Quality Improvement Program Evaluation

January 1, 2014 to December 31, 2014
I. Executive Summary

The purpose of this report is to summarize completed and ongoing quality improvement activities and evaluate the overall effectiveness of the Company’s Quality Improvement (QI) Program. The Clinical Quality Improvement (CQI) department established a process for annual evaluation of QI activities, initiatives and results by utilizing a reporting period based upon a calendar year, January to December, which allows timely reporting of the Healthcare Effectiveness Data and Information Set (HEDIS®) results and other annual measurements. These activities are analyzed for trends which help assess performance in the quality and safety of clinical care and the quality of service provided. This evaluation describes activities derived from the QI Program Description, the QI Work Plan and related QI projects, studies and initiatives.

Due to the development and implementation of an annual comprehensive Disease Management and Maternity Program Outcomes report, disease management outcomes continue to be excluded from the QI evaluation. Please refer to the 2014 Disease Management and Maternity Program Outcomes report for current results.

Medical Mutual’s plans, including Commercial (HMO/POS/PPO/Off Public Marketplace), On Marketplace/Exchange, and MHICO are dedicated to its members’ health and well-being. In addition the Company facilitates quality healthcare through provider and member evidence-based educational materials, interventions, and activities. These clinical QI activities include the development and implementation of patient safety initiatives, methods for monitoring potential quality of care issues, member and/or provider complaints and focused continuity of care initiatives.

Network-Wide Safety

Medical Mutual is committed to a comprehensive patient safety program to afford our members a network of practitioners and providers that consistently demonstrate safe healthcare practices. Components of the Safety Program include:

Mortality Study:
During 2014, 122 cases were referred for the mortality study. Four of the cases (0.3%) were referred for quality code 103 – Unexpected Death, while three cases required review by a Physician Reviewer. In two of the cases forwarded to a Physician Reviewer, a quality issue was identified, but the review outcome recommended trending for occurrence threshold. Neither provider met or exceeded the threshold. No cases required subsequent review by the CQI Committee.

Accessibility to Primary Care Provider (PCP) and Behavioral Health Provider Services:
Medical Mutual established Provider Accessibility Standards for PCPs and Behavioral Health providers, in addition to publishing a member friendly version. The Accessibility Standards are reviewed at least every two years by the Clinical Quality Improvement (CQI) Committee. Measures to assess member satisfaction with access to PCP and Behavioral Health providers include question #4 and #6 on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and member complaints.
Member Complaints:
Member complaints are received from three primary sources: Customer Service, Care Management and the Company’s website, which are then forwarded to the CQI department through the Company’s teleprocessing system. Member complaints are collected throughout the measurement year and analyzed annually at the end of the measurement period. Each member complaint is thoroughly reviewed by a CQI Analyst and a written response is sent to the member per the departmental policy. Outcomes of the Accessibility to Primary Care Provider (PCP) and Behavioral Health Provider Services are reported to the CQI Committee for review and approval in the annual Executive Summary.

Potential Quality of Care Review:
In addition to Mortality and Accessibility/Availability, the CQI Department tracks and monitors all potential and actual clinical quality issues falling into the following categories:
- Quality of Medical Care
- Other Clinical Quality Issues
- Disease and Maternity Management Program Issues

CQI Analysts are expected to initiate review on new cases within thirty (30) calendar days from corporate receipt. For member complaints, an acknowledgement letter is sent within 30 calendar days of corporate receipt of the complaint. When reviewing potential quality-of-care cases, the CQI analyst, using nursing judgment, may close cases without involving a designated Physician Reviewer or the Chief Medical Officer (CMO) if a determination is made that no quality-of-care issue exists.

Quality of care review outcomes are reported in the annual Quality Case Report, which is presented to the CQI Committee for review and approval.

QI Program Resources:
On behalf of the Board of Trustees, Medical Mutual President, Chairman and CEO, delegates ongoing oversight of the Company’s accreditation activities, including quality initiatives, to the CQI Committee, under the aegis of the Chief Medical Officer (CMO), who is responsible for the design and implementation of the QI Program.

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 analytics software for state of the art reporting processes.

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

Following review and analysis of current corporate resources and staffing, Medical Mutual determined that its implementation of a Medicare Advantage product would require additional resources, mostly staffing, as the systems in place are adequate with some adjustment. Implementation is scheduled for January 1, 2016, with additional resources being put into place during 2015.
II  Quality Improvement Program

QI Committee Structure

Following review of clinical and service QI initiatives, the Company determined that the existing committee structure meets current needs and that the available QI resources ensure continued growth of corporate QI program activities.

