

# Health Plan of San Mateo Quality Assessment and Improvement Program Evaluation for 2008 Activities

This program evaluation incorporates results from quality activities carried out in 2008. It should be noted that, based on the HEDIS data collection and reporting schedule, HEDIS results discussed below are of services provided in 2007, which were then collected and analyzed in 2008.

## **QUALITY ASSESSMENT AND IMPROVEMENT PROGRAM EVALUATION OVERVIEW**

The purpose of the Quality Assessment and Improvement Program (QAIP) is to develop and implement a strategy to continuously improve the overall quality of care for Health Plan of San Mateo (HPSM) members who are enrolled in the Medi-Cal, CareAdvantage, Healthy Families, HealthWorx, and Healthy Kids program product lines, and for participants in the San Mateo Access to Care for Everyone (ACE) program. The purpose of the program evaluation is to assess the current status of quality activities and determine the need for program changes to improve performance.

Factors considered in both the development of the QAIP and evaluation include:

- Access to high quality medical care
- Disease prevention and health education
- Effective and efficient use of health care resources
- Organizational commitment to the mission of the health plan
- Continuous evaluation and improvement of member and provider services

HPSM monitors and evaluates care and services using studies and reports that include review of clinical and non-clinical services. Quality studies and monitoring activities are reported on a quarterly basis to the San Mateo Health Commission (SMHC), HPSM's governing body.

This report is a retrospective look at the Quality Assessment and Improvement (QAI) activities performed in 2008 based on the HPSM Quality Assessment and Improvement Plan and the QI Work Plan for 2008. It also outlines areas of focus for 2009.

## **PROVIDER SERVICES—CREDENTIALING AND ACCESS**

In 2008, Provider Services staff reviewed and credentialed/recredentialed 65 new providers for HPSM's physician network. These included:

| <b>Primary Care Providers</b> | <b>Credentialed—New</b> | <b>Recredentialed</b> |
|-------------------------------|-------------------------|-----------------------|
| Pediatrics                    | 2                       | 0                     |
| Family Practice*              | 7                       | 0                     |
| Internal Medicine             | 3                       | 0                     |
| General Practice              | 0                       | 0                     |

| <b>Specialty Providers</b> | <b>Credentialed—New</b> | <b>Recredentialed</b> |
|----------------------------|-------------------------|-----------------------|
| Anesthesiology             | 13                      | 0                     |
| Cardiovascular Disease     | 1                       | 0                     |
| Dermatology                | 1                       | 0                     |
| Emergency Medicine         | 0                       | 0                     |
| Endocrinology              | 0                       | 0                     |
| Gastroenterology           | 2                       | 0                     |
| Nephrology                 | 0                       | 0                     |
| Neurology                  | 0                       | 0                     |
| Obstetrics and Gynecology  | 3                       | 0                     |
| Ophthalmology              | 2                       | 0                     |
| Otolaryngology             | 1                       | 0                     |
| Pathology                  | 0                       | 0                     |
| Pediatric Oncology         | 0                       | 0                     |
| Physical Therapy           | 1                       | 0                     |
| Plastic Surgery            | 1                       | 0                     |
| Pulmonary Disease          | 0                       | 0                     |
| Radiology – Diagnostic     | 6                       | 0                     |
| Rheumatology               | 1                       | 0                     |
| Surgery - Cardiothoracic   | 1                       | 0                     |
| Surgery – General          | 1                       | 0                     |
| Surgery – Neurological     | 0                       | 0                     |
| Surgery – Orthopedic       | 4                       | 0                     |
| Surgery – Thoracic         | 0                       | 0                     |
| Urology                    | 2                       | 0                     |

| <b>Specialists – Other</b> | <b>Credentialed--New</b> | <b>Recredentialed</b> |
|----------------------------|--------------------------|-----------------------|
| Acupuncture                | 2                        | 0                     |
| Chiropractic               | 0                        | 0                     |
| DME                        | 8                        | 0                     |
| Podiatry                   | 1                        | 0                     |
| Optometry                  | 1                        | 0                     |
| Other                      | 2                        | 0                     |

\* Physicians practicing under the Planned Parenthood group

Another 90 specialty providers were added who practice with Palo Alto Medical Foundation, Stanford/LPCH and SMMC.

During 2008, 5 primary care providers retired or terminated from HPSM's network. Since these providers practiced outside of San Mateo County, access concerns did not arise.

To address access concerns in South County for HPSM's pediatric and ob-gyn population, headway has been made in recruitment of Kaiser as a specialty provider for OB, with the children of the mothers who deliver at Kaiser Redwood City becoming Kaiser Redwood City patients, having Kaiser Redwood City as their PCP. This contract should be executed in early 2009.

In addition, to improve South County access, a large practice provider, Palo Alto Medical Foundation, which had been EPO for years, is becoming open to new patients on a limited basis. This contract update was executed in late 2008.

It should be noted that due to changes in the Credentialing Specialist position, there was no recredentialing performed in 2008. This resulted in a lower total number of physicians that were reviewed and credentialed/recruited in 2008 (65) as compared to the previous year (153 new and 43 continuing physicians). Recredentialing will resume in January 2009.

| <b>Physicians Credentialed/Recruited in 2007 vs. 2008</b> |             |             |
|---|-------------|-------------|
|   | <b>2007</b> | <b>2008</b> |
| <b>Newly Credentialed</b>                                 | 153         | 65          |
| <b>Recruited</b>  | 43          | 0           |

Note: See text above for explanation of the difference from 2007 to 2008.

## **MEMBER SATISFACTION**

### **CareAdvantage Survey**

In 2008, a Care Advantage member survey that included questions about member satisfaction with HPSM activities was carried out. A survey was mailed to CareAdvantage members who were continuously enrolled in CareAdvantage from January 2008 through July 2008. Surveys were sent to members in their preferred language; however if a member's language was unknown they were excluded from the survey. The total number of members surveyed was 6,021 and 1,492 members (24.8%) completed and returned the survey. Members were asked about their satisfaction with the customer service they receive at HPSM, their satisfaction with filling their medications, how they feel about information they receive from HPSM, and what type of health topics and benefits they would like.

### **Customer Service**

The majority of respondents (78%) rated customer service as excellent or very good and only 8% rated it fair or poor. Fourteen percent of survey respondents (14%) who had filled a prescription within the last six months had a problem getting their medicine. Many stated

that they had had a problem with a delay in their doctor's approval and drugs that are not covered.

### **Getting Health Information**

Members were asked about the difficulty in accessing written materials and information from HPSM. Only 13% of the respondents found it hard to understand the information from HPSM. Further analyses between different language groups found a higher percentage of Russian speaking respondents (30%) had a hard time understanding information than other groups (23% for Spanish, 21% for Chinese, and 2% for Tagalog speaking). About 20% of the respondents would like to receive written information in a different format, and among them over 83% would like the information in a large print format.

### **Linguistic Services**

Members were asked who they use as an interpreter when their doctor does not speak their language. Thirty-four percent (34%) responded "my child" (over 18) and a significant number (24%) percent responded "no one." Only 36% of respondents indicated that they knew that HPSM provides free telephone interpreter services for doctor's visits.

### **Health Topics and Benefits**

Members were asked about preferred health topics they would like to learn about, the format in which they would prefer to learn about them and the type of benefits they would like in 2009. Most of the health topics that respondents are interested in learning are healthy aging or chronic disease related. The majority of respondents preferred to learn about health topics through mailed information (63%), followed by getting information at their doctor's office (45.6%). The top five benefits that respondents would like CareAdvantage to provide are related to dental, prescription drug, transportation, vision and alternative medicine.

The survey findings provided HPSM with valuable information on how to better serve the CareAdvantage membership.

### **Health Matters Survey**

In fall 2008, 20,000 member satisfaction surveys were randomly inserted in our member newsletter *Health Matters*. We received 102 responses (47 English, 54 Spanish). Despite the low response rate, which is typical of these types of surveys, the responses are very helpful in planning for future issues. Overall, our members found the information in the newsletter very useful. As a result of reading *Health Matters*, the majority stated that they had made a healthy behavior change (82%), made a doctor's appointment (75%), and/or signed up for a health education class (22%). When asked what health topics they would like to read about in the future, many indicated healthy eating, nutrition, diabetes, exercise, children's health, heart/age related conditions, and women's health. An article on these topics had been included in one of our issues in 2008. We will continue to include additional articles in 2009. A couple of members listed other topics including insomnia, osteoporosis, and anemia, which will we also try to include in 2009.

## **PRIMARY CARE AND SPECIALTY APPOINTMENT WAITING TIMES**

### **Primary Care Review**

According to HPSM's DHCS Medi-Cal contract, routine visits for new patients should be available within four weeks from the time of their call. To validate how well HPSM physicians meet this standard, the QAI Department carried out a "secret shopper" telephone survey of primary care physicians (PCPs) who are accepting new patients.

### **Methodology**

Quality Department staff were trained to act as new members for either the Medi-Cal or CareAdvantage line of business for HPSM, and given a script as an outline for calls to provider offices accepting new patients. They were guided to act as themselves (when calling for an adult appointment) or as a parent of a child or teen (if making a pediatric appointment). They were also guided to act as an adult child if they were making an appointment for a CareAdvantage member who is an older adult, or could act as himself or herself. Since a number of the staff are bilingual, they were also asked to make some calls in a language other than English, to check language access as well. All the calls were made between August 14, 2008 and August 31, 2008.

### **Summary of Findings**

Overall, the access to primary care providers for HPSM members meets the recommended guidelines of less than four weeks for routine physical exams from the time of patient contact in most areas of the county, for all patient ages. This is principally because of HPSM's abundance of private primary care providers who belong to the plan provider network.

A total of 78 primary care providers (groups, clinics and solo practitioners) were identified as accepting new patients, and thus could be called as part of the Secret Shopper project. Of these, 16 practices are not included in the data analysis for the following reasons:

- 9 practice sites were no longer accepting new HPSM members so the callers' lists had to be updated
- 4 providers could not be reached, even though the callers attempted to reach them multiple times
- 3 providers could only be contacted via answering machines, which made it difficult to reach them via the Secret Shopper methodology

### **Overall Waiting Time for Routine Appointments**

62 providers are included in the data analyzed. As seen in Table 1 below, fifty-two percent (52%) of the plan's primary care practitioners not only met the "less than or equal to four weeks" standard, but were able to make routine appointments for HPSM members within a

week or less (many within the next day or two). Twenty-four percent (24%) could see the new members within two weeks, and another eight percent (8%) could see the members within three or four weeks, yielding a total of 84% of HPSM primary care providers who met the recommended standard of routine visits within four weeks from the time of patient contact. Thirteen percent (13%) of the remainder would be able to see the members within six to eight weeks. The final two offices (San Mateo Medical Center clinics) could not give scheduled appointment times, but stated that members needed to call back at specific times (first of the month, or 8 am) to get an appointment. They are listed as “other” below.

Table 1. Overall Waiting Time for Routine Appointments

| ≤ One Week | Two weeks | Three to Four Weeks | Six to Eight Weeks |
|------------|-----------|---------------------|--------------------|
| 32 (52%)   | 15 (24%)  | 5 (8%)              | 8 (13%)            |

Other: 2 (3%) - see narration above

### Waiting Time by Provider Type

Table 2 shows the breakdown of access by provider type. Eighty percent (80%) of internal medicine practitioners are able to see their new patients for routine visits within four weeks or less. Forty percent (40%) do so within one week or shorter. Eighty percent (80%) of pediatric providers are able to see their pediatric patients for routine physicals in four weeks or less, and fifty-three percent (53%) can do so in one week or less.

It is noteworthy that, of the 62 providers contacted, 20 are multi-specialty clinics or family practitioners, able to see both adults and children. Of these 20, one hundred percent (100%) are able to see new patients within four weeks or less, and 14 (70%) are able to see them within one week or less. These providers are a key component of the access available to HPSM members.

