Quality Improvement

Humana®

CareSource™

Scope of the quality improvement (QI) program

Covers the assessment, monitoring and improvement of the following aspects:

- Care quality and safety
  - Accessibility to care
  - Availability of services
  - Physical and behavioral health care
  - Outcomes of care delivery

- Service quality
  - Customer services
  - Utilization management
  - Care management
  - Disease management
  - Pharmacy programs

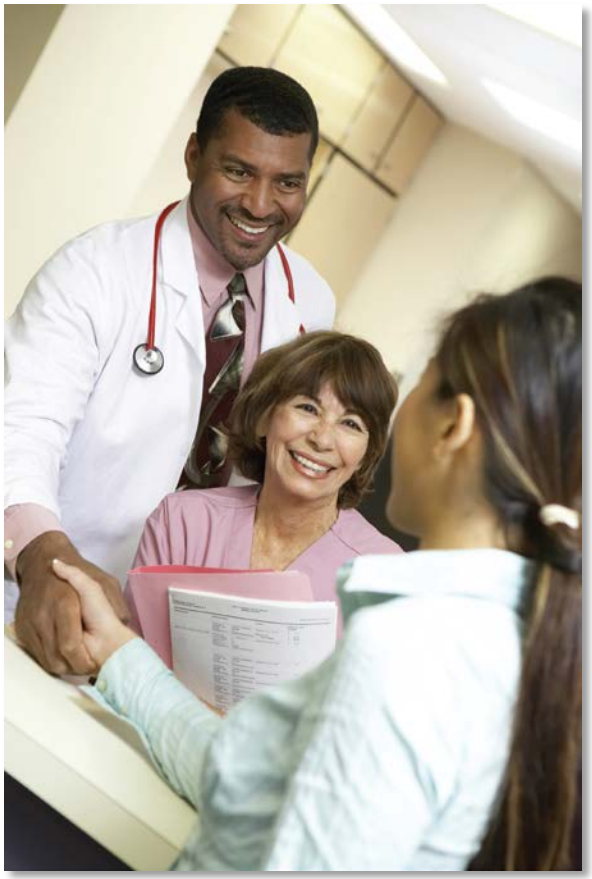
- Care and service experience for members and providers
  - Member and provider satisfaction
  - Review of accessibility and availability standards
  - Utilization trends

QI program goals and objectives

- Improve clinical outcomes for members
- Improve member, provider experience and satisfaction
- Ensure safety of members across settings
- Assess and meet members' cultural and linguistic needs
- Ensure access and availability of care
- Ensure care coordination and continuity of care across settings
- Ensure practitioner adherence to clinical practice guidelines
- Maintain collaborative relationships with network providers, practitioners and regulatory agencies
- Ensure federal and state regulatory compliance and accrediting agency compliance (e.g., CMS, KDMS, URAC and NCQA)
- Identify QI opportunities to develop evidence-based best practices

Healthcare Effectiveness Data and Information Set (HEDIS®) overview

- Tool used by more than 90 percent of health plans in U.S.
- Measure performance on important dimensions of care and service
- HEDIS scores are compiled using claims and medical records



HEDIS measure overview

Adult Body Mass Index (BMI)

- The percentage of individuals 18 to 74 years old who had an outpatient visit and whose body mass index was documented in the medical record.

Controlling high blood pressure

- Individuals 18 to 85 years old with a diagnosis of hypertension with blood pressure readings documented in the medical record and controlled (for HEDIS reporting this measure is defined as greater than 140/90).

Weight assessment and counseling for nutrition and physical activity for children/adolescents

- The percentage of members 3 to 17 years old who had evidence of the following during the measurement year:
  - BMI percentile documentation
  - Counseling for nutrition
  - Counseling for physical activity

HEDIS measure overview

Annual dental visit

- The percentage of members 2 to 21 years old who had at least one dental visit during the measurement year.

Lead screening

- The percentage of children 2 years old who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Well-child visits in the first 15 months of life

- The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a primary care physician (PCP) during their first 15 months of life. The well-child visit must have the following components:
  - Health education/anticipatory guidance
  - Physical exam
  - Health and developmental history (physical and mental)

HEDIS measure overview

Well-child visits in the third, fourth, fifth and sixth years of life

- The percentage of members 3 to 6 years old who had one or more well-child visits with a PCP during the measurement year. The well-child visit must have the following components:
  - Health education/anticipatory guidance
  - Physical exam
  - Health and developmental history (physical and mental)

Adolescent well-care visits

- The percentage of enrolled members 12 to 21 years old who had at least one comprehensive well-care visit with a PCP or an obstetrician-gynecologist (OB/GYN) practitioner during the measurement year. The well-care visit must have the following components:
  - Health education/anticipatory guidance
  - Physical exam
  - Health and developmental history (physical and mental)

HEDIS measure overview

Children and adolescents' access to PCP

- The percentage of members 12 months to 19 years old who had a visit with a PCP.