Accreditation


The Company’s Medical Health Insuring Corporation of Ohio (MHICO) Exchange health plan for the Patient Protection and Affordable Health Care (PPACA) received an Interim accreditation status for its Exchange PPO Product effective December 9, 2013 to June 9, 2015. This product will go through a First Accreditation process May 4-5, 2015.

Practitioner Participation:

Responsibility for various clinical functions inherent in the QI Program is delegated to Chief Medical Advisors (CMAs). Eight clinical committees support the QI program, with each CMA chairing the pertinent clinical committee. The structure and need for each committee has been developed based on the ability of the QI Program to functionally operate within the Company. Physician and clinical committee members are comprised of practicing participating providers from almost thirty clinical specialties. All participating providers continue to practice in their specialty and none are internal or full-time employees of Medical Mutual.

Based upon review and analysis of QI activities, the CQI Committee determined that resources were adequate to support the QI program and the current structure met the Company’s needs throughout 2014.

III. Quality Improvement Activities

Completed and Ongoing Activities

The following list contains quality improvement activities addressing quality and safety of clinical care and quality of service that were either completed in 2014 or are ongoing.

◇ The Company continues to offer members health and wellness programs, including:
  o QuitLine program, which offers our members telephonic counseling and up to eight weeks of nicotine replacement therapy at no out-of-pocket cost.
  o Lifestyle Coaching, a telephonic or online coaching program to take action and achieve personal health goals.
◇ Due to website ordering and delivery issues, access to The Chef’s Garden, a family-run, sustainable growth farm in Ohio that offered more than 600 varieties of fresh lettuces, greens, vegetables, herbs and micro greens was discontinued during 2014.
The CQI department functions include provider Credentialing office review, chart review for supplemental databases, urgent care reviews and HEDIS Hybrid measures, as well as specialized reviews for specific CQI Analyst measures.

The CQI department continues to manage member complaints regarding practitioner physical accessibility, physical appearance or adequacy of waiting and examination rooms. Practitioners who reach an occurrence threshold of three member environmental complaints within a credentialing cycle are subject to an office site visit and medical record keeping review to assess practitioner compliance with Company, national accreditation body and regulatory standards.

The CQI department reviews, tracks and monitors all member, provider and facility written or verbal comments or concerns relating to QI initiatives. Information gathered is analyzed for the identification of issues that would affect the quality of care provided to our members.

In addition to the recently revised quality case tracking and monitoring policy to allow better categorization of different types of potential quality of care issues, the CQI department continues to provide a process for management of misdirected member quality of service complaints. This process facilitates transfer of information to the Professional Contracting department to address complaints mistakenly sent to the CQI department.

To facilitate timelier targeting of newly pregnant members, data queries have been converted to weekly intervals and are uploaded to our delegated Disease Management program vendor’s (Alere) protected FTP site. Targeted members are soon contacted via phone to discuss the benefits of participation in the Maternity Management program. In addition, members placing calls to the Customer Care Center regarding maternity benefits are given information regarding potential enrollment in the Maternity program, as well as the phone number. As with any DM program, members may opt-out if they do not wish to participate.

The Company is committed to promoting the safety of all members. Our patient safety plan is designed to reduce medical errors by utilizing models of continuous quality improvement in a proactive manner and in response to actual occurrences.

The Company acknowledges clinicians who have achieved recognition status in the NCQA Provider Recognition Programs for high level performance in providing patient care. During 2014, the number of network providers participating in any of the recognition programs continued to increase. The Company’s provider directories display the NCQA Recognition Program seal for providers who participate in the following programs:

- Diabetes Recognition Program
- AHA/ASA Heart/Stroke Recognition Program
- Physician Practice Connections
- PCMH Patient Centered Medical Home
- Back Pain Recognition Program

A six-month lifestyle management pilot hypertension program, expanded to additional customers in 2013, was concluded. Pilot project outcomes were reported to the participating groups and a decision was made not to continue with the project.

