record review and claims and encounters data, (such as laboratory, pharmacy and health care utilization) for commercial and Medicaid members. HPN looks to the network of providers to share health care data with HPN in order to generate accurate reports. As part of this annual data collection, HPN's Quality Improvement Department may request access to medical records and charts to abstract specific HEDIS® information. Providers agree to participate in these mandatory quality activities when they contract with managed care plans who maintain state and federal government contracts.

## **15.6 Quality and Patient Safety Reminders**

Maintaining high quality and promoting optimal patient safety are critical goals for the entire health care system. HPN supports physicians and other health care professionals within the health plan network in their crucial roles to achieve these objectives.

### **Tips and Tools for Health Care Providers about Patient Safety**

#### **1. Promote health literacy and greater understanding of medical information by patients.**

##### **Why Promote Health Literacy?**

- People with low health literacy are: often less compliant with treatment and medications; fail to seek preventive care; at higher risk for hospitalization; remain in the hospital longer; and often require additional health care treatment.
- A provider may not be aware that individuals have low health literacy because individuals may be embarrassed or ashamed to admit when they have difficulty understanding their doctors or they may use well-practiced coping mechanisms that mask their problems.

##### **Simple Approaches to Health Literacy**

- Create a comfortable environment to encourage open communication with patients.
- Use simple language/terms instead of medical or technical descriptions.
- Communicate with the patient at eye level (e.g., sit instead of stand).
- Use visual aids in teaching your patient about the procedure or medical condition.
- Have your patients demonstrate or verbally repeat back what they understood.

##### **Additional Tips:**

- Use "I speak cards" to identify languages spoken by your patients
- Use symbols for signage in your office.
- Record primary language and ethnic background information in patient charts.
- Educate your front-office staff on health literacy and cultural competency.

##### **Encourage patients to ask three questions to ensure compliance with medical instructions given.**

- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?

Provide patients with the brochure “Ask Me 3” or direct them to the Web site at: <https://npsf.site-ym.com/default.asp?page=askme3>. These brochures, available in English and Spanish, were created by the Partnership for Clear Health. Brochures can be used by patients to track the answers to the three questions during each office visit.

**Additional Resources:**

- Georgetown University National Center for Cultural Competence: <https://nccc.georgetown.edu/>
- U.S. Department of Health & Human Services, Quick Guide to Health Literacy and Older Adults: <http://www.health.gov/communication/literacy/olderadults/literacy.htm>

## 2. Promote Medication Safety

- Perform a complete medication history, including current and past medications (prescription medications, over the counter medications and herbal products).
- Ask your patient during each visit the medications they take and if they are experiencing any side effects.
- Document and update allergies and adverse reactions in the patient’s medical record.
- Educate patients about medications, including risks, benefits, possible side effects, actions, appropriate administration and what to do if they miss a dose.
- Encourage patients to keep current lists of their medications with them.
- Avoid unnecessary antibiotic use.

**Educational materials** on appropriate antibiotic use are available at: <https://www.cdc.gov/antibiotic-use/index.html>

## 3. Facilitate Continuity and Coordination of Care

- Obtain and include in the medical record, copies of discharge summaries, laboratory/radiology results, consultation reports and other related documents from facilities and health care providers who perform services for individual patients.
- Forward copies of patient’s critical health information such as: the results from the history and physical examination, list of current medications, documentation of major illnesses/surgeries (including allergies) and current treatment plan when transferring a patient to another practitioner.

HPN conducts an annual audit to ensure that appropriate information is being communicated to different health care providers. During the audit, a review is conducted on a random sample of primary physician medical records for health plan members who have received services from home health agencies, skilled nursing facilities, hospitals and ambulatory surgical centers. The goal of this initiative is to ensure that the appropriate discharge summaries and/or operative reports have been disseminated to primary care providers. Results of this annual audit demonstrate that opportunities for improvement still exist. If you have any recommendations to improve the communication process, please contact the HPN Quality Improvement Department at: (702) 562-4666.

## 15.7 Population Health Management (PHM) Program

HPN works to improve the health status of members with chronic conditions through its Population Health Management (PHM) Program. The Disease Management portion of that program includes member and practitioner education and targeted interventions for members who are at higher risk for complications or future health care utilization.

The goal of the PHM Program is to partner with network providers to help members better self-manage their health. Below is an overview of some of the components in the Health Plan of Nevada's current PHM Program.

### Evidence-Based Clinical Practice Guidelines

HPN uses evidence-based clinical practice guidelines as the basis for its PHM Program. You may access these guidelines on the provider section of the HPN website at: <https://healthplanofnevada.com/Provider>, "I need help with", select "Clinical Guidelines". For a hardcopy of a guideline, call 1-877-291-4894.

### Identification for the Disease Management Registry

Members are identified for one of the Population Health programs by using criteria developed under the guidance of primary and specialty care practitioners. HPN uses one or more of the following data sources to identify members with specific chronic conditions such as asthma (pediatric and adult) and diabetes for PHM interventions. These sources include laboratory, pharmacy and claims/encounter (including in-patient and out-patient utilization) data. Once identified, members are stratified according to levels of risk for future health care utilization and potential complications.

### How HPN Works with Members in the PHM Program

Members identified for the Disease Management portion of the PHM Program receive mailings from HPN advising them of the benefits of the programs and a contact number to call if they do not wish to participate or have been identified in error. Individuals who participate in the PHM Program automatically receive certain benefits directly from the health plan and may access other benefits directly or through their primary physicians.

Benefits provided to members directly by the health plan:

- Member-friendly guidelines to help them better manage their conditions.
- Annual flu shot reminders.
- Reminders for important services, such as diabetes eye exams.
- General mailings with condition-specific education at least once a year.
- Telephone calls from R.N. health coaches for individuals at high and moderate risk for future health care utilization.

