INLAND EMPIRE HEALTH PLAN

2017

Quality Management Annual Evaluation

Executive Summary

August 2018

Mission and Vision

The purpose of the 2017 Annual Evaluation is to assess IEHP's Quality Program. This assessment reviews the quality and effectiveness of all studies performed and implemented by various IEHP departments in 2017. The Quality Management Department leads IEHP's Annual Evaluation assessment in a collective and collaborative process utilizing data and reports from committees, departments, content experts, data analysts, and work plans to analyze and evaluate the effectiveness of the Quality Programs. Overall effectiveness of the programs is assessed by analyzing the goals and actions of the study, reviewing qualitative and quantitative results, and defining barriers and next steps. IEHP's mission is to improve the delivery of quality, accessible and wellness-based healthcare services. The organization prides itself in the following five (5) core values:

- Health and Quality before Costs: Place Member's health care needs above all else.
- Team Culture: Dedicated and cohesive team focused on Member care and supporting our Providers.
- Think and Work LEAN: Strive to continuously improve daily operations and delivery of health care services.
- Partner with Providers: Ensure a strong working relationship with our Providers based on mutual respect and collaboration.
- Stewardship of Public Funds: Strive for transparency to the public and prudent fiscal management.

Quality Management Program Description

IEHP supports an active, ongoing and comprehensive Quality Management (QM) Program with the primary goal of monitoring and improving the quality of care, access to care, patient safety, and quality of services delivered to Members. The Quality Management Program provides a formal process to monitor and objectively evaluate and track the health plan's quality, efficiency, and effectiveness. The QM Program is designed to improve all aspects of care delivered to IEHP Members. The following are key areas included in the QM Program scope:

- Defining the Program structure;
- Assessing and monitoring the delivery and safety of care;
- Assessing and monitoring behavioral health services and disease management programs provided to Members;
- Supporting Practitioners and Providers to improve the safety of their practices;
- The QM Committee's oversight of IEHP QM functions;
- Involvement of designated physician(s) in the QM program;
- Involvement of a behavioral healthcare Practitioner in the behavioral aspects of the program;
- Identifying opportunities for quality improvement initiatives;
- Implementing and tracking quality improvement initiatives that will have the greatest impact on Members;
- Measuring the effectiveness of interventions and using the results for future quality improvement planning;
- Establishing specific role, structure and function of the QM Committee and other committees, including meeting frequency;

- Reviewing resources devoted to the QM program;
- Assessing and monitoring delivery and safety of care for Members with complex health needs and Seniors and Persons with Disabilities;
- Assessing and monitoring processes to ensure the Member's cultural and linguistic needs are being met; and
- Quality of Care and Services Strategic Priority. This priority will focus on activities, programs and interventions designed to improve the quality of care and Member satisfaction with our delivery system.

The QM Program includes tiered levels of authority and responsibility related to quality of care and services provided to Members. The line of authority originates from the Governing Board and extends to Practitioners through a number of different subcommittees.

IEHP Governing Board: IEHP was created as a public entity as a result of a Joint Powers Agency (JPA) agreement between Riverside and San Bernardino Counties. Two (2) Members from each County Board of Supervisors sit on the Governing Board as well as three (3) public Members from each county. The Governing Board provides direction for the QM Program, evaluates QM Program effectiveness, and evaluates and approves the annual QM Program Description.

Quality Management Committee: The QM Committee reports to the Governing Board and retains oversight of the QM Program with direction from the Chief Medical Officer. The QM Committee disseminates the quality improvement process to participating groups, Physicians, Subcommittees, and internal IEHP departments. The following are functions of the QM Committee: meet at least quarterly to report findings, report actions and recommendations to the IEHP Governing Board, seek methods to increase the quality of health care for Members, recommends policy decisions, evaluate QI activity results, and provide oversight for Subcommittees.

