PASSPORT HEALTH PLAN

Our mission is to improve the health and quality of life of our members.

Quality Improvement 2009 Evaluation

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Introduction

Passport Health Plan's QI Program provides the infrastructure for the continuous monitoring, evaluation and improvement in care, safety and service. The 2008 QI Program Evaluation considers the network management activities and the Plan's credentialing and recredentialing activities, followed by clinical and service activities, and concluding with an overall assessment of effectiveness and opportunities for 2009.

This evaluation is not meant to take the place of other detailed program evaluations or reports such as annual evaluations for disease, health or utilization management programs. However, it will provide a high level overview of outcomes across all areas of the Plan.

QI Staff and Resources

The Chief Medical Officer (CMO) has responsibility to oversee the QI Program with the assistance of the CMO's staff including the support of two full time medical directors, one part time pediatric advisor, and one pharmacy director. The QI Department, in collaboration with all departments, was responsible for developing the QI Program documents, including the QI Work Plan, and monitoring the progress of all areas. The department is led by the Associate Vice President of Quality Improvement, with day-to-day activities overseen by the Manager of Quality Improvement. Department associates included two registered nurses, one project coordinator and one administrator.

Additional resources were utilized during the year as follows: eight internal registered nurses from the health management department, ten contracted registered nurses and one registered health information administrator worked with the Quality Improvement department part-time to assist in the collection of medical record data. Data gathered was utilized for HEDIS® and assessment against the Plan's criteria for medical record documentation standards, continuity and coordination of care standards, required health outcomes, preventive health and clinical care standards of care.

All departments contributed approximately 25 percent of a full-time employee throughout 2008 to achieve QI Program objectives.

QI staff and resources were adequate in 2008 to meet program objectives.

Participating providers contributed recommendations for the QI Program throughout 2008 by participating on clinical quality improvement and credentialing committees and ad-hoc focus groups.

Members and member advocates contributed recommendations for the QI Program throughout 2008 by participating on both clinical and service improvement committees and ad-hoc focus groups.

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

Committee Structure

All committees contained in the QI Program Description, with the exception of the Internal Quality Review Committee (IQRC), convened the appropriate number of times to meet Program Objectives as outlined in the 2008 QI Program Description. The IQRC met once due to the lack of quality concerns requiring further review.

Network Adequacy and Expansion

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- To assess the Plan's provider and practitioner network against adopted access standards on a quarterly basis.
- Monitor the cultural, ethnic, racial and linguistic needs of the membership and adjust the network, and access to the network as necessary to address the needs of the membership.
- Meet or exceed GeoAccess standards for primary care providers (PCPs) (30 miles/30 minutes urban and 45 miles/45 minutes rural).
- Meet or exceed GeoAccess standards for high volume specialists* (45 miles/45 minutes urban and rural).
- Conduct analysis of services rendered by providers outside of the Plan's network and adjust the network as appropriate.
- Identify opportunities and implement actions as appropriate to address the cultural, ethnic, racial and linguistic needs of the network.

MEASUREMENTS

Overall effectiveness of network adequacy and expansion is measured through GeoAccess reports and language line use monitoring.

FINDINGS

PCP Results:

All members have access to PCPs within the standard listed above. For the urban membership, the ratio is 1 PCP for every 69 members, exceeding the goal of 1 PCP for every 1500 members.
For the rural membership, the ratio is 1 PCP for every 44 members, exceeding the goal of 1 PCP for every 1500 members.

Specialist Results:

All members have access to the high volume specialists within the standard listed above. The Geo Access results are as follows:

Note: GeoAccess is utilized for members living within the Region only. Access needs of foster care and guardianship members living outside of the Region are assessed or addressed on an individual basis.

Cardiology: All counties met or exceeded PHP's required access standard. Members in Larue County have the longest average distance to a Cardiology provider with a distance of 19.25 miles.
OB/GYN: All counties met or exceeded PHP's required access standard. Members in Breckinridge County have the longest average distance to an OB/GYN provider with a distance of 26.4 miles.
Surgery: All counties met or exceeded PHP's required access standard. Members in Carroll County have the longest average distance to a surgeon with a distance of 19.73 miles.
The ratio of high volume specialists to members is 1:118.62, which exceeded the goal of 1 specialist for every 5000 members.

BARRIER

There are no barriers identified at this time.

OPPORTUNITIES

- Continue to monitor for network adequacy on a quarterly basis.
- Continue to conduct analysis of services rendered by providers outside of the Plan's network and adjust the network as appropriate.

Member Cultural Needs and Preferences

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- To monitor and ensure the Plan's compliance with federal anti-discrimination legislation, including Title VI of the Civil Rights Act of 1964 and the Culturally and Linguistically Appropriate Services in Healthcare (CLAS) standards.
- Monitor member access to interpreters in their preferred language.
- Facilitate on-site education and training for participating providers.
- Coordinate the translation of vital member documents into preferred languages and alternative formats, such as large type, Braille and audio.
- Advocate on behalf of members who have been denied interpreter services during a medical encounter.
- Host an annual professional conference for medical and human service providers; and (6) facilitate a best practices committee on cultural and linguistic services that includes representatives of all lines of business in the AmeriHealth Mercy Health Plans family of companies.

MEASUREMENTS

The Plan receives data on members' primary language spoken on approximately one third of its membership from the Department for Medicaid Services (DMS) on a

quarterly basis. Members' language data is also supplemented and updated by the Plan's Member Services, Case, Disease, and Health Management departments.

FINDINGS

Approximately 50% of the total membership has a language spoken identifier. This information is reported as listed below. All providers within the network speak English and 20 PCPs and 39 specialists have been identified through credentialing as speaking Spanish. Providers within the network have reported 40 additional languages spoken.

Top Ten Languages Spoken by Members Other Than English

Language
Spanish
Arabic
Russian
Vietnamese
Afrikaans
Bosnian
Swahili
Korean
French
Chinese

BARRIER

- While the provider community and Plan associates are much more knowledgeable about anti-discrimination legislation and the risks associated with a lack of culturally competent care, each group is in need of additional cultural-specific training related to newly-resettled refugee populations in the service area. In addition, refugees and immigrants continue to need information and training that will help them more quickly assimilate to the local health care system.

OPPORTUNITIES

- Continue the annual health seminar for refugees to provide face-to-face education on pertinent disease and health system topics and to further introduce concepts related to Western medicine, such as preventative health care.
- Continue to research the religious, language, and cultural preferences of newly-resettled peoples in order to provide accurate and appropriate services for this population.
- Continue collaboration with DMS to increase the percent of race, language, and ethnicity data collected and supplied to the Plan.
- Continue to support short and long-term initiatives aimed at addressing barriers to care that are related to cultural and religious bias, preferred language, and other special communication needs.
- Continue to provide face-to-face and written education and training to providers on Title VI and the CLAS Standards.

- Initiate additional contracting if possible as a result of ongoing analysis for members' language spoken as compared to data on contracted provider's 1st and 2nd language spoken.
- Continue to provide quarterly diversity and cultural sensitivity training for Passport Health Plan associates.
- Continue monitoring of access standards and evaluation of membership needs.
- Continue the CLAS Best Practices Council for AMHP Family of Companies.
- Utilize a Cultural and Linguistic Provider Checklist to offer appropriate feedback to provider sites on their level of compliance with anti-discrimination laws, in order to provide services to members/patients which are culturally and linguistically appropriate.

Qualified Providers and Practitioners

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- Facilitate credentialing activities for providers and practitioners that meet or exceed Plan goals (credentialing turn around time (TAT) ≤90 days; recredentialing TAT ≤36 months)
- Credential providers and practitioners in compliance with State, Federal and the National Committee for Quality Assurance (NCQA) requirements. Recredential providers and practitioners every three years.

MEASUREMENTS

Overall effectiveness of the credentialing program is measured through quarterly turn-around-time reports and audited credentialing records.

% of providers creden-tialed for 2009	% of providers with TAT ≤ 30d	% of providers with TAT between 30 and 60d	% of providers with TAT between 60 and 90d	% of providers with TAT ≤ 90d	% of providers with TAT >90d	Avg TAT	Plan Goal
366	72.08%	20.45%	4.55%	97.08%	2.92%	23.61 days	90 days

FINDINGS

Initial credentialing reviews were completed for 366 new providers with 97.08% completed within the Plan goal of 90 days. Recredentialing reviews were completed for 425 providers. In 2009, no providers were terminated from the network and no provider panels were closed subsequent to review by the credentialing committee. There were 24 new organizational providers credentialed during the year and 55 recredentialed organizational providers. All credentialing and recredentialing activities were in compliance with regulatory requirements.

BARRIERS

- Providers dissatisfied with length of time for credentialing process
- Difficulty getting updated information from providers timely for recredentialing.

OPPORTUNITIES

- Credentials verification functions were brought internally and the contract with the Credentials Verification Organization (CVO) was terminated May 2009 with the goal of reducing turn-around-time.
- Negotiate to delegate credentialing function for select providers to Certified Physician Organization.
- Identify members with ER visits or inpatient admissions to include medication categories as "on a controller" and "not on a controller".
- Continue to work with Credentialing Committee to monitor the quality of the provider network.

Delegation Oversight

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- Conduct oversight for all delegated activities (as noted below) via review by the Delegation Oversight Committee (DOC).
- Continue to enhance relationships between Passport Health Plan and its delegates to foster an environment of collaborative quality improvement for delegated services.
- Provide quarterly and annual oversight to assess compliance with State, Federal, and NCQA regulations and/or requirements.

MEASUREMENTS

Overall effectiveness of the program is measured through quarterly and annual delegation oversight reports.

FINDINGS

The following delegation and/or contract arrangements were in place during 2009:

Vendor Name	Delegated/Contracted Activities
Performance Credentialing, (NCQA certified credentials verification organization (CVO) January 1, 2009 – February 1, 2009	CVO services only ***(Credentialing/recredentialing decision making responsibilities and site visits are not delegated)***
Doral Dental Services of Kentucky, LLC (dental benefits manager) January 2009 – June 2009	Network development, credentialing/recredentialing, utilization management, processing of appeals, and claims processing for general dentistry services only. ***(MD services fall under the scope of medical benefits and thus credentialing/recredentialing of***

Vendor Name	Delegated/Contracted Activities
	dental surgeons and utilization management for dental surgery are not delegated.)
MCNA of Kentucky, LLC (dental benefits manager) July 2009 – December 2009	Network development, credentialing/recredentialing, utilization management, processing of appeals, and claims processing for general dentistry services only. ***(MD services fall under the scope of medical benefits and thus credentialing/recredentialing of dental surgeons and utilization management for dental surgery are not delegated.)***
Block Vision, Inc. (vision benefits manager)	Network development, credentialing/recredentialing, utilization management, processing of appeals, and claims processing for general vision services only. ***(MD services fall under the scope of medical benefits and thus credentialing/recredentialing of ophthalmologists and utilization management for eye surgery are not delegated.)***
AmeriHealth Mercy PerformRx, (pharmacy benefits manager)	Network development, credentialing/recredentialing of pharmacies, utilization management (approvals only), provider services call center, and claims processing. ***(Denial decisions, denial notification to members and providers, and appeals are not delegated.)***
AmeriHealth HMO, Inc., (family planning services vendor)	Claims processing services only.
IntelliCare, Inc., now SironaHealth, Inc. (24-hour nurse advice services vendor)	Nurse advice call center and health audio library services only.

Quarterly oversight of delegated activities occurred throughout 2009. Annual oversight visits were conducted for the vision, dental, pharmacy and family planning delegates. Delegates achieved full compliance with health plan requirements.
Performance Credentialing did not receive an annual oversight visit, as they remain a fully certified credentials verification organization through NCQA.

BARRIER

- No barriers are noted for delegation oversight in 2009.

OPPORTUNITIES

- Continue to monitor delegated activities through the Delegation Oversight Committee.

Quality Improvement Activities

HEALTH MANAGEMENT PROGRAMS

ASTHMA DISEASE MANAGEMENT PROGRAM

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- Increase the number of members with persistent asthma age 2-4 on controller medication.
- Increase the number of members with persistent asthma age 5-9 on controller medication.
- Increase the number of members with persistent asthma age 10-17 on controller medication.
- Increase the number of members with persistent asthma age 18-56 on controller medication.
- Increase the overall rate of members with persistent asthma age 5-56 on controller medication.

MEASUREMENTS

Overall effectiveness of the program is measured through annual participation rates and audited HEDIS® results.

Annual Participation Rates - Eligible members are identified and passively enrolled in the Asthma Disease Management Program. Members may "opt out" of the program and elect not to receive Asthma Disease Management Program services by notifying the Asthma Disease Care Managers, either telephonically or in writing. Participation Rates are tracked and reported annually.

	ADM Membership (avg)	Opt Out	Participation Rate
2009	6,531*	0	100%

2009 HEDIS® Results - The 2009 HEDIS® Results are based on calendar year 2008 data.

Measure	2004	2005	2006	2007	2008	2009 Quality Compass® Mean	2009 Quality Compass® 90th Percentile
Ages 5-9 on Controller Med	83.55%	82.34%	95.52%	99.87%	95.45%	92.02%	96.36%
Ages 10-17 on Controller Med	76.63%	78.94%	92.09%	94.11%	91.88%	89.05%	94.02%
Ages 18-56 on	75.75%	76.25%	87.13%	95.33%	89.85%	85.18%	90.85%

Controller Med							
Overall Rate age 5-56 on Controller Med	77.89%	78.85%	91.15%	96.30%	92.13%	88.66%	**92.13%**

Note: While there are no HEDIS® measures for the asthma population age 2-4, Passport Health Plan has chosen to provide interventions for these members as well.

FINDINGS

Measurement year 2008 combined results decreased by 4.17 percentage points; however, the Plan results for all age categories remained above the 2009 Quality Compass® Mean. The combined rate met Quality Compass® 90th Percentile.