Table 2. Waiting Time for Routine Appointments by Provider Type

| Waiting time<br>Prov. Type | ≤ One Week | Two weeks | Three to Four Weeks | Six to Eight Weeks | Total |
|----------------------------|------------|-----------|---------------------|--------------------|-------|
| Adult Medicine             | 10         | 9         | 1                   | 5                  | 25    |
| Pediatrics                 | 8          | 3         | 1                   | 3                  | 15    |
| Family Practice/Clinics    | 14         | 3         | 3                   | 0                  | 20    |
| Total                      | 32         | 15        | 5                   | 8                  | 60    |

Other: 2 - see narration above

A number of providers' offices who did not meet the four week standard or barely met it apologized to the callers for the wait and stated that they would have been able to see them earlier except that they were in the midst of performing school physicals, and after September would be able to see new members within two or three weeks. These were generally solo practitioners.

### Waiting Time by Region of County

Table 3 shows the breakdown of access approximated by region of San Mateo County. This is a qualitative description based purely on a provider's physical location. It is not adjusted by number of members in a region, number of providers already EPO (established patient only) in an area, etc. It only attempts to give a broad-brush view of potential capacity in various county regions.

Table 3. Waiting Time for Routine Appointments by County Region

| Waiting time<br>Co. Region                     | ≤ One Week | Two weeks | Three to Four Weeks | Six to Eight Weeks | Total |
|--|------------|-----------|---------------------|--------------------|-------|
| North (including border of SF)                 | 23         | 11        | 3                   | 3                  | 40    |
| Mid-county                                     | 4          | 0         | 2                   | 2                  | 8     |
| Coastside                                      | 2          | 1         | 0                   | 0                  | 3     |
| South County (including border of Santa Clara) | 3          | 3         | 0                   | 3                  | 9     |
| Total  | 32         | 15        | 5                   | 8                  | 60    |

Note: All provider types have been combined here since no substantial difference was shown by provider type in Table 2.

As is known about the HPSM provider network, the most capacity exists in our North County area, where sixty-six percent (66%) of the primary care providers who are accepting new patients practice. Also, it is where there is the most capacity. Ninety-two percent (92%) of the providers in North County have capacity to see new members within the four week or less standard, and fifty-seven percent (57%) are able to see them within one week or less.

In Mid County, there are only 8 providers (13%) who could be contacted who are accepting new members. Fortunately, seventy-five percent of them are able to see new members within the four week or less standard, and fifty percent (50%) can do so within one week or less. In addition, many of the North County providers are in close proximity to members who live in the Mid County region, so they can also serve this member population.

On the Coastside, only four providers are identified who serve our members as primary care physicians; one was one of the “answering machine” physicians, and was not able to be included in the Secret Shopper methodology. Interestingly, in spite of the low number of providers in this somewhat geographically isolated region of the county, members can be seen quite rapidly. All the providers contacted could see new HPSM members within two weeks or less. One of these three providers is a family practitioner, and the other is a multi-specialty clinic.

In the South County area, a limited number of providers who see new HPSM members are also noted. In the South County, the Secret Shopper project demonstrated the largest percentage of providers compared to the total with appointment waiting times of six to eight weeks (one third). Some of this was likely due to school physicals, as the outliers included a large solo pediatric provider and a busy pediatrics clinic. Further, some of the South County providers do appear to have capacity for new members. Of the total South County providers, sixty-six percent (66%) met the four weeks of less standard, and all of these did so by reporting that they could see patients within two weeks or less. Unlike the North County region, the South County is much larger, and as some of these providers are located in north Santa Clara County, there is a distance factor that could mitigate the impact of this capacity that might not be reflected in the numbers seen. Nevertheless, one of the providers here is a multi-specialty clinic that serves all ages, and another is a relatively new HPSM provider. Both these providers appear to be good options for HPSM members, as they both reported to the Secret Shopper callers that they could see new members within one to two weeks.

### **San Mateo Medical Center Clinics**

Overall, there was improvement in the performance of San Mateo Medical Center clinics in this year’s Secret Shopper project compared to last year. Only one clinic could not be reached despite multiple phone call attempts. This is a significant change from last year when only one clinic could be reached by phone. In addition, although the overall clinic waiting times were outside the four weeks or less standard, and no clinic gave appointment times that met this standard, the waiting times were less this year (six to eight weeks) than they were last year for routine preventive appointments (which ranged from three to four months to “who knows?” last year).

### **OB-Gyn Care**

The same methodology was followed as for PCPs to evaluate access for Obstetrics care as well. The following table demonstrates findings for HPSM Medi-Cal OB providers:

| Region                   | Number of Active Practices | Time until Appt (average or range) | Comment                              |
|--------------------------|----------------------------|------------------------------------|--------------------------------------|
| SF Border                | 4                          | 3 days to 10 days                  |                                      |
| North                    | 2                          | 3 days, 3 weeks                    | 1 indep practice and 1 via Seton NLC |
| Coastside                | 0 (OB on call)             | TBD by MD on call                  |                                      |
| Mid-county               | 4                          | 2 d, 10 d, 4-5 wks                 | SMMC = 4 wks                         |
| South/Santa Clara Border | 7                          | 2 d, 7-10d, 2 N/As                 | 2 N/As: Ans machine/on hold          |

The results show that HPSM members have a number of OB providers to choose from, covering all regions of the county, with the exception of Coastside, where there is no active OB practice, and no labor and delivery service. There are no obvious delays in obtaining a new first appointment. However, Providers Services is aware that there are still many community OB providers who are not willing to accept Medi-Cal members, so we continue to strategize with Senior Managers about how best to address this issue.

### **Specialty Care Review**

HPSM has determined that routine visits for members to see a specialist for a longstanding problem that is not worsening should occur no later than 100 days after referral. This is the longest that any member should have to wait. Target times are, of course, shorter. However, if a member's condition became more urgent (e.g. started to worsen, become painful, interfering with function, etc), then waiting times would need to be determined on a case-by-case basis as determined by the medical necessity of the patient's clinical condition.

In 2008, a specialty provider "secret shopper" telephone survey was conducted. Due to the number of specialists in the HPSM provider network, one half of the specialists were selected randomly for contact, with the other half to be completed in 2009.

In 2008, the specialties reviewed included: Cardiology, Ophthalmology, Orthopedics and Pulmonology.

### **Methodology**

Quality staff received permission from an HPSM primary care provider to pose as her office staff, and called with prepared case scenarios. They then called the offices of the providers of each selected specialty accepting new Medi-Cal or CareAdvantage patients, asking how long it would take to make an appointment for the patient. This information was noted, to determine care access.

## Results

The following tables describe access for each of the specialties reviewed for 2008:

(Note—number is the number of practices, including solo practitioners, groups or clinics.)

### Cardiology

| Region        | Number | Number CA Only | Time to Appt                 |
|---------------|--------|----------------|------------------------------|
| San Francisco | 3      | 1              | 1-2 days                     |
| North         | 5      | 3              | 1-2 days to 2 wks            |
| Mid-county    | 3      | 2              | 1day, 1-2 wks                |
| Palo Alto     | 2      | 1              | 3-4 wks (CA)<br>4-5 wks (MC) |

### Ophthalmology

| Region                                   | Number | Number CA Only | Time to Appt        |
|--|--------|----------------|---------------------|
| San Francisco                            | 7      | 3              | 2-3 weeks           |
| North                                    | 5      | 3              | 1-3 wks<br>(1=5wks) |
| Mid-county                               | 2      | 1              | 1 d, 1 wk           |
| South (San Carlos to Santa Clara border) | 9      | 4              | 1-3 wks             |

### Orthopedics

| Region        | Number | Number CA Only | Time to Appt                         |
|---------------|--------|----------------|--------------------------------------|
| San Francisco | 1      | 1              | Depends on pt condition              |
| North         | 3      | 3              | 3 days to 3 wks depending on pt      |
| Mid-County    | 1      | 1              | On vacation; sees MC pts at SMMC     |
| Palo Alto     | 1      | 0              | Send x-ray and referral to determine |

## Pulmonary

| Region                                   | Number | Number CA Only | Time to Appt                |
|--|--------|----------------|-----------------------------|
| San Francisco                            | 1      | 1              | 6 weeks                     |
| Mid-County                               | 2      | 1              | 2 days, 2 weeks             |
| South (San Carlos to Santa Clara border) | 3      | 1              | 3 days, 3 weeks, 1-2 months |

These results demonstrate:

**Cardiology:** There is no serious delay in access noted; while it would be optimal if the number of providers for Medi-Cal members could increase, overall it appears that members are getting seen in an appropriate time (though South and Coastside members need to travel a bit to get to a specialist).

**Ophthalmology:** There is sufficient access to all areas (except Coastside) with minimal waiting.

**Orthopedics:** This is an area of great need, especially for HPSM Medi-Cal members. At present, there is only one provider in Palo Alto, and SMMC available. In addition, there are a number of private orthopedists in the community who are not HPSM providers. Thus, for 2009, the Quality Department will work with Provider Services and Senior Management to strategize how best to carry out further outreach to this group which is often difficult to attract to public health plans.

**Pulmonary:** This is another area of great need, especially for HPSM Medi-Cal members. In general, pulmonary diseases that need specialty consultation are less common than orthopedic ones. However, these may increase as the population ages. In addition, while there are fewer private pulmonologists in the community than other more common specialist (e.g. orthopedists), any who are not HPSM providers need further outreach.

All the Secret Shopper results, will continue to be evaluated by the QAI program with Provider Services to see where ongoing improvements are needed in our provider networks.

## EVALUATION OF HEDIS 2008 DATA COLLECTION AND REPORTING

Each year, HPSM performs a number of standardized study sets mandated by HPSM's Healthy Families, CareAdvantage and Medi-Cal contracts. We also report Healthy Kids data following the Healthy Families measures that are required. These studies are performed using NCQA and national HEDIS guidelines. This report summarizes the results from 2007 studies that were collected and reported in 2008, and compares them to results from prior years.

## What is HEDIS®?

The Healthcare Effectiveness Data and Information Set, or HEDIS, is a set of standardized performance measures designed to ensure that purchasers and consumers of health care services have the information they need to reliably compare the performance of managed health care plans. The technical specifications for calculating HEDIS measures specify criteria for selecting the population to be included as well as a definition of what constitutes a positive result. The methodology and results used in each study are audited by a “certified HEDIS auditing firm” to ensure that they meet the prescribed technical specifications.

## Which HEDIS Measures Do We Use?

The Health Plan of San Mateo collected HEDIS measures in 2008 based on the Care Advantage, Medi-Cal, Healthy Kids and Healthy Families population of enrollees. Table 1 shows the HEDIS studies performed for each product line.

**Table 1: HEDIS Measures Collected and Reported by HPSM During 2008**

| Measure  | Care Advantage | Medicaid | Healthy Families /Healthy Kids |
|--|----------------|----------|--------------------------------|
| Childhood Immunization Status  |                | H        | H                              |
| Appropriate Treatment for Children With Upper Respiratory Infections   |                | A        | A                              |
| Appropriate Testing for Children with Pharyngitis                      |                |          | A                              |
| Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis      |                | A        |                                |
| Colorectal Cancer Screening  | H              |          |                                |
| Breast Cancer Screening  | A              | A        |                                |
| Cervical Cancer Screening  |                | H        |                                |
| Chlamydia Screening in Women   |                |          | A                              |
| Osteoporosis Management in Women Who Had a Fracture                    | A              |          |                                |
| Controlling High Blood Pressure  | H              |          |                                |
| Persistence of Beta-Blocker Treatment After a Heart Attack             | A              |          |                                |
| Cholesterol Management for Patients With Cardiovascular Conditions     | H              |          |                                |
| Comprehensive Diabetes Care*   | H              | H        |                                |
| Use of Appropriate Medications for People With Asthma                  |                | A        | A                              |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD      | A              |          |                                |
| Pharmacotherapy Management of COPD Exacerbation                        | A              |          |                                |
| Follow-Up After Hospitalization for Mental Illness                     | A              |          | A                              |
| Antidepressant Medication Management                                   | A              |          |                                |
| Glaucoma Screening in Older Adults                                     | A              |          |                                |
| Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis | A              |          |                                |
| Annual Monitoring for Patients on Persistent Medications               | A              |          |                                |
| Use of High Risk Drugs in the Elderly                                  | A              |          |                                |
| Potentially Harmful Drug Disease Interactions in the Elderly           | A              |          |                                |