The following Subcommittees, chaired by the IEHP Chief Medical Officer or designee, report findings and recommendations to the QM Committee:

- Quality Improvement Subcommittee - reviews all Quality studies and Quality projects in accordance with the Subcommittee work plan. Provides oversight of all quality activities related to NCQA, DMHC, DHCS, and CM are on track and up to date.
- Peer Review Subcommittee – reviews all Provider, Member, or Practitioner grievances and/or appeals, Practitioner related quality issues, and other peer review matters.
- Credentialing Subcommittee – reviews individual Practitioners who directly contract with IEHP to deny or approve their participation in the IEHP network.
- Pharmacy and Therapeutics – reviews IEHP's medication formulary, monitors medication prescribing practices by IEHP Practitioners, under- and over-utilization of medications, provides updates to pharmacy related programs, and reviews patient safety reports related to medication.
- Utilization Management – reviews UM criteria, new technologies, and new applications of existing technologies for consideration as IEHP benefits, clinical practice guideline review and is responsible for reviewing and updating UM criteria, preventive care and clinical practice guidelines that are not primarily medication related. The UMSC directs the

continuous monitoring of all aspects of UM, Care Management (CM), Disease Management (DM) and Behavioral Health (BH) administered to Members.

- Behavioral Health Advisory Committee – The BH Advisory Subcommittee directs the continuous monitoring of all aspects of BH services administered to Members. The BH Advisory Subcommittee reviews and approves the Behavioral Health Program annually. The Subcommittee monitors for over-utilization and under-utilization; ensures that BH decisions are based only on appropriateness of care and service; and reviews and updates preventive care and clinical practice guidelines.

Delegation Oversight

IEHP delegates certain Utilization Management, Care Management, Credentialing/Re-credentialing, and compliance activities to contracted Delegates that meet IEHP delegation requirements and comply with the most current National Committee for Quality Assurance (NCQA), Department of Health Care Services (DHCS), and Centers for Medicare and Medicaid Services (CMS) standards. Joint Operations Meetings (JOM) meetings are conducted by IEHP as a means of discussing performance measures and findings, as needed. The JOM includes representation from both the delegate and the IEHP Departments. In 2017, IEHP hosted JOMs with each Medi-Cal IPA. This served as a collaborative approach to discussing IPA performance regarding delegated responsibilities, data, Member Satisfaction results, grievance trends, Global Quality Pay for Performance (GQP4P) and any other findings as needed.

IEHP's Delegation Oversight Committee (DOC) monitors and evaluates the operational activities of contracted Delegates to ensure adherence to contractual obligations, regulatory requirements and policy performance. Elements of delegation are monitored on monthly, quarterly and annual basis for trending and compliance. Delegates who fail to meet the requirements of delegated functions are placed on a Corrective Action Plan (CAP) to ensure that deficiencies are clearly identified, analyzed for root cause analysis and that effective remediation plans are put into place.

The Annual Delegation Oversight Audit (DOA) was conducted using audit tools that are based on NCQA, DMHC, DHCS and CMS standards. Delegation Oversight Audits are performed by IEHP Medical Services departments, Quality Management, Provider Services and Compliance Staff. In 2017, IEHP performed the Annual Delegation Oversight Audit (DOA) for all fourteen Medi-Cal IPAs, with eight (8) of fourteen delegates requiring a Corrective Action Plan (CAP). As a result of the 2016-2017 DOA conducted, IEHP will continue to monitor each of the areas within the Delegation Oversight audit tool and provide on-going training as we see necessary and/or as requested by our IPA partners.

Quality Improvement Initiatives

HEDIS: The Healthcare Effectiveness Data and Information Set, HEDIS®, is one component of the NCQA accreditation process. HEDIS® is used by more than 90 percent of health plans in the United States to measure performance on important dimensions of care and service. IEHP uses HEDIS® results as a tool to help focus its quality improvement efforts and as a way of monitoring the effectiveness of services. Each year, IEHP gathers data and performs analyses on clinical and

service performance measures as delineated by NCQA. The following HEDIS® 2017 data was collected. Multiple measures fall in the following categories:

- ***Prevention screening**:* IEHP saw significant increase in Chlamydia screening and Breast Cancer Screening. IEHP employs several interventions to encourage Members to complete their Breast Cancer Screening such as; placing Care Gap Alerts with the Medical Management System (MedHOK) and Customer Relations Management system (CRM); Member Incentive and Standing Orders Programs; and Member Birthday Calls to serve as reminders.

