2015

Clinical Quality Improvement Program Evaluation

Measurement Year 2015
Clinical Quality Improvement Program Evaluation

The purpose of this report is to summarize quality improvement activities and initiatives, review subsequent results for trends and provide an analysis of the overall effectiveness of the Company’s Clinical Quality Improvement (CQI) Program. The Clinical Quality Improvement (CQI) department has established a process for annual evaluation of CQI activities, initiatives and results. The reporting period is based upon a calendar year, January to December. The following Medical Mutual plans are included: Medical Mutual of Ohio (MMO), Medical Health Insuring Corporation of Ohio (MHICO) and Consumers Life Insurance Company (CLIC). These licensed entities offer a variety of plans and products including: Commercial and Marketplace with HMO, POS and/or PPO products. Medicare Advantage products will be offered beginning in 2016.

All activities and initiatives within the 2015 CQI Work Plan have been evaluated in this report. The Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment Healthcare Plans Survey (CAHPS) results and other annual measurements were analyzed for trends to help assess performance in the quality and safety of clinical care and the quality of service provided to our members.

I. Clinical Quality Improvement Activities and Initiatives

The following activities were either completed in 2015 or are ongoing.

Health and Wellness Promotions

The Company continues to offer members health and wellness programs, including the following:

- QuitLine, this program offers our members telephonic counseling and a supply of nicotine replacement therapy at no out-of-pocket cost.
- Lifestyle Coaching, a telephonic or online coaching program to help members achieve personal health goals.
- Weight Watchers subsidized enrollment for members who have included weight loss in their personal health goals.
- Disease Management and Maternity program, this is a telephonic program for members with heart failure, COPD, diabetes, asthma, coronary artery disease, depression and expecting mothers.
- Prediabetes booklet (Company developed) to provide education to members at risk for developing diabetes
- Diabetes booklet, this booklet was designed to educate members with newly diagnosed diabetes. A multi-channel approach is used to reach members via mail or secure email.
Care Gap Closure and Prevention

Immunizations
- State Immunization Registry, to facilitate accurate targeting for childhood immunization education for members in Ohio, the Company supplements claims data by accessing the Ohio Statewide Immunization Information System (IMPACT). Providers are encouraged to utilize IMPACT.
- Child and Adolescent Immunization Reminders, to encourage immunizations recommended by the Advisory Council on Immunization Practices (ACIP), the Company, in partnership with Pfizer, utilizes postal mail and telephonic messaging through TeleVox (a healthcare message delivery company) to remind parents/guardians that their child has missed an immunization dose.

Preventive Services and Screenings
- Member Profile outreach, to remind members to obtain important preventive services, the Company utilizes a Member Profile outreach, which provides a gender and age specific preventive screening summary to all members over age 40.
- Direct Member Contact, when speaking telephonically to members, the Care Management or Customer Care team evaluates whether the member is receptive to receiving information regarding the necessary preventive service(s).
- Member Care Gap, the Company continued a process to identify care gaps through available data systems and conduct member multi-channel outreach in the following three areas:
  - Breast cancer screening
  - Cervical cancer screening
  - Colorectal cancer screening
- Provider Care Gap letter, the Company continues to produce provider notification letters, which give appropriate providers a list of members they are treating that have not obtained recommended diabetes testing or women's health services.
  - Diabetic missed services - to primary care providers and endocrinologists
  - Women's health missed services- to primary care providers including obstetrics/gynecology providers

Quality of Care

Activities include the following:
- The recently revised quality case tracking and monitoring policy now allows for clearer categorization of the different types of potential quality of care issues.
- The CQI department utilized a vendor to assist with HEDIS medical record retrieval, but continued in-house medical record abstraction for supplemental HEDIS data, HEDIS hybrid measures and specialized reviews.
- The Company acknowledges clinicians who have achieved recognition status in the NCQA Provider Recognition Programs for high level performance in providing patient care. During 2015, the number of network providers acknowledged for participating in recognition programs continued to increase.
Clinical Practice Guidelines published by nationally recognized organizations are adopted, reviewed at least biannually and made available to providers through the Company website.