BARRIERS

- Lack of awareness regarding NIH Guidelines regarding the diagnosis and treatment of persistent asthma.
- Member lack of knowledge regarding asthma control.
- Lack of early recognition and treatment of asthma exacerbation leading to high ER visits/inpatient admissions.
- Lack of recognition of home environmental factors that lead to asthma exacerbations

OPPORTUNITIES

- Identify members with ER visits or inpatient admissions to include medication categories as “on a controller” and “not on a controller”.
- Investigate a possible collaboration with the Passport Health Plan’s pharmacy contractor to have reminders mailed to member when the member does not timely fill the prescribed controller medication.
- Outreach to members “not on a controller” medication as demonstrated through pharmacy claims data with additional written material regarding asthma and the importance of controller medication and encouraging practitioner follow-up.
- Complete quarterly updates to the “not on controller” calls database to include a member mailing.
- Coordinate member educational materials to include a definition of asthma, asthma triggers, information regarding smoking cessation, asthma medications including controller medication, how to take medication, and practitioner follow up.
- Educate members regarding asthma control and signs and symtoms of asthma exacerbation and what to do through utilization of the member newsletter, targeted education mailings, on hold SoundCare messages, Plan website, and face to face.
- Coordinate both member and practitioner education regarding the 2007 NIH Guidelines via newsletters, website, on hold SoundCare messages, and practitioner outreach visits.
- Collaborate with community partners to continue to raise awareness of asthma within the community, such as Green City, Area Health Education Center (AHEC), and the American Lung Association (ALA).
- Collaborate with community partners to continue the *Healthy Hoops* program in 2010.
- Participate in school based educational programs to educate school age children on asthma.

- Outreach to participating practitioners regarding the 2007 NIH Guidelines during provider outreach visits.
- Collaborate with practitioners and their staff members to ensure asthma education efforts are consistent with those outlined in the 2007 NIH Guidelines and Passport Health Plan's Asthma Clinical Practice Guidelines.
- Collaborate with home health agencies to provide home environmental assessments for high-risk asthma members based upon EPA recommendations.
- Utilize an age appropriate symptom assessment tool to help determine asthma control and provide follow-up with recommendations based on the member's level of control.
- Telephonic outreach to members with ER visits or inpatient admissions and not on a controller.
- Telephonic outreach to members with ICU admissions for primary diagnosis of asthma.
- Engage practitioners in participating in the Asthma Advisory Group to assist in program review and interventions as needed.

DIABETES DISEASE MANAGEMENT PROGRAM

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- To increase the percentage of members receiving at least one HbA1c test during the measurement year.
- To increase the percentage of members with a HbA1c of $< 7\%$.
- To decrease the percentage of members with a HbA1c of $> 9\%$.
- To increase the percentage of members receiving a Dilated Retinal Eye Exam during the measurement year.
- To increase the percentage of members receiving an LDL-C screening during the measurement year.
- To increase the percentage of members with an LDL-C level < 100mg/dl.
- To increase the percentage of members with medical attention for nephropathy during the measurement year.
- To increase the percentage of members with a blood pressure level of $< 130/80$ mm Hg.
- To increase the percentage of members with a blood pressure level of $< 140/90$ mm Hg.

MEASUREMENTS

Overall effectiveness of the program is measured through annual participation rates and audited HEDIS® results.

Annual Participation Rates - Eligible members are identified and passively enrolled in the Diabetes Disease Management Program. Members may "opt out" of the program and elect not to receive disease management services, by notifying the Diabetes Disease Care Manager either telephonically or in writing. Participation Rates are tracked and reported annually.

	DDM Membership (avg)	Opt Out	Participation Rate
2009	4,632*	17	99.96%

2009 HEDIS® Results - The 2009 HEDIS® Results are based on calendar year 2008 data.

Measure	2004	2005	2006	2007	2008	2009 Quality Compass® Mean	2009 Quality Compass® 90th Percentile
HbA1c testing	82.73%	81.41%	84.63%	86.17%	87.30%	**80.47%**	89.28%
HbA1c poor control (> 9.0%)*	33.33%	35.37%	34.52%	31.29%	31.35%	44.76%	29.25%
HbA1c control (<8.0%)					59.92%	BASELINE	BASELINE
HbA1c good control (< 7.0)					56.95%	BASELINE	BASELINE
LDL-C testing	83.21%	85.71%	79.67%	79.82%	78.17%	**74.09%**	82.48%
LDL-C < 100	40.39%	41.50%	38.53%	43.08%	45.24%	33.82%	**44.71%**
Dilated Retinal Eye Exams	50.36%	49.43%	52.96%	54.42%	47.62%	52.79%	70.80%
Microalbumin testing/Medical attention for nephropathy	46.47%	51.47%	77.07%	78.68%	78.77%	**76.64%**	85.40%
Blood Pressure controlled < 130/80 mm Hg	-------	------	31.44%	29.02%	33.33%	**30.70%**	41.94%
Blood Pressure controlled < 140/90 mm Hg	------	------	65.01%	60.32%	63.10%	**56.90%**	71.17%

** for this indicator, a lower rate indicates better performance*

FINDINGS

The Plan demonstrated improvement in five of eight measures: HbA1c testing which increased by 1.13 percentage points and exceeded the mean; LDL-C Level <100 which increased by 2.16 percentage points and exceeded the 90th percentile; Nephropathy Monitoring which increased .09 percentage points and exceeded the mean.
Both measures related to controlling blood pressure (130/80 and 140/90) showed improvement and exceeded the mean. Both measures related to HbA1c good control have returned to baseline due to changes in methodology.

BARRIERS

- Practitioner identification of needed testing as recommended by the American Diabetes Association (ADA) and outlined in the Passport Health Plan Diabetes Clinical Practice Guidelines.

- Member lack of knowledge about diabetes.
- Member lack of knowledge of ADA recommendations for testing and results.

OPPORTUNITIES

- Provide telephonic outreach to members' delinquent in Dilated Retinal Eye Exams as well as other ADA recommended screenings.
- Provide member education through targeted mailings, newsletter articles, on-hold messages, telephonic outreach, and one-to-one intervention.
- Collaborate with Block Vision, the Plan's vision care benefits manager, to increase outreach to members delinquent in obtaining their Dilated Retinal Eye Exam.
- Provide practitioner outreach visits to provide diabetes education to office staff and review ADA recommended testing with practitioners.
- *Collaborate with community resources to assist members in getting corrective lenses, if needed.*
- Distribute practitioner compliance results with the Plan's Diabetes Clinical Practice Guidelines.
- Collaborate with practitioners on management of high-risk members.
- Distribute quarterly Provider Reports to inform the practitioners of member adherence to established treatment plan.
- Collaborate with community partners to continue to raise awareness of diabetes within the community such as KDN, ADA, National Kidney Foundation (NKF), Cardiovascular Diabetes Task Force, and local Departments of Health.
- Educate providers in the use of the ikaProHedis+ tool.

MOMMY AND ME PROGRAM

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- Improve member's initiation of prenatal care within 42 days of enrollment with the Plan or within the first trimester.
- Increase the percentage of members that have regular prenatal care. Improve birth outcomes by decreasing the number of preterm deliveries.
- Improve birth outcomes by decreasing the number of low birth weight (1,501 gms to 2,500 gms) babies to 5% or less and very low birth weight (≤ 1,500 gms) babies to 1% or less.
- Increase the number of members who have a postpartum OB practitioner visit between 21 and 56 days after delivery.

MEASUREMENTS

Overall effectiveness of the program is measured through annual participation rates, *Healthy Kentuckians 2010*, and audited HEDIS® results.

Annual Participation Rates - Eligible members are identified and passively enrolled in the ***Mommy & Me*** Perinatal Health Management Program. Members may "opt-out" of the program and elect not to receive ***Mommy & Me*** services by notifying the ***Mommy***

& Me staff, either telephonically or in writing. Participation rates are tracked and reported annually.

	Deliveries	Opt Out	Participation Rate
2009	7,612	54	99.99%

2009 HEDIS® Results - The 2009 HEDIS® Results are based on calendar year 2008 data.

Measure	2004	2005	2006	2007	2008	2009 Quality Compass® Mean	2009 Quality Compass® 90th Percentile
Initiation of Prenatal Care	92.70%	91.98%	89.24%	88.84%	92.15%	81.94%	**92.12%**
Frequency of Prenatal Care	83.45%	87.08%	82.74%	85.94%	85.22%	58.67%	**81.02%**
Postpartum Care	72.99%	79.06%	74.44%	72.1%	76.21%	62.65%	**72.68%**

2009 Birth Outcomes Results -Goals for LBW, VLBW, and preterm deliveries are based on *Healthy Kentuckians 2010.* The 2009 Birth Outcomes are based on delivery information obtained through Utilization Review of delivery inpatient stays.

Measure	2004	2005	2006	2007	2008	2009	***Healthy Kentuckians 2010* Goals**
Low Birth Weight (LBW) (1,501 grams to 2,500 grams)	8.00%	9.00%	10.4%	9.3%	9.6%	9.4%	**≤ 5%**
Very Low Birth Weight (VLBW) (≤ 1,500 grams)	1.8%	1.7%	1.6%	1.7%	1.6%	1.5%	**≤ 1%**
Preterm Deliveries (≤ 37 weeks)	16.9%	20%	21%	20%	19.57%	19.2%	**≤ 7.6%**

FINDINGS

The three Perinatal HEDIS® Measures met or exceeded 2009 Quality Compass® 90th percentile. Initiation of Prenatal Care noted a 3.31 percentage point increase from the previous measurement year. Postpartum Care noted a 4.11 percentage point increase from the previous measurement year. Frequency of Prenatal Care noted a 0.72 percentage point decrease from the previous measurement year.
LBW, VLBW, and Preterm Deliveries remain above the *Healthy Kentuckians 2010* goals. Each birth outcome measure noted a decrease from the previous measurement year with Preterm deliveries noting a 0.37 decrease, VLBW noting a 0.1 decrease, and LBW noting a 0.2 decrease. According to the most recent statistics, the Plan's LBW and VLBW rates are comparable to state and national rates.[1]

[1] National Center for Health Statistics. "*March of Dimes – Peristats*," www.marchofdimes.com/peristats. 2006.

BARRIERS

- Initiation of prenatal care continues to be a difficult measure to increase as members must first have a positive pregnancy test with an estimated date of confinement (EDC) to apply for benefits.
- Lack of member awareness of the importance of regular prenatal care.
- Difficulty in identifying modifiable risk factors the member may have for a poor birth outcome.

OPPORTUNITIES

- Collaborate with Provider Relations regarding the PRP program for specialists.
- Conduct provider visits by ***Mommy & Me*** nurses to OB practitioners to improve identification of pregnant members with risk factors and increase interventions with those members identified.
- Conduct postpartum visits by ***Mommy & Me*** on-site staff to provide member education and assistance with scheduling postpartum OB practitioner visit.
- Distribute postpartum reminder postcards.
- Perform telephonic outreach at two and four weeks postpartum.
- Conduct targeted member education of the Perinatal Clinical Practice Guidelines through articles in newsletters, website updates, on hold SoundCare messages, and one-on-one education.
- Conduct targeted provider education of the Perinatal Clinical Practice Guidelines through on-site visits and website updates.
- Evaluate program interventions to establish which are the most productive and re-organize resources as needed.
- All current interventions continue.

EPSDT

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- Increase the percentage of members receiving at least one EPSDT screen during the measurement year.
- Increase the percentage of members receiving EPSDT screens according to the periodicity schedule.
- Increase the percentage of members receiving childhood immunizations according to the periodicity schedule.
- Increase the percentage of members receiving adolescent immunizations according to the periodicity schedule.
- Increase the percentage of members receiving an annual dental visit.
- Increase the percentage of members receiving a well child visit in the first 15 months of life.
- Increase the percentage of members receiving a well child visit in the first 3rd, 4th, 5th, and 6th years of life.
- Increase the percentage of members receiving an adolescent well care visit.

Postpartum Care

100%

79.06% 79.78%

74.44%

MEASUREMENTS

Overall effectiveness of the program is measured through annual EPSDT participation and compliance rates and audited HEDIS® results.

Annual EPSDT Participation and Compliance Rates - The Department for Medicaid Services (DMS) and Cabinet for Medicaid and Medicare Services (CMS) require the Plan to report EPSDT compliance and participation rates annually, according to the Federal Fiscal Year (FFY). The compliance rate is defined as all eligible members receiving appropriate screenings according to the periodicity schedule. The participation rate is defined as all eligible members receive at least one EPSDT well child screen during the measurement year.

Measure	FFY ending 9/30/08	FFY ending 9/30/09	CMS Goals
Screening Rate	93%	95%	80%
Participation Rate	71%	74%	80%

2009 HEDIS® Results - The 2009 HEDIS® Results are based on calendar year 2008 data.

Measure	2006	2007	2008	2009 Quality Compass® Mean	2009 Quality Compass® 90th Percentile
Childhood Immunizations Combo 2	79.91%	83.85%	83.19%	**73.68%**	85.36%
Childhood Immunizations Combo 3	69.09%	76.99%	73.89%	**67.56%**	80.59%
Adolescent Immunizations Combo 2	65.49%	Retired	Retired	Retired	Retired
Annual Dental Visit	46.69%	49.31%	53.15%	**44.17%**	59.83%
Well Child Visit first 15 months of life	69.14%	70.11%	71.66%	**58.77%**	73.87%
Well Child Visit in the 3rd, 4th, 5th, & 6th year of life	71.33%	72.88%	74.74%	**69.68%**	80.33%
Adolescent Well Care Visit	53.10%	52.03%	53.08%	**41.88%**	56.67%

FINDINGS

Results for both Childhood Immunizations Combo 2 and Combo 3 demonstrated declines in 2008 when compared to 2007 results however, results exceeded the Quality Compass® Mean. Results for Annual Dental Visits demonstrated an increase of 3.84 percentage points from 2007 and exceeded the Quality Compass® Mean.

Results for the three Well Child Visits measures showed improvement in 2008 when compared to 2007 results and each exceeded the Quality Compass® Mean. No measures met or exceeded the Quality Compass® 90th percentile.

BARRIERS

- Limited time by practitioners in a busy office setting to identify needed screenings as recommended by the American Academy of Pediatrics (AAP).
- Member lack of knowledge regarding EPSDT periodicity schedule.
- Member lack of knowledge of AAP guidelines and recommendations for preventive care.