**Table 1: (continued)**

| Measure  | Care Advantage | Medicaid | Healthy Families /Healthy Kids |
|--|----------------|----------|--------------------------------|
| Adults' Access to Preventive/Ambulatory Health Services                  | A              |          |                                |
| Children and Adolescents' Access to Primary Care Practitioners           |                |          | A                              |
| Prenatal and Postpartum Care   |                | H        |                                |
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | A              |          |                                |
| Call Answer Timeliness   | A              |          |                                |
| Call Abandonment   | A              |          |                                |
| Medicare Health Outcomes Survey  | S              |          |                                |
| Years in Business/Total Membership                                       | A              |          |                                |
| Well-Child Visits in the First 15 Months of Life                         |                | H        | H                              |
| Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life             |                | H        | H                              |
| Adolescent Well-Care Visits  |                | H        | H                              |
| Frequency of Selected Procedures   | A              | A        |                                |
| Inpatient Utilization—General Hospital/Acute Care                        | A              | A        |                                |
| Ambulatory Care  | A              | A        |                                |
| Inpatient Utilization—Non-acute Care                                     | A              |          |                                |
| Mental Health Utilization  | A              |          | A                              |
| Identification of Alcohol and Other Drug Services                        | A              |          | A                              |
| Outpatient Drug Utilization  | A              | A        |                                |
| Antibiotic Utilization   | A              |          |                                |
| Relative Resource Use for People With Diabetes                           | A              |          |                                |
| Relative Resource Use for People With Cardiovascular Conditions          | A              |          |                                |
| Relative Resource Use for People With Uncomplicated Hypertension         | A              |          |                                |
| Relative Resource Use for People With COPD                               | A              |          |                                |
| Board Certification  | A              |          |                                |
| Enrollment by Product Line   | A              |          |                                |
| Enrollment by State  | A              |          |                                |
| Language Diversity of Membership   | A              |          |                                |
| Race/Ethnicity Diversity of Membership                                   | A              |          |                                |

A= administrative data only H=hybrid (administrative and chart review) S=survey. Measures with these letters were collected and reported as required by contract.

### How HPSM Conducts HEDIS Studies

HEDIS Studies are selected from a group of measures called “Domains of Care.” Individual HEDIS measures are selected by the Centers for Medicare and Medicaid Services (CMS) for CareAdvantage, the Department of Health Care Services Medical Managed Care Division (DHCS-MMCD) for Medi-Cal, and by the Managed Risk Medical Insurance Board (MRMIB) for the Healthy Families product line. While there are no measures required to be reported for the Healthy Kids line of business,

HPSM collects and analyzes the same measures for Healthy Kids as are collected for Healthy Families.

Since 2006 HPSM has contracted with an NCQA-certified vendor to collect HEDIS data. HPSM analysts provide the plan's enrollment, provider and claims data files to the vendor and the vendor extracts HEDIS data using their certified software. The vendor also performs medical record reviews and provides final HEDIS statistics to HPSM. Results are then reported back to each contract agency. The results are reviewed and discussed at the weekly HPSM Quality Improvement Projects and Initiatives (QIPI) meetings as well as at the QMOC, the QAIC external provider committee, and other committees, as indicated, to evaluate plan performance and to assess the need for interventions to improve performance.

### **Evaluation of Study Methods – Administrative vs. Hybrid**

By comparing our administrative data with previous years of hybrid (medical record abstraction plus administrative data) determinations, we see that administrative data alone generally does not yield an accurate and comprehensive picture of the care received by all health plan members for whom we are responsible. This is due to a variety of differing benefit patterns, aid codes, and eligibility definitions. For some HEDIS measures, we have an option of performing medical record abstraction at the provider site level in addition to using administrative data, in order to gather the most complete data possible. We exercised this option for a number of the reporting measures for the 2008 HEDIS data collection.

HEDIS data abstractors have a narrow window of 3 months to review records for the hybrid HEDIS measures. In 2008, we reviewed (through a contracted vendor) over 8,000 records. The ability to review records is limited by the number/type of HEDIS measures permitted to be hybrid, the sample size/number of records, the location of providers, the provider response and the adequacy of medical record abstractors. Nonetheless, with the dedication of HPSM staff, in particular the work of the Senior Biostatistician, HPSM has been able to report on all required measures since 1998.

### **Capturing Encounter Data**

For HPSM, there are numerous barriers to collecting data that accurately reflect the care rendered by our providers. For example, HPSM Primary Care Providers (PCPs) render services under a capitated payment structure. Since PCPs are not directly reimbursed for the services included under their capitated payment, many choose not to spend extra time submitting complete encounter data to the Plan. Furthermore, Child Health and Disability Prevention (CHDP) program services are excluded from our Medi-Cal contract, so getting data for these encounters relies on the accuracy of data reports we receive from CHDP for these preventive care services. HPSM has worked to address these issues a number of ways. We have

initiated a Pay for Performance program for Medi-Cal PCPs that reimburses them for encounter data. We have also developed a Memorandum of Understanding with, San Mateo County's CHDP program for sharing of data collected on PM160 forms . We expect to see a positive effect from this additional data source reflected in our 2009 HEDIS results.

Other data barriers identified include that some Obstetrical (OB) services that are billed under a global claim are not identified on the claim with the individual dates of the prenatal encounters. Further, prenatal visits and the post partum visit may not have been performed by the same provider. A similar problem exists with data for some of the care provided to adolescent members. If the care rendered involves reproductive or other "sensitive services," the visits, as well as any laboratory testing, may be billed to Family PACT or state fee-for-service Medi-Cal, instead of HPSM. This leads to additional areas where the Plan does not receive complete encounter data.

Some remedies for the above-outlined problems include obtaining state-supplied data transfers directly from CHDP and additional downloads from the County Medical Centers. We have been using this data to supplement numerator events as well as to locate records. However, sometimes we receive the data outside of the narrow timeframes of HEDIS data submission.

We hope to improve our data collection from PCPs with our Pay for Performance (P4P) initiatives, as noted above. Beginning in 2008, HPSM now reimburses Medi-Cal PCPs for each encounter form they submit. We hope that this incentive will improve the accuracy of our administrative data and allow us to better document the care our members receive. So far, we have seen an increase in our overall encounter form submission rate from 5 percent to 12 percent.

### **What Did the HEDIS 2008 Data Collection Show?**

Our HEDIS 2008 data has shown that there has been an increase in the rates of Cervical Cancer Screening and Well-Child Visits 3 - 6 years of age. There was a decrease in the following areas of Comprehensive Diabetes Care: HbA1C, LDL-C and retinal eye exam. None of these decreases were statistically significant. We will continue to monitor them closely.

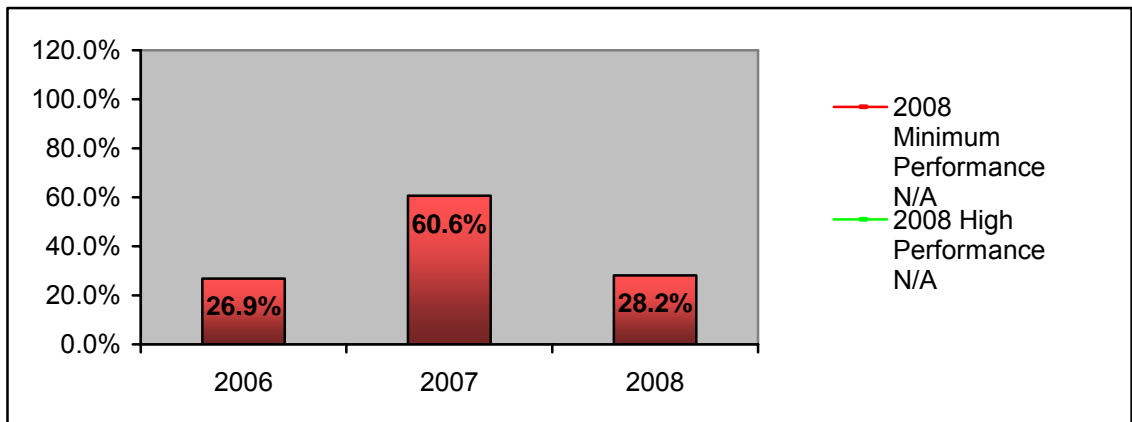
The increases in the rates reflect the continued work of many areas in HPSM, including Member Services, Provider Services, Health Services, Planning and Evaluation as well as the Quality Program. In addition, we have continued to work on improving the quality of our administrative data and the data we receive from the State for the CHDP Program. These efforts have helped increase our administrative rates.

Our HEDIS performance rates are also the result of our providers' commitment to providing quality medical care to our members. Efforts by such agencies as the San Mateo County Immunization Program, and its work to implement an immunization registry, also likely played a key role in the areas of improvement we noted.

This year we only have one measure that is below the MMCD's minimum performance level: Adolescent Well-Care Visits. However, there are still additional measures where there is significant room for improvement. These measures comprise areas of focus for HPSM's quality improvement projects in 2009.

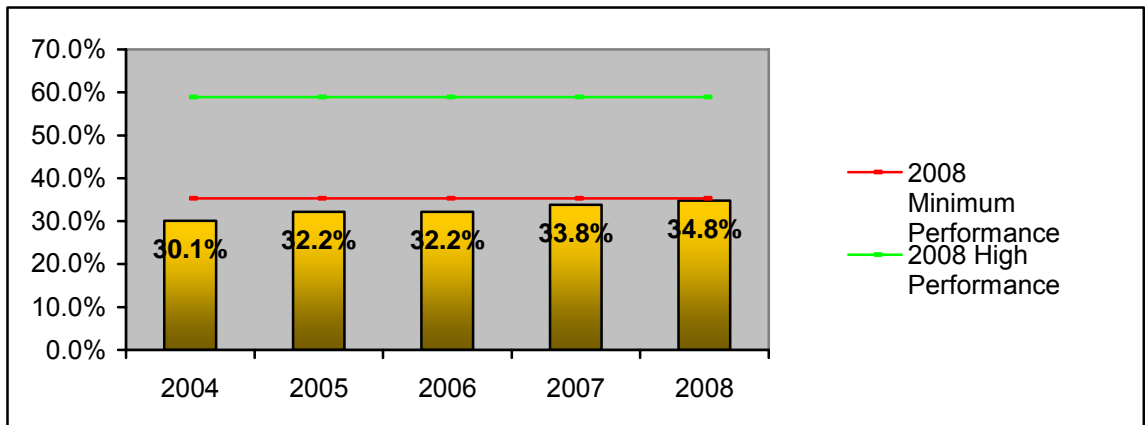
The following is a summary of HPSM's rates for HEDIS 2008 (measuring services performed in 2007), including trends over the last three years:

- **ACUTE BRONCHITIS**—HPSM's percentage of adult members given antibiotics for Acute Bronchitis\*:

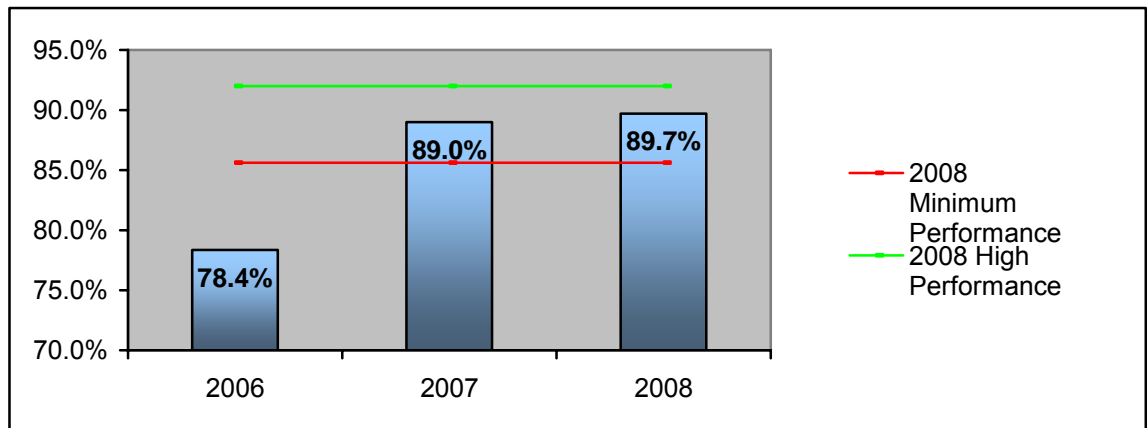


\* There are significant changes in this measure's specifications in 2008 which explains the dramatic decrease of the rate from 2007 to 2008. As the result, no performance levels are established.