Required annual network provider notifications, clinical updates and/or other educational items are published in the Company’s quarterly Mutual News provider newsletter.

Continuity of Care

Behavioral Healthcare:
- To accurately capture compliant behavioral health provider follow-up visits after hospitalization for mental illness, the Company continued two important data collection processes:
  - Care Management oversees and performs post-discharge calls to members and uses custom fields on our Focus Manager discharge screen to help identify opportunities for improved care coordination.
  - Identification and verification of a provider specialty for those submitting claims for behavioral health services when we have no record of specialty on file.
- To better coordinate care and services for members with co-morbid medical and behavioral conditions, the Company continued a dual medical/behavioral Case Management program to ensure that one Case Manager coordinates care for both medical and behavioral conditions when they exist in the same member.
- To encourage appropriate follow-up care for children prescribed medications for Attention Deficit/Hyperactivity Disorder (ADHD), the Company continued two important initiatives:
  - An educational card mailed each month to the parents/guardian of a newly diagnosed child. The card includes information on the importance of timely and regular follow-up care.
  - An educational letter mailed each summer to the parents/guardian of the child regarding the importance of a provider visit when restarting ADHD medication after a summer drug holiday.

Medical Healthcare
- To better identify and coordinate care following hospitalization, the Company utilizes a Voice Response Unit (VRU), an automated telephonic outreach program, targeting members with specific chronic conditions following discharge from an acute inpatient facility. The purpose of the program is to:
  - Identify potential transition of care issues following discharge.
  - Coordinate follow-up office visits if needed.
- To improve continuity of care for asthma members following an emergency department visit or discharged from the hospital, the following letters continue to be sent:
  - Mailing (within 7 days) to members experiencing one of the above events encouraging a follow-up visit with their asthma care provider.
  - Mailing (within 7 days) to asthma care providers (when able to identify) informing them of their patient’s recent asthma event and encouraging them to initiate a follow-up visit, if not already done.
Quality of Service

The CQI department continues to manage member complaints regarding accessibility of after-hour appointments, physician office appearance or adequacy of wait times and examination room availability. In addition, the CQI department continues to track member quality of service complaints. This process facilitates transfer of information to the Provider Engagement Department to address complaints sent to the CQI department as quality of care issues. The Company continues to enhance our provider network. Specialty areas under review for enhancement include but are not limited to include: behavioral health, endocrinology, oncology, cardiology and surgical specialties.

The Service Quality Improvement Committee (SQIC) continues to monitor and report on service measures, including, but not limited to:

- Claims timeliness and accuracy
- Appeals and IRO outcomes
- Telephone responsiveness
- Complaint and email timeliness

Member Experience

Our 2015 initiatives focused on continued improvement of member satisfaction with ease of finding and understanding information. Various redesign projects were launched or continued in efforts to improve our members’ understanding of the information provided to them:

- MMO improved explanation scripts, implemented written Speech Analytics Software to identify inconsistencies in terminology used by customer service staff and decrease confusion regarding what the terminology means to the average member. As a result, written material will contain consistent defined terminology in simple language, customer care specialists will be trained to be aware of this issue and to use consistent terminology to enhance member comprehension.
- The 2015 My Health Plan (MHP), the Company member website, review of website functionality and accuracy of information reported that no links were found to be directing members to incorrect locations.
- The Email Timeliness and Accuracy report revealed the corporate goal for 2014 for member email inquiries was 98 percent of emails are responded to within one day. We achieved and or surpassed this goal each month. There were 40,889 member email inquiries for 2014 and 40,473 of these emails were responded to within one business day.
- Overall, 99 percent of member internet inquiries were responded to within one business day.
- MMO monitors telephone accessibility on a quarterly basis to track performance and address any issues in a timely manner. Member provider calls are handled by a virtual Customer Experience Call Center. The Phone Accessibility Report for the past year identified significant technical difficulties, resulting in a processing backlog. This led to a higher than forecast volume of calls, which resulted in nearly 30 percent higher
wait times. Other initiatives included paper and online EOB redesign, EOB remark code simplification and MHP Claims Summary and Claim Detail redesign.