OPPORTUNITIES

- Continue all 2009 interventions.
- All Health Management staff to participate in targeted phone call outreach for school-age children.
- Collaborate with other PHP Health Management programs to include EPSDT information in mailings directed to children/caregivers (i.e., asthma mailings).
- Collaborate with the Provider Recognition Program to reward providers who demonstrate improvement and/or excellence in performance of EPSDT services including participation and screening rates.
- Provide education regarding access to ika PROHEDIS+, a real-time IT technology program to assist the practitioner to identify members in need of EPSDT screenings.
- Collaborate with Case Management, Behavioral Health and Members Services to assist with additional targeted telephonic outreach.
- Collaborate with community agencies to improve member education, screening and participation compliance with EPSDT services.
- Investigate the feasibility of intermittent chart audit to assist with well child rates.
- Revise the current billing process to include exclusion of the documentation tool for EPSDT screenings.
- Consider adding Lead Screening to reported measures for the program.

Yes You Can! Smoking Cessation Program

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- To reduce the health risks and illnesses associated with tobacco use and secondhand smoke.
- To reduce preventable and premature deaths attributed to tobacco use.
- To decrease the risk for lung and other types of cancer.
- To provide support to members who desire to quit by assisting them in becoming and remaining smoke –free.

MEASUREMENTS

Overall effectiveness of the program is measured through participation rates and quit rates. Quit rates are self-reported and determined as continuously smoke-free at

completion of the program, and at 3 months, 6 months, 9 months, and 12 months after continuously smoke –free status is obtained.

Measure	2007	2008	2009
Total members enrolled in program	229*	480	618
Quit Rate	51%	35%	37%

* rate reflects June through December of 2007.

FINDINGS

In 2009, the Plan enrolled 618 members into the program and 230 members verbalized being smoke-free at the 3 month, 6 month or 9 month timeframe for a quit rate of 37%. In 2008, the plan enrolled 480 members and 170 verbalized being smoke-free at the 12 month timeframe for a 1 year quit rate of 35%. In 2007, the plan enrolled 229* members and 117 verbalized being smoke-free at the 12 month timeframe for a 1 year quit rate of 51%. Of the 229* original members enrolled in 2007, 98 verbalized a smoke-free status of 2 years, for a 2 year quit rate of 42%.

BARRIERS

- Member lack of knowledge regarding the harmful effects of smoking.
- Member lack of knowledge regarding the program's coverage of certain smoking cessation products.
- Member difficulty in smoking cessation due to being heavy and/or long term smokers.
- Lack of support systems to assist with smoking cessation.
- Unable to contact members after three attempts
- No agreement received
- Members can “opt-out” of program

OPPORTUNITIES

- Determine level of member's nicotine addiction.
- Perform readiness assessment on all members interested in smoking cessation.
- Provider education via website, one-on-one visits, and provider newsletter articles.
- Member education via website, community events, member newsletters, and on-hold messages.
- Provide at least weekly telephonic support and education to the member.
- Provide a monthly progress report to the PCP regarding medication and smoking cessation.
- Follow up with the member at 6, 9, and 12 months after completion of the program.
- Collaborate with community resources for additional educational materials and support groups.

ER Program

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- Decrease ER over utilization rates.
- Increase member knowledge of the role of the primary care physician to ensure the appropriate services at the appropriate level of care.
- Decrease member non-emergent use of the Emergency Room for primary care services.

MEASUREMENTS

Overall effectiveness of the program is measured through audited HEDIS® results.

2009 HEDIS® Results - The 2009 HEDIS® Results are based on calendar year 2008 data.

Measure	2006	2007	2008	2009 Quality Compass® Mean	2009 Quality Compass® 90th Percentile
Emergency Room Visits/1000 member months*	65.56	63.44	65.00	**60.17**	39.26

* inverted rate, lower rate indicates better performance.

FINDINGS

Measurement year 2008 results demonstrated an increase of 1.56 visits per/1000 member months when compared to 2007. The emergency room visit rate remained above the 2009 Quality Compass® Mean.

BARRIERS

- Lack of member knowledge of after hours availability of the PCP.
- Lack of member knowledge of when to go to the ER verses PCP office or urgent care.
- Lack of member knowledge regarding home care remedies for non-urgent conditions.

OPPORTUNITIES

- Increase member awareness of the importance of utilizing an established medical home for continuity of care through face-to-face outreach, telephonic outreach, member newsletters, on-hold messages, the Plan's website, newsletter articles, and member educational material.
- Investigate feasibility of program expansion to include case management interventions for additional members with non-urgent ER usage.
- Develop and implement an ER flag for EPSDT members in the outreach queue to note non-urgent ER usage and allow for caregiver education during telephonic outreach
- Increase provider awareness of members on their panel who have eight or more ER visits in a rolling four quarters through the quarterly PCP ER utilization report.
- Provide follow-up communication to those providers with members utilizing, U of L, Kosair and Hardin Memorial emergency rooms.
- Target specific PCP's for outreach through the Plan's PCP Provider Recognition Program proactive outreach triggers.

- Increase PCP awareness of the Plan's comprehensive service bonus given for extended office hours.
- Monitor PCP compliance with contractual after hours telephone requirements.

CLINICAL INITIATIVES AND INDICATORS

APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION (URI)

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOAL

- To increase the percentage of members 3 month to 18 years of age who were given a diagnosis of URI not dispensed an antibiotic prescription on or within three days after the episode date.

MEASUREMENTS

Overall effectiveness is measured through audited HEDIS® results.

2009 HEDIS® Results - The 2009 HEDIS® Results are based on calendar year 2008 data.

Measure	2006	2007	2008	2009 Quality Compass® Mean	2009 Quality Compass® 90th Percentile
Appropriate treatment for children with URI	72.77%	75.28%	75.17%	85.49%	94.48%

FINDINGS

The URI measurement year 2008 results are relatively the same as 2007 results. 2008 results remain below the Quality Compass® Mean.

BARRIERS

- Lack of member knowledge of when antibiotics are needed to treat an illness.
- Lack of member knowledge of the difference between a viral infection and bacterial infection.
- Provider lack of adherence to the Plan's clinical practice guideline: 15.10 Passport Health Plan Viral Upper Respiratory Infection (VURI) in Children Clinical Practice Guideline.

OPPORTUNITIES

- Increase member and caregiver awareness regarding the appropriate treatment of children with upper respiratory infections by providing member/caregiver education through telephonic outreach, Member Newsletters, on-hold SoundCare messages, and member educational material.

- Increase community awareness regarding the importance of appropriate treatment of children with upper respiratory infections by distributing educational at health fairs and events.
- Increase provider awareness of the appropriate treatment of children with upper respiratory infections through the distribution of clinical practice guidelines on the Plan's website, in Provider Newsletters, and through site visits.
- Increase provider site visits conducted by the CHOICES consultant, a pharmacist, to provide education regarding appropriate antibiotic use for Otitis Media, Rhinitis and Sinusitis, Pharyngitis, Cough Illness and Bronchitis.

APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOAL

- To increase the percentage of members 2 through 18 years of age who were diagnosed with pharyngitis, prescribed an antibiotic, and received a group A streptococcus test for the episode.

MEASUREMENTS

Overall effectiveness is measured through audited HEDIS® results.

2009 HEDIS® Results - The 2009 HEDIS® Results are based on calendar year 2008 data.

Measure	2006	2007	2008	2009 Quality Compass® Mean	2009 Quality Compass® 90th Percentile
Appropriate testing for children with pharyngitis	67.77%	72.66%	61.84%	**61.37%**	82.05%

FINDINGS

The pharyngitis measurement year 2008 result declined 10.92 percentage points, however remained above the Quality Compass® Mean.

BARRIERS

- Provider lack of adherence to the Plan's clinical practice guideline: 15.11 Passport Health Plan Acute Pharyngitis Clinical Practice Guideline.
- Lack of member knowledge of the appropriate treatment of pharyngitis.

OPPORTUNITIES

- Increase member and caregiver awareness regarding the appropriate treatment of children with pharyngitis by providing member/caregiver education through member educational material.

- Increase community awareness regarding the importance of appropriate treatment of children with pharyngitis by distributing educational at health fairs and events.
- Increase provider awareness of the appropriate treatment of children with upper respiratory infections through the distribution of clinical practice guidelines on the Plan's website, in Provider Newsletters, and through site visits.
- Increase provider site visits conducted by the CHOICES consultant, a pharmacist, to provide education regarding appropriate antibiotic use for Otitis Media, Rhinitis and Sinusitis, Pharyngitis, Cough Illness and Bronchitis.

BREAST AND CERVICAL CANCER SCREENING

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- To increase the percentage of female members age 42 through 69 who received one or more mammograms during the measurement year or the preceding year.
- To increase the percentage of female members age 24 through 64 years who received one or more Pap tests during the measurement year or the two years prior to the measurement year.

MEASUREMENTS

Overall effectiveness is measured through audited HEDIS® results.

2009 HEDIS® Results - The 2009 HEDIS® Results are based on calendar year 2008 data.

Measure	2006	2007	2008	2009 Quality Compass® Mean	2009 Quality Compass® 90th Percentile
Breast Cancer Screening Rate	50.76%	51.79%	54.76%	**50.78%**	63.00%
Cervical Cancer Screening Rate	67.46%	66.50%	70.80%	**66.02%**	79.46%

FINDINGS

For measurement year 2008, the breast cancer screening results for ages 42-69 demonstrated a 2.97 percentage point increase. The cervical cancer screening result demonstrated a significant increase of 4.3 percentage points. Both rates exceeded the Quality Compass® Mean.

BARRIERS

- Lack of provider focus on preventive care.
- Lack of provider awareness of members who are in need of screenings.
- Lack of member knowledge regarding the importance of screenings, self referral, location of facilities to obtain mammogram, and providing names and phone numbers of Women's Health Providers.
- Lack of member convenience obtaining mammography screening.
- Lack of provider knowledge regarding Plan benefit requirements.

- Lack of member knowledge regarding the importance of screenings and women's health information.
- Member report of fear mammography will be painful.

OPPORTUNITIES

- Increase member awareness regarding the importance of preventive health screenings by:
    - Maintaining a Women's Cancer Screening calls database and utilizing internal resources for targeted member outreach.
    - Utilizing automated outbound call technology for identified members meeting criteria for the screening.
    - Distributing via mail multi-lingual reminder postcards biannually to those members identified as needing a breast or cervical cancer screening with contact numbers for assistance in scheduling.
    - Maintaining member educational material on the Plan's website including a list of all participating mammography facilities with phone numbers and addresses and the mobile mammography units schedule with a phone number to schedule.
- Increase facilities knowledge of Plan's open access benefits by collaborating with mammography facilities to host screening days which are dedicated to the Plan's members. Plan staff assists with identifying members eligible for screening, scheduling the member's appointment, and attending the events to provide face-to-face education regarding preventative health benefits.
- Increase provider awareness of the Provider Recognition Program, a pay for performance initiative that includes breast and cervical cancer screenings, by dedicating a provider relations representative to work with PCP's.
- Increase provider awareness of those members on their panel in need of breast and cervical cancer screenings by:
    - Distributing mammogram due reports and pap smear due reports.
    - Providing a real-time IT technology program, IKA ProHEDIS+.
- Increase provider awareness and adherence to the Plan's Adult Preventive Health Guidelines regarding breast and cervical cancer screenings by posting current guidelines on the Plan's website and publishing the guidelines in Provider Newsletters.

CHLAMYDIA SCREENING

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOAL

- To increase the percentage of female members age 16 through 24 years identified as sexually active, who received at least one test for chlamydia during the measurement year. Note: In MY 2008 the denominator for the eligible population changed from 16 through 25 to 16 through 24 years of age.

MEASUREMENTS

Overall effectiveness is measured through audited HEDIS® results.

2009 HEDIS® Results - The 2009 HEDIS® Results are based on calendar year 2008 data.

Measure	2006	2007	2008	2009 Quality Compass® Mean	2009 Quality Compass® 90th Percentile
Chlamydia Screening Age 16 to 20	52.04%	61.59%	63.05%	**52.67%**	67.31%
Chlamydia Screening Age 21 to 24			73.48%	Baseline	Baseline
Chlamydia Screening Combined			67.31%	Baseline	Baseline

FINDINGS

The calendar year 2008 result for ages 16-20 increased 1.46 percentage points and remained above the Quality Compass® Mean. Due to changes in the measure methodology for ages 21-24 both this measure and the combined measure return to baseline.

BARRIERS

- Lack of provider focus on preventive care.
- Lack of provider awareness of members who are in need of screenings.
- Lack of member knowledge regarding the importance of screenings, self referral, and providing names and phone numbers of Women's Health Providers.

OPPORTUNITIES

- Increase member awareness regarding the importance of preventive health screenings including Chlamydia screening by providing education through:
  - Face-to-face outreach, telephonic outreach, on-hold SoundCare messages, the Plan's website, and Member Newsletter articles.
  - Maintaining a Women's Cancer Screening calls database and utilizing internal resources for targeted member outreach to those members identified as needing a Chlamydia Screening and pap smear. The importance of Chlamydia Screening is discussed during outreach calls to those members identified via the database.
  - Distributing via mail multi-lingual reminder postcards biannually to those members identified as needing a cervical cancer screening which contains information regarding the importance of Chlamydia Screening.
  - Distributing a targeted brochure for teens regarding sexual activity and appropriate screenings including Chlamydia at health fairs and events, including Back to School events, and via individual mailings to age appropriate members identified through the EPSDT program.
- Increase provider awareness and adherence to the Plan's Adult Preventive Health Guidelines and the need to perform Chlamydia Screening for members identified as sexually active by posting current guidelines on the Plan's website and publishing the guidelines in Provider Newsletters.
- Increase provider awareness of the Provider Recognition Program, a pay for performance initiative that includes Chlamydia screening.
- Assist providers in identifying members on their panel in need health screenings including Chlamydia by implementing a real-time IT technology program, IKA ProHEDIS+.

HYPERTENSION

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOAL

- To increase the percentage of member's age 18 through 85 years of age with a diagnosis of hypertension with an adequately controlled blood pressure (<140/90).