- ***Behavioral Health:*** IEHP noted a significant drop for Medi-Cal Membership for Antidepressant Medication Management − Continuation Phase Treatment**.**

- ***Disease Management:*** IEHP noted a statistically significant increase in Blood Pressure Control for Medi-Cal Members. IEHP noted a statistically significant improvement in Pharyngitis testing (CWP), Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB), Use of Spirometry (SPR), Pharmacotherapy Management of COPD Exacerbation (PCE) - Bronchodilator and Systemic Corticosteroid.

- ***Access/Availability of Care Measures***: The Medi-Cal Adults' Access to Preventive/Ambulatory Health Services improved significantly in CY 2016. The Children and Adolescents' Access to Primary Care Practitioners improved significantly for ages 12-24 months and 25 months to 6 years and dropped significantly for ages 7-11 years and 12-19 years.

- ***Utilization*****:** for the utilization measure, the results do not show a statistically significant change. Well-Child visits/prevention processes in place are continued for HEDIS 2018 which include the P4P Program, Members newsletters, and Roster Lists on the Providers' web portal.

***Quality Improvement Studies**:* IEHP implements Performance Improvement Projects (PIPs), HEDIS® PDSA QIPs that are required by regulatory agencies such as DHCS.

1. PIPs – Performance Improvement Projects that focus on testing interventions on a small scale utilizing the PDSA cycle. The PIP process is structured into four (4) phases and includes a total of five modules.

2. HEDIS® PDSA QIPs – Conducted for each HEDIS® External Accountability Set (EAS) measure with a rate that does not meet the Minimum Performance Level (MPL) or is given an audit result of "Not Reportable". IEHP evaluated ongoing quality improvement efforts on a quarterly basis**.**

- **Asthma Medication Ratio (AMR):** IEHP identified that the Asthma Medication Ratio (AMR) has performed significantly lower than the MCMC average from measurement year 2015 to 2016. Asthma continues to be ranked one of the most common diagnoses among IEHP Members. A sample population of 45,741 Members extracted from 2016 data

demonstrated that of Members with asthma, a total of 4,932, or over 10% had at least one Emergency Department (ED) encounter with asthma as the primary diagnosis. Several Members struggle with adhering to their treatment plan due to the complexity or frequency of the dosage or opt to use rescue medications as needed. The analyses demonstrate an opportunity to improve care for IEHP Members with asthma by developing an intervention to address the needs of this population.

- **Childhood Immunization Status-Combo 10**: The Medi-Cal Managed Care Quality Strategy – Comprehensive Review identified immunizations for children as an opportunity to improve the quality of services provided due to the potential negative consequences to an individual and population health if immunizations are not received. IEHP rates demonstrate a slight decline over the past three HEDIS® measurement years. During calendar year 2016, IEHP's Childhood Immunization Status (CIS) Combo 10 HEDIS® rate was 28.01%, placing the health plan in the HEDIS® measurement's 25th percentile. IEHP identified this area as an opportunity for improvement and conducted a drill-down analysis of the CIS-Combo 10 Member population. During January 1, 2017- August 31, 2017, Members who identified as White demonstrated the highest compliance rate of 14.09% followed by Hispanic at 13.09% compliance. Members who identified their ethnicity as Black received the lowest compliance rate of 8.07%. To address this health care gap, IEHP has partnered with the Riverside County Immunizations branch and Black Infant Health to develop targeted interventions.

IHA monitoring: An Initial Health Assessment (IHA) is a comprehensive assessment that includes healthy history, health education needs, physical exam, tests, immunizations, and the Staying Healthy Assessment (SHA)/Initial Health Education Behavioral Assessment (IHEBA). In addition to the DHCS compliance rate of completing the IHA within 120 days of enrollment, IEHP has an internal compliance rate that separates the compliance rates into two age bands. IEHP's internal compliance rates are defined as an IHA administered within 60 days of enrollment for Members under the age of 18 months and within 120 days of enrollment for Members 18 months and older. The compliance rate for Members under the age of 18 months with an IHA within 60 days was 68.26% and 41.95% for Members 18 months and older with an IHA within 120 days. The overall internal IEHP compliance rate was 48.78%, which includes both age band populations. The DHCS compliance rate of an IHA within 120 days was 52.55%. IEHP will continue Member Outreach, Provider Education, to ensure that both Members and Providers are educated on the IHA visit and timeline for having an initial health assessment. Additionally, compliance rates will continue to be monitored in both QI Subcommittee and QM Committee meetings.