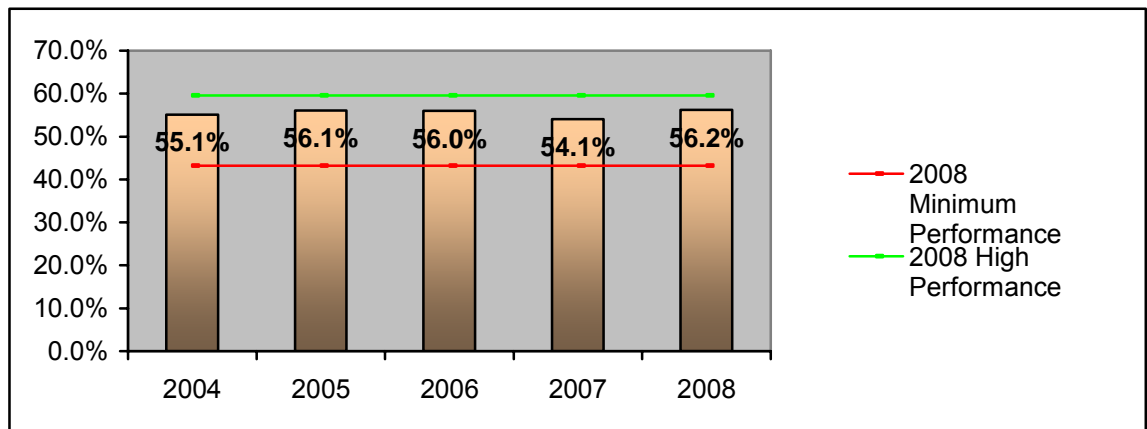
- **ADOLESCENT WELL-CARE**—HPSM's percentage of adolescents with annual well care visits:



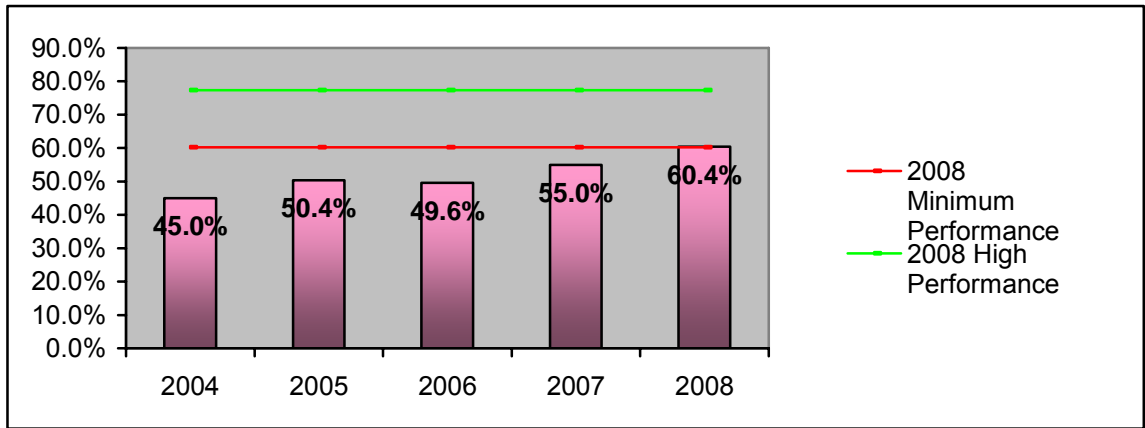
- **ASTHMA MANAGEMENT**—HPSM’s percentage of appropriate medications used for treatment of persistent asthma:



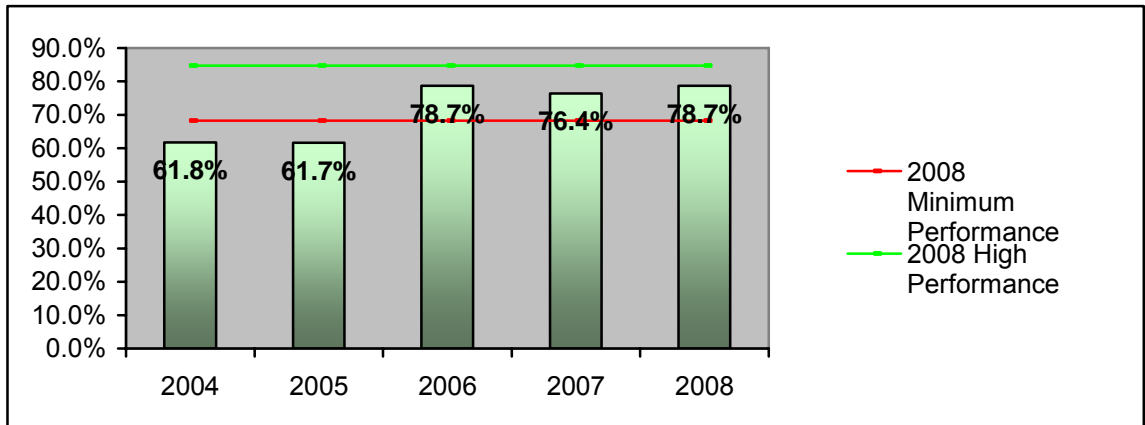
- **BREAST CANCER SCREENING**—HPSM’s percentage of women ages 42-69 who have received a mammogram 1-2 yrs prior:



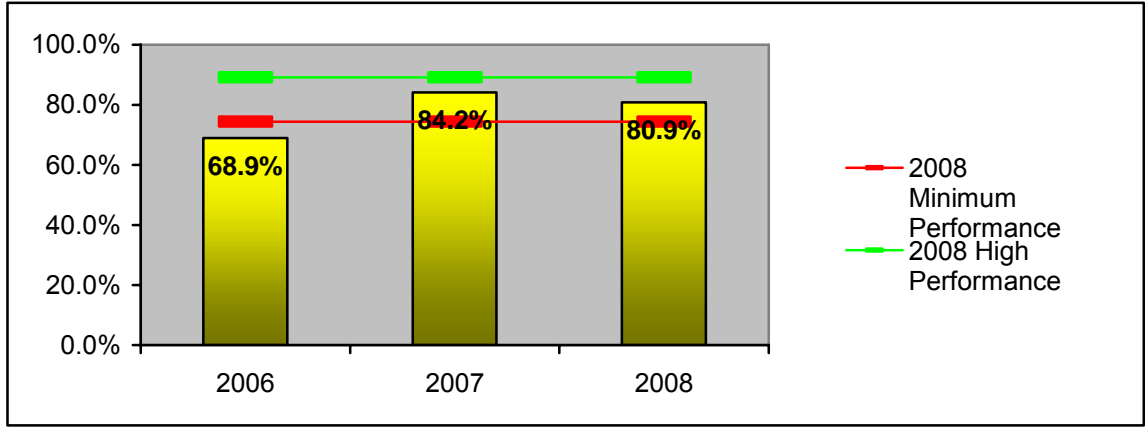
- CERVICAL CANCER SCREENING**—HPSM’s percentage of women ages 24-64 who received one or more Pap tests 1-3 yrs prior:



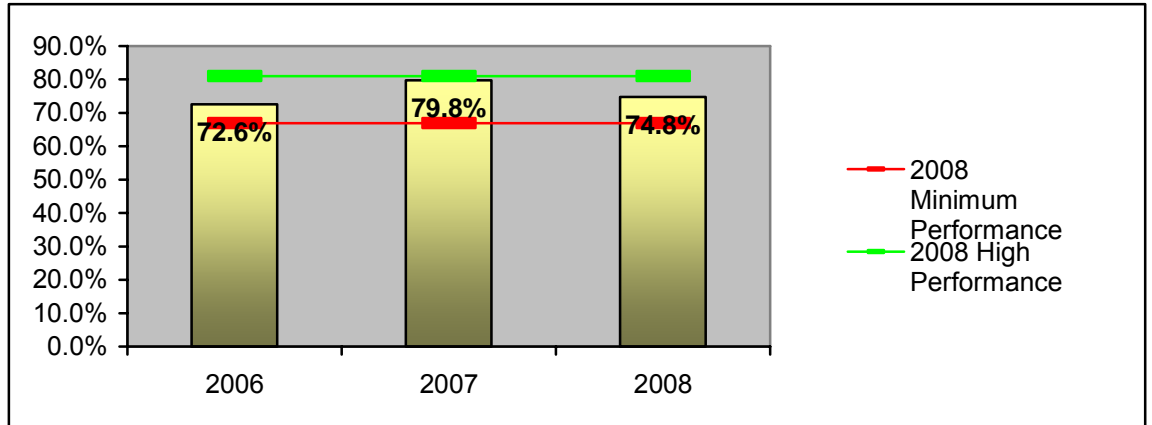
- CHILDHOOD IMMUNIZATIONS, Combo 2**—HPSM’s percentage of children fully immunized by the age of 2:



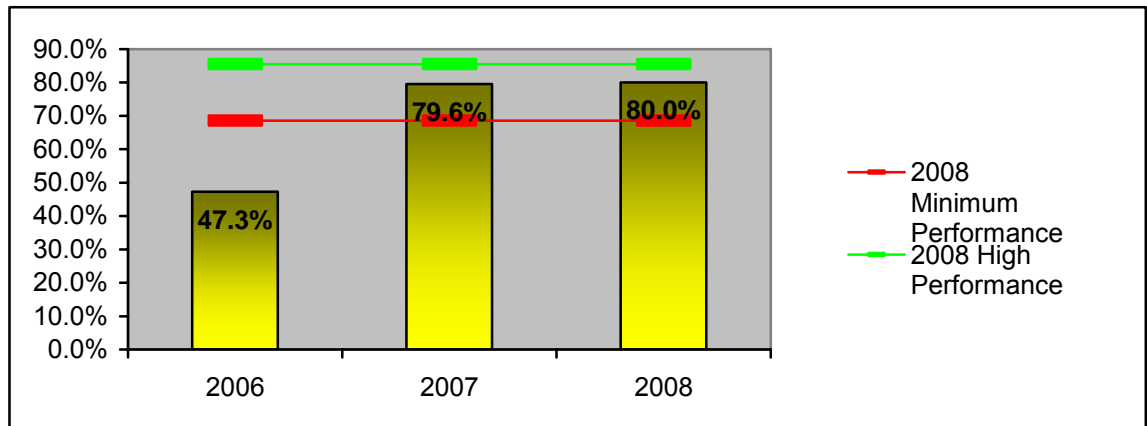
- **COMPREHENSIVE DIABETES CARE: HbA1C**—HPSM’s percentage of diabetic members who had an HbA1C screening in the prior year:



- **COMPREHENSIVE DIABETES CARE: LDL-C**—HPSM’s percentage of diabetic members who had an LDL-C test in the year prior:

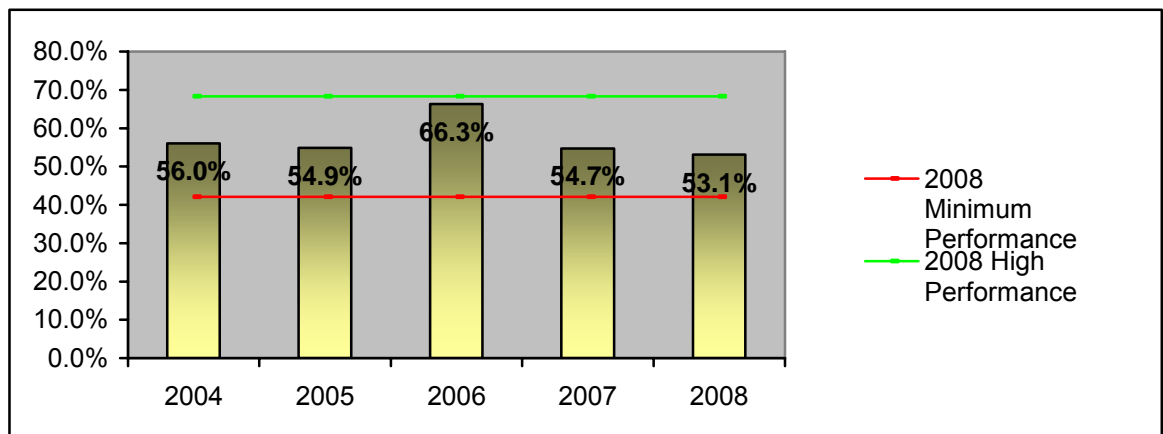


- **COMPREHENSIVE DIABETES CARE: Monitoring for Nephropathy**—HPSM’s percentage of diabetic members who had nephropathy monitored:

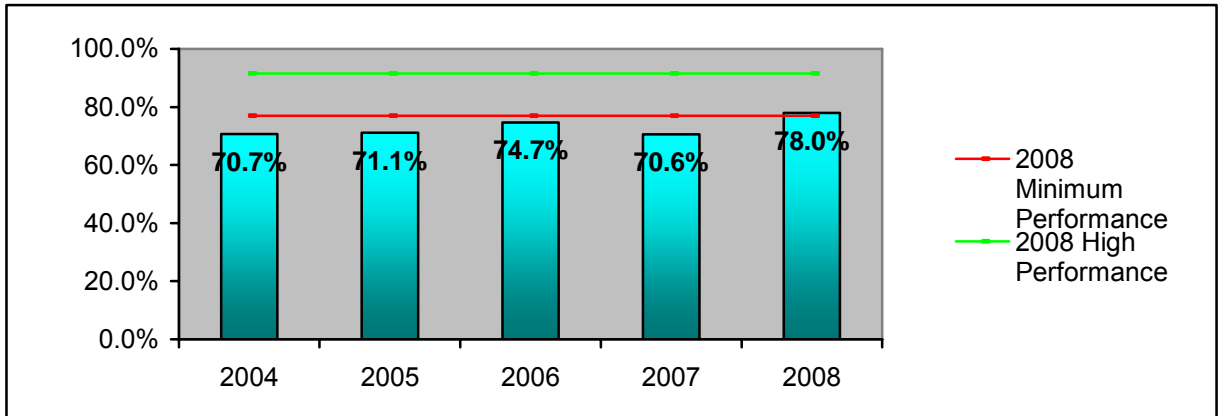


\* There are significant changes in this measure’s specifications in 2007 which explains the dramatic increase of the rate from 2006 to 2007.

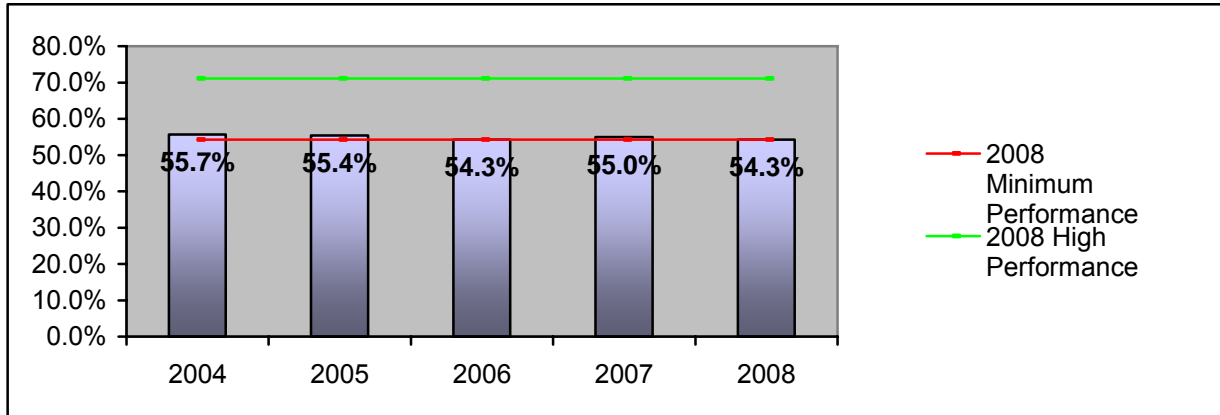
- **COMPREHENSIVE DIABETES CARE: Retinal Eye Exam**—HPSM’s percentage of retinal eye exams in diabetic members:



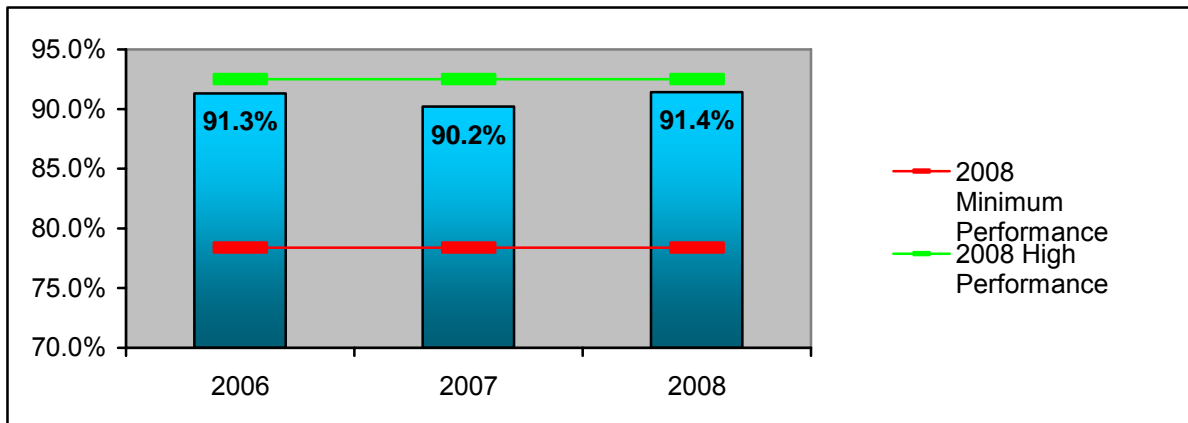
- **PRE-NATAL CARE**—HPSM’s percentage of deliveries that received a prenatal care visit within the first trimester or 42 days of enrollment if the member became enrolled after the first trimester:



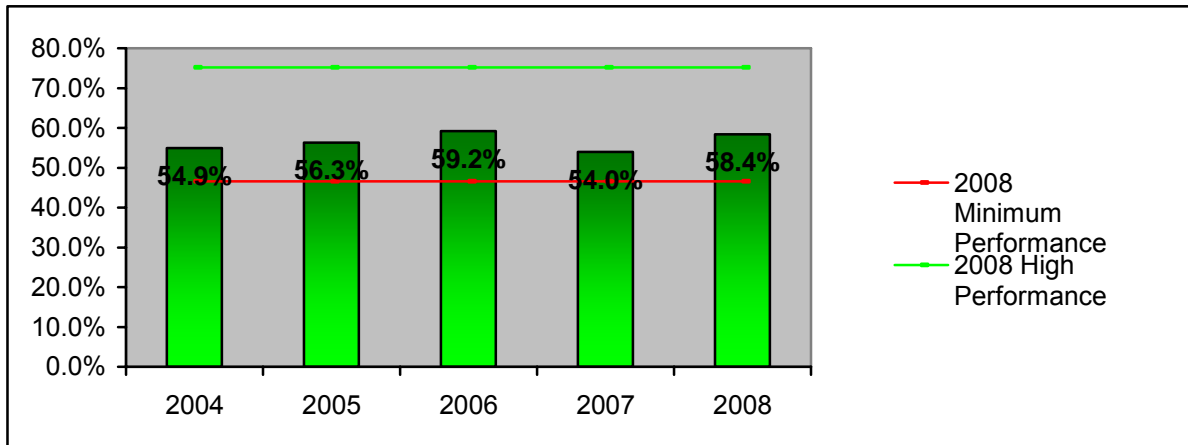
- **POSTPARTUM CARE**—HPSM's percentage of deliveries with a postpartum visit between 21 and 56 days after delivery:



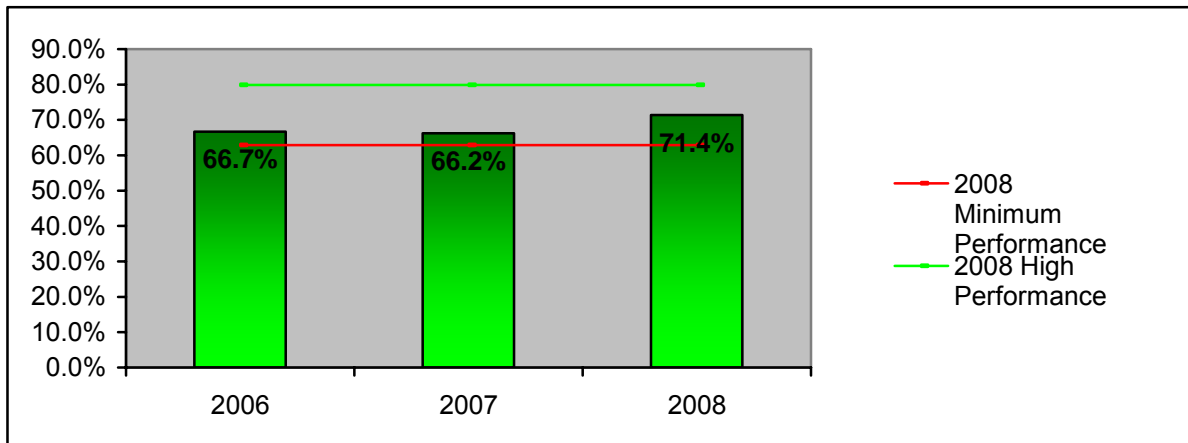
- **URI (Upper Respiratory Infection)**—HPSM's percentage of children 3 months -18 years of age who were not dispensed an antibiotic prescription for URI:



- **WELL-CHILD VISITS**—HPSM’s percentage of children who have had six or more well visits in the first 15 months of life:

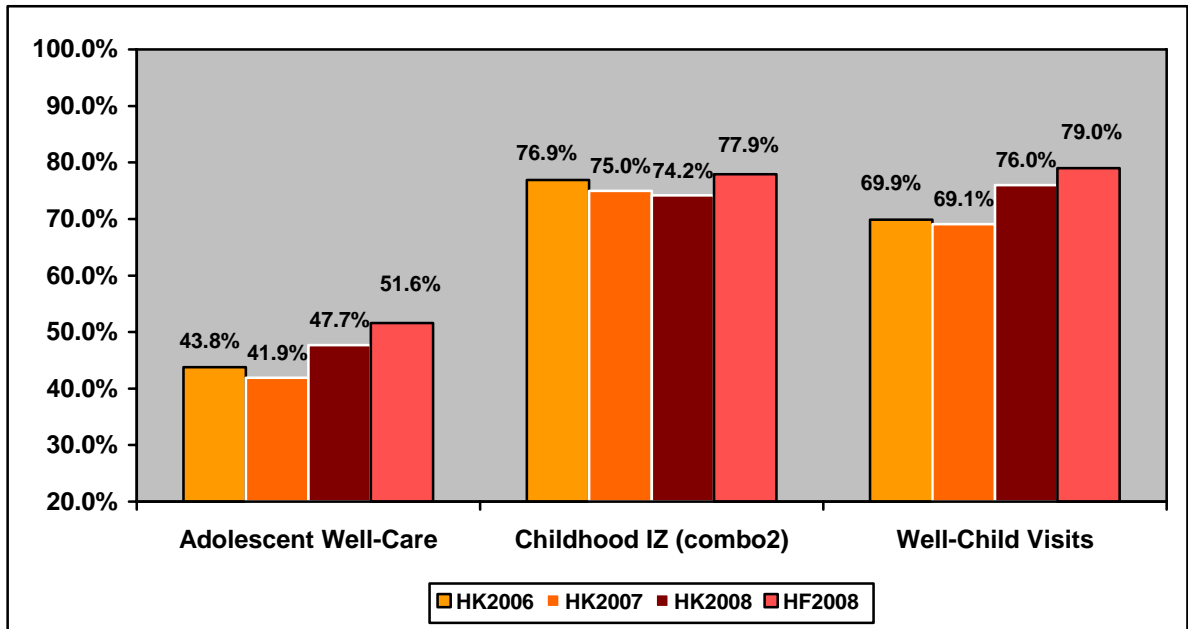


- **WELL-CHILD VISITS**—HPSM’s percentage of children 3-6 years of age who had a well visit in the year prior:

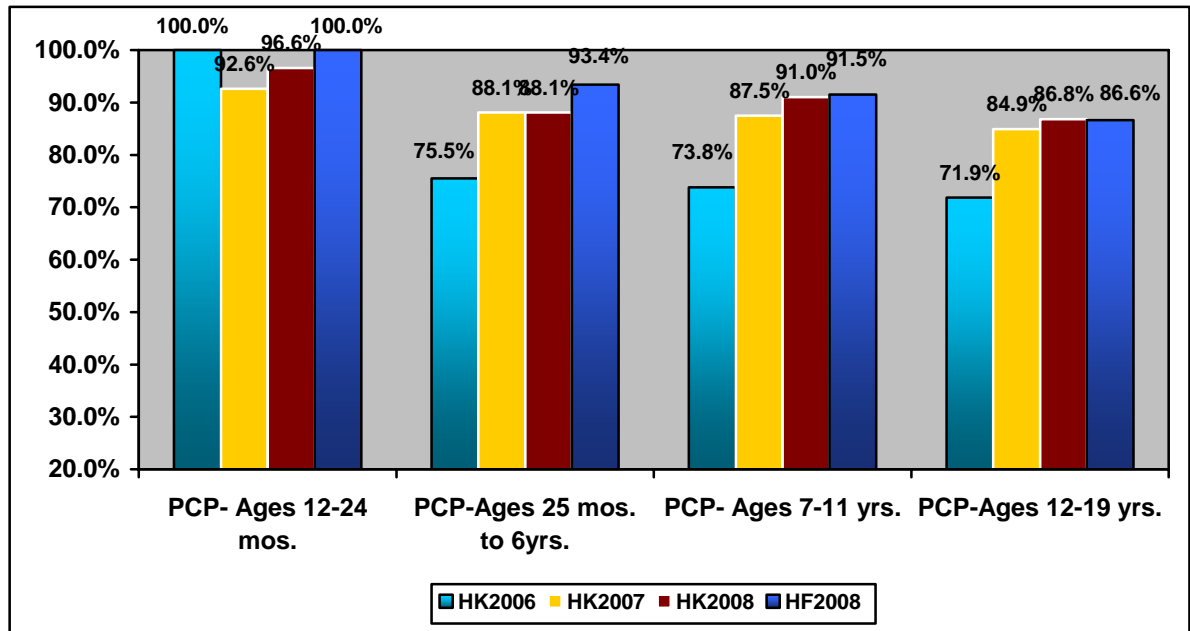


## •Healthy Kids and Healthy Families•

- **HEALTHY KIDS and HEALTHY FAMILIES**—A comparison between Healthy Kids and Healthy Families for the Adolescent Well-Care, Childhood IZ, and Well-Child Visits for Children 3-6 Years of Age measures:



- **HEALTHY KIDS and HEALTHY FAMILIES**—A comparison between Healthy Kids and Healthy Families with respect to the Access to PCP measure:



## GRIEVANCE AND APPEALS

HPSM receives numerous grievance and appeals each year; however in 2008 there was a decline in the number of appeals involving Part D pharmacy appeals. This downward trend is attributed to the fact that a pharmacist with access to member data reviews and is able to approve weekend requests. Many appeals for services are denied and then approved on appeal because additional information is provided to HPSM.

Member grievances involve a variety of issues including concerns about the quality of the patient care experience and patient-provider miscommunication which has led to a misunderstanding, distrust or hurt feelings. However, some grievances involve clinical quality of care concerns. In 2008, there were 13 of these issues for Medi-Cal/Other Lines of Business and six for CareAdvantage. Each was reviewed by one or both of HPSM's Medical Directors and, where indicated, brought forth for discussion and recommended actions at the PRC. In comparison, in 2007 there were eight grievances filed regarding quality of care concerns. Of these, three were for CareAdvantage, four for Medi-Cal, and one was filed by a provider. All of these were reviewed in the same manner as just described. Although there was an increase in the number of these types of grievances filed for 2008, no specific pattern was identified.

**Table: Quality Grievances 2007 vs. 2008 (LOB indicates Member Source)**

|             | <b>CareAdvantage</b> | <b>Medi-Cal</b> | <b>Provider</b> | <b>Total</b> |
|-------------|----------------------|-----------------|-----------------|--------------|
| <b>2007</b> | <b>3</b>             | <b>4</b>        | <b>1</b>        | <b>8</b>     |
| <b>2008</b> | <b>6</b>             | <b>13</b>       | <b>0</b>        | <b>19</b>    |

### **UTILIZATION MANAGEMENT ISSUES**

Utilization management is handled by Health Services staff under the direction of the Health and Provider Services Director, with clinical direction by the Medical Directors. The QAI department becomes involved only when the UM team identifies a quality of care concern that needs further review, and raises that for discussion at the Grievance and Appeals committee meetings. HPSM has monthly Medical Review Management meetings with key Senior Management staff (Executive Director, CFO, Medical Director, Director of Health and Provider Services, etc.) which review ongoing utilization issues, look at trends, look for signs of over or under utilization, and any significant findings can be discussed at the QMOC or the SMHC Finance Committee.

### **2008 QUALITY IMPROVEMENT PROJECTS AND INITIATIVES**

Quality Improvement Projects and Initiatives (QIPs) have been developed to enhance the many HPSM activities that aim to encourage the specific health care practices measured by HEDIS or guided by HPSM's contracts. Each year, we continue to add new initiatives and modify existing programs as we see opportunities for improvement. In 2008, our four Quality Improvement Projects were Diabetes Management, Cervical Cancer Screening (part of HPSM's Living Healthy Women's Program), Decreasing Avoidable ER Visits, and Prenatal Care. Continuing projects geared toward improving HPSM member health status included Postpartum Care, the Immunization Registry Program, the Asthma Improvement Project, the Shapedown Translation Project and the IHA/IHEBA (timely initial health assessment visits) project, as well as ongoing efforts in the areas of Cultural and Linguistic Services including those mandated by SB 853, Health Education and Health Promotion.

As noted earlier in this report, overall there has been an increase in the rates of Cervical Cancer Screening and Well-Child Visits 3 – 6 years of age, but there was a decrease in three areas of Comprehensive Diabetes Care: HbA1C, LDL-C, and retinal eye exam. While these decreases are not statistically significant, we are devoting attention to our entire diabetes program in 2009 with the aim of increasing our rates. We are also continuing to improve our efforts to comply with IHA/IHEBA contractual requirements. These formed the areas of focus for the QIPI efforts of 2008, and point out main areas where HPSM needs to work in 2009. They also are the primary focus of the incentives for HPSM's P4P program for our Medi-Cal PCPs.

The following summarizes those projects and initiatives that impacted HEDIS rates reported in 2008, and describes new and ongoing initiatives. Our plans for 2009 are discussed in the section below on “Proposed 2009 Quality Improvement Strategies.”

- Increasing Annual Adolescent Health Visits:

In 2008 HPSM continued to outreach to providers and members and educate them about the importance of annual adolescent well visits. Providers received information about the annual adolescent well care visit through visits by the Medical Director and Health Educator and through the provider newsletter.

Adolescent members ages 12-18 receive a birthday postcard the month prior to their birthday encouraging them to make an appointment for a well visit in order to receive the movie ticket incentive. Since the inception of the movie ticket program in 2005, the number of members that participated increased from 105 in 2005 to 1,191 in 2008. The largest group of these members belongs to Healthy Kids, followed by Medi-Cal and then Healthy Families members. Articles about the program were also included in the member newsletter.

HPSM reported an increase in the HEDIS Adolescent Well-Care Visit rate to 34.8%. Although this is not a statistically significant increase, there is a small increase that could have derived from the increase in knowledge from members and providers about annual adolescent well care visits as a coverage benefit.

- Asthma Improvement Project:

In order to strengthen the asthma component of HPSM’s quality initiative, we decided to combine its outreach effort with that of Health Services’ Pharmacy program. Our goal is to increase the use of inhaled corticosteroids and other controller medications, and decrease the use of short-acting beta agonist medications for members with persistent asthma. HPSM identified members for this program based on pharmacy claims data. If a member received four or more refills of short-acting beta agonist, their assigned providers were notified. Providers received a prescription form pre-printed with our preferred controller medication along with an asthma toolkit. The toolkit contains clinical forms and patient education materials to help improve asthma outcomes and the quality of care our members receive. The focus is on the appropriate use of controller medications, asthma action plans, and self-management skills, in accordance with NIH guidelines. HPSM’s Health Educator and Medical Director shared these tools with our providers. So far we have outreached to 60 providers, and all were well-received. More are scheduled in 2009.

HPSM partnered with the American Lung Association (ALA) to submit a grant to be able to offer a series of comprehensive asthma classes called Breathe Well Live Well, a validated program shown to decrease the severity of asthma

symptoms, reduce respiratory problems, and increase adherence to prescribed treatment. This is a four-hour class with telephone follow-up before and after the class. Three classes were conducted and approximately 23 members attended each class. Because of this success, the ALA will be offering additional classes for our members in 2009.

Asthma control is another important initiative in our Pay for Performance program in 2008. PCPs who complete Asthma Action Plans for patients are reimbursed when they submit them to HPSM, and then bill for this submission. We hope that this will encourage more comprehensive asthma care of our members, and better adherence to medications by members, as well, since they will have a written plan for what to do with their asthma at its various stages. So far we have received approximately 200 asthma actions plans from our providers and more are expected in 2009.

To further expand our asthma program and improve clinical outcomes, we've developed an asthma registry that identifies our high risk members. In 2009, if PCPs' patients fall in our high risk classification, which is based on hospitalizations, ER visits, and medication usage, the PCPs will receive a report which they can use to follow up with these members. Providers will also receive a packet of patient education materials and a referral slip if they want HPSM's Health Educator to also follow up with the patient. This level of care management with the PCP will help improve health outcomes for our members and ultimately reduce healthcare cost as well.

- Diabetes Initiative:

We began a three-year comprehensive diabetes care initiative in 2007 as HPSM's Medicare QIP for our CareAdvantage (CA) members. HPSM has included members from any line of business in this initiative, but with a special focus on our CA members. This initiative has several components, including member education (promoting individual counseling and group diabetes self-management classes offered at no cost to HPSM members through our community partners) and provider education (providing up-to-date clinical guidelines on diabetes management on the HPSM provider website, and opportunities for provider discussion on diabetes care at meetings of our physician advisory and quality advisory groups).

A third component, the diabetes BINGO card, was discontinued after one year due to low member participation. We conducted a member survey to gain insight into why the BINGO program was not successful, and learned several reasons: (1) Many members said their PCP never discussed the diabetes BINGO program with them; (2) Many members don't know what an A1c test is; (3) Many know that exercise, diet and blood glucose are key to diabetes management but feel they don't need eye, foot or kidney tests; and (4) Many feel that checkups are important but expect their doctor to tell them what to do rather than asking their doctor about specific tests, outcomes, and how to

manage their diabetes care. For members, the gap between these attitudes and beliefs and managing their diabetes care does not seem to have been affected by the BINGO program.

To further develop our program of improving diabetes management, in 2008 we began a needs assessment to help us better evaluate our services and outcomes. We sought input from primary care providers, diabetes education providers, and other health plans. We also sought input through a survey sent to members with a diabetes diagnosis, a survey sent to Care Advantage members, and phone interviews of members with a diabetes diagnosis. Our new member education and incentive efforts will focus on: (1) promotion of diabetes management counseling and classes which are available free to all HPSM members through our hospital partners, (2) an incentive for completion of diabetes care classes (a \$15 Target gift card), and (3) targeted mailings of focused educational materials in English, Spanish, Chinese, Tagalog or Russian to all members with a new diagnosis of diabetes. We are currently in the process of developing these new member materials. Additionally, we provide free diabetes materials to members, and our member health promotion newsletter focuses on diabetes once a year.