Adults' access to preventive/ambulatory health services

- The percentage of members 20 years old and older who had an ambulatory or preventive care visit during the measurement year.

Seven-day follow-up after hospitalization for mental illness

- Individuals 6 years and older who were hospitalized for treatment of selected mental health disorders must have a follow-up consultation with a mental health practitioner (e.g., psychiatrist, psychologist, psychiatric nurse practitioner or clinical nurse specialist, masters prepared social worker, certified marital and family therapist [MFT] or professional counselor [PCC, PCC-S]) within seven days of discharge.

HEDIS measure overview

Prenatal and postpartum care

- The percentage of live-birth deliveries between Nov. 6 of the year prior to the measurement year and Nov. 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:
    - **Timeliness of prenatal care** – The percentage of deliveries that received a prenatal care visit as a member of Humana – CareSource in the first trimester or within 42 days of enrollment in the organization
    - **Postpartum care** – The percentage of deliveries that had a postpartum visit on or between day 21 and day 56 days post-delivery

Humana – CareSource HEDIS focus areas

Diabetes

- HbA1c testing
- HbA1c less than 8 percent (A1c control)
- BP less than 140/90 mm Hg
- Eye exam
- Medical attention to nephropathy

Prenatal/postpartum

- Frequency of ongoing prenatal care
- Postpartum care
- Timeline of prenatal care

Behavioral health follow-up

- Follow-up after hospitalization for mental illness, seven-day follow-up

Women's health care

- Cervical cancer screening
- Breast cancer screening

Well-child care and immunization 0-6 years

- Well-child visits in the first 15 months of life (visits)
- Well-child visits in the third, fourth, fifth and sixth year of life
- Childhood immunization status
- Dental
- Lead screening

KY Medicaid: Objectives

- Improve access, coordination of care
- Provide health care at the local level through the managed care system using public and private providers
- Redirect the focus of health care toward primary care and prevention of illness
- Monitor and improve the quality of the health care delivery system
- Increase health promotion efforts, psychotropic medication management and suicide prevention
- Implement effective and responsive cost-management strategies in the health care delivery system designed to stabilize growth in Medicaid costs

KY Medicaid: Top six targeted health conditions and trends

- Diabetes
- Coronary artery disease screenings
- Colon cancer screenings
- Cervical/breast cancer screenings
- Mental illness
- Reduction in emergency department (ED) usage/management of ED services

KY Medicaid: State-specific measures

- Develop performance measures in collaboration with the commonwealth based on key areas of interest for KY Medicaid population
- Align with the Healthy Kentuckians 2020 Leading Health Indicators
- Address access to, timeliness of and quality of care provided to children, adolescents and adults enrolled in managed care organizations and focuses on preventive care, health screenings and prenatal care, as well as special populations (adults with hypertension and Children with Special Health Care Needs [CSHCN])

KY Medicaid: State-specific measures

- Cholesterol screening
- Prenatal and postpartum risk assessment counseling, education
- CMS-416 EPSDT services: Dental services
- Adolescent preventive screening/counseling
- Individuals with special health care needs (ISHCN) access and preventive care
- Weight assessment, nutrition and physical activity counseling for children and adolescents
- Weight/BMI assessment, nutrition and physical activity counseling for adults

Current Performance Improvement Projects (PIPS)

- HbA1c control
- Physical health risk screening in the seriously mentally ill population
- Well-child visits in the first six years of life with combined interventions
- Smoking cessation among pregnant members