Access to Care

With the rapid growth in IEHP's membership, access to care is a major initiative for the plan to which IEHP has dedicated a significant amount of resources to measuring and improving. IEHP maintains access standards applicable to all Providers and facilities contracted with IEHP. All PCPs, BH Providers, and Specialists must meet the access standards in order to participate in the IEHP network. IEHP monitors practitioner access to care through access studies, review of grievances and other methods. The access studies performed for the year 2017 include the following:

- ***Availability of Providers by Language*:** IEHP monitors network availability based on threshold languages. In order to ensure adequate access to PCPs, IEHP has established quantifiable standards for geographic distribution of PCPs for its threshold languages, which are English and Spanish. These two (2) languages cover over 98 % of IEHP's membership. This annual study assessed the availability of Spanish speaking staff at the Providers office. The results were grouped into PCPs, OB/Gyn. Providers, and Vision Providers. All Provider offices met the compliance goal of at least 85%. The 2017 results are as follows: PCPs are 96.4% compliant, OB/Gyn. offices are 97.1% compliant and Vision offices are 94.4% compliant.

- ***Availability of Practitioners:*** IEHP assesses the network availability for Provider to Member ratio and Time/distance standards for PCP, Specialists and Behavioral Health Practitioners. The results are compared against established ratio standards and time/distance standards (geographic distribution). The results of the 2017 Provider Network Status Study revealed that Occupational Therapy and CBAS Facilities did not meet time/distance standards for Medicare; all other Medicare standards for time/distance, and Provider to Member ratios have been met. For the Medi-Cal LOB, the Internal Medicine PCPs, Pediatrics and CBAS Facilities did not meet the time/distance standards. In addition, the Psychiatry Providers did not meet the Provider to Member ratio standard.

- ***Appointment Access*:** IEHP monitors appointment access for PCPs, Specialists, and Behavioral Health Providers and assesses them against timely access standards depending on the type of visit (e.g. Routine Visit or Urgent Visit). Annually, IEHP collects appointment access data from Practitioner offices using a timely access to care survey. Provider responses are then compared to acceptable appointment time frames to determine compliance. In addition to timely appointment availability, IEHP also evaluates grievance and appeals data to identify potential issues related to access. A combination of both activities help to identify issues and implement opportunities for improvement. For the 2017 Appointment Availability Access study, the goal is for all Providers to reach a 90% compliance rate for an available urgent visit and an available routine visit. The results reveal that 79.7% of PCPs were compliant when surveyed for urgent visit availability and 90.5% were compliant with routine visit availability. For Specialists, 71.5% of Specialists were compliant with an urgent visit appointment, and 76.8% were compliant for routine visit appointments. For BH Providers, (LCSW, MFT, Psychologists) 63.6% and 67.9% of Providers received a compliance score for urgent and routine visits, respectively.

- ***After-Hours access to Care*:** IEHP monitors after-hours access to Providers to ensure that Members have appropriate access to their Provider outside of regular business hours. The criteria for appropriate after-hours care is that the Physician or designated on-call Physician be available to respond to the Member's medical needs beyond normal hours. PCP offices can use a professional exchange service or automated answering system that allows the Member to connect to a live party or the Physician by phone. It is also required that any after-hours system or service that a physician uses provide emergency instructions in the event the Member is experiencing a life-threatening emergency. Annually, IEHP collects Provider after-hours access data from Provider offices using a standardized survey.

Provider responses are then compared to acceptable protocols to determine compliance. PCPs were surveyed as well as the following Specialists types: Cardiology, OB/Gyn, Orthopedic, Oncology/Hematology, Ophthalmology, Endocrinology, and Gastroenterology. BH Providers (Psychologists, Psychiatrists, MFTs, and LCSW) were also surveyed. The goal is to reach a 90% compliance rate for both call types; ability to connect to an on-call Physician, and appropriate protocol for a life-threatening emergency call. The 2017 results revealed the following compliance rates for an On-call Provider: PCP 52.6%, BH 20.3 %, and Specialist 56.0%. For a life-threatening emergency call, the compliance rates are as follows: PCP 69.7%, BH 62.3%, and Specialist 73.1%.