During 2014, the Company continued to use the interactive voice recognition technology of Eliza Inc. to contact members in the Ohio Public Employees Retirement Systems (OPERS) group with a missed service for seasonal influenza immunization.
Clinical Practice Guidelines published by nationally recognized, peer reviewed organizations are adopted and made available on the provider website:

- Alcohol Screening
- Asthma
- Attention Deficit/Hyperactivity Disorder
- Cholesterol
- Continuity and Coordination of Care
- COPD
- Coronary Artery Disease
- Depression, for Behavioral Health and Primary Care Providers
- Diabetes Mellitus
- Heart Failure
- Hypertension
- Musculoskeletal and Chronic Pain
- Preventive Care
- Tobacco Dependence

To facilitate accurate targeting for childhood immunization education for members in Ohio, the Company supplements claims data by accessing Ohio’s Statewide Immunization Information System (IMPACT). To encourage timely immunization as recommended by the Advisory Council on Immunization Practices (ACIP), the Company, in partnership with Pfizer, utilizes postal mail and telephone messaging through TeleVox to parents of children who have missed services for the Pneumococcal vaccine. Approximately 800 children under the age of 2 years are identified each month.

To educate members newly diagnosed with diabetes, the Company sends newsletters, delivered via mail or secure email, each month to members with claim data indicating a new diagnosis of diabetes.

The Company developed a provider missed services reminder. The reminder gives providers a list of members they are treating that have not obtained recommended diabetes testing.

Because prediabetes is a prevalent condition among our members, the Company developed a newsletter to provide education about prediabetes to members that have this condition based on analysis of laboratory results.

Recognition of the need to improve compliance with behavioral health follow-up appointments following hospitalization for mental illness led to the successful continuation of an innovative post-discharge program. The goal of the program is to provide our members and providers with an incentive to comply with post-discharge follow-up visits.

To accurately capture compliant behavioral health provider follow-up visits following hospitalization for mental illness, the Company continued two important data collection processes:
- The addition of fields to our discharge screen for tracking follow-up visits during post-discharge calls to the member to assess the rate of compliance.
- Identification and verification of compliant behavioral health specialist follow-up visits to providers for whom we previously had no record of specialty.

To better coordinate care and services for members with co-morbid medical and behavioral conditions, the Company continued a medical/behavioral Case Management program to ensure that one Case Manager coordinates the care for both medical and behavioral conditions.

To encourage appropriate follow-up care for children prescribed Attention Deficit/Hyperactivity Disorder (ADHD) medications, the Company continued two important initiatives:
- An educational card mailed each month to the parent or guardian including information on the importance of timely and regular follow-up care.
- An educational letter mailed each summer to the parent or guardian regarding the importance of a provider visit when restarting ADHD medication after a summer drug holiday.
To better identify and coordinate care following hospitalization, the Company implemented a voice response unit (VRU), an automated telephonic outreach program, targeting members of a large employer group discharged from an acute inpatient facility. The purpose of the program is to:
- Identify potential transition of care issues following discharge.
- Determine if VRU outreach is a viable means of discharge follow-up versus live telephonic outreach for a large population.

To improve continuity of care for asthma members who were seen in the emergency department or discharged from the hospital, the following letters continue to be sent:
- Weekly mailing to members experiencing one of the above events encouraging a follow-up visit with their asthma care provider.
- Weekly mailing 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.

To remind members to obtain important preventive services, the Company expanded the existing Member Profile outreach, which provides a gender and age specific preventive screening summary.

During 2014 the Company continued a process whereby a customer service team identifies members of a large employer group that, according to claims data, demonstrate a care gap in the following three areas:
- Breast cancer screening
- Cervical cancer screening
- Colorectal screening

If one of the targeted members calls the customer service department about any other issue, the customer service team will remind and/or encourage the member to obtain the necessary preventive service.

Following evaluation and analysis of corporate provider communications, the decision was made to stop publication of the *Eye on Quality* provider newsletter after the 2014 Fall issue and incorporate required annual network provider notifications, clinical updates and/or other informational items into the quarterly *Mutual News* provider newsletter.

Continually work toward meeting our members’ culturally diverse and linguistic needs through adherence to our Cultural Competence Processes (See Appendix A Cultural Competence Report).

A department policy to address serious reportable events continues to be reviewed and revised to optimize tracking and reporting of these events, with the objective of identifying and responding to any quality of care issues that would affect the safety our members (See Appendix B Patient Safety Program and Plan).

See Appendix A: Quality Improvement Activities for a comprehensive analysis of all QI activities in the 2014 QI Work Plan, with trending, barriers and opportunities for improvement also identified.