Benefits available to members through primary physicians:

- Referral to the health plan's specialty clinics.
- Referral to the health plan's Tobacco Cessation Program (members may also self-refer to the program).
- Case management for high-risk members.

Benefits that may be directly accessed by members:

- Participation in the health plan's Health Education and Wellness classes and one-on-one consultations on a variety of subjects including the management of chronic conditions, preventive health and additional topics.
  - Health plan providers may also make referrals to HEW services.
- 24-hour Telephone Advice Nurse (phone number is located on the back of the member's ID card).
- Urgent Care after hours.

### **How Practitioners Can Use PHM Services**

HPN issues member-specific "Gaps in Care" reports to primary physicians on a quarterly basis. Members in the HPN PHM registry who are impaneled to each primary physician will appear on these reports. These profiles highlight whether individual members have received important condition-specific tests and preventive services. These reports allow providers to follow-up with individuals to schedule necessary appointments.

The gaps in care reports supply a variety of information, such as relevant medical test dates and results, flu shot status, utilization information (e.g., ER and UC visits), preventive services (e.g., diabetes eye exams) and/or medication usage and compliance in the previous 12 months. This information will be focused on each individual's specific chronic condition.

Providers may refer individuals for Health Education and Wellness (HEW) classes or the Tobacco Cessation Program -

3 ways to refer patients to Health Education and Wellness

- 1.) Call 702-877-5356
- 2.) Fax to 702-838-1404
- 3.) Visit <https://healthplanofnevada.com/Provider> and sign in to the online provider center

### **Primary Components of some of HPN's Population Health Management Services**

#### **Diabetes**

- Clinical guidelines for providers are available to assist in the management of diabetes. These guidelines can be found in the provider section of the HPN Web site.
- Member-specific gaps in care reports supply providers with detailed information, at the individual patient level, based on their level of risk of future health care utilization and complications and the numbers of diabetes-related services for impaneled members.
- Educational opportunities are available for members including Health Education and Wellness classes that focus on:
  - Diabetes. Classes and one-on-one or group consultations are designed to help members better understand diabetes, how it affects them and how to take control.
  - Smoking cessation. The behavior modification program is designed to help people learn how to make it through the quitting process.
- Annual flu vaccination reminders help members remember to take advantage of this important preventive health service.
- R.N. health coaches are available for people with diabetes at high and moderate risk of future health care utilization. Follow-up phone call contact frequency is determined on member needs.

- Diabetes retinal exam reminders help members take advantage of this important screening exam for early identification of eye problems.
- Complex Case Management services are provided for members who are at high risk of hospitalization or emergency care. The health plan's case managers coordinate services and promote communication among the different providers and facilities. Case Managers help members adhere to treatment plans and facilitate needed services.

### **Pediatric and Adult Asthma**

- Clinical guidelines for providers are available to assist in the management of pediatric and adult asthma. These guidelines can be found in the provider section of the HPN Web site.
- Member-specific gaps in care reports supply providers with detailed information, at the individual patient level, based on the patient's level of risk for future health care utilization and complications and the numbers of pediatric and adult asthma-related services for impaneled members.
- Educational opportunities are available for members including Health Education and Wellness classes for adults and parents with children that focus on:
  - Pediatric and adult asthma. Classes and one-on-one or group consultations are designed to help parents and children, and adults better understand asthma, how it affects children and their families and how to take control.
  - Smoking cessation. The behavior modification program is designed to help individuals learn how to make it through the quitting process and thus provide a smoke-free home.
- Annual flu shot reminders help members take advantage of this important preventive health service.
- Telephone calls from R.N. health coaches are available for parents of children with asthma and adults at high and moderate risk of future health care utilization. Follow-up calls are scheduled according to the member's or child's needs.
- Complex Case Management services are provided for children and their parents and adults who are at high-risk of hospitalization or emergency care. R.N. case managers coordinate services and promote communication among the different providers and facilities. Case managers help adults and families adhere to treatment plans and facilitate services.

If you have an individual who would benefit from participation in this portion of HPN's Population Health Program, please contact the Disease Management team at (702) 242-7346 or (877) 692-2059.

## **15.8 Complex Case Management Program**

HPN offers a comprehensive Complex Case Management (CCM) program free of charge to its health plan members. This program is designed to complement the care provided by physicians and other healthcare professionals while encouraging individuals to become more active participants in their health care.

- The definition of the CCM Program is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

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- The goal of the CCM Program is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

The Complex Case Management Programs works with the following individuals:

- Members with high cost and frequent utilization patterns. These members include individuals who have been hospitalized and/or have used the Emergency Department frequently and/or are taking multiple and potentially high cost medications.
- Members diagnosed with neurological diseases and spinal cord injuries.
- Members diagnosed with cancer who are either being treated outside the service area or are not being managed under a contracted cancer program within the health plan's service area.
- Members with multiple diagnoses who are seeing multiple specialists and require coordination of care.
- Members who have experienced severe trauma (e.g., burns, motor vehicle accidents, etc.).
- Members with chronic illnesses not managed by the health plan's Population Health Disease Management team.
- High risk children and adolescents (e.g., individuals with congenital anomalies, individuals with severe asthma, and individuals on home ventilators).
- High risk pregnant women (e.g., individuals with congenital anomalies, individuals at risk of premature delivery, and individuals presenting with others high risk diagnoses).
- Members with complex medical and psychosocial issues who are referred to Complex Case Management.

If you have an individual who would benefit from participation in the HPN's Complex Case Management Program, please contact the CCM Department at: 702-797-2100 or 877-487-6659.