- ***After-Hours Nurse Advice Line:*** This study assesses the After-Hours access availability for IEHP's Members through a contracted after-hours Nurse Advice line. The purpose of this study is to ensure Members are able to obtain after-hours access to a licensed professional, in a timely manner. Furthermore, an effective program will likely reduce unnecessary Emergency Department utilization. The results show that the rate for Average speed of Answer time (under 30 seconds) and Call Abandonment (under 5%) were met for 2017.

- ***Addressing cultural and linguistic needs of Members:*** The purpose of the study is to identify the linguistic and ethnic diversity of IEHP's PCP and Member populations. More specifically, the study assesses the cultural, ethnic, racial and linguistics needs of Members. In the 2017 Cultural and Linguistic study, the results show that IEHP met the language distribution for English and Spanish PCPs to Member ratio, exceeding the standard of 1.0 PCPs per 2,000 Members for both English and Spanish languages. For Race/Ethnicity, IEHP continues to fall below the goal of 1.0 PCPs per 2,000 Members. Race and Ethnicity is an optional field on the Bi-annual Provider Directory Verification form and on the IEHP Provider Contracting application. Many Providers do not report their Ethnicity; therefore, this may not provide an accurate depiction of PCP to Member Ratios.

Member and Provider Satisfaction

***Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Survey*:** IEHP conducts a comprehensive CAHPS® survey and analysis annually to assess Member satisfaction with healthcare services. This standardized survey focuses on key areas like receiving needed care; receiving appointments to PCPs and Specialists (SPCs); satisfaction with IEHP and its Practitioners; and other key areas of the Plan operations. As a part of the annual evaluation, IEHP reviews the CAHPS® results to identify relative strengths and weaknesses in performance, determine where improvement is needed, and to track progress with interventions over time. Results are reported by Adult population and by Child population.

The 2017 results for the Adult population are as follows: IEHP scored below the 25th percentile for three (3) measures: Getting Needed Care, Getting Care Quickly, and Rating of Personal doctor. The following three (3) measures scored at the 25th percentile: How Well Doctors Communicate, Rating of Health Care, and Rating of Specialist. Rating of Health Plan measure scored at the 75th percentile. The Customer Service measure scored at the 90th percentile.

The 2017 results for the Child population are as follows: For 2017, IEHP scored below the 25th percentile for three (3) measures: Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate. One (1) measure scored at the 25th percentile: Rating of Personal Doctor; One (1) measure scored at the 50th percentile: Rating of Health Care; One (1) measure scored at the 75th percentile: Customer Service; And one (1) measure scored at the 90th percentile: Rating of the Health Plan.

***Provider Satisfaction*:** IEHP monitors performance areas affecting Provider satisfaction. The annual Provider Satisfaction study assesses the satisfaction experienced by IEHP's network of PCPs, Specialists, and Behavioral Health Providers. Information obtained from the survey allows IEHP to measure how well Providers' expectations and needs are being met. The study examines Provider experience in the following areas: Overall Satisfaction, Finance Issues, Utilization and Quality Management Network, Coordination of Care, Pharmacy, Health Plan Call Center Service Staff, and Provider Relations. The results for 2017 show that IEHP scored at the 96th percentile or higher in all composite areas when compared to the SPH Analytics Medicaid Book of Business. (The Book of Business consists of data from 58 plans representing 14,957 respondents in Primary Care, Specialty, and Behavioral Health areas.) 97.1% of surveyed Providers would recommend IEHP to other Physicians.