MEASUREMENTS

Overall effectiveness is measured through audited HEDIS® results.

2009 HEDIS® Results - The 2009 HEDIS® Results are based on calendar year 2008 data.

Measure	2006	2007	2008	2009 Quality Compass® Mean	2009 Quality Compass® 90th Percentile
Adequately controlled blood pressure (<140/90)	63.94%	55.24%	59.08%	**55.77%**	66.58%

FINDINGS

For the measurement year 2008, the results show an increase of 3.84 percentage points. This rate continues to exceed the Quality Compass® Mean.

BARRIERS

- Lack of member knowledge regarding hypertension risk factors, symptoms, treatment, and recommended life style changes.
- Lack of education and awareness of the risks associated with undiagnosed high blood pressure and the need for appropriate treatment and compliance with treatment.

OPPORTUNITIES

- Increase member awareness regarding risk factors associated with hypertension, lifestyle changes to modify risks, and appropriate treatment and self-management skill through face-to-face outreach, telephonic outreach, member newsletters, on-hold SoundCare messages, the Plan's websites, and member educational material.
- Increase provider awareness of the appropriate treatment for persons with hypertension, including preferred pharmaceuticals, by posting current Hypertension Clinical Practice Guidelines on the Plan's website, in Provider Newsletters, and through site visits.
- Increase community awareness regarding risk factors associated with hypertension and the importance of lifestyle modification by:
    - Distributing educational materials health fairs and events.
    - Collaborating with an initiative to develop state wide interventions for prevention of heart and stroke disease.

CHOLESTEROL MANAGEMENT FOR PATIENTS WITH CARDIOVASCULAR CONDITIONS

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOAL

- To increase the percentage of members age 18 through 75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), percutaneous transluminal coronary angioplasty (PTCA) with evidence of LDL-C screening and a screening result of <100 mg/dL.

MEASUREMENTS

Overall effectiveness is measured through audited HEDIS® results.

2009 HEDIS® Results - The 2009 HEDIS® Results are based on calendar year 2008 data.

Measure	2006	2007	2008	2009 Quality Compass® Mean	2009 Quality Compass® 90th Percentile
LDL-C Screening	79.25%	76.38%	77.70%	79.62%	87.16%
LDL-C rate <100mg/dL	40.40%	43.27%	45.92%	**40.12%**	54.50%

FINDINGS

For measurement year 2008 the LDL-C Screening results demonstrated an increase of 1.32 percentage points. The LDL-C rate <100mg/dL also increased of 2.65 percentage points and exceeded the Quality Compass® Mean.

BARRIERS

- Lack of member knowledge regarding the need to obtain cholesterol screening and compliance with treatment of elevated cholesterol.
- Lack of provider adherence to the Plan's clinical practice guideline: 15.6 Risk Reduction for Coronary and Other Vascular Disease Clinical Practice Guideline.

OPPORTUNITIES

- Increase member awareness regarding risk factors associated with high cholesterol, lifestyle changes to modify risks, and appropriate treatment and self-management skills for persons with elevated cholesterol though face-to-face outreach, member newsletters, on-hold SoundCare messages, the Plan’s website, and member educational material.
- Increase provider awareness of the appropriate treatment for persons with elevated cholesterol, including preferred pharmaceuticals, by posting the Plan’s current Risk Reduction for Coronary and Other Vascular Disease Clinical Practice Guidelines on the Plan’s website, in Provider Newsletters, and through site visits.

- Increase community awareness regarding risk factors associated with high cholesterol and the importance of lifestyle modification by distributing educational materials at health fairs and events.
- Assist providers in identifying members on their panel in need of an LDL-C screening by implementing a real-time IT technology program IKA ProHEDIS+.

PERSISTENCE OF BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOAL

- To increase the percentage of members age 18 years and older who were hospitalized and discharged alive with a diagnosis of Acute Myocardial Infarction (AMI) and who received treatment with beta-blockers for six months after discharge.

MEASUREMENTS

Overall effectiveness is measured through audited HEDIS® results.

2009 HEDIS® Results - The 2009 HEDIS® Results are based on calendar year 2008 data.

Measure	2007	2008	2009 Quality Compass® Mean	2009 Quality Compass® 90th Percentile
Persistence of Beta Blocker Treatment after a Heart Attack	64.41%	53.66%	73.59%	85.00%

FINDINGS

Measurement year 2008 results decreased 10.75 percentage points below 2007 baseline results. Please note: For measurement year 2008, data reflects an eligible population of 82 members with 44 numerator events.

BARRIERS

- Lack of member awareness of need continue medication compliance.
- Lack of provider adherence to the Plan's clinical practice guideline: 15.6 Risk Reduction for Coronary and Other Vascular Disease Clinical Practice Guideline.

OPPORTUNITIES

- Increase member awareness regarding the importance of filling all prescriptions and taking all medication as prescribed through telephonic outreach, the Plan’s website, and member educational material.
- Increase provider awareness of the appropriate treatment with beta-blockers for members who have had heart attacks by posting the Plan’s current Risk Reduction for Coronary and Other Vascular Disease Clinical Practice Guidelines on the Plan’s website, in Provider Newsletters, and through site visits.

MEDICAL RECORD DOCUMENTATION AND CONTINUITY AND COORDINATION OF CARE

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- To assess annual medical record review findings and continuity and coordination of care, address individual provider group trends or deficiencies via corrective action plans and Plan-wide trends or deficiencies as deemed appropriate by the Quality Medical Management Committee (QMMC).
- All provider groups will achieve a minimum of 80 percent overall compliance rates with standards.

MEASUREMENTS

Annually, at the time of medical record review in support of HEDIS®, records are reviewed to assess PCP compliance with adopted medical record documentation and continuity and coordination of care standards. Thirty practices were selected from the HEDIS® records. Additionally, fifty PCP sites, including provider groups and individual practitioners, were selected based on the following selection criteria: participating providers with panel sizes of 150 or more members assigned. This year a total of 80 practitioner sites were reviewed. The sites included both rural and urban practices, and represented all PCP practitioner types including internal medicine, general practice, family practice, pediatric, and OB/GYN. Ten records were reviewed for each provider group and three records were reviewed for individual practitioners.

Measure	MY 2006	MY 2008	MY 2009	Plan Goal
Number of sites reviewed	63	65	80	N/A
Medical Record Documentation and Continuity and Coordination of Care Audit Results	94%	94%	95%	80%

FINDINGS

The MY 2008 medical record review results demonstrated an overall compliance rate of 95 percent. This rate is consistent with the overall rate achieved in MY 2006 and MY 2007. One provider fell below the Plan goal of 80 percent compliance.
Twenty-six of the 28 questions assessed exceeded the goal of 80 percent. Twenty-five of the 28 questions assessed exceeded a rate of 90 percent. The questions that fell below goal were question 12, regarding documentation of immunizations, and question 24, regarding documentation of advance medical directives. For MY 2008 question 12, documentation of immunization demonstrated a decline of 9 percentage points from MY 2007. Question 24, documentation of advance medical directives demonstrated a decline of 9 percentage points from MY 2007. Documentation of immunizations has consistently been below goal for the past eight years, and has shown a steady decline over the past three years. The Plan also collected identifying information to distinguish adult from pediatric results. Immunizations were documented for 80 percent of the

pediatric records while only 57 percent of adult records included documentation of immunizations. The result for pediatrics continues to meet the compliance rate. Adult immunization documentation results are well below the goal of 80 percent and continue to decline.

BARRIERS

- Lack of provider adherence to the Plan's medical record review documentation standards.
- Lack of consistency with documentation within the practices.
- Lack of uniform practitioner documentation practices particularly regarding the documentation of adult immunizations and advanced directives.

OPPORTUNITIES

- Raise goal to 90% for medical record review 2010, reviewing calendar year 2009.
- Practitioners will receive their individual results via written communication from the Chief Medical Officer (CMO) in October 2009.
- Provider Relations Representatives will receive notification of the practitioners assigned to them that did not achieve compliance standards.
- Practitioners who fell below the 80 percent compliance goal overall or within specific questions will receive corrective action recommendations and will be asked to sign and return acknowledgement statements. The Plan will then follow up during 2nd quarter 2010 to assess if corrective actions have been implemented.
- Practitioners falling below goal during the last three measurement periods will be referred to the Credentialing Committee at the time of their recredentialing in support of policy QM 5.0 Medical Record Standards and Review.
- Solicit feedback and direction from QMMC committee regarding providers that repeatedly fall below goal.
- All practitioners will receive aggregate results via the next edition of the provider newsletter, which will address common areas of non-compliance, opportunities for improvement and identified best practices. The Plan identified three practitioner groups which continue to score below goal. In consultation with the QMMC, collaboration between Provider Relations and the Quality Improvement department was proposed to provide the three groups one-on-one review of documentation standards and continuity and coordination of care standards and to make recommendations and offer tools to improve documentation practices.
- Increase provider education regarding adult immunizations and advance directives.

PROGRAMS FOR POPULATION WITH SPECIAL NEEDS

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- Stratify membership to identify sub-populations with special needs. Develop activities as appropriate to address special needs.

- Develop and implement new programs and policies, as identified through review of data, to improve the health and quality of life of the Plan's special needs population.
- Provide for the collaborative process in assessing, planning, implementing, coordinating, monitoring and evaluating the options and services needed to meet the needs of members' with special needs.
- Improve the health status and quality of life of members with multiple complex medical conditions.
- Decrease unnecessary hospitalizations and emergency room visits.
- Improve member self-management skills and self-advocacy.
- Provide coordination of care and services to members who have experienced a critical event or diagnosis needing the extensive use of resources and who need assistance navigating the health care system.

FINDINGS

The Programs listed below are currently in place to assist members with special health care needs:

Sub-population	Activity
AIDS/HIV+	This targeted case management program continued in 2009 with focus aimed at assisting members who have a diagnosis of AIDS/HIV+. A nurse case manager and a social worker within the department support this program. This effort also coordinates activities with community partners such as the House of Ruth, Volunteers of America and the AIDS Ministries.
Foster Care/Guardianship	A social worker in the Case Management department is the foster care liaison. The social worker meets with the DCBS supervisor and a nurse case manager once a month and all Plan of Care forms completed by the children's case workers are reviewed. If the child is in need of case management services based on diagnosis or treatment needs, a nurse case manager will work with the foster family and providers to help coordinate services. In addition to service plan reviews, foster children are referred to case management by providers, foster parents, and caseworkers.
Ventilator Dependent Members	This targeted Case Management program continued in 2009 and includes support from a nurse case manager and a physician advisor to improve the coordination of discharge planning in anticipation of the members' transition to the next level of care. The focus of the program is to assist members who are inpatient and ventilator dependent with their coordination of care needs after hospital discharge.
Palliative Care	This targeted Case Management program provides information and guidance for individuals and their families with the overall goal of enhancing personal control as self-efficacy in the management of advanced illness. The nurse case managers have incorporated palliative care principles into the case management process.
COPD	This targeted case management program began in 2006 and includes the support of a social worker and nurse case manager. The focus of the program is to assist members with repeated admissions for exacerbation of COPD in the self-management of their disease and decrease avoidable hospitalizations.
Sickle Cell	The Sickle Cell Disease (SCD) Case Management Program includes enrollment of all plan members with sickle cell disease unless the member declines participation. The program has three goals: to improve the quality of life of members with sickle cell disease; to improve provider compliance with

	standards of care; and to decrease hospital admissions.
Transplant	This targeted case management program focuses on members with complex medical conditions requiring potential human organ transplant or bone marrow transplant. A nurse case manager follows the member for any needs before and after transplant to assist with coordination of care.
Diabetes	This targeted case management program focuses on IDDM members with complex health care needs. A nurse case manager works with the multidisciplinary team of providers to improve compliance and decrease complications and hospitalizations.
Rehab	This targeted Case Management program includes support from a nurse case manager and a physician advisor to improve the coordination of discharge planning in anticipation of the members' transition to the next level of care. The focus of the program is to assist members requiring IP multidisciplinary rehab services with their coordination of care needs after hospital discharge.
CAD	This is a new case management program under development in 2009 to identify members with cardiac conditions to assist with coordination of care.

BARRIER

- No barriers are noted at this time.

OPPORTUNITIES

- Analysis of the membership has not identified the need for additional programs outside of those previously developed.

GUIDELINES

PREVENTIVE HEALTH GUIDELINES

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- Adopt, maintain, and implement preventive health guidelines that support ongoing early detection of illness and disease.
- Revise and distribute preventive health guidelines as necessary to support the membership.

FINDINGS

The following revisions were made to the Adult Preventive Health guideline:

- The guideline was completely reformatted to improve readability.
- Removed information on populations at high risk.

The following revisions were made to the Child & Adolescent Preventive Health Guideline/EPSDT Periodicity Schedule:

- Pages 2 – 9 – Added Mental Health Assessment 7 – 20 year old, Autism Screening 18 and 24 months, BMI 2 – 20 years, and Alcohol and Drug Use Assessment 11 – 20 years old.
- Page 11 – Added the following to the EPSDT/Periodicity Schedule
  - Age changes from 2 to 4 days to include Newborn and 3 to 5 days.
  - Added Length to height and weight.
  - Added Weight for Length for Newborn through 18 months.

- Added Body Mass Index (BMI)/Percentile from Growth Chart.
- Added risk assessment to Blood Pressure for newborn through 24 months.
- Deleted S – subjective, by history and O – Objective, by a standard testing method.
- Changed Vision Screening for Newborn, 24 months, 11 years, 13 years, 14 years, 16 years, 17 years, 19 years, 20 years, and 21 years from subjective, by history to risk assessment to be performed with appropriate action to follow, if appropriate.
- Changed Hearing screening for 3-5 days through 3 years, and 11 years through 20 years from subjective, by history and objective, by a standard testing method to risk assessment to be performed with appropriate action to follow, if appropriate.
- Combined Developmental Progress and Behavioral Assessment to include:
  - Developmental Screening
  - Autism Screening
  - Developmental Surveillance
  - Psychosocial/Behavioral Assessment
  - Alcohol and Drug Use Assessment
  - Changed Heredity/Metabolic screen from 2-4 days through 2 months to Newborn through 4 months range.
  - Changed H&H
  - Changed Lead Screening for 3 through 6 years from subjective to risk assessment.
  - Changed Tuberculin test by adding risk assessment to by 1 month and 6 months, and deleted 15 month risk assessment.
  - Changed cholesterol to dyslipidemia and deleted risk assessment from 3 years, 5 years and changed 18 through 20 years to cholesterol. performed at 20 years with a range of 18 through 20 years.
  - Deleted STD Screening, HIV Screening, and Pelvic Exam.
  - Added STI Screening and Cervical Dysplasia Screening.
  - Added Mental Health Assessment.