Beginning January 2008 we instituted a new provider outreach and education campaign that includes a pay-for-performance component for four key HEDIS-based diabetes care measures (eye and kidney function tests, hemoglobin A1c test values of 7% or less, and LDL cholesterol test values of 100 or less); and development of a provider toolkit including materials for medical office staff and members. We are also continuing the provider education components mentioned above (providing up-to-date clinical guidelines on diabetes management on the HPSM provider website, and opportunities for provider discussion on diabetes care at meetings of our physical advisory and quality advisory groups). We will be developing new provider materials such as a diabetes management checklist in a "prescription pad" style for distribution to patients. This combination of provider and member incentives, which has been successful with the adolescent well visit program, will hopefully improve the comprehensiveness and timeliness of care that HPSM members with diabetes receive.

In June 2008 we submitted a report to NCQA on our CareAdvantage Structure and Process Clinical Quality Improvement diabetes measures, and received a score of 100%.

- Living Healthy Women's Program (breast and cervical cancer screening):

HPSM continued its efforts to increase member mammogram and Pap test rates. As part of the state CAP for the cervical screening measure begun in 2007, letters are mailed monthly to all female HPSM members who have not

had a Pap test in the previous three years. These members also receive phone calls and are sent education materials about breast and cervical cancer screening. Members are assisted in scheduling appointments, escorted to appointments (if requested) and receive an incentive when verification of a mammogram and/or Pap test is received. In 2009, modeling the adolescent well visit program, we plan to develop a birthday card reminder postcard. The postcards will be mailed to members the month before their birthday, informing them of the incentive and reminding them to get their mammogram and Pap screening tests.

HPSM reviews member's breast and cervical cancer screening rates monthly to assess any changes in the rates. The rates are also stratified by the total membership, disabled members and non-disabled members. This data showed that disabled member's breast and cervical cancer screening rates were significantly lower than non-disabled members. This led to the development of a mammogram disability access survey in order to assess the mammogram facilities readiness to provide mammograms to disabled patients. The survey was completed by the facility manager in person, over the phone or by mail. Overall, the survey responses showed that the facilities are accommodating women for mammograms as best they can. Most of the accommodations made at these facilities are for women with physical disabilities. Some areas of improvement include: asking women if any special accommodations are needed at time of scheduling appointments, having longer appointments slots for women with disabilities, advancing skills for modifying mammography positioning techniques and recognizing the special needs of women with cognitive and developmental limitations (not just physical limitations). Three facilities expressed interest in becoming a certified center; five facilities would like to have staff attend trainings to improve their skills in providing accessible mammogram services to women with special needs.

Following the survey, we have started collaborating with Breast Health Access for Women with Disabilities (BHAWD), a local organization that trains mammography technicians on ways to provide accessible services to disabled women. HPSM plans to seek local grant funding to enable us to provide a special training to mammogram facilities in San Mateo County later in 2009. We hope that increasing screening access to women with disabilities will improve our breast cancer screening rates for this group.

- Prenatal and Postpartum Care Program:

HPSM has worked steadily on enrolling and following all pregnant members into our program to ensure timely entry into prenatal care and an appropriate postpartum visit. Once women are enrolled, they receive regular prenatal care, and are assisted in follow-up by HPSM's quality program staff. They also receive attractive incentives at various milestones in their pregnancy, information about community resources, OB referrals, scheduled

appointments, childbirth education classes and education materials. However, we continue to find women who are HPSM members but who we were not able to identify prior to delivery in order to enroll them in the program. Therefore, efforts to improve early identification, including strategies such as the use of pharmacy reports of women picking up prenatal vitamins and enrollment data provided by the Human Services Agency (HSA), are processes that we have continued to follow in order to identify pregnant women early. These efforts are aimed at HPSM members already enrolled who become pregnant. Another effort is tracking pregnant women who subsequently become eligible for HPSM and assisting them to schedule prenatal appointments within 42 days of enrollment as required by HEDIS.

We have also added an early referral and an early OB acceptance incentive in our P4P package. However, we know we need to assist women in learning what to do so that they will come into their PCP's office to see if they are pregnant as early as possible, or the provider incentives will be of no use. So we are working with the San Mateo County Prenatal Social Marketing Committee to develop a marketing campaign to alert women to the importance of early prenatal care.

All of these components will hopefully lead to improved timeliness of prenatal care for our members in the coming years.

- Immunization Registry Program:

HPSM is collaborating with the San Mateo County Health Department Division of Public Health (SMC DPH) to facilitate the participation of private providers in the Bay Area Regional Immunization Registry (BARR). BARR serves as a single population-based data source on immunizations for all health care providers in the Bay Area. Key activities include conducting outreach to HPSM pediatric providers to encourage their participation in BARR, supporting the upload of HPSM patient demographic data into BARR, and assisting with research, training, and implementation of an immunization reminder/recall system. The registry significantly reduces staff time by providing immediate access to complete immunization histories, even when shots were received from different providers and counties; and recommends immunizations currently due. Working together, HPSM and the SMC DPH Immunization Program are continuing this outreach to include more providers and their patients, including HPSM members, in BARR. The goal of this effort is to have SMC children fully immunized by age two. HPSM implemented a reminder recall project to support this goal. HPSM sent out reminder letters to parents of 18-month-olds who are overdue for shots and they are asked to schedule an appointment with their child's PCP. Each provider also received a list of their patients who are overdue and was asked to follow up with them. Members who are not in BARR are asked to send us a copy of their yellow card and we entered this information. If members were still overdue at 21 months of age, our staff helped them schedule an appointment with their

PCP. If they were up to date by age two, we sent them a \$15 gift card, courtesy of First 5.

To continue progress on this initiative, HPSM has included participation in the Immunization Registry as a measure in its P4P program. This has led to four new private providers who had declined registry participation previously. HPSM hopes that this incentive will help expand the use of the registry to more of our private provider network. One challenge is that a number of our private providers use electronic medical records (EMR); at present they can only participate in the registry if they do double data entry—into their EMR, and then again into the BARR. In 2008, BARR has worked with another county on creating data extracts from the EMR and uploading it into the registry. In 2009, we plan to experiment this with five of our pediatric offices. This will make BARR accessible for our EMR providers and allow us to identify and remind members who are past due for immunizations.

- Avoidable Emergency Room Visits:

HPSM continued our participation in the MMCD-DHCS state-wide Collaborative to reduce avoidable emergency room (ER) visits. Based on member and provider survey data on ER use submitted by HPSM and the other health plans, the Collaborative decided to focus on avoidable ER visits for upper respiratory infections among children less than 9. The Collaborative developed common messages on appropriate ER use for all health plans to use in a coordinated health education campaign. The Collaborative incorporated the messages into a poster and brochure for PCP offices, and HPSM's Quality Department will work with our Provider Services Representatives to distribute the materials to PCP offices when the final versions are ready. As part of the health education campaign, we wrote an article about ER use ("Is It an Emergency?") for our Winter 2008-2009 member newsletter.

The Collaborative's other common intervention is for each health plan to partner with a contracted hospital to reduce avoidable ER visits. We have formed a partnership with Sequoia Hospital and are in the beginning stages of setting up communication so that we can receive data electronically on HPSM members seen in the Sequoia ER and develop an appropriate intervention for those visits deemed avoidable.

Another requirement of the Collaborative is for each health plan to develop an individual intervention to reduce avoidable ER visits. On April 28, 2008 HPSM launched a 24/7 Nurse Advice Line (NAL) with our vendor Nurse Response as an intervention to try and reduce avoidable ER visits. We started this service for members who have SMMC clinics as their PCP, since these clinics have limited after hours service, and are often unable to accommodate daytime drop-in urgent care appointments as well. Through the use of

refrigerator magnets and quarterly marketing postcards to announce the NAL and promote its use to eligible members, we have maintained a high call volume since its inception. Another success of our NAL has been the high volume of clinical calls that require triage by a nurse, while most health plans typically experience a high call volume of administrative calls such as requests for member ID cards. In the coming months we will have enough data to be able to start evaluating the effectiveness of the NAL in reducing the total number of ER visits and avoidable ER visits.

- Initial Health Assessment (IHA/IHEBA) Timeliness:

As part of HPSM's contract with DHCS, its providers are expected to see new patients and complete an Initial Health Assessment (IHA) and an Individual Health Education and Behavioral Assessment (IHEBA) within 120 days of the new member's enrollment with HPSM. At the most recent HPSM-DHCS audit, HPSM was cited as a repeat finding for having low percentages of completion of these documents, and little recent documented effort to improve these rates.

As a consequence, HPSM is discussing this project at every QIPI meeting, reviewing the topic monthly at each QMOC, and evaluating progress being made at each QAIC quarterly meeting. A pertinent question raised has been whether or not PCPs have been carrying this out, but using their own forms, not the state's, and that this has not been noted by QAI nurses.

Therefore, in 2008, HPSM sent out a letter to each PCP asking them to state whether, for IHAs, they use the state's forms, or their own, to complete the IHA/IHEBA. If they chose their own, these were sent for review by HPSM. A letter was sent to all of the contracted PCPs and over 50% use the Staying Healthy Assessment Tool. HPSM QAI nurses are able to assess completion of IHA/IHEBA using this information, and the proposed exceptions by the state, to more accurately reflect the efforts HPSM's providers are demonstrating in this area.

HPSM also participated in the Staying Healthy Assessment (SHA) Work Group to develop new SHA tools for providers. HPSM was able to gain input from twelve providers about the SHA tools. HPSM also volunteered in gathering input from patients about the existing tools. This helped the work group determine which areas would be of focus in the development of the new tools.

- Shapedown Translation Project:

Shapedown is a group educational series targeted to help reduce the incidence of childhood obesity in San Mateo County. Currently, educational materials are available in English only. Working in conjunction with the series publisher, HPSM has raised funds to translate the program materials into Spanish to help improve access for families to participate in the program.

Funding for the Spanish translation began in 2007 and was completed in December 2008. Staff applied to several local foundations and received the total amount required from the Silicon Valley Community Foundation, the Peninsula Health Care District and the Sequoia Health Care District. HPSM staff were also able to negotiate with the translation vendor, viaLanguage, to begin the translations while additional funds were being solicited. This allowed for the translation of the books to be completed in 2008, printing to be scheduled for completion in early 2009 and planning for staff to implement the Spanish classes in mid 2009.

- Health Education and Health Promotion

HPSM expanded the classes available to members, particularly in the areas of asthma and nutrition. HPSM revised its health education resource guide that includes a listing of free classes and resources in the community for our members. This is mailed out to every member, included in our new member packets, and disseminated to provider offices. The health education component of each quality project is also important, including integration of outreach to providers and members via provider toolkits, articles in both member and provider newsletters, and follow-up re: provision of care that is consistent with evidence-based practice.

HPSM fights to put better health within reach for our members. We have dedicated a special section in our member newsletter called “Ask Dr. G” where HPSM’s Medical Director answers general health questions submitted from our members. Our health education group’s phone number is also publicized in various member publications. We have received many calls from members asking about health education classes and requesting health education brochures. We try to make the process of obtaining health education information easier by creating different ways members can communicate with us. Our members can call us, email us, write to us, request materials through our website, or obtain some of these resources from their provider. Additionally, there will be a new section on our website containing *Take Action* messages on various health topics that will educate members on key behavioral changes or actions that will improve their health or keep them healthy. We place a large emphasis on primary prevention in all our work because we believe being healthy is for everyone.

- Cultural and Linguistics

In 2008, staff accomplished the following:

- Developed new process to assess bilingual proficiency of new hires.
- Trained staff
  - Provided a successful all staff training on cross-cultural communication.
  - Trained new staff in Member Services, CareAdvantage, Care Coordination and Claims departments on Language Line and interpreter services.
- Educated members and providers about interpreter services
  - Revised the Cultural & Linguistic provider toolkit to include new branding.
  - Included articles in the provider and member newsletter about interpreter services.
- Developed and implemented new policies in compliance with SB 853.
  - Collaborated with other Medi-Cal Managed Care Health Plans and the Department of Managed Health Care to develop consistent policies.
  - Developed database to document race, ethnicity and language data of Healthy Kids, HealthWorx and Healthy Families members.
  - Revised policies and procedures to reflect new regulations.
  - Revised Primary Care Provider contract to comply with regulations.
  - Submitted HPSM's Language Assistance program description and policies to the Department of Managed Health Care.