**Barrier Identification**

Analysis of the QI Program and Work Plan against its goals includes identification of barriers to improvement, developing and implementing initiatives to overcome the barriers identified. Once identified, barriers to achieving program goals during the review period are organized into three categories:
Member barriers include, but are not limited to:
- Incorrect, or lack of, member phone numbers continue to adversely affect enrollment in, and educational initiatives associated with, disease and case management programs
- Some employer groups request that their members be excluded from educational mailings
- Some employer groups elect not to offer the Company’s case and/or disease management programs
- The continued move from HMO/POS gatekeeper products to PPO products affects the ability to identify providers for targeted interventions
- Members selectively choose recommendations they want to adopt based upon personal/family history and/or negatively perceived past experiences
- Noncompliance with advised treatment plans
- During the current period of financial uncertainty, members are reluctant to pay the out-of-pocket expense of copays, deductibles and coinsurance amounts to remain current with recommended preventive healthcare
- An increase in Consumer Directed Health Plans (CDHPs) and High Deductible Health Plans (HDHPs)

Provider barriers include, but are not limited to:
- Incorrect provider addresses continues to adversely affect educational initiatives across the entire QI Program
- Providers’ ability and/or resistance to comply with recommended improvement initiatives and clinical practice guidelines
- Lack of knowledge regarding, or adherence to, current clinical guidelines and recommendations
- Lack of knowledge regarding, or adherence to, coverage for specific recommended tests and/or treatments

System barriers include, but are not limited to:
- Health Insurance Portability and Accountability Act (HIPAA) regulations have adversely affected the ability to access certain types of patient information needed for QI activities
- Distribution of member educational materials via email is hampered by incorrect e-mail addresses and enhanced Spam filters
- The number of specialists who are moving out of the state of Ohio to avoid increased malpractice insurance premiums is adversely affecting member access in certain specialties
- The lack of a suitable instrument to track and monitor all aspects of patient care
- Increased government regulations and changes in administrative policy have increased the need to enhance and deliver member communication at a faster pace

Disease/Chronic Condition barriers include, but are not limited to:
- Difficulty in evaluating the impact of the use of low-cost generic prescriptions.
The lack of a suitable tool to evaluate the impact of plan designs that result in higher member financial liability for prescription medications

Non-compliance with treatment is an inherent component of many disease states/chronic conditions

Members that have no medical history may believe that post-discharge follow-up is not necessary, and likely do not have an established outpatient provider.

Medication samples and low-cost generic prescriptions available through major retailers may influence the accuracy of prescription drug fill and refill data

Trending of Measures

Assessment of performance for quality and safety of clinical care and quality of service includes evaluating both positive and negative trends in the data.

Clinical Quality and Safety

During the 2014 most of the HEDIS measures used to evaluate this year’s overall program effectiveness showed an improvement in rates. Measures that performed well are those scoring in the 50th and 75th Percentile. The measures that performed well and had statistically significant improvement from the prior measurement period include measures such as Children with Pharyngitis (p-value 0.02) and Pharmacotherapy Management of COPD (p-value 0.00). These measures will continue to be monitored, but there will be no major changes to their quality improvement plans.

Measures scoring in the 25th Percentile also saw rate improvements that were statistically significant, for example Appropriate Treatment for Children with Upper Respiratory Infection rate increase was statistically significant from the prior year (p-value of 0.00), The Appropriate Treatment of Adults with Bronchitis rate also had a statistically significant improvement (p-value 0.01) but did not perform as well as competitors. All measures scoring in the 25th Percentile will be re-evaluated and their initiatives will be assessed.

A daily inventory of comments and concerns of our members, providers and facility are documented, review and answered. Each is processed based on the investigative results. The involved parties are contacted in a timely manner and informed of the results or how best to proceed. This is a continuous process in an effort to maintain or quickly identify quality of care issues and resolve them (See Appendix B: 2014 Patient Safety Program Executive Summary)

Service Quality

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
2014 initiatives focused on improving member satisfaction with customer service. A review of complaints, appeals and multiple call backs identified gaps in member understanding, leading to dissatisfaction with the information provided by customer service. Commonly available resources that members utilize to understand their benefits (specifically preventive services) often contain confusing and inconsistent language.

Efforts to improve our members’ understanding of the information provided to them centered on improving explanation scripts, implementation of 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.