BARRIER

No barriers are identified at this time.

OPPORTUNITIES

The adult and child preventive health guidelines will be reviewed and updated in two years or when new information is received.

CLINICAL PRACTICE GUIDELINES

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- Adopt, maintain, and implement clinical practice guidelines that support clinical management of acute and chronic conditions relevant to the Plan membership.
- Annually audit practitioner medical record documentation for guideline compliance.
- Develop and/or revise and distribute clinical practice guidelines relative to the needs of the membership.
- Monitor and provide feedback to practitioners to improve medical record documentation regarding compliance with clinical practice guidelines.

FINDINGS

The Anxiety Disorders Clinical Practice Guideline was reviewed in 2009 and no changes were made.
The Depression Clinical Practice Guideline was reviewed in 2009 and no changes were made.
The following revisions were made to the Hypertension clinical practice guideline:

- Page 1 – Changed bullet 3 and made it 2 bullets.
- Page 3 – Added Characteristics Associated with Resistant Hypertension.
- Page 4 –
    a. Changed physical activity from 30 minutes to 30-45 minutes per day.
    b. Added definition for DASH eating plan.
    c. Changed verbiage on alcohol consumption for men to read 'Men: limit to no more than 2 drinks*(e.g., 24 oz. beer, 10 oz. wine, or 3 oz. 80 proof whiskey) per day'.
    d. Changed verbiage for women and lighter weight persons alcohol consumption to read 'Women and lighter weight persons: no more than one drink* per day'.
    e. Added - 'For overall cardiovascular risk reduction, stop smoking'.
    f. Changed ** - 'Effects are dose and time dependent *and could be greater for some individuals'.*
- Updated Algorithm for Treatment of Hypertension and added new process.

BARRIER

No barriers are identified at this time.

OPPORTUNITIES

The anxiety disorders, depression, and hypertension clinical practice guidelines will be reviewed and updated in two years or when new information is received.

CLINICAL PRACTICE GUIDELINES COMPLIANCE

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- Adopt, maintain, and implement clinical practice guidelines that support clinical management of acute and chronic conditions relevant to the Plan membership.
- Annually audit practitioner medical record documentation for guideline compliance.

- Develop and/or revise and distribute clinical practice guidelines relative to the needs of the membership.
- Monitor and provide feedback to practitioners to improve medical record documentation regarding compliance with clinical practice guidelines.

MEASUREMENTS

Annually, at the time of medical record review in support of HEDIS®, medical records are reviewed to assess practitioner compliance with adopted clinical practice guideline standards. For 2009 medical records were assessed for the following:

- **Perinatal Care CPG** - The clinical practice guideline assessing prenatal exams measures the following indicators: blood pressure, weight, urinalysis for protein and/or glucose presence, uterine size, fetal heart rate evaluation, signs and symptoms of premature labor, and assessment of fetal movement.
- **Diabetes CPG** - The Diabetes clinical practice guideline assessment measures practitioner compliance with the following indicators: lipid profile obtained in 2008, documentation of ESRD, and nephropathy screening by urinalysis or microalbumin obtained in 2008. Documentation of ESRD was added for the measurement year (MY) 2007 review. Charts for review were selected based on claims and pharmacy data in which members were identified with diabetes (type 1 or type 2) and were ages 18 to 75 years old during the measurement year. Specifically those who had two face-to-face encounters with different dates of service in an ambulatory setting or non-acute inpatient setting during the measurement year with a diagnosis of diabetes are identified within the medical claims/encounter data. Those who were dispensed insulin and/or hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis are identified within the pharmacy claims data.
- **Hypertension CPG** - chart reviews for MY2008 assessed practitioners' compliance with 'documentation of the known risk factors of diabetes and/or Chronic Kidney Disease' and 'blood pressure control'. These measures were selected because members with diabetes and/or chronic kidney disease are at a much higher risk for hypertension and identification of these conditions by treating physicians can impact treatment and outcomes. Additionally, assessing for blood pressure control can be an indicator of appropriate management of hypertension. In MY 2007 diabetes and CKD were calculated as a single measure. In MY 2008 these were separated into two measures. Charts for review were selected based on HEDIS® continuous enrollment criteria and ambulatory claims/encounter data in which members were identified with a diagnosis of hypertension on or before June 30 of the measurement year and were between ages 18 to 85 during the measurement year.
- **Sickle Cell Disease CPG** - The clinical practice guideline assessing Sickle Cell Disease measures the following recommended age appropriate indicators: office visits, lab work, prophylactic penicillin (PCN), flu vaccine, pain assessment, pain management, and measurement of spleen size. Charts for review are selected based on claims data that identifies members who were 1 year of age as of December 31, 2008 with the diagnosis of Sickle Cell Disease.

FINDINGS

Detailed analysis is provided in the 2009 Clinical Practice Guideline Audit Results document and reviewed by the Quality Medical Management Committee.

Practitioners receive their individual results via written communication from the Chief Medical Officer (CMO) in October 2009. All practitioners receive aggregate results via a provider communication, which addresses common areas of non-compliance, opportunities for improvement and identified best practices.

BARRIER
No barriers are identified at this time.

OPPORTUNITIES
- Increase provider awareness and adherence to the Plan's perinatal clinical practice guideline through face-to-face outreach, provider newsletters, the Plan's website, and quarterly provider reports.
- Initiate Specialist Provider Recognition Program for OB providers regarding postpartum care.
- Increase provider education regarding appropriate testing for diabetics as outlined in the Plan's clinical practice guideline by distributing the Plan's current Diabetes Clinical Practice Guideline through the Plan's website, in Provider Newsletters, and through provider site visits.
- Continue education to both members and providers by the Diabetes Disease Management program on the importance of diabetic testing and screenings during provider outreach visits and targeted member outreach.
- Continue quarterly provider reports regarding the members assigned to their panel that are delinquent with diabetic testing and screenings.
- Provide provider education on the use of a recently implemented real-time IT technology program that will assist providers in identifying members on their panel in need of necessary diabetes screens.
- Continue distribution of a comprehensive diabetes care tool for utilization in the member's medical record to track all recommended screenings.

PATIENT SAFETY

EVALUATION PERIOD
January 1, 2009 – December 31, 2009

GOALS
- To review all sentinel events and member concerns for quality of care and to determine if standards of care have been followed.
- To foster an environment that assists providers to improve the safety of their practices by providing feedback, requesting corrective action as appropriate and taking action on behalf of the Plan.
- To annually review and update the Plan's Safety Plan.

MEASUREMENTS
A. Sentinel events and member concerns are received as referrals and include the following events:
- All mortalities (anticipated and unanticipated);
- Fetal demise occurring at 20-weeks gestational age or greater;

- Facility incurred events resulting in an adverse member outcome such as:
    1. Unexpected increase in length of stay (LOS)
    2. Elevated level of care
    3. Falls and accidents
    4. Medication errors
    5. IV complications
    6. Equipment malfunction
    7. Delay, inappropriate, or lack of transfer from a general care unit to a Special Care Unit (ICU/CCU) or appropriate facility transfer
    8. Unplanned removal, injury, repair of organ and or body part during surgical procedure or delivery
    9. Nosocomial infection (any infectious process not present within 48 hours of admission)
    10. Neurological deficit present at discharge, which was not present within 48-hours of admission
    11. Transfusion reactions and/or complications
    12. Delay in administration of services that caused a potential or actual adverse member outcome
    13. Induction of labor (for an indication **other than** diabetes, premature rupture of membranes (PROM), pregnancy induced hypertension (PIH), post dates, intra-uterine growth retardation (IUGR), cardiac disease, isoimmunization, fetal demise, or chorioamnionitis), that results in an adverse maternal and/ or fetal outcome
    14. Apgar score of 4 or less at 5 minutes of age
    15. Birth trauma

Quality Improvement 2009 Safety Plan

Objective	Program Elements	Measure	Interventions
To reduce preventable medication errors.	1. Pharmacy newsletter to physicians. 2. Drug recall and safety alerts policy. 3. Physician Rx profiling. 4. Physician Rx education. performed by CHOICES Consultant. 5. Member Rx profiling. 6. Member newsletter. 7. Asthma Disease. Management mailers- appropriate use of nebulizer, turboinhaler, Diskus, and inhaler with a spacer.	1. Date and topics of newsletters. 2. Dates and topics of notifications. 3. Number of profiles completed. 4. Dates, topics and audience of educational opportunities completed. 5. Number of profiles completed 6. Dates and topic of articles placed in newsletters.	1. Pharmacy News February 2009 Pharmacy and Therapeutics Committee Medication Updates: o Important reminders Regarding Submission of Diagnosis Codes for Atypical Antipsychotics. o Tramadol now a Schedule IV controlled substance in Kentucky. o Albuterol Sulfate Nebulizer Solutions o Recent FDA Advisories. The Consumer Healthcare Products Association (CHPA) voluntarily modified the product labels for consumers OTC cough and cold medicines to state “do not use” for children under four years of age. Formulary Updates. Pharmacy Tips/Reminders: o Emergency Medication Supply. o Tramadol now a Schedule IV controlled substance in Kentucky. o Albuterol Sulfate Nebulizer

Objective	Program Elements	Measure	Interventions
			Solution.. 2. Pharmacy News March 2009 Pharmacy and Therapeutics Committee. Medication Updates. Formulary Updates: o Enhanced Online Searchable. Formularies Now Available. o PHP Provider Manual Updated Online. Network Pharmacy Education presentation: "Pharmacoeconomics of Hypertension" Locum Tenens for Participating PHP Providers. Recent FDA Advisors. Provider Workshops Extreme Makeover: "The Efficient, Patient-Centered Practice." Asthma Mailing: "Member Not on Controller Medicine." 2/09. Asthma Mailing: "All Member Mailing Child and Adult." 2/09.
To assure that the Plan's Hospitals and ancillary providers meet the requirements of: Department of Medicaid Services (DMS), Center for Medicaid and Medicare (CMS) and the National Committee on Quality Assurance (NCQA).	1. Provider credentialing. 2. Provider re-credentialing.	1. Number of facilities and ancillary providers successfully credentialed and recredentialed. 2. Number of facilities and ancillary providers not credentialed or recredentialed due to not meeting requirements.	See Provider and Organizational credentialing minutes and QI Work Plan.
To assure that the Plan's network of physician and allied health practitioners meet the requirements of: CMS, DMS and NCQA are fully licensed and insured.	1. Practitioner credentialing and re-credentialing process. 2. Adverse porting/sanctioning process in place.	1. Number of physician and practitioners successfully credentialed and recredentialed. 2. Number of physician and practitioners not credentialed or recredentialed due to requirement not being met. 3. Number of adverse/sanctioning reports.	See Provider and Organizational Credentialing minutes and QI Work Plan.

Objective	Program Elements	Measure	Interventions
To provide members with information regarding childhood and adult immunizations.	1. Member Handbook. 2. Member Newsletter. 3. EPSDT information.	1. Date and topic of articles posted in the member newsletter. 2. Date and topic of articles posted in the provider newsletter.	SoundCare On Hold Messages 1/09, 2/09, & 3/09.
To evaluate and track member quality of care concerns/ complaints.	1. Clinical quality of care case review, evaluation and monitoring. 2. Ad-hoc /focus audits.	1. Tracking and trending report of all member complaints reviewed bi-annually by Provider Services and Clinical Quality Review Nurse. 2. Annual activity summaries presented to Quality Medical Management Committee (QMMC).	See QI Work Plan, IQRC minutes, Tracking and Trending reports.
To provide practitioners with the Plan's recommended evidenced-based guidelines.	1. Clinical Practice Guidelines. 2. Preventive Health Guidelines. 3. KY EPSDT Periodicity Schedule. 4. Immunization Schedule.	1. Committee approval of guidelines. 2. Provider website postings. 3. Provider newsletter publications.	1. Guidelines reviewed, revised and approved a. 1st qtr: Adult Preventive Health. 2. See QI Work Plan. 3. See Website postings. 4. Provider newsletters.
To improve the percentage of high risk members (as defined by the CDC) are receiving annual flu vaccination.	SoundCare – phone reminder. Member Newsletter article. Provider Newsletter article.	Compliance rate: • Numerator: subpopulation. members with flu vaccination. • Denominator: total subpopulation.	1. SoundCare On Hold Messages : 1/09, 2/09, & 3/09.
To provide newborn and infant safety information to parents.	1. Mommy and Me Assessment Form. 2. Mommy & Me Basics magazine. 3. Safe Sleep for Your Baby: Reduce the Risk of Sudden Infant Death Syndrome (NIH publication).	1. Number of members enrolled in Mommy & Me.	1. See QI Work Plan
To provide pre-adolescent and adolescents information via the EPSDT program on Tobacco Use, Drugs, Alcohol and STD's.	Member Newsletter articles. Provider Newsletter articles. Member handouts-EPSDT pamphlet. Pilot/Audit Adolescent Well Care.	HEDIS Chlamydia rate 1. Pilot/Audit results.	1. See QI Work Plan. 2. See HEDIS measures. 3. SoundCare On Hold Messages 1/09, 2/09, & 3/09. 4. Worked in collaboration with DMS/IPRO to develop auditing tool.