The MHICO Marketplace Member Experience report includes all member complaints, appeals and requests for out-of-network (OON) services. The data source of this information is the Contact Online Reporting System (CORS) and Focus Manager (FM). Table 1 below shows the number of complaints and appeals by category.

Table 1. Member complaints and appeals

<table>
<thead>
<tr>
<th>Category</th>
<th>Complaints</th>
<th>Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care</td>
<td>36</td>
<td>0</td>
</tr>
<tr>
<td>Access</td>
<td>3</td>
<td>24</td>
</tr>
<tr>
<td>Attitude/Service</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Billing/Financial</td>
<td>199</td>
<td>122</td>
</tr>
<tr>
<td>Quality of Practitioner Office Site</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>269</td>
<td>148</td>
</tr>
</tbody>
</table>

The following list is a highlight of member experience issues identified:

- There were 24 appeals listed as access issues significant for OON services to be paid at network rates. This was attributed to the MHICO Marketplace PPO product launch in 2014, which allowed coverage for all out-of-network (OON) services.
- Office staff attitude and service complaints increased.
- Many billing and financial complaints were because MHICO Marketplace members were confused about how and when to make premium payments.
- Other provider billing practice issues included the following:
  - Balance billing.
  - Upfront billing of deductible and or coinsurance.
  - Member perception of time spent in office versus time billed for office visits.
  - Non-contracting providers billing for services at contracting hospitals.
- There were no complaints or appeals regarding the quality of the office site facility.

The Company continually works toward meeting our members’ culturally diverse and linguistic needs through adherence to our Cultural Competence Processes. The Cultural Competence Report revealed that the Company met all current requirements for collecting and monitoring population-based information on cultural and linguistic needs and ensuring provider access in to targeted geographical areas.

The following ongoing activities support our corporate efforts to improve quality, safety and service for our members:

- Accessibility and Availability Standards
- Care Management Activities (Utilization Management/Clinical Quality Improvement, Medical Review, Chart Audit)
- Case Management Safety Assessments
- Clinical Practice Guideline Development, Distribution and Monitoring
- Disease Management and Maternity Program Activities
• Alcohol Screening in the Physician Office Setting
• Hospital Comparison Tool (My Care Compare)
• Inpatient Mortality Monitoring and Analysis
• Office Safety Review
• Participation in the NCQA Provider Recognition Programs
• Patient Centered Medical Homes Initiative
• Prescription Medication Monitoring

Overall, 2015 member complaints have dropped 6.2 percent from 2014.

II. Trending of Clinical Quality Improvement Measure Results

Assessment of performance for quality and safety of clinical care and quality of service includes evaluating both positive and negative trends in the quality improvement activities data. The source of this data includes HEDIS, CAHPS and organization-specific measures.

The Medical Mutual Clinical Quality Improvement (CQI) Program is responsive to the ever-changing healthcare environment and strives to continuously improve the quality and safety of healthcare our members receive. Our program employs a team approach to identify barriers and opportunities for improvement. The team reviews trends and addresses quality and safety issues. Appendix A contains a comprehensive list of trended data used in this analysis.

Healthcare Effectiveness Data and Information Set (HEDIS®)

Results from HEDIS 2015 indicate 31 of the 39 measures showed improvement. Measures showing the most significant change, positive or negative, are identified in Table 2 below. Follow-up care for children prescribed ADHD medications had the most significant decrease from the prior measurement period and will continue to be monitored.

Table 2. Top HEDIS Measures with Significant Change

<table>
<thead>
<tr>
<th>HEDIS Measure</th>
<th>2014 Rate</th>
<th>2015 Rate</th>
<th>Percentage Point Change</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 day follow-up after hospitalization for mental illness</td>
<td>46.54%</td>
<td>52.75%</td>
<td>+6.21</td>
<td>0.00</td>
</tr>
<tr>
<td>30 day follow-up after hospitalization for mental illness</td>
<td>69.29%</td>
<td>74.61%</td>
<td>+5.32</td>
<td>0.00</td>
</tr>
<tr>
<td>Follow-up care for children prescribed ADHD medications</td>
<td>40.43%</td>
<td>27.02%</td>
<td>-13.71</td>
<td>0.00</td>
</tr>
</tbody>
</table>
Consumer Assessment Healthcare Plans Survey (CAHPS)