Grievance and Appeals: IEHP monitors performance areas affecting Member experience. The Grievance and Appeal (G&A) Study is conducted annually and reviews case volume and rates to identify trends and assess areas of opportunity to improve overall Member satisfaction. IEHP has established categories and quantifiable standards to evaluate those grievances (i.e. complaints) which are reported to IEHP by Members. Once received by IEHP, all grievances are categorized into the following categories, including but not limited to: Access, Attitude and Service, Benefits, Billing and Financial, Compliance Enrollment/Disenrollment, Quality of Care, and Quality of Practitioner site. Additionally, all grievances are assigned levels to determine the severity. The levels range from Level Zero (no issues found) to Level 4 (issue was found and resulted in significant harm to the Member) The Grievance and Appeals Department regularly analyzes all grievance and appeal data internally. The purpose of the analysis is to identify trends and develop interventions. In 2017, the grievance category with the highest volume of grievances was the Attitude and Service category with 'Practitioner Customer Service' being the top subcategory. The category with the lowest volume of grievances was the Billing and Financial category.

Patient Safety

Potential Quality Incident: IEHP conducts a review of its Potential Quality Incidents (PQI) which include documentation and resolution of PQIs identified by Members and internal sources. The process includes a review of case documents (e.g. medical records) to determine severity and classify into one of the following levels: Level 1 is no issue found, Level 2 is opportunity for improvement, and Level 3 is Unacceptable care or service which requires a Corrective action plan. In 2017, IEHP received 371 Potential Quality Incidents (PQI) cases compared to 405 cases in 2016 (8% decrease). Of the total cases, 177 were identified as Level 1 and 190 cases were identified as Level 2. There was one (1) case identified as Level 3.

Provider Preventable conditions (PPC) Pilot Study: The purpose of the PPC study is to assess the compliance of hospital facilities in their submission of PPCs as outlined in All Plan Letter (APL) 16-011, 'Reporting Requirements Related to Provider Preventable Conditions'. IEHP screens encounter data submission by network Providers and delegates on a regular basis to identify any evidence of PPCs. The data will be reported and presented to IEHP's Quality Improvement Subcommittee (QISC). With this new process in place, IEHP can identify PPCs that were not previously reported by a facility. IEHP will continue to monitor the Encounter Data Mining process to ensure all potential PPCs are reported going forward.

Management of Inpatient Discharge Transitions Study: The Transition of Facility to PCP Effectiveness Study assesses the Plan's effectiveness in managing Members' care transitions from Inpatient Facility to home to Primary Care Provider. Specifically, the study assesses the following three (3) areas: Health Plan Communications with the PCP during hospitalization, Completion of a PCP visit within 14 and 30 days of discharge, and effectiveness of identifying admission and discharges at the Plan in a timely manner. The goal is to monitor and improve continuity and coordination of care across the health care network. The 2017 results show 'Notification to PCP for all admissions at time of admission within one (1) business day' exceeded the goal. The other 2 PCP notification measures (Notification to PCP for planned admissions and Notification for planned and unplanned admissions at time of discharge) did not meet the goal for 2017. In addition, the 2017 results also show that Members are not accessing their PCPs for follow up within 14 days and/or 30 days of discharge.

Reducing Hospital Readmission: The purpose of this study is to assess the effectiveness IEHP's efforts in reducing acute hospital readmission rates. The Reducing Hospital Readmissions study looks at both IEHP's Utilization Management Transition of Care (TOC) Team and IEHP's contracted vendor Charter Healthcare Group (CHG) Transition Care Services to observe if there is a decrease in readmission rates. The study period was from January 1– November 30 in both 2015 and 2016. The goal was to reduce the readmission rate for Medi-Cal Members from 14.73% as observed in 2014, to 12%. The assessment of the rates in 2015 and 2016 demonstrated a reduction but did not meet the goal. The Quality Measures will continue to be monitored and reported to the Quality Improvement Subcommittee annually.

Complex Care Management

Complex Case Management (CCM) Member Satisfaction: The Complex Care Management (CCM) Member Experience Survey is conducted annually to assess Member experience with IEHP's Complex Care Management Program. The survey assesses Members' experience and satisfaction with the services provided by the Care Management (CM) staff, the overall CCM Program, the usefulness of information disseminated, and the Member's ability to adhere to recommendations. The goal is to achieve a 90% satisfaction rate for all satisfaction related questions. The 2017 results show that all Member satisfaction questions met the 90% goal except for Question 13, "Has the information you have received helped you improve your health?" and Question 14, "How helpful was the material with understanding and managing your health?"