Objective	Program Elements	Measure	Interventions
To provide members with information regarding domestic violence resources.	Perinatal CPG Audit Baseline question, “Domestic Violence Assessed during Pregnancy” Care Coordination assessment tool question: “Do you feel safe in your home?” Member Newsletter articles. Provider Newsletters articles.	1. Baseline Assessment of Perinatal CPG question, to be performed during 2nd qtr. 2. Develop and promote domestic violence assessment tool. 3. Article in Member Newsletter. 4. Article in Provider Newsletter.	1. Data abstraction tool previously developed with assistance of DMS and IPRO.
To assure members receive primary care un a safe, accessible, and clean environment.	Develop CR policy and site visit assessment tool.	1. Member complaints regarding office sites are routed to provider services and quality management for follow up. 2. Site visit is performed by one of the quality nurses. 3. Passing score is > 80%. 4. Office site that fails receives a letter with corrective action plan. 5. Reassessment occurs as stated in policy.	1st Qtr 1. One complaint site visit pending.
To identify and report other Plan Member Safety Initiatives identified.	Develop information and provide resources to members regarding emergency preparedness via a member safety web page.	Member website postings	1st In process of determining the types of material and resources available.

Quality of Care	2007	2008	2009
Member Concerns	43	80	153
Sentinel Events	357	368	537

FINDINGS

There was a 48% increase in reported member concerns and a 31% increase in reported sentinel events. Contributing factors to these increases include:

- Increased training throughout the organization regarding identifying and reporting sentinel events and member concerns.
- Collaboration with utilization management and case management to increase accountability for reporting sentinel events and member concerns.
- Clinical Quality Review nurse receives monthly deceased member report and investigates all unanticipated deaths.

Five hundred thirty-seven (537) sentinel event cases and one hundred and fifty-three (153) member concerns were reviewed, fifteen cases were referred to a Plan medical director for additional review and two cases were referred to the Internal Quality Review Committee (IQRC) for review. After review all cases were assigned an outcome code of 0-No quality of care concern.

BARRIERS

No barriers identified at this time.

OPPORTUNITIES

- Continue internal staff education in 2010 with medical management staff to encourage the identification and referral of sentinel events and with member service staff to encourage the identification and referral of member concerns.
- Review physician referral process and committee review process to increase the number of cases for additional review.
- Provide annual training to the Plan medical directors and the committee on the Quality Review Process.

ACCESSIBILITY OF SERVICES

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- Monitor practitioner performance against adopted access standards and implement corrective actions as necessary to maintain and/or increase compliance.
- Monitor member satisfaction with CAHPS® Composite Getting Needed Care.
- To maintain 95% compliance rate within the network for availability standards.

  Primary and Specialty Care Standards:
  - Routine appointments are available within 30 days
  - Urgent appointments are available within 48 hours
  - Pregnant woman in first trimester – preventative care appointment within 14 days
  - Pregnant woman in second trimester – preventative care appointment within 7 days
  - Pregnant woman in third trimester – preventative care appointment within 3 days
  - Overall compliance rate of 95 percent with appointment availability and access standards.

After Hours Access Standards:

- PCPs are required to provide coverage for Plan members 24 hours a day, seven days a week.
- A PCP's office telephone must be answered in a way that the member can reach the PCP or another medical practitioner whom the practitioner has designated.
- The phone must be answered by an answering service that can contact the PCP or designee who can return the call within a maximum of 30 minutes; OR
- Answered by a recording directing the member to call another number to reach the PCP or designee who can return the call within a maximum of 30 minutes; OR

- Transferred after office hours to another location where someone will contact the PCP or designee who will return the call within a maximum of 30 minutes.
- Improve member satisfaction for both adult and child CAHPS® Composite Getting Needed Care.

MEASUREMENTS

Adherence to Plan standards for appointment availability is monitored through site visits conducted by Provider Relations Representatives. The Provider Relations Representative views the provider's appointment book/computer system for compliance with the standard. Currently, each PCP group is targeted to receive two site visits per calendar year and each Specialist is targeted to receive one site visit per calendar year.
Member satisfaction with getting needed care is measured through CAHPS® Composite Getting Needed Care for both adults and children.

Appointment access compliance	2007	2008	2009	Plan Goal
PCP < 30 days	100%	100%	100%	95%
PCP < 48 hours	100%	100%	100%	95%
Specialist < 30 days	100%	100%	100%	95%
Specialist < 48 hours	100%	100%	100%	95%

CAHPS® Measure	2007	2008	2009	2009 Quality Compass® Mean	2009 Quality Compass® 90th Percentile
Composite – Getting Needed Care (Adult)	84%	84%	80%	76%	82%
Composite – Getting Needed Care (Child)			85%	Baseline	Baseline

FINDINGS

In 2009, 240 site visits were conducted. Of those, 99 were to PCP offices and 141 were to specialists offices. As noted in the table above, 100 percent of offices assessed were compliant with all appointment access standards.
The 2009 adult survey results for getting needed care decreased by four percentage points, however it remains above the Quality Compass® Mean. Due to significant changes in the child survey, 2009 results will serve as baseline.

BARRIERS

- Lack of member understanding of the referral process
- Lack of member understanding of the time-frames related to routine specialist appointment scheduling.

OPPORTUNITIES

- Continued to monitor adherence to Plan standards for appointment availability through site visits conducted by Provider Relations Representatives.
- Continued to monitor adherence to Plan standards for after hours phone coverage through site visits conducted by Provider Relations Representatives.
- Continued provider education regarding contractual standards.
- Continued education to new members regarding appointment access standards to encourage appropriate expectations prior to the need for an appointment.
- Improve member satisfaction with getting needed care by:
    - Educating members regarding the referral process via the Plan's member website and newsletter articles.
    - Educating members regarding the time-frames related to routine specialist appointment scheduling.
    - Enhancing telephonic member outreach welcoming new members to the Plan. During calls, members are offered assistance with choosing a PCP, education regarding Plan benefits and complete a personal information form used to obtain demographic information and member's current health status.
    - Educating member services staff on how to work with members to resolve routine specialist scheduling and make referrals to the Case Management department.
- Assess and monitor appointment access and availability via site visits conducted by provider relations representatives.

ADMINISTRATIVE APPEALS AND MEDICAL NECESSITY APPEALS

Evaluation of appeals is included within the 2009 Utilization Management Program Evaluation.

SERVICE INITIATIVES AND INDICATORS

MEMBER SERVICES PERFORMANCE STANDARDS

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- Meet or exceed the average speed of answer (ASA) goal of 40 seconds and the abandonment rate (AR) goal of 5 percent.
- Process 95 percent of category I inquiries within 48 hours and process 95 percent of category II inquiries within 21 days.
- Improve the CAHPS® result for Composite – Customer Service.

MEASUREMENTS

Overall effectiveness for average speed of answer and abandonment rate is measured through reporting from the call center system and the call center documentation system.
Member satisfaction with customer service is measured through CAHPS® Composite Customer Service for both adults and children.

2009 CAHPS® Results - The 2009 CAHPS® Results are based on calendar year 2008 data.

Call Center Measures	1st qtr 2009	2nd qtr 2009	3rd qtr 2009	4th qtr 2009	Average for 2009	Plan Goals
Average Speed of Answer in seconds	1:01	0:42	0:36	0:38	0:44	0:40
Abandonment Rate	5%	4%	4%	4%	4.25%	5%

Category I and II Inquiries	2008	2009	Plan Goal
Category I Inquiries	98%	97%	95% within 48 hrs
Category II Inquiries	85%	94%	95% within 21 days

CAHPS® Measure	2007	2008	2009	2009 Quality Compass® Mean	2009 Quality Compass® 90th Percentile
Composite – Customer Service Care (Adult)	89%	79%	84%	**80%**	87%
Composite – Customer Service Care (Child)			83%	Baseline	Baseline

FINDINGS

Results for calendar year 2009 show a 4 percent increase in total member calls, or 6,595 calls. The Plan achieved the AR goal of 5 percent or less in all four quarters with average for the year of 4 percent. The Plan achieved the ASA goal of 40 seconds or less in two of the four quarters in 2009 with the average for the year of 44 seconds. The department met the processing time goals for category I inquiries but did not achieve the goal for category II inquiries. The 2009 adult rating for customer service demonstrated a five percentage point increase. Due to significant changes in the child survey, 2009 results will serve as baseline.

BARRIERS

- While an increase in membership resulting in an increase in call volume was noted no increase in member service staffing occurred.
- Member Services encountered delays when forwarding contact service forms to the Third Party Liability department, Provider Claims Services Unit, Provider Relations department and the Enrollment department.

OPPORTUNITIES

- Member Service leadership meets frequently with staff to review daily, weekly, monthly and quarterly statistics.
- Continued collaboration among DMS and PHP to resolve issues affecting member eligibility.
- Collaboration with Department of Community Based Services (DCBS) and PHP staff. The collaboration consists of meetings, shadowing workers and conference calls.
- Increased customer service representative knowledge of the eligibility issues as they arise in the enrollment file from DMS or Enrollment.
- Continued member outreach through welcome calls. Complete personal information forms (PIF) while on the call.
- Continued member education through New Member Packets and Member Newsletters.
- Monitor call reports and adjusted staff to cover higher interval time slots.

PROVIDER SERVICES PERFORMANCE STANDARDS

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- Monitor and improve performance as necessary to meet Plan goals and provider expectations for provider services.
- Resolve category I inquiries (inquiry that can be resolved within the department) and category II inquiries (inquiry in which provider services staff must collaborate with other Plan staff to resolve) in a timely manner.
- Meet or exceed the average speed of answer (ASA) goal of 30 seconds and the abandonment rate (AR) goal of 10 percent.
- Process 95 percent of category I inquiries within 48 hours and process 95 percent of category II inquiries within 21 days.

FINDINGS

AR (2%), ASA (21 seconds) goals and the inquiry turn around times for category I (98.8%) and II (96.9%) were met in 2009.

BARRIERS

No barriers are identified at this time.

OPPORTUNITIES

- Performed daily monitoring of all standards which include ASA, AR, and category I and II inquiries.

- Training, coaching and counseling of staff continued as needed with those departments outside of the service team that have the ability to impact these results

PROVIDER CLAIMS SERVICES PERFORMANCE STANDARDS

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- Monitor and improve performance as necessary to meet Plan goals and customer expectations for Provider Claims Services Unit (PCSU)
- Meet or exceed the ASA goal of 40 seconds and the AR goal of 10 percent.

MEASUREMENT

The average speed of answer (ASA) and the Abandonment Rate (AR) are measured through quarterly and annual reports.

Measure	1st Qtr 2009	2nd Qtr 2009	3rd Qtr 2009	4th Qtr 2009	Goal
Average Speed of Answer	:31 secs	:23 secs	:32 secs	:30 secs	:40 sec
Abandonment Rate	1.9%	1.3%	2.0%	1.6%	10%

FINDINGS

The department achieved goal for AR and ASA goal for each quarter in 2009. The average ASA for 2009 was 29 seconds and the average AR was 1.71%.

BARRIER

- Open positions periodically throughout the year caused ASA to increase while positions were filled and trained.

OPPORTUNITIES

- Continued monitoring of ASA and AR.

CLAIMS PROCESSING PERFORMANCE STANDARDS

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- Process all clean claims accurately and timely and improve provider satisfaction with claims processing.
- Process 100 percent of clean claims within 30 days and 100 percent of all claims within 60 days.
- Process 95 percent of claims accurately in accordance with financial and procedural policies.
- Improve provider satisfaction with the timeliness and accuracy of claims payment.

MEASUREMENT

Practitioner Satisfaction Measure	2007	2008	2009
Satisfaction with Timeliness of Payment	91%	97%	97%
Satisfaction with Accuracy of Payment	82%	86%	86%

FINDINGS

For 2009 clean claims processed within 30 days and all claims within 60 days were both slightly below the goal at 98.9 percent and 99.9 percent respectively. Procedural accuracy and financial accuracy both exceeded the goal at 99.1 percent and 99.5 percent respectively.
Provider satisfaction with timeliness of claims payment remained unchanged and accuracy of claims payments increased significantly in 2009 when compared to 2008.

BARRIERS

No barriers are identified at this time.

OPPORTUNITIES

- Continue to monitor claims aging reports on a daily, weekly, and monthly basis.
- Continue to provide examiner feedback daily, weekly, monthly to improve overall individual and departmental performance.
- Continue to identify opportunities for increases in auto adjudication.

MEMBER SATISFACTION

MEMBER GRIEVANCE TRENDS

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOAL

- Monitor member grievances and implement actions as necessary to improve satisfaction.
- To reduce and/or eliminate the top reasons for member's grievances by identifying root causes and implementing interventions.
- to improve member satisfaction with the Plan and providers.

MEASUREMENTS

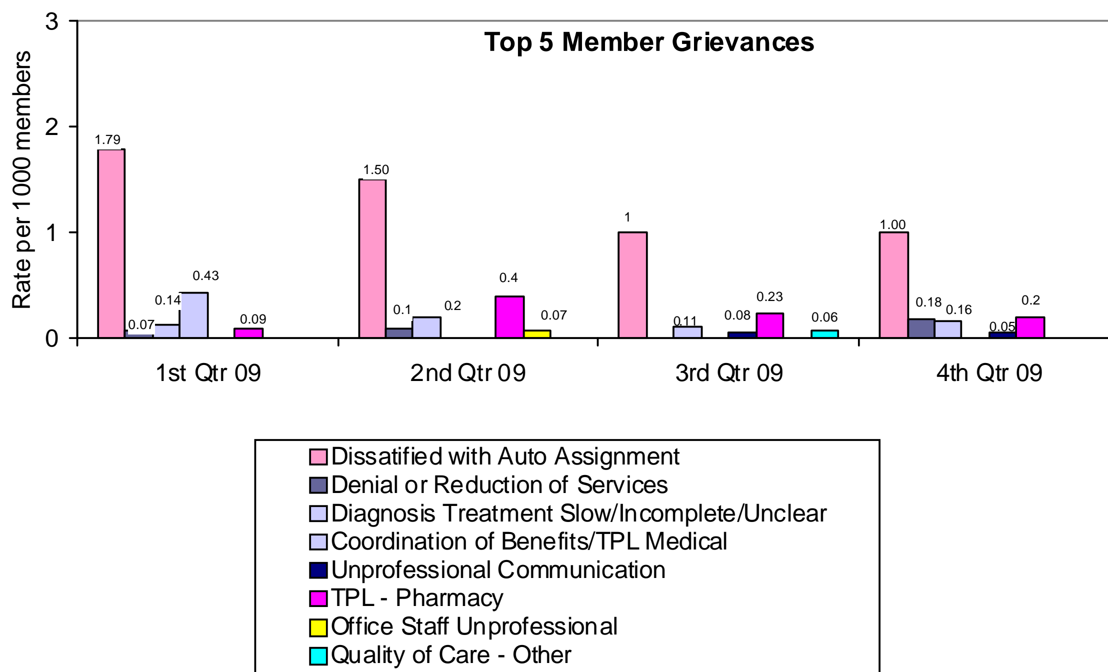
Category	2008 Total Complaints/1,000 Members	2009 Total Complaints/1,000 Members
Quality of Care	2	1
Access	1	1
Attitude/Service	15	8
Billing/Financial	1	0.3

Quality of Practitioner Office Site	0.3	0.9
Total	19.3	11.2

Complaint rates are also calculated by percentage of the total for each category.