Medical Mutual saw no significant improvements in ratings compared to the prior year. The items identified in Table 3 below were driving forces in the overall health plan rating for 2015. Two additional measures scored in the 75th percentile, contributing to the success of the overall health plan rating were:

1. How Well Doctors Communicated (spent time)
2. Plan Information on Costs (found information on cost of services/equipment)

### Table 3. CAHPS Measures

<table>
<thead>
<tr>
<th>CAHPS Measure</th>
<th>2014 Rate</th>
<th>2015 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Measures in the 25th Percentile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of Health Plan (healthcare)</td>
<td>73.11%</td>
<td>64.29%</td>
</tr>
<tr>
<td>Rating of Health Care</td>
<td>83.61%</td>
<td>78.26%</td>
</tr>
<tr>
<td>Rating of Specialist (personal doctor)</td>
<td>87.39%</td>
<td>84.48%</td>
</tr>
<tr>
<td>Claims handled quickly (handled quickly; handled correctly)</td>
<td>93.09%</td>
<td>87.62%</td>
</tr>
<tr>
<td>Getting Care Quickly</td>
<td>89.46%</td>
<td>87.07%</td>
</tr>
<tr>
<td>Service Measures in the 10th Percentile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Got urgent care as needed</td>
<td>90.85%</td>
<td>85.62%</td>
</tr>
<tr>
<td>Written materials or Internet provided needed information</td>
<td>70.37%</td>
<td>62.60%</td>
</tr>
</tbody>
</table>

The greatest opportunity identified in the survey was improving ease of understanding of our written materials and ease of finding information on our Company website. In addition, we will continue to focus on handling claims correctly and quickly.

Even though we had measures scoring in the 25th percentile, these rates were better than the Quality Compass national average (non-PPO) rates for 2014. All measures scoring in the 25th percentile will continue to be evaluated and their initiatives will be monitored more closely for effectiveness.

As part of our CAHPS evaluation, we performed a gap analysis. The gap analysis for MMO and MHICO identified the following opportunities:

- Enhancement of written materials or internet provided information on cost of service or equipment and prescription medications
- Care coordination (getting test results when needed)
- Members receiving flu shot or spray
- Provider discussed risks and benefits of aspirin

Overall, the gap widened on all key measures between 2014 and 2015. Our results show that members are most concerned about information: on benefits; costs of services, equipment and medications; location and availability of network practitioners; and, getting needed appointments. The Company continues to meet all current requirements for collecting and monitoring population-based information on cultural and linguistic needs and ensuring access to providers in targeted geographical areas. Information from all available sources will continue to
be used to continuously improve our efforts to ensure high quality of service and care is provided to our members.

**Patient Safety**

Patient safety is a top concern of our Company and we have several initiatives within our Clinical Quality Improvement program to ensure members receive the best care possible. Our mortality study initiative, ongoing evaluation of member complaints and quality of care case reviews are routinely evaluated to enhance safe medical practices.

**Mortality Study**

The Mortality Study is a patient safety initiative in which a percentage of mortality cases are routinely reviewed. The Cases are selected from a monthly mortality report of members who expired during an inpatient stay. Case review revealed most deaths were not related to a quality of care issue, as indicated in Table 4 below.

**Table 4. Mortality Study**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases reviewed where no quality issue was identified</td>
<td>120</td>
<td>90%</td>
<td>113</td>
<td>93%</td>
</tr>
<tr>
<td>Cases removed from the study (duplication/inappropriate)</td>
<td>9</td>
<td>7%</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Cases forwarded to a physician reviewer</td>
<td>3</td>
<td>2%</td>
<td>5</td>
<td>4%</td>
</tr>
<tr>
<td>Cases determined to have quality of care issue</td>
<td>1</td>
<td>1%</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Cases escalated to CQI Committee</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Providers meeting or exceeding the occurrence threshold following trending</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>133</td>
<td>100%</td>
<td>122</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Member Complaint Analysis**