Care4U Care Management

Care4U population health

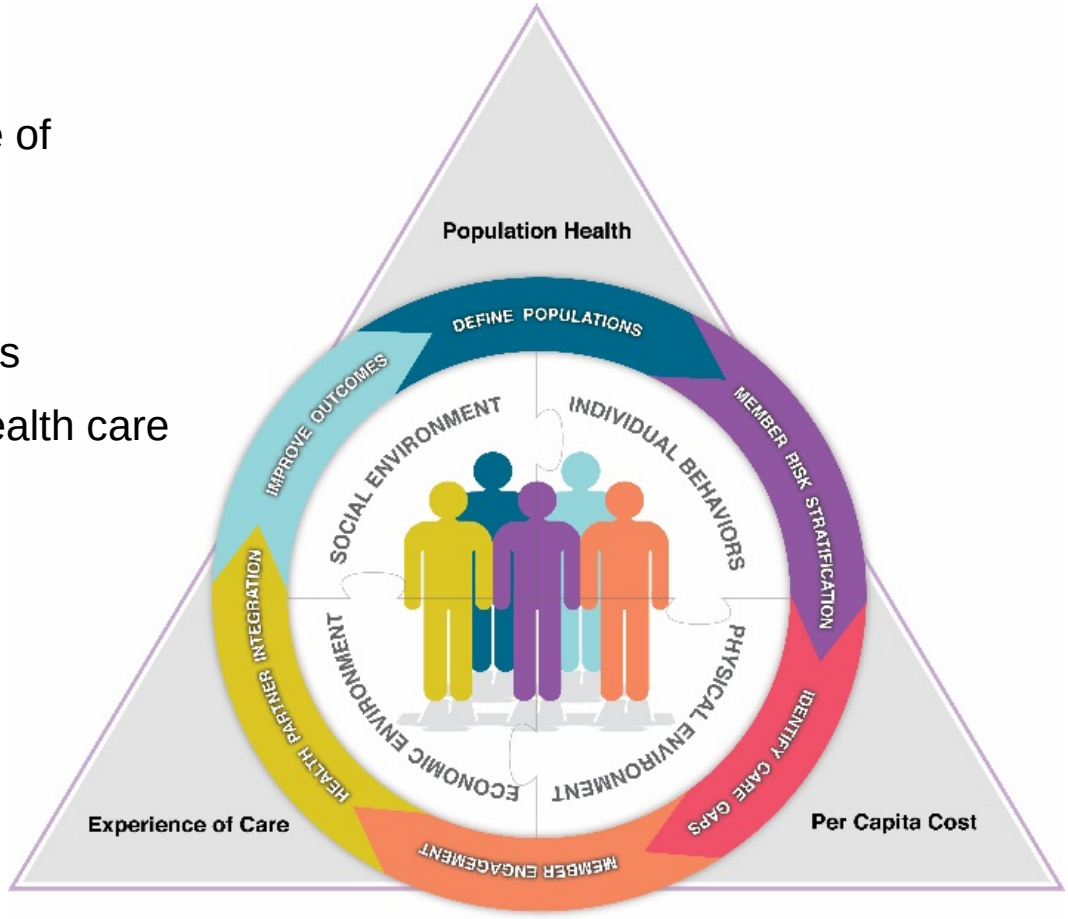
- Dynamic, community based member-centric model of service delivery
- Designed as a population health management approach with care coordination for members
- Multidisciplinary teams responsible for a defined population and sub-populations in the commonwealth of Kentucky

Identifying members for case management/care coordination

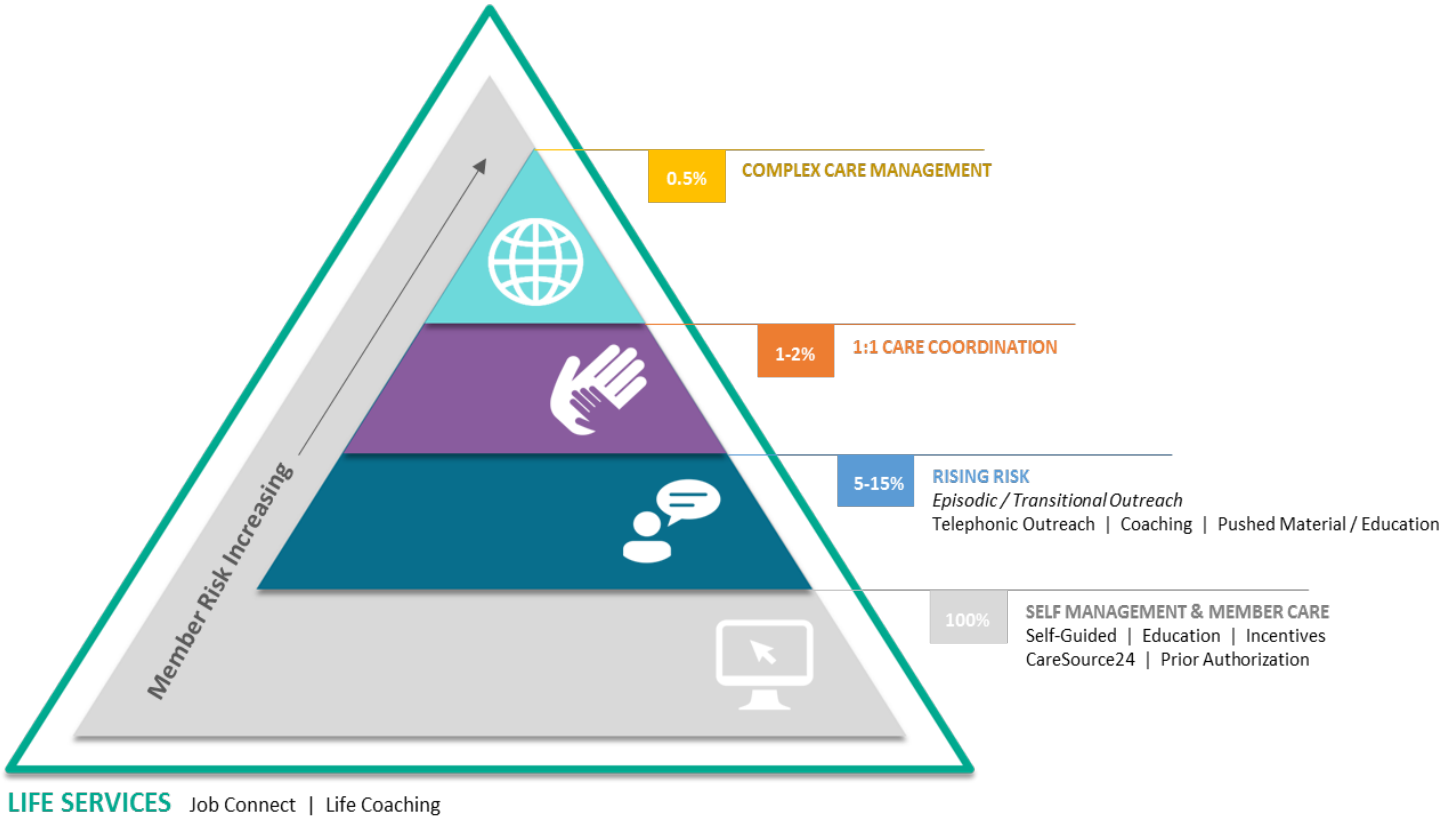
- Adhere to no “Wrong Door Policy”
- Use advanced analytics to understand and prioritize the care needs of the entire membership within Kentucky
- Use analytics to gain understanding of prevalent medical, social and behavioral needs, patterns of care and barriers to access for members