Category	2008	2009
Quality of Care	8%	8%
Access	4%	2%
Attitude/Service	81%	88%
Billing/Financial	4%	1%
Quality of Practitioner Office Site	3%	1%

Additionally, the Plan did a drill down analysis to discern the members top grievances.



FINDINGS

Results for 2009 indicate the most frequent member grievances were:

- Members' dissatisfaction with auto-assignment of Primary Care Provider (PCP).
- TPL - Pharmacy
- Diagnosis treatment slow/incomplete/unclear.

Members' dissatisfaction with auto-assignment of Primary Care Provider (PCP) - The Plan demonstrated a 30% reduction in auto-assignment grievances when compared to 2008. However, dissatisfaction with auto-assignment remained the most frequent complaint in all categories for both years. A multi-disciplinary team met throughout the year to evaluate the auto assignment processes and make recommendations for improvement. Two process improvement were implemented: restructuring of welcome call scripts to include PCP selection at the time of call and

relocation of the PCP assignments for members in rural counties from the Philadelphia office to the Louisville office, allowing Plan staff who are familiar with the providers and counties to make more satisfactory selections.

TPL- Pharmacy - The Plan documented 148 TPL – Pharmacy complaints for 2009. For 2009 the TPL complaint category was broken out into two measures: TPL – medical and TPL pharmacy to better analyze complaint detail. TPL pharmacy issues arise from multiple sources: DMS, Facets, Argus as well as member reported discrepancies. A multi-disciplinary team reviewed this documentation and continues to develop interventions for 2010 to reduce TPL – Pharmacy complaints.

Diagnosis treatment slow/incomplete/unclear - The Plan demonstrated a 43% reduction in diagnosis treatment slow/incomplete/unclear grievances when compared to 2008. but remains in the top five grievance categories.

BARRIER

- Large increase in membership will require reevaluation of staffing in 2010.

OPPORTUNITIES

- Member Services realigned staff to allow all grievances to be transferred to a Special Support Line for handling, resulting in more efficient grievance resolution process. The Plan has been able to reduce grievances and document more robustly as well as ensure accurate resolutions.
- The grievance contact service form (CSF) was redesigned in 4th quarter 2008 and implemented in January 2009. The new CSF reflects more accurate documentation of the grievance and improved reporting capabilities
- Continue analysis of auto-assignment process and identification of areas targeted for process improvement.
- Continue tracking and trending of the most frequent complaints and grievances to identify opportunities for improvement.
- Continue referring member complaints against providers that require immediate intervention to the manager of provider services for resolution.

MEMBER SATISFACTION SURVEY (CAHPS®)

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOAL

- Assess and identify opportunities to improve member satisfaction related to services administered by Passport Health Plan.
- Maintain or improve overall satisfaction rates with the Plan, for both adults and children that meet or exceed NCQA's 90th percentile.

MEASUREMENTS

Member satisfaction is measured through CAHPS® Member Satisfaction Survey for both adults and children.

CAHPS® Measure	2007	2008	2009	2009 Quality Compass® Mean	2009 Quality Compass® 90th Percentile
Rating of the Health Plan (Adult)	79%	77%	78%	**73%**	80%
Rating of the Health Plan (Child)			86%	Baseline	Baseline
Composite Customer Service (Adult)	89%	79%	84%	**80%**	87%
Composite Customer Service (Child)			83%	Baseline	Baseline
Rating of Personal Doctor (Adult)	76%	76%	80%	**76%**	82%
Rating of Personal Doctor (Child)			80%	Baseline	Baseline
Rating of Specialist (Adult)	79%	80%	79%	**76%**	81%
Rating of Specialist (Child)			83%	Baseline	Baseline
Composite How Well Doctors Communicate (Adult)	87%	83%	87%	**87%**	91%
Composite How Well Doctors Communicate (Child)			87%	Baseline	Baseline
Composite Getting Needed Care (Adult)	84%	84%	80%	**76%**	82%
Composite Getting Needed Care (Child)			85%	Baseline	Baseline
Composite Getting Care Quickly (Adult)	84%	83%	83%	**80%**	86%
Composite Getting Care Quickly (Child)			90%	Baseline	Baseline
Composite Shared Decision Making (Adult)	89%	87%	90%	**59%**	**64%**
Rating of Health Care (Adult)	70%	68%	73%	**68%**	74%
Rating of Health Care (Child)			78%	Baseline	Baseline

FINDINGS

Of the nine areas assessed by the adult satisfaction survey, six measures demonstrated improvement, with Customer Service and Health Care increasing by 5 percentage points each when compared to 2008 results. All Adult measures met or exceeded the 2009 Quality Compass® Mean. The child survey has been revised in its entirety and all measures have reverted to baseline. A comprehensive analysis of all CAHPS® results has been conducted, reviewed and approved by the Quality Medical Management Committee (QMMC).

BARRIERS

No barriers are identified at this time.

OPPORTUNITIES

- Increase member awareness of the Plan's benefits, mission, and programs by:
    - Revising approach to welcome calls, speaking to members within one week of coming onto the Plan with an explanation of benefits.
    - Updated greeting on Member Services 800 line to include message from Executive Director and mission statement.
    - Updated Member Services 800 line phone prompts to allow movement with ease throughout the phone system.
    - Educating members and Member Service staff on prior authorization processes and time frames.
    - Educating members on urgent care appointments versus non-urgent care appointments.
- Increase members understanding of name brand drugs versus generic drugs.
- Inform members that they do have choices concerning their treatment and that they need to discuss these with their PCP.
- Increase collaboration among Department for Medicaid Services (DMS), EDS (Kentucky Medicaid Management Information System), and PHP to resolve issues affecting member eligibility.
- Increase provider awareness of the Plan's pharmacy prior authorization process and develop proactive communication regarding changes to the Plan's pharmacy formulary.
- Improve members' experiences with the Plan's customer service area by:
    - Developing departmental consistency review process to evaluate consistency among representatives and identify training opportunities.
    - Increasing member call monitoring to ensure correct information is being provided along with coaching.
    - Implementing a member survey to monitor satisfaction with service received by Member Services real time.
    - re-designing representatives' script to open call with a warmer greeting and a more interactive approach to engage the member.
    - Removing the automated pharmacy prompt to decrease member steps to reach a representative.
    - Ongoing training efforts designed to develop and refine staff customer service skills and increase staff knowledge on Plan benefits and services.
    - Analyzing and refining responsibilities for two Eligibility Technicians and two Research Technicians who are dedicated to resolving member eligibility issues and grievances.
    - Implementing new processes within Member Services to update member's eligibility when system inconsistencies between the DMS and PHP systems cause service delays.
- Improve members' satisfaction with their personal doctor by:
    - Hosting a practice management seminar centered on improving member satisfaction.

- Monitoring member complaints against PCPs via semi-annual complaint reports and conducting outreach to those providers not meeting Plan standards.
    - Continuing to assess member satisfaction as a component of the PCP Provider Recognition Program and distribute results twice annually.
    - Educating PCPs regarding member satisfaction at every opportunity including, provider workshops, roundtables, site visits, and Plan website.
- Improve member satisfaction with their specialists by:
    - Monitoring member complaints against specialist via semi-annual complaint reports and conducting outreach to those providers not meeting Plan standards.
    - Continuing to assess member satisfaction as a component of the Specialist Provider Recognition Program via telephonic member surveys.
- Improve member satisfaction with how well doctors communicate by:
    - Continuing to assess member satisfaction with doctor communication as a component of the Specialist Provider Recognition Program via telephonic member surveys.
    - Increasing members understanding on what questions to ask their PCP (Good Questions for your Good Health).
- Improve member satisfaction with getting needed care by:
    - Educating members regarding the referral process via the Plan's member website and newsletter articles.
    - Educating members regarding the time-frames related to routine specialist appointment scheduling.
    - Educating member services staff on how to work with members to resolve routine specialist scheduling and make referrals to the Case Management department.
- Assess and monitor appointment access and availability via site visits conducted by provider relations representatives.
- Assess PCP's satisfaction with specialists' availability during provider relations site visits and the Plan's annual practitioner satisfaction survey.
- Improve members' satisfaction with their health care by randomly surveying members telephonically in member services to better understand the members' feelings about their health care and their perceived barriers to care.

PROVIDER SATISFACTION

PROVIDER COMPLAINT TREND

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- Reduce and/or eliminate the top reasons for provider complaints by identifying root causes and implementing interventions to correct.

MEASUREMENTS

Provider complaints trends are measured through the call tracking system quarterly and reported to the Quality of Service Committee and the Quality Medical Management Committee.

Provider Complaint Trends	1st Qtr 2009	2nd Qtr 2009	3rd Qtr 2009	4th Qtr 2009
Payment/denial incorrect	13%	20%	17%	18%
Delay > 30 days/no claims on file	12%	5%	4%	3%
Dissatisfaction with info/service provided	2%	7%	12%	2%
Claim denied for no referral/auth	26%	25%	25%	19%
TPL (subrogation) COB	34%	23%	23%	39%
Provider disagrees with billing policy	13%	20%	19%	19%

FINDINGS

The top three provider complaint categories for 2009, in sequential order, were as follows: “TPL (Subrogation) COB”, “Claim Denied for No Referral or Auth”, and “Provider Disagrees with Billing Policy”. Together these categories accounted for approximately 71 percent of all complaints for the year.
Heavy emphasis was placed on additional training for claims representatives when logging calls pertaining to provider complaints; thereby, attributing to an increase shown in complaint trending. In the 4th quarter of 2009 a more intense look at possible system configuration changes took place, as a means to ascertain ways to reduce claims rework relating to claims denied for no referral or authorization. This review did not negate evaluation of other areas for claims processing improvement.

BARRIER

No barriers are identified at this time.

OPPORTUNITIES

- Continued to use the Opportunity Log report to provide feedback to claims processors in situations where the claim was processed incorrectly or education was needed.
- Continued weekly “First Alert” meetings developed to more closely monitor the timeliness of initial claims payments.
- Continued Rework Collaboration meetings with the Philadelphia Claims unit to reduce the number of claim processing errors.
- Continued multidisciplinary team review of all claims processing rules.
- Ongoing staff training, coaching, and counseling on claims policies and procedures with results included as part of the employee performance evaluation annually.
- Continued provider education of claims billing instructions and guidelines.

PROVIDER SATISFACTION SURVEY

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- To improve services the Plan offers to providers by assessing PCP and high volume practitioners' satisfaction with the Plan.
- Improve the rate of provider satisfaction.

MEASUREMENTS

Provider satisfaction is measured annually via the provider satisfaction survey.

Overall Satisfaction with the Plan	2007	2008	2009
Somewhat to very dissatisfied	18%	10%	4%
Neither satisfied nor dissatisfied	7%	10%	9%
Somewhat to very satisfied	**75%**	**81%**	**87%**
Overall Satisfaction with accuracy of claims payment			
Somewhat to very dissatisfied	18%	14%	7%
Neither satisfied nor dissatisfied	9%	6%	3%
Somewhat to very satisfied	**73%**	**80%**	**90%**
Overall Satisfaction with Timeliness of UM Denial Notifications			
Somewhat to very dissatisfied	22%	9%	7%
Neither satisfied nor dissatisfied	20%	17%	9%
Somewhat to very satisfied	**59%**	**74%**	**84%**
Overall Satisfaction with Ease of Pharmacy Prior Authorization Process			
Somewhat to very dissatisfied	31%	16%	25%
Neither satisfied nor dissatisfied	8%	12%	11%
Somewhat to very satisfied	61%	72%	64%
Overall Ease of Referral Submission Process			
Somewhat to very dissatisfied	7%	3%	7%
Neither satisfied nor dissatisfied	12%	6%	4%
Somewhat to very satisfied	81%	91%	89%
Overall Satisfaction with Availability of Specialists			
Somewhat to very dissatisfied	18%	14%	7%

Neither satisfied nor dissatisfied	9%	6%	3%
Somewhat to very satisfied	73%	80%	90%
Overall Ease of Pharmacy Prior Authorization Process			
Somewhat to very dissatisfied	22%	9%	7%
Neither satisfied nor dissatisfied	20%	17%	9%
Somewhat to very satisfied	59%	74%	84%
Overall Accessibility of Provider Relations Representative			
Somewhat to very dissatisfied	31%	16%	25%
Neither satisfied nor dissatisfied	8%	12%	11%
Somewhat to very satisfied	61%	72%	64%

FINDINGS
Of the 279 surveys distributed, 73 were returned for a response rate of 26 percent. Overall, practitioners' satisfaction improved across most areas of the Plan. The most significant areas of increased satisfaction were accuracy of claims payment and timeliness of Utilization Management denial notifications. Practitioner satisfaction with areas related to pharmacy was identified as opportunities for improvement.

BARRIERS
- No barriers were identified at this time.

OPPORTUNITIES
- Continue provider communication and education.
- Continue adding of iEXCHANGE services.
- Continue maintenance of department standards.
- Continue periodic staff training and education as necessary.

Public Affairs

EVALUATION PERIOD
January 1, 2009 – December 31, 2009

GOALS
- Provide accurate, consistent and timely education and communication to members, providers/practitioners, community partners and the general public.

- Provide education, communication and outreach services that support the achievement of the operational, clinical, administrative, and public relations goals of the health plan.