The CQI Nurse Reviewer or CQI Analyst monitors and assesses member experience through the review of member complaints regarding quality of care, quality of service, accessibility to and availability of providers. Any of these complaints could impact patient safety and are taken very seriously. Reported member complaints decreased in the 2015 reporting year. The quantity of member complaints reviewed by the CQI department dropped in 2015. It is possible that fewer members complained in reporting year 2015; however, all inter-facing departments are being re-educated to recognize member complaints and the correct steps to take when a complaint is received. A detailed evaluation of accessibility complaints is contained within the annual Accessibility to Primary Care Provider (PCP) and Behavioral Health Provider Services report.
Table 5. Member Complaints

<table>
<thead>
<tr>
<th>Member Complaints</th>
<th>2014 Complaints</th>
<th>2015 Complaints</th>
<th>Year to Year Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redirected complaints to other departments</td>
<td>536</td>
<td>263</td>
<td>50.9% decrease</td>
</tr>
<tr>
<td>Quality of service complaints</td>
<td>181</td>
<td>123</td>
<td>32.0% decrease</td>
</tr>
<tr>
<td>Quality of care concerns</td>
<td>305</td>
<td>243</td>
<td>20.3% decrease</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1022</strong></td>
<td><strong>629</strong></td>
<td><strong>38.4% decrease</strong></td>
</tr>
</tbody>
</table>

Quality of Care Case Review

Outcomes from our review of quality of care cases for all lines of business are reported in the annual Quality Case Report, which is presented to the CQI Committee for review and approval. Overall, our providers performed well and the number of the quality of care issues remained low. This would suggest that current and newly introduced CQI provider initiatives were effective and improved our ability to assist providers in improving the quality of care provided within in our network and the community.

Potential qualities of care cases are reviewed by a CQI Nurse Reviewer or CQI Analysts; Physician Reviewers are available to help determine if a quality of care issue exists. The table below describes the types of actions taken after a physician review.

Table 6. Quality Cases Evaluated by a Physician Reviewer

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No quality issue identified by physician reviewer</td>
<td>22</td>
<td>47%</td>
<td>12</td>
<td>35%</td>
</tr>
<tr>
<td>Potential quality issue identified and case flagged for</td>
<td>17</td>
<td>36%</td>
<td>19</td>
<td>56%</td>
</tr>
<tr>
<td>trending</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendation of Corrective Action Plan or Letter</td>
<td>8</td>
<td>17%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>of Concern</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality issue referred to Clinical Credentialing</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td>Committee for follow-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>47</strong></td>
<td><strong>100%</strong></td>
<td><strong>34</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Reporting Parameters

The CQI department has consulted with Douglas Einstadter, M.D., MPH, Professor of Epidemiology and Biostatistics, Case Western Reserve University to perform statistical analysis for clinical initiatives. Service related initiatives were reviewed by the Service Quality Improvement Committee (SQIC). Results are reviewed by the Chief Medical Officer and presented to the CQI Committee.
III. Analysis and Evaluation of CQI Program Effectiveness

Components of the CQI Program include committees, resources, and a work plan. Each of these components is summarized below. Once the performance and evaluation of each component is summarized, an overall program effectiveness is described in our conclusion.

CQI Committee Structure

The Chief Medical Officer (CMO) is appointed to chair the CQI committee and assumes responsibility for the design and implementation of the CQI program.

Responsibilities for various clinical functions inherent in the CQI Program are delegated as appropriate, to clinical staff and designated physicians. Eight clinical committees support the CQI program, with the CMO, or a Medical Director chairing pertinent clinical committees. The structure and need for each committee has been developed based on the ability of the CQI Program to functionally operate within the Company. Committee members are comprised of practicing network providers from almost thirty clinical specialties.

Functions of the CQI department include abstraction of medical records for potential quality of care issues, supplemental databases, HEDIS hybrid measures, as well as specialized reviews. The CQI department reviews, tracks and monitors all member and provider, written or verbal feedback relating to CQI initiatives. CQI Analysts use all available data sources, including HEDIS, to monitor and improve quality of care through a wide variety of provider and member initiatives.

Following an internal review of corporate goals and strategy, the Company determined that the existing committee structure while effective could benefit from restructuring to help revitalize and optimize our current efforts.