Care4U care management goals – TRIPLE AIM

- Improving the member experience of care (including clinical quality and satisfaction)
- Improving the health of populations
- Reducing the per-capita cost of health care



Care4U model



Care management member self-management tools

Health risk assessment – Must be completed by members within 90 days of enrollment

MyHealth – Online tool/assessment that can provide members health assessments with journeys to assist with education for targeted areas based on their personal assessment.

MyStrength – Online tool/assessment that can provide members behavioral health assessments with journeys to assist with education for targeted areas based on their personal assessment.

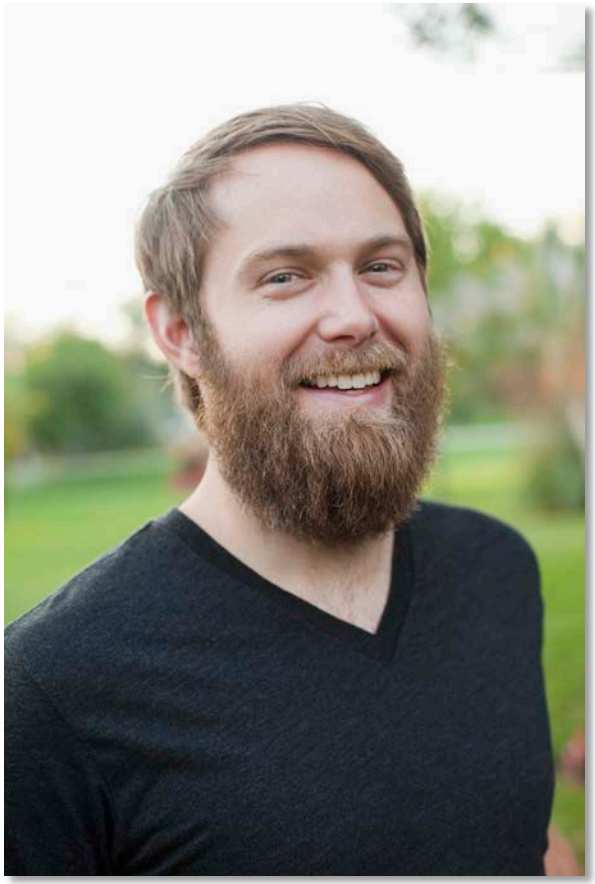
Care4U case management and care coordination process

Case management

- Member assessment
- Goal development
- Care plan development
- Member follow-up

Care coordination

- Member assessment
- Care coordination assistance
- Social services assistance



Our KY market team

Regional staff throughout Kentucky

- RN care managers
- Social work (SW) care coordinators
- Community health workers