MEASUREMENTS

N/A

FINDINGS

- Multiple activities occurred throughout the 2009 to meet the goals of the department. The Public Affairs Department developed and executed an extensive campaign to support the Governor's goal to locate and enroll uninsured but eligible children into the Kentucky Children's Health Insurance Program. In addition to convening a Regional KCHIP Coalition, the project included adding 9 contracted positions: Director of the Regional KCHIP Coalition, an administrative assistant, and 7 Enrollment Specialists. The initiative also included an extensive public awareness campaign that included radio and TV ads, public transportation advertisements, a poster series, two press conferences, and a robust community relations strategy. The Plan set a goal of enrolling 3,500 additional children with this initiative; instead, a total of 11,500 children and teens were added to the membership.
- The team also presented its 8th annual professional conference on cultural competency for healthcare providers.
- The first annual Diabetes Conversation Café event in 2009 was attended by more than 100 people. Participants visited clinicians and other professionals who have expertise in a particular dimension of diabetes, such as nutrition and foot care. The event culminated with an inspirational talk from a local news anchor that is a diabetic, a healthy lunch, and give-aways.
- The Communications division completed over 900 various communication projects by providing comprehensive services, including writing, editing, graphic design, creative development, and fulfillment planning.

BARRIERS

No barriers are noted at this time.

OPPORTUNITIES

- Continue to develop new community collaborations to accommodate Enrollment Specialists and support membership growth. This includes increased relationships with area ministries, food pantries, schools, and health departments throughout the service area. These activities are in addition to participating in interagency meetings, health fairs, back to school events, and meetings to support special population groups including grandparents raising grandchildren, the homeless or near homeless, and young pregnant women.
- Continue work in conjunction with agencies that represent and/or work on behalf of members with limited English proficiency and other language barriers, and those with hearing and vision difficulties.
- Continue to coordinate annual Diabetes Conversation Café.
- Continue participation on several boards including the Coalition for the Homeless, Hispanic/Latino Coalition, Regional KCHIP Coalition, Wheatley Elementary/Making Connections, and the Urban League.

- The Public Affairs Web Team continues provider and member web site enhancements to increase access and usability.

Utilization Management

Information related to the Plan's Utilization Management Program can be found in the 2008 UM Program Evaluation and 2009 UM Program Description.

Statutory Requirements

HEALTH OUTCOMES INDICATORS AND GOALS

EVALUATION PERIOD

January 1, 2009 – December 31, 2009

GOALS

- Assess select health outcomes measures developed in collaboration with the IPRO and DMS, identify barriers and implement actions as appropriate.

MEASUREMENT

Health Outcomes Indicators are measured annually through audited HEDIS® results and medical record review.

Measure Number	Description	MY 2006	MY 2007	MY 2008	Goal
1	The percentage of Primary Care Providers who saw adolescents during the measurement year and provided assessment or counseling for physical activity	36.29%	42.18%	Revised	75%
1A	**Revised** - The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and whose medical record contained evidence of documentation of assessment/counseling for physical activity during the measurement year.			36.12% Baseline	38.12%
2	The percentage of Primary Care Providers who saw child and adolescent	46.61%	67.40%	Revised	75%

	members during the measurement year and provided nutritional assessment or counseling and/or referral to qualified nutritionists or dieticians.				
2	**Revised -** The percentage of child and adolescent members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and whose medical record contained evidence of documentation of assessment/counseling for nutrition during the measurement year.			43.79% Baseline	45.79%
3A	The percentage of adult members who had documented height and weight.	62.50%	66.41%	Revised	
3A	**Revised** - The number and percentage of members 18-74 years of age who had an outpatient visit and whose medical record contained evidence of documentation of height and weight. REPORTING ONLY.			72.50% Baseline	Report Only
3B	The percentage of adult members with documented height and weight that had appropriate weight for height.	15.84%	12.26%	Revised	50%
3B	**Revised** – The number and percentage of members 18-74 years of age who had an outpatient visit and whose medical record contained evidence of documentation of a BMI during the measurement year or the year prior to the measurement year.			30.25% Baseline	32.25%
3B	**Revised** - The number and percentage of members 18-74 years of age who had an outpatient visit with healthy weight for height during the			21.03% Baseline	Report Only

	measurement year or the year prior to the measurement year as identified by medical record review. REPORTING ONLY.				
4	The percentage of Primary Care Providers who saw adults during the measurement year and provided an assessment of counseling for physical activity.	28.10%	23.72%	Revised	75%
4	**Revised** - The number and percentage of members 18-74 years of age who had an outpatient visit and whose medical record contained evidence of documentation of assessment/counseling for physical activity during the measurement year or the year prior to the measurement year.			19.75% Baseline	21.75%
5	The percentage of Primary Care Providers who provide adult member's nutritional assessment and/or counseling and/or referral to qualified nutritionists or dieticians.	19.71%	31.26%	Revised	75%
5	**Revised** - The number and percentage of members 18-74 years of age who had an outpatient visit and whose medical record contained evidence of documentation of assessment/counseling for nutrition during the measurement year or the year prior to the measurement year.			17.75% Baseline	19.75%
6A	The percentage of Child and Adolescent members who had documented height and weight.	84.43%	80.10%	Revised	81.43%
6A	**Revised** – The percentage of child and adolescent members 3-17 years of age			87.76% Baseline	Report Only

	who had an outpatient visit with a PCP or OB/GYN and who had documentation of both a height and weight documented on the same date of service during the measurement year. REPORTING ONLY.				
6B	The percentage of Adolescent members with documented height and weight that had appropriate weight and height.	75.00%	66.54%	Revised	68.21%
6B	**Revised** - The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and whose medical record contained evidence of documentation of a BMI percentile or a BMI percentile plotted on an age-growth chart during the measurement year. (Note: For adolescents 16-17 years on the date of service, documentation of a BMI value is acceptable.)			18.28% Baseline	20.28%
6B	**Revised -** The percentage of child and adolescent members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN, with healthy weight for height during the measurement year as identified by medical record review. REPORTING ONLY.			44.59% Baseline	Report Only
7A	The percentage of Primary Care Providers who saw children for an office visit during the measurement year and conducted an anemia screening between eight to thirteen months of age.	76.96%	70.59%	**Retired**	
7B	The percentage of children between eight and thirteen	11.15%	13.58%	**Retired**	

	months of age who were tested and who meet the parameters for anemia.				
7C	The percentage of Primary Care Providers whose members were identified with abnormal Hgb and Hct who counseled parents/caregivers and/or referred these members for further evaluation.	40.00%	61.36%	**Retired**	
8	The percentage of the Plan's pregnant population who delivered during the measurement year and received prenatal vitamins.	54.60%	39.98%	Revised	31.98%
8	**Revised** - The percentage of pregnant members who delivered between November 6 of the year prior to the measurement year and November 5 of the measurement year who received vitamin supplementation during the prenatal period.			57.50% Baseline	59.50%
9A	The percentage of pregnant members who delivered between November 6 of the year prior to the measurement year and November 5 of the measurement year who received assessment and education/ counseling regarding alcohol use during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO, as documented in the medical record.			67.96% Baseline	69.63%
9B	The percentage of pregnant members who delivered between November 6 of the year prior to the measurement year and November 5 of the			66.99% Baseline	68.66%

	measurement year who received assessment and education/ counseling regarding drug abuse during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO, as documented in the medical record.				
9C	The percentage of pregnant members who delivered between November 6 of the year prior to the measurement year and November 5 of the measurement year who received assessment and education/ counseling regarding nutrition during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO, as documented in the medical record.			64.32% Baseline	65.99%
9D	The percentage of pregnant members who delivered between November 6 of the year prior to the measurement year and November 5 of the measurement year who received assessment and education/ counseling regarding OTC/ prescription medication during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO, as documented in the medical record.			71.12% Baseline	72.79%
9E	The percentage of pregnant members who delivered between November 6 of the year prior to the measurement year and			60.92% Baseline	62.59%

	November 5 of the measurement year who received assessment and education/ counseling regarding domestic violence during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO, as documented in the medical record.				
9F	The percentage of pregnant members who delivered between November 6 of the year prior to the measurement year and November 5 of the measurement year who received assessment and education/ counseling regarding smoking cessation during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO, as documented in the medical record. (NOTE: Numerator includes non-numerator positives for those who were noted as NA for smoking based on documentation in the medical record.[189])			82.28% Baseline	83.61%
10A	The percentage of adolescents 12-17 years of age who had a well care/preventive visit in measurement year and received preventive screening/counseling regarding tobacco.			51.52% Pilot	53.52%
10B	The percentage of adolescents 12-17 years of age who had a well care/preventive visit in measurement year and received preventive			44.44% Pilot	46.44%

	screening/counseling regarding alcohol/substances.				
10C	The percentage of adolescents 12-17 years of age who had a well care/preventive visit in measurement year and received preventive screening/counseling regarding sexual activity.			38.38% Pilot	40.38%
10D	The percentage of adolescents 12-17 years of age who had a well care/preventive visit in measurement year and received preventive screening/counseling regarding mental health assessment/screening.			26.26% Pilot	28.26%
11	The percentage of children 4-18 years of age who had a hearing assessment with an EPSDT provider during the measurement period. (TOTAL)			37.24% Pilot	39.24%
12	The percentage of children 4-18 years of age who had a vision assessment with an EPSDT provider during the measurement period. (TOTAL)			40.53% Pilot	42.53%

FINDINGS

The goal of the workgroup, comprised of PHP staff, DMS staff and IPRO staff, was to develop a new set of measures that are clinically sound, consistent with Healthy Kentuckians goals, and that complement the Plan's quality improvement goals. The workgroup selected the measures, developed indicator specification, and determined which measures were to be pilot, baseline, or on-going measurements for the reporting year 2009 (2008 data). All results are baseline and goals for 2010 were set utilizing NCQA®'s measure for significant improvement.

BARRIERS

- Providers are not consistently utilizing tools to measure Body Mass Index (BMI).

- Provider lack of compliance with the clinical practice guidelines related to child and adolescent and adult preventive health.
- Difficulty accurately recording prenatal vitamins as often members are given samples or recommended to take over the counter children's chewable vitamins. These two scenarios would not reflect prenatal vitamins in the administrative data.

OPPORTUNITIES

- Provide BMI measurement tools for both child/adolescent and adults, reading a food label, and the food pyramid on the provider website.
- Develop a Clinical Practice Guideline specific to BMI's for both child/adolescent and adult.
- Community collaboration on obesity and nutrition for children.

2009 NCQA ACCREDITATION STATUS

Passport Health Plan achieved the following accreditation score based on HEDIS® 2009:

Standards 64.3000
HEDIS® 33.3292
Total Score 97.6292 (Excellence rating)

PERFORMANCE IMPROVEMENT PROJECTS (PIP)

Performance improvement projects are determined in collaboration with the Department for Medicaid Services, Passport Health Plan, and the IPRO.
PIP's include:

- 2006 Sickle Cell - complete 2009
- 2006 Women's Health – complete 2009
- 2007 EPSDT Participation – complete 1st Qtr 2010
- 2008 Perinatal Screening and Counseling – 2nd Remeasurement 2010
- 2009 Smoking Cessation – Baseline
- 2010 Obesity in Children – Baseline

An update on the progress of each PIP is reported quarterly. Annually, a performance improvement project report for each selected PIP is completed by the Plan and submitted by September first to DMS and IPRO for review and recommendations.

Program Impact

The 2009 QI Program was considered to be effective in that the Plan achieved all of its QI Program Objectives. Improvements were noted in both clinical and service activities.

Specific achievements included:

- Ranked as the 13th best Medicaid health plan in the Country by US News and World Report and the National Committee for Quality Assurance (NCQA), maintaining a top 25 health plan status five years in a row.
- Maintained an NCQA excellence accreditation for the 8th year in a row.

- Hosted visit by NCQA related to UHC as a model of a successful Accountable Care Organization.
- Administered the third full year of the Plan's Provider Recognition Program aimed at improving member satisfaction and increasing overall health outcome scores.
- Improved EPSDT screening rate to 95 percent.
- Executed KCHIP awareness campaign and assumed responsibility for coordinating coalition activities. Enrolled over 10,000 additional children in Medicaid or CHIP.
- Enhanced member satisfaction by reducing unnecessary member ID card generation by 5%
- Developed Intensive Case Management/High Utilizer Program
- Implemented interventions for 100 percent of clinical, safety, and service activities as identified and documented in the QI work plan.
- Revised and distributed clinical and preventive health practice guidelines as appropriate.
- Expanded outreach activities to better meet the cultural, ethnic, racial, and linguistic needs of the membership including hosting the annual "Achieving Cultural and Linguistic Competency in Healthcare Conference".
- Expanded the function of the credentialing department by assuming primary verification credentialing processes internally.

Recommendations for 2010

Areas of the QI Program not yet meeting goals were also analyzed and activities directed towards identified barriers have been integrated in the 2009 QI Work Plan. In addition, all activities previously included in the 2008 QI Work Plan will continue in 2009 as appropriate.

Targeted areas of focus for 2009 will include:

- Developing new strategies to improve member and provider satisfaction.
- Increasing health outcome scores not yet at the 90th percentile benchmark for Medicaid plans.
- Continuing process improvements for core business processes such as PCP auto-assignment and use of robot functions for claims auto-adjudication.
- Collaborating with the DMS to improve shared accountabilities such as receipt and loading of member eligibility and TPL files and approval processes for provider participation in Medicaid.
- Maintain national ranking by further improvement in HEDIS® and CAHPS results
- Continue KCHIP outreach and enrollment program to build membership
- Assess medical management effectiveness and identify opportunities for process improvement
- Enhance configuration and testing capabilities to assure accurate provider contract administration

Acknowledgements and Approval

This Quality Improvement Program Evaluation is submitted by:

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Terry Watson, AVP, Quality Improvement Date

Approvals:

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Jacqueline Simmons, MD, MPH, Chief Medical Officer Date

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David Stanley, Interim Executive Director, Chief Financial Officer Date

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Bill Wagner, Chairman, Partnership Council Date

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Larry Cook, M.D., President of the Board, University Health Care Date