Analysis of the 2014 CAHPS 5.0 Member Survey revealed that compared to 2013 information needed by members or in the company internet was more easily attainable. Also, there was a significant increase in courteous and respectful treatment from customer service when providing needed information from the health plans, members reported that overall there was on average 93.40% increase in 2014 from 88.84% in 2013. Further, members reported that providers were significantly more respectful, explained things in a way that was easy to understand, listened more carefully, spent enough time with our members, and seemed informed about care from other providers. The percentage of circumstances under which these always occurred increased to 85.59% in 2014 from 78.48% in 2013.

**Customer Service**
Customer service was tracked by soliciting members for getting information needed, being treated with courtesy and respect by our customer service department. Supplemental information assessed included but was not limited to, ease of access to customer service, accuracy of information provided by customer service and clarity of communication by customer service.

Compared to last year information provided in written form scored higher but ease of filling out forms did not. However, information provided from customer service and courteous and respectful treatment of members scored higher than last year.

**Getting care quickly**
Getting care quickly was tracked by the availability of routine and or urgent case as soon as needed. Supplemental information assessed included but was not limited to, timely response of health plan to provider request, delay in provider’s transfer of information to health plan, authorization timeliness, and ease of authorization process for providers.

**Getting needed care**
Members getting routine and or urgent care scored higher than the previous year
Getting needed care was tracked by how often members got appointments with specialist as soon as needed and how easily members got needed care, tests and treatments. Supplemental information assessed included but was not limited to, benefit coverage of service needed affecting cost to member, timeliness of care, convenience of appointment. Members’ ability to obtain care test or treatment and appointments scored higher than the previous years.
Healthcare Effectiveness Data and Information Set (HEDIS®)

The HEDIS team completed the HEDIS 2014 data abstraction. All HEDIS Hybrid activities continue to be conducted in house. This work involved enhancements to the medical record abstraction process, staff training, customization of abstraction tools, review of standards and enhanced provider medical record pursuit strategies. In addition, HEDIS 2014 was the eighth year that reporting was completed for HMO/POS/PPO as one combined HEDIS result. In 2014, the Company continued to use the NCQA certified software from Inovalon, Inc. to produce HEDIS 2014 administrative and hybrid rates. Also, MMO began it’s planning for the 2014 beta testing of Exchange data.

Reporting Parameters

The CQI department and Douglas Einstadter, M.D., MPH, Professor of Epidemiology and Biostatistics, Case Western Reserve University, performed all data analyses for clinical initiatives. The results were reviewed by the Chief Medical Officer and presented to the CQI Committee. Service related initiatives were reviewed by the Service Quality Improvement Committee (SQIC), which reports to the CQI Committee.

IV. Conclusion of Overall Qi Program Effectiveness

Analysis and evaluation of the overall effectiveness of the QI program, and its progress towards influencing network wide safe clinical practices, is measured through our CAHPS 5.0 Member Survey. Several important items driving our overall health plan rating are identified using CAHPS 5.0 Member Survey data, and include customer service, members getting care quickly and members getting needed care. Most specifically, customer service was identified as one of four opportunities our members indicated as most important to plan satisfaction. Customer service is defined, for this evaluation, as ease of filling out forms and ease of understanding the Explanation of Benefits (EOB).

Medical Mutual has significantly improved on the overall health plan rating compared to last year and continues to show growth over the last two years. Our initiatives continue to progress toward influencing network wide safe clinical practices as demonstrated in the Patient Safety Program Executive Summary, Mortality Executive Summary and the Quality Case Report. Medical Mutual remains determined to provide overall effectiveness in the industry through the QI program by addressing barriers and continuing to identify new opportunities for improvement.

Medical Mutual introduced a Marketplace Exchange health plan in 2014. All network and quality improvement programs implemented apply to the commercial and exchange plans. Although results were monitored to identify any unique outcomes for the exchange plan, none were identified. Analysis of CAHPS and HEDIS results will not be applicable until 2015. As we continue to add new Marketplace and Medicare Advantage products, the evaluation will include monitoring for differences between plans and enhancing the work plan as needed.

Entrance into the Medicare market was initially scheduled for January, 2015, but an overall analysis of corporate structure and resources indicated that additional time was needed to implement required staffing and programs put into place, so implementation was rescheduled for January 2016. This delay
allowed time to ensure that the existing, high quality and effective QI activities applied to our commercial and Exchange business could be offered to our Medicare products as well.