## REGULATORY AUDITS

**Table 2: Provider Review**

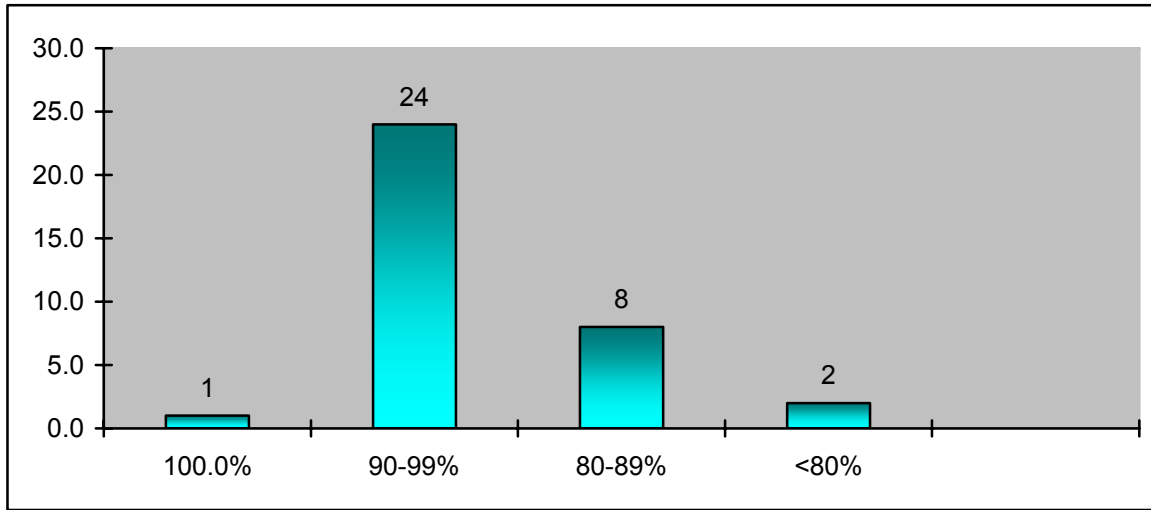
| Total Reviews | Provider Type | Review Type               | Site Score    | Med Record Score |
|---------------|---------------|---------------------------|---------------|------------------|
| 35            | 21 PCP-Adult  | 2 Site Review Only        | 1 – 100%      | 1 – 100%         |
|               | 11 Pediatric  | 33 Site & Medical Records | 24 – 90-99%   | 19 – 90-99%      |
|               | 3 OB/GYN      |                           | 8 – 80-89%    | 10 – 80-89%      |
|               | 0 Referral    | 0 Medical Record Only     | 2 – under 80% | 3 – under 80%    |

Due to staffing vacancies that we were unable to fill despite ongoing recruitment efforts, the Quality Department had no facility site review nursing staff from January 2008 until August 2008. Thus, no audits could be performed during this time. The Quality Department acquired a full-time Facility Site Review Nurse in September 2008. A total of four audits were performed in August and September 2008 and 31 audits were performed in the 4<sup>th</sup> quarter of 2008 (October through December). For the four years prior to 2008, an average of six audits was performed per month. The audit rate of the 4<sup>th</sup> quarter of 2008 exceeded the prior years' per month audit rate by four audits.

### Site Review

“Provider type” identifies providers who contract with HPSM as a primary care provider (PCP) or a referral provider. OB/GYN providers are referral providers but they are “open access” providers for HPSM members for sensitive services. Of the 35 reviews performed in 2008, all were of PCP sites.

“Review type” identifies whether the review performed was of the physical site only, medical records only, or a full scope survey that comprised a site and medical record survey. Of the reviews performed in 2008, two were site only and none were medical record only; most (94%) were site and medical record combined.



In 2008, provider site review scores predominately ranged within the 90-99 percentiles. Medical record review scores also predominately ranged within the 90-99 percentiles.

Comparing this year's site review scores to last year's, 71% of the current year's scores fell in the 90-100% ranges, while last year 80% fell in the 90-100% ranges. For the current year, 23% of site scores fell in the 80-89% range as compared to 18% in the previous year.

For medical record review scores, 61% of the current year's scores fell in the 90-100% ranges, compared with 75% of the previous year's scores. For the current year, 30% of medical record scores fell in the 80-89% range as compared to 25% in the previous year.

#### Site Scores

|        | 2007 | 2008 |
|--------|------|------|
| 100%   | 5    | 1    |
| 90-99% | 48   | 24   |
| 80-89% | 12   | 8    |
| <80%   | 1    | 2    |
| TOTAL  | 66   | 35   |

#### Medical Record Scores

|        | 2007 | 2008 |
|--------|------|------|
| 100%   | 3    | 1    |
| 90-99% | 50   | 19   |
| 80-89% | 18   | 10   |
| <80%   | 0    | 3    |

Site review and medical record review scores are reported as separate rates. A score of 80% is considered passing in each category. Providers must successfully pass each portion of the full scope survey. A minimum score of 80% on the site review survey is required for credentialing. Medical record review may be performed at a separate date following a successful site review.

Network providers who are adding CareAdvantage to their contracting profile usually have a site and medical record review survey performed. If a provider is new to HPSM, a site review survey is performed and the provider will undergo a medical record review during the 3-6 months following the site review.

Providers may be in solo, group or shared office practices. Many providers have multiple office sites. Also, providers may move from one provider site to another and require re-reviews due to changing of address or provider staff.

The QAI department staff works closely with the Provider Services staff to perform reviews in a timely manner so that providers scheduled for credentialing or re-credentialing meet the appropriate timeframes for peer review by the PRC and presentation to the San Mateo Health Commission. This process will continue in 2009.

## **PROVIDER PARTICIPATION IN HPSM'S QUALITY PROGRAM**

HPSM has multiple avenues for physicians to contribute to its quality program. The most important way is through providing high quality and preventive care to HPSM members. Without our providers, HPSM could not offer services to our members.

HPSM's Medical Directors and Provider Services Manager have an "open door" policy. Contact numbers are freely available to physicians. When any physician has a quality improvement suggestion or a quality concern, they are encouraged to contact these or any other HPSM staff to share their thoughts, via phone, e-mail or letter.

There are also formalized ways for HPSM providers to participate in quality activities with the plan. These are via SMHC quality advisory groups. The following lists the activities performed by the physician-focused committees of the SMHC in 2008:

### **Peer Review Committee/Physician Advisory Group**

The Peer Review/Physician Advisory Group performed the following functions at its regular meetings throughout the year:

- Reviewed credentialing applicants and recommended for/against approval.
- Reviewed provider site and medical record review issues.

- Reviewed and gave feedback on quality programs and QIPs.
- Reviewed areas of clinical practice guidelines.
- Served as “focus group” of providers, offering a community physician view on health plan activities, quality plans, pay for performance, etc.

### **Quality Assessment and Improvement Committee**

The Quality Assessment and Improvement Committee performed the following functions at its regular meetings throughout the year:

- Reviewed and gave feedback on quality projects.
- Provided input and insight on HEDIS findings.
- Reviewed and made recommendations about areas of clinical practice guidelines.
- Helped evaluate proposed corrective action quality improvement plans
- Provided assessment and insight on pay for performance program, etc

### **HPSM QUALITY AND PERFORMANCE EVALUATION SYSTEM**

#### ***HEDIS Measures to be reviewed in 2009***

The following HEDIS measures are required by DHCS and CMS/NCQA to be included in our annual review for the coming year:

#### **Effectiveness of Care**

- Childhood Immunization Status
- Lead Screening in Children
- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Chlamydia Screening in Women
- Glaucoma Screening in Older Adults
- Care For Older Adults
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children With Upper Respiratory Infections
- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Pharmacotherapy Management of COPD Exacerbation
- Use of Appropriate Medications for People With Asthma
- Cholesterol Management for

#### Patients With Cardiovascular Conditions

- Controlling High Blood Pressure
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Comprehensive Diabetes Care
- Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Osteoporosis Management in Women Who Had a Fracture
- Antidepressant Medication Management
- Follow-Up After Hospitalization for Mental Illness
- Annual Monitoring for Patients on Persistent Medications
- Medication Reconciliation Post-Discharge
- Potentially Harmful Drug Disease Interactions in the Elderly
- Use of High Risk Drugs in the Elderly
- Medicare Health Outcomes Survey

### **Access/Availability of Care**

- Adults' Access to Preventive/Ambulatory Health Services
- Children and Adolescents' Access to Primary Care Practitioners
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Prenatal and Postpartum Care
- Call Answer Timeliness
- Call Abandonment

### **Use of Services**

- Well-Child Visits in the First 15 Months of Life
  - Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life
  - Adolescent Well-Care Visits
  - Frequency of Selected Procedures
  - Inpatient Utilization—General Hospital/Acute Care
  - Ambulatory Care
- 
- Inpatient Utilization—Non-acute Care
  - Mental Health Utilization
  - Identification of Alcohol and Other Drug Services
  - Outpatient Drug Utilization
  - Antibiotic Utilization

## **Cost of Care**

- Relative Resource Use for People With Diabetes
- Relative Resource Use for People With Cardiovascular Conditions
- Relative Resource Use for People With Uncomplicated Hypertension
- Relative Resource Use for People With COPD

## **Health Plan Description Information**

- Board Certification
- Enrollment by Product Line
- Enrollment by State
- Language Diversity of Membership
- Race/Ethnicity Diversity of Membership

## **Health Plan Stability**

- Years in Business/Total Membership

## **PAY FOR PERFORMANCE AS A QUALITY IMPROVEMENT STRATEGY IMPLEMENTED in 2008**

The Pay for Performance (P4P) Program is a monetary incentive program for our contracted Medi-Cal Primary Care Providers (PCPs). P4P incentivizes our PCPs to provide timely and high quality care to our Medi-Cal members. It also encourages providers to submit data regarding the care they provide to HPSM members. We hope that the financial incentives for our PCPs will dramatically improve our adolescent well visit, initial health assessment and routine diabetes screening rates for our Medi-Cal members, making P4P another strategy in our efforts to achieve improvement in our quality program.

## **PROPOSED 2009 QUALITY IMPROVEMENT STRATEGIES**

To continue the work initiated in 2008, the QAIP's 2009 quality activities will include a QI work plan that outlines the projects, studies and committee work scheduled for 2009. To give strategic emphasis on quality improvement in these key areas in 2009, HPSM plans to have 4 active quality improvement projects. These targeted interventions have set goals to improve HEDIS rates by at least 5%:

1. Increasing Access to Prenatal Care
2. Improving Avoidable ER visits: Statewide Collaborative
3. Improving Diabetes Management (CareAdvantage)
4. Improving cervical and breast cancer screening

In addition, IHA/IHEBA rates will be closely monitored with the goal of increasing this rate by 5%.

Further, we have set two additional internal goals as “stretch” goals for our department.

1. We want to have no HEDIS measure below the Minimum Performance Level (MPL) established by the state Department of Health Care Services (DHCS) for 2009
2. We would like to have two High Performance Level (HPL) HEDIS measures for 2009: “Appropriate Treatment of Children with URI” and “Appropriate Treatment of Adults with Asthma.”

We have chosen the two HPL measures since HPSM was close to the HPL for both of these in 2008. We don’t know what the new HPL values will be in 2009, but we will strive to encourage our physicians to keep up the good work. For the URI measure, we will work to remind our PCPs about only using antibiotics when they have a bacterial diagnosis. And, in particular with our asthma registry, P4P incentive and asthma quality program, we hope to continue improving our PCP activities in this area.

## **SUMMARY**

Progress has been made in quality improvement in 2008, but additional work is needed, particularly in the area of Timeliness of Prenatal Care, as well as in the areas of Adolescent Well Care, Improving Avoidable ER visits, Improving Diabetes Management, and Breast and Cervical Cancer Screening. IHA/IHEBA rates also need to be an important focus, as part of our state contract requirements.

HPSM’s Quality Program will continue to emphasize strategies to increase the quality of care of HPSM members in additional areas such as Immunizations and Asthma Care. We will continue to develop our Pay for Performance and Nurse Advice Line programs, both implemented in 2008. We will also continue our ongoing outreach and collaboration with members and providers and key stakeholder community agencies as part of HPSM’s ongoing efforts to optimize access and the high quality of care that is delivered so that we can continue to improve the health status of our members. These efforts will help to make certain that we are doing all we can to ensure that “Healthy is for Everyone.”