The highest scoring question continues to be "Did your Care Manager treat you with courtesy and respect?" at 99.43%. Questions 15 and 17 assess Members' overall satisfaction with their Care

Manager and their satisfaction with the IEHP Care Management Program. Both questions exceeded the goal of 90%. The CM department will continue to develop trainings and tools that educate CCM Nurse Care Managers on the importance of quality care coordination, recommendations, and reinforcing their role and facilitation in care coordination by increasing the monitoring and oversight of the CCM Program

Complex Care Management (CCM) Population Assessment: IEHP's Complex Care Management (CCM) Program evaluates the effectiveness of processes and resources utilized to provide complex care management services to IEHP's most vulnerable and high-risk members. The goal is to ensure that IEHP targets the appropriate populations in need of Complex Care Management (via administrative identification/stratification and referral processes) and that the CCM Team's clinical experience and knowledge is adequate to handle the identified populations**.** The analysis consists of different populations including such as the Overall Population, Children and Adolescent Population, Individuals with disabilities, and Individuals with serious and persistent mental illness (SMPI). An additional assessment of IEHP's costliest diagnoses and most prevalent diagnoses for hospital stays assist the CCM Program to expand on any of these identified diagnoses and further improve Member care. A comprehensive analysis of findings along with barrier considerations are assessed for CCM Program enhancements. Examples of planned trainings for 2018 include techniques to improve CCM Program participation and identification of CCM potential triggers. The CCM Department also partners with external entities such as Dementia Care Specialists and Homeless Support Services. IEHP strives for continuous process improvement in the CCM program. As additional trends are identified within the populations, the CCM program will respond to the Members' needs and will accommodate staffing changes and training opportunities.

Continuity and Coordination of Care

Continuity and Coordination of Care Study: The purpose of this study is to assess the effectiveness of the exchange of information between medical care and behavioral healthcare. The study assesses the following measures to identify gaps in care and improve coordination of care**:** Effective exchange of information; Diagnosis, treatment, and referral of Behavioral disorders commonly seen in primary care; Appropriate use of psychotropic medication; Management of coexisting medical and BH conditions; Prevention Programs for Behavioral Health; and Special needs of Members with SPMI. For 2017, all measures related to Exchange of Information, Management of coexisting medical and BH conditions, and SPMI show an increase from 2016 to 2017. The percentage of Members who declined authorization for their BH Provider to exchange information with their PCP continue to not meet the goal. For the SPMI measures, most display an increase from the prior year, although 'Adherence to antipsychotic medications for individuals with schizophrenia (SAA)' measure had a slight decrease from the prior year. The outcome in the 2017 study remains consistent thereby giving the Behavioral Health Team an opportunity to increase behavioral health and physical health integration and collaboration with Pharmacy, Health Education and County Mental Health Systems.

Conclusion

Overall, IEHP's QM Program was effective in reviewing data, assessing trends, identifying issues and developing improvement activities within the Health Plan related to access to care, satisfaction and quality of care. IEHP will focus on meeting the 2018 Program goals and completing all initiatives as outlined in the 2018 QM Work Plan. In the next couple of years, IEHP will be working on committee restructure in certain areas to ensure compliance will all regulatory agencies.

As part of IEHP's strategic planning efforts continuing throughout 2016 and 2017, IEHP's Leadership Team identified a critical gap in IEHP's quality performance. The Leadership Team set a goal of reaching a 5-Star Rating by becoming a 5-Star quality healthcare delivery system. A 5-Star Health Plan Rating indicates the highest level in health plan quality and is awarded to health plans who demonstrate strong performance in the areas of clinical quality, member satisfaction, and health plan quality processes. IEHP has designated 5 Strategic Priorities as a framework for focusing organizational-wide efforts and aligning project and process priorities to realize our goal. The five strategic areas are as follows: Access to care and services, Practice Transformation, Quality of Care and Services, Technology and Data Analytics, and Human Development. IEHP is committed to improving the quality of healthcare delivered to its Members through proactive analysis of shared processes and integration of health initiatives that align with the industry and government quality standards; including a preventive health model for outreach and preemptive intervention related to health outcomes.