CQI Program Resources

The Company has dedicated substantial investment and resources to the development and implementation of tools to promote high quality services to our members, including claims processing, data mining and analytical software for state of the art reporting processes.

Staffing resources utilized to support the corporate CQI Program include management staff from a significant number of departments within Medical Mutual, in addition to the Care Management and CQI departmental staffs.

Based upon review and analysis of CQI activities across all lines of business including Medicare Advantage, the CQI department determined that additional human resources would be beneficial to meet our goals and objectives. A supervisor position will be added in 2016 to allow for more coaching and assistance in implementing new initiatives to improve quality of care and service provided to our members. Resources will be requested for a medical coder to assist with coding needs for preventive screenings and additional staffing in the health informatics department.
Summary of CQI Projects (Work Plan Evaluation)

Evaluating the CQI Program and Work Plan against its stated goals and objectives includes identification of barriers to improvement, and then developing and implementing initiatives to overcome the identified barriers. Barriers were identified by the Clinical Quality Improvement (CQI) team through an analysis of HEDIS and/or CAHPS trended rates, a review of literature, and an evaluation of our competitors’ programs, including safety measures. Barriers were then prioritized based upon their related importance. As barriers were identified and new interventions developed, the CQI Committee was asked for input regarding the barriers and potential effectiveness of the proposed interventions. Once identified, barriers to achieving program goals during the review period are organized into four categories. See Table 7 to review our top barriers and interventions.

Table 7. Top Barriers and Interventions

<table>
<thead>
<tr>
<th>Member barriers</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noncompliance with advised treatment plans.</td>
<td>Educate members regarding benefit coverage for preventive coverage.</td>
</tr>
<tr>
<td>During the current period of financial uncertainty, members are reluctant to</td>
<td>Direct parents to reliable sources of information via mail/phone/web.</td>
</tr>
<tr>
<td>pay the out-of-pocket expense of copays, deductibles and coinsurance amounts to</td>
<td></td>
</tr>
<tr>
<td>remain current with recommended preventive healthcare.</td>
<td></td>
</tr>
<tr>
<td>Provider barriers</td>
<td>Interventions</td>
</tr>
<tr>
<td>Incorrect provider addresses continues to adversely affect educational</td>
<td>Provide physicians with nationally recognized National, Evidence-Based</td>
</tr>
<tr>
<td>initiatives across the entire CQI Program.</td>
<td>Clinical Practice Guidelines.</td>
</tr>
<tr>
<td></td>
<td>Create inter-departmental team to improve provider addresses within our data</td>
</tr>
<tr>
<td></td>
<td>systems.</td>
</tr>
<tr>
<td>System barriers</td>
<td>Interventions</td>
</tr>
<tr>
<td>Increased government regulations and changes in administrative policy have</td>
<td>Enhancements in data collection and customer service processes for early</td>
</tr>
<tr>
<td>increased the need to enhance and deliver member communication at a faster</td>
<td>identification of at risk network population.</td>
</tr>
<tr>
<td>pace.</td>
<td>Case management outreach to hospital discharge planners as soon as possible</td>
</tr>
<tr>
<td></td>
<td>to promote and assist with scheduling of post-discharge follow-up visits with</td>
</tr>
<tr>
<td></td>
<td>an outpatient network provider specialist.</td>
</tr>
<tr>
<td>Efforts aimed at data metrics analysis were significantly affected by the</td>
<td>Initiation of enhanced inter-departmental communications between the Clinical</td>
</tr>
<tr>
<td>lack of interim measurements due to insufficient data availability.</td>
<td>Quality Improvement and Health Informatics departments.</td>
</tr>
<tr>
<td></td>
<td>Enhanced staffing and restructuring of both departments was implemented to</td>
</tr>
<tr>
<td></td>
<td>improve process efficiency.</td>
</tr>
</tbody>
</table>
Disease/Chronic condition barriers | Interventions
---|---
Non-compliance with treatment is an inherent component of many disease states/chronic conditions. | Educate members regarding benefits of the Disease Management programs.
| Educate members regarding lifestyle changes to improve health.

**CQI Project Summary**

The CQI Project Work Plan Summary is a fluid working document used to record and evaluate current CQI activity. It provides details on the status of how we are meeting our project objectives. Individual Project Improvement Plans contain details of all initiatives and are used to support the CQI Work Plan Summary. The 2015 CQI Project Work Plan Summary evaluates each of the projects within the QI Work plan and is located in Appendix B. Highlights of the Work Plan Summary are listed below. The following project objectives for this past year’s activities were met:

- Evaluate CAHPS result – results were analyzed and although our overall health plan rating was significantly lower than in the previous year an effective evaluation of our current CAHPS results identified an opportunity to educate members on claims navigation thus improving service and access.
- Evaluate HEDIS results – HEDIS results were analyzed and barriers and opportunities identified for individual measures. Based upon results impacted by the glitches in our medical record retrieval processes, a new vendor was selected for the 2016 HEDIS season.
- To improve asthma medication adherence and medication safety – There were slightly more members compliant with medication adherence 75 percent of the time when comparing MY 2015 to MY 2014. Members with asthma did slightly improve medication adherence attributed to our member outreach initiatives.
- Marketplace beta testing was done for measurement year 2014. Trending is not yet available, so QI initiatives were based upon our Commercial product results.

Projects not achieving their objectives will be prioritized and evaluated by the CQI team to determine focus areas for 2016. The following list contains priority projects of interest:

- Improve communication between BH specialists and Primary Care Providers - Analysis identified the following barriers:
  - Social stigma for mental illness
  - Provider knowledge gaps for related to the importance of communication
  - Ineffective motivation to improve communication
  - Impact of HIPAA on communication efforts
- To improve appropriate treatment post-COPD exacerbation – Claims for appropriate medications post-COPD exacerbation declined slightly in MY 2014, while the number of documented events almost doubled. This will be evaluated to identify opportunities for better coding, claims processing and improved COPD treatment.
• To improve treatment outcomes for members suffering from major depressive disorder – Analysis revealed that in addition to non-compliance, comorbidities with significant symptom burdens, misdiagnosis, ineffective treatment regimens and member provider knowledge gaps effect success rates for this objective. We plan to look at them measure more holistically.

• To ensure proper ADHD medication follow-up for children 6-12 years of age newly prescribed ADHD medication – Analysis revealed a slight down trend in the rate of office visits and the following opportunities have been identified:
  o Encourage offices to schedule follow-up appointments and utilize office reminder systems
  o Encourage office visits after taking a prescribed medication holiday during the summer.

Conclusions of Overall CQI Program Effectiveness

In our analysis and evaluation of the overall effectiveness of the CQI program, barriers and limitations were identified: internal staffing changes; addition of risk adjustment processing system activities; product changes; and, vendor processing difficulties. The CQI team has assessed all of these issues and is implementing improved processes for 2016. Workgroups have been identified to work on each issue and staffing and structure are also being addressed.

Our members indicated better customer service was a key driver to improving our overall health plan satisfaction rate. Areas of customer service we wish to focus on include written materials and our website. Proposed actions include, but are not limited to, continual analysis of the ease of finding information and educating staff that have direct member contact how to find needed information. Our website was revised in 2015 and will be continuously evaluated for additional improvement opportunities.

Our initiatives continue to prove effective in the identification, development and evaluation of progress towards influencing organizationally safe clinical practices. Patient Safety reports, such as the Mortality Report, the Quality Case Report and the Member Complaint Analysis all closely monitor activities for safe clinical practices. Medical Mutual remains committed to improving the overall effectiveness of our CQI program by addressing barriers and continuing to identify new opportunities for improvement. Our CQI project initiatives have assisted in addressing these new opportunities and staff continually research ideas for company growth through vendor offerings, tools and collaborations.

All network and quality improvement programs apply to the MMO Commercial and Marketplace Exchange plans. Although results were monitored to identify any unique outcomes for the Marketplace Exchange plan, none were identified in the first year of beta testing. Entrance into the Medicare Advantage market will begin in January 2016, following a two year preparation which allowed time to ensure that the existing, high quality and effective CQI activities applied to our Commercial and Marketplace Exchange business would be available to our Medicare products as well. The Company is energized for revitalization and expansion in 2016.